Power Makes Us Sick

self-care can’t cure social diseases

action dries your tears

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Power Makes us Sick (PMS) is a feminist collective focusing on autonomous health care practices and networks. PMS seeks to understand the ways that our mental, physical, and social health is impacted by imbalances in and abuses of power. We can see that mobility, forced or otherwise, is an increasingly common aspect of life in the anthropocene. PMS is motivated to develop free tools of solidarity, resistance, and sabotage that respond to these conditions and are informed by a deep concern for planetary well-being.

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Susan Sontag wrote, “Illness is the night side of life, a more onerous citizenship. Everyone who is born holds dual citizenship, in the kingdom of the well and in the kingdom of the sick. Although we all prefer to use the good passport, sooner or later each of us is obliged, at least for a spell, to identify ourselves as citizens of that other place.”

This work is dedicated to all the citizens of that other place.

introduction

How do you answer, “How do you feel?” We suspect that the outright rejection of the moral compass of good and evil, and likewise a rejection of us vs. them, will require more descriptive and polyphonic rubrics through which to communicate with one another about the world in front of us, and ourselves. “How do you feel?” However this feeling surfaces into language, it is never so much that we feel “bad” as that we feel “ill”. And it is never so much that we feel “good” as that we don’t feel “bad”. We know too much, and yet the knowledge hardly moves us an inch. We don’t have to actually see the bruises of the soft power regulating our movements to feel the symptoms. And sometimes we see actual bruises. Whether or not these feelings can be brought to light in words, there are ways of knowing that exceed existing diagnostic frameworks. Self-care can’t cure social diseases. What is next? How do you feel?

The idea of a social body is not new. The seduction of membership to it has been leveraged by conservative forces who seek to groom this social body into a compliant mechanism which serves them their profit. Citizens of the social body deemed too dangerous are excised and disenfranchised. But we do not have to follow this order. We understand the natural, human, and animal worlds as interconnected and overlapping, subjugation as the disease affecting them all in kind, and healthcare (understood as caring for the health of one another) as the single most powerful method for bringing about the better world we seek.

Most of us are not doctors. Most of us don’t know each other. But we are all tired of being told by those in power that we aren’t doing it right, that we can’t do it right without them or their tools, or that we must pay for our healing. Many of us are tired of feeling sick most of all.

We have all witnessed, benefited from, and performed a kind of healing that exceeds conventional or holistic models of health. As such, we have no direct allegiance to or alliance with either. It is in this way that we can speak of a ‘we’, an indeterminate ‘we’, unified by our sharpening skills and tests of accountability. We are a small, shape-shifting, and growing group of simultaneous antagonizers and care-workers, waged and unwaged, but proudly amateur. We invite all the citizens of that other place.

Social diseases work their way into and between us. We must contend with the urge to take care of ourselves, and to immunize against one another's bodies. To isolate us is the tactic of our enemy. Healing the social diseases that surround and threaten to reinfect individual bodies necessitates the deterritorialization of 'sickness' and 'health' as a general framework for assessing a body. We are all sick, because we have all experienced sickness as an event of disempowerment. As we stretch towards our own healing, we must not turn away from one another.

Most of us are not doctors. We are amateurs with no fear of the regimes of professional accreditation. Some of the most committed healers practice their work far outside of licensure (but rarely outside of consent). In sickness, we are encouraged to reach out and give this network its call to action, ask it to help us heal. In health, we are responsible for reciprocating this healing hand, out of love and gratitude, not debt. Nourished by all our relations, we are dividual. Your health and my health are reflexive of one another, and their health hangs in this balance. We reject self-care because we have never ourselves been alone. Against academies. Against the atomization of self-care.

PMS believes another world is possible. While pain is not to be feared, inflicted pain is not to be tolerated. While sickness is not to be feared, inflicted sickness will not be tolerated. We see the project of PMS as the prefiguration of an emancipation against the relentless illnesses of our times. Existing biopolitical structures are, of course, failing us. In many ways, the dominant modes of activity within the radical left operate on boom and bust cycles of militant resistance (led predominantly by notions derivative of virulent masculinities). We support this militancy, and we support the need for responding to emergent struggles with vigilance. But we will only give ourselves to a practice that is focused on setting strong roots; on sharing with one another the skills that are important for an ongoing struggle in the direction of that other place, and against those who would trap us there.

We recognize that one of the most integral aspects of state domination is to instill in us anxieties and panic about how to be political in the right way. This reflects in our practices of resistance around health; too often we are criticizing, discoursing, panicking, doing almost anything but actually healing. Healing under capitalism is like obsessively fidgeting with a just hardened scab. But likewise, healing is not to be found in complete ignorance of the confines of a surveilled and fractured existence. "Cameras ain't on the outside—they on the inside."

The power of the state, the omnipresence of it, diminishes every time we look in the eyes of a friend, of a stranger, and listen to what they need. As we listen, we slip out of the regimes of extractive time and impatience. Fuck the fake heartbeat of clocks. Every time we educate ourselves and opt for the teacher and classroom that does not require pay, we strengthen horizontally, and we heal by

putting no one under. Healing is honoring that resistance is a slow process, and declaring that we desire to see the increased strength, vitality, and well-being of our friends, neighbors, comrades, and full social ecologies more than we desire to see the state at all. There is no one person that deserves the cold shoulder as much as the state's austere violences. In this condition, it shrinks, it desiccates. We share informal, illegal, and decentralized forms of care like they are the very waters which support a life in common—because they are. We fight to live because we see that the vulnerability of our bodies, and others bodies, teaches us patience and compassion and dedication every day. As we are able to provide for one another's health, the state itself can't but fall, or at least we would no longer care if it did.

Power Makes us Sick is a creative research project focusing on autonomous health care practices and networks from a feminist perspective. PMS seeks to understand the ways that our mental, physical, and social health is impacted by imbalances in and abuses of power. We understand that mobility, forced or otherwise, is an increasingly common aspect of life in the anthropocene. In this quest for nomadic or placeless solidarity, we must start with health. PMS is motivated to develop free tools of nomadic solidarity, grounded resistance, and sabotage that are informed by a deep concern for planetary well-being.

What follows is our ongoing research at this stage, including report backs on solidarity clinics in Greece, attempts at health autonomy networks in New York City, the ceremonial foundations of healing relations emerging at sites of indigenous resistance such as Standing Rock, and writing, media, and projects that embody the work of PMS.

Alternate Nostril Breathing

An exercise you can use to engage both halves of the brain.

1. Sit up straight, if you can, and close your eyes.
2. Bring one hand to the left or right nostril and close off nostril with finger tip.
3. Breathe in deeply.
4. Alternate nostrils, covering the other nostril with an adjacent finger.
5. Exhale slowly.
6. Breathe in deeply.
7. Alternate nostrils again.
8. Repeat steps 3-7 as many times as desired, try for at least 5 deep breaths for each nostril.

[notepad]

- How do we create and support autonomous structures for health?
- How do we create and support autonomous structures for health that have the potential to cure cancer?
- How do we cure diseases overlooked by the current models?
- How do we access existing technologies that have been concealed from us because they are unprofitable?
- Can we use the equipment, technologies, the pain scales, the diagnostics of the existing order?
- How many people does it take to perform a blood test, including the process of obtaining the results?
- How can we protect our anonymity from the eyes of the state?
- How can we retain confidential records of our health to circulate with one another?
- How can I stay up for 48 hours straight?
- How can we restructure our daily activities in order to afford two sleep periods per 24 hours?
- What do we do when we can’t be together?
- What is a self-governance that is not subservient?

- How can we become ungovernable?
- How can we become untreatable?
- Where will my health records be tomorrow?
- Where can we store the stolen radiology equipment?
- Do we know anyone who knows how to perform heart surgery?
- How can we learn to frame every social problem as a problem of health?
- What would happen if we did?
- Can we weaponize the Hippocratic oath?
- How can we utilize elective medicine? Body modification? Transhumanism, biohacking? Can these things be salvaged?
- How can we take colors, smells and textures of plants, oceans and waterways, flowers and fresh fruits and vegetables as legitimate forms of therapy?
- How can we rethink therapy so that it is available to us all of the time?
- How do we recognize the perversions of the therapeutic?
- How can we criticize while also conveying love and acceptance, especially to those who cause us harm?
- How can we weaponize emotionality and affectedness?
- What are the strategies to build an alt Meals on Wheels in America?
- How do we learn about models for community health already used informally by marginalized communities?
- How do poor people do elder care? Childcare?
- How do uninsured people help each other access medicines and medical attention?
- How do you set a boundary without setting up a border?
- How can we redeem our lives histories of suffering and trauma through grounded spiritualities?
- How might this take us beyond our ethnic, national, and other non-elective borders?
- How can we take sobriety seriously, and plurally?
- How can we deconstruct sobriety?
- How can we self-determine through sobriety?

- How do we assess need instead of abnormality?
- When does illness become a weapon?
- How can we understand the patient as teacher?
- What does it look like to treat “a body” rather than “the body”?
- What does it feel like to heal a body, to love a body, to know a body, to see a body, to touch a body, etc.?
- How can we care for the health of a social ecology?
- What does informed consent look like when we acknowledge that no one is an expert?
- What is women’s health?
- What different methods for birth control are being used in local contexts?
- How should sexual assault and rape-related trauma be discussed in the field of autonomous mental health?
- Is LARPing a viable therapy for assault or rape-related trauma?
- How can we build capacity to provide the translation needed to offer care without borders?
- How can we build capacity to provide the transportation of people and materials needed to offer care without borders?
- Do we need a network of “professionals” that we can consult?
- What is the history of radicalism among these “professionals”? Is there material to salvage?
- Have you ever had a good doctor, midwife, nurse, lover, friend, environment?

Safe Space

from Against Innocence *by Jackie Wang*

The discursive strategy of appealing to safety and innocence is also enacted on a micro-level when white radicals manipulate “safe space” language to maintain their power in political spaces. They do this by silencing the criticisms of POC under the pretense that it makes them feel “unsafe.” This use of safe space language conflates discomfort and actual imminent danger — which is not to say that white people are entitled to feel safe anyway. The phrase “I don’t feel safe” is easy to manipulate because it frames the situation in terms of the speaker’s personal feelings, making it difficult to respond critically (even when the person is, say, being racist) because it will injure their personal sense of security. Conversation often ends when people politicize their feelings of discomfort by using safe space language. The most ludicrous example of this that comes to mind was when a woman from Occupy Baltimore manipulated feminist language to defend the police after an “occupier” called the cops on a homeless man. When the police arrived to the encampment they were verbally confronted by a group of protesters. During the confrontation the woman made an effort to protect the police by inserting herself between the police and the protesters, telling those who were angry about the cops that it was unjustified to exclude the police. In the Baltimore City Paper she was quoted saying, “they were violating, I thought, the cops’ space.”

The invocation of personal security and safety presses on our affective and emotional registers and can thus be manipulated to justify everything from racial profiling to war. When people use safe space language to call out people in activist spaces, the one wielding the language is framed as innocent, and may even amplify or politicize their presumed innocence. After the woman from Occupy Baltimore came out as a survivor of violence and said she was traumatized by being yelled at while defending the cops, I noticed that many people became unwilling to take a critical stance on her blatantly pro-cop, classist, and homeless-phobic actions and comments, which included statements like, “There are so many homeless drunks down there — suffering from a nasty disease of addiction — what do I care if they are there or not? I would rather see them in treatment — that is for sure — but where they pass out is irrelevant to me.” Let it be known that anyone who puts their body between the cops and my comrades to protect the State’s monopoly on violence is a collaborator of the State. Surviving gendered violence does not mean you are incapable of perpetuating other forms of violence. Likewise, people can also mobilize their experiences with racism, transphobia, or classism to purify themselves. When people identify with their victimization, we need to critically consider whether it is

being used as a tactical maneuver to construct themselves as innocent and exert power without being questioned. That does not mean delegitimizing the claims made by survivors — but rather, rejecting the framework of innocence, examining each situation closely, and being conscientious of the multiple power struggles at play in different conflicts.

On the flip side of this is a radical queer critique that has recently been leveled against the “safe space” model. In a statement from the Copenhagen Queer Festival titled “No safer spaces this year,” festival organizers wrote regarding their decision to remove the safer-space guidelines of the festival, offering in its place an appeal to “individual reflection and responsibility.” (In other words, ‘The safe space is impossible, therefore, fend for yourself.’) I see this rejection of collective forms of organizing, and unwillingness to think beyond the individual as the foundational political unit, as part of a historical shift from queer liberation to queer performativity that coincides with the advent of neoliberalism and the “Care of the Self”-style “politics” of choice. By reacting against the failure of safe space with a suspicion of articulated/explicit politics and collectivism, we flatten the issues and miss an opportunity to ask critical questions about the distribution of power, vulnerability, and violence, questions about how and why certain people co-opt language and infrastructure that is meant to respond to internally oppressive dynamics to perpetuate racial domination. As a Fanonian, I agree that removing all elements of risk and danger reinforces a politics of reformism that just reproduces the existing social order. Militancy is undermined by the politics of safety. It becomes impossible to do anything that involves risk when people habitually block such actions on the grounds that it makes them feel unsafe. People of color who use privilege theory to argue that white people have the privilege to engage in risky actions while POC cannot because they are the most vulnerable (most likely to be targeted by the police, not have the resources to get out of jail, etc) make a correct assessment of power differentials between white and non-white political actors, but ultimately erase POC from the history of militant struggle by falsely associating militancy with whiteness and privilege. When an analysis of privilege is turned into a political program that asserts that the most vulnerable should not take risks, the only politically correct politics becomes a politics of reformism and retreat, a politics that necessarily capitulates to the status quo while erasing the legacy of Black Power groups like the Black Panthers and the Black Liberation Army. For Fanon, it is precisely the element of risk that makes militant action more urgent — liberation can only be won by risking one’s life. Militancy is not just tactically necessary — its dual objective is to transform people and “fundamentally alter” their being by emboldening them, removing their passivity and cleansing them of “the core of despair” crystallized in their bodies.

Another troublesome manifestation of the politics of safety is an emphasis on personal comfort that supports police behavior in consensus-based groups or spaces. For instance, when people at Occupy Baltimore confronted sexual assaulters, I witnessed a general assembly become so bogged down by consensus procedure that the only decision made about the assaulters in the space was to stage a 10 minute presentation about safer spaces at the next GA. No one in the group wanted to ban the assaulters from Occupy (as Stokely Carmichael said, “The liberal is afraid to alienate anyone, and therefore he is incapable of presenting any clear alternative.”) Prioritizing personal comfort is unproductive, reformist, and can bring the energy and momentum of bodies in motion to a standstill. The politics of innocence and the politics of safety and comfort are related in that both strategies reinforce passivity. Comfort and innocence produce each other when people base their demand for comfort on the innocence of their location or subject-position.

The ethicality of our locations and identities (as people within the US living under global capitalism) is an utter joke when you consider that we live on stolen lands in a country built on slavery and genocide. Even though I am a queer woman of color, my existence as a person living in the US is built on violence. As a non-incarcerated person, my “freedom” is only understood through the captivity of people like my brother, who was sentenced to life behind bars at the age of 17. When considering safety, we fail to ask critical questions about the co-constitutive relationship between safety and violence. We need to consider the extent to which racial violence is the unspoken and necessary underside of security, particularly white security. Safety requires the removal and containment of people deemed to be threats. White civil society has a psychic investment in the erasure and abjection of bodies that they project hostile feelings onto, which allows them peace of mind amidst the state of perpetual violence. The precarious founding of the US required the disappearance of Native American people, which was justified by associating the Native body with filth. Andrea Smith wrote, “This ‘absence’ is effected through the metaphorical transformation of native bodies into pollution of which the colonial body must constantly purify itself.” The violent foundation of US freedom and white safety often goes unnoticed because our lives are mediated in such a way that the violence is invisible or is considered legitimate and fails to register as violence (such as the violence carried out by police and prisons). The connections between our lives and the generalized atmosphere of violence is submerged in a complex web of institutions, structures, and economic relations that legalize, normalize, legitimize, and — above all — are constituted by this repetition of violence.

Report: Proyecto Cuclillas - The Squat Project

Spanish:

Proyecto Cuclillas es un colectivo de arte compuesto por tres chilenxs residentes en Buenos Aires. El proyecto consiste en una plataforma de investigación y práctica transdisciplinaria que tiene como objeto de estudio el cuerpo y su representación. El cuerpo es entendido como territorio político y su análisis se centra en dos posturas específicas: el cuerpo sentado y el cuerpo en cuclillas.

En el baño, en la escuela, en el cine, en el comedor, en el transporte, en el trabajo. Nuestra vida transcurre de silla en silla. Esto, sin duda, no fue siempre así. La imagen del hombre sentado en una silla puede entenderse como símbolo de la domes- ticación del cuerpo y la im- posición de una cultura aje- na. La tensión que surge del binomio sillacuclillas sirve para visibilizar y evidenciar el actual contexto neocolonial en el que nos encontramos.

A través de una serie de acciones, intervenciones, investigaciones, instalaciones y convocatorias pretendemos contribuir a desnaturalizar la figura del cuerpo humano sentado en una silla y reivindicar la postura ancestral de las cuclillas para comer, estudiar, parir o recrearse.

English:

Proyecto Cuclillas (The Squat Project) is an art collective composed of three Chileans living in Buenos Aires. The project consists of a research platform and transdisciplinary practice whose object of study is the body and its representation. The body is understood as political territory and its analysis focuses on two specific positions: the body sitting and the body squatting.

In the bathroom, at school, at the cinema, as we eat, in the transport, at work. Our life goes from chair to chair. It was not always like this. The image of the man sitting on a chair can be understood as a symbol of the domestication of the body and the imposition of a foreign culture. The tension that arises from the binary of chair/squat serves to visualize and evidence the current neocolonial context in which we find ourselves.

Through a series of actions, interventions, research, installations, and open calls we intend to denaturalize the figure of the human body sitting on a chair and reclaim the ancestral posture of the squatting to eat, study, give birth, or recreate.

Report: Greek Solidarity Clinics

Flora, a psychiatrist at the workers' solidarity clinic at the squatted VIOME factory in Thessaloniki, told us:

> "In the worker's health center, we made a health card, which means a card of history. It is a piece of paper. We made it, all of us, in the assembly. In this health card we ask questions about the data of the patient. We ask questions about if he's married or not married, okay. Where he lives, if he owns his house, if his house is under debt, if he can warm up the house, questions like that about the way he lives in the house, with whom he lives and all that. Then we ask questions about the history of work. What kind of work have you been doing? What kind of work do you do now? What is the satisfaction of the work? What are the dangers of the work? What does the work do to your body? To your psychology? Do you work in a place where there is no sunlight or dangerous conditions? It is called the worker's health center, so we try to cover all of the important aspects of work.
>
> "Then we try to find out if he has a problem, if there are people around him to support him. And in what way, if he has a health problem, if he has a financial problem. We ask questions about how he feeds himself, his diet, how he eats. How he sleeps. If he exercises, what are his body actions. We ask if he walks and how he moves around. There are many questions. We cover all of this. We cover the dental history. And then in between we cover the family history. We use the family tree. We learned in between us, we made our own family trees. We studied the family trees of each other and the problems, just to understand what it means. So in this diagram we have a family tree of three generations. Apart from the diseases, which are important...we try to understand the relationships, also. If they have good relationships, if they have conflicts, what kinds of problems, like deaths or major events or if they have been an immigrant and all of that. We try to make a whole picture of the patient and then we start the medical history.
>
> "Then we go out and the doctor examines the body. This is sometimes two hours. It is a long story. We tried to make it so that the patient would have this. Then we stop at the end and we have a coffee and we talk between us between what we think about him in many ways. We use the social clinic's big network of doctors and collaborator-activists and hospitals. We use this network for that. So we decide which kind of examinations we want and we tell him...we say, now that you are going to lose [your job], you have had some losses in the past and you may need some help there. Or if he has a disease and he doesn't take care of himself, we make something for it.
>
> "And then he may come the second time, now we are discussing the second time. Now we are discussing how we are going to follow up.

> Normally, the medical way, it is ‘bring me your examinations’, I tell you your examinations, we say you are well. We try to make it different. Sometimes there are people who ask the psychotherapist to have a discussion on something more.
>
> “Now we are talking about the next year, how we are going to go forward. Of course, we need to change some things in the card/chart, because there are some questions that are missing like the question ‘what kind of events in your life are things that have affected your health’. Questions that are about how he thinks about it, how he thinks his job has affected his health, not just what we think. Or how his relationships have... Trying to make him more energetic because we say that our purpose is to have the whole of his life, whatever it means, and also for him to be energetic in that. We don’t know what we mean [by ‘energetic’], we mean it in many ways...[to] discover it in some way.”

This winter, we traveled to Greece to shadow and interview participants in solidarity clinics in Thessaloniki and Athens. In the wake of austerity measures that left literally half of Greece’s doctors in the public hospitals and outpatient clinics without work all at once, self-organized clinics have cropped up around Greece providing a range of services to citizens, refugees, and migrants. We learned about the difference between ‘social clinics’ and ‘solidarity clinics’ in the Greek context. Although these terms are often used interchangeably by visitors, it is clear that their conflation is not appreciated.

While both types of facilities operate on a volunteer basis, providing care to citizens and noncitizens alike, their further operational and ideological differences mean that they serve very different functions in the community. Social clinics such as MKIE, the Metropolitan Community Clinic at Helliniko, do not eschew collaboration with the state or other major non-governmental organizations such as Doctors Without Borders, etc. As a result of having more resources at their disposal - sometimes including grants from state agencies or property to house their operations - ‘social clinics’ attract volunteers who are looking for a professional context to provide medical care to patients that they might no longer have access to as a result of major budget cuts.

The social clinics are fulfilling an important role in the fucked up state that is Greece right now by providing quality medical services to great numbers of people. They closely resemble the state-run hospitals that have failed them, but the workers are unpaid. This resemblance affords them a kind of authority in the eyes of the average Greek citizen seeking medical care, allowing them to serve broader sections of the population. On the other hand, this resemblance hinders their freedom to experiment with new strategies for operating as healthcare providers in their local contexts.

Solidarity clinics, on the other hand, although variously factional in their specific political motivations, have roots in the autonomous movement within Greece. These clinics tend to be housed within larger occupied social centers. This means that they are already operating illegally. They run solely on the basis of donations from individuals (including donated equipment from comrades in Germany and elsewhere), the surplus and detritus of other institutions, the support from the social movements they are a part of and support, as well as the volunteered time and efforts of their members. To be honest, we had expected a certain degree of dysfunctionality, or maybe chaos, that we really did not find. In these clinics, major decisions are made in assemblies often composed of the doctors, organizers, 'receptionists', and sometimes care seekers. Many of the participants told us that although the assemblies can go a bit long in Greece, they appreciate what happens as a result of this process. The assemblies give them a chance to step back and reflect on what is working or not from their operations.

An anonymous member of No Borders said:

> "There is also a huge mistrust...[of] the doctors. Back in the day when I was in Lesvos, the doctor was the master of the field. People would just believe in a doctor because he had his red cross sign, nothing else. We had many problems with doctors for example, in Lesvos, I fought with many of them. I punched one, also.
>
> *[They light a cigarette. Someone interrupts in French motioning to some wood, presumably asking if he can have it. "Take it, take it," they say.]*
>
> "So yeah, we had a problem. People were coming believing they were *doctors*, and they were stepping in, and then we were like 'what the fuck?' For example, this guy was a doctor, he came from the UK, and when the patient was almost gone, he started praying to Allah to take him away peacefully. And I was like 'what the fuck, man?' and that was the punch. Like 'what the fuck, wake up' If you are about to send him to Allah, then just quit and let me try, or let somebody else try. Because if that's all you can do, then, well, I will try and do something even though I am not a doctor."

Many of the doctors from solidarity clinics that we spoke to touched on the same point: the medical practice in Greece both before and after the crisis does not leave enough time and space for understanding the needs of the patient. They felt rushed, they felt anxious, they felt pressured. They felt pressured to find a short-term solution to the problem within fifteen minutes in order to see the next patient. Although the internal structures are various and multiple, all of the doctors stressed how much they appreciated the new relationship to time afforded to them now that they have the time to practice on their own terms. The grassroots nature of these projects means that patients - now understood as 'care

seekers' - elect (elect is a relative term when you have few other options) to attend these self-organized clinics, in the sense that they are new frameworks that they have not been otherwise directed towards. If they have a good experience, they return. This means that care seekers develop a different and perhaps more informal relationship with their volunteer providers. Often the clinics do not 'advertise' their services widely and are thus seen by locals in the community or refugees in need that are directed there.

Our No Borders friend also told us:

> "It is the first, it goes last because you can't have it, but it is the first one, otherwise you cannot really act... Look, one thing you can do in general...I believe in databases. That's my god, databases. They tell you all the things that you need to know. For example, you see on the log, oh fuck, every week there are like ten children that are sick, eventually when you have ten children sick every week, the problem is not in the medicine, the problem is not in the amoxicillin, it's in the building."

*We asked a doctor at the ADYE clinic at K*VOX about the clinic's security protocols:*

> *Will you provide services to anyone here?*
>
> "We do not allow any fascists or any racist or any sexist behavior, but you cannot KNOW. So assurance is always a part of the problem, but you cannot simply just eradicate this problem. Anyone can be close to the police, but we cannot live like that. I don't want to live like that. We cannot live in fear. If he is... I don't care. But what if someone is, say, a police officer in plain clothes? We try to figure out, first of all. Because the people in the entrance are not only... their role is to inform and to ask 'how did you find the place' or things like that... so they do try to play the part of...
>
> *They are like security?*
>
> "Yes, they are also something like security. But I'm sure if someone comes here they would not find anything bad. We do not kill people, or... [everyone laughs] It is illegal. This place here is illegal. It is illegal to be here, so it is illegal to provide any health care in illegal places, so we are illegally giving healthcare, but if someone would like to accuse us, he could do that, but it is not. This is not so simple to understand, because there is a certain situation here. Exarchia is a place that, everyone knows why he is here, so people are connected in a way that they can find us here. It is not public, it is not advertised. We always keep our program, schedule posted for the month, but we are illegal. We are illegal in the way that the state says so, but we are not illegal in the way

that we are... having our best... way to help someone. This is the best excuse, I think."

After visiting a variety of clinics in Athens, there was one clinic we decided we wanted to focus on for our research. We visited the ADYE (Autonomous Health Structure in Exarcheia) clinic, housed within the squatted social center K*VOX in January. After describing our interests to their assembly, we were invited to shadow the participants - doctors, receptionists, patients - in order to more clearly understand their successes and struggles. There were many aspects of the operations of the clinic that surprised us, and we learned so much from our time there. Perhaps the most profound realization for us was the banal quality of so many of the visits. The services provided were certainly transforming the participants quality of life, but a significant portion of the 'work' could be performed by any concerned person. There's something powerful that happens when you can confer with another about your own body. A man visits because he just fell off his motorcycle and wants to check that the scrapes on his knees are okay. Another man visits, with a translator, just to ask that someone give him more bright white bandages for his wrist to boost his confidence. We were also really excited about the system they developed to keep records of the care seekers. As an illegal clinic providing services for vulnerable populations, there is a need to retain anonymity to protect all participants from state repression. However, as a clinic that has been in operations for a few years, there are many care seekers that they see on a regular basis. They found that they needed a records system that was useful for their purposes. As such, they track just enough information that they are able to confer with one another about who has already been seen, etc. When the information is available, they write down the first initial, age, gender, a short summary of any relevant medical history, what they visited for, and what the outcome was. (Sometimes they can't communicate with care seekers to ask for their age, etc. because of translation issues.) We're excited about the way that they are able to develop a log system tailored to their purposes that protects all those involved. For PMS, we are wondering how similar methods, or otherwise forms of encryption, might be applied to our databases. We're wondering if there are nurses, amateur or otherwise, that we can support in developing solidarity clinics in other locales, especially the US, or folks doing this kind of work that we should be in touch with. But that's a whole conversation for another time.

On Harm Reduction and Needle Exchange Programs

excerpts from:
“Meth Modernity” by Jason Pine
“On Drugs” by David Lenson
“Capitalist Realism” by Mark Fisher

It became apparent in the early eighties that the idea that would be called harm reduction needed to be invented. Around this time, activists started to understand that access to sterile needles was critical to AIDS prevention, and that it needed to happen fast if the death toll of the disease was to be curbed. Before organized efforts to establish needle exchange programs, the task was sometimes undertaken by individuals who would distribute clean needles informally in places they knew injecting drug users to meet. Doctors and nurses would quietly leave packs of syringes in view of persons they knew to be injecting drugs, then walk out of the room. From a public health standpoint, distribution of sterile needles seemed like an obvious thing to do, and not one that was particularly costly. Public opinion and politics, however, did not agree. The idea that needle exchange programs condone or encourage drug use remains widespread. In Europe, the first needle exchange program was founded in 1984 by the Amsterdam Junkie Union, a drug-users advocacy group, in response to the decision of an inner-city pharmacist to stop selling syringes to injecting drug users. Support came from the Dutch municipal Health Services, they provided an anonymous, accessible service that became a model for those seeking to implement needle exchange programs elsewhere in the world.

In the summer of 1988, a man named Dave Purchase took matters into his own hands, organizing the first needle exchange program in the United States. It consisted of a table in downtown Tacoma, and it was illegal. Initial funding came from the Mahatma Kane-Jeeves Memorial Dope Fiend Trust. Community leaders and residents protested and issued memos, but Purchase did not yield. Eventually, the Tacoma program became the Point Defiance AIDS Project, which inspired other advocacy organizations like the National AIDS Brigade, Act-Up, and the North American Syringe Exchange Network. Many of these organizations were met with political and social resistance, and were forced to remain underground and operate illegally.

The federal ban on funding for needle exchange programs was not lifted until 2016, and still contains restrictions on the use of federal funds on the syringes themselves. Research into the effectiveness of needle exchange programs has similarly been barred from receiving federal funding. Even in places

where needle exchanges are funded locally and are permitted by municipal or state law to operate, police harassment of staff and “clients” is common.

Outside In, which was founded in 1968 in Portland, Oregon, was one of the first free community health clinics in the United States. Founded to serve homeless youth, its services have evolved with the needs of the communities that use it. Its needle exchange program, started in 1989, was the third to go into operation in the country. It also provides free naloxone kits and training. Naloxone, brand name Narcan, is an opiate antagonist that can save someone who is overdosing. In 2014 the needle exchange at Outside In served 4,322 people. I was one of them. Later, I volunteered there.

The service is anonymous. You need to register, but all you are asked to provide is your initials and date of birth, which are used to generate a kind of ID code. You are given a card with that code on it, but if you lose it it’s fine, because you can just tell them your date of birth and initials and they find you in the system. There’s an introductory explanation when you first register, but it’s quick, laying out the way the exchange works:

1. Bring your used needles, preferably capped. Drop them one by one into the large sharps container, counting them as you go so the volunteer knows how many to give you. There is a maximum of fifty needles per person per day, but if you bring more you receive a “credit” to your “account” to be picked up at a later date.
2. You can also get clean cookers, water, cottons, tourniquets, condoms–– all essential, since a clean needle is useless if you’re sharing a dirty spoon.
3. Don’t buy or sell drugs in the vicinity of the exchange; if you do, you’ll draw the heat and ruin it for everyone.

In addition to providing crucial harm reduction services, it brings some of the most vulnerable and underserved segments of the population into a therapeutic setting where they can begin to access health services. The mainstream medical establishment can be hostile to injecting drug users. Rising naturally out of the ways in which injecting drug users help one another to access clean needles (“Hey, you got any clean rigs?” “Yeah, I gotchu.”), needle exchange programs are some of the most inspiring examples of community public health projects, representing a model that can be implemented effectively anywhere there is a need, without necessarily relying on legality.

A tweaker is someone who uses methamphetamine on a regular basis. To tweak is to bug out, to be overcome and to become other, albeit an other within a familiar repertoire of tweaker ways. A tweaker gets amped and gets onto

some*thing*—an object of interest or fear, the materiality of an object, or materiality itself—and won't let it go.

Fired up and looking for somewhere to go, the tweaker plants his tweak in a task. Inspired and interested, she forages and burrows and hoards in rhythmic perpetuity. Stereotypy. When it's aimed at the job—roofing, cement, assembly line, foundry—things can finally work out well. With your strong back and weak mind you can work longer. Finally, beyond what dulls, something good feels within reach. But when the tweak is unleashed, they say it can tear shit apart. That's when you start cluckin', bent over like a chicken with your ass in the air and your face in some business, making a mess of things. "I'd get to fixing everything," a sobered meth cook told me. "But usually it was working when you started," said his wife. "Yeah, I was a shade tree of all things."

Maybe it is easier to think of it this way: the drugs we take, and our anticipation of what they will do to or for us, are expressions of who and what we want to be. Embedded in our choice of highs is the question of our aspirations, fears, and identity. An opiater I once knew divided drug users into augmenters and diminishers. The augmenters want to live faster, telescoping the consumerist process of desire and acquisition into the course of an evening or an hour. And so they shoot speed or snort cocaine. The diminishers want to defeat the process by leisurely patterns of dosing and contemplation, and so they shoot heroin. In both cases what is at stake is an idealized version of the self. The drug a user takes to assume an ideal self may have as much or as little significance as the clothes he chooses to express his character, or to costume the role she hopes to play each morning. People for whom drugs have deadly consequences are usually those who seek to play a role they are unsuited for, whose choice of drugs is based not on who they ideally are, but on someone completely different whom they wish to become. They lack the resources to construct the high they have chosen, and they experience madness.

Character really is destiny for druggies.

The bio-medical model of addiction must be de-emphasized, if not abolished entirely. It's easier to empathize with an addict if you see them as suffering from a disease, but this political expediency is short-lived. What could a junkie politics look like?

the addict is only sick insofar as she has contracted a sick society

The current ruling ontology denies any possibility of a social causation of mental illness. The chemico-biologization of mental illness is of course strictly

commensurate with its depoliticization. Considering mental illness an individual chemico-biological problem has enormous benefits for capitalism. First, it reinforces Capital's drive towards atomistic individualization (you are sick because of your brain chemistry). Second, it provides an enormously lucrative market in which multinational pharmaceutical companies can peddle their pharmaceuticals (we can cure you with our SSRIs). It goes without saying that all mental illnesses are neurologically *instantiated*, but this says nothing about their *causation*. If it is true, for instance, that depression is constituted by low serotonin levels, what still needs to be explained is why individuals have low levels of serotonin. This requires a social and political explanation; and the task of repoliticizing mental illness is an urgent one if the left wants to challenge capitalist realism.

How are people already caring for each other in the spaces of the state's neglect?

Report: NYC Health Autonomy

The [Greek] social clinics are fulfilling an important role in the by providing quality medical services to great numbers of people. They closely resemble the state-run hospitals that have failed them. This resemblance affords them a kind of authority in the eyes of the average citizen. On the other hand, this resemblance hinders their freedom to experiment with new strategies for operating as a healthcare provider in their local contexts.

The metro population of New York City is around 20 million, almost twice that of the entire population of Greece (11 million). With the socio-economic stratum in NYC encompassing the situations of individuals from 0 and negative income to those with personal capital in the billions, fit into a geographic space that is no larger than the landmass of Hawai'i, residents of this particular megacity hold neither a shared history of social upheaval, nor a coherent picture of the limits of the state to respond to crises of social well-being in the same way as do the citizens of Greece. Therefore the infrastructure for autonomous health in NYC has a more nodular composure than it does in a place like Greece, where austerity measures have affected and engaged most people.

There are a few institutions within NYC that resist the state apparatus in its specific operation of permitting health care by conditions of race, class and 'legal' status. These centers support populations for whom disenfranchisement has violent consequences. Certain hospitals in the city have reputations for definitely supporting patients on Medicare and Medicaid, or who are uninsured. Bellevue Hospital in particular bears a history of having altered patient information in order to offer direct intervention to individuals as they applied for care through Medicaid. There are also a few clinics dedicated to serving populations whose marginalized identities have disabled them from securing economic stability and

sufficient healthcare; Callen-Lorde Community Health Center serves LGBTQ patients regardless of ability to pay. Beyond these institutions, there are also action groups in the city who specifically focus on informing those with interest about different skills and technologies, of both thought and object, that can be used to support their health needs, as well as to create robust social networks that are equipped to solve their own crises, from the bottom up. These groups recognize that eradicating social diseases requires vigilant interpersonal support and accountability. A few local manifestations of decentralized, non-corporate infrastructures concerned with community health come to mind:

Brujas (collective): Based out of the Bronx, Brujas are "a group of native and afro descendant women born in New York who focus on creating and cultivating opportunities for feminine and artistic empowerment." I follow their Instagram feed (@wearebrujas) where they share hosted events like herb workshops, jam sessions, studio recording workshops, skate events, conversation groups, urban indigenous workshops, self-defense workshops, and fundraisers.

Holy Mountain (dance/music event series, organized by Ladyfag): "3 Floors. 4 Rooms. 8 DJs. New York City, the first time we climbed the HOLY MOUNTAIN together, we reached its peak and touched the heavens...We invite you once again to journey with us to a place where darkness is light, music is god, and dancing will set you free. Welcome to HOLY MOUNTAIN."

Spectrum/Dreamhouse (queer event space/visual and sonic collaboration organized by Gage of the Boone): "The Spectrum is a space for queer and queer-friendly artists to rehearse, and present their work." Holding down a queer-friendly space for dance and nightlife expression, both Spectrum/Dreamhouse and Holy Mountain are an intentional antidote to wage-labor's social flow of bodies and capital in the rigid stratum of urban space.

The Base (community space and organizing group): "The Base is an anarchist political center in Bushwick, Brooklyn. The mission of the space is to spread ideas and practices to the broader populace and provide a place where individuals can learn, grow, and organize outside of traditional activist and educational institutions." Organizers at The Base have developed a Community Action Team for presence building and dispatched defense responses to targeted communities, a Rapid Response Network to bypass engagement with the police's militarized racial, prejudiced and sexual violence when a need for immediate intervention nevertheless arises in neighborhoods, self-defense and fight classes, prison letter writing nights, and occasionally, The Base acts a host for Icarus Project (mental-health) info sessions.

Mayday Space (community space and organizing group): "A community space and organizing hub in Bushwick, Brooklyn for engaging programming, event hosting & social justice activism for all of NYC." Mayday is a

family-friendly space which hosts Spanish language classes, weekly kitchen collective dinners, film screenings, discussion events, and regular anti-gentrification workshops and brainstorming sessions.

Woodbine Community Health Clinic (community space and organization): “Located in Ridgewood, Queens, Woodbine is an experimental hub for developing the skills, practices, and tools for inhabiting the Anthropocene. We host workshops, lectures, discussions, and serve as a meeting and organizing space.” The health clinic itself is located in the basement of the community space, with a health library. Coordinated by a practicing doctor and a few amateur care-workers, both the clinic space and the upstairs space host skill share workshops and open houses.

One of the issues with building autonomous health care infrastructure in a place like New York City is that most of the people with incentive to use their resource to benefit marginal and underserved populations, are often transplants and are themselves alien to the communities in need. In this way, outreach efforts and tracks of engagement or action fall within more regular patterns. In many cases, communities never get the chance to self-determine or collectively outline their own needs, requests or demands from the broader social network of the city. Nor are their own existing care-networks understood or taken seriously as starting points. Something that Mayday Space in particular has, is a framing, a venue, and a set of programming that is inclusive to whole families. More than anything, in Mayday there is space for kids to run around and play without stepping on the toes of those attending the events. Simply put, Mayday immediately serves a critical community need, which is to be accommodating to local residents who want to be political and parent at the same time. It is centering the belief that families need the resource to engage with their communities most of all, as it is often within families that the flows of intergenerational care knowledge intersect. What is critical in the development of autonomous health networks and clinics at places like The Base or Woodbine, and beyond, is that the outreach happens as the community at hand, and on the ground, needs it to. As those in this city and elsewhere see the stakes of our isolation rise, proper care for the social body will require the urgent inclusion of, and concession to guidance by, those of us who have always been communizing our care, out of needs based in our survival, and not ideation…

Report: Standing Rock

From the period between April 2016 and February 2017, thousands of Native American and non-native peoples came to live together in an encampment along the bank of the Cannonball River in North Dakota. Self-described as ‘water protectors’ (not protesters) these people came to stand together in protection of the waters of Lake Oahe and the Missouri River from being put under extreme, irreversible risk by the placement of the Dakota Access (Oil) Pipeline (DAPL). Two of the camps, Sacred Stone, and Rosebud were on the tribal reservation land of the Standing Rock Sioux. The main camp, Oceti Sakowin (‘Seven Council Fires’), was on the treaty land granted to these tribal networks, which has since been assumed (in violation of the Fort Laramie Treaty signed in 1851) by the federal government. This treaty land is where the pipeline now lies.

People came to Standing Rock for many reasons, to dissent to the violation of historical treaties, to amplify the vibrancy, as well as the contemporary struggles, of Native American communities and of other indigenous people all over Turtle Island (Americas) and the world, to protect Mother Earth, our one environment, and to honor and protect the waters that bring life to all. Existing together in a temporary space was often times a pressure-cooker environment where natives and non-natives had to work through processes of decolonization, as well as acknowledge the direct effects of colonial oppression such as substance abuse, and translations of cycles of abuse and violence, most especially domestic, sexual violence, and the disease of depression. Below are some observations of cultural processes upheld by many of the Lakota and other native people at Standing Rock which gave evidence to ways of being together and relating that had liberatory, revelatory, and unifying capacity:

Lakota Language: I learned many times that in Lakota there is no word for ‘I’. There is also no word which means ‘goodbye’, instead there is only ‘see you later’. In this way, and much like the phrase ‘Mitakuye Oyasin’, which means ‘All our relations, all are related’, all relationships between humans, plants, animals, land, and water are cyclical and interconnected, with the language itself enacting this longevity even if you do end up not seeing someone or some place again. Lakota and other native people also called one another (and familiar non-natives) brother and sister, grandmother and grandfather, often, referring not to possession or nuclear, exclusionary families, but rather to the significance of the shared knowledge within these categories and roles. The community value and appreciation of the elder’s wisdom was embodied in every contextualization of one or another person’s name by their place in that extending inclusive family. Broad family trees reflect a small part of the limitlessness of mitakuye oyasin.

Camp Regulations: The indigenous peoples of the camp asked that no alcohol, drugs, or guns be brought to Standing Rock. In this way, resistance was grounded in the spiritual reminders of the humility of existence in the face of ‘all our relations’. On the frontlines or in the camp, limiting these weapons of reaction let prayers and thoughts for purposeful awakening encompass the energy returned to DAPL.

Prayer: Stating one’s intention to the world, and being grateful for all that nourishes you, was the foundation of the prayers offered in common and in private in the camps. There were prayers before every meal, and the various sacred fires of the 3 camps were sites of prayer all day and all night.

Meals: To honor the networks of care and knowledge, and the bodies that nourish and give life, meals were served in a particular sequence where elders, women and children were offered their meal plates first.

Traditional Living and Communing Structures: Whether in tipi structures, or yurt structures, the indigenous living spaces of traditionally nomadic peoples of this and other lands are often organized with a heat source in the middle, and into a circular form, where facing the heat structure also means facing one another and communing. Especially in the dead of winter, conservation of heat and resources also means interior private space is far more rare; personal need in this situation is addressed by the community, often publicly, socially, as opposed to by hegemonic systems of desires, working privately. These ‘confrontational’ realities produced by circular living and communing structures are also reflected in different ceremonial practices such as the drum and song circles, the talking circles, and the sweat lodge ceremonies, critical to inipi, or purification rites.

Mni Wiconi, water is life.

our projects

Here are some projects PMS is working on right now. Get in touch if you are interested in working on these things, too.

A new theory for *informed, enthusiastic* consent that can be applied to all disciplines, or perhaps all modes of activity. This theory would take inspiration from the notion of informed consent from the medical field & social sciences, and the enthusiastic consent—yes means yes!—discourses that have emerged in reaction to a culture of rape (and that are reflected in the legislatures of states like California). If we can prefigure a form of consent that feels good for everyone, we can extend this to working conditions. Once formed, we intend to use this model within PMS itself to organize the work (i.e. labor) performed within and amongst the group. Put another way, individuals and the group at large will only perform tasks that they understand and are excited about. In this way, we can prefigure a world absent of coercion, bubbling up with a joy from below (or deep in the belly). As part of this theory we acknowledge when and how scarcity is a myth. We also acknowledge that some jobs, some modes of healing, some engagements with another simply might not need to take place (if they depend on coercive tactics). Down with the bullshit jobs! Up the flunk!

An accountability model for health - mental, physical, and social - that can operate irrespective of place. This tool would be informed by the integrated model of health implemented by the clinic at Vio.me in Thessaloniki and the mental health questionnaire developed by the Icarus Project in NYC. It is a triage system that helps participants understand the complete picture of a person’s health first through a longform interview, followed by periodic ‘check-ins’ or urgent calls with the committed group. In this case ‘health practitioners’ are understood as those who share the responsibility of one another’s health. Through long term support and awareness of individual and social patterns, the health care practitioners can connect health care seekers with local resources, provide consultation, and solidarity.

A guide for creating a personal inventory which charts the parameters of the private and public resources around us in order to ground ourselves in our psychosomatic space, everyday. This personal topography exercise is meant to help people take an assessment of the room and resource available, both within and outside of their body, which can be used to consciously and proactively contribute to social health of the common, on a minute to minute, hourly, and daily basis.

Here is some stuff that we are reading right now.

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