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To cite this article: Piyush Pushkar & Louise Tomkow (2021) Clinician-led evidence-based activism: a critical analysis, *Critical Public Health*, 31:2, 235-244, DOI: [10.1080/09581596.2020.1841112](https://doi.org/10.1080/09581596.2020.1841112)

To link to this article: <https://doi.org/10.1080/09581596.2020.1841112>



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Published online: 27 Nov 2020.



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Clinician-led evidence-based activism: a critical analysis

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ABSTRACT

We introduce and critique a previously unexamined form of evidence-based activism (EBA): clinician-led evidence-based activism (CLEBA). In recent years funding of, and access to, the UK's National Health Service (NHS) have been depleted through cuts, privatisation, and the reduction of universal healthcare. In these austere and hostile times, the legitimacy of those drawing attention to resultant health inequalities is eroded. One tactic that doctors have adopted while advocating for the delegitimized has been CLEBA: strategic use of clinical authority in the production and mobilization of knowledge for the governance of health issues. To illustrate the concept, we analyse two cases of CLEBA in the NHS in which we have participated. The first resisting cuts and privatisation of the NHS, the second resisting the charging of forced migrants for healthcare. By analysing CLEBA as a tactic, we show how doctors work to effect progressive goals by lending legitimacy to their allies, who are delegitimized by opponents as 'loony-left', 'shroud-waving' 'health tourists'. This approach to the problem of legitimacy separates CLEBA from EBA. Whereas EBA seeks to rebalance unequal social relations within a doctor-patient collective, CLEBA capitalizes on the symbolic power of doctors to contest unequal social relations out with the collective. By lending clinical authority to activist discourses, CLEBA consolidates forms of collective agency in which certain actors remain illegitimate. In contrast with EBA, where the rebalancing of legitimacy itself is prioritized, CLEBA reinforces a hierarchy of legitimacy that places clinicians on top.

ARTICLE HISTORY

Received 29 February 2020

Accepted 16 October 2020

KEYWORDS

Austerity; asylum; evidence-based activism; hostile environment; legitimacy

The National Health Service (NHS) is England's system of public healthcare. What the NHS is, what it provides, and for whom, are changing. Since the global financial crisis and subsequent recession, health and welfare institutions have seen funding restrictions. Simultaneously, the British government has restricted migrants' healthcare entitlements as part of a strategy to decrease migration to the United Kingdom (UK). Thus the contemporary political context combines fiscal constraints with an extension of bordering practices. The logics of austerity and hostility to migrants have collided and fed one another. Various forms of resistance have arisen in the NHS, including protest groups campaigning against cuts, privatization and charges for migrants. This resistance has been countered through strategies of delegitimization. This conceptual paper explores one form of such resistance, introducing a previously unexamined form of evidence-based activism (EBA): *clinician-led* EBA (CLEBA). In order to illustrate and critique CLEBA, we describe two NHS campaigns that use the symbolic power of clinicians to address the problem of legitimacy.

The paper has two aims. The first is to introduce the concept of CLEBA, delineating it from EBA. In Rabeharisoa et al.'s (2013) and Walker et al.'s (2018) descriptions of EBA, the activists in question are patients, service users, and civic actors. These individuals collaborate with clinicians and scientists

and strive to rebalance unequal power relations by engaging in knowledge production. In EBA, knowledge production and dissemination are positioned as sites of political struggle, whereby influence can be wrested from credentialed authorities, such as doctors. In contrast with EBA, the cases of CLEBA we describe illustrate how the legitimacy of doctors is mobilized. We therefore define CLEBA as a form of EBA concerned with the production and mobilization of knowledge for the governance of health issues, which involves the strategic use of clinical authority.

The second aim of the paper is to explore a tension between legitimacy, credibility, and authority. We argue that this tension lies at the heart of EBA and CLEBA's differing conceptualizations of collective agency. Whereas EBA seeks to rebalance unequal power relations *within* a doctor-patient collective, CLEBA seeks to capitalize on the credentials of doctors in order to contest unequal power relations *outwith* the collective, by lending credibility to the voices of the delegitimized. In other words, the campaigners who use CLEBA understand the process of collective enquiry to be subordinate to achieving other progressive goals. We use the work of Kyriakides (2015, 2018b) to analyse CLEBA as a 'tactic' and focus on the possible consequences.

The structure of the article is as follows: first, we review the literature on evidence-based activism. Second, we describe the political context in greater detail, using two cases to define the contours of what we call CLEBA. Third, we put the literature on EBA into conversation with Bourdieu's theorization of symbolic power and anthropological literature on tactics. In so doing, we build a critique of CLEBA that identifies how its conceptualization of collective agency departs from that of EBA and locates the risks of that departure, namely that CLEBA might reinforce unequal power relations. Finally, we test our analysis of CLEBA by applying it to a case outwith our own experience, that of Cuban social medicine.

Evidence-based activism and legitimacy

Theorizations of EBA (Rabeharisoa et al., 2013; Walker et al., 2018) have built on the more established concept of evidence-based medicine (EBM). EBM was defined by its founders as 'the integration of the best research evidence with clinical expertise and patient values' (Sackett et al., 2000, p. 1). EBM opened up clinical judgement to transparency and scrutiny (Timmermans & Berg, 2003), but maintained a supposedly apolitical epistemology. Evidence-based activism (EBA) goes further than EBM, in that it engages in the politics of knowledge production itself. In 2013, Rabeharisoa, Moreira and Akrich proposed the:

'notion of 'evidence-based activism' to capture patients' and health activists' groups' focus on knowledge production and knowledge mobilisation in the governance of health issues ... [In] contrast to health movements which contest institutions from the outside, patients' and activists' groups which embrace 'evidence-based activism' work 'from within' to imagine new epistemic and political appraisal of their causes and conditions. 'Evidence-based activism' entails a collective inquiry associating patients/activists and specialists/professionals in the conjoint fabrics of scientific statements and political claims' (2013, p. 2).

The patient groups doing EBA organized around specific conditions, such as AIDS or ADHD. For them, knowledge was not just a resource, but was itself the target of activism, since 'knowledge – and the collective negotiation of what counts as such – has become central to the governance of healthcare services, programmes and systems' (Rabeharisoa et al., 2013, p. 7). As patient groups engaged with research as active contributors to methodological and research questions, they secured greater influence. This influence reached questions of treatment access, as well as more upstream questions, such as how disorders are diagnosed or even defined.

Thus EBA widens the ambit of legitimacy – people whose knowledge counts – to include patients and lay experts. However, Rabeharisoa, Moreira and Akrich do not define legitimacy. We use the term carefully, considering its relationship not just to credibility (not false), but also relevance (worthy of attention), and accordance with laws, rules and norms (valid). Considering legitimacy in this way sheds light on its alignment with pre-existing structures of power. We understand legitimacy to be

a form of symbolic capital (Bourdieu, 1991), which we elaborate on below. Challenges to knowledge production are only deemed legitimate if they accord with certain norms, which the powerful have greater influence over in the first place.

CLEBA in changing times

In this section we outline cases from our own experience to illustrate what we mean by CLEBA. We acknowledge that our proximity to the cases coloured our descriptions. However, such proximity also facilitated closer insight into activists' tactics. In these cases of CLEBA, actors seeking more influence in particular political spaces did not challenge the power and legitimacy of doctors, but instead capitalized on them. The cases facilitate the subsequent discussion of how CLEBA consolidates – rather than redistributes – symbolic power.

Both cases describe the aforementioned resistance to increasing austerity and hostility in the NHS. People in power have sought to silence these forms of resistance through decredentializing activists (for more on silencing, see Burgess, 2016; Kurtz et al., 2008; Van Den Tillaart et al., 2009; Wooley, 1993). Theodossopoulos has referred to the othering of anti-austerity protesters in Greece as 'orientalization' (Theodossopoulos, 2014, p. 488). By portraying protestors as uninformed or childlike, their critiques can be dismissed as dangerous, wrong or inconsequential. We understand the silencing and orientalization in the two cases we describe as attempts to *delegitimize*. Activists were described as 'loony left', 'shroud-waving', misguided 'conspiracy theorists', complaining about non-existent problems or unwarranted fears. Similarly, forced migrants were described as scheming 'healthcare tourists'. The ability to speak and campaign *legitimately* is crucial when looking to effect change, thus the issue of legitimacy in activism is central. Both cases show how doctors' legitimacy can be leveraged to effect progressive goals.

Case 1: the austere environment in the NHS

The Health and Social Care Act 2012 ushered in a massive reorganization of the NHS. Services were forced by the legislation to compete with one another, rather than collaborate, resulting in fragmentation (Leys, 2016). More recent non-legislative changes have attempted to re-integrate services (Walshe et al., 2018), but funds have remained restricted (for more on NHS reforms, see (Hammond et al., 2017, 2018; Krachler & Greer, 2015; Leys, 2016; Pushkar, 2019; Timmins, 2018; Walker et al., 2018). Waiting times have increased (QualityWatch, 2019), staff morale has nosedived (Beech et al., 2019), many quality indicators and outcome measures have deteriorated (Scobie, 2019). At the same time, the period of austerity has been found to correlate with 120,000 more deaths than were expected (Watkins et al., 2017), improvements in life expectancy have stalled and inequalities in health have widened (Marmot et al., 2020).

Starting in August 2017, Pushkar spent 13 months doing ethnographic fieldwork in Greater Manchester with political activists campaigning against cuts and privatization in the NHS. Participant-observation involved attending the meetings, stalls, conferences, protests, and other actions of a number of groups. In this article, we focus on one group, that we will call Dunning Keep Our NHS Public (DKONP), an affiliate of Keep Our NHS Public (<https://keepournhspublic.com>). We have changed the names of all research participants and places within Greater Manchester to preserve anonymity.

Galen, a member of DKONP, was a retired professor of medicine, clinician and health service manager. Most of the rest of the group were also retired. Most of them had worked in public services, many in education, very few in healthcare. When opportunities came up to speak to outside audiences, Galen was usually put forward. He used his own medical and institutional knowledge in the arguments he put forward in his books, lectures, interviews, and other engagements when campaigning. However, he also relied on the information gained from discussions with other members of the group, who had done their own research since 2012 and themselves become

experts on NHS reforms. They read official documents, attended local government and NHS organizational meetings, asked questions, and reported back to the group.

Even if he was an unofficial spokesperson *for* the group, he did not see his own voice as more important than anyone else's *within* the group. When a question arose regarding how far to publicly challenge the council, he argued that any questions being put to councillors by group members should be pre-agreed by the whole group. Galen felt that DKONP should seek to be 'known as a reliable source of information and informed dissent'. His sense that the best way to work towards such a reputation was through group discussions – sharing information and coming to consensual resolutions as to how best to present it – shows how the campaigning group could be viewed as what Rabeharisoa, Moreira, and Akrich called an 'epistemic community' (Rabeharisoa et al., 2013, p. 16). By this they referred to collectives in which all members could be legitimate contributors to the knowledge production process. The knowledge in question for DKONP was: (a) regarding what reforms were taking place, and (b) what dangers such reforms carried for staff, patients and public.

Although DKONP acted as an epistemic community with regards to knowledge production, the fact remains that when it came to knowledge *dissemination*, the group tended to put forward the person they deemed to carry the most authority: Galen. Often, he would be arguing against other people who could also be understood as experts: managers, clinicians or hybrid clinician-managers (Hewison, 2002). Jones (2016) has written of how clinicians were often put forward to make bureaucratic arguments to the public, particularly when they related to controversial issues such as service rationing. Pushkar witnessed this himself, with multiple managers and politicians explaining to him that reform plans were 'clinically led'. Jones and Exworthy (2015) argue that clinical leadership has been used in the NHS as a rhetorical strategy to elide other forces underlying decisions made by managers. The concealment of fiscal pressures and political organising indicates what was really meant by clinical leadership of reform plans: clinician-managers did not necessarily use their clinical expertise to determine what the best course of action would be to protect citizens' health. However, they did lend their authoritative voices to the way the final plans were presented to the public.

There was a symmetry between politicians' desire to present reforms as 'clinically-led' and DKONP's desire to be represented by Galen. In an important sense, all of DKONP's members were experts, by virtue of the years they had spent researching and campaigning. However, they were aware that they would not all be seen as equally legitimate speakers. To illustrate the point, we recall a meeting at which DKONP members debriefed after having watched an interview that Galen had given on television. The presenter had not given a full description of Galen's background. In the clip, Galen's report of the rationale for the protests was accompanied by a differing opinion from a health think tank researcher. At the debrief, one person commented on the fact that Galen had articulately laid out all of their objections: 'You were excellent. But you should have mentioned you were a professor. In [the reporter's] theatre, you were just a protestor. Someone else was the expert.'

Case 2: the hostile environment in the NHS

In 2012, the British government outlined plans to decrease net migration 'from the hundreds of thousands to the tens of thousands' (Travis, 2013). Theresa May, who was Home Secretary at the time, said the aim of the plans was to create 'a really hostile environment for illegal migration' (as cited in Kirkup & Winnett, 2012). The Immigration Acts of 2014 and 2016 set out to fulfil this aim by restricting migrants' welfare and healthcare entitlements. Both state and non-state actors are now mandated to carry out bordering practices including monitoring people who access state services, with non-compliance carrying the threat of criminal conviction. In 2017, NHS charging regulations were extended; irregular migrants must now pay before receiving treatment. Charges apply to non-urgent secondary care and community services allied to primary care, including mental health, drug and alcohol, and community midwifery services. Hospital trusts not complying with these policies face sanctions. Tomkow (Kang et al., 2019) has been one of several scholars and NGOs that have

documented the deleterious effects of these legislative changes for the health of migrants (Harris & Hardwick, 2019; Potter, 2015; Potter et al., 2017).

Whilst writing a PhD exploring the health of older asylum seekers and refugees, Tomkow conducted research interviews with older people seeking asylum in the UK. Many of them recognized the power imbalance between Tomkow and them, but did not see it as problematic. One research participant stated: 'I share my experience and you are going to use my experience to help more and more people. I'm free to talk to you'. Another suggested: 'I really wish the immigration system can change, maybe you can meet them [Home Office] and tell them'. For the older migrants, the ability of the clinician-researcher to effect change motivated them to participate in the study. Many suggested Tomkow should change the system and help others, however their ideas as to how that change would be realised were vague or unrealistic.

Tomkow's PhD research (Tomkow, 2019) also showed how perceptions of credibility were crucially important for asylum applicants. In contrast with other legal procedures, asylum applications often involve no witnesses and have little corroborating documentary evidence to draw on. The Home Office's decision makers delineate between 'genuine' refugees and 'welfare cheats, asylum shoppers [and] bogus refugees' (Sweeney, 2009, p. 701) based on whether they find the asylum applicant's account to be credible. The participants in Tomkow's research interacted with various facets of the governmental asylum apparatus, at each stage having their credibility questioned and eroded.

Galvanized by first-hand accounts of migrants' marginalization, and mindful of her relative privilege, Tomkow became increasingly involved with Medact (<https://www.medact.org>), a group of healthcare professionals who campaign on issues of social justice. Here she noticed her medical title opened avenues of political contestation not open to her research participants. She was invited to write blogs for news publications, to speak on the radio, to give talks. When she participated in a protest outside a Manchester hospital with a group of other doctors, the event attracted national media attention.

When communicating in blogs or giving talks, Tomkow told the stories of the people she had met during her research. One of Tomkow's aims for her PhD was to produce research that evidenced the problems with charging migrants for NHS care. Like the activists described by Rabeharisoa et al. (2013), Tomkow made knowledge production the target of her activism. To this end, she and Medact conducted a survey of healthcare professionals and interviewed migrants who had used NHS services. The results demonstrated what migrants and activists already knew: that both service users and healthcare professionals had limited awareness of migrants' eligibility for NHS care and that this could lead to health problems.

Tomkow led on the publication of Medact's research (Tomkow et al., 2019), as well as her own (Kang et al., 2019). Tomkow was aware of how knowledge can be transformed by the framing of its communication when deciding what to do with the survey and interview results. As a group, Medact decided to wait until the research had been published in a journal before communicating the results to hospital managers. The publication did not make migrants' accounts more true, but when communicated through a biomedical frame (Rushton & Williams, 2012) in a peer-reviewed publication they did become more credible. Anecdote became 'evidence'. Perhaps Tomkow could not walk straight into the Home Office, as suggested. However, she could make strategic use of scientific evidence that she was in a position to produce. By representing the views of migrants in the format of a scientific paper – a mode of knowledge production and communication to which she had privileged access as a doctor trained in research methods – Tomkow *legitimized* them.

CLEBA as a tactic

Both cases share three key facets. First, insofar as empirical evidence was being sought with the aim of using it in the furtherance of political goals, they both constituted EBA. Second, the political goals being sought – namely, the abolition of bordering practices in healthcare and the resistance of cuts

and privatization of the NHS – were shared by the clinical and non-clinical actors involved. Third, having generated an evidence base, a conscious decision was made to use doctors to disseminate that knowledge. It is this third facet that allows us to describe our cases as CLEBA, thus differentiating it from the EBA described by Rabeharisoa et al. (2013) and Walker et al. (2018). In this section, we evaluate CLEBA as a tactic.

Given the questions already raised regarding what the rhetoric of clinical leadership can conceal (Jones, 2016; Jones & Exworthy, 2015), it behoves us to clarify what we mean by ‘clinically led’. As the leadership role of the clinician was different in each case, perhaps clinician-fronted EBA or clinician-presented EBA might be better descriptions. We believe clinician-led EBA remains a better fit, because it corresponds more adequately to how the work of legitimacy is done. It is the performance of leadership by the clinician that bestows legitimacy upon the evidence so produced.

The legitimacy so bestowed can be understood as a form of symbolic power. Bourdieu (1986, 1991) expanded notions of how classes are produced and reproduced to include not just financial but also social and cultural resources. Within these resources, symbolic capital referred to the signifiers that denoted a higher social position, and thus greater capacity to exert influence and accumulate more capital. Therefore, when actors occupy a social position, their behaviour is interpreted through a prism of pre-existing class hierarchy, where the cultural expressions of the most powerful are valued most highly. Certain behaviours reinforce social hierarchies in the same way that the possession of financial capital does.

Applying Bourdieu to our cases, we interpret anything that marks out doctors *as doctors* as symbolic capital. Presumed expertise, grasp of academic research techniques, capacity to produce and disseminate credible knowledge were not just skills, but also forms of prestige thought to be particularly accessible to doctors. Whether or not doctors believed that themselves, they took advantage of it, thus reasserting their own distinction. How, then, should we evaluate doctors’ use of their own symbolic capital as a tactic?

As Kyriakides (2018a) has recently noted, tactics are usually considered simply as means of achieving victory over an opponent. He argues that there is much to be learnt from instead focusing on the social relations within which a particular tactic has been chosen or fallen upon. Tactics work through persons and personal connections. Thus the question of scholarly interest moves from how successful a tactic might be for achieving a goal, to what kinds of relations of power led to the use of a tactic in the first place. And, crucially for Kyriakides (2018b), how did the use of such tactics themselves influence those relations? In common with Bourdieu (1991), he considered neither social status nor social relations to be fixed. In his own ethnographic work on thalassaemia patient organizations, he noted not just how and why actors alighted on particular tactics, such as forming associations, but also on how such associations formed ‘infrastructures of alliance’ (Kyriakides, 2018b, p. 478). By this he meant the consolidation of social relations in particular structures with a regard not just for achieving current goals, but also for negotiating and managing the contingencies of the future. Thus Kyriakides pointed towards the possible consequences of the use of particular tactics, bearing in mind the processual nature of social dynamics.

In both of the cases we describe, doctors formed alliances with groups of people whose own voices had been silenced by processes of delegitimization. The tactic of allying with professionals perceived to be able to tell an ‘authoritative story’ (Biehl, 2013, p. 412) draws its strength from the social position held by those professionals. Indeed, political actors have long made use of the symbolic power of healthcare professionals. Cortell and Peterson (Cortell & Peterson, 2009, p. 256) suggest global health organizations such as the WHO use ‘biomedicalism’ as a frame through which they appeal to policy makers and the public. Rushton and Williams (2012, p. 160) argue biomedicalism capitalizes on doctors’ perceived ‘expertise, scientific method and neutrality’ to influence governance actors.

In our cases, previously delegitimized people sought to ally with doctors. Orientalized activists and migrants, aware of how their resistance had been silenced by powerful others in this austere and hostile environment, saw the best avenue for effecting change as allying with another group of

powerful others. In turn, doctors, drawing on their perceived 'expertise, scientific method and neutrality' (Rushton & Williams, 2012, p. 160) were able to lend legitimacy to activist campaigns.

As such, CLEBA departs from what Rabeharisoa et al. (2013) argue is distinctive about EBA. For them, EBA constituted collective projects of knowledge production in which both patients and professionals were 'legitimate contributors to these collectives' activities and policies' (Rabeharisoa et al., 2013, p. 16). Like EBA, CLEBA starts from a perceived illegitimacy of some actors' voices. However, whereas EBA seeks to rebalance power relations, resisting the silencing of the oppressed and working to legitimize those voices, CLEBA opts for a different strategy that leaves the power differential between doctors and the delegitimized voices of their allies unchallenged. Put otherwise, EBA seeks to rebalance unequal power relations *within* a doctor-patient collective, aiming for the restoration of agency to each individual within the collective. CLEBA seeks to capitalize on the credentials of doctors in order to contest unequal power relations *outwith* the collective, in order to effect progressive goals that clinicians and their allies deem more important.

The tactic chosen by the two cases we describe saw some unequal social structures as objectionable and others as useful to contest the former. So what? Those engaging in political activities are always called upon to prioritize some goals over others. A cursory glance at social movements studies will confirm the common-sensical view that, often, this prioritization means putting off addressing one form of injustice until a more urgent one has been overcome (Moore, 1978). However, as Kyriakides (2018b) argued, the alliances that are formed as a tactic to achieve one goal remain in place even after the battle to achieve that goal has finished. In this sense, tactics are not just shaped by social relations, but also have an ongoing influence on the social structures to which they were a strategic response.

For Bourdieu (1986), owning and investing capital facilitates the accrual of further capital, thus consolidating one's class position. CLEBA's lending of legitimacy is just such an investment of symbolic capital, quite different from the redistribution of legitimacy inherent in Rabeharisoa et al.'s (2013) model. Kyriakides' insight alerts us to the possibility of reinforcing a form of collective agency that embeds the illegitimacy of migrants or activists in new ways, by making them dependent on the symbolic power of clinicians rather than problematizing clinical authority itself. The danger, then, of not questioning the inequalities of symbolic power between doctors and activists or migrants, is that the differential is reinforced. In CLEBA doctors perform leadership of the collective because they consider it to be the best way to contest structural delegitimization. However, the question of why nobody believed the other members of the collective in the first place remains unanswered. In fact, unasked.

Latin American social medicine – testing the model

Before concluding, we apply our argument to a case from outwith our own experience: Latin American social medicine, specifically in Cuba. The aim of this penultimate section is to test our theorization and further develop it. Latin American social medicine followed a social justice approach to both healthcare and the social and historical structures that result in unequal health outcomes (Birn & Muntaner, 2019). Its practitioners were not just doctors, but also scholars, activists, and in some cases state leaders, such as Salvador Allende. The long history of Latin American social medicine has its roots in sociological analysis, steeped in the legacies of Paulo Freire and Orlando Fals Borda (Abadia-Barrero, 2019; Abadía-Barrero & Bugbee, 2019; Abadía-Barrero & Martínez-Parra, 2017). Thus its discourse has maintained the importance of a collaborative approach to knowledge and practice. As one of Latin American social medicine's archetypes, Argentinian doctor and contributor to the Cuban Revolution, Che Guevara, put it:

'integrating the doctor or any other health worker into the revolutionary movement [is essential], because ... the work of educating and feeding the children ... and ... of redistributing the land from its former absentee landlords to those who sweat every day on that very land without reaping its fruits – is the grandest social medicine effort that has been done in Cuba' (Che Guevara, quoted in Birn & Muntaner, 2019, p. 822).

Guevara recognized and valued medical expertise while also trying to fit it into a revolutionary struggle underpinned by egalitarian ideology. Thus he spoke not of doctors leading the struggle, but of doctors 'integrating' into the revolutionary movement.

However, in practice, Cuban social medicine has not eliminated differentials in social status. In the revolutionary period, the Cuban government explicitly used its commitment to realizing the human right to healthcare as a defining characteristic of its reforms. The health of all citizens was recognized as a good, so the state trumpeted its own willingness to devote effort and funds to the medical profession. Brotherton (2012) has illustrated how state healthcare policies and the rhetoric surrounding them contributed to the Cuban people developing medicalized understandings of themselves, thus consolidating the importance of – and their dependence on – biomedical professionals. Following the collapse of the Soviet Union, when the Cuban state's available funds reduced significantly, Cuba made further use of its highly developed healthcare system by encouraging health tourism. Thus a two tier system was created, in which foreign tourists could pay to receive better healthcare than the Cuban people themselves. The two systems existed interdependently, with foreign patients effectively paying for the healthcare of Cubans, which was limited and yet still more comprehensive than other countries of a similar GDP.

Guevara's attempts to 'integrate' doctors into political struggles suggests he was consciously attempting to disavow the symbolic capital of doctors, to further an activism more akin to Rabeharisoa et al.'s (2013) model than the CLEBA we have described. He recognized the interrelatedness between clinical authority and other forms of power. However, the revolutionary movement still defaulted to the use of biomedical authority in the furtherance of wider progressive goals. The results were positive insofar as Cuban health outcomes outperform other countries of a similar size and economic output. But doctors maintained an elevated social status. Just as Bourdieu would have predicted, power reproduced itself. In our cases, if we have neglected to even ask the question of how we can equalize relations of symbolic power within the collective, then the case of Latin American social medicine further highlights the risk that we have little chance of finding an adequate answer.

Conclusion

We have identified and described CLEBA, delineating how it differs from EBA. The illegitimacy of some actors' voices is the impetus driving both. In the austere and hostile environment of the contemporary UK, the existential situation facing forced migrants and the political situation facing NHS activists is dire. Both are systematically delegitimized. This paper has documented one response: CLEBA, knowledge production and dissemination partially or fully led by clinicians. Comparing EBA to CLEBA has outlined some dangers inherent in the conferral of legitimacy by lending clinical authority to orientalised discourses. CLEBA may be a tactic that responds to the structural inequalities of the past and present. However, the approach perpetuates other inequalities into the future, consolidating forms of collective agency in which certain actors remain illegitimate. Whereas EBA prioritized a rebalancing of legitimacy itself, CLEBA risks reinforcing a hierarchy of legitimacy that places clinicians at the top.

Acknowledgements

We would like to thank everyone we met through our work with DKONP and Medact. We all deserve – and have a right to – health and healthcare.

We thank our PhD supervisors for their support and feedback. This paper was also hugely improved by Flora Cornish's thoughtful feedback, as well as the comments of the anonymous peer reviewers.

Disclosure statement

We have no financial interests to declare.

Funding

This work was supported by the Economic and Social Research Council [9801149]; Wellcome Trust [203337/Z/16/Z].

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