

Applying Anarchist Principles to Healthcare

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Abstract

My work on revisioning healthcare has consistently emphasized the sacred-profane dialectic, hermeneutic approaches to medicine, and the necessity of transforming hierarchical medical structures. This article demonstrates how these concepts find their natural political expression in anarchist philosophy. Through extensive analysis of anarchist intellectual history—from Proudhon through the Spanish Revolution—I show that the structural transformations my framework requires align most closely with anarchist principles of mutual aid, anti-coercion, decentralization, and horizontal organization. My critiques of mechanistic medicine, Cartesian dualism, and hierarchical authority in healthcare are not merely philosophical but demand the political reorganization that anarchism provides. By wedding my theological and phenomenological insights to anarchist praxis, we can envision medicine organized around sacred presence, interpretive engagement, and genuine healing relationships rather than institutional power and profit extraction.

Keywords: Anarchist Healthcare, Mutual Aid Medicine, Sacred-Profane Dialectic, Hermeneutic Medicine, Therapeutic Presence, Horizontal Organization, Patient Autonomy, Healthcare Decentralization, Anti-Hierarchical Medicine, Kropotkin, Proudhon Mutualism, Bakunin, Emma Goldman Nursing, Spanish Revolution CNT, Anarcho-Syndicalism Healthcare, Worker Cooperatives, Sacred Listening, Interpretive Engagement, Convalescence, Cartesian Dualism Critique, Medical Paternalism, Prefigurative Politics, Community Health Collectives, Voluntary Association, Federated Healthcare Networks, Ungar-Sargon Revisioning Framework

1. Introduction

Over the past decade, my scholarly work has developed a comprehensive critique of contemporary medical practice. In "Revisioning the Soul of Medical Practice," I argued that modern healthcare has lost touch with the sacred dimensions of healing, reducing patients to biological mechanisms and practitioners to technical functionaries [1]. In "Worn Out Philosophical Ideas Still Pervade the Practice of Medicine: The Cartesian Split Lives On," I demonstrated how mind-body dualism continues to distort medical understanding despite centuries of philosophical refutation [2]. In "The Patient History—Reimagining the Body in Illness," I proposed treating patient narratives as sacred texts requiring hermeneutic interpretation rather than data extraction [3]. These critiques, along with my work on sacred listening, therapeutic spaces, convalescence, and the integration of theological frameworks into clinical practice, share a common thread: they challenge the reduction of healing to technical intervention and call for medicine grounded in presence, meaning, and relational depth [4-8]. What I have termed the

"sacred-profane dialectic" captures this tension—medical practice must honor both the material (profane) and the transcendent (sacred), both biological mechanism and existential meaning [9].

But critique alone proves insufficient. If hierarchy, commodification, and mechanistic reductionism structurally characterize contemporary medicine, then transformation requires not merely philosophical reorientation but political reorganization. My framework describes what healthcare should be; anarchist philosophy provides the structural principles for achieving it. This article demonstrates that alignment—how the medicine I envision requires the organizational forms anarchism articulates. The question driving this analysis is: What political philosophy most coherently supports the healing I advocate? The answer, I argue, is anarchism. Not because anarchism is merely compatible with my vision, but because the values my work emphasizes—autonomy, mutual respect, horizontal relationships, resistance to coercive authority, sacred presence—find their necessary structural expres-

sion in anarchist organization.

2. The Sacred-Profane Dialectic and Hermeneutic Medicine

Before examining anarchist principles, I must clarify my own theoretical commitments. My work rests on several interconnected claims:

2.1. The Sacred-Profane Dialectic: Healthcare exists in tension between the profane (material, technical, manipulable) and the sacred (meaningful, dignified, transcendent). Modern medicine errs by collapsing this dialectic, reducing healing entirely to technical intervention while ignoring existential and relational dimensions. As I argued in "Sacred and Profane Space in the Therapeutic Encounter," authentic healing requires honoring both domains—medical expertise alongside interpretive engagement, biological intervention within meaningful encounter [9].

2.2. Hermeneutic Approaches: Patients are not merely bodies to be diagnosed but persons whose narratives demand interpretation. In "Hermeneutic Approaches to Medicine: From Objective Evidence to Patient as Sacred Text," I proposed that clinical encounters should follow hermeneutic principles: listening for meaning, attending to context, recognizing multiple valid interpretations, respecting the irreducibility of lived experience [10]. The patient history becomes a text to be interpreted rather than data to be extracted [3,4].

2.3. Critique of Cartesian Dualism: The mind-body split that has dominated Western medicine since Descartes produces pathological consequences—ignoring psychological dimensions of physical illness, treating bodies as machines, dismissing subjective experience as mere epiphenomenon. My work consistently challenges this dualism, arguing for integrated understanding of embodied persons [2,11].

2.4. Therapeutic Presence and Sacred Listening: Healing requires genuine presence—the clinician's capacity to be fully attentive, to listen without agenda, to create space for the sacred to emerge. In "The Art of Sacred Listening," I described how therapeutic presence involves recognizing divine concealment and revelation within clinical encounters, creating what I term "sacred silence" where authentic meeting becomes possible [4].

2.5. Critique of Hierarchical Authority: Medical hierarchy—the traditional arrangement where physicians command and others obey—violates human dignity and undermines healing. In my work on "From Sacred to Secular Heresy," I analyzed how medical institutions mirror religious hierarchies in controlling knowledge and maintaining power [12]. True healing requires horizontal relationships based on mutual respect rather than coercive authority.

2.6. Convalescence and Wholeness: Modern medicine's focus on acute intervention neglects convalescence—the space between illness and health where integration and meaning-making occur. As I argued in "Between Illness and Health: What Happened to Convalescence?", rushing patients back to productivity denies them necessary time for healing as transformation rather than mere res-

toration [6].

Economic Critique: Healthcare organized around profit corrupts healing relationships. In "The Profit Paradox," I documented how pharmaceutical industry practices and profit-driven systems subordinate patient welfare to financial extraction [13]. Authentic medicine requires economic arrangements that serve health rather than wealth.

2.7. These themes Converge: healthcare must honor human dignity, resist reduction to mechanism, create space for meaning and presence, reject hierarchical domination, and organize economically around healing rather than profit. But what political framework supports these commitments? What organizational principles would embody these values?

3. What Anarchism Actually Means

Before demonstrating the alignment between my work and anarchist principles, I must clarify what anarchism entails. The word "anarchy" commonly connotes chaos, violence, disorder—a misunderstanding that serves those benefiting from hierarchical systems. If anarchy means chaos, then hierarchy must mean order, and any challenge to authority becomes unthinkable. Classical anarchist thought concerns itself with liberty, solidarity, mutual aid, and human cooperation without coercion [14,15]. Anarchism fundamentally challenges hierarchical authority, asking: Why should some people have power over others? By what right do they command obedience? The anarchist answer is stark—no one has such a right. Authority must be continuously justified by those subject to it, and the moment it becomes coercive rather than freely acknowledged, it loses legitimacy [16].

This does not mean anarchists oppose all organization or coordination. Rather, they envision social arrangements based on voluntary association, mutual aid, and horizontal rather than vertical relationships. People can cooperate, make collective decisions, and accomplish complex tasks without bosses and subordinates. They have done so throughout history, whenever free to organize themselves [17]. The resonance with my work should already be apparent. My critique of medical paternalism challenges physicians' claimed right to command patients. My emphasis on voluntary, mutually respectful relationships aligns with anarchist insistence on horizontal organization. My resistance to bureaucratic control mirrors anarchist opposition to hierarchical domination. The connection deepens as we examine specific anarchist thinkers and historical examples.

4. Healthcare as Mutual Aid

Pierre-Joseph Proudhon (1809-1865) was the first to call himself an "anarchist," transforming a term of abuse into a positive vision. In "What is Property?" (1840), he declared "Property is theft!"—a critique of exploitation through ownership divorced from use [18,19]. Proudhon distinguished between "property" (the right to profit from others' labor, to extract rent and interest) and "possession" (the right to own what one directly uses). The former enabled exploitation: the latter secured independence [20,21].

Proudhon opposed both capitalism and state communism, proposing instead "mutualism"—voluntary economic cooperation where independent producers exchange goods and services based on labor value, coordinated through mutual credit rather than capitalist markets or state planning [22]. Mutualism represented his attempt to synthesize autonomy and solidarity, avoiding exploitation while preserving liberty.

For healthcare, Proudhon's framework illuminates the problem my work identifies. Medical knowledge functions as "property" in the exploitative sense—hoarded by credentialed professionals who profit from others' need, gatekept through licensing and professional monopoly. This arrangement serves professional power and economic extraction rather than healing and health. My advocacy for open knowledge sharing, demystification of medical expertise, and hermeneutic approaches that honor patient interpretation directly challenges this monopoly. When I argue in "Hermeneutic Approaches to Medicine" that patients must be active interpreters of their own experience rather than passive recipients of expert pronouncements, I am essentially arguing for healthcare knowledge as "possession" rather than "property"—used directly by those who need it, shared freely rather than hoarded for profit [10].

Proudhon's mutualist vision—voluntary associations exchanging services based on mutual benefit rather than profit extraction—describes precisely the economic arrangement my critique of profit-driven medicine implies. In "The Profit Paradox," I documented how pharmaceutical corporations and insurance companies extract wealth while subordinating patient welfare [13]. The alternative I implicitly advocate—healthcare organized around meeting needs rather than maximizing profit—aligns with Proudhon's mutualist economics. Moreover, Proudhon's federalism—coordination through voluntary cooperation among autonomous units—mirrors my emphasis on decentralized, context-appropriate care. My argument in "Revisioning Healthcare Spaces" that healing environments must be designed for local contexts rather than standardized for efficiency resonates with Proudhon's insistence that organization should emerge from bottom-up federation rather than top-down imposition [5].

5. Anti-Authoritarianism and Medical Hierarchy

Where Proudhon emphasized economic mutualism, Mikhail Bakunin (1814-1876) focused on abolishing hierarchical authority. He defined the state as "coercion, domination by means of coercion, camouflaged if possible but unceremonious and overt if need be [23]." Bakunin saw no possibility of reforming hierarchical institutions—they must be destroyed and replaced with federations organized from the bottom up [24]. Bakunin extended his critique to all forms of imposed hierarchy, famously writing: "If God really existed, it would be necessary to abolish him," seeing divine authority as ultimate justification for human subordination [25]. He insisted: "We do not admit the government of man by man any more than the exploitation of man by man [26]." For Bakunin, freedom required destroying every institution claiming the right to command obedience.

The parallel to my work on medical hierarchy is exact. Throughout my publications, I have challenged paternalistic authority in medicine—the traditional arrangement where physicians command and patients obey, where professional hierarchy determines who speaks and who listens, where credentials confer power rather than merely acknowledge expertise. In "From Sacred to Secular Heresy," I analyzed how medical institutions parallel religious hierarchies in controlling knowledge and maintaining authority [12]. Just as religious hierarchies claim interpretive monopoly over sacred texts, medical hierarchies claim diagnostic monopoly over bodies and illness. Both systems punish "heresy"—challenges to authorized interpretation—through excommunication (license revocation, professional sanction).

My argument that patients must be treated as sacred texts requiring interpretation directly challenges this hierarchy [10]. If patients are texts, then multiple valid interpretations exist. Professional expertise contributes one reading among others, not the only authorized meaning. The patient's own interpretation of their experience holds primacy, not because patients always know "best" in some technical sense, but because their autonomy and self-determination take precedence over expert authority. This is precisely Bakunin's point applied to medicine: expertise does not justify dominance. That I know more than you about neurology does not give me authority over your body or choices. Knowledge creates responsibility to inform, not power to command. My emphasis on therapeutic relationships as voluntary, continuously consented to by all parties, my insistence that healing requires mutual respect rather than hierarchical control, my critique of coercive psychiatric practices—all express Bakunin's fundamental insight that freedom is incompatible with domination [9,27].

Bakunin's quarrel with Marx—his warning that any state, even one claiming to represent workers, would create new forms of domination—parallels my critique of healthcare reform that merely replaces private with public bureaucracy. Centralized control, whether corporate or governmental, still subordinates healing to institutional power. My work implicitly advocates for healthcare organized horizontally, through voluntary cooperation, with power genuinely distributed among all participants.

6. The Biology of Healing

Peter Kropotkin's "Mutual Aid: A Factor of Evolution" (1902) challenged social Darwinist claims that competition drives evolution [28]. Through extensive research, Kropotkin documented that cooperation and mutual support were as fundamental to survival as competitive struggle—perhaps more so. In harsh environments like Siberia, animals survived through cooperation rather than competition. The same applied to human societies: medieval guilds, village communes, friendly societies all demonstrated mutual aid as viable organizational principle [29,30]. Kropotkin's insight directly supports my work on healing as relational rather than merely technical. If mutual aid is woven into biological and social life, then healthcare organized around competition and hierarchy works against our nature. Medicine based on mutual support—where communities collectively ensure everyone receives care,

where patients and clinicians cooperate as equals, where knowledge is shared freely—aligns with how humans actually function when not constrained by coercive institutions.

My emphasis on sacred presence and therapeutic relationship as essential to healing reflects this biological reality [4,9,27]. Healing is not merely technical repair of biological mechanism but relational process requiring mutual engagement. The patient who feels genuinely seen, heard, respected as person rather than processed as body—this patient heals more fully than one receiving technically identical treatment within coercive, alienating structures. Contemporary research vindicates this insight. Therapeutic alliance—the quality of patient-clinician relationship—predicts outcomes across medical conditions [31]. Social support affects immune function, cardiovascular health, mortality risk [32]. Loneliness increases disease and death [33]. These aren't peripheral effects but central realities: we are social beings whose health depends fundamentally on the quality of our relationships and communities.

My argument for convalescence—for time and space where healing can occur beyond acute intervention—resonates with Kropotkin's emphasis on mutual aid [6]. Convalescence requires community support: people who care for the ill person, who provide practical help and emotional presence, who create conditions for recovery. Rushing patients back to productivity denies them necessary time for integration and meaning-making. But more, it reflects an economic system that values labor-productivity over human flourishing, that treats persons as productive units rather than ends in themselves. Kropotkin's vision of mutual aid organizing economic and social life challenges this instrumental logic. If healthcare were organized as mutual aid rather than commodity exchange or bureaucratic service delivery, convalescence would become possible again. Communities would support members through illness and recovery, not because it's economically efficient but because mutual care is what communities do.

7. Nursing as Sacred Practice

Emma Goldman (1869-1940) united anarchist philosophy with hands-on healthcare work in ways that illuminate my framework. Goldman practiced nursing for ten years in New York City, experiences that profoundly shaped her political thought [34]. She valued nursing for the economic independence it provided, the direct contact with working-class struggles, and most significantly, the possibilities for care based on solidarity rather than hierarchy [35]. Goldman described nursing as "a vehicle to understand people's struggles and as a way of translating political philosophy into meaningful, practical solutions [36]." She didn't separate nursing from anarchism—they were integrated expressions of commitment to human liberation and mutual support. This integration parallels my work attempting to unite theological reflection with clinical practice, sacred presence with medical intervention.

Goldman's advocacy for reproductive autonomy—publicly teaching birth control despite legal prohibition, enduring repeated arrest and imprisonment—exemplifies resistance to medical paternalism

that my work advocates [37,38]. Control over one's reproduction is fundamental to bodily autonomy. Goldman refused to defer to state authority or medical gatekeeping in defending that autonomy. Her example suggests what anarchist healthcare might look like: clinicians who see themselves as allies rather than authorities, who share knowledge rather than hoard it, who advocate for patients against unjust systems rather than enforce compliance. This is precisely what I advocate in my work on therapeutic relationships—the clinician as companion in healing rather than commander of treatment, as interpreter alongside the patient rather than sole authority over meaning. Goldman shows that anarchism in medicine isn't abstract theory but concrete solidarity with those seeking health and autonomy. My work on sacred listening and therapeutic presence describes the phenomenology of such encounters; Goldman demonstrates the politics [4,9]. Together they suggest medicine practiced not through hierarchical authority but through mutual respect and voluntary cooperation.

8. Anarchist Healthcare in Practice

The Spanish Civil War period (1936-1939) provides crucial historical evidence that large-scale healthcare can function through anarchist organization. The CNT (Confederación Nacional del Trabajo), an anarcho-syndicalist union representing over 1.6 million workers by 1936, created horizontally organized healthcare systems in anarchist-controlled territories, particularly Catalonia [39-41]. Healthcare workers organized through elected councils rather than administrative hierarchies. Hospitals and clinics were collectivized, with governance shared among doctors, nurses, staff, and patient representatives. The system prioritized meeting community health needs over profit or bureaucratic control [42-44]. Local health centers maintained autonomy while coordinating regionally for resource sharing and specialized services.

This wasn't chaos but careful organization through voluntary cooperation. Medical supplies were pooled and distributed based on need. Rural areas previously lacking healthcare received attention monopolized by wealthy urban clients. The system emphasized preventive care and public health over profitable procedures [44]. The CNT's structure embodied anarchist principles. *Sindicatos únicos* ("special unions") brought together all workers regardless of profession, breaking down artificial hierarchies between physicians, nurses, and other healthcare workers. National committees were elected annually from different localities to prevent bureaucratization. All delegates were subject to immediate recall. This massive organization employed only one paid secretary [45].

Admittedly, the experiment was cut short—internal conflicts, war exigencies, and ultimately fascist victory ended these innovations. But the Spanish experience demonstrates that large-scale healthcare can function through horizontal organization, that expertise need not translate into hierarchy, that workers and patients can collectively manage complex systems. This historical example directly addresses objections to anarchist healthcare organization. The CNT managed hospitals, clinics, pharmaceutical production, and public health initiatives across an entire region while coordinating a war effort. Critics predicted chaos and collapse—neither

occurred. The system functioned, often more equitably than what it replaced, until destroyed by external force rather than internal dysfunction [46].

The Spanish experience also illuminates the relationship between structure and values that my work emphasizes. The anarchist health system didn't merely deliver care differently—it embodied different values in its organization. Horizontal structure enacted respect for worker autonomy. Federated coordination demonstrated mutual aid operating at scale. Open assemblies created space for voice and participation. The means reflected the ends, prefiguring the society anarchists sought to build. This is precisely what my framework requires. When I argue that healthcare spaces must honor the sacred, that therapeutic encounters must create conditions for genuine presence, that healing requires horizontal relationships, I am describing values that demand structural embodiment [4,5,9,27]. We cannot practice sacred medicine through profane structures of domination. The form must match the content. The Spanish anarchists understood this; my work theorizes it.

9. How my Framework Aligns with Anarchist Principles

Having examined anarchist history and theory, I can now demonstrate the precise alignments between my revisioning work and anarchist political philosophy. These aren't superficial similarities but necessary connections—my framework requires anarchist organization to become real. My central theoretical contribution—the sacred-profane dialectic—describes healing as occurring in tension between technical intervention (profane) and meaningful encounter (sacred). Modern medicine errs by collapsing this dialectic, reducing healing entirely to technical manipulation [9]. Anarchist anti-hierarchical organization is not accidentally but necessarily related to this dialectic. Coercive hierarchy fundamentally violates human dignity. When physicians claim authority to command patients, the encounter is no longer one of mutual respect but of domination. The sacred is banished because one party has been reduced to object rather than honored as subject.

Conversely, horizontal relationships grounded in voluntary cooperation create conditions where the sacred can be present. When no one claims authority to impose meaning or treatment, when all participate as equals in deliberation, space opens for genuine encounter, for interpretive engagement, for healing that respects the whole person. My critique of mechanistic medicine thus finds its natural political expression in anarchist organization. The revisioning I advocate—toward medicine that honors both technical and transcendent, that makes space for meaning alongside mechanism, that practices presence rather than merely processing patients—requires not just philosophical reorientation but structural transformation through anarchist principles.

10. Hermeneutic Approach Aligns with Mutual Aid

My argument that patients should be treated as sacred texts requiring interpretation rather than objects of technical manipulation challenges professional monopoly over meaning [10]. If the patient is a text, multiple valid interpretations exist. Professional expertise contributes one reading, but the patient's own interpretation holds

primacy. This hermeneutic approach naturally aligns with anarchist mutual aid. Rather than hierarchical knowledge transmission (expert to passive recipient), hermeneutic engagement involves mutual interpretation—clinician and patient together constructing understanding. This is mutual aid applied to meaning-making: both parties contribute what they can (professional knowledge, experiential knowledge), both receive understanding neither could achieve alone. My emphasis on sacred listening—creating space for patients to articulate their experience without agenda or premature interpretation—embodies mutual aid's respect for autonomy and contribution [4]. The clinician doesn't impose meaning but facilitates the patient's own process of understanding. This requires the humility and equality that anarchist principles emphasize.

10.1. Critique of Cartesian Dualism Resonates with Anarchist Anti-Reductionism

My work challenging mind-body dualism parallels anarchist resistance to reducing persons to productive units or biological mechanisms [2,11]. Both challenge instrumental rationality that views humans as means rather than ends, that fragments persons into component parts manageable through technical expertise. Anarchism insists on recognizing whole persons—not merely workers or consumers or patients but autonomous beings with complex needs, desires, relationships, meanings. My argument for integrated understanding of embodied persons, for attention to psychological and spiritual dimensions of illness alongside physical, expresses this same commitment to recognizing human wholeness.

The connection deepens when we recognize that Cartesian dualism serves hierarchical power. By splitting mind from body, subjective experience from objective measurement, modern medicine justifies ignoring patient testimony in favor of technical assessment. The patient's report of pain becomes less "real" than imaging studies showing tissue damage. Lived experience gets dismissed as "merely subjective" compared to "objective" data. Challenging this dualism—insisting that subjective experience is real, that meaning matters, that persons are irreducible to mechanism—supports patient autonomy against professional authority. It's an anarchist move: refusing reduction that enables domination, asserting the primacy of lived experience against expert abstraction.

10.2. Decentralized, Context-Appropriate Care

My work on sacred presence and therapeutic listening emphasizes that healing requires genuine encounter—the clinician's capacity to be fully attentive, to listen without agenda, to create space where authentic meeting becomes possible [4,9]. This cannot be standardized or protocolized. Each encounter is unique, requiring response to particular persons in specific contexts. This aligns directly with anarchist principles of decentralization and subsidiarity. Decisions should be made as close as possible to the point of care, by those actually involved in the encounter. Distant administrators and bureaucrats cannot prescribe what sacred presence looks like—it emerges in the specific relationship between these particular persons at this moment. My critique of healthcare spaces designed for efficiency rather than healing implicitly demands decentralization [5]. If healing environments must honor local

context, cultural meaning, particular needs, then standardized corporate design fails. Anarchist federalism—local autonomy within voluntary networks of mutual support—provides the organizational principle my work requires.

10.3. Profit-Driven Medicine Demands Economic Reorganization

In "The Profit Paradox," I documented how pharmaceutical corporations subordinate patient welfare to profit extraction [13]. My work on healthcare reform consistently argues that economic arrangements must serve healing rather than wealth accumulation [47]. This is not peripheral to my framework but central—profit motive corrupts healing relationships, reduces care to commodity, creates perverse incentives that harm patients. The anarchist alternative—mutual aid and cooperative organization—directly addresses this critique. If healthcare facilities were owned collectively by workers and patients, if economic relations were organized around meeting needs rather than maximizing profit, if surplus was reinvested in community health rather than extracted for shareholders—these arrangements would embody the values my work articulates. Proudhon's mutualism, Kropotkin's mutual aid, the Spanish anarchist cooperatives all demonstrate viable alternatives to profit-driven healthcare. My critique points toward these alternatives even when I don't explicitly name them as anarchist.

10.4. Community Support Through Mutual Aid

My work recovering the concept of convalescence—the space between illness and health where integration and meaning-making occur—cannot be realized within current economic arrangements [6]. Profit-driven systems pressure patients back to productivity, denying necessary time for healing as transformation. Anarchist mutual aid provides the economic and social framework for convalescence. If communities organized to support members through illness and recovery, if economic arrangements didn't require constant productivity, if care were mutual responsibility rather than commodified service—convalescence becomes possible. This isn't nostalgic romanticism but recognition of social conditions necessary for genuine healing. My clinical observations that rushed recovery often produces incomplete healing, that patients need time for meaning-making and integration, that healing involves transformation rather than mere restoration—these insights demand social reorganization that anarchist principles articulate.

10.5. Prefigurative Politics: Building the Medicine we Need

Anarchist prefigurative politics holds that means must reflect intended ends [48]. We cannot create freedom through coercion, equality through hierarchy, or solidarity through competition. Applied to healthcare, the process of care must itself embody values of dignity, autonomy, and mutual support. This principle perfectly captures my framework. When I argue that healthcare spaces should support reflection and encounter rather than maximize efficiency, that clinical time should allow genuine engagement rather than rushed processing, that therapeutic relationships require presence rather than protocol—I am advocating prefigurative practice [5]. The architecture of care—physical, temporal, relational—should manifest the values we claim to serve. More importantly, prefigurative politics provides strategy for transfor-

mation. We don't wait for revolution to begin practicing differently. We build alternatives now, in the cracks and margins of existing systems. Every act of solidarity, every challenge to hierarchy, every moment of genuine presence and mutual respect—these are steps toward the medicine we need.

This is how my work should be understood—not as abstract ideals awaiting implementation but as prefigurative practice. When I describe sacred listening, I'm not proposing a technique to be learned but a way of being that embodies different values [4]. When I argue for hermeneutic approaches to patient narratives, I'm not suggesting better methodology but practicing resistance to reductionism [10]. When I critique pharmaceutical profit extraction, I'm not merely analyzing but refusing complicity with exploitation [13]. The medicine I envision is already emerging wherever clinicians resist hierarchical authority, share knowledge freely, advocate for patients against institutions, create time for genuine encounter, honor patient autonomy. These aren't preparation for future transformation—they are the transformation itself. Anarchist prefigurative politics names what many healthcare workers already practice intuitively: building the new world within the shell of the old.

11. What Anarchist Healthcare Looks Like

My theoretical alignment with anarchism implies practical organizational forms. What would healthcare look like if structured according to principles my work articulates?

11.1. Patient-Clinician Microteams: Small care teams including patients, operating with rotating facilitation and consensus decisions. Rather than physicians commanding, leadership rotates based on specific tasks. For medication decisions, the pharmacist facilitates. For navigating insurance, the patient who's become expert. For understanding social determinants, the social worker. This embodies my argument that multiple forms of expertise exist, that patients hold irreplaceable experiential knowledge, that healing requires horizontal relationships [10,27].

11.2 Mutual Aid Health Collectives: Clinics owned collectively by workers and residents, reinvesting surplus in community health rather than extracting profit. These collectives determine priorities democratically—emphasizing what communities identify as needed rather than what generates revenue. This realizes my critique of profit-driven medicine while embodying Kropotkin's mutual aid and Proudhon's mutualism [13].

11.3. Sacred Clinical Spaces: Healthcare architecture designed for healing rather than efficiency—natural light, acoustic privacy, areas for contemplation, artistic expression affirming dignity. This manifests my argument that spaces shape possibilities for encounter, that the sacred requires architectural expression, that healing environments must honor rather than undermine presence [5].

11.4. Time for Presence: Encounters lasting as long as needed rather than maximizing billing. Teams organizing continuous presence rather than fragmented shifts. This realizes my emphasis on sacred listening and therapeutic presence, my argument that

healing requires time for genuine engagement not compatible with profit-maximization [4,9].

11.5. Open Knowledge Networks: Medical knowledge shared freely rather than hoarded behind paywalls and professional gatekeeping. Peer learning allowing clinicians to develop skills through mutual teaching. Patients participating as active interpreters of their own experience. This embodies my hermeneutic approach, my challenge to professional monopoly, my insistence that healing knowledge belongs to communities not corporations [10].

11.6. Community Governance: Local review boards with participatory membership developing context-appropriate standards. Representatives from patients, clinicians, community members deliberating together about quality, safety, accountability. This realizes my critique of distant bureaucracy while embodying anarchist principles of decentralized decision-making.

These aren't utopian fantasies but logical implications of my theoretical work. If healthcare must honor sacred-profane dialectic, if healing requires hermeneutic engagement and therapeutic presence, if profit corrupts care and hierarchy violates dignity—then organizational forms must embody these insights. Anarchist principles provide the political framework my work requires.

12. Addressing Objections

12.1. "It won't Scale": This objection assumes centralized hierarchy is necessary for coordination at scale. But complexity theory suggests self-organizing systems often handle complexity more effectively than top-down control [49]. The Spanish anarchist healthcare system managed an entire region during war. Large-scale coordination doesn't require hierarchy, just different organizing principles—transparent information sharing, modular autonomy, federated cooperation.

12.2. "Quality will Suffer": How ensure quality without hierarchical enforcement? Through transparent peer review and community accountability. Those most affected by poor quality—patients and frontline workers—have strongest motivation to maintain standards. Current quality assurance systems often fail spectacularly while imposing enormous burden. Horizontal organizations can maintain high standards through different mechanisms—collective responsibility, learning from errors, prevention through participation.

12.3. "Power Imbalances Persist": Even with best intentions, clinicians possess professional knowledge and authority. Won't asymmetries recreate hierarchy? Asymmetries of knowledge don't automatically create hierarchy—only when joined with coercive power. My hermeneutic approach distinguishes between authority (recognized expertise freely acknowledged) and authoritarianism (coercive power imposed through hierarchy) [10]. The goal isn't eliminating all difference but preventing any difference from becoming coercive power.

12.4. "This Faces Overwhelming Opposition": Entrenched interests—pharmaceutical companies, insurance corporations, hospital systems, professional organizations—benefit from current arrangements and will resist transformation. But anarchist strategy doesn't assume we'll ask permission. Change happens through direct action—building alternatives here and now, creating cracks in existing systems, practicing mutual aid wherever possible [50]. My work is already anarchist praxis—every essay challenging hierarchy, every argument for patient autonomy, every critique of profit extraction contributes to transformation.

13. Conclusion

My work on revisioning healthcare—emphasizing sacred-profane dialectic, hermeneutic engagement, therapeutic presence, critique of hierarchy and profit—finds its necessary political expression in anarchist philosophy. These aren't separate projects but integrated vision: the medicine I describe requires the organizational forms anarchism articulates. Anarchism offers not blueprint but direction—toward autonomy and mutual aid, toward horizontal organization and voluntary cooperation, toward care that honors both profane and sacred dimensions of healing. From Proudhon through Kropotkin to Goldman and the Spanish Revolution to contemporary mutual aid networks, this tradition provides tested principles and inspiring examples.

The question isn't whether anarchist healthcare is possible—humans have organized healing collectively, without hierarchies, in countless times and places. The question is whether we have courage to build such systems now, in the belly of institutions that resist any limit to their power. We begin where we are, with what we have. Every time I write about sacred listening, I practice prefigurative politics. Every time a nurse advocates for a patient against administrative pressure, anarchist healthcare emerges. Every time clinicians share knowledge rather than hoard expertise, horizontal medicine is born. Every time we create space for genuine presence, the sacred is honored.

These aren't preparation for future transformation—they are the transformation itself. We don't wait for permission to practice medicine differently. We start now, building relationships and structures that prefigure the healing we seek. My work theorizes this transformation; anarchist politics provides its framework; our daily practice makes it real. The medicine we need is the medicine we make together, through solidarity rather than domination, through cooperation rather than competition, through sacred presence rather than technical reduction. That medicine is possible. It is necessary. And in countless small acts of resistance and mutual care, guided by the vision my work articulates and the politics anarchism provides, it is already emerging.

Addendum: Critical Reflections on Anarchist History and Limitations

Any honest application of anarchist principles to healthcare must acknowledge anarchism's historical limitations and ongoing critiques. This addendum examines anarchism's failures, internal contradictions, and persistent challenges—not to abandon the

framework but to apply it more carefully to medical practice. Anarchism's practical history is largely one of defeats. The Paris Commune (1871) lasted mere months before violent suppression. The Russian anarchist movement was crushed by Bolshevik repression following initial revolutionary participation in 1917 [51]. The Ukrainian Makhnovist movement (1918-1921), despite military successes, ultimately fell to the Red Army [52]. Italian anarchist activity during the Biennio Rosso (1919-1920) failed to achieve lasting transformation despite factory occupations [53]. Most devastatingly, the Spanish Revolution (1936-1939)—anarchism's greatest practical achievement—ended in fascist victory and decades of repression [46,54].

These weren't accidental failures but revealed structural problems. As Chris Day argues in "The Historical Failure of Anarchism," the movement has "refused to learn from its historic failures, preferring to rewrite them as successes [55]." Anarchism became "theoretically impoverished," marginalized from major 20th-century revolutionary movements, reduced to critiquing others rather than building viable alternatives [55]. For nearly 80 years following Spain, anarchism played minimal role in anti-colonial struggles, national liberation movements, or socialist transformations globally. These failures suggest caution in applying anarchist organization to complex systems. Healthcare requires sustained coordination, resource management, and knowledge transmission—precisely where historical anarchism struggled. The Spanish healthcare collectives functioned briefly during wartime crisis but never demonstrated long-term viability under normal conditions. We cannot simply assume anarchist principles will succeed in healthcare when they failed elsewhere.

The Problem of Scale and Coordination

Anarchists have persistently struggled to reconcile local autonomy with large-scale coordination. While small communes and affinity groups function well horizontally, scaling to cities, regions, or nations proves difficult without hierarchy. The "iron law of oligarchy"—Robert Michels' claim that all organizations inevitably develop oligarchic tendencies—haunts anarchist practice even when theoretically rejected [56].

During the Spanish Revolution, anarchist collectives faced coordination problems: how to allocate scarce medical resources between regions, standardize training and quality, manage complex supply chains. The CNT created coordinating bodies that increasingly resembled the bureaucracies anarchists opposed. This suggests not anarchist hypocrisy but structural necessity—certain organizational functions may require centralization regardless of ideology [57].

Modern medicine's complexity—specialized knowledge, expensive technology, pharmaceutical research, public health coordination—may require organizational forms that anarchist principles cannot accommodate. My work emphasizes local context and individual interpretation, but healthcare also needs standardized protocols, evidence synthesis, and coordinated response to epidemics. Pure decentralization could fragment knowledge and create dangerous variation in quality. Anarchism's history includes periods of

political violence and terrorism. From the 1870s through early 1900s, anarchists assassinated heads of state, bombed public spaces, and advocated "propaganda of the deed"—spectacular violent acts meant to inspire rebellion [58]. While most anarchists eventually rejected this strategy, it damaged the movement's reputation and revealed tensions between revolutionary rhetoric and ethical practice.

Even non-violent anarchist movements struggled with coercion. Spanish collectives sometimes forced peasants to join through economic pressure or threat [59]. The line between voluntary association and coerced participation proved difficult to maintain under crisis conditions. Goldman herself, despite advocating non-violence, periodically defended political violence rhetorically [60]. Healthcare inevitably involves power—over bodies, over treatment decisions, over resources. My framework emphasizes voluntary relationships and patient autonomy, but medicine also requires authority in emergencies, with incapacitated patients, in public health crises. Pure voluntarism may prove inadequate when rapid action is necessary or when patient decisions threaten others (contagious disease, violent behavior). Anarchist principles offer no clear guidance for these situations.

The Individualist-Collectivist Tension

Anarchism contains unresolved tension between individualist strains (Max Stirner's egoism, individualist anarchism) and collectivist traditions (anarcho-communism, anarcho-syndicalism). Individualists prioritize personal autonomy, rejecting obligations even to voluntary associations. Collectivists emphasize mutual aid and social responsibility. Attempts to synthesize these—Proudhon's mutualism, for instance—satisfied neither fully [61,62]. This tension surfaces practically: How much can communities demand from individuals? What obligations accompany membership? When does social pressure become coercion? Anarchist theory provides no definitive answers, instead celebrating plurality and refusing dogmatism—which can mean lacking guidance when conflicts arise [63]. My work emphasizes both patient autonomy and therapeutic relationship, individual interpretation and mutual engagement. But these can conflict. What when patient autonomy produces harmful outcomes? When individual choices burden communities? When personal interpretation contradicts evidence? Anarchist frameworks offer no clear principle for resolving these tensions beyond continued dialogue—which may prove insufficient in medical crises.

Theoretical Poverty and Strategic Vagueness

Critics charge anarchism with theoretical underdevelopment compared to Marxism's systematic analysis of capitalism, class structure, and historical materialism [64]. Anarchism offers compelling critique of hierarchy and state power but less sophisticated understanding of economic systems, less developed strategy for transition, fewer concrete proposals for organizing complex societies. As one critic notes: "anarchism offers people who want to make revolution very little in the way of a coherent plan of action [55]."

This theoretical poverty produces strategic vagueness. Anarchists know what they oppose (state, capitalism, hierarchy) but remain unclear about process: How exactly does transformation happen? How do we organize healthcare for millions without bureaucracy? What coordinates pharmaceutical research, medical education, emergency response? Anarchism provides principles (mutual aid, voluntary cooperation, horizontal organization) but limited practical guidance for implementation [65]. My work critiques existing medicine but must also specify alternatives. Invoking anarchist principles isn't sufficient—we need detailed proposals for organizing medical education, coordinating research, managing epidemics, allocating scarce resources, maintaining quality, handling conflicts. Without such specificity, anarchist healthcare remains inspirational vision rather than practical program.

Anarchist practices face constant threat of "recuperation"—absorption and neutralization by the systems they oppose. Horizontal organization becomes "participatory management" that maintains hierarchical control while co-opting the language of democracy. Mutual aid becomes corporate "team-building." Critique of bureaucracy justifies privatization rather than transformation [66]. This happened repeatedly: worker cooperatives operating within capitalist markets often reproduce exploitative relationships; participatory budgeting becomes consultative theater without real power transfer; "alternative" healthcare institutions get absorbed into corporate systems. The challenge isn't merely resisting external repression but maintaining radical principles against subtle internal corruption [67]. My proposals for patient-clinician microteams, mutual aid collectives, sacred spaces risk recuperation by the institutions they critique. Hospitals could implement "participatory care teams" while maintaining administrative hierarchy. Insurance companies could market "holistic wellness" while extracting profit. "Patient-centered care" becomes brand rather than transformation. We need strategies specifically addressing recuperation, not merely ideals easily corrupted.

Race, Gender, and Colonialism

Classical anarchism emerged from 19th-century Europe, reflecting the limitations of its context. Early anarchists often ignored or inadequately addressed racism, colonialism, patriarchy. Proudhon held reactionary views on women and Jews. Bakunin made anti-Semitic statements. The movement generally failed to engage anti-colonial struggles [68,69]. Only recently has anarchist theory seriously grappled with these issues through Black anarchism, anarcho-feminism, and indigenous anarchism [70,71]. This historical blindness suggests anarchism alone proves insufficient for addressing healthcare injustice. Medical racism, colonial violence in medicine, gender-based medical abuse—these require analysis and strategies beyond classical anarchist critique of state and capitalism. Intersectional approaches are necessary that anarchist frameworks don't automatically provide [72]. My work must explicitly address how sacred presence and mutual aid resist racism, sexism, colonialism in medicine rather than assuming anarchist principles automatically liberate. Healthcare inequity reflects multiple overlapping systems of domination that require specific analysis. Anarchist organization could reproduce

existing hierarchies around race, gender, ability, nationality unless consciously addressed.

Incorporating Critiques: A Chastened Anarchism

These limitations don't invalidate anarchist principles for healthcare but demand careful application. A "chastened anarchism" acknowledges:

- **Historical Failures Teach:** We must study why anarchist experiments failed, not romanticize them. Spanish healthcare collectives lasted months, not decades. What organizational problems emerged? What would sustained anarchist healthcare require?
- **Scale Matters:** Small-scale horizontal organization differs fundamentally from coordinating complex systems serving millions. We need specific proposals for federating local autonomy while maintaining necessary coordination.
- **Strategy Requires Specificity:** Beyond critique and principles, we need detailed implementation plans. How exactly do anarchist microteams handle emergencies? How do mutual aid networks manage specialized surgery? What coordinates pandemic response?
- **Power Persists:** Anarchist healthcare won't eliminate all power differentials—expertise, knowledge, experience create asymmetries. Rather than denying these, we need practices ensuring they don't become domination.
- **Intersectionality is Essential:** Anarchist principles must explicitly address racism, colonialism, patriarchy, ableism in healthcare. Horizontal organization alone doesn't guarantee justice.
- **Recuperation Requires Vigilance:** We must anticipate how institutions will co-opt anarchist language while maintaining control. What distinguishes genuine transformation from neoliberal mimicry?

My work benefits from anarchist frameworks while remaining alert to their limitations. The sacred-profane dialectic, hermeneutic engagement, and therapeutic presence I advocate require structural transformation that anarchist principles articulate. But implementing these ideas demands more than anarchist theory currently provides—it requires detailed, context-specific planning that learns from anarchism's failures while building on its insights. This addendum doesn't abandon anarchist healthcare but approaches it critically, recognizing that good intentions and compelling principles don't guarantee success. The medicine we need must be built carefully, learning from both anarchism's inspiring vision and its sobering history of defeat [73-95].

References

1. Ungar-Sargon, J. (2024). Revisioning the Soul of Medical Practice. *Arch of case Rep: Open*, 1(1), 01-07.
2. Ungar-Sargon, J. (2024). Worn out philosophical ideas still pervade the practice of medicine: The Cartesian split lives on. *Int J Phys Med Rehabil*, 1(3), 1-10.
3. Ungar-Sargon, J. (2024). The patient history-reimagining the body in illness. *Am J Med Clin Sci*, 9(5), 1-9.
4. Ungar-Sargon, J. (2025). The art of sacred listening: divine

- presence and clinical empathy in contemporary medical history taking. *J Religion Theology*, 7(2), 36-48.
5. Ungar-Sargon, J. (2025). Revisioning healthcare spaces: lessons from spiritual community in contemporary medical practice. *Am J Med Clin Res Rev*, 4(6), 1-17.
 6. Ungar-Sargon, J. (2024). Between illness and health: what happened to convalescence?. *Adv Med Clin Res*, 5(1), 62-67.
 7. Ungar-Sargon, J. (2025). Applying hermeneutics to the therapeutic interaction: the act of interpreting the patient history as a sacred text. *Int J Psychiatry Res*, 8(1), 1-6.
 8. Ungar-Sargon, J. (2025). Divine presence and concealment in the therapeutic space. *EC Neurology*, 17(5), 1-15.
 9. Ungar-Sargon, J. (2025). Sacred and profane space in the therapeutic encounter: moving beyond rigid distinctions. *Am J Neurol Res*, 4(2), 1-9.
 10. Ungar-Sargon, J. (2025). Hermeneutic approaches to medicine: from objective evidence to patient as sacred text. *Adv Educ Res Rev*, 2(1), 40-45.
 11. Ungar-Sargon, J. (2025). Beyond the Cartesian split: the dreambody approach to chronic pain and healing. *Addiction Res*, 9(1), 1-12.
 12. Ungar-Sargon, J. (2025). From sacred to secular heresy: parallel mechanisms of control in religious and medical institutions. *Int J Religion Spirituality Society*, 15(1), 65-75.
 13. Ungar-Sargon, J. (2025). The profit paradox: a critical review of pharmaceutical industry practices in modern medicine. *Int J Nurs Healthcare*, 1(1), 1-13.
 14. Martin, P., & Laurin, A. C. (2023). What can anarchism do for nursing?. *Nursing Philosophy*, 24(3), e12437.
 15. Graeber, D. (2004). *Fragments of an anarchist anthropology*. Prickly Paradigm Press.
 16. Wolff, R. P. (1998). In defense of anarchism. Berkeley: University of California Press.
 17. Ward, C. (1973). *Anarchy in action*. London: Freedom Press.
 18. Proudhon, P. J. (1970). *What is property? An inquiry into the principle of right and of government*. Tucker BR, translator. New York: Dover Publications.
 19. Proudhon, P. J. (2011). *Property is theft!: a Pierre-Joseph Proudhon anthology*. AK Press.
 20. Proudhon, P. J. (2022). *Theory of property*. Kelso SL, Smith B, translators. Cambridge: Cambridge University Press.
 21. Strong, D. R. (2014). Proudhon and the labour theory of property. *Anarchist Studies*, 22(1), 31-50.
 22. Vincent, K. (1984). *Pierre-Joseph Proudhon and the rise of French Republican socialism*. New York: Oxford University Press.
 23. Bakunin, M. (1990). *Statism and anarchy*. Shatz MS, translator. Cambridge: Cambridge University Press.
 24. Franks, B., Jun, N., & Williams, L. (Eds.). (2018). *Anarchism: a conceptual approach*. Routledge.
 25. Bakunin, M. (1916). *God and the state*. Tucker B, translator. New York: Mother Earth Publishing Association.
 26. Bakunin, M. (1953). *The political philosophy of Bakunin: scientific anarchism*. Maximoff GP, editor. New York: Free Press.
 27. Ungar-Sargon, J. (2025). A new vision for the physician-patient relationship: integrating spiritual, intuitive, and holistic dimensions. *Adv Med Clin Res*, 6(1), 75-82.
 28. Kropotkin, P. (1902). *Mutual aid: a factor of evolution*. London: William Heinemann.
 29. Todes, D. P. (1989). *Darwin without Malthus: the struggle for existence in Russian evolutionary thought*. New York: Oxford University Press.
 30. Beito, D. T. (2000). *From mutual aid to the welfare state: Fraternal societies and social services, 1890-1967*. Univ of North Carolina Press.
 31. Ungar-Sargon, J. (2024). Healthcare reforms within and without. *Am J Med Clin Sci*, 9(5), 1-9.
 32. Ungar-Sargon, J. (2024). Capitalism and health care: a critique. *Japan J Med Sci*, 5(1), 174-184.
 33. Ungar-Sargon, J. (2025). A healing space for caregiver and patient: a novel therapeutic clinic model integrating holistic healing principles. *Med Clin Case Rep*, 5(1), 1-11.
 34. Goldman, E. (1931). *Living my life*. New York: Alfred A. Knopf.
 35. Connolly, C. A. (2010). "I Am a Trained Nurse": The Nursing Identity of Anarchist and Radical Emma Goldman. *Nursing History Review*, 18, 84.
 36. Danner, M. E., p. 96.
 37. Women in Medicine Legacy Foundation. (2020). *Radicalization of a nurse: the story of Emma Goldman*
 38. Wexler, A. (1984). *Emma Goldman: an intimate life*. New York: Pantheon Books.
 39. Bookchin, M. (1998). *The Spanish anarchists: the heroic years, 1868-1936*. Oakland: AK Press.
 40. Paz, A. (2007). *Durruti in the Spanish revolution*. AK Press.
 41. Dolgoff, S. (Ed.). (1974). *The anarchist collectives: workers' self-management in the Spanish Revolution, 1936-1939*. Black Rose Books Ltd..
 42. Guillamón, A. (1996). *The Friends of Durruti Group, 1937-1939*. Oakland: AK Press.
 43. Seidman, M. (1991). *Workers against work: labor in Barcelona and Paris during the Popular Fronts*. Berkeley: University of California Press.
 44. Mintz, F., & Sharkey, P. (2013). *Anarchism and workers' self-management in revolutionary Spain* (pp. 46-50). Oakland, California: AK Press.
 45. Peirats, J. (2014). *The CNT in the Spanish Revolution. Vol 1-3*. Hastings: Christie Books; 2001-2005.
 46. Orwell, G. (1938). *Homage to Catalonia*. London: Secker & Warburg.
 47. Ungar-Sargon, J. (2025). Beyond reductionism or wishful thinking? Tensions between evidence-based practice and spiritual frameworks in contemporary healthcare. *Trends Int Med*, 5(1), 1-10.
 48. Gordon, U. (2005). *Anarchism and political theory: contemporary problems [dissertation]*. Oxford: University of Oxford.
 49. Plsek, P. E., & Greenhalgh, T. (2001). The challenge of complexity in health care. *Bmj*, 323(7313), 625-628.
 50. Day, R. J. (2005). *Gramsci is dead: Anarchist currents in the newest social movements*. Pluto Books.

51. Avrich, P. (2005). *The Russian anarchists*. Oakland: AK Press.
52. Malet, M. (1982). *Nestor Makhno in the Russian Civil War*. London: Macmillan Press.
53. Williams, G. A. (1975). Proletarian order: Antonio Gramsci, factory councils and the origins of Italian communism, 1911-1921. (*No Title*).
54. Graham, H. (2002). *The Spanish Republic at War 1936-1939*. Cambridge University Press.
55. Day, C. (1996). The historical failure of anarchism. Libcom.org.
56. Michels, R. (1915). Political parties: a sociological study of the oligarchical tendencies of modern democracy. Glencoe: Free Press.
57. Van der Walt, L., Schmidt, M., & Schmidt, M. (2009). *Black Flame: the revolutionary class politics of anarchism and syndicalism*. Ak Press.
58. Merriman, J. (2009). The dynamite club: how a bombing in fin-de-siècle Paris ignited the age of modern terror. New York: Houghton Mifflin Harcourt.
59. Mintz, F. (2013). Anarchism and workers' self-management in revolutionary Spain. Oakland: AK Press, 156-167.
60. Falk, C. (1990). Love, anarchy, and Emma Goldman. New Brunswick: Rutgers University Press, 242-268.
61. Stirner, M. (1995). The ego and its own. Byington SK, translator. Cambridge: Cambridge University Press.
62. Marshall, P. (2010). Demanding the impossible: a history of anarchism. Oakland: PM Press.
63. Jun, N. (2011). *Anarchism and political modernity* (p. 272). Bloomsbury Academic.
64. Wigger, A. (2019). Anarchism and Marxism in an age of neoliberal crisis. *Crit Sociol*, 45(4-5), 485-487.
65. Newman, S. (2010). The politics of postanarchism. Edinburgh: Edinburgh University Press.
66. Boltanski, L., Chiapello, E. (2005). The new spirit of capitalism. London: Verso.
67. Mudu, P., Chattopadhyay, S. (2017). Migration, squatting and radical autonomy. New York: Routledge.
68. Anderson, W. C, Samudzi, Z. (2017). The anarchism of blackness. The Anarchist Library.
69. Ramnath, M. (2011). Decolonizing anarchism: an antiauthoritarian history of India's liberation struggle. Oakland: AK Press.
70. Ervin, L. (2016). Anarchism and the Black revolution. London: Pluto Press.
71. Heckert, J. (2016). Anarchism and sexuality: ethics, relationships and power. New York: Routledge.
72. Roberts, D. E., Obasogie, O. K. (2011). Race and genetics in biomedicine: the FDA and BiDil. *N Engl J Med*, 365(19), 1743-1745.
73. Shanafelt, T. D., & Noseworthy, J. H. (2017, January). Executive leadership and physician well-being: nine organizational strategies to promote engagement and reduce burnout. In *Mayo clinic proceedings* (Vol. 92, No. 1, pp. 129-146). Elsevier.
74. Gould, S. J. (1997). Kropotkin was no crackpot. *Nat Hist*, 106(6), 12-21.
75. Carr, E. H. (1961). Michael Bakunin. New York: Vintage Books.
76. Nelson, A. (2011). *Body and soul: The Black Panther Party and the fight against medical discrimination*. U of Minnesota Press.
77. Gorsky, M. (1998). The growth and distribution of English friendly societies in the early nineteenth century. *Economic History Review*, 489-511.
78. Swann, T. (2023). 'Anarchist technologies': Anarchism, cybernetics and mutual aid in community responses to the COVID-19 crisis. *Organization*, 30(1), 193-209.
79. Bookchin, M. (1995). Social anarchism or lifestyle anarchism. *An Unbridgeable Chasm, Edinburgh* (online: <http://raforum.apinc.org/article.php3>).
80. Raymond, E. (1999). The cathedral and the bazaar. *Knowledge, Technology & Policy*, 12(3), 23-49.
81. Chan, L., Kirsop, B., & Arunachalam, S. (2011). Towards open and equitable access to research and knowledge for development. *PLoS medicine*, 8(3), e1001016.
82. Benkler, Y. (2013). Practical anarchism: Peer mutualism, market power, and the fallible state. *Politics & Society*, 41(2), 213-251.
83. Holloway, J. (2002). Change the world without taking power. *New Politics*, 9(1), 175-179.
84. Bakunin, M. (1950). Marxism, freedom and the state. Kenafick KJ, translator. London: Freedom Press.
85. Kinna, R. (2016). *Kropotkin: reviewing the classical anarchist tradition*. Edinburgh University Press.
86. Kropotkin, P. (2021). Mutual aid: a factor of evolution. Leach D, Kinna R, editors. Oakland: PM Press.
87. Falk, C. (1990). Love, anarchy, and Emma Goldman. New Brunswick: Rutgers University Press.
88. Restakis, J. (2010). Humanizing the economy: co-operatives in the age of capital. Gabriola Island: New Society Publishers.
89. Whyte, W. F., & Whyte, K. K. (1991). *Making Mondragon: The growth and dynamics of the worker cooperative complex* (No. 14). Cornell university press.
90. Hsieh, N. (2016). Incommensurable values and the politics of recognition. London: Rowman & Littlefield.
91. Weick, K. E., Sutcliffe, K. M. (2007). Managing the unexpected: resilient performance in an age of uncertainty. 2nd ed. San Francisco: Jossey-Bass.
92. Esenwein, G. R., & Shubert, A. (1995). Spain at War: The Spanish Civil War in Context, 1931-1939. (*No Title*).
93. Horvath, A. O., DelRe, A. C., Flückiger, C., & Symonds, D. (2011). Alliance in individual psychotherapy. *Psychotherapy*, 48(1), 9.
94. Holt-Lunstad, J., Smith, T. B., & Layton, J. B. (2010). Social relationships and mortality risk: a meta-analytic review. *PLoS medicine*, 7(7), e1000316.
95. Cacioppo, J. T., & Cacioppo, S. (2014). Social relationships and health: The toxic effects of perceived social isolation. *Social and personality psychology compass*, 8(2), 58-72.

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