ABSTRACT:

Body Stories: On Trans-Poetics as Feminist Science Studies

In Spring 2015 I begin medical transition. The archive starts with a few empty testosterone vials that I line up along my windowsill. A few months later, I have a small wooden cigar box full of them. I begin to save receipts. I keep voicemails from my insurance company until the storage on my phone is full and it no longer takes photos. I store old prescriptions from before and after my name change process that could never reasonably be of use. I catalogue personal notes from visits, letters for flying with needles, my new birth certificate, all the medical letters it took to get the new birth certificate, emails. I record videos documenting my bodily shifts. A year later my little brown folder has started to bulge out at the sides. My project begins from the sticky place of critiquing Medicine while embodying lifelong engagement with it.

This work utilizes my medical records as a point of departure for a conversation between two archives of transition -- one that my doctors collectively produce and one that I am making through poetic and critical response to these 'body stories' the documents tell. Transgender healthcare has long maintained the epistemic authority of the field of Biology in its understanding of bodies. What does my trans body have to say about and to the field of Medicine? How does poetry about my experience of transition resist the silencing reductionism of Science? This work primarily draws on Karen Barad's notion of agential realism and Donna Haraway's attention to naturecultural entanglements to investigate the many material-semiotic

bodies trans medicine is constituted through and among. This creative piece offers interventions in my medical archive riddled with Scientific reductionism and explores what a transexual-poetics can offer as a a recuperative methodology, an instigation of conversation with and against the techno-biopolitical relations of trans medicalization. The project takes its form in three chapters. The first explores chest surgery as a site of normalization and naturalization. The second investigates the question of the ‘passive’ ingredient in testosterone, cottonseed oil, and interrogates the biomedically unseen. The third introduces the question of becoming patient both as an affective-temporal description and as a docile subject of care.

Body Stories:

On Trans-Poetics as Feminist Science Studies

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1. *INTRODUCTION*

In Spring 2015 I begin medical transition. The archive starts with a few empty testosterone vials that I line up along my windowsill. A few months later, I have a small wooden cigar box full of them. I begin to save receipts. I keep voicemails from my insurance company until the storage on my phone is full and it no longer takes photos. I store old prescriptions from before and after my name change process that could never reasonably be of use. I catalogue personal notes from visits, letters for flying with needles, my new birth certificate, all the medical letters it took to get the new birth certificate, emails. I record videos documenting my bodily shifts. A year later my little brown folder has started to bulge out at the sides. A friend finally asks me about my insistence on archiving this relationship to Medicine.

I begin collecting out of terror, a fear that I will need some evidence of my being later on when Medicine decides I am no longer worthy of access to this particular ontological experiment. I am deeply attached to a knowing of myself as 'trans', and yet know nothing about what this shifting, slippery category is. What does it mean to hover in and around 'trans', already claiming it and yet still exploring what it can mean? What does it mean to be creating the archive that I'm working from? What does it mean to insist on this collection?

My archive has gaping holes, so I decide to reach out to my doctors for the totality of my medical records. I start with my childhood doctor's office. Then my health clinic. Then the hospital where I started hormones. Then my surgeon's office. Each time there is a fee or the option to send to another clinic. One time I ask about this fee, confused as to why it costs money to print several pages and hand them over the counter to me but is free to print the pages and pay

to mail them to another medical provider. I never receive the answer to this question but find out later this is a fully legal and common practice. In this process of document acquisition I find myself more entangled with medicine than ever before. Unsurprisingly, I am faced with a narrative of myself I do not recognize. I am immersed in hundreds of documents that are about me but not written for me. I am asked multiple times if I am sure that I want these records sent to me, not a doctor. The asking itself, it seems, is a violation of the script of Medicine. This script reads: the patient is, the doctor does.

Faced with a desk full of these documents, I decide to use these medical records as a point of departure for a conversation between these two archives of transition -- one that my doctors collectively produce and one that I am making through poetic and critical response to these 'body stories' the documents tell.

My research questions bloom from finding myself absent or misread in my archive. I stop each time at the question of 'my body'. I keep coming up against this desire to write about transition, about a process of becoming, without abandoning flesh and blood. At first I articulate that I am scared of 'leaving my body absent'. Then I rethink this understanding of 'my body': Why is the language that comes easily to me, the language I have to insist on my authenticity, still so caught up in this idea of 'having a body'? What does it mean to 'have a body' if not to also cut out, exclude, and ignore other bodies, human and nonhuman, and technologies intimately woven through my ontological experience? Is this insistence on a singular and whole body not already the project of western Biomedicine and liberal humanism? In fact, 'my body' isn't absent from my medical records in the way I had originally thought, but rather my self is. In "A Body Worth Having?," Ed Cohen, thinking with the Okanagan First Nations and theoretical

biologist Dorian Sagan, challenges the notion of 'the body' as a singular, boundaried object, suggesting instead the notion of contextually dependent embodiment. Cohen argues that an understanding of 'the body' as something to be 'had' is an extension of a discourse of liberal personhood: "Strictly speaking, 'the body' does not naturally exist. Or, to put it more affirmatively: 'the body' only exists within a political ontology that distinguishes the human organism both from its life-world and from 'the person' to whom 'it' supposedly belongs" (119). The question of 'the body' and even 'my body' is critical to engage with in this project as it is one of Medicine's central myths upon which it builds its standards for health and diagnosis. 'The body' is an impossible consolidation, representing a singular model of the organismic dimension of human existence as a race-less, gender-less, sexuality-less, species-less abstraction. This understanding of 'the body' is not a natural phenomenon but rather one that has been naturalized[1] . It is a historically and contextually contingent creation.

While beginning this process of medical transition I return to writing and reading poetry, a practice that I hadn't approached for years. I find critical theory at this same moment and begin to locate my experiences in considerably larger power structures. This process is not my own, but surrounded by and guided by peers and professors who push me deeper and deeper into a love of questions. I am drawn to texts that give me new words for my world. Language takes on a particularly heavy importance in my life in a multitude of ways: granting access to services, legitimizing my gendered experience, naming myself. Poetry offers me my own tools for playing with language, becoming a storyteller not just a subject of stories.

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[1] Cohen argues that this naturalization of 'the body' as the living location of personhood came to be during the late 17th century in Europe through the language of legal doctrine. He argues that it is in the Habeas Corpus Act that 'the body' legally appears as the counterpoint to monarchal violence, and serves as a legal referent upon which our modern normalization of 'the body' as a discrete, bounded entity is derived.

So how to move forward without supplanting poetry as a more authentic understanding of my experience than Medicine's reductive one? How can I resist merely 'supplying the subjective'?

This project requires a mapping of another world view that doesn't replicate the bounded and defended body. Poetry on 'trans' medical experience offers possibilities for thinking outside of the discourse of 'the body' as a thing with distinct and knowable edges. Where the medical record always reduces my flesh and blood to this boundaried framework of 'the body', poetry provides the opportunity to locate other human and non-human bodies in the storytelling of these experiences, to look at what Cohen calls the "life-world" (119). In my writing I can 'flesh out' my doctors, surgeon, environment, or surgical-hormonal technologies of transition, re-situating their roles in my experience. At the same time, it offers me space to explore the material components of transition with the tools of queer and feminist theory.

The fiction of 'my body' as measurable, observable, and knowable is centered in the medical records where material-discursive technologies and the bodies of others are considered materially irrelevant. Poetry offers my experience room to shift, play, and converse with the mechanisms of medicalization. Poetry enters into this project as a conduit for experience, a literary device for resisting the narrative that the Biochemical is the only and ultimate arbiter of truth about trans bodies. I am interested in poetry as a process of restoration and reinsertion of the entanglements left out by Medicine's methodologies of knowing.

In the interest of being responsible to the importance of language, this project follows a few techniques for marking power. My use of an uppercase B Biology refers to the discipline, not the 'stuff of the world' itself for which it is commonly mistaken. This differentiation is

important given how readily knowledge on the material 'stuff' of bodies is presumed to belong only to Biology and its methodological tools. I capitalize Medicine and Science to draw attention to these words as differentiated from the lowercase and pluralized medicines and sciences. Medicine with a capital M does not merely refer to anything ingested or performed in a practice of healing, but rather to a particular way of knowing matter rooted in a western history of Science -- the Medicine with hegemonic power. This lowercase/uppercase practice is intended to offer recognition to the medicines and sciences not represented as authentic understandings of bodies and materiality, like poetry. As Banu Subramaniam and Angela Willey describe in the Introduction to the *Catalyst* issue "Science Out of Feminist Theory":

"...when we use the words "Science" or phrases like "the biosciences," we mean knowledge that is produced through the legitimizing apparatus of various institutions, approved by reviewers and published (or legitimated by patents), i.e., this is "official" knowledge. Someone can produce scientific knowledge in their garage or kitchen, but not "Scientific" knowledge. For the latter, we use "sciences"—small s, and plural—to mean knowledges that are scientific by all measures except that they are not authenticated by the official apparatus of science. In other words, sciences refers to vast and diverse disciplinary and extra-disciplinary contributions to knowing our worlds." (10)

Capital S Science operates here as a practice of storytelling just like non-authenticated sciences. Science is a narrative resource for telling stories about bodies, but one developed on the privileging of 'objective', 'unlocatable' vision. This is not an argument for relativism, which merely insists on relative truths with no recognition of their situatedness or partiality. Any discourse taken as universal, even a feminist one, is necessarily incomplete and enacts the very

violence it seeks to displace. As Sandra Harding clarifies, feminist standpoint theory "argues against the idea that all social situations provide equally useful resources for learning about the world, and against the idea that they all set equally strong limits on knowledge." (449) Rather, this critique rests on using poetry as an apparatus for re-inserting partial, embodied, and locatable knowledges into my archive of medical transition.

In "Situated Knowledges", Donna Haraway describes how vision has always been central to the objectivity claims of Science. To counter this logic of objectivity as a fixed, disembodied gaze, she calls for feminist practices of vision -- knowledges that are situated, a partial view from somewhere in particular. She writes, "it is precisely in the politics and epistemology of partial perspectives that the possibility of sustained, rational, objective inquiry rests" (585). This search for new feminist visionings requires new instruments of vision. Poetry on embodied transition and medical experience is an instrument of this visioning. Poetry offers me a partial perspective from which to begin making sense of this thing we might call gender transition -- to look at what this process might mean and what becoming in this particular moment, space, time, and ontological formation feels like. The arena of 'trans' medicine is a particularly generative site to examine and begin to resist the reductionism and mechanistic determinism of the Scientific Method.

When I refer to Scientific reductionism I am referencing what Richard Lewontin and Richard Levins describe as the thinking of a complex system as a sum of many small parts, all of which can be reduced and added together to understand the whole[2]. Mechanistic determinism follows this same Cartesian logic, with the argument that bodies work like predetermined

[2] In "Let the Numbers Speak", Lewontin and Levins unpack two techniques of statistical inference, contrast analysis and correlational analysis, arguing that while statistics as a methodology aims to let the numbers speak for themselves, the real work is actually reliant on the *a priori* decisions used in the analysis.

machines and that through this understanding, a future path can be known. These arguments are inherently linked to a belief in universality -- an understanding that all humans have same parts (mechanistic) and that the reactions of human bodies are then knowable and predetermined (determinism). The critique here is that to understand human bodies through reductionism is to reduce variability to *one* human body, a body that is thought of as separate from the interwoven components of the environment, and to categorically exclude all things 'outside' of that body. Haraway articulates that this Scientific project of reducing complexity with the goal of translation becomes violent when "one language (guess whose?) must be enforced as the standard for all translations" ("Situated Knowledges" 580). My project then differs from many Scientific investigations of gender transition in that I argue the following: the failures of Medicine to engage with my embodiment as a trans person is not because Science isn't putting enough time or money into research on trans bodies, but because the reductionist tools it has at its disposal are not adequate by themselves for thinking about the multiplicity of trans experience. I am interested in thinking through my experience through an alternative methodology, poetry, and recuperating this project of embodied knowing as an authentic science itself. I follow what Christian Gundermann names a *warm body science*, one that moves away from the *cold body* language of "distinct particles, substances, and mechanisms" and instead addresses "the energetic entanglement and relationality of all embodiment." (3)

By reading my medical archive of transition, I trace this other understanding of embodiment -- how my experience blooms outward into others, an entanglement of multiple organisms and technologies. As Karen Barad writes, "Entanglements are not unities. They do not erase differences; on the contrary, entanglings entail differentiatings, differentiatings entail

entanglings. One move – cutting together-apart." ("Diffracting Diffraction" 176) For this reason I enter this project with the hopes of pushing back against the singular, reductionist story Medicine tells about my body. I look to my own medical archive -- its gaps, misreadings, and *a priori* assumptions -- to interrogate the limits of Medicine for understanding trans bodies.

If my medical record is one archive for knowing bodies, what other archives do I have to draw from? What does it mean to claim a medical record as mine when it was not produced by or for me? What archives of body knowledge get marginalized in the conversation around gender transition and what might I cull from them? These questions lead me to my creative writing as an integral mechanism for critique, reinsertion, deconstruction, and play with Medical narratives. Poetry is not 'the body itself' nor are the tools of medicine, for example lab results or doctor's notes. However, poetry on my experience of medical transition has creative and alternative potential for thinking about bodies that more rationalist prose doesn't. Much of the power of poetry's alternative potential comes through play, what I will call poetry's ability to *tease* Science. I think of my poetic engagement with Medicine as a teasing, an invocation of imagination to disrupt some of the core assumptions at the center of the project of the Scientific method. Poetry has the capacity to trouble the idea of a single narrator, abruptly end sentences and rethink grammar, or use metaphor to draw together seemingly disparate objects of inquiry. Laura R. Micciche notes in "Writing as Feminist Rhetorical Theory":

"Play is not in excess to writing. Writing as play means that fictional elements are valid aspects of critical writing… play does not connote non-seriousness, or at least it doesn't have to. It's more akin to a serious effort to organize meaning around a logic of one's own making rather than one provided or assumed.

Such an effort embraces assertions of agency and intention. Play is difficult, risky business when it comes to writing because the possibilities are endless." (182-3)

Play means using poetry to entertain the absurdity of Scientific objectivity. It allows the fiction in poetry, the un-truths, to begin to question the singular Truth of Medicine and 'the body'. Play is possible when the object of knowledge refuses to sit still, refuses to perform adequately or predictably, refuses to remain only an object. Because "the same kinds of social forces that shape objects of knowledge also shape (but do not determine) knowers and their scientific projects" (Harding 453), poetic play troubles the unidirectionality of the Medical gaze. Poetry is a material-discursive technology that can use the experiences of the Scientific object to look back at and speak back to the knowers. Poetry is essential in this project as a deconstructive tool but also as one of generative world-building and knowledge making: "We—feminist science studies scholars—must learn to think of ourselves not only as critics or students of science, but as makers of scientific knowledge." (Subramaniam and Willey 12)

I begin this project from the sticky place of critiquing Medicine while embodying lifelong engagement with it. While Science and Medicine understand knowledge production in a positivist framework, as a deeply impersonal and predestined process of acquisition, I begin from curiosity and desperation. This is a project of making sense, of deciphering as I go along.

I am interested in applying the language of teasing to poetry for its playful, sexual implications. Teasing is a word with shifting meanings, tethered to the closeness between play and hurt. It can mean to tantalize by arousing desire or curiosity often without intending to

satisfy it[3]. To tease or to "be a tease" in a sexual sense can refer to a flirting technique where denial implies harm, often a phrase used to degrade a non-compliant (usually female) sexual partner. Teasing also can refer to the 'backcombing' of hair, a movement against the grain that produces a new tangled effect. Alternatively, it can reference a process of disentangling, as in 'to tease out'. As Angela Willey shows us in “Engendering New Materializations”, the story of feminist (re)engagement with Science is predicated on the romance myth of an anti-essentialist Science and a Science-friendly feminism, two disciplines distant and separate but now attracted to one another, made up, ‘engaged’ even, in the field of New Materialism. This ‘romance’ relies on the idea that Science and feminism hold equal epistemological weight and thus join together for the good of both parties. Teasing poetry allows for another way to do a trans-materialist intervention that rejects the raced and heterosexually-coded romance narrative between Science and feminism. My poetry doesn’t ask to be included in Medical research, but appropriates and queers medicalized language by revealing it as strange, situated, partial. In other words, this strategy reveals that feminism was not missing the material tools of Science to think about bodies, but has had material engagements with bodies all along. Feminism has not ‘progressed to forgive Science’, as this narrative of New Materialism suggests, nor has Science shed its violence by embracing plasticity (which Willey reveals as also deeply implicated in violent narratives). Instead, poetry about embodied experience claims its own place as a study of the material, teasing the methodologies of Science.

Sarcasm is often used in teasing, a technique that requires voice, tone, vocal speed to decode the biting message, never simply just the words. This is a deeply embodied form of

[3] “Tease.” Merriam-Webster's Learners Dictionary, *Merriam-Webster*. Accessed April 21, 2019. https://www.merriam-webster.com/dictionary/tease.

knowledge that usually requires in-person presence to decode and stands in stark contrast to the Scientific objective, distant viewer. Another form of teasing is to pretend to give something which the other desires while actually withholding it, or to give it very slowly. This technique speaks to Science's desire for direct and unfettered access to information, in this case trans subjectivity. My poetry is not invested in clarity or whole vision, it isn't easily quotable without context, and it doesn't follow the linear narratives of subject interviews or even conventional auto-ethnography. Where Science is interested in producing a complete, single vision of its object of inquiry, poetry includes the emotional as well as concrete and complex sensory experience which always insists upon a layering[4]. Teasing is a world of multiples that holds space for my utilization of poetry as a method of speaking back to Science. Poetry teases Science's understanding of the material by describing embodiment in sensation, experience, and metaphor without reliance on biologizing language or an obligation to clarity. Transexual-poetics offers a space for describing trans embodiment that appears to promise Science's fetish object of the vulnerable and transparent object, but then denies the confining, quantifiable, linear, reducible narrative of bodies that Science so desperately desires, especially bodies it claims to 'not yet understand'.

[4] In the anthology "Troubling the Line", poet Samuel Ace uses poetry as a methodology of teasing biological essentialism, refusing the reader the separation of 'reality' and metaphor. He writes, "*I met a man who was a woman who was a man who was a woman who was a man who met a woman who met her genes who tic'd the toe who was a man who x'd the x and xx'd the y I met a friend who preferred to pi than to 3 or 3.2 the infinite slide through the river of identitude a boat he did not want to sink who met a god who was a tiny space who was a shot who was a god who was a son who was a girl who was a tree I met a god who was a sign who was a mold who fermented a new species on the pier beneath the ropes of coral*" (431). Ace invents a language and grammar logic of his own to describe a transitory gender in contrast to a stable, known body. Through the invention of words like "identitude", the repetition of familiar language into un-clarity, and the mixing of images of human bodies with landscape and environment, Ace teases medicalized language as the only method of knowing bodies. The language choice in "I met a man" prioritizes the aesthetics of sound and rhythm over easily identifiable visuals or recognizable narratives of gender transition. I find a teasing in Ace's work through the embodied experience of hearing the syllables bang together, in the mouth and in the air.

I use the specific language of *transexual* to call up histories of Medicine that haunt our practices of naming and at the same time, histories of trans engagement with language that are ones of appropriation and play. This is a filling in of partial perspectives without the assumption that they will ever create a whole. A flirtation with Medicine, a borrowing of language, this teasing. I am interested in transexual-poetics with a single *s* building on Riki Anne Wilchins' use of the term *transexual*:

"Since I'd never liked the word to begin with, I stayed with the spelling I liked. This also seemed a way of asserting some small amount of control over a naming process that has always been entirely out of my hands-a kind of quiet mini-rebellion of my own. I think transactivist Dallas Denny captured the spirit of the whole enterprise: "Yeah, we'll change it to one until they all start using it. Then we'll go back to two, or maybe to three."" (Wilchins 15)

I am grounding this exploration in a critical transexual-poetics because poetry leaves space for the splicing, movement, and non-linearity that is required to fill in what is missing. In this project, my transexual-poetics are about opening possibilities for new assemblages between myself and my life-world. I continue an understanding of creative prose from trans poet kari edwards who asks, "so then what is a narrative of resistance? what is a narrative that informs and resists at the same time?" (8) edwards rejects a form of individualism that she playfully calls "islandism" which is composed of turning inward, celebrating the capitalist vision of a unique individual (even a subjugated one), believing in a stable body. Instead of using writing to find or articulate oneself, a true self, she is interested in how narratives of resistance rest on finding connections and assemblages with others: "shift, transform, find multi-connections and use many

ways of distortion to swerve out of the way of the oncoming train. there are new connections where there may not have been connections. seeking out multiple connections creates new systems that takes us into communities where we would not normally go, and the more we can get outside ourselves the more we can connect with others. “truth=maybe.” (9) I am interested in this web of partial connections, the maybe truths that emerge out of my writing in contrast with the capital T Truths of Biomedicine -- this oncoming train. I keep returning to CAConrad’s words: “It’s ALL Collaboration. Anyone who ever fed you, loved you, anyone who ever made you feel unworthy, stupid, ugly, anyone who made you express doubt or assuredness, every one of these helped make you…” (94-95) Who makes me up? Who and what am I responsible to through this making? I am not yet ready to release a knowing of myself solely to the disciplines of Science which have so crudely and inconsistently handled me. I return again to my primary motivations in beginning this project. By finding these lineages, tracing the entanglements, I find that I am not alone. It is a joyful practice in shifting isolation and interrogation back upon these mechanisms of reductionism. This is a project of resisting separation. When Wilchins writes, “I intend to wage a struggle for my life. I intend to fight for my political survival” (25) I feel a closeness in time and experience. I turn to poetics as a tool in the struggle for my life.

2. THE CUT(S): ON NORMAL, NATURAL, AND CUTTING AS KNOWING

In September of 2016, after a year of chasing clinicians, I get a copy of my insurance guidelines [5] for bilateral mastectomy coverage. It reads:

If a plan covers surgical treatment for gender dysphoria, the Covered Person must meet all of the following qualifications[6] prior to surgery:

- *Persistent, well-documented gender dysphoria; and*
- *Capacity to make a fully informed decision and to consent for treatment; and*
- *Age of majority in a given country, and*

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[5] United Healthcare Commercial Coverage Determination Guideline: Gender Dysphoria (Gender Identity Disorder) Treatment

[6]

1.

Well-documented *well-controlled*
fully informed *continuous*
full time *real life*
identifiable *external* *and/or evidence-based*

2.

this feeling where I submit my body to your cold hands you flip me over
a small frame wet paper peels, a little rind of sweating fruit my bare manhood
on a soft leather table you're prodding while you and this immense and thundering voice
lift my flimsy gown to see.

3.

Well-documented this feeling where I submit my body to your cold hands *well-controlled* you flip me over
fully informed a small frame *successful* wet paper peels, a little rind of sweating fruit my *continuous* bare manhood
on a soft leather table *full time* you're prodding while you and *real life* this immense and thundering voice
identifiable lift my flimsy gown *external* *and/or evidence-based* to see.

- *If significant medical or mental health concerns are present, these must be reasonably well-controlled; and*
- *The covered person must complete 12 months of successful continuous full time real life experience in the desired gender, and*
- *The covered person may be required to complete continuous hormone therapy. In consultation with the patient's physician, this should be determined on a case-by-case basis through the Notification process; and*
- *The treatment plan must conform to identifiable external sources including the World Professional Association for Transgender Health Association (WPATH) standards, and/or evidence-based profession society guidance.*

My surgeon's office requires an additional letter stating how long I have been in therapy, confirmation of a diagnosis of gender dysphoria, the duration of time I have been living full-time as my "desired gender", and the therapist's opinion regarding my readiness for surgery.

I see a gender therapist for a year. Right before the letter is due she tells me she has a $300.00 fee for reports and letters. I pay it.

On October 25th, 2016 she sends the letter I have been waiting for:

Re: [redacted] *Sambrook (DOB* [redacted]*)*

Dear Dr. [redacted],

This is a letter of recommendation for [redacted] Sambrook (aka Ben Sambrook), who is a psychotherapy client of mine to be a candidate to undergo chest surgery to continue his transition from natal female to transgender male. From this point forward I will refer to [redacted] as Ben.

I am a licensed independent clinical social worker, and have been so for thirty years or so. I am working as an independent private psychotherapist. My work focuses on adult, adolescent and children psychotherapy. I have several specialties including LGBTQ issues, transgender and transsexual and inter-sexed issues, as well as the 'usual suspects' of a generalist psychotherapist.

I first began working as a psychotherapist with Ben in the fall of 2015. His diagnosis then and now is GDD Gender Dysphoria (302.85). He describes a lifetime preoccupation with desires to be the opposite gender, and is distressed with his biologically designated one. Ben officially began living as a man in September of 2015. Ben has stated that his feelings of being the wrong person as far as gender is concerned first started in elementary school. He remembers that he tried 'really hard to be a girl'. By the time he reached middle school, he tried to 'pass' as feminine, wearing femmy 'girl clothes', but he was unable to be buoyant and [redacted] he was hospitalized.

Ben is followed medically by [redacted] *who is a nurse practitioner with Bay State's gender health program. [sic] and whom I refer many of my clients to. Ben has been taking testosterone since about April of 2015. The testosterone has had a positive effect, lowering his voice, changing his facial features and general physique. He has been very pleased with the results.*

Ben is currently a sophomore at Mount Holyoke College. Ben has a partner who [redacted] *Ben has many friends at MHC and* [redacted]

[redacted]

It is my clinical opinion that Ben is an excellent candidate for FTM top surgery, in order to continue his transition to be a transsexual male. He understands and accepts that this is a permanent surgery. He understands the limitations of surgery and hormones, and knows that they may not change him completely to his satisfaction.

Ben presents with a normal mental status. He always came to his sessions appropriately dressed and well groomed. He expresses a full range of affect. He is free from any delusional thinking, presents with no formal thought disorders. He is without suicide [sic] or homicidal ideation. I find him to be a responsible, self reliant, independent person. It has been a pleasure to work with him in helping him realize his authentic self.

If you have any further questions please contact me.

Sincerely,

[redacted], *MSW, LICSW*[7]

I begin with this letter, with this prying, violent articulation of a me-that-is-not-me. My experience of gender is so fundamentally different than this version of myself, this "natal female to transgender man", this "opposite gender" preoccupation. Her words make real a particular experience that is not my own. This letter becomes meaningful as a symbol against which my need to recuperate my body from the epistemic authority of Medicine becomes clear. I need a filling in, a repairing, a restoration of a personal, embodied narrative of my transition.

In her 1992 piece "The Promises of Monsters", Donna Haraway offers up the term "material-semiotic actor" to highlight how "bodies as objects of knowledge are material-semiotic generative nodes. Their *boundaries materialize in social interaction* among humans and non-humans, including the *machines and other instruments* that mediate exchanges at crucial

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[7] Dear,
From this point forward: a letter, a candidate, or so.
His diagnosis then and now, unable to be buoyant
a lifetime preoccupation
without voice,
changing His facial features and

He understands and accepts
the limitations of satisfaction

He always came
a full range of self with

No further questions

interfaces and that function as delegates for other actors' functions and purposes." [emphasis added] (298) The apparatuses of bodily production in my case are all of the actors, the human–technology assemblages. I cut them together-apart with poetry to expose their processes of making and unmaking gender. I think with poetry here as another apparatus of body production, one that might allow space for my experience. Haraway sees bodies not as discrete, isolated matter but as matter in a constant state of production, emerging through a variety of entanglements with other beings. In this chapter I focus on three material-semiotic intersections that produce my body: before/after mastectomy photography as a visual technology, interpersonal dialogue between surgeon and patient, and written Medical documentation of 'my body'.

Material-semiotic in this sense means an understanding of ontology where the distinction between the material and semiotic is no longer in existence; both elements are co-constitutive. I am interested in cuts as a physical intervention in the skin, as semiotic separations, as moments of intra-action between Medicine and my experience. I am drawn to Karen Barad's notion of the agential cut as a point of departure for understanding the material-semiotic experience of gender affirmation surgery. Barad's concept of agential realism proposes the 'intra-action' of matter and discourse - the inseparability of objects and technologies of observation. Agencial cuts do not produce absolute separations but rather cut things "together apart":

"*What the agential cut does provide is a contingent resolution of the ontological inseparability within the phenomenon* and hence the conditions for objective description: that is, it enables an unambiguous account of marks on bodies, but only within the particular phenomenon. Strictly speaking, there is only a

single entity—the phenomenon—and hence the proper objective referent for descriptive terms is the phenomenon." (Meeting the Universe Halfway 348)

It is through this ontological inseparability that Barad is interested in restoring agency to matter and the way that it has been cast as ground, not actor. A Scientific view of objectivity would insist that 'my body' is a distinct entity, changed by a surgeon whose own body and apparatuses' of surgery are also separate. I instead read this moment on the operating table onto-epistemologically, an entanglement in phenomena. In "Nature's Queer Performativity", Karen Barad proposes a reworking of the notion of performativity to account for materialism and posthumanism. This entails a new thinking on the familiar notions of discursive practices, materialization, agency, and causality, among others. As Judith Butler writes in "Bodies That Matter", "Subject to gender, but sujectivated by gender, the "I" neither precedes nor follows the process of this gendering, but emerges only within and as the matrix of gender relations themselves." (7) Butler critiques the sex/gender distinction as relying upon a figuring of nature as "before" intelligibility. This thinking, Butler argues, forces sex (the inanimate, nature) to be replaced/displaced/absorbed by gender (the true, cultural). For Barad, post-modern thinkers of performativity have ignored the application of this theory to nature. She argues that it is useful to think matter performatively; entities are not individual or self-contained but rather exist as phenomena: ontologically entangled, intra-acting components. Phenomena, in this context, means the way nature acts or performs given the exact circumstances, entanglements, and convergences at that given space and time. Barad sees performativity as linked not "only to the formation of the subject but also to the production of the matter of bodies" (Posthumanist

Performativity 126). She resists the idea that nature is raw matter, unchanged by apparatus of observation. Everything is a continual relating. Objects of nature, human and non-human, do not exist on their own. Like Butler's "I", there are no relata that pre-exist their relating.

Barad looks first at Bohr's model of the atom and the discontinuous movement that occurs during a quantum leap of electrons making a transition from a higher energy level to a lower one. Because electrons move from one energy level to another without ever having been in-between, Barad calls this the atom's "discontinuous movement" (Nature's Queer Performativity, 39). She argues that these discontinuous movements where an electron "will have had to already wind up where it was going before it left" (Nature's Queer Performativity, 40) trouble the very notions of space and time. Barad also addresses how quantum physics calls into question the binary categories of atoms as either waves or particles. She references the recent slit experiments which illustrate that electrons run through the experiment not in a static way but rather appear as waves or particles based on how the apparatus was designed. This illustrates that identity is not fixed, nor does it precede its intra-action with certain apparatuses: identity is performative. Barad identifies this phenomena as the inseparability of "things" and "apparatuses." Thus, the "very nature of the entity -- its ontology -- changes … depending on the experimental apparatus used to determine its nature" (Nature's Queer Performativity, 42). What is made separate by Medicine, excluded, is never really separate. If matter's ontology changes depending on the experimental apparatus used to determine its nature, then this is an exploration of how the matter of my body "becomes" in Medical apparatuses of observation. I follow Barad's tradition of seeing all matter as being in a constant state of doing, becoming with others in intra-action. Another useful tool for binary troubling is Barad's onto-epistemology:

"Practices of knowing and being are not isolatable, but rather they are mutually implicated. We do not obtain knowledge by standing outside of the world; we know because 'we' are of the world. We are part of the world in its differential becoming. The separation of epistemology from ontology is a reverberation of a metaphysics that assumes an inherent difference between human and nonhuman, subject and object, mind and body, matter and discourse." (Barad, "Posthuman Performativity" 147)

Drawing on Barad's thinking I reject the separation of ontology from epistemology and read self-written poetry on my experience of surgery as an onto-epistemological project, an authentic body knowledge of trans subjecthood. Assigning, playing, and speculating is the work of the poem. If research is framing an object, drawing lines around a particular thing, cutting away the excess, then poetry too is an authentic form of bodily research. An isolation of sensation, a moment. Poetry gives me the specifics of partial experience, not the illusion of a universally applicable truth.

It is with this theoretical approach that I play, interrogate, and write with the medical documentation of my surgery. If Barad's "agential cut" is not an absolute separation but a cutting "together-apart", in what ways does my therapist's letter cut "together-apart" (Nature's Queer Performativity, 32) on my form? If matter's ontology changes depending on the experimental apparatus used to determine its nature, then how does my body "become" in these medical apparatuses of observation (photographs, doctor's notes, insurance claims)? Rather than beginning with the idea that my body, the surgeon's body, pre and post-op photos, or the hospital are distinct and pre-existing entities, I think of my surgery as a phenomenon, a material–discursive entanglement. In this understanding, the bodies, language, text, and images

that constitute this intra-action are already entangled. It is not that my body receives a cut from a separately determinate surgeon's knife but rather that the incision *makes* the agencies of intervention separable from its 'cause' (the 'object') within the phenomenon. In the cut, there is always a connection at the point of separation. Always a stitching together of things.

The night before surgery I take a shower eat warm rice and saag paneer try to calm a body what kind of pain is being opened and sewn shut? little shrimp man all curled up

I haven't eaten in 12 hours I have been very good about this command: no water
I have been swallowing my own spit my lips have started grabbing onto one another
handed the oxycodone, I whisper: may I drink?

Command: no deodorant a check in: what procedure are you having?
I am unsure whether to say top surgery or bilateral mastectomy or flattening or expanding or partial or becoming or cut or cut or cut

A check in: what is your name? I have had a nightmare for several weeks that I will stutter over this question what will the drugs do to my speech?
Who am I if I can not name?

when the surgeon comes in I don't recognize her she looks different under the white light
she draws on my chest with a purple sharpie later during healing I will observe the
bleeding purple, yellow iodine bruise I will start to worry that I might be rotting
a wet yellow leak from a stitch dissolved too soon I look straight ahead
she must smell me if she is this close she must know I am sweating and have followed the
command: no deodorant she must feel my skin knowing it will separate in her hands

I am entering a cold bright light, it is entering me. Command: count from ten

I am feeling nothing but a tight bandage heaviness back bound to the bed
I am wheeled through the ward I am gliding and the lights all reflect in blue tile

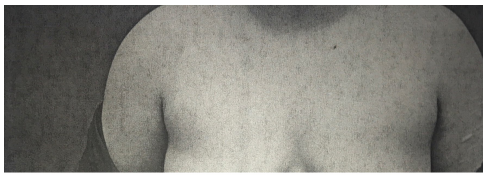
I drink five whole containers of cranberry juice never ending hunger a nurse comes in for the night check doesn't read my chart only treats my wound wraps The Body wipes the blood relieves the pressure I feel like I'm going to burst up and around the throttle of bandage

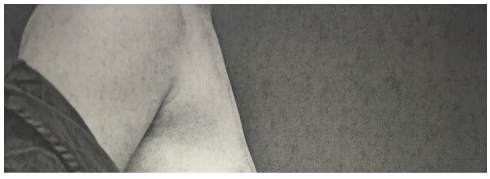
Please little blue blanket wrap my feet grip the numb ankle hide the puffing bruise
I take three laps around the children's ward a taught marionette suspended by two

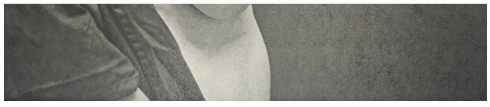
bloody tubes I've never felt a weakness that takes my whole body in a fist and yanks forward doubles me over

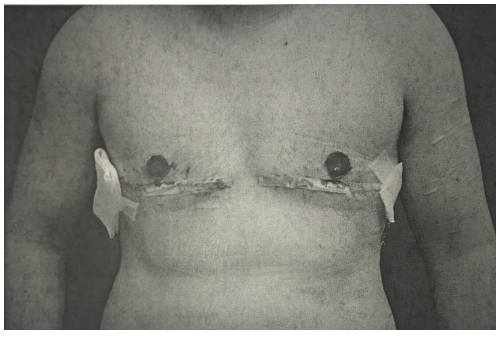
I wake up several times the first night a flashing police light the rolling of garbage bins to the curb the beep of a locked car my stiff back my mother curled up beside me, eyes closed, her head drooping like a damp scarecrow making it to the bathroom is slow and dizzy my hand has begun to sting where the needle enters above the knuckles the sliver of light through an open door grabs my throbbing eye a bright slice

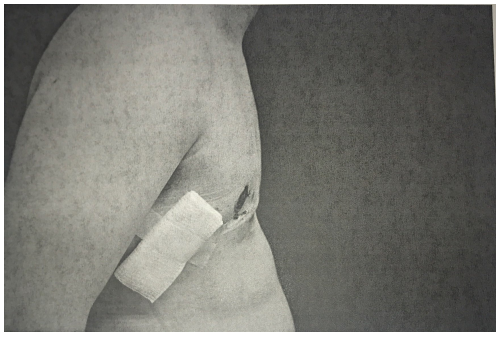
During my pre-operative appointment I am asked to stand against a light blue wall shirtless. The Physician's Assistant tells me to stand facing her. She lifts a camera to her face and snaps twice. I recognize the make and model of the camera. She doesn't shift the aperture or shutter speed from their automatic setting. My body is captured through auto-focus. I turn to my left, then my right. The photos disappear until I request them as a part of my file a year later. The eerie blue wall is obscured by the low quality black and white scan I receive in the mail. Even I am not entitled to a quality image of my own body.



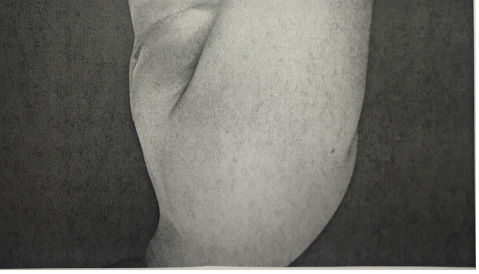
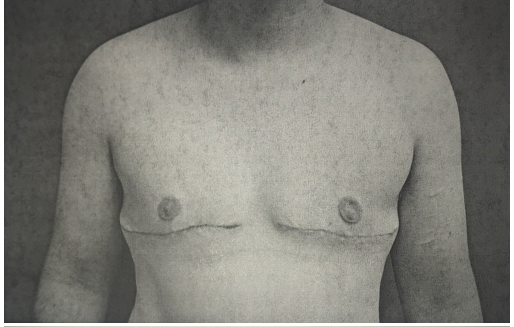
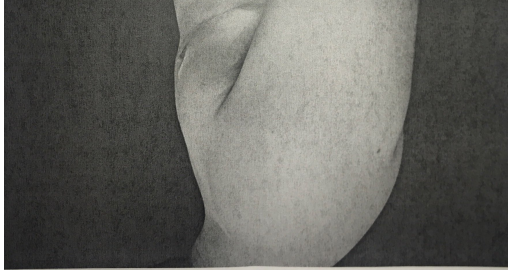
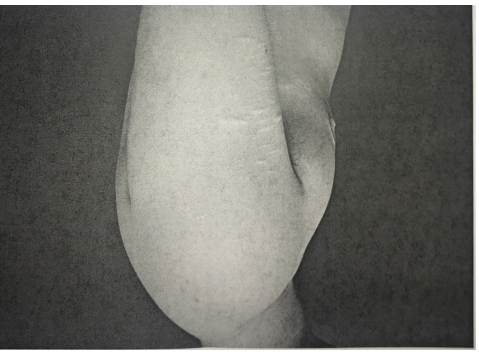
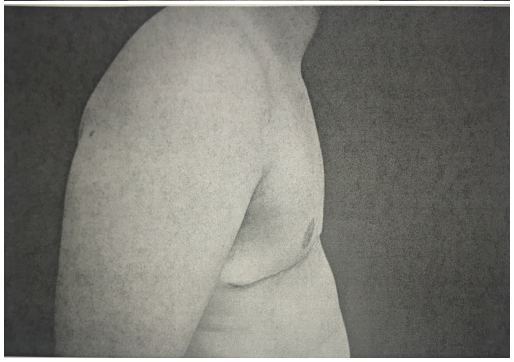
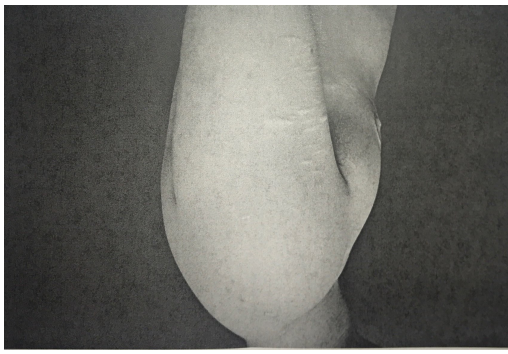
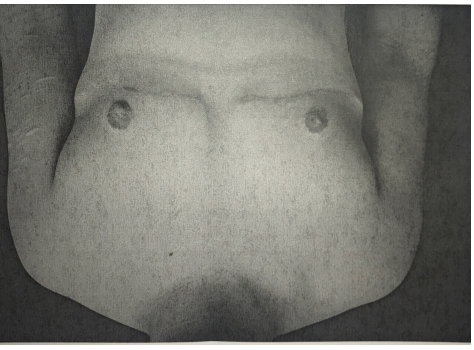
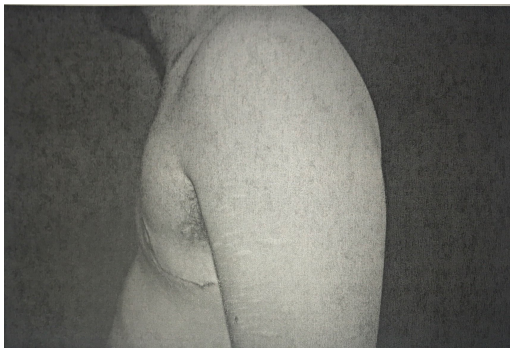
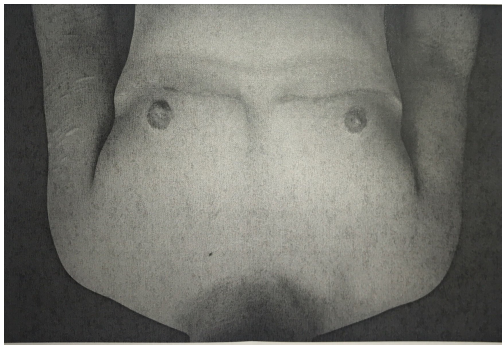
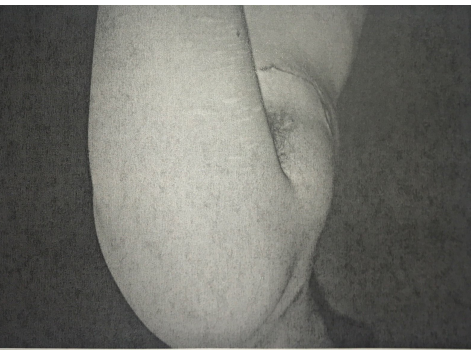
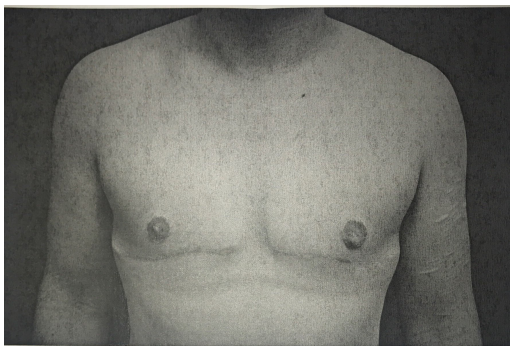
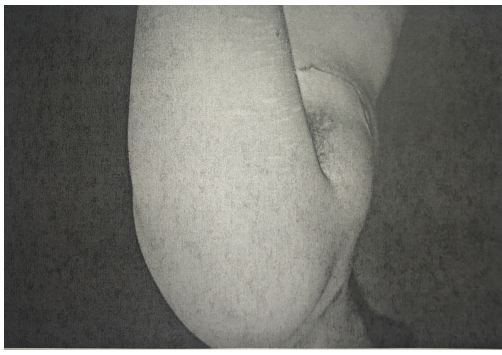
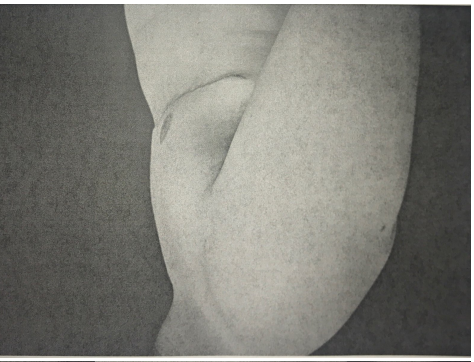
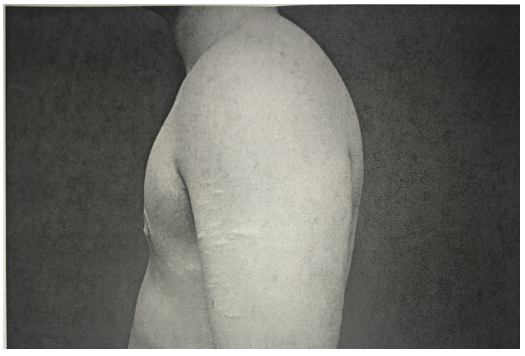


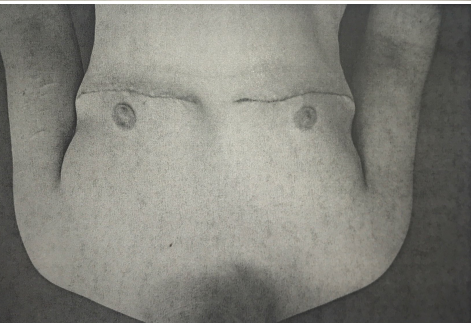
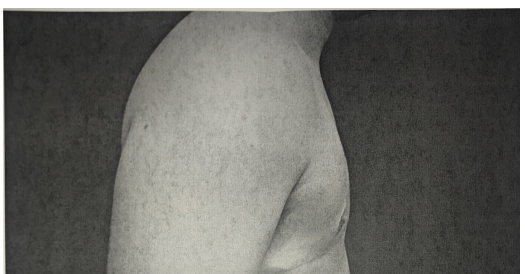
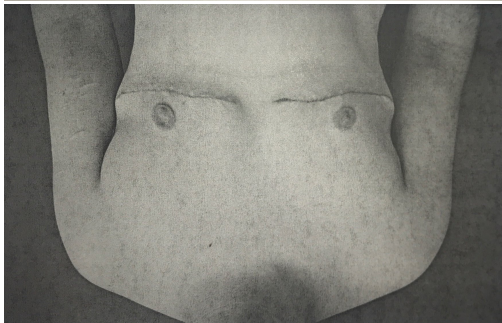






Preoperative and post-operative photography is an integral element of the cosmetic surgery procedure. The use of the camera in this context claims my body epistemologically, as well as those who will see these images - the nurses, the hospital, the insurance company. It is a cut that separates the photographer from the subject and yet draws both together in intra-action. These photos fix in time a particular moment of *before* and *after*. There is a specific uniformity to the task, a distancing from the subject. No face, just a small greyscale chest. This process and the images themselves produce my body as raw matter. It is through this medical apparatus of observation that I become patient. I enter a file with hundreds of other people like me. Same blue wall. Same stance.

THE IDEAL MALE CHEST AND NORMALIZATION

> a small room inside another small room a slow elevator cold nipples a hard white light being read incomplete and in excess needing to be trimmed down a small square frame on the wall with sharp corners a graduate certificate thirteen botox needles a smiling white woman with even whiter teeth breast implants hanging from a shoe organizer looking upward towards the ceiling feeling a cold tape measure slip down across my collarbones armpit a deep maroon gown a purple marker the surgeon says: *See how normal -- I mean, natural that will look?*

When my surgeon slips over the tricky terrain of language she reveals her role in the creation of my body. Natural means *if this body will become normal through her touch, it must be abnormal now*.

I am standing with my shirt off, cold and semi-naked in an all white room purple marker wet licking a small dotted line under my armpit

The political push around trans identity is often to resist narratives of artificiality or creation, clinging instead to stories of originality and nature. Becoming (rather than being) opens up possibilities for a feminist ontology that instead situates all bodies as material-discursive entanglements, never purely natural or whole. In what is now a seminal essay in trans studies, "My Words to Victor Frankenstein", Susan Stryker responds to the devaluation of trans lives through the lens of a creature (Frankenstein's Monster) speaking back to its maker (Dr. Frankenstein). She argues that embracing transexual monstrosity is a form of subversive resistance -- that there is power when "we verbally declare the unnaturalness of our claim to the subject positions we nevertheless occupy" (241). When Stryker calls for trans people to "rise up

from the operating tables of our rebirth" (242), to trouble the presumed authority of our makers, she also questions the perceived naturalness of a non-transexual embodiment:

> "You are as constructed as me; the same anarchic womb has birthed us both. I call upon you to investigate your nature as I have been compelled to confront mine. I challenge you to risk abjection and flourish as well as have I. Heed my words, and you may well discover the seams and sutures in yourself." (241)

Claiming artificiality and monstrosity in this case allows for the seams and sutures of the plastic surgery industry, medical language, and embodiment of my doctors themselves to be realized. How has the idea of a 'normal male chest' been stitched together by the bodies, experiences, *a priori* assumptions of my surgical team? And how has my surgeon's embodiment also been produced through incisions in medical training, Scientific literature, and lived always-gendered experience?

Similarly, in ''Transmogrification: (Un)Becoming Other(s)'', Nikki Sullivan makes a case for thinking about becoming in relation to body modification and trans embodiment. She calls for a thinking of "transmogrification: that is, a process of (un)becoming strange and/or grotesque, of (un)becoming other" (561). If all matter is in a constant process of becoming through intra-action, as Barad writes, then no body pre-exists its relating to others. No body is purely uncut. Transmogrification might allow for us to situate the "ways in which all bodies mark and are marked" (561). In this section I attempt an excavation of the proportions of my chest. My surgeon's replacement of "normal" with "natural" in this interaction signifies a desire

to bring my body into alignment with an understanding of a particular, historically and contextually situated understanding of a "normal" male chest.

While plastic surgery bases its ideal nipple placement and chest contour on the 'average male nipple', this average is effectively a fictional body. All understandings of the ideal chest are based on a variety of anatomic studies which are in themselves raced, classed, and gendered. A particularly useful metaphor present in this context is the graft - a word used in the figurative context to describe a shoot inserted into another plant and then shortly thereafter used in the surgical context to describe a transplant of living tissue. The Greek "graphion" from which it has etymological roots references a 'stylus, writing implement' from "graphein" 'write'[8]. I am interested in this ongoing relationship between cutting and writing as it relates to my own free nipple graft procedure by finding the multiple intersections of these entanglements.

In "Composing Queerness and Disability", Robert McRuer explores the concept of (de)composition as it relates to both writing and bodies. Hegemonic writing composition, he argues, is tied to the fetishized final product, the creation of a whole from unruly parts. He calls this our "corpo-reality", a name for the current approach to composition based on applicable skills, clarity, organization, measurement and marketability. In order to challenge the heteronormativity and "straightness" in these understandings of composition, McRuer calls for the "contingent universalization" (157) of queerness and disability and suggests we move towards desiring a loss of composure, a critical de-composition. He asks, "What would happen if, true to our experiences in and out of the classroom, we continually attempted to reconceive composing as that which produced agitation -- to reconceive it, paradoxically, as what it is?"

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[8] "Graft." Merriam-Webster's Learners Dictionary, *Merriam-Webster*. Accessed April 21, 2019. https://www.merriam-webster.com/dictionary/graft

(149) If "straight" composition is paradoxically built on disavowing the messy writing process and composing bodies that constitute it, then a critical de-composition challenges this by refusing to erase the mark of the cut and to naturalize a whole and complete. A process of de-composition, which I employ here, holds space for the disjointed, irregular collage that both text and bodies are.

The physical position of my nipples is part of a larger positioning of my body in relation to the field of plastic surgery. Medicine in general and plastic surgery in particular has been a site of normalization and naturalization, that is the production of a particular visual bodily aesthetic as "normal" and "natural". My nipple proportions, scar placement, and incision technique are historically and contextually situated in plastic surgery's understanding of maleness, symmetry, and beauty. I look to plastic surgery journals and Nipple Areolar Complex reconstruction techniques to find the sites in which these "cuts" are performed and look at the *a priori* assumptions that undergird the production of 'normal' and 'natural' chests. While transexual bodies have long been figured as inauthentic because of their proximity to the medical apparatus of plastic surgery, Haraway's work on the artificial/natural binary insists that all bodies are created and produced by technoscientific practices: ''If organisms are natural objects, it is crucial to remember that organisms are not born; they are made in world-changing technoscientific practices by particular collective actors in particular times and places'' ("The Promises of Monsters" 279) The concepts of a "normal" or "natural" body are not intrinsic, but are made through cuts that distinguish normal from abnormal.

I look to this moment where my embodiment is marked 'unnatural' by my surgeon as a point of departure from which to locate the excluded histories of plastic surgery by which

'normal' and 'natural' chests are produced. I begin with a passionate attachment to this chest in particular, the one produced through incisions, discursive and material, that cut my surgeon and me together-apart.

Melvin A. Shiffman, surgeon and editor of the American Journal of Cosmetic Surgery, opens the first chapter of "Nipple-Areolar Complex [9]Reconstruction: Principles and Clinical Techniques" with the assessment that "the breast is an organ for infant feeding but is also a structure that exudes sexuality to most males." (3) The breast, as understood by plastic surgery, becomes marked by an understanding of the physical matter as linked to heterosexual desire ("exudes sexuality") and gendered reproductive capacity ("for infant feeding"). The grammatical ordering of these phrases situates the breast in a particularly odd dichotomy. The matter of the "breast" is imbued with agential capacity for seduction because it "exudes sexuality" and at the same time is produced as inactive, passive resource through the language of "for feeding" rather than "to feed". While the discussion of the Nipple Areolar Complex and breast augmentation techniques in this literature are not limited to women's bodies, the definition of the breast in the origins of the Nipple Areolar Complex becomes synonymous with a 'female' breast. This breast is an example of the material-discursive -- matter produced through language and simultaneously produced through surgery. Language does not merely describe matter in the same way that plastic surgery does not merely reproduce an already existing "normal". Normal is created and re-created in these discourses of medicine, through text, image, body, and scalpel.

My relationship to Medicine's NAC starts from the NAC's origin in women's breast augmentation. While the first NAC reconstruction is reported to have been performed in 1946

[9] In this system, The Nipple Areola Complex (NAC) refers to the name under which the nerve endings, smooth muscles, and lymphatic system of the nipple are solidified.

(Shiffman v), techniques are being altered and developed at the modern moment leading to a battle of definition and redefinition over the "ideal" proportions and locations for nipple placement. While eager to define the 'ideal body', plastic surgery seems more hesitant as to their promise of fulfilling these results. "Beware of patients who expect excellent results without complications," Shiffman cautions, "since you will never satisfy them despite forewarnings of possible poor results. These patients can become litigious and be a thorn in your side for years." (19)

Much like the uneasy relationship between promise and execution, there is the looming desire for better mathematical formulas for reconstruction at odds with the unpredictable, even resistant nature of healing bodies. In one of the earliest studies attempting to suggest parameters for ideal nipple placement, the authors measured 100 males of "ideal body weight" between the ages of 17 and 30 to determine the "appropriate areola size" (33). The race of the 100 men remains undisclosed as do the *a priori* assumptions undergirding the category of ideal weight. In this literature on anatomical nipple parameters or, in other words, the search for/creation of normal, even the temperature of the space complicates these calculations. "The subjects were in a warm room in order to prevent cold-induced nipple contraction", the authors note. 'Warm' here operating as an undefined category, an understanding again that all bodies will respond in identical and predictable ways to the same room. Statistical significance stands in for universal applicability. "The nipple-areola location that we have determined in this study should be applicable to all male heights and weights," (35) the authors conclude.

> Where is your end? Fill me up stitches fingers holy needle bound you are inside of me and you know it absent doctor stiff white coat I can feel the bruise of where you left just hanging open waiting to be sealed a little foaming mouth do you think you've made me someone beautiful? *hold me and keep off* gently it goes the history of our making into this crevice where I'm picturing you too I am rabid beyond the fog but I lay still a damp and throbbing chest

A more recent anatomical study and statistical analysis had the goal of producing a faster technique for creating an "aesthetically pleasing male chest" (Tanini and Lo Russo 951). This study relied on a formula derived from "the anatomical features of the objectively ideal male chest of water polo players" (995). The question of the "aesthetically well defined" (Tanini and Lo Russo 952) relies on the assumption of a universal appeal, an erasure of race, class, gender, disability, and sexuality in the formulation of desirability. The authors are resistant to what they see as the central flaws of previous studies -- either nipple placement being determined by the surgeon's discretion alone or by formulas difficult to utilize quickly on the operating table. They propose an alternative placement technique that involves identification of the lateral margin of the pectoralis major muscle through palpation. The surgeon is thus required to estimate through physical contact with the patient's chest using the index finger. Knowing, in this case, requires not only the visual but the act of touch. As María Puig de la Bellacasa asks in her chapter "Touching Visions", "Is knowledge-as-touch less susceptible to be masked behind a "nowhere"? We can see without being seen, but can we touch without being touched?" (97) Do the surgeon's finger width, nerve endings, or pressure of touch not become intimately tangled with the Nipple Areolar Complex? How does the experience of palpating a patient's chest change the surgical technique or relationship to the patient?

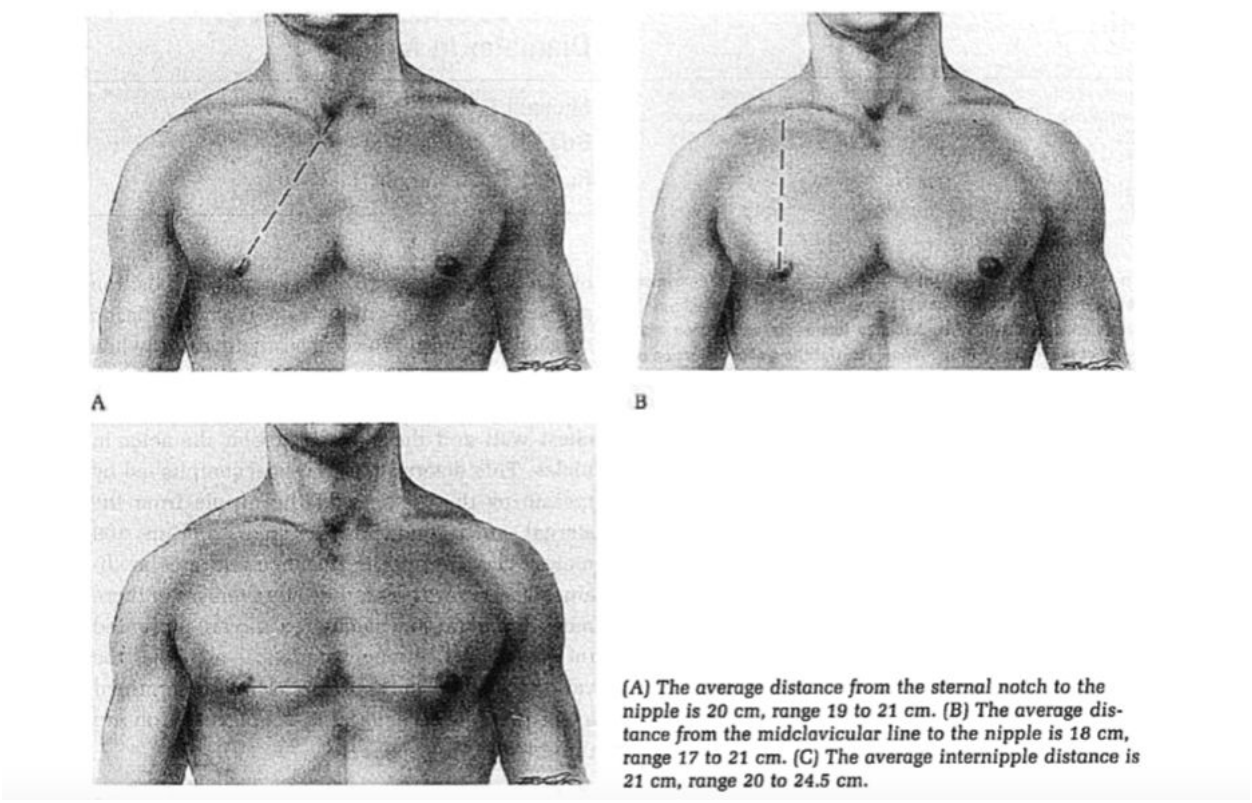
Returning to the metaphor of the graft suggested earlier, a free nipple graft survival is dependent on the process of de-epithelialization. De-epithelialization is a technique developed in the 1930s, shortly after the introduction of free nipple grafting in 1922 (Wamalwa et al. 23), and refers to the process by which a graft or area of skin is "thinned out of the split thickness or full thickness skin layer" (Draf 764). In other words, de-epithelialization is the removal of the epithelial layers of the skin which contain no blood vessels in order to facilitate the connection of the graft with a blood source. The idea is to display a seamless nipple with minimal scarring and full blood flow. Sensation is not the primary surgical goal of a free nipple graft. The cutting away produces a fragile site for healing together.

I am counting down to 21 days when the risk of infection plummets fine thank you healing well or minimal pain or a slow walk around the park my whole body a tender pulse when I change the tape parts of my skin are torn red and raised angry I try to coax the mouth of the band-aid with oil *come loose* *let me be* *let me heal* all I smell is sweat coconut oil heavy summer breeze a sifting pollen skin settling on my shoulders all I can reach is the first cabinet but the marble is so cool for laying my hot face the shower buckles this flimsy tape purple ink runs down my belly I once saw dark matter caught in the drain and cried
convinced it was
the nipple

While proposing mathematical formulas for the ideal chest in "Men's Nipple-Areola Complex", Richard Vaucher and Raphael Sinna concede that "the positioning of the NAC is often realized depending on the appreciation and the experience of the surgeon." (49) While plastic surgery tries desperately to abstract breast augmentation procedures to a "simple, reproducible method" (Agarwal et al. 1305), no body responds according to the promise of reproducibility in mechanistic determinism. This centering of reproducibility is present even in

the mathematical equation for nipple placement as determined in “Configuration and localization of the nipple-areola complex in men.”:

“To localize the nipple-areola complex on the thoracic wall de novo, at least two reproducible measurements proved to be necessary, composed of a horizontal line (distance from the midsternal line to the nipple = A) and a vertical line (distance from the sternal notch to the intersection of line A, = B). The closest correlation for the horizontal distance A was given by the circumference of the thorax: A = 2.4 cm + [0.09 x circumference of thorax (cm)], (r = 0.68). The best correlation to calculate the vertical distance B was found using the distance A and the length of the sternum: B = 1.2 cm + [0.28 x length of sternum (cm)] + [0.1 x circumference of thorax (cm)], (R = 0.50).” (Beer et. al.)



(A) The average distance from the sternal notch to the nipple is 20 cm, range 19 to 21 cm. (B) The average distance from the midclavicular line to the nipple is 18 cm, range 17 to 21 cm. (C) The average internipple distance is 21 cm, range 20 to 24.5 cm.

[10]

As Jay Prosser notes, "Tissue engineering will erase most effectively the differences of those bodies upon which surgical work is performed, enabling all bodies to pass as integral and original: whole. Behind this most cutting-edge technology is the quite nostalgic aim of restoring lost, absent, or malfunctioning material flesh, the integrity of the human being." (92) The human being, a fiction of Medicine that lies at the center of plastic surgery, haunts me with the question of "newness". Is this a new chest? An old chest? A chest that once almost was but wasn't? A chest that could have been? I hear many trans men talk of their bodies after surgery as if they were seeing a version of themselves that had always existed. What does it mean to imagine an

[10] From Beckenstein, Windle, and Stroup, "Anatomical Parameters for Nipple Position and Areolar Diameter in Males."

embodiment, a feeling of wholeness, that relies on restoring a past that never was? Jay Prosser argues that in trans narratives, "surgery is made sense of as a literal and figurative re-membering, a restorative drive that is indeed common to accounts of reconstructive surgeries among nontranssexual subjects and perhaps inherent in the very notion of reconstructive surgery." (83)

In the second week after surgery I am online, searching my surgeon's name to find videos of other patients in an attempt to match my recovery timeline to theirs'. This healing feels too slow. My interest in watching these videos while bedridden springs me forward temporally, jumping from week one to four to a year post-operative. I find a video of a man online who had the same procedure with the same surgeon several years earlier. A little red bar on the video reminds me this is one I have seen before but I watch again anyway. In the past I have ignored his descriptions of revision but this time I listen. He describes returning to the surgeon for the removal of a small piece of leftover nipple. I realize the pink patch directly above my own scar is also a leftover part of my old nipple. Suddenly the wholeness illusion, the idea that this is only *my* chest, begins to decompose. Haraway offers the notion of non-reproductive kinship relations as a way to "live and die well" ("Staying With The Trouble", 160) in an era of environmental destruction that she calls the Chthulucene. Her proposed technique of thinking kin outside of ancestral or genealogical ties has generative possibilities for thinking differently about my relationality to these other patients.

Haraway writes, "Kin-making is making persons, not necessarily as individuals or as humans. I was moved in college by Shakespeare's punning between kin and kind—the kindest were not necessarily kin as family; making kin and making kind (as category, care, relatives without ties by birth, lateral relatives, lots of other echoes) stretch the imagination and can

change the story." (161) This thinking of kin shares some elements of 'chosen family', a family-making technique of lifesaving importance to those of us for whom the western (and capitalist) structures of family fail to provide safe or affirming community. Critically, however, kin-making is not about choice nor is it only about human animals, it is a recognition of the compulsory entangled assemblages of our beings with others. The notion of consent is not relevant to these becomings-with that we are pulled towards, as we are already deeply and intimately bound together. The site of the graft, my little leftover nipple, is a small key to a much larger kinship network with my surgeon's other patients. I am drawn to the same bilateral incisions that begin and end just like mine with our nipples placed almost identically. We are grafted together through our surgeon's technique. "Kin is an assembling sort of word," Haraway argues, "All critters share a common "flesh," laterally, semiotically, and genealogically. Ancestors turn out to be very interesting strangers; kin are unfamiliar (outside what we thought was family or gens), uncanny, haunting, active." (162)

I find this possibility for kin-making comforting, not only for a recuperation of family lost, but for thinking differently about reproduction and childbearing in my trans embodiment. Narratives around trans reproduction and parenting often have a genealogical understanding of kin, one that is always hierarchized (parent to child). "Have you thought about having children?" I was once asked, perched on a cold exam table immediately before starting hormones. The implication of this question was not only to figure parenthood as at odds with hormone replacement therapy and transition, but to understand making kin through only one frame of reproduction: cis-hetero human babymaking, or what Paul Preciado playfully and accurately calls "culturally assisted reproduction" (298). To imagine my common flesh grafting me together

in kinship with others, including but not limited to other trans people, means ever-expanding possibilities and responsibilities for being and having children, brothers, sisters, siblings, parents.

> There will be a picnic for every patient of my surgeon, who is no longer mine but ours. In fact, nothing is mine but we have identical nipples. Critters of a common flesh and two long incisions across the skin. We will learn each other's names. Call each other kin. He will bring a basket of warm fruit that has been sitting in the sun. There will be the huge sea and a shrinking land mass as the tide changes. There will be the loud and soft of a flapping flag. Little damp feet running through a sprinkler. They will be cradling a baby in their arms. Not mine, but almost. And only because so many others love him. Another will breathe deeply. Golden sun turning red. Moss. We will look down and see mushrooms. The many-legged bodies of significant others emerging out of grass to play amongst our toes. *Lift me*, a little one will cry, thrusting two sticky hands into the air. Maybe this will be annual. No definitely, it will be. Because there won't be any planes now that the fuel is gone. There will be massive and well organized carpools. Almost.

BEING READ

In "Handholds and Other Kill Floor Mnemonics", Kara Wentworth's creative text/video project explores animal slaughter as a material-semiotic process. By framing cuts as material-semiotic devices, Wentworth creates a short film of methods of dissection on the kill floor to show how bodies are not mere passive material but active agents in the methods and techniques of disassembly. This piece, while dealing with a non-human animal, opens space for an understanding of disassembly as a particular way of knowing a body, how "cutting and knowing are known together with metal on flesh" (5). Slices in the skin made by butchers while holding the animal, what Wentworth calls "handholds", are an opening for how the body "guides the process of how to take it apart" (4). What knowledge is produced through cutting? How does

my trans body *matter* and come to be meaningful in the process of being cut? Wentworth writes, "Just as dissecting a text or memorizing its lines might be ways of knowing a written object, taking apart an animal and distinguishing its parts are ways of knowing a body." (4) When I wake up from surgery I notice my incisions do not perfectly fall along the purple dotted lines drawn in the waiting room. Once opened, my fat and blood and tissue insisted on a different path. There was a necessary process of response to my material flesh that could not have been calculated beforehand. Even the stiff measuring tape used to determine an optimal distance for nipples and find the contours of my muscles failed the response of my skin. Weeks later my surgeon tells me to wait for the swelling to go down. "There is no way to know how the body will react," she says. *Respond*, I think.

The stitch closest to my sternum begins to open itself up I see white tissue; and
I buy steri-strips and pinch the skin together but it gapes; and
A small open mouth, and
I used to watch my mother removed the hemmed stitches on pants. I become obsessed with the possibility of my chest ripping open with that same sound; and
the wild fray of decomposing black thread
like little spider legs reaching

,and
runny yellow liquid, chunky matter
to measure the leakage

;and
my swollen chest
nipples like small sea sponges, a mushroom head, a not-yet-blooming buttercup.

the surgeon writes,

Procedures Today:
None

Counseling:
- We discussed the pertinent risks, benefits, and alternatives to the patient's considered procedure, as well as her expectations. Plastic Surgery operations have subjective outcomes which may be dependent upon patient anatomy and expectations. While a specific result cannot be guaranteed and peri-operative problems may occur, every effort will be made to deliver a satisfactory result in a safe and ethical manner.

- We discussed gynecomastia / mastectomies in further detail.

- After reviewing the risks, benefits, and alternatives, the patient is most interested in the above treatment plan. All chests have pre-existing asymmetry and that no matter the procedure chosen, he will continue to be asymmetric post operatively. Gynecomastia reduction is a complex operation which trades scar for improved contour. Scar quality cannot be predicted and contour irregularities may occur. Skin contracture may or may not be adequate. Pedicled procedures may or may not preserve nipple function and risk nipple viability. Nipple grafting procedures do not risk nipple death, but may not take well and do sacrifice nipple aesthetics and function.

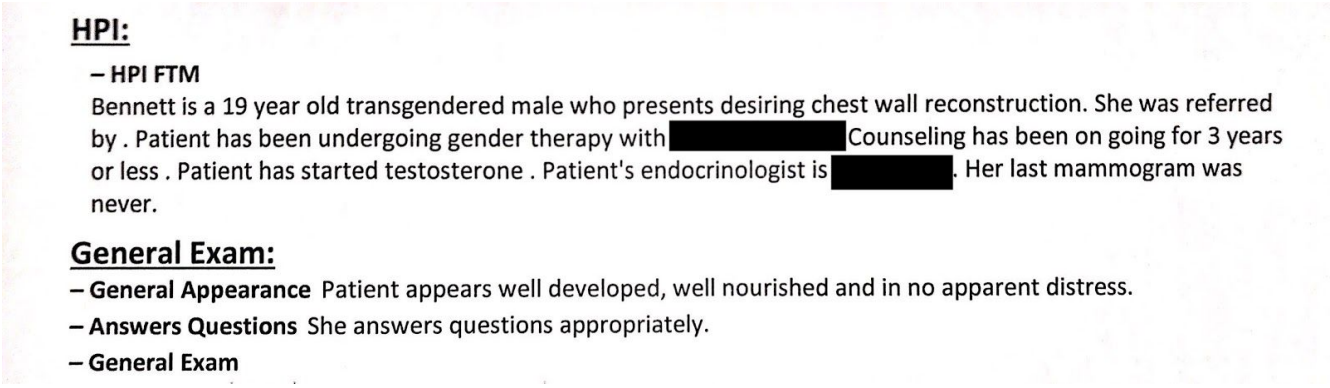
PA, would like procedure in May after school gets out.

Final Comments:
Patient was instructed to follow-up send to insurance for pre-authorization.

Signature:

I read this disclosure not just as a liability requirement but as evidence that bodies "can offer, guide, and push back as they are rendered meaningful" (7). Healing becomes a process of the body responding to touch and to meaning. I see my body's perceived incongruence weaved throughout the text specifically in the inconsistency of pronoun use. As I review my surgeon's notes I am fascinated with the in/ability to distinguish my gender as it belongs in documentation -- the relationship between "male" and "she". "He" was the verbal default before I undressed while "she" dominates in the written word. In documentation my surgeon writes, "We discussed gynecomastia / mastectomy in greater detail". Gynecomastia is a heavily gendered condition, the enlargement of breasts specifically for boys or men. Mastectomy is the procedure to remove a breast, typically for women. I am interested in the slash, the relationship between these two

words and the way it marks my body as both man and woman. Wentworth addresses this process of distinguishing as "both a knowing process: mentally separating x from not-x, and a material process: separating x from not-x with a knife's blade." (5) My surgeon begins this knowing process in the office, separating man from woman, raised from flat. In the operating room she practices again: fat from muscle, skin from bone, flesh saved from flesh discarded. I am interested in the unmarked assumptions here that rest on an understanding of 'normal'. The observation that "reduction is a complex process that trades scar for improved contour" does not just observe neutral truth, but creates it. Are scars undesirable? What is improved contour? What are good nipple aesthetics? And especially interesting in the question of 'male' nipples - what is a nipple function and how does one know if it is gone? To feed? To feel? To stiffen in reaction to heat or touch?



HPI:

– HPI FTM

Bennett is a 19 year old transgendered male who presents desiring chest wall reconstruction. She was referred by . Patient has been undergoing gender therapy with [redacted] Counseling has been on going for 3 years or less . Patient has started testosterone . Patient's endocrinologist is [redacted]. Her last mammogram was never.

General Exam:

– General Appearance Patient appears well developed, well nourished and in no apparent distress.

– Answers Questions She answers questions appropriately.

– General Exam

In this chart HPI is an acronym for "History of Present Illness", a category to which FTM (Female to Male) is ascribed. Despite the fact that the diagnosis of gender dysphoria is the medical justification for my insurance coverage, the label of FTM, a marker of identity that I don't use to describe my embodiment, is applied as the illness. Another logical fallacy appears in

that I am legally considered to be female until my surgeon provides a letter to the Chicago Department of Human Services confirming my surgery. I have to be male enough for insurance to need the surgery as a confirmation of that maleness, and female enough to need it as 'proof' of my maleness for my birth certificate. Where does female begin and male end? As evidenced by my shifting pronouns in this documentation, even my surgeon does not know.

The sentence "She was referred by ." stands out in all its absurdity with the blank space where a doctor's name should be. Maybe it didn't matter all that much. Maybe someone forgot to go back in and enter it. Perhaps the information was too deep in my chart. Omitted out of some lack of medical importance, this blank space stands in stark contrast to the three years of therapy and multiple letters necessary to receive the referral. My relationship to testosterone and gender therapy are marked as important evidence of my "present illness". The sentence "Her last mammogram was never" again employs an absurd grammar logic. In this documentation, collage (cut/paste) produces my body and the bodies of many others who have also been inserted into this Madlibs-style form. The inclusion of the word "never" defies grammatical rules and contradicts the order of the preceding language. This cut/paste technique of inserting the same required information from patient to patient produces absurdist text. The cutting apart-together of this standardized document cannot hide its own illogical violence.

Under general exam, another evaluative metric presumed to be equally applicable in all cases for all bodies, the Physician's Assistant writes, "Patient appears well developed, well nourished and in no apparent distress". These observations taken to be neutral and objective refuse to reveal their own situatedness. Well developed physically or relationally? How is distress determined? To be considered eligible for surgery I was asked to perform and endlessly

document my distress. Now in a pre-screening for surgery, I am observed as having none. Later the PA writes, “She answers questions appropriately.” ‘Appropriately’ takes on a multitude of meanings in this context given the long history of medical gatekeeping practices producing a metric for ‘appropriate’ answers to questions about surgery. In one context ‘appropriately’ might pertain to mental health, meaning that the patient verbally responds to questions, makes eye contact, and exhibits typical social behavior. In another context it relates to displaying an authentic trans identity, meaning that the patient expresses distress over his current body, verbalizes no fears about surgery, and consents to all questions about his gender identity.

Bennett N. Sambrook (6085)
20 years old, Female DOB: [redacted]

PLASTIC SURGERY PROGRESS NOTE

Allergies / Medications:

- **Allergies** No Known Allergies
- **Current Medications** Depo-Testosterone 100 mg/mL intramuscular oil

Post-Operative Procedure & Date:

- **Post-Op Days From Procedure**

Mastectomy: 8 months, 4 weeks, 1 day ago

- **Procedure Selection - Progress**
  - Mastectomy

SOAP Mastectomy:

- **Progress Details - Mastectomy**

	1st Visit	2nd Visit	3rd Visit
Date	5/10/17	6/23/17	2/2/18
Pain Level	0	0	0
Suture Removal	Not Needed	No	No
Incision Site	Dry and intact	Dry and intact, Infection not present, Nipple grafts pink and adherent	Dry and intact, Infection not present
Drain	Drain removal - Custom	Non-applicable	Non-applicable
Progress Details	areola grafts pink	good symmetry	good symmetry
Progress Plan	Continue current care	Continue current care, Gentle wash, Scar Fade	Continue current care
Patient Experience	No need for pain medication	No need for pain medication	No need for pain medication
Activities	No strenuous exercise	No heavy lifting	No restrictions
Notes	path neg, fu 6 wks	doing very well	very happy with results; noticed flank swelling has gone down. Discussed liposuction or weight loss if desires further contouring

Progress:

- **Progress Evaluation**

	Yes
Patient problem is better	☑
Patient is pleased	☑
Patient has no complaints	☑

Photos:

- **Post-Operative Photos** POD 1st Visit, POD 2nd Visit and POD 3rd Visit

In a follow up appointment 8 months post-op the Physician's Assistant logs progress details in a chart. Under the category "Patient Experience" she writes, "No need for pain medication" for all three visits. Under "Progress Evaluation" she checks three discrete boxes: "Patient problem is better", "Patient is pleased", "Patient has no complaints". These categories succeed in framing physical pain at the essential marker of my experience. Is/was my body a problem? Am I pleased? Do I have no complaints?

> examined scars: the puffy first month, the soft u-shaped pink, the white thin ridge, two weeks later I winced for the pinch of stitch removal but felt nothing saw pricks of beading blood felt a tug but no sting I had no relationship to this new body yet just a sour smell a deep iodine stain once yellow now creeping into brown the nurse snaked a long clear tube out of my armpit I had begun to think of these drains as a part of my body I had learned to maneuver a thin shirt over two bulbous cups to pinch thumb and finger down to empty

3. PASSIVITY, COTTONSEED OIL, AND THE UNSEEN

A warm day in Spring: I have recently started testosterone and have been worried about the cause of a small, hot bump I find a few days after each subcutaneous injection in my upper thigh. A few months later I discover that my testosterone is suspended in cottonseed oil, an oil extracted from the seeds of cotton plants known to have a particularly high rate of contact with pesticides. I bring this information to my doctor and ask if this could be related to the itchy, red mound. My doctor says it is definitely possible and that I can switch to testosterone suspended in a different oil if it continues. He does not know this is not covered by insurance. He leaves a few months later to pursue a new medical degree. I ask my new doctor the same question. She says, "Cottonseed oil? I didn't even know there was oil in it."

Donna Haraway notes that "caring means becoming subject to the unsettling obligation of curiosity, which requires knowing more at the end of the day than at the beginning." ("Staying With The Trouble" 36) Curiosity, she writes, "should nourish situated knowledges and their ramifying obligations." ("When Species Meet", 289) I become curious about the bump and sting, curious about the viscous oily solution and its slippery ambiguity, curious about the pesticide I introduce to myself, curious about what this means for my embodiment and the earthly critters who now constitute it through manufacturing, production, harvesting, and delivery. I become curious about the living things who share soil with 'my' cotton and how the legacies and histories of cotton have found their way into my bloodstream. In an effort to trace this tangle, I decide to call the number on the back of the vial to find out about the oil. The manufacturer of my DEPO-TESTOSTERONE® Testosterone Cypionate Injection, USP C-III is

West-Ward Pharmaceutical which I find out is now a subsidiary of Hikma Pharmaceuticals USA Inc. ("West Ward Pharmaceuticals Now Hikma") The website promises the same "tradition of excellence", the same dedication to better health and the same commitment to "quality, reliability and care[11]". From the manufacturer I find just one description of my drug: Clear, Yellow Oleaginous Viscous Solution.

The FDA listing of Testosterone reads as follows:

Each mL of the 200 mg/mL solution contains:

Testosterone cypionate ..... 200 mg

Benzyl benzoate ..... 0.2 mL

Cottonseed oil ..... 560 mg

Benzyl alcohol (as preservative) ..... 9.45 mg

In "Healing as Metaphor", Ed Cohen explores how Medicine understands autoimmunity in terms of aggression/response, a framework that he attributes to Medicine's naturalized adoption of an immunity metaphor. To Cohen, metaphor is a linguistic substitution of one thing for another. The immunity metaphor, then, is a substitution of the political language of "immunity", originally applied in the legal context, to Biomedical bodies. He traces this lineage of how immunity came to be attributed to Biomedical bodies and argues that it is because of this metaphor (which Science does not recognize as a metaphor at all) that Biomedicine is limited in

[11] https://www.hikma.com/about/

what it can know about autoimmune healing and treatment. He suggests replacing the immunology metaphor that speaks in the language of invasion with a healing metaphor that embraces the healing power of imagination. Much like Cohen I am not interested in dismissing Biomedicine's lifesaving tools or that arguing that quantitative measurements are always inefficient for treating bodies, but in looking for alternatives to "suture the gaping wound between the unknown dynamics of the human organism and the reflexive activities of human understanding" ("Healing as Metaphor") for which Medicine's immunity metaphor fails. In fact, I do need to acknowledge that particular forms of quantification are important to me, politically and personally. There are various forms of mediation, one of them being data, and they have their place in an ethical and just practice of caring for bodies. My project operates with the same understanding as Cohen that the problematic of Biomedical technologies is the tendency to treat them as unmediated truth, as reality itself. When using quantitative data I am interested in asking questions to situate its use: What purpose does it serve? How does it come about? How is it produced? How is nature produced, for whom, and at what cost[12]?

The separation of "true" medicine from "imagination" is at the center of the project of western Bio-science. This logic relies on a heavily cultivated myth that through Science we have access to the 'reality' of bodies directly. While immunology has supplanted itself as a natural and ahistorical framework, Cohen historicizes this phenomenon as a particular metaphor for understanding bodies. Where healing "traditionally expressed the enmeshment of living beings in the universe and affirmed their fundamental connection to the matrix from which they arose"

[12]Paraphrased from Donna Haraway in the National Geographic special "Donna Haraway Reads the National Geographic on Primates".

("Healing as Metaphor"), Scientific medicine supplanted this idea with the metaphoric innovation of immunology. It is through this logic that it becomes naturalized for medicine to understand illness in relation to the individual.

Cohen attributes many of his own successes in recovery from Crohn's Disease to imagination, recognizing that his miraculous healing was not just a function of what doctors did not know, but what they *could not know* through the Biomedical model. Before the discourse of immunology, a particular metaphor for understanding health and bodies that emerges in the mid nineteenth century, healing was the primary discourse for understanding engagements with illness. Healing is now portrayed as anachronistic and inefficient in the era of Bioscience's immunity metaphor. This 'invention' of immunity and the fiction of the bounded, individual body is the framework on which Scientific reductionism is built. Scientific reductionism, the reduction of complex bodily interactions to small parts so as to make them studiable, understands all the complexities of bodily engagement to illness as attributable to aggression/response. In the immunity metaphor a universal 'body' is a finite, bounded object waging war against a separate, invading force of illness usually of single origin. If the illness is not of a single origin, as the logic goes, Scientific reductionism is capable of breaking down the illness to several single origins. This metaphor is integral to producing "the body" as a singular organism, distinct from environment and any microbial agent of disease. This metaphor of immunity was successful for illnesses easily assimilable to this model and deeply inefficient at treating those which are not. This is to say that this inefficiency, the 'blind-spots' of Medicine, are the places from which I begin my own exploration.

It is on this naturalization of the discourse of immunity that the placebo rests. Unlike the paradigm of mechanistic determinism, placebo effects or what Cohen calls "imagination", are difficult to reproduce reliably. As such, the placebo or self-healing potentials of the body, are at odds with Medicine's insistence on deterministic, mono-causal, and quantifiable medicine. In "The Placebo Disavowed", Cohen traces the history of Medicine's rejection of the placebo and interest in mono-causal logic as the ultimate arbiter of truth: "The axiom that only one cause is needed for an effect [*"il ne faut qu'une cause pour un effet"*] defines determinism as the epistemological ground for Biomedical truth. The imagination, which admits of over- or non-determinations, contravenes this principle and hence must be debunked as the source of misguided or even dangerous healing practices." ("The Placebo Disavowed" 9) He argues that the placebo becomes a stand in for the translation between the imaginary and the material, the way that Medicine attempts to figure the two as ontologically distinct.

I want to follow two threads departing from Cohen's turn towards healing as metaphor. The first thread addresses the question of the placebo and Medicine's claim to know active from passive and cause from effect. What does Medicine understand to be an "active" ingredient in hormone replacement therapy and what is passive or ignored? How does looking to the 'passive' 'ingredients' open up alternative ways for thinking about entanglements of bodies in transition that Medicine neglects? The second thread is a curiosity about alternative methods for processing bodily contingency -- what Cohen calls technologies of "imagination". How does writing about or self-documenting hormone replacement therapy function as an imaginative technology? What does it do to and for us that Biomedicine can't explain?

Somewhere there is a home somewhere there is a home within a street within a body that is a Huge Big River thrusting into a mountain bed an uncontainable force Every Friday I ritualize my manhood a drip from the tip of a needle a sharp longing a huge long dive you watch me sting while the whole earth buzzes beside me

My stomach flops like a sparrow in a car tire

I think about what it means to create how becoming is so often read for inauthenticity as if we aren't all shifting sometimes as if we aren't all swaying side to side in our becoming as if we aren't all engulfed by the whole need to put a stop to it to end someday

I used to be scared at the thought of doing anything for my whole life the same way but now it feels nice Every Friday morning I open my small brown box and line up two needles, one syringe, one small bottle the size of my thumb, one alcohol wipe, one small CVS generic brand band-aid one day there will be an unused needle and maybe my fat will begin to billow out around the spots that it used to

I remember right around the time my dick started growing I could hardly walk comfortably I remember telling you it felt like sandpaper in my underwear I've always been a leg crosser but now sometimes I catch a glimpse of myself in a window and I uncross I feel ashamed of doing this and sometimes I don't sometimes I'm just trying to go one moment unnoticed It took me four years to pierce my ear and I bled all over the sink and down my hand and a little got stuck in the arm hair at the base of my wrist all because I don't trust another person with my pain come closer until you're all inside and I'm releasing a cold yellow liquid into my upper thigh and you're coming to my shoulders to pray this residual throb this hot bump this
warm hand

Cohen's exploration of the placebo offers a particular lens through which to tease the Biomedically unseen -- to consider agential what is Medically considered to be a passive and inactive ingredient. Biomedicine's measure of its own effectiveness, its ability to see, rests on the idea of measurable and quantifiable 'active' ingredients. In order to problematize the binary of active and passive, to return to an understanding of healing that regards the "life-world" as

integral to understanding somatic bodily changes, I am interested in what is the 'passive' ingredient in my testosterone bottle: cottonseed oil.

Cohen argues that there is generative potential that "the unknown and unknowable may harbor for our experiences of illness and disease." ("Healing as Metaphor" 8) While trans identity is not a disease, it is handled with the same messy hands of medicalization as illness, and thus subject to its same mechanisms of knowing. Much like illness, trans identity is legible to Medicine only through the lens of symptom, cause, and cure. Hormone replacement therapy is a component of this process of 'cure' and thus subject to the same logic of the immunity metaphor. To paraphrase Medicine's story of Testosterone: *Patient distress is treated with Depo-Testosterone, a medicine typically administered through intramuscular or subcutaneous injection. The patient can self-administer but not self-source, can not save, must use small amounts that come in 1 ML bottles in the state of Massachusetts ("Fact Sheet"). There have been no reports of acute overdosage and testosterone is a controlled substance and a Schedule III drug ("The Controlled Substances Act"). The drug contains multiple ingredients but Testosterone cypionate is considered the only active ingredient. All other ingredients, the environment, context of injection, method of administration, or relationship to doctor are irrelevant to the somatic experience of the drug. The drug will affect all bodies the same way.* While some doctors actively engaged in the process of administering hormones will recognize through experience the more obvious flaw of mechanistic determinism, the presumption that testosterone will affect all bodies the same, the agential roles of 'passive' ingredients are still deeply ignored. The replacement of healing as metaphor with immunity ensures the following 'blind-spot': you never know whether what you're excluding might be significant. While there

might be findings of Biomedical significance being overlooked that could be important to life-saving concerns of trans patients, there is always political significance to the medically unseen. 'My' testosterone is "compounded" with cottonseed oil, a mixing together of two or more things. As Haraway writes, "Never purely themselves, things are compound; they are made up of combinations of other things coordinated to magnify power, to make something happen, to engage the world, to risk fleshly acts of interpretation. Technologies are always compound." ("When Species Meet" 250) My pharmacy compounds testosterone[13] in cottonseed oil and this compounding opens me up to a joining with others. Cottonseed oil is far from inactive.

I need to trace my contact zone story with cottonseed oil in order to attempt right-relations with both human and non-human entities. Looking at this passive ingredient means making ties and knots of my own, stringing "the unknown--and perhaps unknowable" ("Healing as Metaphor" 8) together to see whom and what this ontological experiment of hormone therapy touches. My attachment to the very specific compound of cottonseed oil bumps up against the intentional cutting of these tentacular lines by pharmaceutical corporations and leads me to ask: How are the production histories and sourcing practices of a drug made inaccessible for patients? What does asking the questions most people do not ask, investigating the 'irrelevant', do? If the "Me" is constructed through these tentacular connections with

[13] While tracing the entanglements of the active ingredient, testosterone, is outside the scope of this work, it's historical and biopolitical entanglements have been richly investigated by a number of feminist scholars, significantly Preciado (2008) who extends Foucault's biopolitics into the pharmocopornographic era and Gill-Peterson (2014) whose research travels with the animate testosterone molecule to pursue a theory of racialized and trans embodiment. However there are a few interesting elements of testosterone's manufacturing law that bind me back to this project. Trademark law has a curious stranglehold on testosterone production given that a drug company cannot patent the manufacture of simple testosterone because they did not invent the chemical formula for that hormone (it is "naturally occuring"). A drug company must develop a new unique formula or delivery method to apply for a patent for that drug. Drug companies may then profit solely for a number of years before other companies are permitted to create generic or brand-name equivalents. (Center for Drug Evaluation and Research)

cottonseed oil and by extension, cotton, how is my embodiment tied to the histories of the cotton plantation and slavery? It is the small, hot bump on my leg that first asks these questions.

When I call Hikma to inquire about the cottonseed oil I reach a woman on the phone with a thick southern accent. She cannot give me any information about the sourcing of the cottonseed oil, only that my particular testosterone comes from a manufacturing facility in Terrugem, Portugal and a distribution facility in Eatontown, NJ. She seems nervous and keep asking me *why* I want to know. Has there been a problem? Are you experiencing an allergic reaction? Of course the only frame for recognizing a 'passive' substance's agency is through allergy, a bodily response easily assimilable to Biomedicine immunity metaphor. I tell her I am just interested in knowing and she goes quiet. I write again over email hoping to get more information.

Medical Information Enquiry

2 messages

Bennett Sambrook <[redacted]edu> [redacted]
To: us.hikma@primevigilance.com

Hi - I am a customer who uses your drug Testosterone Cypionate Injection, USP C-III. I am looking for any information you can give me about the cottonseed oil the drug is compounded with, specifically where the oil is sourced from.

Thank you,
Ben Sambrook

US Hikma <us.hikma@primevigilance.com> [redacted]
To: Bennett Sambrook <[redacted]edu>

Ref: MI-02252019-2045

Dear Bennett Sambrook,

Thank you for sending your inquiry regarding testosterone cypionate injection. You enquiry has been escalated, and a response will be provided as soon as possible.

If you have further questions, please contact Medical Information for Hikma Pharmaceuticals USA Inc. at (877) 845-0689. Thank you for your inquiry.

Regards,

Ebony Kennedy, PharmD, RPh

Medical Information Associate

On behalf of Hikma Pharmaceuticals USA Inc., formerly West-Ward Pharmaceuticals Corp.

Response from Hikma Medical Information

3 messages

US Hikma <us.hikma@primevigilance.com> [redacted]
To: "[redacted].edu" <[redacted].edu>

Reference number: MI-02252019-2061

Dear Dan,

Thank you for contacting Hikma Pharmaceuticals USA Inc. I am responding to your medical information request regarding Testosterone Cypionate Injection and the following topic:

- Source of cottonseed oil

Testosterone Cypionate injection is indicated for:

- Primary hypogonadism
- Hypogonadotropic hypogonadism

In response to your specific enquiry, please note the following information below:

- Cottonseed Oil is the refined fixed oil obtained from the seed of cultivated plants of various varieties of Gossypium hirsutum Linn, or of other species of Gossypium (Fam Malvaceae)

The Testosterone Cypionate Injection Prescribing Information is attached for your review.

If you have further questions, please contact Medical Information for Hikma Pharmaceuticals USA Inc. at (877) 845-0689.

Sincerely,

Bianca Carmo, MPharm, RPh
Medical Information Officer
On behalf of Hikma Pharmaceuticals USA Inc., formerly West-Ward Pharmaceuticals Corp.

Bennett Sambrook <[redacted].edu> [redacted]
To: US Hikma <us.hikma@primevigilance.com>

Hi Bianca,
Thanks so much for this follow up. My question was actually about your sourcing practices. I would like to know where the cottonseed oil your manufacturing plant uses is sourced from, not the source of cottonseed oil in general. Would you be able to help me find out more about this?

Thanks,
Ben Sambrook
[Quoted text hidden]

US Hikma <us.hikma@primevigilance.com> [redacted]
To: Bennett Sambrook <[redacted].edu>, US Hikma <us.hikma@primevigilance.com>

Dear Ben,

I apologize for the misunderstanding.

In fact, the information regarding "where the cottonseed oil your manufacturing plant uses is sourced from" is considered proprietary and it cannot be shared at this time.

The Testosterone Cypionate Injection is manufactured in our manufacturing plant in Portugal.

Hikma products are approved by the FDA and the approved ingredient information is available within the package insert supplied with all products distributed and sold.

If you have further questions, please contact Medical Information for Hikma Pharmaceuticals USA Inc. at (877) 845-0689.

Sincerely,

Bianca Carmo, MPharm, RPh
Medical Information Officer
On behalf of Hikma Pharmaceuticals USA Inc., formerly West-Ward Pharmaceuticals Corp.

Aside from the curious name switch where I was addressed as Dan, the most interesting language from this email exchange was the invocation of proprietary protections. The term "confidential business information" which includes "proprietary information" is sourced from section 777(b) of the Tariff Act of 1930 and protects "information which concerns or relates to

the trade secrets, processes, operations, style of works, or apparatus, or to the production, sales, shipments, purchases, transfers, identification of customers, inventories, or amount or source of any income, profits, losses, or expenditures of any person, firm, partnership, corporation, or other organization, or other information of commercial value, the disclosure of which is likely to have the effect of either impairing the Commission's ability to obtain such information as is necessary to perform its statutory functions, or causing substantial harm to the competitive position of the person, firm, partnership, corporation, or other organization from which the information was obtained, unless the Commission is required by law to disclose such information." Though its application to drug manufacturing is relatively recent to the 20th century, the word proprietary here has its etymological roots in the Medieval Latin *proprietarius* "owner of property" and was used earlier in English as a noun meaning "proprietor," also "worldly person" (c. 1400). [14] Ironically, it is this same proprietary that refuses my search for worldly entanglements[15].

In following this thread, cut short by the dual scissors of capitalism and the pharmaceutical industry, I focus on the information I do have: that my oil comes from a specific manufacturing plant in Portugal and that my oil is derived from the seed of cultivated plants of various varieties of Gossypium hirsutum Linn.

I find that West-Ward Pharmaceuticals Corp. is a wholly owned, U.S. subsidiary of Hikma Pharmaceuticals PLC, based in Amman, Jordan with headquarters in London, England ("West-Ward Pharmaceuticals"). West-Ward has six total manufacturing facilities worldwide

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[14] "Proprietary." Merriam-Webster's Learners Dictionary, *Merriam-Webster*. Accessed April 21, 2019. https://www.merriam-webster.com/dictionary/proprietary#etymology.

[15] While this lack of access to my drug's information reeks of a capitalist intervention, it is not the only place in which my leaky cottonseed research trail has been stemmed. As I begin to look to the histories of cotton itself, my access is deeply mediated by academic paywalls. For those of us curious about tracing our entanglements, it proves very difficult without these resources.

and two based in the U.S. West-Ward is of great financial importance to Hikma, representing 51% of Hikma's group sales in 2014 ("West-Ward Pharmaceuticals") In researching the Portuguese injectables manufacturing plant I find a warning letter from the U.S. Food and Drug Administration citing significant violations of current manufacturing practice regulations for finished pharmaceuticals on October 21, 2014. The FDA establishes this recent incident as "a repeat violation from [their] September 2011, June 2007, and March 2004 inspections" ("Warning Letters") In a close out letter one month later, the FDA affirms the (unlisted) corrective actions taken by the corporation as in compliance with the requests of the warning. The original complaints related to "production controls and environmental monitoring, which the FDA said could compromise sterility at the factory and the strength, quality, and purity of the drugs it produces." (Bradshaw) Questions of sterility and purity take on one particular meaning in this investigation - they insist on an understanding of the drug as pure prior to "mishandling and/or poor aseptic technique" ("Warning Letters"). The activity of the cottonseed's entanglement, embroiled in thoroughly polluted histories of the plantation, large scale displacements, globalization, forced labor, environmental destruction, and extinction of local species goes unrecognized under the medical definition of an inactive ingredient.

Cottonseed oil as a commodity grew as a wealth out of waste crop, a by-product of the cotton manufacturing industry. Cotton's colloquial name "white gold" (Desrochers and Szurmak 10) is a derivative of its history as a profitable resource obtained by Europeans through colonization, largely in India. Prior to its widespread industrial cultivation in North America, cotton was domesticated everywhere it occurred in the wild from the Indus Valley Civilization in the northwestern regions of South Asia to the Yucatan Peninsula (upland cotton) and Peru (pima

cotton). Cotton was wild in southern Africa and was domesticated in the Middle East and around the eastern Mediterranean (Desrochers and Szurmak 3). The word "cotton" is a derivative of the Arabic word "qutn" (Desrochers and Szurmak 10). Cotton production in Europe was largely unsuccessful due to the failure of British and French colonial administrators to secure the product from growers in the colonies. With the relationship of mechanized cotton production to modernity and manufacturing, raw cotton exports were linked to the United States' growing place in the global economy and central to the history of capitalism. As Sven Beckert identifies, industrial capitalism emerged "from the violent cauldron of slavery, colonialism, and the expropriation of land from native peoples." (119) In this cauldron metaphor, there is no distinguishing between its violent contents. We can look to cottonseed production, and its counterpart cotton, to see the mutually constitutive systems of capitalism, chattel slavery, settler colonialism, and indigenous displacement and genocide.

Cotton is *the* plant that comes to mind in the United States in relation to slavery and one of the main plantation products of the deep South. The displacement of humans, plants, and non-human animals is part of this nascent capitalist machinery that finds its origins in the plantation. This phenomenon is characterized by an exploitation of indigenous labor and replacement of landwork techniques that came before. Rather than understanding the legacies of cotton to genocide, enslavement, and environmental destruction in a logic of comparing, I follow the work of K. Wayne Yang who reads settler colonialism as a set of technologies. The project here is not to provide a history of cotton but to trace the spindly fingers of the crop's entanglement with violence in many forms -- violence that my cottonseed-consuming body is implicated in. Yang argues that settler colonialism produces bodies through relationship to the

land. He sees the settler–native–slave triad as a useful figurative shorthand for describing relationships under settler colonialism, but critiques it for producing distinct identities which ignore the intersecting and contradictory ways they are contextually contingent. Technologies of settler colonialism which make land into property also remake Indigenous and African bodies. Understanding these technologies, he writes, creates pathways for decolonial work:

> "Alienating the life out of Black life is required to subject black bodies to industrial technologies of mass killing and caging. Alienating the Indigenous spirit life out of the land is required to subject land/animals/people to mass reapings. Removing land from people also means making war ontologically inherent on certain peoples….Blackness is about the flesh, and the flesh is land—both are biomatter. Thus, by seeing land as biopolitical, I am seeing how the nonhuman critique in Black studies aligns with the more-than-human critique in Indigenous studies." (Yang 18)

By thinking land as a biopolitical target, we can understand farming as based on the separation of plant and animal life into "parts with exchangeable value, extractable value, or disposable value" (Ibid.). Yang understands what he calls the anthropocentric pitfall as a continual return to the racialized human subject which undermines "the work that Indigenous studies has done to emphasize the geopolitical, the land, and the circle of relations that do not begin and end with the human." (Ibid.) Thinking of the land as a biopolitical target allows for an understanding of cotton's entanglement with the many living things of the land.

Cotton's relations to the people, land, flora, and fauna of the United States have long been entwined with toxicity. Even from the early years of cotton cultivation in the South, it has been identified as responsible for killing manure ruminants and posing threats to livestock health

through its natural toxin gossypol (Brooks 354). The environmental destruction was once so immediately present that "it was seriously considered to discontinue the production of cotton, since the seed were injurious to man, beast, and plant" (Desrochers and Szurmak 6). Interestingly, it's toxin gossypol, a polyphenol isolated from the seed, roots, and stem of the cotton plant, is now a topic of biomedical inquiry, tested as a male contraceptive because of its capacity to cause persistent infertility (Coutinho 259) and explored as a possible cancer treatment alongside chemotherapy (Xiong et. al. 27). The cultivation of cotton in the American south has also been related to another environmental toxin -- arsenic. In his book "The War on Bugs", organic farmer, scholar, and activist Will Allen writes of this use of arsenic in relation to its entanglements with American farming, bugs, and food production. Arsenic was sold as an effective pesticide, known for its unique ability to eliminate hard-to-kill pests:

> "Armed with testimonials and editorial arguments, companies aggressively promoted the use of arsenic against everything that crawled, flew, hopped, or rotted, in spite of the known risks that emerged in the widespread food poisonings during the 1890s. As a result of these sales campaigns, arsenic became the most widely used pesticide from 1880 until the 1950s… [the chemical companies] developed a strategy that highlighted successful farmers who had won county and state fair prizes for perfect fruits, vegetables, grain, cotton, or tobacco by spraying arsenic on them." (82)

Cotton is now one of the most pesticide ridden crops on the planet, with around 5% of pesticides and 14% of insecticides sold being destined for use on cotton. 75% of cotton insecticide use is used in five countries (Brazil, India, China, US, Pakistan) and cotton is the fourth largest market for agricultural chemicals overall ("Is Cotton Conquering it's Chemical

Addiction?"). I am interested in these numbers not as objective truth, but as a mediated language for understanding scale. For those of us with what Haraway calls a "no-nonsense commitment to faithful accounts of a 'real' world" ("Situated Knowledges" 579), these numbers take on the critical importance of recognizing harm done. Statistics is not the only language through which to communicate the violent impact of pesticides and insecticides, and certainly is one with more than its fair share of *a priori* assumptions, but it is a mediated form that might allow us to situate the geographically widespread phenomena of chemical-agricultural use. These reports are but one method of empirical observation of phenomena to consider in imagining onto-epistemologically just futures.

In "The Great Cottonseed Industry of the South" a disturbingly celebratory history of the cottonseed oil industry published in 1911, author Luther A. Ransom attributes the possible introduction of the oil to agricultural production by Dr. Benjamin Waring in South Carolina in 1826 (15). The industry gained commercial importance in the South around 1880 (Ransom 16), with the byproducts of the refining process being utilized by various industries for soap manufacturing, mattress and pillow production, and stock feeding (Ransom 22). Ransom writes,

> "There is not an article produced by the oil mills that cannot be used in some form by the grower of the seed, and just as the values increase so will the value of seed for milling purposes be enhanced. It is not difficult, therefore, to point out the close relation existing between the cotton farmer and the cotton mills. Their interests are mutual…" (Ransom 22).

It is critical here to look at these mutual interests not just in profit, but in the structures that enabled the profit, the "cauldron" that Beckert describes of capitalism, chattel slavery, settler

colonialism, and indigenous displacement and genocide. Ransom's own description of the rise of the cottonseed oil industry, the figure of a singular "cotton farmer", leaves entirely absent the legacy of slavery.

While knowing there are tangled knots and threads that depart from cottonseed oil that I could never adequately historicize, this process is a beginning to make sense of who and what this compounding joins me with. The question is not 'what steps am I required to take?', an abstract moral obligation which is the fetish object of liberal humanism, but rather 'what am I now able to do with and among this broader kinship network?' Cottonseed oil entangles me in these histories to which I might be more accountable than if I relegate it to the realm of the passive as Medicine does. My small, hot itchy bump that begs me to ask these questions does not ensure answers, only openings upon openings through which to see whom I am in non-optional company with, as Donna Haraway articulates. This includes devastated Southern ecologies, the enslaved Africans trafficked for the increased production of cotton, the sick children of arsenic fields both human and non-human, and the Creek, Cherokee, Chickasaw, and Choctaw nations subject to terror, genocide, and containment through the stolen land of the Southeast United States.

4. BECOMING PATIENT

Dear Dr. Morrison Here it is I'm bleeding again A soft eggplant stain a rising and falling a sharp and stiff welcome from my body I'm typing a letter to you from my small work computer and the sound of the air conditioner is panting

Dear Dr. Morrison, I just wanted to reach out because something about 2 or 3 days of cramping (4 on a pain scale) here's future me opened in three holes struggling to sit up I don't want to be cut open again a year later I can't afford a blood test right now. we continue on and off for a week. surely I can hurt in all the same places as a woman and not be her I'm crossing my legs and there is work I should be doing

Dear Dr. Morrison I am still in Oakland for the next 3 weeks the man at the bus stop called me brother but I had no cash to thank him he had no idea I was doubled over with a leak I take the bus to work sitting inside myself coaxing the blood out and away I'm unfamiliar with the healthcare situation out here Last night: I wake up to a cold room and K is sleeping beside me the fan buzzes my whole torso aches I fumble for some ibuprofen and I am held in a cradle of night I think of falling asleep on the floor just for some pressure on my back I see the street light through the window flickering and my hips glow hot I am on fire and also shivering I only brought so many pairs of underwear to stain

Dear Dr. Morrison It is four months later and I am behind on my bloodwork. The bleeding has stopped. I only ache *there* on bad days. My migraines are unbearable. I have finally started losing my hair and now when I look in the mirror I see my dad. Sometimes it feels right that another Sambrook boy will slowly start to thin. Each time I get my blood drawn I think of being 8 or 9 at the doctor's office, a finger prick that raised a spreading red bead, the panic of seeing my own inside. The blood more than the sting. The suddenness of it all. I was anxious for days if I knew we had an appointment. Wouldn't eat. Eventually my mom stopped telling me in advance, just picked me up after school and started driving home in the wrong direction. I still know that feeling when I see the hospital I place a cold hand at the base of my neck and press.

Dear Dr. Engell Again my prescription has bounced. You have written my dose wrong even though I knew the state regulations would shut down a schedule II drug in this quantity. I tell you this. You say: "Let's just see." Recently I have been trying to find the words for the sort of full body throb when you do not feel my need. It's a strange thing tethering your body to mine. But we were already bound. I had a dream once where prescriptions started fluttering out of my open mouth. In the background you were saying: "It is a new system after all. This just takes time." I don't know where I was but it was all blue and white. Isn't it always? I don't tell you I have enough testosterone stockpiled to start a small pharmacy. Fear creates bizarre collections.

Dear Dr. Engell I tried your language on in my mouth. When I was 13 I'd never heard the word transexual only knew the words mutilate or die and Last week C told me me this story about the bison farm on Russell Street that isn't a bison farm any longer. They bought it when the world was at the height of the bison meat craze but eventually had to sell it because the animals started resistinging slaughter. Apparently bison can jump 6 foot fences. Bison can rip metal transport vehicles into stiff aluminum ribbons. Bison refuse the factory farming system with such ferocity that the health food market gave up. (Now it's a vegan restaurant.) I picture that feeling: a large beast tethered a wild buck against something hard a wriggling to expand I have felt the full weight of muscle in survival mostly it's the waiting it's the looking and not being seen

In this chapter I explore the question of becoming patient in its dual meanings as adjective and noun, as an affective-temporal description and as a docile subject of care. I use the language of 'becoming' rather than 'being' to call attention to the production of myself as patient - a process rather than an ontological given. In my medical records I find myself called many names I did not choose for myself -- a former legal name, *she*, female, FTM. The one I find most interesting is patient. This is not only a naming of my experience, but a relational and categorical naming, a naming that makes no sense without its implied counterpart "Doctor". Patient is a genderless, ageless, raceless object upon which the idea of a universal Medicine might act. I will read the use of the word 'patient' in my doctor's notes as the production of what Michel Foucault called the medical gaze to illustrate how this language produces a docile subject via the means of corrective training: hierarchical observation, normalizing judgment, and examination. I supplement this understanding with a Baradian framework of agential realism to read each patient/doctor encounter as a phenomena. I am interested in contextualizing my patient identity within the particular methodology used for the writing of my record, a standardized method of treatment protocol developed in the late 1960s known as the SOAP notes. I question the normalization of my doctor's categories of diagnosis, explore embodied experience of

examination, and this experience of prolonged care, of becoming affectively patient. As Andrea Long Chu observes in a review of Juliet Jacques' memoir, "Trans is a study in waiting" (Long Chu, 143).

In her poetry collection "Patient: Poems", Bettina Judd reads her own experience as a gynecological patient alongside the experiences of other Black women upon whose bodies the field of gynecology was developed, namely Anarcha Westcott, Betsey Harris, Lucy Zimmerman, Joice Heth, Saartjie Baartman, and Henrietta Lacks. By layering and enmeshing a multitude of voices, she links the historical violence of Medicine towards Black women with modern Medical treatment, locating continuing and entangled body stories. In her opening poem Judd writes, "In 2006 I had an ordeal with medicine. To recover, I learn why ghosts come to me. The research question is: Why am I patient?" (1) This dual play with the category as something to have (patience) and something to be (patient) opens as she attempts to trace the "bloodline" that entangles her with the bodies of others. Similarly, she uses "recover" both as a synonym for healing and as a project for reconstituting these body stories. The waiting, suffering, and patience required is dependent upon the production of the category patient. I draw on Bettina Judd's word play here to recognize 'patient' as a collective name for an object of Medical research, a particular framing of bodies in the apparatus of Biomedicine that situates the practitioner as the knower and the patient as the object of knowledge. Judd's final poem of the book is titled "To The Patient", a recognition that patient is a category of multiple, seemingly applicable to anyone who visits a doctor, and at the same time singular ("the"), a category of powerlessness.

The two 'patients' are etymologically bound together, emerging in the mid 14th century from the Latin *patientem* meaning "bearing, supporting, suffering, enduring, permitting". The

word patient originally meant 'one who suffers'. This English noun comes from the Latin word *patiens*, the present participle of the verb, *patior*, meaning 'I am suffering'.[16] This relationship to suffering and endurance casts the patient as a passive object, the recipient of illness' harm and doctor's cure. This production of 'patient' is articulated through what Michel Foucault names the Medical gaze.

In his book "The Birth of the Clinic", Foucault is interested in a genealogy of medical discourse, charting a shifting of the Medical gaze from the 18th to the 19th centuries. He argues that by looking at the language used to describe bodies and illness, we can find out much more about what it means to be a patient or a doctor in these particular moments. Foucault argues that it's not that we can arrive at a more true objectivity by analyzing the subjective, but that we should analyze the *a priori* assumptions that inform the objective, showing them to be subjective, contextual and historically contingent. With the medicalization of gender transition, trans subjectivity has become an object of Scientific inquiry and trans subjects have become objects of study through the creation of "patient".

Foucault developed the concept of the "medical gaze" to describe a shift in the medical profession that made it possible to separate the patient's body from the patient's person. It is in this historical moment from the 18th century to the 19th century that Medicine makes its appearance as a clinical science. He writes that this shift makes it possible "for the patient's 'bed' to become a field of scientific investigation and discourse" ("Birth of the Clinic, xv) and the patient's body an object of Scientific observation. Foucault also insists that the function of speech is not mere observational (what he calls commentary) but productive: "Is it not possible

[16] "Patient." Merriam-Webster's Learners Dictionary, *Merriam-Webster*. Accessed April 21, 2019. https://www.merriam-webster.com/dictionary/patient.

to make a structural analysis of discourses that would evade the fate of commentary by supposing no remainder, nothing in excess of what has been said, but only the fact of its historical appearance?" ("The Birth of the Clinic" xvii)

Foucault expands in his next book "The Order of Things" where he articulates his goal as not to excavate a history of ideas or even of Science, but rather "an inquiry whose aim is to rediscover on what basis knowledge and theory became possible; within what space of order knowledge was constituted; on the basis of what historical *a priori*, and in the element of what positivity, ideas could appear, sciences be established, experience be reflected in philosophies, rationalities be formed, only, perhaps, to dissolve and vanish soon afterwards." ("The Birth of the Clinic" xxiii) What Foucault names an *episteme* "defines the conditions of possibility of all knowledge, whether expressed in a theory or silently invested in a practice." ("The Order of Things" 183) In other words, it is the set of unconscious assumptions in a given epoch that make certain thoughts thinkable and certain questions askable. Science itself becomes a crucial part of the process of normalization because it produces a standard, a consensus arrived at by people who are born into an *episteme*. *Epistemes* are important to recognize in that they determine the epistemological assumptions that make possible the experiments, language, and categories of Scientists. Of critical importance to my work, the *episteme* of the 21st century during which doctor's engage with trans bodies, medicine, subjecthood, and experience determine what kinds of knowledge can be accepted or rejected as fact. It is during this same *episteme* that I request my records, write my poems, exist.

THE PROBLEM-ORIENTED MEDICAL RECORD

I now come to the question of Medical methodologies for producing the category of patient by examining the doctor's notes from my health clinic. The Subjective, Objective, Assessment and Plan (known colloquially as a SOAP note) is an acronym that represents a common method for logging symptoms and developing treatment plans. The method divides doctors notes into four categories: *Subjective* symptoms that the patient reports, *Objective* symptoms than can be observed or measured by a medical professional, a clinical *Assessment* of the needs of the patient based on the former information, and a *Plan* for treatment. This technique was developed by Dr. Larry Weed, known as the "father of the problem-oriented medical record" (Wright et. al 964) (POMR), with the goal of standardizing and structuring previously inconsistent patient charts. Weed's problem-oriented approach was first developed in 1964, gained traction in 1968 with his paper 'Medical Records that Guide and Teach' in the New England Journal of Medicine, and is now a cornerstone of medical and nursing education (Ibid. 967). In his landmark publication, Weed expresses a desire for "a more organized approach to the medical record, a more rational acceptance and use of paramedical personnel and a more positive attitude about the computer in medicine." (Weed 593) The POMR created a method for charting interactions with patients and later was responsible for the introduction of a computerized problem list. Weed developed the problem-knowledge coupler, a computer system for linking a series of symptoms to potential diagnoses. As illustrated in the following oral history charting his accomplishments, his goal was to give Medicine 'the tools of precision' that he perceived Science to have:

"As a scientist, you have a very specific project. That's your research. You work on it and work on it, and you finally get it written up. You get it published in a journal. The scientist works under a disciplined system of review and publication of his work. A physician works in a chaotic system of keeping and organizing data and has no systematic review and correction of his daily work." (Wright et. al, 964)

The development of the POMR was largely in response to medical specialization and the increasing likelihood that many doctors would be engaging with the medical record of a given patient. The design was intended to ensure that "historical data will not be based on a single encounter with anyone, and busy physicians, who represent a wide spectrum of abilities, habits of thoroughness, attitudes and levels of efficiency, will not risk important omissions." (Weed, 596) Weed created four sections to the problem-oriented medical record: 1. A database of all a patient's information 2. A complete problem list 3. Plans for treating each problem as articulated in SOAP format and 4. Daily progress notes, also organized by problem and written in the SOAP format. I am interested in the use of the SOAP format in my medical records for two reasons -- the first being its slippery delineation between Objective and Subjective patient symptoms and the second being the failure of this standardizing system to actually eliminate the experience of the clinician from the patient's record. I look to the places where this Objective / Subjective split join, create one another, collapse together, and are always inextricably linked. Subjective, from the Latin "subject-[17]" meaning 'brought under', is defined in the POMR as relating to

[17] Joy Ladin's poem "The Subject Disappears" teases this category of the subject, produced by Western liberal humanism and Science:

It's hard to make small talk
when the subject disappears. Excuse me:

have you seen my I? Have you heard
which way it's pointing, whose heels it's sniffed?

““subjective” experiences, personal views or feelings of a patient or someone close to them” (Lew and Ghassemzadeh) where the Objective category is reserved for physician collected data from the patient encounter. The only data considered to be objective are vital signs, physical exam findings, laboratory data, imaging results, or other diagnostic data. In this understanding, symptoms are the proper object of the patient while signs are the proper object of the doctor: “An example of this is a patient stating he has “stomach pain,” which is a symptom, documented under the subjective heading. Versus “abdominal tenderness to palpation,” an objective sign documented under the objective heading.” (Lew and Ghassemzadeh)

Does it buy you drinks, give you shivers,
did it turn you on last night, stumble out at dawn,

tail between its legs, identifying its repetitive desolations
with the descending scale

of a bird that moaned in the distance?
Was it clever, patient, self-reflexive,

doomed to some dim archetypal quest,
did it crash in on itself like a waterfall, has it lost its sense

of beginnings and ends, does it stretch itself
toward opposite horizons, a tragic rainbow,

whose no can only mean yes?

Ladin’s ‘subject’ begins with a polite plea to be heard, “Excuse me:”, to find what is a lost and shifting articulation of the self. The pronoun used for the “I”, her subjecthood, becomes ‘it’ -- a dehumanized object. However, Ladin refuses to leave this subject without agency. The subject “sniffs”, “points”, even “turns you on”. Her last phrase, “whose no can only mean yes?” is isolated by a line break to stand alone, juxtaposing the subject’s agency against the power denied to it. While the ‘no’ might be articulated, only a yes is heard. I am interested in applying Ruha Benjamin’s concept of informed refusal here to Ladin’s subject’s unheard “no”. Benjamin argues that in a feminist postcolonial bioethics we should reclaim informed refusal, not just informed consent. Benjamin reads the concept of refusal as integral to stories of “those who attempt to resist technoscientific conscription” (967) whom she calls *biodefectors*. She argues that *biodefectors* should not only be read as research subjects refusing the choices made available to them, critiquing what is, but also as visionaries of just futures “with a vision of what can and should be” (970). Ladin’s description of the subject whose no can only mean yes, who I read as a trans figure, aligns with Benjamin’s figure of the *biodefector*, reaching towards an ethics of a shifting, unstable, self-determined “I”. In the context of trans medical care so heavily determined by the fight *to* consent to hormones and surgery, the question of the “no” is often overlooked. One can only refuse what is presented as optional.

I turn now to a reading of my SOAP notes for their ability to produce me as 'patient' through the means of corrective training that Foucault outlines in his book "Discipline and Punish": hierarchical observation, normalizing judgment, and examination. I look at three of my medical documents, one from the first day I started hormones, the second for a physician's note to change my legal documents with Social Security, and the third for a prescription renewal after surgery.

Foucault argues that from the 18th or 19th century, Medicine transitioned from a dialogue between doctor and patient where the organizing question was 'What is the matter with you?' to the question of the 19th century, 'Where does it hurt?' (xviii) The 18th century Medicine was bound up in classification (species and classes of disease) and understood embodiment as irrelevant to the structure of the disease. Foucault also understood a shift during the 18th century to the centralization of medical knowledge as it became entangled with government thus creating "an authority for the registration and judgement of all medical activity" ("The Birth of the Clinic", 28) This transition linked the role of Medicine to the role of the state in which instead of being limited to authority on "a body of techniques for curing ills and of the knowledge that they require" the role of Medicine expanded to "embrace a knowledge of *healthy man*, that is, a study of *non-sick man* and a definition of the *model man*." ("The Birth of the Clinic", 34)

This shift from Medicine as investment in health to Medicine producing and defining normality is of great importance to the Medicine I encounter now and the methodologies of normalization I experience. This Medical turn to defining disease in the language of the "normal" and the "pathological" is the system of the problem-oriented model. The SOAP note is

the methodology by which to identify the pathological, in my case marking the pathology as my gender itself. This method doesn't allow for Subjective to exist without Objective, or for Plan to exist without Assessment. I argue that to read my experience through the SOAP notes methodology in this document means to recognize that my healthcare needs as a trans person "queer" the temporal order of diagnosis, forcing the physician to chart a patient produced plan (the final step) in the Subjective category (the first step).

Sambrook, [redacted] **N** Pt #: [redacted] DOB: [redacted] Age: 19 yrs Sex: Female
4/1/2016 1:30 PM with [redacted] NP for **PC SAME DAY**
Encounter #: A8240-52 Appointment Reason: Starting Hormone Therapy

Vitals

BP=132/84; Temp=97.9 F Oral; Pulse=84; Resp=16; Height=5 ft 3.5 in; Weight=136 lbs; BMI=23.7
Smoking Status: Never smoker
4/1/2016 1:35 pm by [redacted]

SUBJECTIVE

comes to day with request to initiate hormonal therapy. Comes with medication, syringes and needles as ordered by [redacted] of Baystate Adult Medicine. Patient states he was seen earlier and will be seeing this practice in follow up in 6 months. This is first injections and feel confident in performing.

OBJECTIVE

Medication Administration #1

Medication Administration #1

Medication Name: Testosterone Cypionate
Medication Dose: 0.3 ml
Medication Strength: 200 mg/ml
Medication Form: IM injection

Date	Lot Number	Expiration Date	Amount Administered	Route Administered	Comments	Initials
4/1/2016 2:38 PM	J-15-068	10/2017	0.3 ml	Intramuscular	right upper outer leg	sjf

ASSESSMENT

Diagnoses
Gender identity disorder in adolescence and adulthood (F64.1)

Encounter Code
Professional: ESTAB PT W/ COMPLAINT LOW COMPLEXITY (99213);

PLAN

Administer testosterone 200mg/ml 0.3ml IM weekly. Here for first dose and review of self administration. RTC for follow up as needed. Reviewed prescription with student. Signed release to obtain records from Baystate Adult medicine. Reviewed process of refilling prescription. RTC prn , plans to self administer in future.

Signed by [redacted], N.P. on 4/1/2016 3:41:46 PM

In Encounter #: AB240-52 the nurse practitioner writes, “comes to day [sic] with request to initiate hormonal therapy.” The problem-oriented medical record is not designed to manage patient requests, only patient problems. In this particular record detailing my first day on hormones, I “present” with the problem of my gender identity already “solved” -- gender dysphoria diagnosed, needles acquired, medicine in hand. The Subjective box is used instead to

narrate my affective state towards a self-administered shot, noting my confidence. I argue that this methodological approach to detailing an encounter is not intended to document an exchange, given that doctor's questions and inquiries are left absent, but rather to produce me as a patient, the object of a plan. So what happens when the patient arrives with a plan? When the assessment, a self-knowing, is conducted by the patient? Throughout this document the subject of a given statement is left absent, replaced with a verb, for example "comes to day" (who comes?) and "this is first injections [sic] and feels confident in performing" (who does?). The patient doesn't need to be named because the hierarchical unidirectionality of the medical gaze contextualizes the notes as always about the singular body of the patient. The category of Subjective, and thus the literal box on the form, always belongs to the patient and the Objective always to the doctor. The SOAP notes work in sequential order, beginning with the 'less official' knowledge of the patient, moving to the observations of the doctor, then to the assessment of the doctor, and finally to a plan. This logic presupposes that the doctor's Observations are always independent from and prior to Assessment, that the Subjective patient report is not informed by or connected to the doctor's Objective one, and that the Assessment is an objective, reproducible, codeable conclusion based exclusively on the patient's symptoms and not the doctor's positionality. The SOAP notes methodology centers symptoms and as such, any patient need that doesn't produce symptoms -- in my case, requesting to have a nurse witness me perform my own injection -- must still be documented in this format. It is the slippages and oddities that my transness produces in this forced documentation that reveal its normalizing power.

Language translates symptoms into signs of disease and thus creates the person with unique experiences into a patient with a named condition[18]. This is the production of diagnosis and description which "does not mean placing the hidden or the invisible within reach of those who have no direct access to them; what it means is to give speech to that which everyone sees without seeing—a speech that can be understood only by those initiated into true speech." ("Birth of the Clinic" 115) Here I think back to my doctor sliding my medical records across the table after refusing to transfer my documents without an in person meeting. "Our policy is to review the record with you at the time of the release," she writes over email. When I arrive to pick up the records she asks, perhaps recognizing my lack of initiation into true speech, "Do you even know how to read labs?" The language of Medicine here is the labs, a signification system like any other that is also a mediation. It is this language that is perceived to have direct access to bodies, thus rendering those who can read it more capable of "knowing" those bodies.

In a Foucaultian model, disease doesn't exist prior to its naming, but rather comes into being through the naming. The naming reduces to a single word a variety of bodily experience. In other words, a diagnosis or description comes to mean something based on a collective

[18] The job of medicine is ideally not to cure disease but to care for patients. This is in direct contrast to the medical and legal understanding of treatment as inherently tethered to diagnosis in which doctors will rarely treat symptoms without giving something a name (and now, in the era of insurance, a number too). As Sarah Nettleton explores in "I just want permission to be ill', patients who have symptoms that have "no identified organic basis" (1168) are often acribed the label "MUS" for medically unexplained symptoms, but they cannot be ascribed an insurance code which leads to patients facing extreme difficulty accessing care. Legitimacy only through quantifiable means leaves many patients without legal protection. As Joseph Dumit observes, "One must have laboratory signs in order to be suffering; one must suffer in code in order to be suffering in fact, or one does not suffer at all." (580)

agreement on what that categorization entails. International Classification of Diseases (ICD) codes are an example of this in that my embodiment has at various posts in recent historical memory been figured as transsexualism, transvestism, gender dysphoria, or in our age of insurance codes and late capitalism, ICD codes F64.0, F64.2, F64.8, or F64.9. However to invoke Barad here, it's not that we are studying the same patient and merely using different language, but that the patient itself is onto-epistemologically different, produced through new intra-acting phenomena.

In looking at the Assessment category of this document I am interested in the specific gender dysphoria diagnosis attributed to me, F64.1. The International Classification of Diseases (ICD) code F64.1 is a billable code used to specify a diagnosis of gender identity disorder in adolescence and adulthood. The temporality of a gender identity diagnosis is particularly interesting in that unlike other illnesses where a past presence of the illness has no bearing on the current state of the illness, previous history of gender non-conformity is considered relevant if not essential to the diagnosis in the present. In other words, having once had the flu doesn't make a patient's current experience of the flu any more or less true, but being a gender non-conforming child produces a more Medically authentic transexual adult. There is a specific code not only for my gender's current state (marked inconsistently as FTM, gender dysphoria, transgender, transgendered) but for inscribing this logic back into the past. It is interesting to think here with Gabrielle Owens' argument for an understanding of adolescence as a mechanism of Foucault's biopower. She sees one of the regulatory mechanisms of biopower as locating trans phenomena in the "presumably pliable stage of adolescence where state intervention appears to be developmentally natural and necessary". (22) Owens locates this fairly recent social category

of adolescence alongside the emergence of medical discourses in producing a type of person, one who needs to be protected, and as a moment that gendered *becoming* occurs. This framing thus situates adulthood as the final temporal arrival of adolescence in stable selfhood. She argues that the temporal variability and complex range of possibilities for gendered subjectivity that emerge from transness highlight "the contingency of any subjective arrival" (23). My doctor's invocation of gender dysphoria in adolescence attempts to situate gender transition, movement, instability in adolescence with the arrival of a stable, albeit trans, gender in adulthood. This presupposes not only a stable body[19] throughout time, but a stable understanding of gender as well.

Using Barad's argument that quantum physics troubles the "absolute boundary between here-now and there-then" (Diffracting Diffraction, 168), I read possibilities for the temporal multiplicities of trans experience to disrupt the linear temporal progression of the SOAP notes. Barad argues that an atom's behavior in quantum physics experiments destabilizes temporality in notions of the past as physicists discovered that an electron's categorization as a wave or particle in the course of an experiment could be determined afterwards. The experiment was an extension of the double slit experiments in which physicists attempted to observe a particle after it goes through a slit and before it hits a detector wall. Barad argues that their findings illustrate a radical reworking of the past, a fundamental destabilization of what it means to "be" in "space" or "time" : "the atom's *identity, its ontology, is never fixed, but is always open to future and past reworkings!*" (Nature's Queer Performativity, 43) Rather than seeing this experiment as erasing the past after the fact, she argues that space and time are "intra-actively produced" (Nature's

[19] Who is the boy in the pink overalls? The girl? The haircut? The time it takes to call this an exceptionally well-lived life? The tumble through the weeds and the soft damp afterwards? The She? The He? The first time a razor sliced her cheek? The last time you put both hands flat on my chest and called me into being? Who is the man holding that cold stethoscope? Who was the boy shirtless on the beach with her fists buried in the sun?

Queer Performativity, 44) together in phenomena. Barad offers a new term, spacetimemattering, to think otherwise about a stable temporal body:

> "The point is that the past was never simply there to begin with and the future is not simply what will unfold; the ''past'' and the ''future'' are iteratively reworked and enfolded through the iterative practices of spacetimemattering—including the which-slit detection and the subsequent erasure of which-slit information—all are *one phenomenon*… Space and time are phenomenal, that is, they are intra-actively produced in the making of phenomena; neither space nor time exist as determinate givens outside of phenomena." ("Meeting the Universe Halfway", 315)

Causality too fails if identity is not fixed or unchangeable. Nature, as represented in Barad's example of atoms, troubles origin stories, space, notions of linear time, and individuality. In other words, nature herself, though cast as heterosexual/natural, is anything but. She bends, slips, and intra-acts in phenomena. She is composed not of separate woven parts, but entangled intra-actions. Matter is no longer a thing, but a "doing".

This appointment, categorized as Encounter #: AB240-52, offers possibilities for thinking about this doctor/patient moment as a phenomena of already entangled bodies and apparatuses. By definition an "encounter" typically does not happen alone. For example, "I encountered myself" appears to be an oxymoron or at the very least, poetic. Where the SOAP notes format provides separate boxes for patient and doctor, verbal information and medical documentation, assessment and plan, I would like to think through this "encounter" to re-situate the multiple bodies entangled in this phenomena. This is not a project of separating out the various "pure" sources which are separate and come together in this encounter, but rather thinking of Encounter

#: AB240-52 as a phenomena where our intra-action produces my gender and the Doctor's. Writing poetically about these encounters from the perspective of patient does not study the same 'thing' (my body) in two different ways, but rather my poetic language forms a different phenomenon with my 'body' than the language of my doctor does. Even the standardizing language of the SOAP notes cannot prevent the production of new phenomena in each encounter.

Voice_Test_Almost_1_Month 5/26/16

there is a deep echo to the room and my voices bounces I remember the first shot / the night before I spend an hour tugging a balled sock around in my underwear unsure what the nurse would think of a bulge / back to the drawer / back in my pants / back to the drawer / when the time comes I pull my pants down and lean over to cover my crotch / I stay like this / an oddly contorted thing / while she pops the glass bottle out of the cardboard / the air conditioner makes an quiet hum / no amount of preparation describes the force needed for insertion / the resistance of skin / I stick the needle in fast and deep / my thigh twitches / no blood / the nurse says / *wow, you really were ready*

Through a Baradian understanding 'my body' is not naturally 'trans' or 'male' or even the same 'body' as the adolescent one described in my diagnostic code. I am produced as 'trans' in intra-action with the perceptions of my nurse practitioner, the historical moment and vocabulary of gender available to her and to me, and the logic of the SOAP note.

Sambrook, [redacted] N Pt #: [redacted] DOB: [redacted] Age: 19 yrs Sex: Female
12/14/2016 9:15 AM with [redacted] M.D. for **PC VISIT**
Encounter #: A14399-90 Appointment Reason: letter for id change

Vitals

BP=120/82 Left Arm; Temp=98.6 F Oral; Pulse=96; Resp=16
Smoking Status: Never smoker
12/14/2016 9:14 am by [redacted]

INITIAL ASSESSMENT

Chief Complaint: gender confirming identification change

SUBJECTIVE

Student here requesting a letter for Social Security Administration to change his gender officially from female to male. Student came out as a transmale prior to staring college here in the summer of 2015. He changed his name at that time to Bennett. He pursued therapy with [redacted] beginning in about January 2016 and started on testosterone prescribed by [redacted], NP at the Baystate General Medicine Practice in Springfield. He plans to seek consultation for top surgery in January. He is a resident of Vermont, but was born in Illinois. He has been working with an attorney through GLADD to help with him navigate the steps needed to change his gender and name officially. He reports that he can change the SSN first, then use that to change his driver's license. He will need a letter from a surgeon to change his birth certificate in Illinois, and then he can change his passport. He reports that he is certain of his desire to transition to the male gender. He provided me with a template that can be sued to support him in applying to SSA for such a change. We have supported him here since April, 2016 and have records from [redacted] NP.

Allergies
Reviewed by [redacted], *M.D. on 12/14/2016 4:57 PM*
NO KNOWN DRUG ALLERGY

Medications
Reviewed by [redacted], *M.D. on 12/14/2016 4:57 PM*
TESTOSTERONE INECTION

[redacted]

OBJECTIVE

Look well, presents as male.

ASSESSMENT

Transgender male who is taking step towards medical and surgical gender confirming treatment, now starting to make his official identification conform with his new gender.

Diagnoses

Gender identity disorder, unspecified (F64.9)

Encounter Code
Professional: ESTAB PT W/ COMPLAINT MOD COMPLEXITY (99214);

In this next encounter, Encounter: A14399-90, my chief complaint is listed as “gender confirming identification change”. The centralization of this encounter around the

problem-oriented model ensures that even legal gender change is always a Biomedical problem. There are a few moments of language choice that, despite trying desperately to remove my doctor from this narration, reveal the doctor as producing me as the patient. The most notable category in this encounter is the Objective section which simply reads, "Look [sic] well, presents as male." Because the Objective is the proper object of the doctor and not the patient, male is presumed to be a category that is acontextual, ahistorical, and visually observable. Is the 'looking well' dependent on the male presentation? An independent but presumably equally objective observation? 'Looking well' is a category that makes logical sense in the Objective category only if Medicine understands the doctor as a sole authority for making claims about the authenticity and healthiness of bodies. What is included in the Subjective section of my record troubles claims of Scientific Objectivity. The phrase "We have supported him here since April, 2016" is a fascinating description that is both affective and temporal. The phrase has the possibility to mean that I have been affiliated with this clinic since April 2016 or it could mean that the clinicians at the clinic have affirmed my gender identity appropriately (or colloquially "been supportive") since 2016.

It is also here that Foucault's hierarchical observation is linked with the SOAP notes' Objective category. Where power in the past controlled bodies through "confinement and enclosure - thick walls, a heavy gate that prevents entering or leaving" the new method of control came through observation marked by "the calculation of openings, of filled and empty spaces, passages and transparencies." ("Discipline and Punish" 172) While my health clinic is built for observation architecturally, unidirectional and hierarchical mechanisms for observation are also used in the form of lab work and digital healthcare technology. I am required to complete regular

labs and come for visits at the discretion of my doctor to maintain my prescription which are all documented in a digital online database. I have been asked multiple times to sign disclosure forms for my others doctors at another facility to send over my records to this health center, which I am reluctant to do. We communicate almost exclusively through electronic means. This replacement of face-to-face interaction limits access to certain healthcare networks for patients. As Maria Puig de la Bellacasa asks, "Is the reversibility of touch, its potential of consequential corelationality, of shared vulnerability, invalidated when patients cannot reach who is touching them?" (109) This possession of all labwork, doctor's notes, and Scientific records of my transition operate with the goal of instituting "a single gaze to see everything constantly. A central point would be both the source of light illuminating everything and a locus of convergence for everything that must be known: a perfect eye that nothing would escape and a center toward which all gazes would be turned." ("Discipline and Punish", 173) While I am a participant in the encounters with my doctor, any notes, poems, or art I produce on the engagement are not included within this record of observation. In contrast, the Objective category of the SOAP notes, the authenticated observation, is reserved for anything a physician can observe, palpate, or test. As the difficulty (and cost) of obtaining my own records suggest, the patient is not truly intended to have access to this methodology for hierarchical observation called our medical record.

The tangling of the Biomedical and legal affirmation of my gender identity is also a critical component of this document. In order to change the gender on my Social Security card, I was required to obtain "Medical certification of appropriate clinical treatment for gender transition in the form of an original letter from a licensed physician." (Personal medical records,

September 2018) Foucault theorizes that beginning in the 1600s the fields of Science are being used to arrive at a rational ideal of what it is to be a human being and thus become the authority on bodily truth. The field of Medicine is a critical part of the social structures that normalizes thought and is relied upon to produce a definition of "appropriate clinical treatment" based on *a priori* Biomedical understandings of "gender" and "transition". My writing about my gender produces a body of poetic work, a therapeutic intervention, a consciousness raising. My doctor's writing about my gender legally verifies a different body. Only one of our writings holds institutionalized epistemological weight.

Sambrook, Bennett Nicola Holton Pt #: [redacted] DOB: [redacted] Age: 20 yrs Sex: Female
9/26/2017 10:00 AM with [redacted] NP for **PC VISIT**
Encounter #: A19937-74 Appointment Reason: Follow up

Vitals

BP= ⚠ 122/94 Left Arm; Temp=97.5 F Oral; Pulse=92; Resp=16; Height=5 ft 2.75 in; Weight=137.6 lbs; BMI=24.6
LMP: 05/20/2016
Smoking Status: Never smoker
9/26/2017 10:03 am by [redacted]

SUBJECTIVE

comes today for check in for the fall Had top surgery in May 2017 which went very well, is pleased with results and has fully recovered with full range of motion. continues with testosterone cypionate 200mg/ml 0.3 ml subq weekly. pleased with physical change in facial hair, voice, muscle development. Last labs done in April here at HC, see results. Continues in counseling off campus. needs renewal of testosterone prescription, next dose is 9/29/17. Does not need needles of gauges at this time. uses 18 g x 1in to draw and 25 gauge x 5/8 in to inject. Prefers 10 ml vial if available.

Allergies
Reviewed by [redacted], *NP on 9/26/2017 9:15 PM*
NO KNOWN DRUG ALLERGY

Medications
Reviewed by [redacted], *NP on 9/26/2017 9:12 PM*
TESTOSTERONE INECTION

Problem List/History

Problem List
Transgender FtM

OBJECTIVE

happy, talkative increased facial hair on upper lip, chin, increased upper body size of neck , upper arms and chest. Wt stable

Physical Exam

GENERAL:
well-nourished, well-appearing, and in no acute distress

ASSESSMENT

Diagnoses
Gender identity disorder, unspecified (F64.9)

Encounter Code
Professional: NEW PT W/ COMPLAINT LOW COMPLEXITY (99203)

PLAN

Defer labs until Nov 2017. send printed script to CVS in Northamptan per pat request.

Orders

MEDICATION ORDERS
TESTOSTERONE CYPIONATE 200 MG/ML INTRAMUSCULAR SOLUTION; 0.3 ML SUBQ WEEKLY; QTY 1 MILLILITER;

For Foucault, the examination is the process by which "formalization of the individual within power relations" (190) occurs. The examination, through formalizing the body of the patient in a Medical system of language, produces me as an object known as "patient". The

examination subjugates my experience into a discrete, knowable figure, forcing me to articulate my own experience through the lens of the knowledge it has acquired. This methodology operates, as Foucault articulates, to make every individual a 'case' through its documentary techniques. The patient, now as the object of physician descriptions, undergoes examination "as the fixing, at once ritual and 'scientific', of individual differences, as the pinning down of each individual in his own particularity" (192). It is here I argue that this system of healthcare rests on the examination and thus, healthcare is always also an opportunity for control. However by reading the way my trans embodiment enables gaps and slippages in my SOAP notes, this provides an opportunity for resisting the notion that these mechanisms of power observe without being observed, or produce without being produced. I read Barad's notion of agential realism as a useful tool for push back on "the fixing" mechanism of the examination. Barad draws on Danish physicist Niels Bohr's ontological conclusions in his study of particles to craft an agential realist account of matter. Barad is interested in Bohr's work as it reveals that the object of study (the particles) were never a fixed, ontologically distinct thing, but rather changed formation in relation to the process of knowing (the apparatus through which they were observed). In other words, there is an inherent indeterminacy of object and apparatus, always an inseparability of their relation. Barad writes:

"Apparatuses are not inscription devices, scientific instruments set in place before the action happens, or machines that mediate the dialectic of resistance and accommodation. They are neither neutral probes of the natural world nor structures that deterministically impose some particular outcome. In my further elaboration of Bohr's insights, apparatuses are not mere static arrangements in the world, but rather, apparatuses are dynamic (re)configurings of the world, specific agential

practices/intra-actions/performances through which specific exclusionary boundaries are enacted." ("Posthuman Performativity", 134)

The methods by which one comes to know any object (the tools of measurement, conceptual tools, environment of measuring, the scientist or doctor themselves) are implicated in the very ontology of the thing being observed. I am interested in this important cornerstone of agential realism in that it refuses the split between doctor and patient that the SOAP notes rely upon. In this way, my doctors, are also constructed through our intra-actions -- they themselves are made intelligible as doctors/knowers/clinicians through the knowledge-making of my transition.

5. CONCLUSION

Movie on 5-4-16 at 1.24 AM

I remember a warm June day / wet grass / tilting my neck back into the sun / looking for an angle where the light could catch / this tiny field of new hairs / raised and coarse

Movie on 5-26-16 at 10.56 PM

This month / I shower and shave often, thrilled by the sting of a razor / sit down on the floor of the shower to touch forehead to knee / I leave the water running until the mirror fogs / I like to see myself distorted / skin and steam and eucalyptus shampoo / I return to my bed: a cup of chamomile tea still warm, a tiny syringe already filled / engulfed in blanket

Movie on 8-31-16 at 12.19PM

round baby cheeks baby fat face, now
comfortable tummy the
halfway month or it's
water weight it's 5 months and my falsetto just broke
I think I'm going to shave my head
Come January

I bought a dick online and
I think I had an accident
every single time
I remember:
Naked before a shower, holding the soft silicone to myself trying to pee. I crouched slightly, widened my stance. This was it, a steady stream. Then feeling

warm and wet
down my shin

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