At the Intersection of Health Care and Human Rights: Violations of Medical Neutrality and The Emergence of Medical Resistance

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In 2011, Egyptian doctors were screaming at soldiers who are beating them that they are doctors, that their white coats set them apart, and that they are just trying to do their job. In 2013, Turkish doctors were being tear gassed, while attempting to treat patients through the choking smoke aimed at their makeshift infirmaries. In 2020, medics participating in Black Lives Matter protests were tear gassed and shot with rubber bullets while trying to treat protestors injured with the same military grade weapons. As asymmetrical conflicts—where one side holds more power than the other—have increased in occurrence across the globe, medicine and medical professionals providing care to protestors have increasingly come under direct threat. However, according to international humanitarian law, particularly the norms of medical neutrality, access to health care during conflict is a human right, and the delivery of medical care should be protected even in the direst of conflicts.

There are documented cases of doctors emphasizing that their assistance to protestors is not a political statement, and insisting that they are truly neutral actors in the conflict (Hamdy & Bayoumi, 2015; Aciksoz, 2015). However, it appears that operating under the traditional assumption of medical neutrality is increasingly difficult in contemporary state-civilian conflicts, when medicine is increasingly targeted by state violence, and doctors find themselves inadvertently choosing the side of the more vulnerable (protestors) during conflicts. When medicine becomes politicized, as it has in the cases above, what becomes of medicine, medical neutrality, and the medical professionals who seek to uphold it?

To understand, challenge, and reframe current paradigms regarding human rights, medical neutrality, and conflict protocol, this paper will conduct a theoretical and critical analysis of existing literature and their implications for past and current events. In showing how medical neutrality reaches its limits during crisis, I explore both direct and indirect violence perpetrated by the state and subsequent implications for the delivery of health care during conflict. I also apply Hollander and Einwohner's conceptual model of resistance to medical practices in intrastate conflicts, and argue that professionals within the medical community have actively used medical practice to resist state oppression

in conflict zones. In demonstrating the increasing difficulty of maintaining medical neutrality and the extent of medical resistance, I investigate cases of intrastate conflicts in Egypt, Palestine, Kashmir, and the United States.

In the cases I describe, when medical neutrality is violated, medicine becomes political in two ways: medicine becomes a target of state violence, and in turn, medical professionals resist oppression and may become political actors. This political action can take multiple forms of resistance; medical professionals may resist the actions of oppressive states by speaking against the state or using medical practice to actively aid in protest efforts. By examining the actions and intentions of medical personnel during social and political conflicts as a result of medicine being politicized, an emerging movement of medical resistance can be seen as medical professionals use their skills and occupation as their mode of resisting occupation and oppression.

Violations of Medical Neutrality by States

The principle of medical neutrality, which Physicians for Human Rights defines as "the principle of noninterference with medical services in times of armed conflict and civil unrest" (Physicians for Human Rights, 2019, para. 1), dates back to 1864, when the first Geneva Convention established that during war, medical personnel, equipment, and facilities should remain unharmed (International Committee of the Red Cross, n.d.). Medical neutrality stipulates that in conflicts, opposing sides should allow medical resources and personnel to remain unharmed in the midst of all violence, so that doctors and nurses can continue treating the injured in an objective and impartial manner. In return, doctors and nurses perform their duties as neutrally as they can, providing care to all regardless of race, religion, or political affiliation. Around the world, doctors invoke this principle to justify tending to injured protestors and other dissidents during conflict.

The conditions for health care to be provided safely are clearly defined in international law, yet, we continue to see countless documented abuses and violations of these conditions all over the world. During the 2011 Arab Spring protests in Egypt, doctors initially avoided participating in the protests, and thus were not subjected to the same police brutality that protestors endured. They were marked by their white coats and consequently spared by police and other military forces, as was appropriate per the practices of medical neutrality. This was the norm until November 2011, when protests resumed, and, for the first time, doctors found themselves to be the targets of police violence. Doctors were arrested, shot at, and beaten in the streets (Hamdy & Bayoumi, 2015). This provides the first of many examples of how medicine is politicized; in this scenario, medicine and medical professionals became a victim of the political conflict, initiating the first step in medicine itself becoming politicized on both sides of the conflict.

Similarly, in the winter of 2008 in Palestine, dozens of medical facilities and ambulances were bombed by the Israeli military, resulting in the deaths of medical personnel (Pfingst & Rosengarten, 2012). During popular protests against Indian rule in Indian-controlled Kashmir in 2016, according to a report by the UN Office of the High Commissioner for Human Rights, doctors, paramedics, and ambulance drivers were physically assaulted by security forces (Office of the United Nations High Commissioner for Human Rights [OHCHR], 2018). As Hamdy and Bayoumi (2015) argue, when we observe the state failing to uphold its national obligation to protect its citizenry, we cannot expect for them to then uphold any sort of international obligation to protect medical neutrality. These incidents reveal the ways in which democratic governments all around the world are violating medical neutrality and committing human rights abuses. Contextualizing these events with the experiences of doctors and medics reveals how medicine becomes political; as the state inflicts violence on medical professionals and instigates the first violation of medical neutrality, it becomes easier to understand why medical professionals would seek to resist oppression and operate in favor of the protestors.

Another example of state-inflicted violence on both civilians and medical personnel is that of "atmospheric violence." This form of violence was first conceptualized by Peter Sloterdijk, who posited that military use of poisonous gases introduced a new age of warfare in which the atmosphere and surrounding environment become the main target, rather than the physical body (Sloterdijk, 2009). Documented cases of such violence can be found in Egypt, Palestine, and Kashmir, with police and military forces deploying techniques of chemical warfare. Hospitals in Tahrir, Egypt and Srinagar, Kashmir were targeted with teargas canisters, creating uninhabitable work environments and preventing doctors from providing care to those injured in the field (Hamdy & Bayoumi, 2015; OHCHR, 2018). In Palestine, land was found to be toxic due to the use of poisonous munitions such as carcinogenic tungsten shrapnel, leaving the land inhospitable and noxious to future inhabitants (Pfingst & Rosengarten, 2012). The implications of atmospheric violence are less obvious and may go unrecognized as violence in the eyes of the international community. This is because the severity of such human rights abuses is often hidden behind the veneer of humane methods of "crowd control," allowing officials to defend the actions of their security forces by labeling them as nonlethal. Regardless of the debate whether atmospheric violence is moral or immoral, it still interferes in the operations of medical personnel and thus is a violation of medical neutrality. Consequently, this violation contributes to the aforementioned politicization of medicine; atmospheric violence prevented the work of doctors and medics and violated their work spaces. Interfering with their work due to a political conflict politicizes the very role that medicine plays and inclines medical actors to resist state violence.

Structural Violence and its Visceral Remains

While instances of direct violence against civilians, medical personnel, and medical infrastructure are shocking, they are more rare than instances of indirect, structural violence committed against vulnerable populations. The insidious nature of structural violence is harder to place and therefore often goes unidentified in the broader spectrum of human rights abuses. One way in which states inflict structural violence is by manipulating medical professionals. In Egypt, the state was known for pressuring doctors to mistreat and even torture protestors if the state needed information from them. They were also pressured to falsify medical information, such as lying about someone's cause of death on the death certificate to make it look like an accident (Hamdy & Bayoumi, 2015). In Palestine, nurses work for little to no pay for weeks at a time due to delays in processing their paychecks on the state's part (Wick, 2008). This forces nurses to compromise their needs and choose between their commitment to providing medical care and caring for their families. In this situation, although the medical professionals were not being directly physically harmed, their work was being obstructed and they were not allowed to practice medicine impartially. This too counts as a way in which medicine is politicized; in this case, the state is attempting to use medical actors as a tool in the conflict, using medicine to further their agenda and oppress the dissidents.

The consequences of sustained violations of medical neutrality are visceral and become embedded in the collective psyche of the people. In Egypt, people have a deep mistrust of the state, and, as a result, have a deep mistrust of doctors and state medical resources (Hamdy, 2008). A doctor's medical education is the result of a public education system, which is controlled by the state. This knowledge, coupled with the instances in which doctors are used in interrogations to torture protestors and falsify death certificates, is more than enough to create a lasting suspicion in the minds of the Egyptian people. This is harmful to health care infrastructure because a central necessity of effective health care is trust between the patient and physician. This mistrust will likely carry on for generations to come, and the lack of trust between Egyptians and state medicine will continue to erode the health care system. Additionally, there have been incidents of the state discrediting medical professionals who speak out against them, calling them "druggies, spies, or thugs," creating a poor image of doctors and nurses in the public eye and further reducing public trust in the health care system and making individuals less likely to seek necessary medical attention (Hamdy & Bayoumi, 2015, p. 232). This lack of trust in the public health care system runs so deep in the Egyptian people that they recognize their health problems as larger extensions of all the shortcomings of their country. In interviews done by Dr. Sherine Hamdy in an Egyptian dialysis ward, her interlocutors revealed their perceptions of their illness and explained their understanding of how their

suffering was a result of a domino effect of many underlying issues in Egypt. They connected their failing kidneys to contaminated food and water, which were caused by broken sewage systems, which were caused by a corrupt state that put profits over people and refused to address crumbling infrastructure (Hamdy, 2008). They were able to place their chronic medical condition within the broader scheme of Egyptian politics and public administration, demonstrating an acute awareness of how their state had failed them. Egyptians are not alone in this mistrust of the state. In Kashmir, protestors are afraid to get medical help due to fear of being arrested in the hospitals. (OHCHR, 2018). In Israel, Palestinians are afraid to go to Israeli hospitals because they fear that they will be treated worse than Israeli patients (Wick, 2008). With such evident cases of structural violence, it is no wonder why civilians in conflict zones have such a deep mistrust in their state and are unable to bring themselves to put their faith in their health care system. The civilians' evident knowledge of their crumbling healthcare infrastructure being a result of state neglect and violence aids in contextualizing the politicization of medicine; though it is not physically violent nor a deliberate action the state in the midst of conflict, the healthcare system exists as a victim of state neglect and furthers negative sentiments harbored by protestors and medical professionals alike when they come under attack.

Other forms of structural violence include the deliberate and systematic obstruction of medical services, such as those enforced in Kashmir and Palestine. In Kashmir, curfews and communication blockades affected the ability of individuals to get the medical attention that they needed in a timely manner. The same curfews also affected the ability of doctors to reach patients at the hospital and prevented them from providing medical services (Anjum & Varma, 2010). This kind of structural violence, while not immediately recognized as violence according to international human rights accords, is extremely detrimental to health care infrastructure and prevents doctors from doing their work effectively and impartially. Similar types of violence can be observed in Palestine: checkpoints, road closures, and curfews prevent Palestinian people from accessing healthcare in times of dire need (Wick, 2008). Ambulances are constantly held up at checkpoints, causing a delay in medical treatment, at times even resulting in the death of the patient being transported (Pfingst & Rosengarten, 2012). These kinds of delays, those that leave people in waiting for hours when their life is on the line, ultimately inflict harm in the same severity that direct violence does. Patients are required to get permits to cross certain checkpoints, but usually face delays in obtaining these permits (Wick, 2008). Even upon obtaining a permit, patients who brave the checkpoints during normal hours are inundated with long wait times and pointless interrogations that cause them to miss their appointments and further delays medical treatment (Pfingst & Rosengarten, 2012). This kind of structural violence takes the form of administrative and bureaucratic inefficiency, and is a

deliberate strategy used to repress and increase the suffering of civilians. Here, healthcare is withheld as a political punishment and demonstrates, again, how medicine is politicized and targeted in intrastate conflicts.

The Transformation of Medical Neutrality

Peter Redfield argues that medical neutrality is a vestige of interstate war and should be reevaluated in the context of intrastate conflicts (Redfield, 2013). I agree and, based on the given examples above, I would even extend his argument to say that medical neutrality is no longer able to protect medical professionals during conflict. The whole purpose of medical neutrality was that each combative side would reap some sort of benefit from following the principle. Under medical neutrality as it functions in interstate conflicts, each side can rest assured that their own wounded soldiers will receive proper medical attention from their opponent, provided that they also provide medical care for enemy soldiers who are in need. This model of health care during conflict does not work in intrastate conflicts due to the asymmetrical nature of the conflict; the state is far more powerful in this scenario and does not benefit from upholding medical neutrality. In such situations, there is no incentive for the state to provide medical care when their opponents are their own people, which, in their view, absolves the responsibility to uphold medical neutrality. Thus, we are presented with our first gap in the current model of medical neutrality: lack of accountability.

As a consequence of the aforementioned lack of accountability, states no longer feel obligated to abide by the policy of noninterference in medical resources and care. While medical neutrality should ideally create a safe and neutral environment in which doctors can freely practice medicine, in reality, doctors are never provided with adequate circumstances to practice true medical neutrality. As a product of the state, doctors are investments that the state chooses to call upon. And, because the state is in the position of power within the frame of the state-civilian conflict, they will inevitably put pressure on the medical community to serve their interests. An example of this can be found in a testimony given by a doctor in Egypt, who was trying to explain to a police officer that he was simply attempting to do his duty and treat the injured, and that he should have immunity from the brutality in the streets. The officer responded, “it is I who orders you who to treat” (Hamdy and Bayoumi, 2012, p. 229). Health was, in this case, viewed as a political tool, and the doctor’s role was reduced to an agent of the state. Additionally, the difficult conditions that the medical personnel are forced to work in further puts pressure on them. When a doctor is pressured by the state to torture a dissident or to falsify information regarding the health conditions of a patient, they are breaking their commitment to provide medical care equally and impartially. This is where the paradox is presented; any attempt at medical neutrality in accordance with the state is not true neutrality and it favors the side of the oppressor, due to the inevitable

pressure that one will receive from the state. On the other hand, medical neutrality itself becomes problematic in the context of asymmetrical conflict, in which aid to civilians becomes so much more necessary than aid to state actors (who have their own health infrastructure and resources). As described by Hamdy and Bayoumi (2015), "to practice medicine at all was to take a stand against the State's dehumanization of the protestors" (p. 236). The notion of medical neutrality rests on a sense that both sides are equal; yet, this is less and less true in situations of domestic unrest that we are seeing erupting all over the globe. Yet, when doctors intercede on behalf of the most vulnerable, they become susceptible to critiques of bias and politicization.

The consequence of this is that medical personnel are now forced to choose between putting their lives at risk by supporting the protestors or becoming political tools manipulated by the state. By failing to create a neutral environment for health care staff to effectively perform their duty, the state is not honoring its side of the commitment to medical neutrality. As a result, medical personnel feel the need to resist politicization by the state and sway their favor and support to the side of the dissidents. This phenomenon can be observed in multiple accounts of doctors in conflict zones. For example, a doctor in Egypt, after viewing the police aiming their weapons at a hospital, completely understood and supported the mission of the revolution (Hamdy and Bayoumi, 2015). It appears that upon seeing the injustices being committed, medical personnel will choose to support the side of the protestors and throw themselves fully behind the cause, shedding all pretenses of neutrality. Another instance of this can be observed in Palestine, where many prominent medical figures in the public eye are also key political players in Palestinian political parties (Wick, 2008). This demonstrates how seeing the state act against those not in power will push "medical neutrality" to favor the dissidents. Medical personnel can only allow themselves to practice medical neutrality so long as the state continues to create an environment in which medical neutrality can be practiced. If the state breaches this tenuous relationship in any way, medical neutrality ceases to exist, and the medical personnel are forced to make the choice between helping the protestors or submitting to the state, further negating the intentions of medical neutrality. In a way, this both balances and imbalances the scale of the conflict. It balances the power dynamic slightly more, giving more traction to the protestors with the medical and political support of the doctors, yet imbalances the political forces at play due to the doctors no longer being truly "neutral" actors in the situation.

Expanding the Definition of Resistance

In order to understand why something as empirical and neutral as medicine can be used to both further and subvert state violence, the definition of resistance must be expanded to fit the many varied forms of resistance. Resistance is the result of medicine being politicized, and it

explains how medical actors become move from a neutral position to a political one in opposition to the state. The word resistance brings to mind images of protests, riots, and social revolutions as powerful statements against an oppressive adversary, often challenging governments or social institutions. This is how resistance is most commonly defined, "involving the resisters' use of their bodies, or other material or physical objects" (Hollander and Einwohner, 2004, p. 535). Indeed, these methods of outward, unmistakable resistance gain the most recognition in the public eye. However, resistance comes in many different forms; some are visible and recognizable, like protesting, but others are more subtle yet equally powerful and important.

Many scholars refer to resistance as synonymous with social movements, protest, and material resistance, such as marching (Hollander and Einwohner, 2004, p. 535). Loud, vocal expression is characteristic of this kind of resistance, such as that seen in the #MeToo movement, allowing women the space and courage to come forward with experiences of sexual assault. However, there are a multitude of other actions whose characteristics can be considered resistance as well. Symbolic expressions, such as art, music, and dance can also be ways of preserving one's identity and experience. An example of this can be seen when Hawaiian women used their traditional stories, dance, and native language to resist and protest the annexation of Hawaii to the United States (Hollander and Einwohner, 2004). It can also be seen in the absence of noise, in the silence that occurs when someone kneels and refuses to recite the United States Pledge of Allegiance. Though these actions have different characteristics and qualities in their execution, the intention is the same; to express opposition to a given action, institution, or status quo. As posited by Jocelyn Hollander and Rachel Einwohner (2004), "the concept of resistance is socially constructed," and thus the definition of resistance can be expanded and understood in many other methods and forms (p. 548).

According to Hollander and Einwohner (2004), the classification of resistance comes down to recognition and intent. For an action to be classified as resistance, it must first be recognized as resistance, by either the actor, the target of the action (usually the oppressor, to whom the resistance is directed), or the observers. It is here in the literature on recognition and intent that many scholars disagree on how to classify an action as resistance. Some scholars believe that an actor must intend for their action to be considered resistance for it to count as such. However, another group of scholars contends that intent is difficult to identify from an outsider's perspective, as an actor may be incapable of expressing intent, making it an inefficient and potentially inaccurate way of studying resistance. Yet a third group of scholars believe that intent can be impossible to determine and argue that resistance can be subconscious (Hollander and Einwohner, 2004, pp. 542-543). This disagreement on the classification of resistance can make it difficult to study resistance in terms of intention, due to resisters often having to hide their actions and be

discreet for fear of further persecution at the hands of the oppressor. Additionally, it can be difficult to study instances of resistance when the resister hides their actions from public view (Hollander and Einwohner, 2004, p. 540); if an action cannot be viewed by anyone other than the resister, neither the target nor an observer can recognize the action as resistance. However, this does not diminish the action's validity as an act of resistance; it simply means reframing models of resistance to better fit contemporary conflicts.

Hollander and Einwohner (2004) provide a working definition of the concept of resistance and propose seven forms of resistance, four of which I will focus on in this analysis. Overt resistance is the most obvious form of resistance that is most visible and easily recognized as resistance by the actors, targets, and observers, such as protests, riots, and rallies. Covert resistance includes acts of protest that are intentional, but go unnoticed by the targets, such as messages spread by word of mouth or deliberate yet subtle attempts to impede or delay the actions of oppressors. Unwitting resistance occurs when the actor does not intend for their actions to be considered resistance, but a target or observer classifies it as such. Target-defined resistance occurs when an actor does not intend for their action to be considered resistance, yet is recognized as resistance by the target and the target only (p. 545).

It is, of course, important to note that there are limitations to using this model. For one, as a third party observer, one has a restricted view and interpretation of the resister's actions; without witnessing the action firsthand or talking to the resister, it is impossible to analyze every facet of the incident from a researcher's perspective. Additionally, it is possible that the same action can be classified as more than one type of resistance, depending on either the intention of the resister or the perspective of a scholar interpreting the event as an observer. Nonetheless, by using these definitions of resistance and by analyzing various interviews with resisters, I can attempt to classify their actions as resistance to some extent, enough so to frame my argument that the medical community uses medicine to subvert political authority and resist state violence. Resistance is crucial to understand as the second step in the politicization of medicine, showing how the state's targeting of medicine and medical professionals (step one) functions to turn the medical community in favor of the dissidents and causes them to actively resist all forms of oppression by the state.

Medical Practices as Resistance and a Subversion of Political Exploitation

It is common for doctors, nurses, and other medical personnel to work during protests; after all, it is their duty to provide medical care to everyone who is in need. However, in cases where doctors tend to patients in the streets in the midst of protests, their choice to practice medicine "requires a political stance that directly challenges the status quo of state

violence" (Hamdy & Bayoumi, 2015, p. 225). In choosing to aid protestors in medical need, medical personnel recognize that unjust bodily harm has come to innocent people. Since this individual has come to harm at the hands of the state, the doctor, nurse, or medic is choosing to act in defiance of the state's actions, and is thus acting in resistance. In my research, I came across three distinctly compelling cases of medical resistance in Egypt, Palestine, and the United States that I will use to elaborate on my application of the concept of resistance.

Revisiting the Arab Spring protests of 2011 in Egypt, doctors were pressured to protect and aid the state by giving up protestors to the police, falsifying medical records of protestors' causes of death, and even torturing political dissidents (Hamdy & Bayoumi, 2015). Seeing the treatment of the protestors at the hands of the Mubarak regime spurred many doctors to action, compelling them to donate medical supplies and provide aid to protestors in the field hospitals. Many doctors initially claimed that they did not support the protests; one doctor, in particular, stated that he did not agree with the protests' message initially, and provided medical services out of a "sense of duty as a physician" (Hamdy & Bayoumi, 2015, p. 236). It appears as though he felt compelled to join the fray to uphold the mission of medical neutrality rather than to sympathize with the protests' cause. Though doctors may not have intended this as a political act, it was read by the Egyptian state as resistance. The state took this act of resistance as a threat and saw it as the medical community aligning themselves politically with the protestors; thus, this "resistance" can be categorized as target-defined resistance from the state's perspective, and unwitting resistance from the "resister's" perspective. The military retaliated towards medical personnel by targeting their white coats, and "aiming their guns… at the hospital" (Hamdy & Bayoumi, 2015, p. 236). After this experience, many doctors "[became] a complete supporter of the protesters and the revolution" (Hamdy & Bayoumi, 2015, p. 236). This shows how unwitting resistance—in this case, imparting medical services—can transform and become overt resistance: intentional, observable, and recognizable by targets and third parties alike. Many doctors "joined the street demonstrations as protestors themselves" over grievances such as security for doctors, rights of poor patients, and lack of government health care spending, demonstrating another act of overt resistance (Hamdy & Bayoumi, 2015, p. 236). When the state manipulated doctors and used their medical abilities to hurt civilian protestors, as with the torture of protestors and falsification of information, the state used medicine in a way that is contrary to its purpose of promoting health and well-being. In response, medical personnel subverted the exploitation of their practices by the state, and ultimately used their training to aid in resistance; the medical community took their practice, the very skill being used by the state to oppress political dissidents, and used it to actively resist the state's actions. By using medical practice to treat protesters and aid in their

efforts, doctors were supporting the Arab Spring and making a political statement, risking becoming targets of state violence themselves.

In Palestine, medical professionals are often in the front lines of resisting oppression as well, although their methods are different from that of Egyptian doctors and medics. Since Palestinians have to combat Israeli occupation, their methods of resistance are less traditional in the sense that many of them defer from outright protesting in the streets. Israeli occupation of Palestine, an ongoing crisis, created a system of curfews, checkpoints, and closures that cut off Palestinians' access to medical care and other essential services (Wick, 2008). Many Palestinian officials believed that the only lasting solution to this issue was building infrastructure, and they did so by fighting for permits, licenses, and other legal avenues to resisting oppression. They did this publicly, following the nature of the *Sumud* movement that encourages staying steadfast and persisting openly, "with the tolerance of the occupier" (Wick, 2008, p. 336). Eventually, with persistence, the Israeli government had to comply with requests, and Palestinian officials were able to open departments and bring many modern medical technologies to Palestinian territories (Wick, 2008). This method of resistance fits the characteristics of overt resistance, as the actors, targets, and observers recognize that the actors are actively resisting their oppression. A more subtle way of resisting the effects of occupation was by creating a working network of health care professionals that could be reached by phone in the event of a medical emergency. The system arose out of a need for medical guidance for women who went into labor during curfew and could not get to hospitals in time. A family could simply call a number and be referred to someone who could guide the mother and father or other family member through childbirth (Wick, 2008). The result was a fluid, self-sufficient operation that could help women to "avoid the fear, humiliation, and danger" of having to reach a hospital during curfew and also actively resist the isolating effects of occupation (Wick, 2008, p. 347). This network of care fits the qualities of covert resistance, as the act of resisting the effects of curfew were intentional, but were not recognized by the Israeli state, since the network was essentially just a series of phone calls. These actions by Palestinian medical professionals demonstrate a way in which the medical community subverts political exploitation by using medical practice. Despite the Israeli government's attempts to keep the Palestinian health care system crippled and ineffectual, the doctors found a way to continue providing medical care that was accessible to most everyone, working around the curfews and checkpoints. The Palestinian ways of resistance perfectly illustrate how resistance comes in many forms, and demonstrates the ways in which the medical community plays a significant role in actively resisting oppression from political actors.

Finally, there are many recent cases of medical resistance that can be seen in the United States, particularly as a result of the Black Lives Matter protests that started in late May 2020. Protests erupted all across the nation

in outrage over the murder of George Floyd, the most recent of countless black people who died due to police brutality. In response, the federal and state governments authorized police and military force against protestors, often in the form of rubber bullets and tear gas. In many cases, medics and medical students were initially civilian participants in the protests, not actively seeking to use their medical skills in the protests. A medical student noted that she attended "as a sign that there is someone in the medical community who is here supporting the cause" (Grillo, 2020, para. 2). Upon seeing a protestor injured for the first time, she stepped in to help out of impulse; afterwards, the student took care to bring medical supplies with them to future protests to best put her skills to use, stating that she "decided to just continue going to the protests with the purpose of actually helping people who were hurt" (Grillo, 2020, para. 4). The circumstances of these protests resonate with that of medics in Egypt, with the medical professionals acting after reacting to the horrific situation in front of them. Not only are they recognizing that the police brutality inflicted disproportionately on black and brown people is wrong, but that the violence inflicted on Black Lives Matter protestors is also wrong. Although their first reaction was to simply use their training where they saw fit, by continuing to use their training with the explicit purpose of aiding protestors, medics are now actively resisting the state's actions, using medical knowledge to combat the effects of the state's violence and facilitating the safe continuation of protesting. This fits the characteristics of unwitting resistance becoming transformed into overt resistance; not intended as resistance at first, but recognized as such by the targets and observers, and in turn shifting into intentional resistance. And, similar to Egypt again, there have been many reports of medics themselves being shot with rubber bullets or sprayed with tear gas, even though they can clearly be seen treating patients (Grant & McDonough, 2020). This sort of behavior by law enforcement, deliberately attacking medics, further suggests that this kind of resistance by medical professionals can be classified as overt resistance, as it is clear that the target (the state and law enforcement) is also recognizing the action as resistance. Additionally, other doctors are addressing the crisis in a different way, taking to social media and the news to share important medical knowledge and start difficult conversations about racial injustice in the United States. Some doctors have taken to social media to educate people on disparities in health care that black people face, such as a doctor who went viral for highlighting systemic racism in health care (Chen, 2020). Other doctors are sharing their medical knowledge with news media, such as basic remedies to protect oneself from tear gas (Calise, 2020). While none of these actions seem to be actively resisting against any one institution or actor, they require the doctors to determine that the current status quo, instituted by the state, is unjust and that those who are resisting against the state are doing so for the right reasons. This in turn encouraged the medical professionals to speak out against what was happening in some

way so that others may educate and protect themselves. So, while the most recognizable aspect of the Black Lives Matter movement is the widespread protest, it is important to recognize the other work that is being done to actively resist the state's violence against protestors. While it does not directly resist the oppressive actor, it enables and supports those who do, making it count as resistance.

Conclusion

By studying the cases of Egypt, Kashmir, Palestine, and the United States, one can recognize the shortcomings of the medical neutrality model and find the gaps that make it inoperable. Direct violence in the form of attacks on medical infrastructures, such as doctors, ambulances, and hospitals, show the willingness of the state to cross the clear international boundary set by medical neutrality. Furthermore, the indirect attacks in the form of structural violence continue to wear away at the efficacy of health care systems, going largely unnoticed in the shadow of other blatant human rights abuses. The violence inflicted by the state and the subsequent violations of medical neutrality politicize medicine, targeting the healthcare system and medical professionals caught in the conflict. The result is active resistance by the medical community to the state's oppression of civilians, causing medical professionals to politically align with the dissidents in the conflict. Additionally, as these four cases have demonstrated, studying acts of resistance requires an in-depth analysis of the action, its intention, the result, and the target's reaction. By expanding our definition to fit other modes of resistance, we can better understand social movements and collective protest, recognizing resistance as a contribution from every actor. All of this goes to show the need for a reevaluation of our current system of international accountability in the preservation of health care. Particularly in the case of medical resistance, one can see that health care professionals often have a front-line position in many resistance movements. Their technical training gives them knowledge and authority over matters pertaining to the body, and since the body is the first to be put in harm's way during a protest, medical personnel have a unique jurisdiction over modern-day resistance. Their authority gives the medical community a great deal of power in this matter, which, once they have decided they cannot be neutral actors, they can use to resist and subvert political exploitation by oppressive actors. Medical resistance appears to be ever emerging in the wake of medical neutrality violations, and hopefully, more study can be used to broaden and expand the subfield. Modern challenges to health care and conflict require modern solutions, and the medical community may just be at the forefront of sociopolitical revolutions and conflict transformation.

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