## From stakeholders to communities of care

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### Introduction

In the past years we witness an increasing attention on community participation initiatives (Palmer, 2020) as an approach in addressing social and economic inequalities. Such participatory practices are being increasingly institutionalized and depoliticized resulting in undermining or ignoring the associated conflictual aspects of decision-making and power asymmetries (Esposto and Moini, 2020). The absence of problematising issues of power and the multiple dimensions of community renders community participation to be manipulative, passive and utilitarian (Wallerstein et al., 2011) conveniently shifting the responsibility of solving problems of social injustice to communities (Popay et al. 2021), or limiting the engagement of community members to consultation (Wallerstein et al., 2011). Despite the expansion of these depoliticized dynamics, neoliberal policies are continuously contested by numerous grassroots organizations and solidarity networks that propose mutualist and community participatory initiatives. Among them are social and cooperative clinics, workers collectives and a range of other grassroots initiatives all connected by a strong ethos for mutualist practices and a political aspiration to put in practice a distinctive set of social relations and value system (Cabot, 2016, Checchi, 2023, Kokkinidis and Checchi, 2023).

Furthermore, dominant models of organisations tend to conceal the antagonistic nature of stakeholders. Mainstream theories try to depict ways to harmonise the interests of different groups, while aiming to a supposedly common goal. From the original studies of Freeman (1984) in the field of strategic management, the relevant literature has gained prominence particularly since the early 2000s with scholars looking at a range of aspects aiming to reflect more on the operationalisation of stakeholder theory, from value creation (Andriof et al., 2022) to innovation and entrepreneurship (Alvarez and Sachs, 2023, Watson, Wilson and Macdonald 2020) and from responsible leadership (Patzer, Voegtlin and Scherer, 2018) to agonistic CSR (Dawkins, 2021). Noteworthy is the work of Kujala *et al.* (2022) that provides a systematic review of the literature on stakeholders engagement, illustrating the instrumental logic of stakeholders' engagement in management literature and pointing to what they refer as the 'dark side' of stakeholders engagement where 'taken-for-granted assumptions, such as jointness of interest, trust, and positive outcomes of stakeholders engagement' (Kujala et al., p. 1146) are challenged, opening up opportunities for new avenues for future research.

With this in mind, this chapter focuses on two case studies: the Space to Breath Collective (S2BC), the first yoga and wellbeing cooperative in the UK and a Social Clinic of Solidarity in Thessaloniki (hereafter KIA), a grassroot health care initiative. These cases are interesting as they show the necessity to rethink the idea of stakeholders in organisational settings that explicitly aim to be radically transformative. Alternative organisations like S2BC and KIA reconfigure distinct and potentially conflicting interests from a perspective of care that transforms the practices and the subjectivities at stake within and around organisations. The idea of care and caring is central to our analysis. However, we should note that we look at care not as a private affair or an ethical matter, but rather as a central organisational principle that is fundamentally collective and political. Building caring infrastructures is a constant struggle and one that requires genuinely collective efforts. Hence, we introduce the idea of communities of care (The Care Collective et al., 2020) as it best describes our two cases and their shared organisational and governance principles based on mutual support, processes of commoning (e.g. common resources, common spaces) and participatory democracy. Our analysis aims to illustrate how the overcoming of a traditional stakeholders' approach passes through the emerging of an alternative diagram of power, a set of affective relations reconfigured through performative intra-actions between the members of

these communities, their discourses, their practices, the multiple materialities that constitute these spaces. This theoretical perspective connects Barad's relational ontology to Deleuze's interpretation of Foucault, allowing to explore the repoliticisation of care and the reconfiguring of stakeholders into careholders.

Drawing on data collected through a range of qualitative methodologies (semi-structured interviews, participant observation and informal group conversations) we look at alternative practices of organising where different stakeholders within and outside the organisation deliberately engage with the underlying and structural power relations that define their relevant positionalities within the organisation and, more widely, in the social and economic context in which they operate. Through a series of empirical examples of alternative organisations, we look at the efforts to take seriously the notion of stakeholders to the point of rejecting it altogether in order to reinvent relations and interactions for practices of collective organising. For S2BC, we look at the process of transforming the cooperative into a veritable community of care. Its assembly welcomes all stakeholders (instructors/workers and students/customers) with potentially conflicting interests. Despite the conflicting economic interests at stake between teachers and students, we observed the emergence of a community of care where the distinction between stakeholders is reconfigured from a perspective of care. Through this process, we note an implicit and experimental trajectory of politicising community and care against market drives and individualistic isolation. This political approach is instead ostensibly adopted at KIA. The identification of two separate stakeholders, doctors and patients, is addressed from a political perspective that acknowledges, assesses and transgresses the relevant power relations that support that separation. In the attempt of making sense politically of those power relations and of the genealogy that produces the apparatuses of division inside and outside the clinic, we look at how discursive and material practices concur to turn those power relations into an anti-hierarchical, mutualistic and horizontal process of transformation: the adoption of a common label (proserhomenos) for all incomers in the clinic, reconfiguration of healthcare practices, collective therapeutic processes.

**Theoretical framework**

Barad's concept of performativity emerges through the constitution of her relational ontology, drawing attention to the material irreducible connectedness of being understood dynamically as becoming. Barad's materialist stance is largely predicated upon Niels Bohr's agential realist ontology that rejects the dichotomy between words and things by focusing on '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, p.814). Both phenomena and discursive practices are material in the sense that both participate in the universe's becoming: they do not stand in a relation of externality to one another. Yet, they are not reducible to each other. Their relation is of mutual implication and mutual entailment. And this relation needs to be understood as always ongoing, producing multiple reconfigurings and rearticulations, essentially dynamic. 'This dynamism is agency. Agency is not an attribute but the ongoing reconfigurings of the world' (Barad, 2007, p.141).

The performative character of Barad's materialist ontology lies in this understanding of becoming as the agential intra-activity of matter. Intra-action refers to the continuous (self-)reconfigurations of matter through multiple entanglements which produce what Barad calls apparatuses, dynamic reconfigurings of the world 'through which exclusionary boundaries are enacted' (Barad, 2003, 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. Yet, boundaries are not defined once and for all: apparatuses are performatively constituted in the dynamic practices of intra-action and are therefore open-ended with boundaries continuously being contested and reworked. 'Boundaries do not sit still' (Barad, 2007, p.171). Subsequent iterations of specific practices determine a temporary stabilisation of boundaries, but, at once, opens the possibility of reconfiguring practices whose iteration will then produce new boundaries and therefore new

apparatuses. But no apparatus is given in isolation and 'any particular apparatus is always in the process of intra-acting with other apparatuses' (Barad, 2003, p. 817).

Barad's theory accounts for how matter comes to matter in a double sense. On the one hand, it analyses how the world has come to its existing configuring. On the other hand, its performative stance unveils both the contingency of the existent and the possibility for change with an implicit ethico-political stance: 'Particular possibilities for acting exist at every moment, and these changing possibilities entail a responsibility to intervene in the world's becoming, to contest and rework what matters and what is excluded from mattering' (Barad, 2003, p.827). We argue that stakeholder theory in general displays a crystallised a way of prioritising individual interests and the antagonism that is inherent to this perspective, while reflecting the material underpinning of traditional organisations within a capitalist mode of production. What matters in organisations is individuals and their stakes, with financial stakes mattering more than any other sort of stakes. Care is performatively excluded from mattering. What we see at work instead in the two organisations we discuss in this chapter is a radical intervention in the world's becoming that rather than looking at those who hold a stake in the organisation, actively holds space for caring and for being cared for. We consider this intervention as eminently political.

However, while a political dimension is largely absent in Barad's work (Harding, Ford and Lee, 2017), we propose to supplement Barad's ontology with Foucault's work. Despite Barad's own engagement with Foucault seems to bar this trajectory, a Deleuzian reading of Foucault allows for such a theoretical enterprise. Deleuze's Foucault is a hybrid theoretical compound that draws a transversal line between Foucault's analysis of power and Deleuze's ontology (Deleuze, 1985, 2006, Deleuze and Parnet, 1995).

While acknowledging the proximity of Deleuze's and Barad's concepts, Hein (2016) rejects the possibility of connecting their ontologies as ultimately incommensurable. For Hein, Barad still holds a binary logic where 'the matter/discourse binary has not truly been undone' (Hein, 2016, p. 137) deriving from a philosophy of identity and transcendence incompatible with Deleuze's philosophy of difference. But, as demonstrated above while discussing intra-action, difference is central to Barad's ontology: 'The world is intra-activity in its differential mattering' (Barad, 2003, p. 817).

Furthermore, against an overdeterministic reading of Foucault, Raffnsøe Mennicken and Miller (2019) recovers a dimension of performativity where 'agency is dispersed and co-produced, rather than something that remains in control of it'. And this performative agency is immediately connected to the problem of organizing: 'performativity itself is an inherent condition of possibility for organizing and the exercise of power more generally' (Raffnsøe, Mennicken and Miller, 2019, p. 175).

For bridging Barad's performativity and Foucault, we look at how Deleuze re-elaborates Foucault's (1995) concept of diagram: 'Diagram is power. One can call diagram the exposition of a relation of forces or of a set of relations of forces. One can call diagram any distribution of power to affect and power to be affected, that is any emission of singularities' (Deleuze, 2014, n.p.). Here power is understood as an ontological domain (somehow corresponding to Deleuze and Guattari's plane of consistency) whose nature is distinctively discerned through the interplay of forces (microphysics). This distinguishes power as a domain from historical formations (the domain of knowledge and archives, corresponding to Deleuze and Guattari's strata). The latter consists of forms that emerge through a concrete interlacement of discursive and non-discursive multiplicities. Power as a domain instead is informal. Forces are 'unformed matter' whose interplay (affecting and being affected) expresses 'non-formalised functions' (Deleuze, 2006, p. 77). The diagram selects a whatsoever multiplicity (a set of forces as unformed pure matter) and organises it according to a function whatsoever (imposing a task or making something probable). The informal dimension of the diagram determines a distinction in nature with the concrete forms that emerge (a school, a clinic, a solidarity clinic, a yoga studio, a community of care). Formalised matter emerges as the diagram operates by organizing the strata and provisionally determining their homeostatic equilibrium. This occurs through concrete machinic assemblages that mediate the relation between the plane of unformed matter (i.e. power, the diagram) and the strata.

Although this would have deserved a more extensive elaboration beyond the scope of this chapter, we can trace the conceptual trajectories where Barad can encounter this Deleuze-Foucault hybrid. The common starting point is the understanding of matter as agentic, self-differentiating and in continuous

becoming. The entanglement or interlacement between plane of consistency-the informal-power with the strata-historical formations-archive remains somehow implicit in Barad. The former appears only as the ever-present possibility of contesting and reconfiguring what matters and what is excluded from matter(-ing). Barad's focus on strata appears instead under the guise of phenomena and material-discursive practices enacted through relatively stable boundaries. Accordingly, the apparatuses presiding at the (re-)articulation and (re-)configuring of phenomena and material-discursive practices can be thought in relation to the idea of concrete machinic assemblages that codify and formalise unformed matter and unformalised functions.

This encounter helps to read Foucault and Deleuze through the lens of a posthuman materialist understanding of performativity, while it contributes to Barad's ontology through a closer attention to power. Power matters: an entanglement to be read both with power-as-adjective and matters-as-noun, and with power-as-noun and matters-as-verb.

**Beyond holding a stake: practicing mutual care in a yoga studio**

S2BC is the first yoga and wellbeing cooperative in the UK. It is a not-for-profit community of interest company operating in Leicester. The story of the S2BC starts after the closure of a popular yoga studio in the city centre. Due to financial pressure and high operational costs, the studio closed despite the large following. This represented an important loss for many yoga students who suddenly were stranded and looking for alternatives. It is from this loss that the idea of the S2BC emerged. Three students started exploring the possibility of opening a new yoga studio in the area. Out of a beautiful friendship emerged on the yoga mats, a former sales agent, a psychotherapist and an architect converted to yoga teacher decided to start this adventure. For as much as this may immediately sound like a typical story of entrepreneurial initiative spotting a market opportunity, it is already at this stage that we can observe the fluidity of stakeholders and the possibility to transcend the idea of stakeholder altogether. Rather than a business opportunity that would pose them as entrepreneurs or owners of a new business venture, the three original founders of S2BC responded to their own need of a studio where to practice yoga. In a traditional stakeholder framework, they would classify as students/clients/users about to turn entrepreneurs/owners. Yet, we argue that there is an additional layer of complexity due to the specific nature of the industry and to the explicit intentions of the stakeholders involved. First, while yoga can be commodified into a lucrative business, it has the potentiality of representing a form of resistance to neoliberal conceptions of care. Although this potentiality is often either latent, co-opted or suppressed, this is the trajectory that S2BC started to explore. Secondly, in the intention of the founders of S2BC, the stakeholders affected by the closure of the studio are not only customers. While the previous yoga studio did regard them only as customers, there was something that exceeded their stakeholders' classification. As yoga students somehow united in a virtual yoga community formed by a loose sense of belonging, common affinity and a vague collection of values, they represented an anomaly that does not fit traditional stakeholders' evaluation. In this anomaly, we see the political potential of an alternative and transformative diagram of power that problematises the idea of stakeholders with conflicting interests and experiments with the elaboration of collective, horizontal structures of care. This is the potential that progressively becomes actualised in the S2BC.

This collective dimension is explicit in the choice of the name. At the beginning, it was more an intuition or a wishful commitment worth exploring and experimenting with. Although the collective formally consisted of only three people, the name reveals the aspiration of including everyone that enters the new space. After the formal constitution of a registered community interest company, the founders identify a small space to be converted into a yoga studio. The space is rented to teachers who pay a fee and keep the rest of the money from students attending their classes. Interestingly, even the three founders pay their fees as students to attend classes. Although the model is sustainable as it covers the expenses of the studio, it requires a huge amount of unpaid time for the three founders and it does not elicit any particular sense of collective or community: 'We felt like we were the Uber of yoga, but without making any money out of it' (Dave).

In March 2021, S2BC finds a new home. Its renovation is the first embryonic process of overcoming a restricted perspective on distinct stakeholders and the development of a community in practice. For months, several people took up hammers, brushes, staple removers, and sanding machines without any prior experience of how to use these tools. As Marx would put it, from each according to their ability, but also their inabilities! The previous grey and dusty offices transformed into a radiant welcoming space. Making the space was the result of a community in the making. The two processes cannot be distinct: a yoga teacher (re-)turned architect, students turned painters, unpaid contractors turned friends in multiple intra-actions with a space, its dust, its large windows and the passers-by, the brushes, the thousands of staples that held firm a worn out carpet to be removed, the empty coffee cups everywhere, the yoga mats waiting to find a floor to be rolled out, origamis, epoxy. In these material encounters, a community of care emerges.

The idea of community of care is borrowed from The Care Manifesto (The Care Collective et al., 2020). The constitution of S2BC integrates this perspective in its objectives: 'to create a community of care through activities which foster collective wellbeing. Our co-operative strives to make yoga, meditation, and wellbeing accessible, inclusive and participatory'. A community of care goes well beyond the idea of stakeholders as distinct groups or individuals with distinct and at times conflicting interests. Here care replaces interest. This does not mean that conflicting interests disappear or are strategically concealed. On the contrary, interests and potential conflicts are spelled out and discussed collectively: the reconfiguring of a new diagram of power is a matter of deciding what matters and what is excluded from mattering. This issue was addressed during one of the first assemblies. As soon as the new studio opens, the three founders decide to open the organisation and turn it into a proper collective. The monthly assembly is open to anyone who cares to join, it does not depend on a formal membership in the organisation. Since the first assembly, the attendees are a surprisingly heterogenous group. Out of the first 17 attendees, 4 were yoga teachers, 2 practitioners, 1 photographer, 6 regular students who used to attend the previous studio, 2 who helped with the renovation but never attended classes at the previous studio, 1 new student. Interestingly, there is also one person who attends classes in a different yoga studio as they live quite far but loves to attend the assembly and help with any task that can be done from remote. At the second assembly, one of the attendees (a student) noted that this heterogenous composition could potentially engender significant divergencies in terms of interest: students might want to pay less for their classes or have their contributions to the organisation recognised in a monetary form, while teachers might want to maximise their pay, perhaps charging students more. The intervention was welcomed with scepticism by most of the attendees. A student objected that teachers put a lot of extra work in terms of preparation, welcoming students before and after the class, tidying up the studio after the class, promoting the studio, etc. Another student noted that the price of the membership was already low compared to other studios in town. Some of the teachers shared what they were getting paid at other studios, noting how the proposed compensation was better than elsewhere. The following assemblies reinforced this point. As the studio increased its revenues over the following months, also the pay for teachers increased accordingly. Every time that a new increased pay rate is announced at the assembly, cheers and applauses welcome the announcement: a moment of genuine celebration and care. We also observed that in months when the revenues decreased, teachers accepted the lower pay rate announced at the assembly without registering any form of disappointment or complaint. Instead, most of the initiatives or ideas to expand the visibility of the studio (i.e., leaflets, promo code for free class, connections with local council) and increase revenues came from students, rather than from teachers.

As an intentional community of care, S2BC shows an ethos that has substantial political implications. An alternative way of organising a yoga studio with the ambition to develop a more holistic approach to wellbeing that takes into consideration the role of community and tackles the risk of exclusionary practices inherent to the wellbeing industry. A community of care is a practice of resistance against the atomisation of neoliberal societies and the individualising marketized approaches to mental health and wellbeing. The assembly represents a moment of autogestion and mutualism. Yet, the politicisation of care through these aspects is embryonic. While these ideas were explicitly discussed during assemblies,

we noted how many of the attendees were not familiar with these ideas or struggle to perceive their involvement in the collective as political. This reluctance is the obvious consequence of the depoliticization of community engagement and participation, but also the starting point for an experimental trajectory that includes a moment of further reflection and education, disseminating resistant considerations and attempts of politicisation of spaces of care.

**From stakeholders' engagement to building a health community: Doing health care differently.**

KIA is a social clinic located near the city centre of Thessaloniki in Greece. It 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. At its prime, it counted more than 350 members (medical and non-medical personnel) while providing free medical care to over 10,000 people every year. Financially the clinic is supported by solidarity groups in Greece and across Europe, while none of its members is financially remunerated for their work. The governance of the clinic is the responsibility of its members through weekly divisional meetings and a monthly general assembly meeting (Kokkinidis and Checchi, 2023). The cooperative ethos and political aspirations of its members are engrained in the very fabric of the clinic, particularly visible in the design of the space and its distinctive odours, the casual dress codes, a range of organisational artifacts and other materials and objects, all offering simultaneously a sense of disorientation and rapport, the constant blurring of organizational boundaries and opening of new possibilities for different material entanglements and alternative ways of exerting power.

Building communities of care is a constant struggle that involves a range of initiatives and practices within a complex ecosystem aiming to nurture new forms of social relations and social practices and ultimately create a distinctive value system. Community development in this context goes beyond the idea of stakeholders' engagement and participation in a progressively depoliticised fashion that is privileging a focus on the psycho-social characteristics of communities while ignoring the wider social and economic factors that reproduce inequalities in the first place (Popay et al., 2021). In the case of KIA, this is evident in their participation across social movements and networks on local and translocal levels. They have an active role in the recently established network of Social Clinics that brings together social clinics from 4 European countries (Greece, Italy, Germany and France) with the aim to spread the idea of community-based health care initiatives and health commons, organise collective actions, and promote initiatives for developing more egalitarian healthcare systems to address health inequities. In previous years, we can identify several notable examples of KIA's strong presence in social movements and solidarity networks, albeit at a more regional level, participating in solidarity events and struggles against water privatization and gold mining in Skouries, and been involved in the creation of the Workers' Clinic in the premises of the recuperated factory of Vio.Me in Thessaloniki, Greece. The Workers' Clinic is a good example of bringing together seemingly distinctive struggles (the struggle against austerity and unemployment and the struggle for free health care to all) and create the conditions for new socio-spatial formations to emerge, transforming the relationship between citizens, workers, medical professionals, (working) spaces and communities, not as isolated entities but as part of entangled socio-spatialities of resistance (Daskalaki and Kokkinidis, 2017). With this in mind, social clinics like KIA constitute more than just buffering systems to the exclusionary health policies and the progressive erosion of the public service, offering emancipatory paradigms of building communities and organising health differently.

At a discursive level, the idea of introducing the term incomers (proserhomenos) to refer to everyone entering the clinic is a collectively agreed principled choice guided by clearly defined and articulated political aspirations in transforming the traditionally hierarchical spaces of a health care provision to a community of health. The incomer is stripped from the distinctive and hierarchical positionalities (e.g. doctors vs patients) of a traditional health care setting, experiencing more symmetrical relations that create a sense of a shared identity that eventually instigate relationships of mutuality working towards the collective co-creation of a health community. It also brings forth the plasticity of a co-created egalitarian space, where boundaries between different medical professionals as well as between the

expertise of a medical professional and the passivity of the patient are altered, creating the conditions to challenge the power relations deriving from conventional medical and organisational practices. Ultimately, using alternative discursive practices set the foundations for building a health community that is guided by participatory practices and egalitarian relationships.

This is of course far from easy particularly during the designing and implementation of medical procedures, collaborative practices, and decision-making processes. Tensions that emerge from the spectre of the traditional hierarchical models of healthcare remain apparent, doctor might defy cooperation, or the patient-incomer often remains passive and is reluctant to engage, all testaments to the persistence of hierarchy that characterises medical practices. Yet, these instances also illustrate the messiness of mundane practices, 'particularly cogent for alternative organizations that experimentally engage with novel reconfigurings of power' (Kokkinidis and Checchi, 2023, p. 297).

Looking more closely to their organisational practices and some of their initiatives, we can begin to recognise that developing a health community is not an external intervention on a target group (Rifkin, 2009) but an ongoing process that require the active participation of all the users as equal. We can also witness how boundaries are disrupted when people eventually disengage from traditional positionalities of power, when new practices challenge the meaning of being a caretaker or a caregiver, when cooperative processes nurture a new value system and transform the very substance of our relationship to care and caring. The entrance of the clinic is a transformative threshold where the long-standing hierarchical relations between different stakeholders' groups (medical professionals, patients, community members, researchers) are gradually eliminated. This is particularly evident in their established decision-making processes, the everyday operations, and the more experimental medical practices. For example, patient-incomers can actively participate both in their departmental assemblies (e.g. the assembly meetings of the division they volunteer for) and in the general assemblies, and contribute, as equal, to the shaping of strategic objectives and internal processes as well as the co-designing of initiatives and events. Work at the clinic is voluntary and non-remunerated, and patient-incomers can also volunteer across several posts in the secretarial team, as dentists' assistants or at the pharmacy. They are also often involved in more experimental medical practices initiated by the *Other Medicine Team* of the clinic. Such initiatives include the diabetes group session and the integrative medicine, where all incomers (medical professionals, practitioners and patients) had an active role in the designing of these sessions and some of the tools used (e.g. Health Card). These initiatives provide a more holistic approach to medical care and have gradually generated new ways of 'knowing' about healthcare, alter organisational boundaries and disciplinary silos, transform professional identities and nurture new social relationships. At the diabetes group for example, each session involved medical personnel and non-medical personnel, diabetes patients and their relatives or friends all coming together to share their knowledge and experiences and develop action plans as equals irrespective of roles or specializations. In similar fashion, the integrative medicine initiative was designed to offer a holistic approach to medical treatment where the dynamic intra-actions between human and non-human agents (e.g. the Health card specifically designed by incomers for the purpose of these sessions), 'had unanticipated effects for all, 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' (Kokkinidis and Checchi, 2023, p. 299).

Their approach stood in sharp contrast to well established norms and modes of contact between doctors and patients, prompting doctors to create an emotional detachment from their patients by dehumanizing them, e.g. reducing them to a biomedical event (Monrouxe, 2009). This process of dehumanization (Haque and Waytz, 2012) is reproduced by technologies such as the nursing documentations and practices that influence the relation between doctors and patients. Heartfield (1996) for instance describes how a scientific discourse of rationality and objectivity, depersonalize both the patient and the nurse. Documentation protocols strip nurses from their intuitive knowledge while patients are reduced to mere objects and passive recipients of medical treatment. In contrast, the 'health card' co-designed at KIA by 'proserhomenos', despite its record-keeping function, functioned as

a ‘tool’ that instigated discussions about the social, personal, and work life of individuals rather than specific medical conditions, an intra-action that had unanticipated effects for all ‘proserhomenos’, prompting doctors and patients to reinvent new ways of connecting with each other.

These ‘deviant’ practices question well established norms of the medical profession, opening up a range of previously unanticipated possibilities both in terms of how members understood their professional identities and how they were practicing medical care as well as how incomers experienced health care and reinvented their relationships with medical professionals. Reflecting on the experiment with the Diabetes group sessions and integrative medicine, Margarita also pointed to the organizational and political dimension of these experiments,

> We have the desire to cooperate, to work together irrespective of our professional identity, and we want to experiment with different practices. It relates with what we call Holistic medicine where we try to connect the medical condition with the social context. The physical, the psychological and the social are all connected. I am not aware myself of any other place (whether public facility, private or social clinic) that has involved people that are not medical professionals, with the medical treatment. People begin to learn, to form an opinion of their own.

Indeed, several of our participants that were either patients or joined the group due to health issues reported a gradual change in their attitude towards doctors and what they perceived as an ‘accepted behavior…’. With time, people begun to get more involved, to ask questions and feel more comfortable to share their ideas without the fear of ‘upsetting doctors…’. As Froso and Vangelis argued,

> They realized that they used to talk only about the medical condition when they were visiting a doctor and that was because they believed that this is what they were expected to do. This is of course something that mainstream medicine produces by fragmenting the human body to small parts, disconnected from the whole; from the social context. By introducing alternative practices, such as ‘proserhomenos’ instead of doctors and patients, it was a learning experience for all of us. People begun to realize that this was an open space to talk about more than just diabetes for instance and reflect on the whats and the hows, talk about their personal life, their work, everything else but their actual ‘health issue’.

This process of ‘becoming a proserhomenos’ is crucial for actualizing this participatory relation of mutuality between doctors and patients, and while aforementioned practices shared a degree of intentionality, other participatory initiatives, such as the cooperative dentistry (for a more extensive analysis please see Kokkinidis and Checchi, 2023), were far from intentional and emerged gradually in a context of tensions, temporal contestations and ongoing deliberation, opening up unanticipated possibilities. Dentist-Incomers saw their implicit sense of ‘ownership and ‘control’ over patients to be challenged when they were asked to work together with others on the same patient-incomer or when uncontroversial mundane practices and hygiene procedures (such as the sterilisation of equipment and their use or choices about raw materials) were transformed into matters of intense contestation that required ongoing negotiation and collective agreement.

The case of KIA offers interesting perspectives on how these ongoing processes of creating a health community presupposes an experimentation with discursive and material practices that are questioning both the production of knowledge and the authority of medical apparatuses. ‘Expert’ knowledge is reoriented in a more horizontal and symmetrical way between all incomers (medical professional, patients and the wider community). Therefore, the creation of a health community here is not an instrument, but a necessary political principle dictated by an explicit political understanding of healthcare and, even more importantly, a more general radical stance of resistance against inequality. These practices of resistance need to be understood in their ongoingness and in the context of antagonistic struggles, where neoliberal societies progressively attempt to erode social infrastructures and widen inequality (Collins, 2019, Harvey, Piñones-Rivera and Holmes, 2022). We deliberately chose

to present some of their mundane initiatives and discursive practices as experimental without measuring their efficacy. By pointing more towards their political aspiration to build a health community our intention was to highlight more the potentialities of antagonistic practices to create alternative forms of organizing and radical empowerment (Checchi, 2021).

**The sociomateriality of communities of care in the making**

Our chapter so far has focused on the participatory practices contributed to the creation of communities of care. In this section, we would like to shift our attention to the intra-action of human-non-human matter and bring more attention to the affective relations that emerge from these intra-actions. On both spaces discussed in this chapter, the cooperative ethos and communal aspirations of their members are engrained in the very fabric of these initiatives, particularly visible in the design of the spaces as well as their distinctive odours, visual stimulus (e.g. the dress codes, and the range of organisational artifacts and other materials and objects) and sounds (e.g. the sound of the wooden floor or the use of music in the process of community building exercises), that bring forth the belongingness, mutual respect and active participation of a community in the making.

When we first visited KIA, our encounter was marked by pleasant odours, temporary confusion, and a burst of sensory stimuli. Odours, although rather neglected, can help us navigate across organisational space, create visual representations, make sense of what is allowed and what is prohibited, help us connect or keep us apart. In this particular case, the smell of coffee not only offered a sense of intimacy that a conventional clinic is usually lacking but it encoded the space with a particular meaning (Canniford, Riach and Hill, 2018, Riach and Warren, 2015). The dominance of coffee over other odours (such as that of sickness and medicine) usually present in health care settings, was more than just a welcoming surprise. It constituted the embodiment of intimacy and belongingness; the sensing of horizontality and participatory practices integral to the shaping of a community of care. After all, as Allen (2022) nicely explains, odours are actively shaping our understandings of ourselves and the world, shaping our subjectivities and relations with each other. Odours matter and contribute to the mattering of organisations. The boundaries of an organisation are also determined by its distinctive odours, those smells that are expected to be found because of typical practices and interactions. Yet, as Sarah (a yoga teacher often attending other classes: what kind of stakeholder should she be?) puts it: 'S2BC is not so *incensy* as all other yoga studios. Even my flat smells of incense more than S2BC'. Incense is a distinctive odour of any other yoga studio, evoking relaxation and calm, an invitation to slow down and leave behind the stress of work. Teachers often light up an incense stick even at S2BC, but the smell is not so dominant, perhaps as it is mixed with a variety of other unexpected and unusual odours. Even for months and months after the inauguration, the pungent smell of paint has been a common presence. The toilets, the corridor, the stairs, the banisters, the doors, the rooms upstairs: every week there has been a new surface to host the encounter of paint, brushes, and voluntary work. Not only did the smell of paint disrupt the ordinary and expected odour of incense. Its persistence spoke of an ongoingness, continuous reconfigurings, multiple renovations and small touches, a call to all its members to take up a brush and offer their work and their time to the space: such is the mattering of a diagram of mutual help.

All these distinctive odours were intra-acting with visual stimuli, further contributing to this unique experience of sensing organisational life differently. Whether we look at the absence of traditional stimulus such as the white robe or the picture of a village at Chiapas hanging over the medical couch, we are once again encountering a moment of rupture from the traditional hierarchical structures of a clinic. The kids' drawing decorating the waiting area, the posters from various grassroots initiatives and the political pamphlets (as oppose to medical marketing brochures), the picture of a village at Chiapas (as opposed to a medical certificate) or Che Guevara poster (as opposed to Hippocrates) are all visual representations of the members aspiration to create a community of care, and part of the everyday practices attending to the affective dimension of community organising stripped from the hierarchical structures of the medical profession. At S2BC, it is a 6ft wide stopped clock to constitute that unusual

materiality that visually interacts with the members of the studio and with the passers-by in the street. The clock faces the street, while stubbornly refusing to perform its prescribed function. For SB2C, it is an ever-present agenda item for each assembly: its reparation is constantly postponed because it takes time to take a decision on whether the clock should tell time again. The stopped clock becomes the visual stimulus that invites us to hold on and reflect. Care and the mattering of a community of care are slow processes. Taking care of time can also mean to leave a clock still.

Odours and visual stimuli were part of the everyday organisational processes and experimental practices on both organisational settings (KIA and S2BC) and so it was sound stimulus (from cracking noise of the wooden floor to the background music during meetings). In line with studies such as that of Keevers and Sykes (2016) on how food and music are instrumental in creating the possibilities for people to work together, to participate and to build a sense of belonging, we too found instances of how the sharing of food contributes to bring people together, go past professional differences and strengthen mutuality and collaboration with each other. At S2BC for instance, the first assembly was sweetened by the home-made brownies offered by one of the members. The assembly has slowly developed its own food rituals. Before the assembly, a couple of members gather the orders for tea and coffee and pop up in the café downstairs. After the assembly, most of the attendees go for pizza, a moment to continue the discussions that started in the studio, or better still, an assembly about the assembly to debrief, laugh and destress. Sharing food becomes an essential moment for the organisation. For some it is the highlight of the morning: not too bothered about contributing to the assembly, their attendance is only instrumental to participate to the lunch.

**Communities of care: experimenting beyond interests**

When care becomes the primary focus of the various members of a community, we find that interests, understood as material gains from an individualistic and selfish perspective, are deliberately side-lined. Those who enter S2BC are not characterised by the way in which they hold their interests, their stake in the organisation. From the founders to the teachers and the students, whoever enters the space seems to be primarily seeking a sense of being cared for. A need for care is what characterise most if not all members of the collective, irrespective of their function or role. And progressively this need transforms into a willingness if not an obligation to care for others, for the community, for S2BC. From stakeholders to careholders perhaps: giving and receiving care, from each according to their ability, to each according to their need, outside a logic of exchange. In several instances, we have observed students welcoming first timers, showing them around, explaining the ethos of S2BC, rolling out a mat for them. We have observed people sharing their emotional predicaments while taking their shoes off before a yoga class, or informal breakfast clubs following the morning classes.

This is a practical attempt to resist the individualising logic of the market and the progressive erosion of community bonds and infrastructure. It shows a political potential, a posture of resistance and creation. That political potential is what we see as fully actualised at KIA. A radical take on care that starts from a critique of the neoliberal destitution of public health care and progressively explores the power relations inherent to the medical regime. If medicalised care is also a matter of power, the idea of 'proserhomenos' is an experimental attempt to exert power differently, or better still, to explore what care means despite power.

In both our case studies, we see practices where distinctions between stakeholders are taken seriously, where stakeholders' matters are also matters of power. It is not simply a matter of advocating 'a multi-voice, polyphonic approach to stakeholder involvement' (Boje, Burnes and Hassard, 2012, p. 2). It is about reimagining alternative organisations as truly transformative: transforming inescapable forms of power, reconfiguring diverging interests from a perspective of care. Communities of care become the encounter of needs for care and capacity of caring for others. What happens when care becomes a principle of organising? What does it mean to care for an organisation and being cared for within an organisation? Holding care is an approach, a stance, a positioning that is incompatible with the idea of interest. While the latter emerges directly from an individualised perspective proper of a market logic,

the idea of solidarity and mutualism requires to acknowledge inherent power relations and conflicting interests, while reimagining practices and relations despite and beyond the stakes distinct individuals hold within an organisation. This does not mean that care becomes a way of neutralising or harmonising conflicting voices. Rather, it displaces the conflict where it is mostly needed, politicising care as a form of resistance that traces an experimental trajectory of transformation beyond capitalism and its individualising logic of selfish interest.

We observe these dynamics at stake in those material processes and practices where organisations come to matter, their material intra-actions. Following Barad (2003, 2007), organisations determine their boundaries distinguishing what matters from what is excluded from mattering. Both in a traditional clinic and in a mainstream yoga studio, care, understood as a collective and participatory set of actions, matters, but only to the extent that is depoliticised (Popay et al., 2021). What is excluded from mattering is the wider implications on social and political inequalities, how care is eroded by neoliberal waves of privatisation and the continuous attack to infrastructures of solidarity and mutual help. The idea of re-politicising care that we find as an embryonic potential in the first steps of S2BC and as a radical intentional commitment at KIA is a contestation of these material boundaries. Transformative organising passes through new alternative reconfigurings of what matter and what is excluded from mattering. Introducing a Foucaldian lens within Barad's ontology, we look at how the repoliticisation of care at stake in these organisations is an attempt to take power relations seriously: on the one hand, it is a matter of detecting dominant ways of organising and generating trajectories for resisting them; on the other hand, this resistance reveals its creative potential and its constructive character (Checchi, 2021 Lilja, 2022) by reimagining alternative ways of handling power within organisations. In our case studies, care becomes the lens through which power can be reconfigured: taking care of power for the creation of relations of care that soften and displace (rather than replace) relations of power. This is the transformative approach that turns relations between stakeholders and their conflicting stakes into relations between careholders and their mutual care. These new performative reconfigurings of power are truly material as they come to matter through multiple intra-actions that entangle humans, spaces, discourses, odours, visual stimuli, food, and a variety of more or less intentional practices. These material intra-actions are arranged into new diagrams, diagrams of (politicised) care that reconfigure dominant ways of organising care: from the neoliberal clinic to KIA, from the fashionable yoga studio to S2BC. In these experimental trajectories, each stakeholder sets aside their stakes, holding care for the organisation, its material multiplicities, and its functions: a new diagram of care and careholders.

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