

# Power matters: Posthuman entanglements in a social solidarity clinic

Organization

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## Abstract

This paper develops a materialist and performative conception of power, proposing a theoretical framework that bridges Barad's intra-active agential ontology and Foucault's microphysics of power. The article uses empirical data collected from a social clinic in Greece where the traditional apparatus of the clinic is contested and experimentally reconfigured. We focus on three overlapping themes and reflect on how power relations materialize themselves through everyday practices and multiple entanglements between human and non-human agents. We argue that these entanglements constitute the dynamic matter of power: their performative reiteration determines how power matters. By showing how power materially exceeds the manifest intentions of human agents, our case study aims to contribute to an idea of alternative organising that accounts for the materiality of mundane posthuman entanglements within an antagonistic understanding of power.

## Keywords

Alternative organizing, Barad, entanglements, Foucault, intra-action, performativity, power, social clinic, sociomateriality

## Introduction

Imagine entering a clinic and finding no doctor: would that still be a clinic? Imagine being ill but once you enter the clinic, you are not a patient. Does it mean you are no longer ill? No, but you are

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at least stripped of the passivity that the word ‘patient’ implies. This is what happens at the Social Clinic of Solidarity in Thessaloniki (*Koinwniko Iatreio Allileggyis* - hereafter KIA). The entrance is a transformative threshold: once you pass through that door, you become a ‘proserhomenos’, a Greek word meaning that someone is ‘coming into’, ‘engages in/with’ and ‘presents oneself’. No doctors, no patients, not even researchers. Entering our research site turned us into ‘proserhomenos’, a term used by KIA’s members to describe anyone intra-acting within the clinic (irrespective of their role). Through the use of the term ‘proserhomenos’ and other experimental and mundane practices, KIA aims to eliminate the hierarchical effect of medical distinctions between doctors and patients, while performatively instigating a community of health. We look at how KIA’s resistance against traditional models of healthcare turns into a strategy for exerting power differently.

Recent developments in organization studies (OS) have shown the potential for a performative reading of Foucault’s power (Raffnsøe et al., 2016), as the relationality at the core of his model. Yet, as Foucault’s microphysics is ultimately anthropocentric, we engage with Barad’s (2003, 2007) materialist ontology to address these shortcomings and to acknowledge how non-human entanglements actively contribute to the ongoing reconfiguring of power. KIA, with its experimental practices and supple boundaries, represents an ideal case study to look at the mattering of power and in particular how power emerges in continuous intra-action with diverse resistances: both in relation to austerity, exclusion of migrants, mainstream approaches to medicine and in relation to the development of internal structures of power within KIA. While Barad helps us to understand KIA’s reconfiguring of power in terms of reiterative intra-actions and their transformational dimension, Foucault helps us to address this from the perspective of antagonism, strategies and resistance. This materialist and performative conception of power becomes manifest in processes of alternative organizing which substantially reconfigure traditional forms of organizations through experimental practices (Papadopoulos, 2018), while engaging in multiple oppositional confrontations. We look at posthuman material entanglements reconfiguring traditional forms of power at stake in mainstream clinics: from Che Guevara posters (against the customary anatomy posters) to doctors in plain clothes (against white coats) who refuse to be called doctors.

KIA was established by a group of medical professionals and activists in 2012 as a reaction to the austerity policies implemented in the Greek national health care system that left over 3 million people without access to health care (Evlampidou and Kogevinas, 2019). It counts more than 350 members (medical and non-medical personnel) while providing free medical care to over 10,000 people every year. None of the members is financially remunerated. KIA is supported (both financially and with medical supplies) by solidarity groups in Greece and across Europe, and individual donations. Those supporting the clinic are not involved in its governance; that is solely the responsibility of its members through weekly divisional meetings and a monthly general assembly meeting.

This paper begins by presenting the theoretical and methodological framework of the research. It explores contemporary debates in OS on power from a Foucauldian perspective and the relevant literature on Barad’s concept of performativity which allow us to introduce our theoretical perspective that connects Barad with Foucault through a materialist reading of power. Our analysis of findings turns around three overlapping themes: ‘this is not a clinic’, ‘the proserhomenos’ and ‘the matter of power’. Our analysis focuses on how power relations materialize in mundane processes of organizing and experimental initiatives. Often neglected in empirical studies on sociomateriality, we look at ‘more mundane materialities’ (Keevers and Sykes, 2016) that distinguish KIA from other traditional clinics: casual clothes instead of white coats, a Che Guevara poster, a pervasive smell of coffee. These elements intra-act with proserhomenos performatively forming everyday posthuman entanglements that exceed the intentions of those (humans) involved. The article aims

to contribute to an idea of alternative organising that accounts for the materiality of mundane post-human entanglements within an antagonistic understanding of power.

## **Foucault's power and Barad's performativity in OS**

Foucault represents a watershed for the understanding of power in OS. Previous conceptualizations of power have converged towards a repressive model, where power is imposed over others (Clegg et al., 2007) and retained as a possession or a property (Clegg, 1989). This traditional account of power was criticized for being over-deterministic by ignoring and depriving the agency of those subjected to power. Following Raffnsøe et al. (2019), the Foucault effect in OS can be analysed through four waves characterized by specific shifts in focus: disciplinary power (Burrell, 1988); discourse (Clegg, 1987); governmentality (Dean, 2013); and subjectivation and ethics (Iedema and Rhodes, 2010; Randall and Munro, 2010). Despite criticisms of an alleged transcendent over-determinism ultimately nullifying subjectivity and agency (Caldwell, 2007), recent Foucault scholarship has widely demonstrated that an idea of power as transcendental and oppressive is fundamentally alien to his work (Checchi, 2014; Elden, 2017), presenting power as productive, relational and therefore contested.

Furthermore, since the late 1990s, conceptualizations of performativity have strongly influenced OS. We focus on the material turn (Gond et al., 2016) which introduces a relational ontology largely predicated on the posthuman conception of matter developed by Barad (2003, 2007). Scholars in OS who have engaged with this perspective have consistently referred to the concept of sociomateriality as developed by Orlikowski (2007, 2010) and Orlikowski and Scott (2008). Empirical studies on sociomateriality have often looked at intra-actions between human and non-human agents focusing on new technologies: Blackberry, Google and synthetic worlds (Orlikowski, 2007, 2010); intra-actions in call centres (Nyberg, 2009); computer simulation technology for automotive design (Leonardi, 2011); virtual media in the hotel industry (Orlikowski and Scott, 2013); and smartphones and staff identities (Symon and Pritchard, 2015). To an extent, this focus on recent technologies risks retaining an implicit human/ nonhuman divide (Kautz and Jensen, 2013). For this purpose, Keevers and Sykes (2016) propose to focus on 'more mundane materialities' through their analysis of food and music in a community-based organization, quite aligned with Harding et al.'s (2017) attention to business suits and the name-plates on senior managers' doors.

Regarding healthcare, Jones (2014) applies sociomateriality to his empirical study in a hospital critical care unit. But the clinic has also often been analysed through a Foucauldian framework as a disciplinary space (Pryce, 2000) or a site of governmentality (Nettleton, 2006). Particular attention has been given to the issue of power in the relation between patients and professionals (Nyberg, 2012). The analysis of power outside the clinic has discussed how neoliberal reforms and their managerialist practices determine a problematic disjunction between doctors' commitment to individual patients (the professional discourse of care) and their concern as managers (the organizational discourse of efficiency) (Iedema et al., 2004). Our case study represents a radical form of alternative organizing where the disjunction between doctor and manager is deconstructed and recomposed in alternative and creative configurations that performatively affirm new forms of subjectivation – *proserhomenos* – and new ways of exerting power.

## **Theoretical perspective**

Barad's (2007) concept of performativity emerges through her relational ontology: related entities (*relata*) do not pre-exist the relation but emerge performatively through that very relation. We are

thrown into a posthuman scenario where the distinction between the human and the non-human is no longer applicable for the irreducible connectedness of matter.

Barad's materialism rejects the dichotomy between words and things by focusing on the 'causal relationship between specific exclusionary practices embodied as specific material configurations of the world (i.e. discursive practices/(con)figurations rather than 'words') and specific material phenomena (i.e. relations rather than 'things')' (Barad, 2003: 814). Both phenomena and discursive practices are material and do not stand in a relation of externality to one another. Yet, they are not reducible to each other. Their relation is of ongoing mutual implication and mutual entailment, producing multiple reconfigurations. 'This dynamism *is* agency. Agency is not an attribute but the ongoing reconfigurings of the world' (Barad, 2007: 141).

The performative character of Barad's ontology poses becoming as the agential intra-activity of matter. If the idea of inter-action presupposes two pre-existing entities, intra-action refers to the continuous (self-)reconfigurations of matter through multiple entanglements. The figure of the doctor for example emerges through material entanglements between medical knowledge (and the intra-actions that pertain to its historical creation as a scientific discipline (its conditions of productions through universities, its certification through a degree, etc.), techno-scientific objects (e.g. the stethoscope), clothing (e.g. the white coat), patients (and the intra-actions that define a human body as ill) and spatial infrastructures (e.g. the hospital, the clinic). These intra-active entanglements produce what Barad (2003) calls apparatuses, dynamic reconfigurings of the world 'through which exclusionary boundaries are enacted' (p. 816). Boundaries allow the emergence of locally stabilized phenomena through discursive and material practices of exclusion that determine what is not accounted for in relation to a specific phenomenon. The clinic can be considered as an apparatus whose boundaries determine a series of exclusions: who/what (not only which humans, but also which drugs, techniques, machines) can cure, who/what can be cured (which bodies, which diseases), what can appear (anatomy posters, health-related leaflets), what discourses can circulate (how symptoms and their etiologies are perceived, identified and managed). Yet, 'boundaries do not sit still' (Barad, 2007: 171). Apparatuses are performatively constituted through dynamic intra-action and are therefore open-ended with boundaries continuously being contested and reworked.

Barad's theory accounts for how matter comes to matter by looking at how the world has come to its existing configuring, the contingency of its existence and the possibility for change. KIA represents a perfect case for understanding this agential dynamism and the reconfiguring of boundaries. Through experimental practices that entangle humans, techniques, objects and discursive formations, KIA rescues what is excluded from mattering in other Greek clinics: uninsured patients, the social and economic status of patients in understanding disease, the promotion of other political events of solidarity in the city. In KIA, *proserhomenos*, whoever transits through that space, are what matters: an attempt to create boundaries while minimizing exclusions.

Barad's approach helps us to highlight how these experimental practices are ethically oriented towards a reconfiguring that challenge injustice through a politics of possibilities: 'ways of responsibly imagining and intervening in the configurations of power, that is, intra-actively reconfiguring spacetime-matter' (Barad, 2007: 246). KIA shows this ethical tension and the reconfiguring of the clinic apparatus displays the transformative potential inherent to matter and its dynamic tension towards new possible apparatuses. However, we turn to Foucault to understand this reconfiguring of matter from a strategic perspective: reconfigurings are not only affirmative, but also oppositional, embedded in multiple antagonisms. Despite Barad attentively engaging with the question of power, affirming how the contingency of power opens material possibilities for its reconfiguring, her agential realism is only marginally concerned with the idea of resistance and the oppositional and antagonistic dimension that resistance implies. With Foucault, we propose to read Barad through the perspective of antagonistic strategies. This helps us to focus on *how* power matters at

KIA: the reconfiguring of power occurs through multiple confrontations that traverse the borders of its apparatus. At KIA, power comes to matter through resistances against state-imposed austerity, against the apparatus of the traditional clinic, against the divide between doctors and patients, but also through the resistances that it encounters internally against its experimental practices (resistance against abandoning the patient-doctor divide, resistance against sharing tools in dentistry).

Foucault's microphysics of power shows how any apparatus, despite its apparent stability, is traversed by a multiplicity of antagonistic forces: 'Just as the network of power relations ends by forming a dense web that passes through apparatuses and institutions, without being exactly localized in them, so too the swarm of points of resistance traverses social stratifications and individual unities' (Foucault, 1978: 96). From this microphysical perspective, any entity (a body, an institution, an apparatus) is deconstructed as the effect of the antagonistic confrontations between forces. Points express the interaction (or intra-action?) between two forces. Their interaction is expressed in terms of affects: each force can either affect, be affected or resist. It is their antagonistic confrontation that determines which affect is displayed by each force. A power relation is the coupling of a capacity to affect and a capacity to be affected. As power relations can be deployed in a wider network of power, likewise dispersed points of resistance can configure their own coordination: 'it is doubtless the strategic codification of these points of resistance that makes a revolution possible, somewhat similar to the way in which the state relies on the institutional integration of power relationships' (Foucault, 1978: 96).

Looking at the clinic as an apparatus, we can see a similar confrontation between two strategies. While the traditional clinic expresses the institutional integrations of sedimented power relations, KIA is the revolutionary codification of dispersed and otherwise isolated points of resistance: against austerity, against the state, against medical profession, against the passivity of patients, against the boundaries that isolate the disease from the body and the individual from the community. But this oppositional stance simultaneously affirms an alternative way of exerting power, a reconfiguring of power. Our focus at KIA is to decipher how a strategy of resistance organises its own strategy of power and how it deals with its (internal) resistances.

Barad (2003) criticizes Foucault's conceptualization of power for focusing exclusively on the social and relegating matter to a passive pole. For Barad, Foucault's power remains anthropocentric and fails to account for the agency of nonhuman actors. There are indeed only few traces in Foucault's work where we find a direct problematization of how nonhuman forces actively participate to power relations (Lemke, 2015). Yet, his microphysics of power still allows for an overcoming of the human/nonhuman divide. We read Foucault's microphysics through Barad's posthuman materialism in order to retrieve the complexity of the forces and the multiple antagonisms that traverse KIA. We look at how mundane materialities actively participate in the reconfiguring of power: a smell of coffee that unexpectedly invades a medical space, bacteria that force reluctant dentists to find a shared practice of sterilization of their shared tools, unusual posters.

This materialist reading rescues Foucault's power from its alleged anthropocentrism and allows us to address the complex material entanglements which Barad presents in her agential ontology. We propose to read Barad's intra-action of matter from an antagonistic perspective: performative reiterations entangling human and nonhuman forces that strategically affect, are affected by and resist each other. In a sense we could say that power (affect, be affected, resist) is how matter intra-acts.

Power largely exceeds the intentions of the human subjects involved. KIA's material reconfiguring of power is not yet consolidated and sedimented in a stable apparatus as it remains a strategy of resistance. It is ethically oriented towards politics of possibility, while firmly engaged in antagonistic confrontations. The traditional clinic persists within KIA as its strategic adversary:

disoriented patients looking for a white coat while staring at the poster of Che Guevara on the wall. The interest of the case study is that the dynamic reconfiguring of power within KIA is traversed by a multiplicity of dispersed confrontations that involve both human and nonhuman entanglements, including more mundane materialities like smells, clothes and tools. Power matters: it is an entanglement to be read both with power-as-adjective and matter-as-noun, and with power-as-noun and matter-as-verb.

## Data collection and analysis process

Following a sociomaterial approach we were presented with a range of practical issues throughout our research. Firstly, we had to reflect on our orientation, using data collection methods that embrace multimodality while being mindful not to privilege or trivialize the social over mundane materialities. We used participant observation diaries, semi-structured interviews, documentation and photography, in a reflective manner. The data collection was conducted between June 2016 and July 2017 with particular attention to relationality, action and in-situ processes (Davies and Riach, 2018) that allowed us to explore and reflect on how agencies (or their absence) become imbricated and transformed within temporary spatial configurations.

Our initial focus of analysis was the relationship between human agents and objects such as the health card used in the integrative medicine sessions. The health card is a 6-page-long form featuring four categories: (a) basic personal information, (b) social life, (c) lifestyle and (d) full medical record. Our sociomaterial approach was useful in gaining insights about the ways in which bodies, objects and space are intra-actively entailing material agencies. Through these mundane entanglements, we then explored how power relations come to matter. During our 20 days at KIA, we were involved in the daily (mainly administrative) activities and had the opportunity to participate in several frontstage and backstage processes. We recorded our observations individually at the end of each work shift. We then collated them in a reflective diary (104 pages). We conducted 3 semi-structured interviews and 4 group discussions (between 3 to 9 participants) that lasted between 1 to 2.5 hours (over 12 hours in total) and which we recorded with the consent of the participants. At each interview and group discussion, the participants were given an assurance of confidentiality, although their real names are disclosed as per their request. In addition, we had over 100 informal discussions with *proserhomenos* who were aware of our role and gave their verbal consent for their views to be reported; yet, we have anonymized their names. Our data collection process also included interactions with nonhuman materialities from brochures and posters to furniture and medical equipment.

Our data analysis had several iterative stages and employed a 'diffractive methodology' (Barad, 2007, 2011), a practice that involves 'reading in and through texts, artefacts and material-discursive practices in a way that places them in conversation with each other' (Keevers and Sykes, 2016: 1650). From the discursive use of the term '*proserhomenos*' to the layout of the office and the various experimental practices, we have tried to create a nonlinear engagement with concepts and examples from our fieldwork and engage all these aspects in 'a dynamic relationality to each other' (Barad, 2007: 93). Rather than assuming that there are pre-given entities or organizational boundaries in the context of the clinic, we consider these boundaries as enacted in uncertain performative reiteration. Seeing objects as things with their own agencies rather than simply consider them as artefacts, has been very useful for our post-human approach where 'objects make us, as part of the very same process by which we make them' (Miller, 2010: 60).

In the first stage of our data analysis we did a free coding of the transcripts from the recorded interviews and group discussions based on our focus of analysis. In the second stage, we identified themes from the transcripts and from the reflective diary. We also used, to a lesser extent,

photography to revisit our experience and reflections in the diaries, to initiate discussions among ourselves about our interpretation of our data and to question how these images affect us. Photography was useful in recognizing and reflecting on our own agency in taking these photographs. It helped us question and reflect on our choice of the photos taken as much as how, for example, a photo with Che Guevara's poster above the examination bed has affected our engagement with KIA. We did multiple analysis on each of the initial themes, questioning each other's interpretations until we agreed on the over-arching theme of our work, 'power and performativity'.

The third stage of our analysis was abductive, re-reading our transcripts and the initial themes we had identified alongside Barad's works on performativity and Foucault's microphysics of power. Here we noted the agency of more mundane materialities (clothes, posters, medical equipment, etc.) entangled with proserhomenos in a variety of uncertain and experimental practices. Questioning the agency of the white coat or of dental tools prompted us to reconceptualize objects, bodies and health care spaces as entanglements that actively contribute to KIA's reconfiguring of power. For example, how the use of casual clothing for all proserhomenos challenged well established hierarchical relations in the medical space or how shared dental tools intra-act with bacteria and sterilizing protocols forcing even reluctant proserhomenos to cooperate. The outcome of this process was the emergence of three overlapping themes that constitute the focus of this paper: 'this is not a clinic', 'the proserhomenos' and 'the matter of power'.

### **This is not a clinic**

KIA is located near Thessaloniki city centre, in a building owned by the Labour Centre (a trade union organization). From outside, it hardly resembles a clinic but a small signpost at its entrance reassures visitors. Once through the entrance, you immediately notice something is missing: from the doctors' white coats and the blue outfits of nurses to the distinctive smell of a clinic, a blending of medical odours and sickness, that situates the body within the particular setting of a medical space and shapes doctors' and patients' behaviour accordingly. Smell can enact a conception of bodies as 'strong' or 'weak', 'abled' or 'disabled', 'touchable' or 'untouchable'; it can instigate memories and emotions that would enable certain behaviours while suppressing others. Yet, the absence of this distinctive smell at KIA calls for a new cartography of the clinic and the active reconfiguration of the embodied experiences of doctors and patients alike, blurring organizational boundaries and opening possibilities for different material entanglements and alternative ways of exerting power.

There is very little to resemble a clinic, if not for the pharmacy and some medical equipment in the dental office (see Appendix 1). A sense of sheer disorientation has marked our first encounter with KIA:

Surprisingly pleasant smell. Need to double check I am in the right place lol. . .Need to find somebody to tell them I am here but. . .who am I supposed to talk to? They all look the same, no uniforms. I need to figure out who works here. (Observation Notes)

At the entrance, there is a small front desk where all the secretarial activities take place. The available computer, while in prominent position, is hardly ever used and all records are kept manually in dossiers alphabetically stored in the bookcase next to the secretarial desk. People wear casual clothes and, if not for the secretarial desk, you would hardly distinguish the personnel from the patients: a blurred border is the hallmark of all KIA's entanglements. On the right-hand side, a small door leads to the pharmacy with few people behind the counter. Opposite the secretarial desk, a small room with a curtain serves as a kitchen where the smell of coffee often covers all other odours, welcoming

everyone to what is otherwise a clinic. The walls of the corridor are decorated with kids' drawings and posters from local grassroots initiatives while the usual marketing brochures of medical products are replaced by pamphlets about local and international political struggles.

I quite like the posters, rather unusual for a clinic but choosing Che Guevara is a nice touch! The doctor's offices look odd, minimal with a desk, few chairs, the examination bed and Emiliano Zappata smiling alongside Che Guevara. (Observation Notes)

Across the waiting area, there is the dental office with two working stations, and the two main consultation-examination rooms used by GPs and psychologists. In these rooms, the usual decoration of a doctor's office with big bookcases full of volumes of medical encyclopedias, statues of Hippocrates, human anatomy posters or medical degrees hanging on the walls are absent. Instead, the gazes of Emiliano Zapata and Che Guevara are a subtle indicator of KIA's politics, its peculiar material entanglements and its ways of understanding power. Che Guevara's poster intra-acts with KIA's mission and its strategy of resistance (Foucault, 1978) that codes a series of otherwise dispersed antagonisms: the doctor as revolutionary hero fighting neoliberal austerity through primary health care – solidarity against neoliberal healthcare, the doctor/activist against the doctor/manager. Even the doctor's desk that is usually placed in between the doctor and the patient (a boundary exhibiting and reinforcing power) is missing. Instead, it is placed in the corner of the office, facing the wall, displacing the boundary and creating a common space.

The clinic has several divisions, some of which operate twice a month (cardiology, otolaryngology, dermatology, psychology and physiotherapy). Our focus, however, is mainly on those divisions that operate daily (pharmacy, dentistry and pathology) and on the initiatives of common diabetes sessions, cooperative dentistry and integrative medicine. As in any other clinic, each division results through a series of boundaries that emerge through the intra-actions of knowledges in distinct medical disciplines, the agency of the doctor and their specialization in a specific discipline, and the physical partition of space within the clinic. Power matters through these boundaries and their relevant exclusions (Barad, 2003). At KIA, boundaries are supple: people move from one division to another, traversing roles and identities (as in cases of patients becoming assistants), intra-acting differently with matter (e.g. how medicines are organized in the shelves or how dental equipment is sterilised).

It was interesting to work at the reception today, a bit nervous at first but I think I did a pretty good job with keeping records and everybody was so approachable. (Observation Notes)

Funny how many times I confused a visitor with a doctor, but it was nice to chat with people in the landing. I need to find out more about the 'proserhomenos', they use it a lot. (Observation Notes)

The clinic thus creates a sheer sense of disorientation as the traditional clinic persist despite its absence. The blurring of boundaries contributes to the emergence of new possibilities, new imaginative relationships, and the reconfiguration of the apparatus of the clinic. Traditional norms and patterns of behaviour normally at work in a mainstream clinic are radically reconfigured at KIA. The absence of the traditional white coats does not allow visitors to identify doctors. Everybody wears casual clothes and you cannot tell the difference between a doctor, an administrator, a patient, a researcher. Traditional boundaries and entanglements are suspended: the doctor has to reconfigure her professional identity as much as the patient has to reinvent her role. It is the very encounter of a doctor (or an administrator?) and a patient (or a researcher?), stripped of their sedimented identities, that performatively produces a new agential entanglement: 'proserhomenos'.

## The Proserhomenos

The 'proserhomenos' is a veritable 'discursive practice/(con)figuration' mutually entangled with 'specific material phenomena' (Barad, 2003: 814). It is an experimental entanglement designed at KIA to transform the apparatus of the clinic and the way in which power is exercised. It instigates relationships of mutuality towards the collective co-creation of a health community, bringing forth the plasticity of a co-created space by altering the boundaries between the expertise of the medical professional and the passivity of the patient.

*Margarita:* We reject the de facto 'weakness' that occurs from a medical diagnosis, that automatically puts the patient in a socially marginalized position, and of course in relation to the doctor/expert or whoever is positioned as the 'healer'.

It attempts to rearticulate these boundaries by excluding exclusionary practices entailed by traditional discursive practices/(con)figurations. 'Proserhomenos' excludes the commonly used notion of patient that connotes someone socially 'weak' and marginalized, the idea of 'clients' often used in private clinics, and the idea of 'beneficiaries' commonly used in other social clinics as it bears a charity connotation. This is how KIA manifests its distinctive political stance, sketching the apparatus of a more-than-social clinic, from a space of health care provision to a health community, a space of experimentation with alternative medical practices and new entanglements that contest the dominant modes of spacing and ordering (Foucault, 1984, 1986) of a clinic.

Yet, the actual entanglements that materially emerge through the performative reiterations of KIA's everyday practices arguably swerve from the intentions of those who attempted to craft them. This signals the emergence of new and unintended boundaries. While most of the personnel adopt the word consistently, those visiting KIA for medical treatment are less likely to do so, de facto sticking to their traditional connotation of patients. We often witnessed the persistence of an underlying antagonism between KIA's alternative mode of organizing and the spectre of the mainstream clinic. Despite its absence, the traditional clinic deploys its ongoing antagonism through dispersed practices that are reluctant to engage with KIA's reconfiguring of power. The recalcitrant proserhomenos who asks for the doctor or the proserhomenos-dentist who defies cooperation performatively are not a mere expression of this ongoing antagonism, but its performative enactment.

Resistances to KIA's reconfiguring of power are also determined by how proserhomenos envisage the future of the clinic. For some, KIA is but a temporary solution to austerity and will become superfluous once access to healthcare becomes universal; others put emphasis on the idea of creating a 'health community' whose spatial boundaries extend beyond the medical facility. Those inclined to adopt the first position were often, perhaps unintentionally, reproducing the same categorizations and hierarchical relations that exist in conventional clinics. Interestingly, they would rarely use the term 'proserhomenos' to describe themselves or others unless explicitly brought up during our conversations. Doctors often displayed a strong voluntarist attitude, emphasizing their '*personal responsibilities as medical professionals. . .*' (Thanasis), the '*need to take action and help those in need. . .*' (Anon.), and '*not to stay indifferent. . .*' (Anon.). Participating at KIA was perceived as a 'professional duty', and a means to define who they are (health care professionals) but also who are they not (indifferent doctors). In a similar fashion, the non-medical personnel would exhibit a voluntarist attitude and strong sense of solidarity and reciprocity, '*helping those in need. . .*' (Anon.) and '*giving something back. . .*' (Anon.) while they are characterized by a general disinterest in relation to the organisation of the clinic. As for most patients, their interaction at KIA is limited to receiving their medicine and medical treatment, exhibiting the same attitude as in any mainstream medical facility.

On the other hand, those envisioning KIA as a health community shared a rather critical stance towards power dynamics in dominant western medical practices and an interest in experimentation with alternative medical treatment. These engaged 'proserhomenos' were particularly vocal about the idea of KIA being something 'more than just a social clinic', and a space that could gradually be transformed into a 'health community', contrasting the hierarchical and disciplinary nature of mainstream medicine to the egalitarian character of the health community. They would be reflective on their own position of within wider power relations, consistently describing themselves and others as 'proserhomenos' and rejecting all notions of voluntarism as that would repropose a distinction between personnel and patients, a divided community.

The contemporary presence of these two kinds of proserhomenos (reluctant v. engaged) shows the antagonistic fabric of organising, particularly cogent for alternative organizations that experimentally engage with novel reconfigurings of power. It is through uncertain and contested everyday practices that KIA traces its own strategy. For instance, sharing dental tools create the conditions to reinvent the relations between proserhomenos, while reconfiguring dentistry as a cooperative enterprise. The blurring of boundaries and how they are continuously being contested and reworked is evident in the ways in which apparatuses are performatively constituted in the dynamic practices of intra-action. The sedimented stability of the boundaries enacted in the relationship between doctor and patient is disrupted once a patient changes role and becomes a member of the clinic, working on secretarial activities or at the pharmacy. In such cases, our participants appeared to have been completely disengaged from 'being patients' and become 'proserhomenos'. The supple boundary between caregiver and caretaker entails a non-exclusionary entanglement where distinctions are suspended. In some cases, their intra-action could be limited to performing the work they are assigned; yet in other cases they would actively engage in a range of experimental practices across the clinic, question medical authority and reinvent their relations with others. For example, Anna's first intra-actions as caretaker, visiting the clinic for a health-related issue, was disrupted once she got involved in initiatives such as that of the integrative medicine and the production of the health card. Anna attended general meetings, contributing to the designing of the health card and participating in the diabetes group session; her opinion carried the same weight as that of those with medical training. After a meeting about the future of the altermedicine team and KIA, we noted

It is about 21:00 and I am heading to a meeting that has been organized by the altermedicine team in a local bar. I arrive there and we are about 9 people. There is music in the background and we are talking about the future of KIA. Anna, is not a medical professional, yet she is as much active and vocal as all others about what they have done and what they should do, nothing seems to hold her back. I feel a bit strange too that I have been asked to share my thoughts. (Observation Notes)

Furthermore, irrespective of members' perception of the clinic, their identities were constantly renegotiated through special conduct with certain artefacts. Our own identity would regularly change throughout the day. We felt, and were seen, more like proserhomenos while answering a phone or assisting a visitor during our secretarial duties, we connected more with the personnel at the pharmacy when organizing the medical supplies, and revisited our initial identities (as researchers) when returning to our notepads or using our digital recorder. We also observed how proserhomenos-dentists would re-negotiate their professional identities through their intra-actions with shared dental tools (as we later describe in this paper).

Becoming 'proserhomenos' does not eliminate the issues of power associated with the medical profession or their assigned role within the clinic, yet it creates conditions for the reconfiguring of existing boundaries, the enactment of certain practices as well as the rejection of others. In the next

section we will try to unfold in more detail the material practices that produce new ways of exerting power, disrupting the dominant apparatus of the clinic.

## The matter of power

A recurrent theme in our interviews and group discussions was that of power. Our participants put a great deal into reflecting on the relationships between doctors and patients, the expectations that derive from their professional identities and how medicine as a science creates and reproduces certain power relations. KIA's medical personnel generally problematized their role and their authority,

*Froso:* There are always very specific power relations at play between doctors and patients. When you put on a white coat, you present yourself as the 'doctor'. You often do not realize that it is your institutional role that creates these power relations.

Doctor and patients generally adhere to their set roles: the doctor is responsible for providing medical care as she holds the 'expert' knowledge, while the patient willingly conforms to all the established norms that require her passivity. Despite KIA's rejection of this model, most patients continue to behave as they would if they were in a mainstream clinic, even feeling uncomfortable to ask questions about their treatment options as that could '*upset the doctors*. . .' (Anon.). To challenge existing power relations and boundaries, our participants put emphasis on the idea of a health community, as a mean, to resist the power relations that persist despite KIA's attempt to exclude them by,

*Vangelis:* . . . finding different ways to operate the social clinic. To involve everyone in all our processes irrespective of whether they are health professionals or not. We need to put the community at the heart of everything we do.

This is evident in a range of everyday practices that involved *proserhomenos*: from our own involvement in redesigning the health card to experimental initiatives like cooperative dentistry, integrative medicine and the diabetes group sessions. Such initiatives question the ethics of western medicine and critique the boundaries reproduced by the partitioning of dominant medical practice which,

*Froso:* . . . creates tensions by distinguishing the psychological from the physical, the context from the individual, the doctor from the patient. It remains 'silent' about the relationships that these distinctions create and reproduce. It divides the body into many parts but does not reconnect them. This is what we try to do, we try to reconnect them.

Our participants pointed to their everyday encounters at the clinic to reflect on the material conditions that challenge medical authority and produce new ways of 'knowing' about health care. They shared several stories about their experience at the diabetes group sessions and of the integrative medicine initiative. Further reflecting on the context of the diabetes group sessions, they typically last for about 2 hours with 16 *proserhomenos* in attendance: medical personnel (GP, dentist, psychologists, pharmacist, dietitian and physiotherapist), non-medical personnel, diabetes patients and their relatives or friends. These sessions were designed based on a holistic approach to medical care (giving equal emphasis to physical, psychological and the social conditions) and their purpose was to help those with diabetes through the sharing of knowledge and experiences irrespective of participants' own roles or specializations. During these sessions, some appeared to put more

emphasis on matters related to their personal lives and working conditions or the role of and relationship with the doctor, as opposed to their condition's symptoms. As one of our participants recalled, the diabetes sessions helped her to reflect on her lifestyle and work patterns, to change her social life rather than simply relying on medicines to regulate her blood sugar levels.

Such alternative practices question well established norms of the medical profession, prompting some proserhomenos to go as far as to propose the idea of a clinic that is 'no longer a clinic', a clinic that has no doctors or patients:

*Margarita:* In the diabetes sessions, we did not distinguish between doctors and patients. Some had degrees and specialized knowledge, but the idea was that the initiative will consist of a support team and the processes would be collectively agreed so that everyone involved will have an equal role. Who was the 'healer' in that context?

*Researcher:* Are you implying that you were all patients and healers at the same time?

*Margarita:* Exactly. Because if you ask me what was the illness and who was the patient? I will ask you back whom? The doctor or the patient? So, they both change in terms of how they perceive themselves and their role in all that.

This experimentation with alternative practices opened a range of previously unanticipated possibilities. For example, the integrative medicine initiative was designed to offer a holistic approach to medical treatment. These sessions typically lasted around 1.5 hours whereas a Health card designed at KIA was integral to the process of these sessions. Vasilis described his experience participating in these sessions as something 'fascinating':

You realise that a symptom related with a specific condition such as high blood pressure can in fact be triggered from underlying family causes and that you need to make changes in your personal life in order to address your medical condition; that is something I never thought about. Maybe other doctors did but I didn't and so for me it was fascinating to see the connection between the physical, the psychological and the social.

As our participants reported, the health card assists in creating a visual mapping of main events in the proserhomenos' life and helps them draw connections between these events and their medical condition. As Elektra stressed,

It is like a visual mapping, a genogram that you can see important events of your life [in] and relate them to a medical condition. For example, you might realise that the loss of an important person in your life is related to your medical condition. Of course, you can tell me, is this not obvious? Well, in many cases it is not. It is this connection between medical conditions and life events that we tried to do, that in conventional medical practice is ignored or neglected.

The use of the card had unanticipated effects for all proserhomenos however, prompting them to invent new ways of connecting with each other, encouraging doctors to reflect more critically on the conventional practices of their specialization and patients to reflect more on their own experiences living with a health condition and become more active in dealing with it.

So far, we have identified several experimental practices that intentionally created possibilities for more collaborative relations. In other cases, such as the cooperative dentistry initiative, we found that such possibilities were not intentional and had gradually emerged once dentists had to work alongside other dentists and non-medical professionals. As Kostas and Thanasis stressed, these new collaborative practices challenge that sense of 'ownership' and 'control' over patients typical of mainstream dentistry. This was evident in references to dentists as 'artists' and to patients

as ‘canvases’, where dental treatment was seen as unique to the individual doctor: ‘*I have my own technique. . .*’ or ‘*each one of us uses a different approach. . .*’ were common responses that show reservations towards cooperative dentistry. Thanasis reflected on the difficulty of working with others and how it differed from his experience at his private office:

You normally work alone or with your assistant but here [KIA] you had to work with other 50 dentists. We managed to cooperate well, but this is not something easy, it is actually very difficult because you begin a treatment and somebody else would finish it. I mean you start working on a patient and then you finish the session but the next time they visit they will continue with another dentist; and they must continue from where you stopped.

He further reflected on how dentists connect to objects, such as ‘*how you sterilize the equipment. . .*’ or choosing ‘*what materials to use. . .*’ as something that needed to ‘*be negotiated*’ and ‘*collectively agreed*’ between dentists and non-medical personnel. The relationship with dental tools was also presented as a source of tensions and disruption of the dentist’s authority while the absence of private ‘ownership’ forced all proserhomenos involved to negotiate and re-configure their professional identity. Reflecting on the challenges of working with others and their interaction with common dental equipment, our participants described a range of initiatives introduced at KIA such as collectively setting specific protocols and knowledge sharing processes on mundane practices like the sterilization of dental tools.

The dentist as an ‘artist’ vs the ‘cooperative dentist’ is an illustrative example of the persistent antagonism within KIA and the role of the tools in resolving this conflict. Tools are collectively owned, and they have specific necessities (need to be sterilised for instance) and this constitutes their agency that acts upon the actions of the conflicting strategies of dentistry. The mundane non-human entanglement of the dental tools, bacteria and sterilising chemicals modifies the actions of all dentists, subsuming them into a unique strategy that match the wider KIA’s way of exerting power differently.

In this section, we have tried to reflect on a range of experimental initiatives that have contributed to the development of new ways of interaction and knowledge that challenge mainstream practices and the dominant order of the medical profession. Our intention was to illustrate how existing boundaries are contested and destabilized, and how new apparatuses are performatively constituted through the dynamic intra-actions between human and non-human agents that are internally traversed by strategic confrontations.

## Discussion and conclusion

The traditional clinic can be defined as an apparatus where power is performed through a series of stable boundaries: intra-active entanglements that decree divisions, exclusions and set practices. Boundaries allow us to distinguish a doctor from a nurse or the cardiology department from the dental surgery. Each boundary performatively constitutes a power relation: every time passive patients submit their bodies to the expertise of the doctor; medical power is affirmed and the boundary is reinforced.

In the intentions of its most engaged proserhomenos, KIA deliberately rejects the apparatus of the traditional clinic altogether: access should be universal, no distinctions between whoever enters the clinic, collective decision making, cooperative practices. The boundaries of the traditional clinic are suspended: they do not vanish, but they persist through their absence. We still look for a white coat, for an anatomy poster, for the degree hanging in the doctor’s office. KIA produces an effect of disorientation by suspending these entanglements. Their absence is remarkable, their

absence matters: it matters for the personnel who intend to invent a new apparatus for the clinic, it matters for the patient that expects to trust people with a white coat and needs to readjust their expectation, it matters for the researcher who wants to appreciate the originality of KIA's experimental practices. The absence of traditional boundaries matter as they performatively keep intra-acting within KIA's walls. The two apparatuses intra-act in the sense that each does not pre-exist the relation (Barad, 2007); their distinction (traditional clinic vs. social solidarity clinic) performatively emerges through that very relation – there would have been no KIA if clinics were already based on solidarity and mutualism. But this intra-action is antagonistic: an oppositional confrontation between two adversaries, two strategies (Foucault, 1978, 1982).

How does KIA intra-act through this relation? How does KIA's strategy of resistance against the traditional clinic organizes its own exercise of power? Supple boundaries: whereas the apparatus of the traditional clinic tends to reinforce the stability of its boundaries, KIA blurs these divisions through mundane and experimental practices, as in the case of the integrative medicine project for instance, where doctors from different specializations work together. Even the smell of coffee invading the clinic from the kitchen signals a supple boundary in sheer contrast with the careful exclusion of this smell in traditional medical facilities.

The dynamic intra-actions at stake in these experimental practices result in open entanglements that challenge not only traditional exclusions, but the very act of excluding. As Froso put it earlier, '*[western medicine] divides the body into many parts but does not reconnect them. This is what we try to do, we try to reconnect them*'. KIA tries (therefore with a manifest experimental tension) to reconnect the many parts into which a whole clinic is divided. Not only that, it also blurs the division between a medical facility and the rest of the community. While a traditional clinic connects to the community exclusively in relation to health, KIA connects itself with the community also at a political and social level both through the posters and the political pamphlets that populate its space and through active participation in local struggles. KIA's experimental practices define a horizon for a radically different way of exerting power: supple boundaries, expansive (re-)connections. It questions power and its exclusionary practices by trying to exclude those very practices that determine exclusions. The performative mattering of power at KIA occurs through a process that aims to avoid divisions (e.g. the absence of the table dividing the doctor and the patient) and to (re-)connect previously separated parts (e.g. the expertise of the doctor and the patient's knowledge). By doing so, it still sets a boundary that excludes how power matters in traditional clinics, revealing the material opposition between these two strategies. As such, power does not disappear, but it is performatively reconfigured.

The adoption of the term 'proserhomenos' is the hallmark of how KIA addresses how power matters. With Barad, proserhomenos is a discursive practice/(con-)figuration that reconnects all subjects circulating within KIA. It does not set boundaries between them (a doctor vs. a nurse vs. a patient vs. an assistant). It invites individual subjects to engage with their constitutive connectedness. While traditional discursive practices/(con-)configurations (e.g. a doctor – the entanglement of white coat, expertise, medical diploma, etc.; a patient – the entanglement of morbidity, affected organs, casual clothes, smell of illness, etc.) focus on what disconnects and distinguishes individuals, proserhomenos exalts their connectedness and commonality. Still, to an extent, the attention to proserhomenos seems to restore the idea of a human agent, reintroducing the dichotomy between human and non-humans. This seems to be the ever-present challenge for empirical studies on sociomateriality (Kautz and Jensen, 2013; Mutch, 2013).

No element in a materialist and posthuman ontology can be deemed exclusively human or non-human. In our case, proserhomenos cannot be thought of as (human) subjects, but as material entanglements that emerge in a series of dynamic intra-actions. It is through the intra-action with KIA's entrance that human subjects are reconfigured as proserhomenos. They do not pre-exist their

intra-action: there is no KIA without 'proserhomenos' and vice versa. The door has its own agency as it performs a boundary: it materially leaves out those who are not proserhomenos *yet*. Through their intra-action, the matter of the door turns into KIA's boundary and the (human) matter that walks in becomes a proserhomenos. Once inside, other experimental practices highlight how proserhomenos, as a discursive practice/(con-)figuration, operates at the level of matter beyond the human – nonhuman divide. In the case of cooperative dentistry for instance, proserhomenos form novel relations with their tools. The encounter entangles dental tools, bacteria, sterilization methods and various proserhomenos. Bacteria act upon the tool and, consequently act upon the proserhomenos who is forced to sterilize the tool. As the same tool will be used by different proserhomenos, the latter are forced to agree upon a sterilization method. Proserhomenos (as discursive practice/(con-)figuration) intervenes at this stage: the decision needs to be negotiated and collectively agreed between dentists and non-medical personnel, reconfiguring traditional exclusionary practices.

Even the resistances to becoming proserhomenos show the entangled and relational nature of this materialist ontology. Following Foucault (1978), if there are resistances to becoming proserhomenos, there is power inherent in this process of reorganization of the traditional organizational order in healthcare. We see a reconceptualization of the idea of intentionality within power relations that becomes distributed and dispersed. 'Power relations are both intentional and nonsubjective' (Foucault, 1978: 94). Intentions are neither inherent to the discourses enunciated by singular individuals (what our participants say in the interviews), nor to the decision of the assembly that governs KIA (the collective choice of the label proserhomenos). From this perspective, we looked at practices and material entanglements to recover a distributed agency and intentionality that is nonsubjective (and eminently beyond the human/non-human divide): the declared intentions of speaking bodies are the actual product of power entanglements rather than the cause of these entanglements. In the becoming-proserhomenos argument, we retrieve discursive-material practices that affirm a supposed intentionality of KIA (their deliberate choice of implementing the term to contest traditional hierarchies) and phenomena within this apparatus that exceed that form of intention (e.g. the proserhomenos who still fear 'upsetting the doctors'). This focus on the entangled and relational nature of power with these differential and unpredictable effects reflects the 'implicit characteristics of the great anonymous, almost unspoken strategies' (Foucault, 1978: 95) that not only structure and produce society and organizations but constitute the dynamic intra-agency of matter. At the level of forces, the proserhomenos who keeps acting as a patient is a form of resistance, a force that does not let itself be affected by another force. This point of resistance within KIA is the effect of a sedimented relation of power that is coded in the wider strategy of the traditional clinic. The recalcitrant proserhomenos is the effect of an ongoing confrontation between the two strategies, a persistent opposition that affects KIA's material reconfiguring of power.

The theoretical encounter between Barad and Foucault can help scholars in OS to address both the agential and transformational potential of matter (Barad's emphasis on possibilities and reconfigurings) and its antagonistic and oppositional character (Foucault's microphysics). This is especially urgent for alternative organizations, where experimental practices are performatively confronted with the persistence of opposing strategies. KIA represents an alternative organization that emerges as the coding of dispersed points of resistance into a strategy (Foucault, 1978) while simultaneously orienting its intra-action towards the ethical horizon of justice for a politics of possibilities (Barad, 2007): strategic opposition and transformational reconfigurings. The dimension of power is then understood as a matter of performative intra-agentic reiteration of practices. With Barad, we can follow the process of mattering of power relations or how power relations come to matter in a double sense: how power relations materialize themselves in the actual processes of organizing on a day to day basis, but also how power relations come to matter (become relevant) in the sense of becoming the object of material-discursive practices of contestation and reconfiguration. With Foucault, we reflect on how apparatuses, both in their specific enactment of quasi-stable

boundaries and in their antagonistic intra-action with other apparatuses, operate, strategically determining and being determined by material relations that ultimately correspond to relations of power. In our case study, this strategic dimension emerges both in KIA's intra-action between the apparatus of the traditional clinic, the apparatus of the neoliberal clinic and the apparatus of austerity, and in the entanglement of KIA's proserhomenos with the doctor-patient apparatus, the white coat and the apparatus of disciplinarization of knowledges that sustains medicine qua science.

This theoretical perspective allows us to rethink power in organizations as radically open to its continuous reconfiguration. In KIA's case, we engage with an intentional attempt of operating upon this ontological openness. Far from being stable, power matters in uncertain and contested ways. Power can therefore be materially rearticulated through practices that alter ordinary boundaries. KIA's boundaries are deliberately maintained as supple, but this does not fully exclude the persistence of traditional divisions (e.g. the recalcitrant proserhomenos who either wants to reaffirm her authority as doctor or her passivity as patient). Beyond (or despite!) the intentions of its engaged proserhomenos, power emerges performatively through experimental, uncertain and mundane practices that entangle human and non-human forces alike. As such, power remains open to modification at the very level of matter towards an open horizon for an alternative and less exclusionary mattering of power.

At KIA, power matters through performative experimentations that produce uncertain and unexpected outcomes. It produces a radical disorientation that poses the question whether KIA is *still* a clinic: is it still a clinic if there is no doctor? Is it still a clinic if there is a Che Guevara poster? To some extent, KIA as an apparatus continuously intra-acts with the apparatus of the traditional clinic. Yet, it exceeds that intra-action, forming a completely novel apparatus on its own. Several proserhomenos saw KIA as a 'more-than-social clinic'. KIA becomes an apparatus that progressively materializes a (health) community that reconnects otherwise separated parts. It is not only the body of the patient to be reconnected, but it is a whole community to be brought together through solidarity and mutualism.

To conclude, in this article we discussed the reconfigurings of power in an alternative organization from a performative perspective. The intra-action of Barad's agential ontology and Foucault's microphysics of power allows us to rethink how power matters by highlighting the contested and experimental nature of a materialist and posthuman ontology. We looked at how even mundane materialities like clothes, smells and tools actively contribute to the mattering of power. KIA represents an interesting case study to appreciate these dynamics. KIA reconfigures how power matters through mundane and experimental practices that entangle human and non-human elements in uncertain and contested ways. This allows us to rethink the materiality of power through the antagonistic intra-actions of everyday posthuman entanglements. Even a strong smell of coffee, a Che Guevara poster and a sterilizing protocol are matters of power.

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## Appendix I – Photographs from KIA

**The Doctors' offices** (*A doctor's desk, a picture of Che Guevara and Zapata above the examination bed and of a stethoscope - a more enlarged image in the third photo – with a title 'salud desde abajo y a la izquierda: rebelde y solidaria' or 'Health from below and to the left: Rebelious and in Solidarity' that has a direct reference to the Zapatistas experiments with primary health care*)



**The Dentists' office** (A name plate in memory of a comrade dentist who donated her dental equipment to the clinic alongside children drawings. One of the two dental chairs)



**The Waiting area** (Posters of Chiapas, immigrants in hunger strike, antifascism and solidarity to Kurdish people in Kobani)



**The Pharmacy and Landing Area**

