

CHEST SURGERIES OF A DIFFERENT 'NATURE'

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Abstract

For men with gynecomastia, where 'gynecomastia' is the medical term for 'excess breast tissue' (Wray et al., 1974, p. 40), surgical intervention is assumed to the extent that the post-surgical body is naturalised. In contrast, for transsexuals assigned female at birth, the same surgical procedure is often perceived as 'mutilation' of the natural. Clearly, some cuts are considered to do harm while others are thought to correct it. Through a close comparative analysis within medical discourse, this paper explores the inconsistencies between the discursive figurations of gynecomastia surgery and transsexual chest surgery, in particular, in relation to the ways in which notions of the 'natural' and 'normal' are employed. Grounded in the theoretical framework of somatechnics, the question is not how do these processes act on 'natural' male and female bodies, but rather, how do they constitute particular bodies as 'naturally' male and female?

Naturalisation is achieved within medical discourse through the use of multiple and varied themes that intersect with the natural, and upon which the natural is grounded. This paper focuses on the location of 'disorder' as a central theme in this process, comparing the mental health diagnosis of gender dysphoria (APA, 2013) for transsexuals requesting chest surgery to the attribution of bodily disorder in the case of men with gynecomastia, and the subsequent normalisation of psychological discomfort in their desire to remove their 'breast' tissue. Revealing the discursive operation of this difference, this paper emphasises the material and ethical implications of the inconsistency.

Keywords: transsexual; gynecomastia; natural body; chest surgery; sex

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A common condemnation levelled against transsexuals who pursue surgical intervention as part of their re-embodiment process is that of being unnatural or of being constructed. This accusation of construction rests on the assumption of a natural body, free from 'harm', physical intervention, modification, and 'mutilation'. In the case of the FTM¹ body, it is situated in opposition to the natural male body: always 'not-quite', 'not-enough', 'not-real', 'incomplete', or 'fake'. This article engages directly with this accusatory juxtaposition through close comparative discourse analysis within the medical domain, focusing on the inconsistencies between the discursive figurations of FTM chest surgery and gynecomastia surgery (the removal of 'excess' breast tissue or fat in men with gynecomastia), with particular attention being paid to different figurations of the 'natural' body. These two surgical practices are articulated significantly differently within medical discourse and it is this difference, overwriting a practical and functional similarity, that highlights the distinct ontological presuppositions underlying these medical practices. As well as revealing the inherent cisgenderism² within these medical fields (Ansara, 2012; Ansara & Hegarty, 2012), my larger aim, in considering this analogous surgical procedure conducted on men with gynecomastia, is to disrupt the notion of the 'natural' male body commonly assumed to be that which the FTM body fails to be.

There have been a variety of academic studies concentrating on the construction of the body through 'sex reassignment surgery',³ but this article shifts the focus. As with critical theoretical approaches to the question of race, some of which have shifted their attention toward whiteness (Dyer, 1988; Frankenberg, 1993), and some recent scholarship on disability, which has turned to the issue of normality (Davis, 1995), I focus not on the constructed body but on that against which it is always compared and found lacking: the 'natural' body. As such, this article is an attempt to emphasise the ways in which the 'natural' body is itself constructed, in particular, highlighting the technologies through which the body of sexual difference is naturalised. After all, 'there is no reference to a pure body which is not at the same time a further formation of that body' (Butler, 1993, p. 10).⁴ Until we know precisely

1 For the purposes of this medical critique, I need to clearly define two sets of bodies as they are marked within the medical domain so I use, on one hand, 'transsexual', and more specifically, 'FTM' to refer to those transsexuals assigned female at birth, and, on the other, 'men with gynecomastia'. I recognise that not all individuals described by these medical terms identify with them, and some may actively critique them, but my focus is on medical discourse not self-identity. Thus the use of transsexual and FTM indicates not those who identify with either term, but the concept as constructed within medical discourse.

2 Cisgenderism refers to the assumption that bodily sex and gender identity are naturally aligned and any deviation from this is considered unnatural and abnormal.

3 Again, I recognise that some people critique this phrase and prefer the terms 'gender affirmation surgery' or 'gender confirmation surgery' (e.g. Ansara and Hegarty, 2012; Vanderburgh, 2009), however I am concerned with how these practices are represented within medical discourse so I use the term I most often find there.

4 Some transgender scholars and activists (e.g. Haritaworn, 2008) criticize Butler for the so-called erasure of transgender lives and experiences, while others find her philosophical perspectives on the nature of the body to be productive in rethinking embodiment, as I do.

how the notion of the natural operates within and across different contexts, we cannot escape the tyranny of the natural and the harmful exclusions enacted in its name.

Making connections between surgical practices and emphasising the disjunctions between the regulatory frameworks surrounding them has the potential to reveal the relation between ‘bodies of flesh’ and ‘bodies politic’ (Sullivan, 2005a, p. 328). The nature of state interest in the body can especially be read through and within bodies of knowledge circulating in the medico-juridical realm, in which the notion of the natural body and its corollary concept, bodily integrity, are particularly potent (Bridy, 2004; Currah and Moore, 2009; Loeb, 2008; Sullivan, 2005a, 2007; Sullivan and Stryker, 2009). Sullivan (2005a) asserts that Hobbes’ vision is one that continues to resonate within current social imaginaries, ‘of the modern body politic as a cultural construct founded on an a priori or “natural” body’ where, ‘(material and moral) integrity is both the original and perfect condition, and the necessary condition for the continued well-being of its members and of itself’ (p. 328). As such, practices perceived to be assaults on the integrity of the ‘natural’ body are taken to be threats to state sovereignty, which in turn, are considered to justify the state’s regulation of the body, or in Foucault’s (2003) terms, ‘bioregulation by the state’ (p. 250). This is codified in criminal law concerning bodily harm as the state’s interest in ‘the preservation of the natural completeness and normal appearance of the human face and body’ (Bridy, 2004, p. 153).

Insofar as members of the medical establishment are seen to be operating in accordance with this declaration, the state delegates regulatory authority over the body to the medical profession itself (ibid). Thus, medicine is concerned with protecting the state’s interest in the body, which, in the current context, involves the maintenance of the ‘two-sex model’. According to Laqueur (1990), this relatively recent concept refers to the contemporary Western social imaginary that figures male and female as ‘stable, incommensurable, opposite sexes’ grounded in ‘sharp corporeal distinctions’ (p. 5-6). My project of mapping citations of the natural within specific dominant Western medical contexts highlights the operations of this medical regulation, and thus joins others in making visible the ‘micro powers of modern regulatory apparatuses’ and searching for ‘points of fissure’ in them (Currah and Moore, 2009, p. 4).

As such, I am not engaging with this material in order to make evaluative judgements concerning surgical body modification, nor am I interested in obscuring the differences between the FTM body and the gynecomastic body, or the surgical processes they may go through; rather, I aim to emphasise the political implications of the inconsistencies between the discursive figurations of FTM chest surgery and gynecomastia surgery; not merely what particular categorisations mean, but, more importantly, how they work and how they come to matter. My intention is to join Sullivan (2007) in shifting our ethical imperative from the assessment of body modification, which leaves us stuck in the dead end of derision versus valorisation, to the political interrogation of ‘the “social imaginaries” - the perceptual schemas - that constitute embodied subjects and their affective investments in ways that incite and then discriminate against particular bodies and bodily practices’ (p. 407). This critical analysis provides the means to contest the narration of the ‘natural’ body, which continues to represent the ground upon which transgender people are pathologised

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and excluded from social and political life: denied state recognition, housing, employment, and basic human rights, including the right to knowledge and the right to health.

Somatechnics

I situate my work within the framework of somatechnics, which is a theoretical approach that attempts to reconceive the body, technology, and the relation between them. Outlined in the first book-length edited collection that engages with this concept, *Somatechnics: Queering the Technologicalisation of Bodies* (2009), Sullivan and Murray frame somatechnics as:

...an attempt to highlight the inextricability of soma and techne, of 'the body' (as a culturally intelligible construct) and the techniques (dispositifs and 'hard technologies') in and through which corporealities are formed and transformed. This term, derived from the Greek soma (body) and τεχνη (craftsmanship), supplants the logic of the 'and', suggesting that technes are not something we add or apply to the body, nor are they tools the embodied self employs to its own ends. Rather, technes are the dynamic means in and through which corporealities are crafted, that is, continuously engendered in relation to others and to a world. (p. 3)

In contrast to the view that technology is separate from the 'natural' body, something that acts *on* the body for good or bad, somatechnics emphasises the constitution of the body *through* technology, where this concept is not limited to the explicitly technological but includes all forms of discourse and practice. Grounded in contemporary poststructuralism, this is a theoretical framework in which embodiment is understood 'as the incarnation or materialisation of historically and culturally specific discourses' (ibid, p. 3). Material existence is not something that precedes these structuring dynamics, but is something that depends on them. Rather than presuming that bodies are 'simply mired in being unless they undergo explicit, visible, and identifiable transformational procedures', somatechnics operates under the central principle that all bodies are 'entwined in (un)becoming', or, in other words, that 'all bodies mark and are marked' (Sullivan, 2006, p. 561). In short, somatechnics emphasises the technological constitution of *all* bodies.

Somatechnics draws from a wide variety of disciplines, including feminist theories of the body, transgender studies, queer theory, critical race studies, disability theory, and post-structuralism. From these fields, my research relies most heavily on academic work that emphasises the contingency of current beliefs about the sexed (and raced, classed, and disabled) body, and focuses on the ways in which these conceptions are produced and naturalised (Butler, 1993, 1999; Davis, 1995; Foucault, 1990; Grosz, 1994; Haraway, 1991; Heyes, 2007; Laqueur, 1990; Shildrick, 1997; Stryker, 2006; Sullivan, 2005b). Through the recognition that all bodies are constituted through the vast array of knowledges, spatial relations, state and judicial regulations, political regimes, and other culturally and historically

located social ‘imaginaries’⁵ through which we be-come, this framework provides a way of thinking beyond the natural/constructed binary. Terry and Urla describe this perspective in their introduction to *Deviant Bodies: Critical Perspectives on Difference in Science and Popular Culture* (1995):

Bodies do not exist in terms of an a priori essence, anterior to techniques and practices that are imposed upon them. They are neither transhistorical sets of needs and desires nor natural objects preexisting cultural (and, indeed, scientific) representation. They are effects, products, or symptoms of specific techniques and regulatory practices...Knowable only through culture and history, they are not in any simple way natural or ever free of relations of power. (p. 3)

As Grosz (1994) says, ‘there is no “natural” norm; there are only cultural forms of body, which do or do not conform to social norms’ (p. 143).⁶

This theoretical approach challenges the sex/gender distinction, itself a relatively recent historical development, which is mapped on to the natural/constructed binary, where the notion of gender as construct is grounded on the idea of sex as ‘natural’ foundation. Instead of asking how particular processes act on the ‘natural’ male and female body, I turn to the question of how bodies are constituted as naturally male and female through particular processes. I shift from noun to verb in asking how are bodies ‘maled’ and ‘femaled’ in certain contexts? What specific themes are employed in order to produce the binary of the sexed body? I join the body of critical work that is invested in making the work of being male or female visible, in other words, highlighting the extent to which male and female are modes of becoming. I am concerned with revealing, what I call, the technologies of the natural or naturalisation techniques, the specific discursive operations through which the male and female body are materialised as natural.

The Body in/of the Text

Somatechnics, with its recognisably Foucauldian influence, is based on a conception of the inextricability of discourse and materiality. Here, discourse is not merely descriptive, representing a real materiality that is always elsewhere, rather it is constitutive and productive of forms of embodiment; the distinction between signifier and signified does not apply in this framework for we come to be to the extent that we submit to discourse. This is not to say simply that we are determined, far from it, for that would imply a notion of power as singular; bodies are the sites and manifestations of the multiplicity of discursive regimes, and this provides the corporeal with the potential of recalcitrance in the face of

5 Gatens (1995) uses the term ‘imaginaries’ to refer to ‘those ready-made images and symbols through which we make sense of social bodies and which determine, in part, their value, their status and what will be deemed their appropriate treatment’ (p. viii).

6 Some academics within transgender studies find Grosz’s scholarship problematic in relation to transgender bodies because of its reliance on the ‘facticity’ of sexual difference (e.g. Salomon, 2010). While I appreciate its limitations in this regard, I find it productive in its articulation of the notion of becoming in relation to materiality.

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dominant power configurations. So, discourse analysis is ultimately an exploration of bodies and their (trans)formations. After all, it is the reading of the stories we tell about our selves, stories completely imbricated in shaping the contours of our bodies.

My analysis is based on a body of medical literature situated in a Western context, that includes dominant clinical guidelines, select authoritative articles, and influential historical approaches. After reading a wide survey of the material in order to map out each field, I focus on close textual analysis of a few exemplary texts, not necessarily those that are most representative but those that are influential within the field and those that are particularly rich in (un)naturalisation techniques.⁷ I start with the World Professional Association of Transgender Health's *Standards of Care* (WPATH SOC) because it provides the foundational framework for 'sex reassignment surgery' in many contexts, particularly in Western Europe, the United States and Canada. Then, from the small pool of texts specifically on FTM chest surgery, I focus on those written by experienced, well-respected practitioners in the field who are at the forefront of determining the parameters of this domain, both past and present. In relation to surgical approaches to gynecomastia, I focus on those texts that have become 'classics' in the field of gynecomastia surgery. Their level of influence is evident through the extent to which they are cited throughout the literature, both in relation to gynecomastia surgery and FTM chest surgery, and also through the fact that surgical techniques have been named after some of the authors, such as, the "Webster technique" of peri-areolar incision.

Both the medical sub-specialties of FTM chest surgery and gynecomastia surgery are situated within the broader domain of 'breast' surgery but they are currently situated as distinct. According to Letterman and Schurter in *The Surgical Correction of Gynecomastia* (1969), the first surgical treatment for large male 'breasts' was performed by Paulus Aegineta, who practised in the latter half of the seventh century. Although the current concepts of sex and gender underlying both gynecomastia surgery and FTM chest surgery make the aims

7 In relation to FTM chest surgery: *Care of the Patient Undergoing Sex Reassignment Surgery (SRS)* (Bowman and Goldberg, 2006); "Standards of care for the health of transsexual, transgender, and gender-nonconforming people, version 7" (Coleman et al., 2011); "The Surgical Treatment of Transsexual Patients: Limitations and Indications" (Edgerton, Knorr, and Callison, 1970); "The Role of Surgery in the Treatment of Transsexualism" (Edgerton, 1984); "Chest-Wall Contouring in Female-to-Male Transsexuals: Basic Considerations and Review of the Literature" (Hage and van Kesteren, 1995); "Reduction Mammoplasty in Gender Dysphoria" (Kenney and Edgerton, 1990); "Creation of a Male Chest in Female Transsexuals" (Lindsay, 1979); *The Harry Benjamin International Gender Dysphoria Association's Standards of Care for Gender Identity Disorders, Sixth Version* (Meyer et al, 2001); "Surgery: Female-to-Male Patient" and "Surgery: General Principles" (Monstrey, 2007).

For gynecomastia surgery: "Gynecomastia" (Braunstein, 2007); "Circumareolar Mastectomy in Female-to-Male Transsexuals and Large Gynecomastias: A Personal Approach" (Colic and Colic, 2000); "Concentric Circle Operation for Massive Gynecomastia to Excise the Redundant Skin" (Davidson, 1979); *Gynaecomastia* (Hall, 1959); "Surgical Correction of Massive Gynecomastia" (Letterman and Schurter, 1972); "Gynecomastia" (Menville, 1933); "Gynecomastia as a physical finding in normal men" (Nuttall, 1979); "Transareolar Incision for Gynecomastia" (Pitanguy, 1966); "Classification and Surgical Correction for Gynecomastia" (Simon et al, 1973); "Surgery for Gynecomastia" (Teimourian and Perlman, 1983); "Mastectomy for Gynecomastia through a Semicircular Intra-areolar Incision" (Webster, 1946); "Correction of Extreme Gynecomastia" (Wray et al, 1974); and "Gynecomastia: An Outcome Analysis" (Wiesman et al, 2004).

and understandings of these seventh century surgeries very different, both forms of contemporary surgical practice are grounded in these surgical techniques. However, while the medical discourse on FTM chest surgery references that of gynecomastia surgery, (borrowing its surgical techniques but framing them in relation to the ‘pathology’ of transsexualism), as discursive fields they remain markedly separate. FTM chest surgery has often been situated as a specific case of reduction mammoplasty on women, while gynecomastia surgery has remained distinct. As the fields of gynecomastia surgery and FTM chest surgery have become established, surgeons practicing within them have tended to mark gynecomastia surgery, FTM chest surgery, and reduction mammoplasty on women as distinct specialisations, despite the common occurrence of one surgeon practicing all three. In fact, the text, *Circumareolar Mastectomy in Female-to-Male Transsexuals and Large Gynecomastias: A Personal Approach* (Colic and Colic, 2000) is exceptional in its consideration of both sets of patients together. These discursive boundaries are significant because of the extent to which they contribute to the materialisation of the body. The border between the medical literature of gynecomastia surgery and that of FTM chest surgery defines the FTM body as absolutely distinct from the gynecomastic body, and the association between FTM chest surgery and reduction mammoplasty situates the FTM body as female, while the disassociation of gynecomastia surgery from both renders the gynecomastic body as male from the very outset.

There is also a significant structural difference between the medical discourse surrounding FTM chest surgery and gynecomastia surgery. Discussions of FTM chest surgery are situated within a framework guided by professional standards, while the medical discourse concerning gynecomastia surgery is not situated within such a disciplinary structure. Despite surgical practices designed to reduce the size of male breasts historically preceding FTM chest surgery, there is no professional association ‘devoted to the understanding and treatment of’ gynecomastia, as the World Professional Association for Transgender Health (WPATH) defines itself in relation to ‘gender identity disorders’ (‘Homepage’, n.d.). There is no consensus on standards of care produced by such an association, as there is in relation to transsexuals, where it is a comprehensive authoritative document that was originally written in 1979 and has now been updated seven times, the most recent in 2011 (Coleman et al., 2011). The non-existence of professional guidelines specific to gynecomastia surgery can be attributed to gynecomastia surgery being readily offered with few, if any, conditions. The American Society for Aesthetic Plastic Surgery simply states, ‘men of any age who are healthy and emotionally stable are considered good candidates for male breast reduction surgery’ (‘Male Breast Reduction’, n.d.). Clearly, desire for the surgery is not taken to be a sign of emotional or mental instability as in the case of FTM chest surgery, where it is this assumption that necessitates the presence of a professional organisation concerned with defining the parameters through which to determine the nature of mental instability and whether surgery is the appropriate treatment. These distinctions between the ‘material existence’ (Foucault, 1970, p. 100) of statements made within the medical discourse surrounding FTM chest surgery and gynecomastia surgery are both a consequence of the ontological presuppositions at work in each field and a reinforcement of those assumptions, thereby becoming naturalisation techniques in themselves.

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Having revealed the significant contextual anomalies, I now engage with the content of the specific discursive domains under consideration. In reading the medical literature, I pay specific attention to the ways in which the terms 'natural' and 'normal' are used, as well as terms used as synonyms and their antonyms, such as, in relation to normal, 'typical', 'common', 'appropriate', and 'abnormal', 'atypical', or 'unusual'. I am also as aware as I can be of the silences because what goes unsaid is that which is taken for granted, in other words, that which is most 'natural' or most 'normal'. The comparative approach toward the medical discourse of FTM chest surgery and gynecomastia surgery is particularly effective in revealing the silences in each discursive network because what is absent in one becomes loud and clear when placed in proximity to its presence in the other. Read through and against each other, the medical discourse of FTM chest surgery and that of gynecomastia surgery reveal the ways in which the 'natural' body is constructed through particular bodily modifications and excluded from others. I identify the central theme through which this (un)naturalisation is achieved within medical discourse as the notion of harm, which employs in its service other themes that intersect with the natural and upon which the natural is grounded, such as conceptions of disorder, bodily integrity, regret and authenticity. In this article, I focus on the notion of 'disorder' and the differences between how it is associated with FTM chest surgery and gynecomastia surgery, and the ways in which bodily integrity or, referencing the above discussion on state regulation of the body, 'natural completeness' is undermined or maintained through surgical intervention. Throughout, I remain as aware as I can be of the ways in which the naturalisation techniques concerned with the sexed body employ other power dynamics in their service, such as race, class, and ability.

Disorder

The notion of 'disorder', which according to the *Canadian Oxford Dictionary* refers to 'an ailment or disturbance of the *normal* state of body or mind' (Barber, 2004, my emphasis), grounds the ontological presuppositions at work in these medical discourses. It is applied to both FTM patients requesting chest surgery and men with gynecomastia but, despite the fact that these patients often share psychological discomfort with their bodies and a persistent desire for surgical transformation, it is used in significantly different ways. The distinct locations of the 'disorder' within these two medical contexts have the effect of naturalising the pre-surgical FTM body in the former and the male body without 'breasts' in the latter.

Within the medical discourse on FTM chest surgery the disorder is located in the mind, previously through the designation of Gender Identity Disorder (GID)⁸ but within the most recent iteration of the WPATH *Standards of Care* (SOC) (Coleman et al., 2011) and

8 According to the DSM-4, Gender Identity Disorder refers to 'a strong and persistent cross-gender identification, which is the desire to be, or the insistence that one is, of the other sex,' as well as 'persistent discomfort about one's assigned sex or a sense of inappropriateness in the gender role of that sex' (APA, 1994, p. 576).

the DSM-5 (APA, 2013)⁹, through the attribution of gender dysphoria. This diagnosis, on which access to chest surgery for FTM patients is often dependent, is considered a mental health issue. The WPATH *Standards of Care* include the following definitions in the introductory pages:

Gender dysphoria refers to discomfort or distress that is caused by a discrepancy between a person's gender identity and that person's sex assigned at birth (and the associated gender role and/or primary and secondary sex characteristics)...Some people experience gender dysphoria at such a level that the distress meets criteria for a formal diagnosis that might be classified as a mental disorder. (p. 168)

In terms of treatment protocol, the location of the disorder in the mind leads to a recommendation of psychotherapy or, at the very least a mental health assessment, before proceeding to physical intervention. By implication, the 'normal' state of mind assumed by the diagnosis of gender dysphoria consists in bodily comfort and no distress in relation to sex and gender. The conceptualisation of gender dysphoria as a mental health concern figures the pre-surgical body in a specific relation to the natural; through the containment of the abnormal within the mind, the body of the pre-surgical FTM is effectively rendered normal and natural.

In contrast to the medical framing of FTM chest surgery, the 'disorder' or 'disease' associated with gynecomastia is firmly located within the body; more specifically, it is contained within the 'breast' or 'breast tissue'. The very use of the term 'gynecomastia' dissociates the breasts from the body on which they are found; gynecomastia stems from the etymological roots of the Greek *gyne* meaning woman and *mastia* meaning breasts, so it literally translates to 'woman's breasts'. The implication of this designation of the breasts as not-male, despite being found on male bodies, is that the male body without breasts is discursively framed as natural from the very outset. This occurs in spite of the medically recognised commonality of the condition, especially during puberty and in old age. Directly after the attribution of 'abnormality' in the most recent article under consideration, Wiesman et al. (2004) assert the normality of gynecomastia, acknowledging that studies have shown the incidence to be as high as 65% in 14-year-old boys and from 40-60% in the adult male.

Other language used in defining gynecomastia is also far from neutral. It is often described as the 'excessive' development of 'breast' tissue in men and is thought to be caused by a hormonal 'imbalance'. These terms further the effect of rendering 'breasts' on men thoroughly abnormal and unnatural. As such, psychotherapeutic management is never considered as a treatment or even an eligibility requirement for surgery; instead, the treatment options are limited to physical intervention: radiotherapy, hormonal therapy, and surgery, although surgery is claimed as the most effective (Webster, 1946; Braunstein, 2007). In most of the literature treatment of some sort is assumed. So, in this use of the term 'disorder' the normal, and by implication, natural state of the male body is framed as one without 'breasts'.

9 I am aware of multiple community discussions on the removal of this designation as a mental health disorder and the implications of this on the provision of medical insurance but I am not engaging with this issue here because I am concerned with the ways in which these chest surgeries are described within medical discourse and the implications of this on our understandings of the natural body.

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As opposed to the construction of gender dysphoria, which rests on the notion of distress within the WPATH *Standards of Care*, the psychological discomfort of men with gynecomastia is frequently acknowledged but rarely included as an element of the disorder. Webster, in his foundational article introducing the semicircular intra-areolar incision in 1946, wrote:

The psychic trauma caused by the 'reproach of effeminacy' is the main reason for operative interference in gynecomastia of the benign type. In modern life when exposure to the body is so frequent, and this is particularly the case in military life, the gynecomastia patient is subjected to jibes and teasing from his fellows. The repeated ridicule may bring about changes in the individual's behavior patterns. He hesitates to undress before others in the gymnasium or on the beach, and he refrains from going in swimming. He may even shrink from exposing himself in a thin undershirt. Thus, a complex is started which may lead to severe psychotic disturbances. (p. 560)

Not only is 'psychic trauma' not pathologised in relation to gynecomastia, it is taken unequivocally as an indication for surgery. As Pitanguy reiterates in 1966,

Surgery is justifiably and principally indicated for those patients who have excessive preoccupation with their feminine appearing deformity, those who are so preoccupied that their behaviour is disturbed and, consequently, their ability to face life situations effectively. (p. 414)

Hall, in his comprehensive treatise from 1959, even considers the psychological distress of the parents in relation to the need for surgical intervention: '[p]arents may be more distressed than patients, although this is not easily detected with certainty during a single interview and in any case is probably an indication for surgical treatment' (p.146). The recognition of psychological discomfort in relation to the gynecomastic body undermines the diagnosis of gender dysphoria, which presupposes the normal state of mind to consist in bodily comfort and no distress. Here, psychological discomfort is considered entirely appropriate and normal rather than a mental health issue and is, unquestionably, taken to be justification for surgery. In relation to FTMs, distress is pathologised, while for men with gynecomastia it is normalised.

Within the medical literature focused on etiological considerations of gynecomastia, it is more common to question the attribution of 'disorder' to the condition of gynecomastia (Nuttall, 1979; Braunstein, 2007). In *Gynecomastia as a Physical Finding in Normal Men* (1979), the endocrinologist Nuttall measures the level and incidence of gynecomastia in a small sample of 306 members of the Reserve Air Force Unit and those applying for admission. These men were defined as 'normal' on the basis of passing the medical qualifications for military service which includes, of relevance to the evaluation of gynecomastia, a lack of enlargement of the liver, 'normal' genitalia, no chronic medication or alcohol intake, and a body weight within the United States Air Force limits (ibid, p. 338). Nuttall (1979) found that 36% of 'normal' adult men between the ages of 17 and 58 have breasts, with a low of 17% for the 17 to 19-year-olds and a high of 57% for those over 45. He concluded that '[t]

these data indicate that palpable gynecomastia is common in normal adult men', and went on to say that this 'high prevalence must be taken into consideration when attributing gynecomastia to a drug or disease state' (p. 338). More recently, Braunstein (2007) also appeals to the commonality of the male body with 'breasts' when he asks, should gynecomastia among older men 'be considered to be pathologic or a part of the *normal* process of aging' (p. 1235, my emphasis)? However, even in these instances within the medical discourse where men with gynecomastia are both normal and natural, the desire to remove them is also considered both normal and natural. Although Braunstein (2007) acknowledges the high incidence of physiologic gynecomastia, he still recommends surgical removal for those patients who are simply 'troubled by their appearance' (p. 1236).

Whole versus Part: Sex and gender

In relation to FTM patients, the notion of disorder is generally applied to the *whole* – the FTM patient effectively becomes the disorder – while in reference to those presenting with gynecomastia, the disorder is contained within a *part*. As well as being evident within descriptions of each disorder, this difference is also expressed through the language used to refer to the patients themselves. FTM patients have their very own identifying label, 'the transsexual', while patients with gynecomastia have no corresponding term. Gynecomastia is described as a disorder that 'occurs' or 'presents' in 'normal males', merely a 'relatively common condition' that men 'have' or live 'with'. They are not reduced to the disorder; rather it is limited to a part which is merely attached *to* them but not *of* them. In Foucault's terms, 'the transsexual' has become a species, while gynecomastia remains a condition. Notably, the 2011 WPATH *Standards of Care* have made an attempt to counter this phenomenon through the definition of a disorder as 'a description of something with which a person might struggle, not a description of the person or the person's identity' (p. 169). However, this statement does not adequately undermine the sense that the disorder is applied to the whole person through the mental health diagnosis.

Only twice does a corresponding term to that of transsexual appear within the medical literature on gynecomastia surgery. In Colic and Colic's (2000) discussion of circumareolar mastectomy in which they include both FTMs and men with gynecomastia, they give the breakdown of their 17 patients as '12 female-to-male transsexuals and 5 extreme gynecomastias' (p. 450). Later, they revert back to the more common description of 'patients with gynecomastia (sic)' (p. 453). The more significant example is in a small section of Menville's 1933 article on the histological characteristics of gynecomastia. In his discussion of gynecomastia being the 'result of...a lack of sex differentiation in the sex organs', a condition which he defines as bisexuality and associates with 'hermaphroditism and pseudohermaphroditism', he uses the label 'gynecomast' (p. 1056). It is primarily limited to one paragraph within which he reports on cases of 'gynecomasts who have nursed infants' (ibid). Employing 'gynecomast' as a noun implies the recognition that these particular bodies cannot strictly be reduced to 'man'. However, the anecdotal style of the description of such 'remarkable' cases, taken largely from a book published in 1897 and entitled *Anomalies and Curiosities of Medicine* which stands in stark contrast to the technical mode employed in the rest of this medical study, has the effect of relegating these bodies to the mythical.

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The denaturalisation of the 'gynecomast' is further achieved through certain operations of racialisation. The stories Menville (1933) tells, as opposed to the case studies he presents, exoticise these bodies, always situating them geographically and racially elsewhere. Throughout the remainder of the article the term 'gynecomast' is noticeably absent, as Menville (1933) reverts to the more regular approach of describing gynecomastia as merely a condition men or boys may have or develop, and the 'gynecomast' never appears again in the medical literature.

The diseased part, the 'breast' tissue that is framed as containing the disorder of gynecomastia, is further demarcated from the rest of the body through the use of sexed and gendered terms. The patient's sex and gender are rarely questioned or threatened, remaining male and masculine despite discussions of the causes of gynecomastia being linked to intersexuality (although the term 'intersex' is never applied).¹⁰ The list of underlying causes sometimes includes one or more of the following: 'hermaphroditism',¹¹ Klinefelter syndrome, incomplete androgen insensitivity, and 'testicular feminization' (now generally called complete androgen insensitivity syndrome). This is never acknowledged in the medical literature – the term 'intersex' is noticeably absent – and the possible presence of one of the above so-called 'disease processes' rarely threatens or disrupts the presupposition of the natural male body. Writing in 1956, Hall goes so far as to advocate secrecy to contain the threat of Klinefelter's syndrome, asserting that the patient 'be treated as male, regardless of chromosomal sex, and neither he nor his relatives informed of the genetic sex in cases where this is female' (p. 147). While concealment is not encouraged in more current literature, the continued use of 'men' and 'male' in reference to intersex bodies functions as a similar form of denial and an erasure of the sex variations implied by these 'conditions', of which gynecomastia can be read as a sign.

In contrast to the maintenance of the body as unequivocally male, the breasts are repeatedly sexed and gendered as other, as female or feminine. I have already mentioned that the term 'gynecomastia' itself, which translates to 'woman's breasts', does this distancing work, but many of the descriptions of the disorder also operate in the same way. From the historical to the most recent, Webster in 1946 defines gynecomastia as a condition in which 'the appearance of the breast simulates that of the female' (p. 557) and Wiesman et al. in 2004 describe it as 'the presence of femalelike mammary glands in a male' (p. 97). There are moments within the medical discourse when the breast is acknowledged as male but the enlargement of the breast is rarely included in this identification. Rather, there are multiple examples of it being described with terminology such as 'feminine shape', 'feminine appearance', and 'feminine appearing deformity'. Through these discursive devices the offending breast tissue is rendered entirely distinct from the whole, which remains the 'normal male' body without breasts.

This is very different to the ways in which sex and gender are applied to the FTM patient.

10 Or the phrase 'Disorders of Sex Development' (DSD), a recent iteration of the medical grouping of these bodily conditions that has been adopted by some within the medical domain but critiqued by others as a form of pathologisation (e.g. Diamond, 2009).

11 I use quotation marks here to emphasise that this is the expression used in the medical texts despite pressure from activists to avoid use of this term.

The FTM pre-surgical body is, without question, sexed as female and the descriptions of FTM chest surgery generally further the maintenance of the ‘two-sex model’ (Laqueur, 1990). Kenney and Edgerton, in their foundational surgical description in 1990, feature an image of the female and male torso separately in order to highlight the differences. The caption reads:

Compared with the female chest wall pattern, in a male chest appearance, the nipple-areola complex is smaller and higher in position in the chest wall. The inframammary fold is also more oblique, following the inferior margin of the pectoralis major muscle. (p. 549)

In comparison, an image in Letterman and Schurter (1972) comparing gynecomastia to the ‘normal’ male chest consists in one chest containing both, rather than two distinct bodies separated by a large divide:

Figure 1. Wrinkle lines in “normal” male chest (left) versus gynecomastic chest (right)

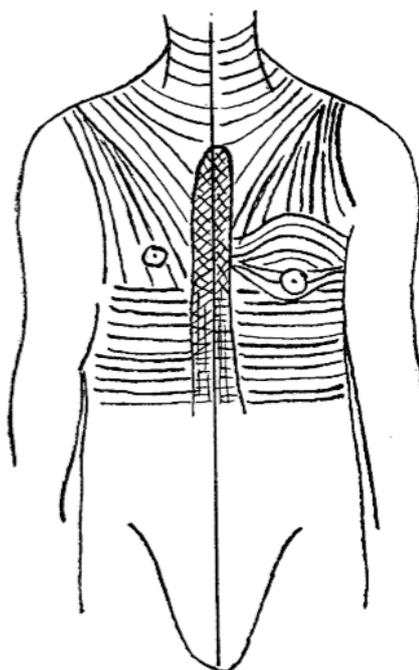


FIG. 1. On the one side are portrayed the wrinkle lines in a normal male chest, on the other those present in a patient with marked gynecomastia.

Credit: Letterman, Gordon, and Maxine Schurter. (1972). “The Surgical Correction of Massive Gynecomastia.” *Plastic and Reconstructive Surgery* 49.3: 259

Hage and Kesteren’s 1995 article builds on Kenney and Edgerton’s (1990) approach by identifying awareness of sexual difference as fundamental to FTM chest surgery, warning that:

[i]n order to obtain satisfactory results in chest-wall contouring as part of gender-confirming surgery in female-to-male transsexuals, the surgeon should be aware of the differences between the female and male mammary anatomy and should take notice of the possible techniques to overcome these differences. So far, not much attention has been given to either (p. 386).

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However, the significant difference between these two texts, separated by only five years, is the absence of the recognition of gynecomastia in the later text. Both reference Davidson's 'doughnut technique', but only Kenney and Edgerton (1990) acknowledge it as a surgical procedure developed for the treatment of gynecomastia. For the purpose of Hage and Kesteren's (1995) approach based on the emphasis of 'sexual difference', the male body with breasts cannot be included alongside the FTM body because it undermines their assertion of the absolute difference between the sexed male and female body. This distinction from the gynecomastic body is also found within both Monstrey (2007a) and Bowman and Goldberg (2006), where gynecomastia is acknowledged but only in order to assert the difference between the surgical practices of gynecomastia surgery and FTM chest surgery. This difference is declared despite the fact that a comparison of Bowman and Goldberg's (2006) 4-point categorisation of breast size and skin quality for FTM patients and Simon et al's (1973) influential classification of gynecomastia reveals the extent of the similarities, both in relation to the description of the breasts to the surgical technique recommended, from intra-areolar incision ('keyhole' approach) to free nipple graft. The 2011 WPATH *Standards of Care* (SOC) even acknowledge the similarity in breast augmentation procedures for the 'MtF patient' and the 'natal female patient' but maintain the distinction between FTM chest surgery and gynecomastia surgery through the lack of comparable recognition (Coleman et al., 2011, p. 203). Despite this, the SOC have made big strides in attempting to undermine the 'two-sex model'. There is little reference to the notion of opposite sex, which presumes the sexual binary, and an emphasis on 'the diversity of gender identities and expressions' (p.180).

As mentioned above, Colic and Colic's (2000) article, which focuses on 'circumareolar mastectomy in female-to-male transsexuals and large gynecomastias', is rare precisely because it does not make an absolute distinction between the FTM body and the gynecomastic body. The introduction begins:

[b]reast reduction or amputation in female-to-male surgery presents a specific surgical problem: obtaining a good breast shape of the masculine type. Over a 2-year period, 17 patients (12 female-to-male transsexuals and 5 extreme gynecomastias) were operated on using the circumareolar approach for subcutaneous mastectomy...This technique provides naturally flat masculine breasts. (p. 450)

Although FTM chest surgery is presented as a 'specific surgical problem' and the patients are nominally divided into two groups, they all undergo the same surgical procedure in this study in order to achieve 'naturally flat masculine breasts'. However, the general disassociation of FTM chest surgery from gynecomastia surgery in the medical discourse on the former, rather than the acknowledgement of the overlap, grounds FTM chest surgery in the distinction between the female and male body, firmly situating the pre-surgical body as unequivocally female.

This also has the effect of maintaining the post-surgical body as female; the surgical modifications are never enough to fully 'overcome' the 'sexual difference'. Rather than aiming for the achievement of a male chest, Hage and van Kesteren (1995) define the principal objective of the surgery as 'to masculinize the chest by deleting the female contour'

(p. 386). Bowman and Goldberg's (2006) paragraph on revisional surgery captures this tension beautifully:

Performing an aesthetically pleasing subcutaneous mastectomy in the biological female who desires a male chest can be a challenging operation. It differs from mastectomy for breast disease (or as a prophylactic measure) since the goals are very different: the aim of chest surgery in the "FTM" is not just to remove all of the breast tissue, but also to recontour the chest to create a masculine appearance. The procedure is also usually more difficult than a gynecomastia correction since the "FTM" transsexual often has considerably more breast volume and a greater degree of ptosis (natural droop) to contend with. (p. 26)

The pre-surgical body is unquestionably asserted as that of a 'biological female' and, although the patient may wish for a 'male chest', the surgery can only deliver a chest that has a 'masculine appearance'. In contrast, gynecomastia surgery is figured as merely a 'correction', such that the male body both precedes surgery and is maintained through surgery. In relation to FTM chest surgery, the appearance of the chest is described as male, while, in relation to gynecomastia surgery, it is the chest itself that is characterised as male. In the former maleness is an attribute, in the latter it is the ground. As such, the goal of gynecomastia surgery is not concerned with maleness, because that is taken for granted; rather, the focus is on the normal, in terms of 'size and contour' (Webster, 1946, p. 574). Only in the most recent texts on FTM chest surgery does the materialisation of a male chest become possible. Monstrey (2007a) summarises Hage and van Kesteren's (1995) goals as 'the creation of an aesthetically pleasing male chest' (p.137) and, in the 2011 WPATH SOC chest surgery is described as 'creation of a male chest' (Coleman et al, p. 201). Here, although the chest is not framed as male initially, (the male chest is created not restored), it does at least *become* male. However, in general, the distinction remains – through FTM chest surgery, the chest remains female or at the most not-male and *becomes* merely male-looking, male-like, or 'male-lite',¹² while, through gynecomastia surgery the chest *is* naturally male and simply becomes normal.

To summarise, in both the medical discourse on FTM chest surgery and that of gynecomastia surgery, there is an opposition between male and female, and it is this that is taken to drive the desire or necessity for surgery, (except in the WPATH *Standards of Care*, where the driving opposition is situated between gender identity and assigned sex, which is not necessarily limited to the binary division of male and female) (2011, p. 168). However, throughout, the borders marking the opposition are located in different places, where in relation to FTM chest surgery it splits the whole and threatens bodily integrity, while in relation to gynecomastia surgery it functions to contain the whole and guarantees the survival of bodily integrity throughout the surgical intervention. As such, FTM chest surgery is conceptualised as a significant transition, while gynecomastia surgery is not because it does not constitute a border crossing in this context. The difference between these bodily figurations effects a number of factors that underlie the (de)naturalisation of the body modifications under consideration, most notably in relation to the attribution of harm.

12 I owe this expression to Amy Fox, a colleague and student of mine who constantly challenges perceptions.

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Conclusion: 'Above all do no harm'

The different conceptions of 'disorder', and the ways in which sexed bodies are materialised through them, translates into an ethical issue in relation to one of the fundamental principles of medical care, '*primum non nocere*' (above all do no harm). This phrase has been in common use for over a century and is currently one of the fundamental principles of medical care (Smith, 2005). From Edgerton's passionate presentation in 1984 in defence of surgery for transsexuals to Coleman et al's (2011) recognition of the ethical challenges of such surgery, the debate over whether 'sex reassignment surgery' constitutes a violation of that principal tenet continues to rage. In the WPATH *Standards of Care*, one of the first considerations in relation to surgery is the recognition of the 'resistance against performing surgery on the ethical basis of "above all do no harm," understood to be grounded in the ethics of altering "anatomically normal structures"' (Coleman et al., 2011, p. 199). The defence against this resistance is forceful; however it is in part through this debate, through the overbearing presence of the presupposition that this surgery 'does harm' as well as the defence against that belief, that the pre-surgical body is rendered 'anatomically normal', 'healthy', and 'natural'. Throughout the medical literature on gynecomastia, there is not one mention of this ethical consideration, because 'breasts' on men with gynecomastia are generally not considered to consist in healthy tissue. The surgical removal of this tissue is not understood as an act of harm to the body, an act of harm to bodily integrity, to wholeness, as it is in relation to the FTM body, because of the differing boundaries of the natural male and female body within these two discursive contexts. In the medical discourse on gynecomastia, it is the post-surgical body that is framed as natural, in spite of the direct construction of the body through the medical practice of subcutaneous mastectomy.

Medical discourse is not merely representative of the body and the medical technologies applied to it; it is a technology itself through which bodies are materialised in specific forms. Thus, the language of surgical practice is not merely descriptive, it changes the very configuration of the body under the surgical knife. Reading medical discourse is a strategy of intervention in the materialisation of bodies produced in the service of hierarchical structures of power. Through it, we can become aware of the specific strategies employed within these particular fields of medical discourse and, armed with this knowledge, we can attempt to undo them. The medical discourse around gynecomastia surgery is a particular example of a somatechnology operating at the level of the ontological. Gynecomastia surgery is effectively a process of *becoming natural*. This article has discussed some of the ways in which the notion of harm operates as the central technique through which this constitution of the natural is effected, and some of the consequences of this – what we consider to be harmful to the body, what we consider an attack on the integrity of the body, is grounded in our relation to the natural. Through the attribution of male breasts as harmful, surgical modification in the form of gynecomastia surgery is assumed to the extent that the post-surgical body is naturalised. In contrast, for transsexuals assigned female at birth, it is the surgical procedure itself that is considered harmful, often perceived as a 'mutilation' of the natural body. Clearly, some cuts are considered to do harm while others are thought to correct it. While within the medical realm these determinations of harm are taken to be neutral and self-evident, based on the presupposition that the natural is that which should not be harmed, this article emphasises the extent to which the notion of harm itself is used

to contour the boundaries of that natural. The material effects of these discursive appeals to nature has a significant impact on the embodiment of FTM patients in comparison to those undergoing gynecomastia surgery. I hope this article has the effect of changing the relation of trans bodies to the natural, although rather than claiming trans bodies as natural in the same way that post-gynecomastia-surgery bodies are figured, I would like us to consider the extent to which all bodies are constituted through and by technologies or, in other words, to what extent all bodies are ‘not-quite’ the natural.

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