CONTRIBUTORS

ABIGAIL B. BAKAN
JOSEPHINE BAKER
ANIQUE ELLIS
ALOYS FLEISCHMANN
VANESSA GREAVES
RACHEL ALPHA JOHNSTON HURST
DAZE JEFFERIES
REISA KLEIN
HON LEONG
SALLY LOUGHRIDGE
RACHAEL PACK
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REIMAGING BREASTS

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Front Cover Image: Sally Loughridge, "My Terrain." Copyright 2012 American Cancer Society, Inc.
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EROTIC. MATERNAL. CULTURAL. SYMBOLIC. MEDICAL. WHAT ARE BREASTS? HOW ARE THEY IMAGINED? AND WHO GETS TO DECIDE?

REISA KLEIN, GABRIELLE M. SIEGERS AND DOROTHY WOODMAN

The three of us, each in our own way, have varied and long term relationships with breasts. Growing up, we have experienced years of watching our own bodies change before our very eyes, often mediated through the male gaze. And that changing terrain that we call our body-self continues to shift and alter, as reproduction, aging, and—for one of us—breast cancer leave their marks. Through their presence or absence, breasts are largely visual, even more so through their objectification and fragmentation in media representations and advertisements as well as medical imagery and cosmetic procedures, reconstructions, and prostheses. These visual "imagings" of our ever-changing breasts, along with their inherent fluidity and textures, prompted us to begin ongoing conversations that are occurring across a number of disciplines, including humanities, social sciences, and the arts, but also biology, oncology and medicine.

Breast imaging in medicine has shaped how we understand these material objects as self-evident. At the microscopic level, the medical gaze concentrates on breast tissue as a form of synecdoche. Such medical imaging informs surgeons as to the location of breast tumour tissues to be removed, and radiologists as to where to direct radiotherapy, either to debulk tumours prior to surgery, or to eradicate potential remaining malignant cells after removal of the primary tumour. These procedures suggest that breasts are contingent upon how they are framed through medical techniques. Biopsies, small pieces of tumour removed with a needle, prior to surgery and/or tumour tissue removed during surgery are sent to the pathology lab, where they are processed, stained, and undergo assessment by a pathologist to determine characteristics of the tumour, such as stage and type, that inform further patient treatment. The whole is contained within the part; the breast's narrative is relayed through its cells.

From a scientific perspective, imaging provides an invaluable tool to monitor breasts over time and detect pathological changes that could lead to a cancer diagnosis. Mammography (low-dose x-ray) is a standard imaging technique used for routine screening, which is somewhat controversial (Bleyer et al.; Coldman et al.; Helvie and Bevers; Nagler et al.). Ultrasound, computerized axial tomography (CT or CAT), magnetic resonance imaging (MRI), or Positron Emission Tomography (PET) may also be employed to support diagnostic and treatment decisions. If breast cancer is diagnosed at a later stage, bone scans, X-rays, CT, or PET imaging may be used to detect metastases, tumours that may have formed in other areas of the body, such as bones, brain, lungs, and liver. Thus, multiple imaging modalities are used together in the diagnosis, treatment, and follow-up monitoring of breast cancer patients.

While these visual tools are widely employed as per guidelines set out by provincial and national organizations, their use is not without controversy and discussion, as benefits and risks should be considered in each individual case. For example, some research suggests that widespread mammography screening has no impact on breast cancer patient mortality (Bleyer et al.), whereas other research shows that early detection enabled by mammography is saving women's lives (Coldman et al.; Helvie and Bevers). Of course, the potential harm due to radiation exposure must be weighed against the benefits of early detection. False positive and false negative interpretations of imaging bring their own layers of anxiety that are detrimental to health. Yet, by and large, the benefits of these medical imaging techniques are thought to far outweigh any associated risks. As such, even medical imaging does not necessarily provide a value-free or neutral understanding of the breast, but is co-constituted by social, cultural, economic, and political influences. The process is thus both diagnostic and aesthetic; breasts are thereby reimaged. From local biopsies, we then turn to cross-species experimentation. The latter process is explained, with examples of histological analysis, in the article "Imaging Human Breast Tumours in Different Species: How Human are They?" by Gabrielle M. Siegers et al. in this issue.

Turning from the microscopy of the medical gaze to the macroscopy of cultural analysis, we find discussions about breasts as symbols and sites of asymmetrical power. A representative survey of this field includes historical studies, cultural critique, and intersectional feminist and queer interventions. Marilyn Yalom, in her survey of Western Europe and North America's history of breasts, has situated the varieties of investments in the representation of breasts and their functions as means for the surveillance and discipline of women's bodies for large scale political, religious, and sexist purposes (Yalom). Barbara Ehrenreich has engaged with her experiences of breast cancer to investigate and expose the corporate, political, biomedical, and gendered agendas with which breast cancer patients and "survivors" are burdened ("Smile or Die"; "Welcome to Cancerland"). And others, such as Audre Lorde, have provided groundbreaking reflections, often through their own experiences of breast cancer, on the intersectional forces that operate to oppress queer women of color and pressure "survivors" to conform to normative feminine and healthy bodies (Lorde).

The field of discussion is by no means homogeneous. Diane Herndl revisits Lorde's arguments and proposes a somewhat different, posthumanist approach for determining whether to reconstruct (or reimage) the breast (Herndl). Considering cultural forces more generally that influence women's understandings about their breasts and experiences of breast cancer, Samantha King takes a panoramic view of the pink culture driving philanthropic interests closely tied to corporate interests (King). Queer theory also informs new conceptualizations about breasts. Kim Hall asks us to consider the assumptions underlying claims that a breast is truly female and how queer-breasted experiences offer important counter-imaginings (Hall). Trevor Mac-

Donald provides important reflections and reimagings of breasts/chests by transmen who have given birth and how they make decisions about lactation (MacDonald).

As we met together to conceptualise this project, we wanted to build on these productive and sometimes competing perspectives by bringing new understandings and visual imaginings to the table. We were looking for new ways forward that could not only break through the conventional binaries of gendered, racist, heteronormative, colonial, and neoliberal tropes, but would also experiment with conceptual innovations. In short, in *reimaging breasts*, we want to explore resistant and subversive voices and images where breasts are not just enclosed biological body parts, but where they are complex "assemblages" that are co-constituted by materialities and discourses (on assemblage, see Braidotti; Grosz; Deleuze and Guattari; Puar). These diverse biological, biomedical, socio-cultural, and politico-economic interactions refigure the boundaried imagings of the breast, one example being the use of breast tissue for penile reconstruction (Safak), another the use of abdominal tissue in TRAM flap breast reconstruction ("TRAM Flap Reconstruction"). Representations of breasts as landscapes, for example, in Lorde's cancer journals, Sally Loughridge's piece in this issue, or the imaging of breasts through their haunting absence in Hollis Sigler's art, are only a few examples of how breasts are being reimaged (Lorde; Sigler). By engaging with the tissued, leaky, and plastic (Shildrick), our approach considers new implications for the breast as rhizomatic, emphasizing relations and movements, rather than stabilizing tropes of gender, sex, body, and identity. Unlike the legacy of the phallus, where its essentialist signification, logics, and grammars constrain by their necessary creation of the "Other," the breast's capaciousness offers multiple absences and presences that mobilize bodies, discourses, and spaces as assemblages and tactics.

In contemporary cultures, across borders and territories, breasts are increasingly "popping up" physically and culturally in new places: as inflatables atop buildings ("Giant Breast") and bobbing in canals (Stake), as architectural innovations (Versteeg) and mis-renderings in anatomical representations (e.g., images of milk ducts; see Dean), images circulating on social media (Hocking), and art created with/by "boobs" (Kirkova). We look to popular culture's emergent "play" with breasts as new bodily displays of protest. Building on these new re-imaginings, this special issue initiates a fluid and re-productive space for reimaging and milky writing (Cixous) in which those who read some or all of this journal could traverse and generate new conversations. Like milk-ducts and the expansive unbordered territory of the breast, this journal was envisioned as a rhizome—a proliferating, non-linear assemblage that, in its best form, would extend its life-force beyond even the infinities of the web. We are thrilled to use the electronic journal platform for this—its rhizomatic relationship to other diverse conversations and its accessibility to diverse readers create an ideal environment for this project.

In this edition, you will find paintings, photographs, medical imaging, poetry, personal and analytical essays, and even podcasts. They are all, in the spirit of the rhizome, connected within the perimeters of the journal genre, and free-floating enough to reach beyond it. They invite multi-sensory experiences as vital components of critical thinking and reflection. We welcome you to dip into the journal, in whole or in parts, and to let these contributors take you back into your own bodies, experiences, and selves, and consider how the archive of bodily experiences, dreams, affects, intellects and technologies can restructure the very paradigmatic foundation upon which these are understood and processed over time. This work may extend into the larger contexts in which you labour, reproduce, create, and engage as citizens during this time of crisis, calling us to reimage our place within and among all that are part of a global community.

Contributors have brought creativity to this discussion in diverse ways. In the abstract for "Seawater/C-cup: Fishy Trans Embodiments and Geographies of Sex Work in Newfoundland," Daze Jefferies eloquently writes:

> I think with my augmented breasts—beyond the medical archive and away from the clinic—as an embodied inquiry into trans geographies of sex work in the island world of

> Ktaqamkuk/Newfoundland, Canada. Employing the felt knowledges of my breasts in visuals and poetics, I illustrate fishy entanglements shared between my sex work and breast augmentation that have reframed my social and sexual embodiment. Engaging with my breasts as a contact zone of embodied dis/pleasure, economic promise, and social violence, I suggest that paying creative attention to trans women's breasts might reimage notions of trans sex-working desire.

These words exemplify this edition's larger project: to engage diverse experiences and relationships, images and language, so as to dissemble the constraints of representation and reflection (in all their forms) in the neoliberal and Cartesian hegemonies that continue to hold us hostage to outmoded, harmful, and moribund praxis.

Anique Ellis and Josephine Baker's collaborative poetic prose "Reclaiming Breast" startles us from the outset. We wonder: why the singular? We take out our red pen to correct. In so doing, we become the auditor addressed by the poem—we are implicated in the politics it names and resists. This disruption of grammarly expectations strikes at the heart of the hegemonic modes of representation and thinking about women's bodies. It disables the ideological signifier. Breast must always be pluralized—to say otherwise is to deviate from accepted practices. The poem continues to veer between plural and singular, inviting the grammatical disruptions that punctuate the poem throughout. The struggle to speak is to resist the ideological grammars that coerce representation of words and ideas, of breast itself, and in so doing, to disrupt oppressive cultural and social grammars that discipline the body: "My breast does not define me, so don't define my value, femininity, or worth with my breast."

In "Going Flat: Breast Cancer, Mastectomy and the Politics of Choice," Abigail Bakan examines her own personal journey of "going flat" as an alternative to breast reconstruction. She challenges the paternalistic biomedical push for breast conservation where breast cancer is (re)affirmed as a loss, a lack and an absence. Through a new collectivity of women choosing to "go flat" Bakan advocates for a politics of choice and a reimagining of surgical options following surgical treatments for breast cancer that foregrounds women's rights and bodily autonomy.

In "Revealing Narratives in Before and After Photographs of Cosmetic Breast Surgeries," Rachel Hurst breathes life into otherwise "unremarkable" images of pre- and post-surgical cases, deriving unexpected layers of meaning from the photographs by binding them to real-life stories of women who have undergone plastic surgeries. In short, Hurst reimages these images and reconnects the de-individualized torsos to women who have been in their place, filling in some of the gaps by shedding light on what is—by design—hidden from the intended narrative embodied by such photographs.

Vanessa Greaves's stunning torso sculpture "Broken" challenges us to contemplate the implications surrounding a missing breast. Defiant in its beauty and solidity, this piece encourages us to focus on and appreciate what is present as opposed to what is absent, yet acknowledges the inner struggle women face when coming to terms with their altered self after mastectomy.

Sally Loughridge's artwork and reflections in "Rad Art: A Journey Through Radiation Treatment" offer remarkable paintings of breasts as landscapes accompanied by brief reflective statements as she contemplates her experiences of breast cancer through image and text. She writes in her opening reflection: "I had always thought of my breasts as a matched pair. But since I received a diagnosis of breast cancer, they have become distinctly individual. I am anxious about starting radiation, and I feel protective of my right breast—in a familiar, motherly way." Playing with old tropes in new ways, Loughridge expresses the incommensurability of her experiences, opening up vistas for expansive reimagings.

In "Running for the Future," Rachael Pack considers images used for the Canadian Breast Cancer Foundation's 2013 Run for the Future fundraising campaign, revealing unexpected messaging projected from images of children taking steps to create a better future without breast cancer. Pack is compelling and articulate, arguing that the "queering of time" employed by the fundraising campaign conveys a sense of duty on Canadians to take steps to protect heterosexual nuclear families of the future. Pack's surprising analysis will certainly stimulate interesting discussions with respect to ethics, communication, feminism, politics, and intersectionality.

In "Imaging Human Breast Tumours in Different Species: How Human are They?," Siegers et al. consider in a *gedankenexperiment* the philosophical question of whether implanted human breast tissue can still be considered human once it is growing within another species, and show striking images of such hybrid entities. While enlightening readers about aspects of scientific research, this piece discussing implantation of human tissue into other living species raises questions about borders and categories in numerous ways, most importantly for this issue, concerning where breasts begin and end, or if they do at all.

Dorothy Woodman and Aloys Fleischmann's haunting "Still Life" also asks the audience to consider where the body begins and ends. Their unique collaboration results in art that incorporates multiple perspectives simultaneously. The public/private movement and display of the prosthesis invites opportunities for his, as well as her, experience, challenging ideas of fixed subjects and objects. As the prosthesis both stands in for a body part and is incorporated into a painterly photograph and still life, the binaries are blurred in ways that create new arrangements and discourses that set the stage for a new breast politics.

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SEAWATER/C-CUP: FISHY TRANS EMBODIMENTS AND GEOGRAPHIES OF SEX WORK IN NEWFOUNDLAND

DAZE JEFFERIES

Abstract: *In this work of autoethnographic research-creation, I think with my augmented breasts—beyond the medical archive and away from the clinic—as an embodied inquiry into trans geographies of sex work in the island world of Ktaqamkuk/Newfoundland, Canada. Employing the felt knowledges of my breasts in visuals and poetics, I illustrate fishy entanglements shared between my sex work and breast augmentation that have reframed my social and sexual embodiment. Engaging with my breasts as a contact zone of embodied dis/pleasure, economic promise, and social violence, I suggest that paying creative attention to trans women's breasts might reimage notions of trans sex-working desire.*

Resume *: Dans ce travail de recherche et de création autoethnographique, je pense avec mes seins élargis—au-delà de l'aspect médical et clinique—comme dans une enquête incarnée sur les transgéographies du travail du sexe dans le monde insulaire de Ktaqamkuk, à Terrre-Neuve au Canada. Utilisant visuellement et poétiquement les expériences tactiles de mes seins, j'illustre les relations complexes qui se sont établies entre mon travail sexuel et l'augmentation de mes seins qui ont transformé mon incarnation sociale et sexuelle. Examinant mes seins comme une zone de contact entre le dé/plaisir corporel, l'espoir de gain économique et la violence sociale, j'avance qu'un intérêt créatif pour les seins des femmes trans pourrait créer une nouvelle image des notions de désir dans le travail sexuel des trans.*

INTRODUCTION

Dry-swallowing preciously mint-scented turquoise and peach cream pills, the growth of my breasts began in late 2014. One morning, two weeks into hormone replacement therapy (HRT) with estrogen, I squeezed my right nipple and a milky clear substance (pathologized as galactorrhea) shot out for the first time. More exciting than alarming, this experience symbolized the female leaking out of me. Over the next few months, while new kinds of tingles and feelings figured into my embodiment as a young trans woman, my body began to shift. Textures of my coarse skin, hair, and nails became thinner and softer while breast buds pushed through. Fleshy interactions and sensuous engagements with the environments around me grew out of my chest. All my growing pains became corporeal guides through sex change and the nippy island weather systems of Ktaqamkuk/Newfoundland, Canada.[1]

As I moved further away from an embodiment that could be read as male, my medical transition became intimately connected to my experience as a sex worker. Many of my Johns would inquire about my interest in surgeries: breast, facial, and genital. While some of them sought my companionship for a one-time fling and realized that I could not yet provide the ultimately troubled transsexual fantasy they desired, recurring clients would remark about the beauty of my "transformation" as my face softened and my breasts began to round out with each passing month. These clients formed two kinds of affinity with my breasts: while a number of them loved my A-cup boobs, and preferred small and perky tits over a large and pillowy bosom, the rest had shown excitement at the idea of fondling big, soft breasts on my body. I too had a complicated relationship with my breasts. Eight months into my medical transition, as my fishy social body became increasingly read as female, a lack of boobs that were big enough to balance out my physical frame triggered a growing experience of dysphoria with my chest. In my longing for gender pleasure, and in the realization that breast implants would also be an investment into the unknown timeline of my future as a sex worker, I knew that I desired breast augmentation.

After consulting with a physician in late 2015 about my needs for top surgery, a single plastic surgeon in Newfoundland and Labrador (NL) welcomed me as a patient without hesitation. A year and a half into my medical transition, while balancing my undergraduate studies, creative practice, and survival sex work, I had saved enough money for breast implants. In July 2016, two months before I started grad school, my $8,000 augmentation mammaplasty was performed at the Health Sciences Centre in the capital city of St. John's. My first surgery of any kind, it signified a major step in my transsexual body project, but I had absolutely no idea what to expect. A fish out of water, I didn't know any other trans women islanders who were able to access top surgery. The only critical knowledge that I could find about trans breast augmentation came from documentary YouTube vlogs of both pre- and post-operative surgical bodies, as well as from discouraging articles within the medical archive.

While feminist scholars have used qualitative research to explore issues of desire in trans women's sexual, surgical, and social embodiments (Bauer and Hammond 6; Vartabedian 58), there is a significant gap in the qualitative literature regarding trans women's breasts. For several decades, our breasts have been objected to primary study by clinicians and medical researchers in order to illustrate a variety of complications (Kanhai et al. 480; Pritchard et al. 2278). From conditions of breast cancer to skin necrosis to symmastia (breast confluence at the middle of the chest as a result of implant displacement), the study of trans women's breasts within the clinic has warned both patients and physicians to be forethoughtful of uncertain risks associated with hormones and surgery. While this body of scholarship draws attention to very real exceptional outcomes of breast augmentation, and it demonstrates the importance of grappling with medical risk, I am unsettled by the way it dangerously frames trans women's desires. Recognizing how trans women's bodies have been grossly objectified and inappropriately examined—with our desires made invisible—in much academic inquiry (Namaste, *Invisible Lives* 1), I argue that there is a critical need for creative and heartful figurations of trans women's breasts beyond the clinical theatre (Ross 74).

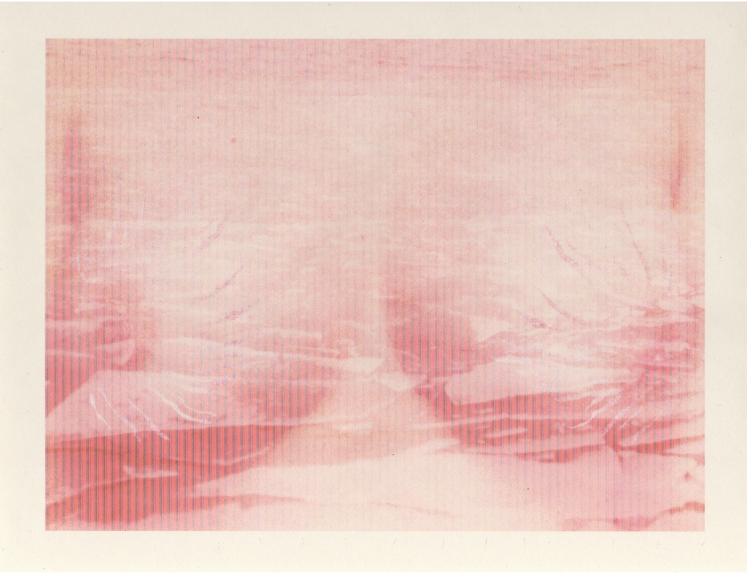

Fig 1. Some Numb (digital photography and illustration printed with distorted ink on recycled paper). 2019.

Using creative methods of inquiry (research-creation) to explore the breasted embodiments of trans women's lives is one way toward such an artful transsomatechnics (Stryker 38; Sullivan 283). Following the curious interest of medical professionals to study the effects of breast augmentation upon trans women's "work and artistic production" (Weigert et al. 1429), this essay furthers intellectual conversations about the use of creative practices to situate trans women's embodiments within social and geographic environments (Arsenault 66; Plett 221; Ross and Karbusicky, *Tremblement de Chair*). In the next section, I briefly outline the current medico-legal landscape of trans care in NL to illustrate how trans women's access to coverage for breast augmentation is made troublesome by medical policy. Calling attention to my sex work as a domain that made accessing top surgery possible on my own terms, which in turn fundamentally changed my social embodiment and marketability as a trans escort, I suggest that trans women's breasts must be imagined otherwise. Within the context of a rural island geography, I ask: How might creatively working with breasts, beyond the medical archive and away from the clinic, be one way of doing transsomatechnics in Newfoundland? How might breasts be central to trans matters in this place?

From letters written to MHAs (Members of the House of Assembly), calling for the accessible coverage of transition-related surgeries (TRS), to protests at Trans Marches to sex-working ads to a range of life writing, visuals, and performance art—embodiments and figurations of the breast have been used by trans women, trans men, and non-binary Newfoundlanders to negotiate with our body projects and politics for a number of years.[2] For example, in my piece, *Some Numb* (Fig. 1), layering my bosom upon pans of harboured sea ice is a way to map the titillation of my incredibly sensitive post-operative breasts within Newfoundland's difficult climate and island geographies (an assemblage of sensuous socio-spatial relations). Guided by trans scholar Viviane Namaste's ways of producing trans knowledges beyond the medical archive, I think with my breasts as an inquiry into trans fishy embodiments and geographies of sex work in Newfoundland (Namaste, *Oversight* 43). Using visuals and poetics, I begin to creatively map how my breasts have reframed both my marketability as a sex worker and my social embodiment as I navigate through this island world. Engaging with my breasts as a contact zone of embodied dis/pleasure, economic promise, and social violence, I suggest that paying creative attention to trans women's breasts might reimage notions of trans sex-working desire.

GEOGRAPHIES OF TRANS CARE IN NEWFOUNDLAND AND LABRADOR

While trans people in NL have been able to access HRT with informed consent for over a decade, and we have recently gained increased access to affirming gender markers on medico-legal documents, until a short while ago we have been stuck in the only Canadian region to still require an out-of-province assessment for transition-related surgeries (TRS). Before late 2019, in order to access surgical care funded by the NL government, trans patients were first required to obtain a referral for surgery at the CAMH (Centre for Addictions and Mental Health, formerly the Clarke Institute of Psychiatry) Adult Gender Identity Clinic in Tkaronto/Toronto, Ontario. An arena of erasure, gatekeeping, and negligence in which trans bodies are selectively authorized to access care, this clinic has been critiqued by trans activists and community members across Canada (Namaste, *Invisible Lives* 190). Actively seeking to avoid the drama of this clinic, many trans folks in NL have chosen to fund surgeries with our own labour, on our own terms. At the same time, community members and our allied physicians have continued to push for accessible trans care, and the result is a changing landscape of TRS that are eligible for provincial coverage. While breast augmentation has long been mis/understood as a cosmetic surgical practice, as of early 2019, it now qualifies as an insured procedure for transfeminine patients under NL's Medical Care Plan (MCP), but only when there is breast aplasia (non-development of breast tissue) after 18 months of HRT. This means that most trans women who desire breast augmentation will not be eligible candidates for surgery if the slightest bit of breast tissue exists.

How might physicians measure breast aplasia differently across the diversity of trans bodies? What doctors are willing to challenge this criterion as an act of transmisogyny? While I know many trans women islanders who desire augmented breasts, and a handful of local girls who are funding their own surgeries, the possibilities of accessing coverage for breast augmentation are made troublesome by the work of erasure in medical policy that does not recognize top surgery for trans women as a more-than-cosmetic encounter. According to many trans women islanders, who are not sex workers and who do not have the income of an independent trans escort, this added coverage as it currently exists was a failed victory from the start. My social position as a highly desired sex worker made accessing breast augmentation a quick possibility at the age of 21. While often pushing me into a network of fetishization, secret desire, and disembodiment as a trans escort in a small city, the labour of my sex work has been an economic safety net within which I have been complexly tangled. In the context of my life outside CAMH's clinical theatre, as a way to better understand "the value of not assuming that official narratives of our clinical history tell the whole story, or real story" of trans women's lives and embodiments, I observe the relationship between my breast augmentation and sex work as a way of navigating through NL's messy medico-legal institutions (Namaste, *Oversight* 43).

Fig 2. A Hundred Hands All Over (digital photography and illustration printed with distorted ink on recycled paper). 2019.

Following works in transsomatechnics that refuse colonial logics of gender to imagine trans embodiment otherwise (Benaway 113; cárdenas 52), this essay illustrates the significance of creative academic inquiry into trans women's breasts. If trans women's top surgeries are to be understood as embodied processes toward improved qualities of life, as well as acts of creative transfiguration (Ashley and Ells 24), activists and physicians in NL must continue to challenge the ethics and medical discourse of augmentation mammaplasty as an unnecessary cosmetic procedure. Simultaneously, we must also recognize a series of fleshy, material, and social complications that can take form through breast augmentation. The second half of this essay grapples with some of these troubles by asking: How are pleasure, risk, sex, and violence complexly mapped upon trans women's social bodies by way of un/bearing breasts? Outside of the clinical theatre, and the genital-centric model of trans surgical care (Spade 324), what might become of trans women's breasts? Thinking with these questions, I creatively map a flux of fishy relations (disembodiment, microaggressions, and objectification) that have materialized through my breast augmentation in order to complicate the spatial politics of trans women's surgical bodies.

FISHY FELT KNOWLEDGES OF BREAST AUGMENTATION

The visuals and poetics that guide my felt knowledges have been formed in relation with the larger conceptual framework of my current research-creation that I call *feeling fishy* (for more on felt knowledges, see Million; Springgay; Tremblay; Vaccaro). A dynamic point of encounter between trans embodiment, queer ephemerality, and Atlantic ecology, feeling fishy materializes in my work as a creative and critical mapping of the ways that trans women's lives in Newfoundland are entangled with the island's oceanic geographies (Jefferies, "Myths" 21). Informed by histories of the term *fish* in communities of trans women across Turtle Island—queerly endearing vernacular that emerged in the 1970s as a way to symbolize the different market niches of cis and trans women's sex-working bodies—feeling fishy, in this essay, represents a slippery embodiment toward livable futures (Ridley 483). Following Black trans scholar Dora Santana, whose transatlantic poetics flow between body, water, and energy, and for whom "water is the embodiment of trans orientation," feeling fishy is a way of coming to terms with a disembodiment that is in constant flux both at and in the hands of others (Santana 183).

“Fishy … That’s something we say amongst ourselves … It means she looks real … Two perfectly shaped D-cup breasts on a tiny frame. God damn it, bitch. Those are fishy,” articulates trans artist Nina Arsenault in her autobiographical production, *The Silicone Diaries* (212-13). In my reading of this quote, feeling fishy speaks to the divine artfulness of many trans women’s body projects. Both iconicized and made abject over her surgical transfiguration, Arsenault’s work offers insight into the effects of surgery upon her social body. In her article, *A Manifesto of Living Self-portraiture*, she describes the slippery complexities of sex work, surgery, and sociality upon the temporalities of her embodiment. She says: “Because I was personifying new social and sexual roles, people treated me accordingly. This quickly and radically altered my relationships to others and my environment—power, privilege, oppression” (66). Arsenault’s lived experience illustrates the coexisting disposability and desirability of trans women’s bodies that shift with and across the spaces we inhabit. Feeling fishy, then, is also about queer displacement. Recognizing the different spatial relations of my breasted embodiment, one that is desired and objectified by Johns within the privacy of the home, and my social body, one that is often made spectacle and disposable by strangers in public space, I understand how my breasts continue to frame my fishy social location as a young trans woman islander.

Over the past three years, in the act of moving through public space in St. John’s, my breasted embodiment has been subject to an array of social violence, including harassment and catcalling, transmisogynistic slurs, looks and expressions of disgust, as well as non-consensual touches from strangers. Frequently objectified by others, my large and perky breasts have facilitated gross harassment from men and continuous shaming from women, specifically in moments of uncontrollable nipple show-through. I generally find this ignorant behaviour more illuminating than disorienting because it offers insight into the workings of transmisogyny in social space. However, the unwarranted stares, scoffs, winks, whistles, and comments each shape a troubled relationship with the augmented breasts that I could not imagine becoming anything more than gender-affirming as a young transsexual. Although I am often able to ignore the weight of these environmental microaggressions, the most challenging part of moving through St. John's as a trans woman with visibly augmented breasts is encountering the smug misgendering and the intentional erasure of my womanhood by strangers, primarily other women (I am left to wonder why). At the beginning of my medical transition, I had no way of knowing how much social violence would be directed at me simply by embodying trans womanhood with breast implants. Taken together as ongoing challenges that I continue to experience as I move through social space, these forms of ignorance influence the difficult temporalities of my breasted embodiment.

At the same time, as one of the few local trans women escorts in St. John's, whose current body project aligns with the archetype of erotic transsexual desire for many male clients, my bosom has ushered me into a new economic milieu. For Johns who specifically and only desire a trans partner with soft curves and big breasts, my body is a market niche. As these men fondle my chest and suckle my nipples, the phantasies of their trans-amorous desire corporealize in the act of synchronously touching my breasts and genitals. For a large number of these clients, whose hegemonic masculinities prevent them from thinking critically about their desires to share touching encounters with trans women, or from doing the work of opening up to the beautiful diversity of transfeminine embodiments, my breasts become erotic spectacles and the most significant markers of my womanhood. Read side by side, these brief experiences of disposability and desirability illustrate how, for both social strangers and sexual clients, the imagined geography of my body is fishy in different ways. As my augmented breasts incite violence from strangers in public space, and become spectacle to my clients in the privacy of our encounters, feeling fishy is a form of knowledge that comes to me like a slow berth,

> washing over
> jelly-like jiggles
> of more-than-skin
> and nipples suckled

by hundreds of men
whose
oil-stained hands
cling to my chest
as if they might drown
in the fiction
of my pleasure
while I wait
to escape
each other's capture.

Grappling with the fishy intricacies opened up by my bosom in sensuous socio-spatial relations, these poetic fragments attempt to reframe notions of pain and pleasure in my life as a trans woman sex worker. In her beautiful novel, *Little Fish*, writer Casey Plett interrogates the inevitable complexity of trans girl drama that shapes her protagonist Wendy's everyday life. Set in Winnipeg, a city with a significantly larger population than St. John's, she writes: "When Wendy first transitioned, there was someone to notice and comment every step of the way … She had no language for it at the time. And she didn't think any of it out of place … Like, duh, if you grew tits, your friends were gonna talk to you about your tits" (Plett 220). By recognizing how our many ways of moving through the world are structured by transmisogyny and gender-based violence, I identify with Wendy's awareness that trans women's bodies are bound together with the politics of place. And when Plett writes, "In every section of the city it seemed Wendy had a memory of someone who had treated her body with the casualness they would only treat their own" (Plett 221), I can't help but feel the touch of embodied memory on my breasts again.

Fig 3. Quare Tickles in Scum (digital photography and illustration printed with distorted ink on recycled paper). 2019.

Outside of the objectification and ignorance that have facilitated a difficult personal relationship with my bosom in social and sexual environments, my post-operative embodiment has also been refigured by sensory complexities beneath my skin stretched over silicone. In my piece, *Quare Tickles in Scum* (Fig. 3), the assemblage of water, light, breast, and moon jellyfish symbolizes several imagined geographies and sensuous temporalities of my embodiment. Shortly after my top surgery, I lost all sensation in my breasts and nipples for half a year. As nerve functions slowly began to return, I experienced searing pain and electric shocks on the regular. From total numbness to incredible discomfort, I continued to do survival sex work with my recurring clients. Aside from the fact that moon jellyfish look like floating breast implants, drawing relations between the sting of a jelly and my post-operative bursts of searing pain is an attempt at mapping the sensory vulnerability of my breasts over months of being fondled by Johns. Needing to work with my sexual body for economic necessity, my negotiation of displeasure was a way to avoid the risk of jeopardizing my relationship with clients who secured my income each month. Feeling fishy, I creatively interrogate this transaction as a form of disidentification within which:

> here
> in transatlantic scum
> my kind of whore
> is known to sink,
> make kin
> with a rugged bottom
> (the weight of
> his body,
> an ocean
> to drown in)
> and wait
> for the stinging
> to grow weak.

Reflecting upon a loss of feeling in my bosom for the first six months of my surgical recovery and the present erotic hypersensitivity of my nipples—both of which have complicated my sex work—allows me to take the fishy felt knowledges of my breasts elsewhere. In my attempt to trouble creatively what might become of trans women's breasts outside of the clinical theatre, contextualizing the vulnerability of my skin stretched over silicone, alongside the disposability and desirability of my social and sexual body, helps me think more critically and emotionally about the influence of augmentation mammaplasty on trans women's lives and embodiments.

What might my breasted embodiment come to represent beyond the growing transmisogyny I experience as I move through and with this island world? How might I think about pleasure beyond the domain of survival sex work and the ways that my body has been clung to by hundreds of rural men with complex desires and rough hands? Acknowledging the assemblage of embodied dis/pleasure, economic promise, and social violence that has materialized with my breasts, my top surgery cannot simply be understood as an act toward the improved quality of my life. Certainly, it has troubled and influenced my embodiment as a trans woman sex worker in ways that I could not imagine before surgery. Three years post-op, I continue to question the oceans of felt knowledge that my breasts have opened up. I do not believe that being made spectacle by Johns in the privacy of the home, or by strangers in social space, fits into the schema of gender affirmation that I had imagined before top surgery. Nonetheless, these acts of objectification and transmisogyny shape a fishy embodiment that I am forced to grapple with as a trans woman in a small city at the edge of a dying world.

CONCLUSIONS

In the sublime isolation of my sex work, a geography of performance within which the phantasies of clients go unpoliced, the story of my gender dysphoria that has been lessened through breast augmentation is complicated by Johns who pay good money to co-create sensuous temporalities with me based on their imaginations of transsexual embodiment. In public space, the narrative of my top surgery as an act of agency is troubled by the fact that I have learned to keep my breasts concealed most of the time in order to avoid unwanted violence. In fishy relation with the social and sexual environments I inhabit, working with the felt knowledges of my breasts—from social violence to bawdy fetishization to sensory numbness—reveals something slippery about the co-constitutive natures of trans bodies and sensuous geographies (Hayward 245; Tourmaline, *Atlantic is a Sea of Bones*; Twist 48). Using visuals and poetics to make sense of my embodiment helps me question: Who and what am I becoming with hundreds of hands and lips all over my bosom? How do I escape psychic capture from the economic marketability that has changed my life, and the social violence with which I have been faced, as a trans woman sex worker in Newfoundland? As a contact zone between bodies and worlds apart, what are the precarious temporalities and unknown futures of my breasts?

In this essay, I have contributed to a collection of creative and intellectual works that explore the embodiments of Newfoundland women using affective and sensuous engagements with place (see Jefferies, "Intimacy" 130; Norman and Power 59). By interrogating creative and emotional geographies of my sex work, I have tried to illustrate how my augmented breasts continue to shape and guide my trans self-in-creation through embodied, economic, and environmental troubles. Pulled back and forth through felt knowledges, thinking with my breasts has been both unsettling and therapeutic. As I write and visualize together the fishy entanglements of augmentation mammaplasty and sex work in my life, I feel the hands of clients, chasers, strangers, and lovers all over my body again. As I reflect on my painful disembodiment during the first six months after my surgery, I am tickled by the numbness of my body's reaction to jelly/fishy implants placed under my skin. As I continue to experience microaggressions and objectification, I think toward the future temporalities of my breasted embodiment in social and sexual environments. Returning to the fishy fragments of my research-creation, I acknowledge my position as just one body within a community of trans women islanders who, for several decades, have desired and fought for surgical care that is medically necessary, complexly affirming, and fundamentally entangled with our survival (Hilliard 1). In the context of my social location as a sex-working trans woman islander, using creative methods of inquiry to make sense of fishy trans embodiments and geographies of sex work has allowed me to better understand the contemporary and historical natures of trans women's lives in Newfoundland. Mapping the felt knowledges of my breasts in slippery movements through sex-working time and social space, I am learning to embrace an ocean of unknown futures for this buoyant, fishy body.

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IMAGE NOTES

All images created by Daze Jefferies.

NOTES

1. I include both geographic regions of the province Newfoundland and Labrador in my writing only when referring to medico-legal policy and access to care on a provincial scale. When working with trans women's creative geographical and ecological relations to the island of Newfoundland, I do not make reference to Labrador.↵

2. See my self-published poetry collection Milky Moksha (2016), which explores embodiments of my sex work to interrogate the complexities of island trans womanhood in Newfoundland. The poem CAME THROUGH, in particular, interrogates my relations with clients during the first two months after my breast augmentation: “two great circles intersecting / float me on / absorb me into the culture of another / out on the water” (73).↩

RECLAIMING BREAST

AUTHOR: ANIQUE ELLIS

CO-AUTHOR: JOSEPHINE BAKER

The body, the breast is powerful, not to be restricted, constricted, not to be defined by shape, size, prominence, or the choice to nurture or not. Breast! A part of the woman's body not the woman. Forget the politics of the push bra. Victoria's real secret is; a man's erotic desires projected upon women with unrealistic body and breast ideals and expectations.

Let my breast be, just that, Breast, no push-up, or cleavage pressure. I am not my breast and my breasts are not me. Creation story does not say, “In the beginning God created… the breast.” God created a woman with breast. Evolution does not say there was a big bang and the breast came forth, nor does it say the breast evolved. My breasts are mine, not me. They are a part of me not my whole. I am a woman with breast, not a breast with woman. My brain thinks not my breast, my heart beats not my breast, my feet walk not my breast, my hands create not my breast.

To patriarchy; MY breasts are not perfectly symmetrical, apple shaped or prominent, nor will they ever be. Pear shaped, enlarged, chest breasts are breast, not meant for you to police, commercialize, politicize, eroticize, or fetishize. My breast does not define me, so don't define my value, femininity, or worth with my breast. Let me decide how my breasts should be treated or why they look the way they do. My breast, my choice, my way.

GOING FLAT: BREAST CANCER, MASTECTOMY AND THE POLITICS OF CHOICE

ABIGAIL B. BAKAN

Abstract: *Breast cancer, if it advances, is life threatening. It is also widespread. My life was changed when I was diagnosed with breast cancer. There was much that I did not expect, including a hegemonic culture of "breast conservation." I opted to "go flat" after bilateral mastectomy, resisting reconstruction plastic surgery. A politics of choice—like that demanded for reproductive rights—has yet to find similar resonance in the world of breast cancer treatment. This article considers reconstruction hegemony and the emerging movement to advance the choice to be, in words coined by a pioneering Facebook group, Flat and Fabulous.*

Resume : *Le cancer du sein, s'il se développe, est une menace de mort. Il est aussi très répandu. Ma vie a été transformée lorsque j'ai été diagnostiquée avec un cancer du sein. Il y avait beaucoup de choses auxquelles je ne m'attendais pas, en particulier l'hégémonie d'une culture de la préservation du sein. J'ai choisi d'adopter l'"option platte" après une double mastectomie et de résister à la tentation de la chirurgie plastique de reconstruction mammaire. Une politique du choix—comparable à celle qui s'applique aux droits de reproduction—n'a pas encore trouvé d'écho dans le domaine du traitement du cancer du sein. Cet article considère l'hégémonie de la reconstruction mammaire ainsi que l'émergence d'un mouvement promouvant le choix comme étant—selon les termes inventés par un groupe de pointe sur Facebook—"plat et parfait"!*

INTRODUCTION: BREAST CANCER, MASTECTOMY, AND THE POLITICS OF CHOICE

Breast cancer is scary. If it is left untreated, the cancer will advance and become a life threatening disease. According to data collected in 2017, breast cancer will take the lives of an estimated 5,000 women in Canada per year ("Breast Cancer Statistics"). Breast cancer is also a gendered disease. While men are susceptible to breast cancer, the rate of diagnosis is much less than for women, with estimated deaths at 60 per year according to the same data. These scary statistics, however, are not isolated abstract figures. They are also associated with politically and socially constructed barriers that limit access to information, quality public health care, and other forms of economic, gendered, racialized and health-related support (see Lorde; Sontag; King; Hendler; Turner; Brenner). All diseases demand attention from multiple disciplinary lenses (consider, for example, the social and political factors that enter into experiences of HIV-AIDS, cholera, malnutrition, or the recent COVID-19 pandemic). Cancer, however, requires an especially interdisciplinary analysis; it has proven to be particularly entwined with and shaped by the stigma of death (Mukherjee).

For those who are able to access effective medical treatment, particularly in the early stages of the disease, the risk of death from breast cancer however drops steeply. Significantly, 87 percent of those diagnosed with breast cancer will survive at least five years ("Breast Cancer Statistics"). Many will live long, healthy lives, and moreover, survival rates are increasing. Between 2003 and 2012, the death rate declined by an average of 2.6 percent per year, and the death rate today is the lowest recorded in Canada since 1950. The Canadian Cancer Society estimates that between 1987 and 2012, over 32,000 cancer deaths were avoided ("Breast Cancer Statistics"). The reason for this decline is widely considered to be based on the expansion of cases that are detected at an early stage, in the case of breast cancer through mammographic screening and improvements in treatment options.

Most of us are touched by cancer, either in our own health conditions or through the experiences of friends or loved ones. As life expectancy increases, one in two will face a cancer diagnosis according to projected averages. And most will live for some time even if diagnosed with cancer—overcoming, coping, or adapting as treatments continue to be researched and made available to designated populations. Importantly, even many who have been given terminal cancer diagnoses live long and healthy lives (Turner). We need to dissociate cancer from presuming an outcome of death, and begin conceptualizing a rich and meaningful life *after a diagnosis* of cancer.

In 2016, my life was changed when I was diagnosed with breast cancer. This occurred from a routine mammographic examination, unaccompanied by any palpable symptoms. Suddenly I became one of those statistics. There was much that I did not expect, one aspect of which was a hegemonic—or dominant—culture of what is referred to in the medical profession as "breast conservation" (or "breast-conserving" surgery and treatment). The challenges and problematic nature of the hegemonic culture of breast conservation is the subject of this article. I was privileged to be able to access the most advanced medical treatments available; I was and remain surrounded by multiple communities of outstanding support; and I have now been given the "all clear" following the original diagnosis. However, following a bilateral (double) mastectomy, I was also met with a barrage of highly sophisticated and unexpected information, and considerable formal and informal pressures, regarding how to cope with my treatment. Specifically, I was repeatedly invited to "replace," "rebuild," and "reconstruct" the absented breasts. I found that my decision to adapt to my new, disease-free body by "going flat" brought me into an emergent, new political moment.

Surgery is the first line of treatment for breast cancer. However, as my experience demonstrates, treatment often comes along with much more than medical attention. The Canadian and US medical community overwhelmingly advocate for breast conservation. But how does one respond to such a standardized norm? It seemed to me that there should be some choice here.

My research and experience have indicated that life after breast cancer is currently framed according to a presumption of breast deficit—in other words, that mastectomy only means loss, lack, and absence. In my experience, however, there is also much that is gained from the experience of "going flat", and this needs to be understood for its positive elements as well as the negative ones. Breast reconstruction has been and will be a positive and healthy option for some women. But, a politics of choice—such as the politics that came to mark the movement for reproductive choice in Canada—has yet to become the norm in breast cancer treatment. Choice is conceived here as enabling those diagnosed with breast cancer to consider available treatment and post-treatment options without pressure based on gendered and patriarchal norms that idealize female breast conservation as the optimal outcome.

Advancing genuine choice regarding life after breast cancer is timely. Given that more women are living after treatment of breast cancer, the political and social contexts that shape treatment and post-treatment options—*choices*—are starting to be revealed, bringing the hegemonic attitude towards breast reconstruction into sharp relief and contest. The remainder of this article is divided into two parts: the first critically examines the hegemonic promotion of breast conservation and reconstruction; the second turns to Flat and Fabulous—a name drawn from a Facebook support group for women who choose not to have reconstruction after breast cancer surgery—and the politics of choice. The article concludes with some considerations for future advocacy and research.

BREAST CONSERVATION AND RECONSTRUCTION HEGEMONY

A moment of reflection and personal ethnography might assist in contextualizing this argument. Once I made it clear that I was not interested in reconstruction, I was informed by a caring practitioner associated with the hospital where I was treated that there was an offer to "change your mind at any point." There is apparently no statute of limitations in Ontario for publicly insured reconstruction following breast cancer. I found myself surrounded by experienced and expert breast cancer professionals who confirmed this—doctors, interns, nurses, social workers, receptionists, and volunteers. At almost every turn, I was asked if I wanted to have reconstruction during or after surgery, even though I had made it abundantly clear that I did not. There was obviously an institutionalized directive to "inform" patients about reconstruction, repeatedly, and even after it was recorded that such information had been duly delivered. I felt that there was a sort of collective, unspoken professional anxiety about my decision to live as an adult flat-chested woman. I was informed, again repeatedly, that I would likely regret my decision. This is part of a general culture of paternalism that is normalized in the breast cancer medical world (see Lagnado). I was surprised, however, to learn how deeply this paternalism has affected treatment options for breast cancer. My choice to "go flat" was, apparently, at best unusual and unfamiliar, at worst considered self-destructive. While this was not easily traceable to any single source, the general culture of "offering reconstruction" was clearly the norm among practitioners. The aim was to ensure that I was really, fully, truly informed of the option to have new breasts "reconstructed" either from transplanted tissue (autologous reconstruction) or using breast implants.

I was invited shortly after diagnosis to attend an annual event that takes place in over 30 cities across Canada and the US: National Breast Reconstruction Awareness (BRA) Day ("BRA Day"). I attended the Toronto event in October 2016, and learned a great deal, not least about hegemonic breast conservation. The event featured practicing plastic surgeons who specialized in the procedure, and women who had reconstructed chests, in well-planned public presentations. BRA Day also featured numerous information booths as well as a "show and tell lounge," where women with reconstructed breasts shared shirtless stories. Significantly, National Breast Reconstruction Awareness Day traces its origins to an initiative by a Canadian plastic surgeon, Dr. Mitchell Brown, in 2011. Brown is credited with coining the expression "close the loop on breast cancer," now a brand slogan for BRA Day ("Breast Reconstruction Awareness Day" 1).

The event, *inter alia,* is presented with a tone of joy and celebration. It forwards the potential for newly built "breast mounds" to redress the sense of loss that comes from breast deficit. For those who have already concluded they are seeking reconstruction, it is likely very useful. However, it is also seemingly untroubled by decades of feminist and intersectional analyses of the patriarchal gaze and objectification of the female body. In fact, impressionistically, diversity does not even figure into the projections and images associated with the extensive material promoted by BRA day in Toronto, a city known as one of the most ethnically diverse in North America. Indeed, even the history and context of the idea of breast augmentation in the medical field seemed oddly absent (see Peters and Fornasier). Instead, the event praises the plastic surgeons, mostly but not exclusively male, and their skill in rebuilding absented female breasts ("All About BRA Day"; see also Hill et al.).

Certainly, the event is not intended to be anything more than a day of information to enable options and support for those who are on a path towards reconstruction after breast cancer surgery. Perhaps criticism due to omission could be read as unfair. However, based on my own experience at the October 2016 Toronto event (the first to be organized after my diagnosis and treatment), as well as the October 2018 Toronto event (which I attended with the eye of a researcher), and related research, the messaging is dangerously one-sided. Indeed, breast reconstruction is presented as a necessity to "close the loop on breast cancer," turning the iconic pink ribbon, which is open at the bottom, into a closed, and complete, figure eight. Women are invited to be and feel "whole" again when they sport reconstructed breasts. Then they will be, apparently, fully healed after the physical and emotional hardships of a breast cancer diagnosis and treatment.

With many years of my own and others' feminist scholarship and activism upon which to stand (see Bakan and Stasiulis; Bakan and Kobayashi; Abu-Laban), it soon became obvious that there was a need for greater attention to a politics of choice in the world of life after breast cancer. There have been, arguably, several waves in breast cancer treatment, as there have been in feminist theory and activism generally, even if the framework remains contested (Orr et al.). Historically, breast cancer was commonly treated with “radical” mastectomies, a major surgical intervention which removed the entire breast as well as lymph nodes and portions of muscle tissue along the chest wall, and sometimes additional bone mass. This method was advanced by Dr. William Stewart Halsted (1852-1922), who established a school of breast cancer treatment grounded on the principle of ever-widening surgical excision particularly associated with the Johns Hopkins Hospital (Halsted). Another US surgeon, Willy Meyer, independently advanced the same surgery as a way to treat breast cancer (Mukherjee 60-72). The results, in terms of treating cancer as a life-threatening disease, were significant; women who were diagnosed with breast cancer and treated with radical mastectomies lived longer. However, the impact on their quality of life following the surgery was harsh: “With the pectoralis major cut off, the shoulders caved inward as if in a perpetual shrug, making it impossible to move the arm forward or sideways” (Mukherjee 65).

Fortunately, over time this standard treatment has come to be seen as unnecessary (Veronesi et al.). The transformation in standard treatment is itself a product of advocacy for women’s health as well as advances in medical research regarding cancer generally. Currently, mastectomy is commonly seen as a last resort following other treatment options, and when conducted is normally a “simple” mastectomy surgery that preserves the musculature in the chest wall. Advocacy for “breast conservation” therefore follows a wave of advance in the treatment of breast cancer that is related explicitly to wider advances in women’s rights and women’s health.

Enter the issue of breast reconstruction. This can be seen as consistent with attention to breast conservation as a challenge to the predominant reliance on radical mastectomies. However, breast reconstruction is not a treatment for cancer, but addresses the results of surgery that are part of cancer treatment. For some women, reconstruction has led to a sense of restored health, agency, and well-being following the devastating realities of breast cancer diagnosis and treatment (Anstett). But this major and complex surgery has also become identified as an inevitable, or necessary, part of the breast cancer “journey.” Here, the gaze on the objectified female breast and the related patriarchal and racialized history of medicalization and healthcare in capitalist societies such as Canada and the US are consistent with the perspectives that inform the advancement of breast conservation hegemony (Stasiulis and Bakan 107-139; Calliste). The major "choices" presented at BRA day revolve around options about the type of reconstruction: immediate or delayed reconstruction; transplanted tissue or implants; transplants from the stomach, back, or buttocks. Information about the risks and side effects of reconstruction are generally minimized. Also minimized or absented are other options that avoid reconstruction altogether—going flat on one or both sides, or the addition of creative tattoos. The options promoted on BRA Day are not unique, but typical of the breast cancer industry. One study published in 2016, designed to assess how patients in the US are informed about breast reconstruction (conducted over 20 months at a single site, among 126 patients planning mastectomy) concluded that knowledge of the risk of complications was particularly low, with only 15 percent of respondents indicating they were accurately informed; the majority lacked information or were misinformed (Lee et al., "How Informed" 1105). Further, there is a racialized, classed, and potentially heteronormative dimension to this knowledge: "Lower knowledge was associated with non-white race, less education, lower income, and single relationship status" (Lee et al., "How Informed" 1105-06).

The rise of the breast conservation wave is also located geopolitically. It is traceable largely, though not exclusively, to the US medical establishment. In a context of widely privatized medical insurance, the costs of breast reconstruction in the US were prohibitive up until recently. Accessing the procedure was particularly discriminatory for breast cancer patients from rural areas, low-income economic status, and those who were racialized minorities (Lee et al., "Quality of Patient Decisions"). However, following considerable advocacy, the Women's Health and Cancer Rights Act was passed in the US in 1998, a law that requires group health plans to cover reconstructive procedures (Anstett 3). In Canada, where there is generally more widely accessible public health, "breast reconstruction after cancer surgery is covered by most provincial and territorial health insurance plans" ("Breast Reconstruction"). However, the educational context and promotion of the breast conservation industry has closely followed the US pattern. Notably, while breast reconstruction surgery is automatically covered by the Ontario Health Insurance Program (OHIP), for example, revision of scars to achieve a fully flat appearance after mastectomy is not ("Frequently Asked Questions").

FLAT AND FABULOUS AND THE POLITICS OF CHOICE

The pivotal alternative to breast reconstruction following mastectomy, the choice to "go flat" either asymmetrically or symmetrically, has received far less attention. Still emergent, and only through advocacy among those who have elected this path, this option is currently gaining legitimacy and recognition. Information regarding the limitations of and alternatives to reconstruction has been generated by women's choices and reflected in a current of social awareness. However, data on trends according to available statistics regarding reconstruction after mastectomy is a contested field (Joyce). According to one 2015 study in the US, only 25 percent of women in that year who underwent mastectomies had immediate reconstruction following breast cancer treatment, yet "[m]edical literature largely starts from the assumption that [women who have mastectomy] want to have reconstruction and emulate their missing breast(s)" (Joyce 4). The number of women opting for breast reconstruction after mastectomy increased in the US by 35 percent between 2000 and 2015 (Rabin, "After Mastectomies"), but it is not clear if this rate is continuing (see Anstett 4; Yang et al.). It is estimated that overall, in the US, "roughly 25 percent of double-mastectomy patients and 40 percent of single-mastectomy patients opt out of reconstruction" (Guthrie, "Why More Breast Cancer"). There is no doubt, however, that reconstruction is the medically advocated norm, where it is assumed that "[b]reast reconstruction can help restore body image and alleviate distress associated with mastectomy," even though this assumption is not based on substantive research on actually "evaluated patient perceptions and outcomes" (Pusic et al. 2500).

Certainly, for some, reconstruction is an affirming and healthy option. The goal of surgical reconstruction following mastectomy is to produce “breast mounds,” either from tissue transplanted from the woman’s body or through implants. Surgically constructed or tattooed nipples complete the procedure. To the external observer these often “look and feel” like natural breasts. But to the woman herself, the breast mound is often numb and lacks feeling. Despite the promotional climate in the medical industry, a systematic review of US studies (up to 2009) on reported outcomes comparing those who had and had not undergone reconstruction following mastectomies indicated that there were no notable differences between the groups in terms of “quality of life, body image and sexuality” (Lee et al., “Patient-Reported Outcomes” 129). For those who have had reconstruction, complications can be extensive. These can include failure of the surgery resulting in a need for deconstruction, hardening of the tissue surrounding a breast implant (capsular contracture), implant rupture, and various serious illnesses. The latter include breast implant-associated anaplastic large cell lymphoma (BIA-ALCL), a form of cancer (Grady). In 2019, the US Food and Drug Association (FDA) Commissioner issued a statement indicating new information suggesting potentially higher risks of BIA-ALCL, and warned two breast implant manufacturers (Mentor and Sientra) with letters for failing to comply with FDA requirements (“Statement from FDA Commissioner”; “FDA Issues Warning Letters”; see also Grady and Rabin). Also in 2019, Health Canada issued a statement indicating a higher rate of confirmed and suspected BIA-ALCL than previously reported, and alerting health care professionals to attend to signs and symptoms of the disease (“Health Canada Will Be Updating Its Safety Review”; see also Cribb and McLean; Adhopia and Ouellet). Notably, one of the major identified sponsors of BRA Day in Toronto, 2018, was Mentor, one of the implant corporations that received a warning letter from the FDA. This is suggestive of motivations for the celebratory breast reconstruction awareness event based more on generating sales and reproducing patriarchy than on expanding health and wellness following breast cancer treatment.

The hegemony of reconstruction discourse presumes a singularity to the "woman" who has had breast cancer surgery that is starkly unaffected by decades of feminist debates, not only in scholarship, but also in policy and daily life in contemporary civil society (see "BRA Day: Breast Reconstruction Awareness"). My own observation of the Toronto, 2016, National BRA Day event saw a large audience of several hundred women, featuring two women speakers and a panel of plastic surgeons. Anecdotally, the examples and stories forwarded at BRA Day appear to be demonstrably profiling white women, and the assumption of heteronormativity was widespread. These are characteristics identified to be consistent with cancer treatment generally in Canada and the US (see Taylor and Bryson). I returned to observe the Toronto BRA Day in 2018, and the largely white demographic had not changed, even in a city which is noted for being among the most racially diverse in North America (see "BRA Day: Breast Reconstruction Awareness").

Those seeking other options have, however, been asserting the legitimacy of their choices. A growing body of scholarly research, investigative reporting, social media, films, and blogs are challenging the predominant assumptions that go with the widespread "image of a smiling, pink clad woman with round breasts" so ubiquitous in "breast cancer awareness marketing" (Joyce 3). This current is indicated qualitatively and anecdotally by a social media Facebook group, Flat and Fabulous, founded by two women who met through *The Scar Project,* a 2011 documentary about young breast cancer survivors (Jay). The Flat and Fabulous Facebook group received wider public attention when an article was written in *The New York Times*, calling attention to the reconstruction industry and the experiences of those who came to the decision to go flat (Rabin, "'Going Flat' After Breast Cancer"). The article was based on extensive research with medical practitioners and women who had had breast cancer. It stated the case clearly about the pressure for reconstructive surgery following breast cancer treatment, placing this in a wider context. The *Times* article deserves quotation at some length:

> In promoting the surgery, doctors cite studies that suggest breast reconstruction improves a woman's quality of life after

> cancer. But some women say that doctors focus too much on physical appearance, and not enough on the toll prolonged reconstructive procedures take on their bodies and their psyches. Up to one-third of women who undergo reconstruction experience complications. A systematic review of 28 studies found that women who went without reconstruction fared no worse, and sometimes did better, in terms of body image, quality of life and sexual outcomes. "That's the dirty little secret of breast reconstruction: The risk of a major complication is higher than for the average elective surgery," said Dr. Clara Lee, an associate professor of plastic surgery at Ohio State University who performs the procedure. Ms. Cuozzo, who appeared in the Facebook video … spent a year having her breasts rebuilt after a double mastectomy, but after four infections in five months, she had the implants removed. The reconstruction, she said, "was getting worse than the cancer." (Rabin, "'Going Flat' After Breast Cancer")

More voices were and are coming forward from multiple sources, including film and blog posts, as well as multidisciplinary scholarly research (see, for example, Guthrie, *Flat*, "How Sexism," and "Why More Breast Cancer"; Skene; Joyce; Gao; "A Matter of Choice"; Brown and McElroy; Newman). These are signals of a rising new, vibrant social movement, one that is already indicating and affecting change. For example, the Canadian Cancer Society now lists "Choosing to Stay Flat" on its website ("Choosing to Stay Flat"). In April 2018, a collective of "flatties" in the United States came together to launch the website Flatclosurenow.org, which is "dedicated to ensuring breast cancer patients and providers understand that 'going flat' is a valid, beautiful, and healthy surgical option after mastectomy" (*Flat Closure Now*).

Returning to my personal experience, I have been heartened to have the opportunity to join a number of closed Facebook groups, specifically dedicated to advocacy and support for those of us who have chosen to go flat after breast cancer diagnosis and mastectomy. These Facebook groups are a central support for those who need a community, and also serve as centres for movement building to advocate for change. These Facebook groups include: Flatties Unite; I Wanted to Be Flat; Flat in Canada; Flat in Toronto and GTA; and Fabulously Flat. The numbers reported are in the hundreds for some sites, others are in the thousands. Another group supports women who have had breast implants and have experienced serious and often unrecognized or minimized health challenges as a result: Breast Implant Illness and Healing by Nicole. The group has over 113, 000 members (Nicole).

As the community of those who resist the hegemony of breast conservation and reconstruction grows, new language has evolved to express the experiences and range of emotions. One important term that is gaining traction is "flat denial," defined as "when a surgeon's actions deny their patient a flat mastectomy result, whether through misalignment of expectations, lack of training or intentional disregard" (Bowles). Kimberly Bowles, who identifies as a "Pittsburgh scientist, artist, wife, mother, cancer survivor and flat advocate," started Not Putting on a Shirt. This site offers extensive resources "for optimal surgical outcomes for women who choose to go flat after mastectomy" (*Not Putting on a Shirt*). It is inspired by Kim's story, when she arranged a plastic surgeon at the time of her double mastectomy, and explicitly requested a flat result. As she was going into surgery on the operating table, the surgeon informed her that he would leave excess skin, in case she might "change her mind" and opt for reconstruction (*Not Putting on a Shirt*). This action was taken without consent, but has been defended in the months following as consistent with established medical practice.

Again returning to my personal situation, my choice to go flat was also resisted, but ultimately the surgeon agreed and the procedure followed smoothly. However, this agreement was not without challenge, as it was outside the normal hierarchy of medical authority. As my treatment plan was being finalized following final tests and diagnosis, an attending nurse waited until the surgeon had left the hospital room following final sign-off. At this moment, she informed me, "With any other surgeon, we would be sending you for a psyche assessment now." The implication was that my decision to opt for a double mastectomy to address early stage breast cancer was the product of mental instability. Indeed, some medical professionals have asserted such choices constitute a disease separate from cancer, apparently "an epidemic" (Lagnado). The questioning of a patient's psychological stability in order to refuse or redirect treatment is of course not uncommon in the medical profession, targeting, for example, women, Black communities, trans people, the LGBTQ community, people with disabilities, and immigrants (see Roberts 90-91; Garner; Sontag; Lorde). My experience, however, is perhaps notable because I had advocated for a kind of surgery identified in current medical guidebooks for practicing breast surgeons to generate "highly curable" results, a phrase rarely associated with cancer treatment ("Princess Margaret" 107). For Kimberly Bowles and many others, experiences are far more serious: "They go into mastectomy expecting a flat result, and wake up to something completely different" (*Not Putting on a Shirt*; see also Guthrie, "How Sexism").

Finding community in the face of such experiences is crucial to healing. Community support also inspires advocacy to expand choice, and in turn serves to break barriers regarding ascribed norms regarding gender and ability. This movement is consistent with the goals of disability studies and activism that have challenged the dominance of the idea of the "normal" healthy body. This is the "normal body" that is assumed to be the same as the "healthy body." When the normal becomes ill or impaired, it is expected to demand repair with prosthetics and other material and social devices (see Betcher; Erevelles).

One indication of the success of the going flat movement is change in fashion options, including forwarding new clothing designs for women with one breast ("uniboobers") or no breasts ("flatties"), and web-based initiatives such as Empowerhaus.co and Idontneedtwo.com. One particularly important fashion intervention has been sponsored by Ana Ono, which features designer lingerie for women who have been treated for breast cancer (Dale; Isis). In 2019, New York fashion week included the Ana Ono runway show (now an annual event) notably featuring a diverse group of models all of whom were living with stage 4, metastatic breast cancer. This form of breast cancer is a progression of the disease that affects 30 percent in the

US of those who are diagnosed, but is the subject of only 3-7 percent of research dollars (Isis).

Ana Ono New York Fashion Week, credit Charise Isis 2019

This movement is only recently coming into wider public view. However, attention to the politics of choice and women's rights following mastectomy is not new. For example, in 1980, Black feminist author Audre Lorde shared her story of dealing with breast cancer and finding herself scolded by a nurse for declining to wear a prosthetic to a follow up appointment (Lorde 60). As she boldly stated:

> a woman who has one breast and refuses to hide that fact behind a pathetic puff of lambswool which has no relationship nor likeness to her own breasts, a woman who is attempting to come to terms with her changed landscape and changed timetable of life and with her own body and pain and beauty and strength, that woman is seen as a threat to the "morale" of a breast surgeon's office! ... I refuse to have my scars hidden or trivialized behind lambswool or silicone gel. I refuse to be reduced in my own eyes or in the eyes of others from warrior to mere victim.... (Lorde 61-62)

In sum, there is an apparent need for a shift in the paradigm, from a standardized assumption of "closing the loop" on breast cancer through a hegemonic focus on breast conservation and reconstruction to a politics of informed choice. The latter has been advanced in another context, women's reproductive health.

The Canadian pro-choice movement advocated for a woman's right to choose over decades of activism and advocacy. It can serve as an important model regarding the social, political, and economic context of women's health more generally, and is suggestive of a way to reimagine options following surgical treatment for breast cancer. The pro-choice movement advocated for the rights of women to control their bodies, but also to demonstrate capacity to make life and death decisions. These were specifically associated with reproductive freedom, considering options to terminate safely an unwanted pregnancy, or to make an informed choice to carry a pregnancy to term (Pelrine; Brodie et al.). Framing abortion in this way, by associating it with women's right to choose, was ultimately successful in challenging abortion laws in Canada. Certainly, major gains have been achieved regarding issues associated with women's choices to have or not to have children, and relatedly, to choose if or when to terminate an unwanted pregnancy. Considering choice in this manner is distinct from a focus on the neoliberal market model of "choice," which idealizes the abstract individual as if devoid of material and political difference (for a critique, see Abu-Laban and Gabriel).

Instead, the lessons of the pro-choice movement link medical issues with those of social, economic, and political rights, and can be suggestive of an intersectional approach (see Crenshaw; Bakan and Abu-Laban). The gains are signified by the 1988 *R. v. Morgentaler* decision, when the Supreme Court of Canada invalidated previous federal legislation that criminalized access to abortion services on grounds of violation of the Canadian Charter of Rights and Freedoms. However, this is not only an historical example. Advocacy continues to be needed to ensure women's right to choose regarding access to publicly funded abortion across the provinces of Canada (see Johnstone; Johnstone and Mcfarlane).

An important proviso regarding the relationship of these issues is in order. In forwarding a politics of choice, it is not suggested that pregnancy is comparable to cancer; simply put, pregnancy, unlike cancer, is not a disease. Rather, the suggestion is that there are grounds to extend a conversation in terms of a critique of patriarchal norms, women's agency, gendered issues of bodily integrity, intersections of gender, race, ability and class, and life or death decisions. These involve a relationship between people who are diagnosed with breast cancer, including women and men, and a medical system that includes trained, professional practitioners, and extensive informational and technical resources. From this perspective, the issues of choice drawn from decades of public policy and social movement advocacy associated with reproductive rights can be brought into dialogue with the politics of women's altered bodies after mastectomy, and related matters of quality of life after breast cancer.

CONCLUSION: TOWARDS FUTURE RESEARCH

The preceding discussion has attempted to name and question the hegemonic paradigm of breast conservation, and relatedly, assumptions of breast deficit as the main effect of mastectomy. Alternatively, other options, including the option to go flat, deserve greater attention. A politics of choice, inspired by, but not identical to, the politics advanced in Canada regarding abortion rights, can be helpful in such a conversation. Considering a politics of choice regarding life after breast cancer treatment has the potential, arguably, to expand our understanding as well as to open space for wider social and medical communities. Rather than assuming that there is a single "normal" and universalized healthy outcome to breast cancer treatment, we would be well served to imagine multiple open-ended outcomes where agency and choice are centred among multiple potential, and potentially positive, options.

This remains, however, challenging territory. For example, intersectional approaches to choice at the interface of agency and the medical establishment are relevant, including experiences of transgendered/transsexual men and women. The ready access to breast reconstructive surgery for women diagnosed with breast cancer is notably in contrast to requests from trans communities seeking similar plastic surgery. Men who have been diagnosed with gynecomastia, the medical term for excessive breast tissue, are also generally supported in obtaining desired surgery (Garner). Yet there are demonstrable barriers faced by male-to-female trans people seeking medical support for breast construction, a surgical procedure very similar to post mastectomy breast reconstruction (Garner). These, and other related examples, could potentially be brought into a wider public conversation under the umbrella of a politics of choice.

And, to conclude, a final note on my personal experience. Fourteen months after mastectomy surgery, I returned to another hospital for a second surgery, this time a day clinic procedure with two plastic surgeons for scar revision, to produce a flatter outcome following the mastectomy. An attending nurse was on intake, one I had not met previously. When she looked at my chart and saw my flat chest, she burst out in laughter—as in deep hold-your-belly guffaw laughter. Spittingly, she stated, “Flatter than flat? That’s a new one!” However, the surgery, again, went well. After the procedure, following the careful and professional attitude of the surgeons, who were of course her superiors in the medical hierarchy, the attitude of the attending nurse changed. As I changed clothes and received post-op instructions, she was now demure. “You could wear a T-shirt, I see,” she stated. “And maybe you’ll start a trend.” I replied, “Already have. Read the *New York Times*.” I exited with a bit of bounce in my step.

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REVEALING NARRATIVES IN BEFORE AND AFTER PHOTOGRAPHS OF COSMETIC BREAST SURGERIES

RACHEL ALPHA JOHNSTON HURST

***Abstract**: Feminist cosmetic surgery scholars have been attentive to cosmetic breast surgeries as emblematic of a range of issues and questions. Breast implant and reduction surgeries have been analyzed by scholars as psychologically beneficial, as representative of unethical practices in the cosmetic surgery industry, as exemplar of the objectification of women's bodies, and as connected to powerful cultural ideas about breasts. A curious dearth in previous scholarship is a sufficient engagement with the ubiquitous library of photographs that document these procedures. This essay discusses before and after photographs of cosmetic breast surgeries, which occupy a liminal space as medical and sexual, verification and fantasy. In this essay, I argue that before and after photographs of cosmetic breast surgeries should be read as revealing of*

***Resume** : Les chercheurs qui se spécialisent dans le domaine de la chirurgie plastique féminine se sont intéressés à la chirurgie cosmétique du sein comme étant emblématique de tout un éventail de questions et de sujets. Les implantations mammaires et les opérations de réduction ont été analysées par les chercheurs pour leurs aspects psychologiques bénéfiques, pour l'exemple qu'elles offrent de pratiques contraires à la déontologie dans l'industrie de la chirurgie plastique, pour l'objectification qu'elles font du corps féminin, pour leurs liens profonds avec les idées culturelles sur les seins. Curieusement plus rare parmi toutes ces recherches est l'étude de l'omniprésente collection de photographies documentant ces pratiques. Cet article discute des photographies pré- et post- chirurgie plastique mammaire qui occupent une place liminaire entre le médical et le sexuel, entre le vérifiable et l'imaginé. Dans cet essai, je propose l'idée que les photographies pré- et post- chirurgie plastique mammaire doivent être interprétées* *the conditions under which patients and surgeons operate, rather than solely as proof of an operation's results. To make this argument, I focus on two examples of before and after photographs – one of a breast augmentation and one of a breast reduction – and guide my analysis of the images in relation to narrative interviews with three women who underwent cosmetic breast surgeries.*

comme la révélation des conditions dans lesquelles patientes et chirurgiens opèrent, plutôt que comme la simple observation du résultat de l'opération. Afin de soutenir cet argument, je me concentre sur deux exemples de photos pré- et post—l'une d'une augmentations mammaire et l'autre, d'une réduction—et je conduis mon analyse en m'appuyant sur l'interview de trois femmes ayant subi une opération de chirurgie plastique mammaire.

Feminist cosmetic surgery scholars have been attentive to cosmetic breast surgeries as emblematic of a range of issues related to embodied experiences of gender and sexuality. Although some scholars have considered the role of before and after photographs in advertising and decision-making processes, they have not given due attention to the highly standardized style of photography that appears on surgeons' websites to demonstrate these outcomes. In this essay, I argue that before and after photographs of cosmetic breast surgeries should be read as revealing of the conditions—individual and structural—under which patients and surgeons operate, rather than solely as proof of an operation's results. To make this argument, I focus on two examples of before and after photographs—one of a breast augmentation and one of a breast reduction—and guide my analysis of the images in relation to narrative interviews with three women who underwent cosmetic breast surgeries. At first glance, the images I discuss are utterly unremarkable, due to the repetition of similar images on virtually every website advertising cosmetic breast surgery. However, in this essay, I maintain that when considered alongside women's narratives of their cosmetic breast surgeries, the meaning of these photographs becomes manifold and surprising, much like the experience of undergoing the surgeries themselves. These images, I argue, exist at the nexus of medicine and sexuality, past and present, as well as verification and fantasy.

I begin this essay with a synopsis of feminist analyses of cosmetic breast surgeries, which interpret these surgeries variously as exemplars of the objectification and sexualization of women; as psychologically beneficial acts that enable patients to feel more at home in their bodies; and finally, as connected to powerful and multivalent cultural ideas about breasts. These analyses provide a rich and multifaceted context for thinking about the function of photography for cosmetic breast surgeries. After this necessarily concise summary, I extend a theoretical framework for reading my two examples as illuminative of the terrain of cosmetic breast surgeries. Kaja Silverman recently posited that photography is disclosive, rather than evidentiary; in her words, as an object that is of this world, it is “the world’s primary way of revealing itself to us” (7 and 10). In my book, *Surface Imaginations: Cosmetic Surgery, Photography, and Skin*, I argued that the contemporary conditions of the cosmetic surgery industry are shaped by the seductive fantasy that an alteration on the surface of the body will result in an improvement of one’s interior life, aligned with a promise that our bodies are limitlessly transformable and most of all, controllable (19). I call this fantasy “surface imagination.” Silverman’s contention that the photograph is disclosive is provocative to me, as I previously understood the use of photographs within cosmetic surgery as objects of aspirational evidence. This essay provides an opportunity to reflect on how these two ways of understanding photographs are in tension with and complement one another. Before delving into the photographs, I offer a sketch of the methodology I use to connect three narratives of cosmetic breast surgery by Tonya, Leah, and Melinda (all pseudonyms), with an analysis of two archetypical before and after photographs found online. Conceiving of photography as disclosive pushes me to rethink the function of before and after photographs beyond their more commonly perceived status as evidence. This rethinking is a useful intervention to better understand what these photographs mean to women considering and undergoing cosmetic breast surgeries, as well as their use in medicine and popular culture.

Analyses of cosmetic breast surgeries exist amongst the earliest feminist investigations into the relationship between culture, images, and the cosmetic surgery industry. These initial discussions typically presented cosmetic breast surgeries as objectifying and harmful, a capitulation to visual preferences generated by men through the beauty and pornography industries. For example, Kathryn Pauly Morgan claims that "de-skin[ning] and altering the contours of women's bodies" to look like "mannequins with large breasts in the shop windows of modern patriarchal culture" happens in a context where women are subject to "compulsory attractiveness," which is "defined as attractive-to-men," and where women are compelled to direct their sexuality towards men (46 and 32). Other early feminist approaches emphasized the sexualization of women's breasts in cosmetic surgery, linking breast augmentation with foot binding, as a means to "increase sexual desirability" (Spitzack 39). A common thread that connects several of the objectification analyses is a concern about the creation of pathologies such as "micromastia" to justify breast implants (Bordo 44; see also Morgan 39-41; Spitzack 38). Although contemporary analyses of cosmetic surgery tend to be more nuanced, such analyses of breast augmentation continue to have an afterlife in anti-pornography analyses, as well as trans-exclusionary radical feminist analyses of transgender surgeries (see Dines; Jeffreys).

Cosmetic breast surgeries are frequently explained as having a beneficial psychological outcome, because patients report they can dwell more easily within their bodies because their internal image of their body is more closely aligned with its outward appearance following surgery. Kathy Davis's *Reshaping the Female Body: The Dilemma of Cosmetic Surgery* was the first scholarly text to take this claim seriously. She argues that while cosmetic surgery has been sensationalized as the domain of the rich, vain, and famous, the majority of women who undergo cosmetic surgery desire to appear "ordinary" (Davis 12). More importantly, women's active engagement with cosmetic surgery resists cultural expectations for women to be passive and compliant. Davis concludes that cosmetic surgery can be a means for women to become "embodied subjects, rather than objectified bodies" (114). Debra Gimlin's interviews with women who underwent breast augmentation reveal that women combined the narrative that cosmetic surgery is psychologically beneficial with the narrative that they were hard-working people and thus morally entitled to surgery (86-88). These interviews also show an intriguing alignment with popular discourses about the importance of self-care for women. As I will discuss shortly, my interviews with three women who underwent cosmetic breast surgeries within the context of a project about cosmetic surgery more generally also reflected the idea that these surgeries were a form of self-care and taking control of one's life (Hurst).

And finally, feminist scholars have argued that cosmetic breast surgeries cannot be analysed outside of a broader understanding of the socio-cultural meanings of breasts, particularly those produced by beauty and celebrity cultures, as well as ideologies of motherhood. Within a discussion of surgeons' claims that cosmetic surgical body modifications are quickly and easily integrated into patients' body image, Virginia Blum astutely notes that a woman's sense of her breast implants "belonging" to her self-concept of her body is limited "only insofar as breasts ever belong to women and are not culturally coded for visual pleasure, as a signifier of femininity" (32). Arguing that we currently live in a "surgical culture" where the body is transformed into a two-dimensional plane through cosmetic surgery, Blum situates cosmetic breast surgeries as inseparable from the "public spectacle of femininity," which alienates women from their bodies, particularly parts of the body that are highly gendered and sexualized, like breasts (33). Like Blum, Meredith Jones posits that celebrity culture—which is highly invested in ongoing bodily transformation to meet contemporary trends and demands to appear youthful and feminine—is inseparable from how cosmetic breast surgeries are interpreted (139-43). Both scholars note the contradictory status of breasts as both sexual and maternal. Analyzing breast augmentation through the methodology of the psychoanalytic case study, Alessandra Lemma argues for a psychoanalytic praxis that is concerned with what effects the significant rise in cosmetic surgery has on individual psychical experiences, particularly as patients experience psychological distress post-cosmetic surgery (24). In *Minding the Body*, she devotes a case study to a patient who undergoes breast augmentation in relation to her experiences of having and being a mother, which

Lemma investigates through the lens of cultural ideologies as well as the patient's singular experience (23-40).

Each of these feminist perspectives has addressed, to varying degrees, the relationship between the idealized image and the body. The insights of these scholars guide my analysis in *Surface Imaginations*, which theorizes that the photograph is the idealized surface of the cosmetic surgery industry, counterposed against the skin as the de-idealized surface. The photograph is capable of interminable transformation, without the pain or time required to recover physically, or the uncertainty of the results of an operation. For these reasons, I conceptualized the photograph as "reminder, evidence, and promise" in cosmetic surgery (92). The skin, on the other hand, is uncontrollable: it bleeds, hurts, scars, and changes throughout time, no matter what we do.

I did not enter into this project with the intention of inquiring into the status of photographs in cosmetic surgery; however, my inquiry into surgeon's websites, women's magazines, and interviews led me to situate the photograph as central to cosmetic surgical practice. I was particularly surprised by the degree to which photography functioned as a medium for patients to visualize the effects of a cosmetic surgery on their body, as well as how my interviewees used photography as a way of documenting the changes to their body, which I explore extensively in my book. I came to see photographs as primarily items of evidence in cosmetic surgical practice, and I located these photographs within a variety of other identity and evidentiary photographs like driver's licenses and mug shots (113-15). Further, I argued that photographs of cosmetic surgery act as fantasy objects that provide evidence as either memories of previous embodiments or assurances of potential embodiments.

In her reconsideration of the history of photography, Silverman proposes that we rethink the photograph as not the invention of a handful of men, not as an object with an indexical relationship to its subject, but rather as an ontological and social revelation (87). In this reframing, photography is a fundamentally human activity that "develops … *with us* and *in response to us*" (Silverman 12). Photographs are *not* representations of something that is no longer there, but instead they are receptive surfaces through which the world discloses itself to us through the camera in a singular fashion that is radically different from our look (Silverman 47 and 123). Silverman develops her analysis through a deliberation on early photographs (daguerreotypes, and those produced by the camera obscura, for example), as well as contemporary fine art photographs (particularly those created by artists who reclaim early photographic practices). She does not discuss the implications of her argument for contemporary vernacular photography and digital photography, yet as this is the first in a three-volume series, it is possible that she will do so in the future. This argument is profoundly different from how I understood photography in *Surface Imaginations*, where I emphasized the evidentiary qualities of cosmetic surgery photographs. Silverman's insight compels me to push my analysis further to ask what impressions of the cosmetic surgery industry and encounter exist in ordinary before and after photographs.

When photography is considered an index or as evidence, images possess a quality of "pastness," in that the referent exists in the historical moment of the photograph (Silverman 2-3). In this conceptualization, photographs are dispassionate objects of remembrance or confirmation, faithfully encompassing the past in an image. Before and after photographs of cosmetic breast surgeries enclose two discrete moments in breasted life, moments that viewers understand as separate: "before" is past, and "after" is present. In this way, the use of before and after photographs both relies on and disturbs the quality of "pastness" that indexical or evidentiary understandings of photography possess. This is because before and after photographs invite the viewer to consider the transformation of the patient's body in the present and also to imagine the possibility of transformation in their own future. Working with Silverman's exegesis of Walter Benjamin's early work on photography, photographic images are not fixed, but rather developmental, reaching through time and space for a look that could "recognize" and "redeem" an image (7). When a photographic image reaches a look of recognition and redemption, "the present discovers itself within the past, and the past is realized within the present" (Silverman 7). Before and after photographs of cosmetic breast surgeries have been considered by many scholars (including me) to fix bodies in time for the dual purposes of advertising a surgeon's skill and narrating a patient's bodily transformation. The past is rejected as abnormal or deficient and the present is celebrated as a victory. However, if I follow Silverman, before and after photographs can also be thought of more disruptively: not as linear narratives that separate past from present, but as mutually constitutive and disclosive of the individual and structural factors that shape how patients obtain surgery.

I work from the premise that even the most mundane photographs of cosmetic surgery are not transparent and knowable, but instead that before and after photographs can be read as part of a system of signs pointing to the fantasies of the cosmetic surgery industry. Typically, photographs like the ones I discuss in this essay are dismissed as banal and uninteresting, or as manipulated and unreliable. Thus, they are not typically the material of scholarly consideration, which prefers extraordinary examples like "extreme" makeovers, artists who use cosmetic surgery, or fictional explorations of the before and after image in visual culture. As a result, ordinary photographs of cosmetic surgeries are under-theorized and presented as though they can be read transparently (if they are presented at all). My research is interested in novel ways to understand the embodied experience of undergoing cosmetic surgery, an experience in which patients navigate a complex visual terrain of individual desires and socio-cultural ideals. This complexity leads me to use creative methodologies like poetic transcription (using interview transcripts to craft texts inspired by the conventions of poetry) in order to investigate the meaning of cosmetic surgery for those whose lives intersect with its ideologies and practices (Hurst 34-40). Here, I propose that another creative and speculative way to better understand my interviews with cosmetic breast surgery recipients is through expanded inquiry into the kinds of before and after photographs they described in our conversations. My analysis in this essay builds on, and extends my earlier work on these interviews, which were analysed through a grounded theory approach that considered the interview as an intersubjective and intertextual commitment (see Glaser and Strauss; Clarke; Charmaz; Shostak). Rather than take these images for granted, I reconsider them through the lens of Silverman's argument that photographs are a way that the world (of cosmetic surgery) reveals itself to us as viewers.

Specifically, I think that Silverman's argument has profound consequences for how we look at photographs such as these:

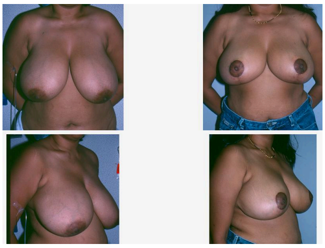

Figure 1. Otto Placik, Patient No. 7181-Dr. Placik-Breast Reduction, Chicago Illinois-Arlington Heights-four-plate photograph, *Wikimedia Commons*, 17 July 2011, https://commons.wikimedia.org/wiki/File:Patient_No._7181-Dr._Placik-Breast_Reduction,_Chicago_Illinois-Arlington_Heights-four-plate_photograph.jpg.

Figure 2. Otto Placik, Dr. Placik Breast Augmentation, *Wikimedia Commons*, 26 June 2009, https://commons.wikimedia.org/wiki/File:Dr._Placik_Breast_Augmentation.jpg.

Figures 1 and 2 are before and after photographs of breast reduction surgery (figure 1) and breast augmentation surgery (figure 2). These surgeries were performed by Dr. Otto J. Placik, a plastic surgeon practicing in Chicago, who uploaded several photographs of his surgeries to Wikimedia Commons, because he "believe[s] a picture is worth a thousand words" (Placik). My selection of these two photographic sets is driven by their free-use status, as Placik registered them with Creative Commons. Photographs like these can be located on virtually any website of a cosmetic surgeon who offers cosmetic breast surgery as a part of their practice. However, my decision not to choose photographs directly from a surgeon's website stems from the assumption that patients would know their photographs were being used by their surgeon, but not expect them to be used otherwise, as they might with an image uploaded to an open access media repository. The photographs are arranged in a grid that would be called a "full-face" view and a "three-quarter" view, if we were looking at facial portraits; it should be noted that the two views give the appearance of heightened objectivity, as it is quite common not to include the three-quarter view in surgeons' before and after galleries. These two perspectives aim to give the viewer a sense of the visual attractiveness of the patient's breasts, as well as their size and volume. The photographs begin at the patients' necks, and end at their waist or hips. We read the images from left to right, as though reading English text, and the photographs on the right ostensibly show the viewer what has happened as a result of the surgery. The photographs on the left-hand side—the "before" images—attempt to show the viewer what is pathological about the patient's breasts; on the right, the viewer is encouraged to make an assessment of how successful the surgeon was in correcting the pathology.

The style of these photographs encourages an objectifying gaze, as the viewer sees only a de-individuated torso that seems curiously disembodied even though all we see is a body. Deborah Lupton observes that "the iconography of medical advertising is a revealing insight" into the disconnection between doctors and patients, as no body contact is implied through the image, which fragments the body into pieces and strips the patient of their individuality through a dehumanizing and anonymous encounter (72). Arranged in a makeover style of transformation, the "after" photographs locate the surgery as the central change to the body, even though other elements of the women's bodies have changed in order to make the "after" image more normatively flattering through weight loss, jewellery, and tanning. But most notably, as viewers we have no concept of how much time has passed since the women underwent their surgeries, which would have inevitably caused swelling, bruising, and scarring. Some scarring is visible in the "after" photographs of the breast reduction, although the size and colouration of the scars suggest that they were taken some time after the operation, and no scarring whatsoever is apparent in the "after" photographs of the breast augmentation. The makeover framing of the photographs diminishes the reality that these women underwent surgery, even though the "before" photographs (unusually) contain signs of a medical environment, as one woman is apparently receiving intravenous fluids and the other woman is wearing a bandage on her inner elbow, as though she has recently had a blood draw. And of course, the makeover framework lessens our awareness of the pain and discomfort involved in recovering from cosmetic breast surgeries.

The use of the makeover trope in before and after photographs by cosmetic surgeons suggests an equivalence between changing one's appearance through makeup, dieting, and hairstyling and changing one's appearance through surgery. In *Surface Imaginations*, I brought together Elizabeth A. Ford and Deborah C. Mitchell's analysis of movie makeover narratives with Kathy Davis' analysis of cosmetic surgery narratives. Both tropes define the makeover or surgery as a defining moment of the protagonist's life; as an outcome or reward for suffering through hardship; as defined by a series of deliberations; and as a way to confirm one's identity (Hurst 64-66). The combination of cosmetic surgery and movie makeover narratives, in a range of photographic practices apparent in women's magazines, surgeon's websites, and personal photographs, conceals more than reveals what happens in cosmetic surgery (Hurst 72). Although I would still maintain that this is accurate when considering the surgical process and healing period following a surgery, Silverman's reevaluation of the disclosive potential of photography encourages me to reconsider what before and after photographs might reveal of the conditions under which patients engage with the cosmetic surgery industry. Through this process of reconsideration, I was surprised to find that these somewhat mundane photographs *did* express themes of my interviews conducted with three women who underwent cosmetic breast surgeries, even though they reveal very little about the process of undergoing surgery.

I interviewed three women in 2007 and 2008 who had undergone cosmetic breast surgeries, which formed part of the research for my book. Tonya and Leah received breast reduction surgeries that were covered by provincial health insurance. Tonya's surgery happened nine years before we met, while Leah's surgery was comparatively recent, having occurred just over a year before our interview. Although a commonly-held assumption is that breast reduction surgery is a medically necessary procedure, patients—especially those who have access to government-funded health insurance—indicate that framing breast reduction as "medically necessary" or as "reconstructive" surgery is instead a successful strategy to gain access to funded cosmetic surgery (see Naugler, "Crossing" and *To Take a Load Off*). This was true for both Tonya and Leah, who discussed their surgeries in cosmetic and emotional terms, as both interviewees had experienced a kind of hyper-visibility as well as unwanted sexual attention as a result of their large breasts. Melinda underwent breast augmentation surgery at a privately-run clinic and paid for her own surgery. This is typical for Canada, with the exception of breast implants that women receive after a mastectomy, which is classified as a "reconstructive" surgery. Her surgery occurred three to four years before our interview (she could not remember exactly when the surgery happened). Melinda explained that her surgery was a way to reclaim her body after an abusive relationship, and further, as a return to the way her breasts looked when she was pregnant and breastfeeding her daughter, a time when she felt powerful in her embodiment. This is a necessarily brief introduction to these interviewees, and more detailed information and analysis about their experiences of coming to, undergoing, and living after cosmetic surgery can be found in my book. For now, I would like to turn back to the before and after photographs of breast reduction and augmentation in relation to Tonya's, Leah's, and Melinda's narratives of their surgeries.

Tonya described her consultation appointment as a profoundly disembodied and "very degrading" experience, where her breasts—which were a "heavy source of shame" for her—were treated as though they were not a part of her body, and instead as objects to be evaluated as either "too big … too ugly … too saggy" through photography. Based on the way Tonya described the process of being photographed "from the front and side" in order to be assessed by a "review panel … a faceless panel of doctors" who would determine whether or not her surgery was eligible for provincial health insurance coverage, the photographs on the left in figure 1 could be the outcome of the appointment she described. Tonya also discussed looking at after photographs of breast reduction surgeries in a "standard textbook" that her surgeon offered in response to her request to see what scarring she could expect. While Tonya was critical of how the photographs of her breasts would be used to visually assess her eligibility for insurance coverage based on appearance rather than medical need, she accepted the realism of the photographs such as those in figure 1.

Leah, on the other hand, had looked at some breast reduction photographs on the Internet and was not convinced that they provided an accurate representation of surgical results. She linked this incredulity with the commonplace idea that it is unwise to seek medical information from the Internet, as the risks will always be exaggerated. Unlike Tonya, Leah did not have photographs taken as a part of her intake appointment. Nevertheless, her experience of being assessed in the clinic is also present in figure 1. Because she did not trust the evidentiary power of photographs, Leah felt that she needed to place her trust in the surgeon instead. Although she described him as a "nice man" and a "good" surgeon, her description of being assessed by him was not flattering. He was in the consultation room for just five minutes, "flicked open" her hospital gown, and treated her breasts and body as though he "was a mechanic dealing with parts."

The sterile and detached disposition of figure 1 discloses this experience, as the viewer is not encouraged to see the subject as a person entering into a medical relationship to change a part of her body that might be associated with a range of feelings related to sexuality, maternity, shame, and pathology, but instead as "parts" that can be "dealt with." The fragmented body in figure 1 uncovers the vulnerability and objectification in the encounter, as well as the experience of having one's breasts manipulated and evaluated as though they are entirely separate from one's self.

One significant difference between figure 1 and figure 2 is the presence of scarring in figure 1. This scar—which encircles the woman's nipples and runs down vertically toward the crease where her breasts and torso meet—has a visual function in the photograph that is parallel to the popular assumption that breast reduction surgery is a reconstructive, medically necessary procedure. The scar's apparition suggests and reinforces the idea that patient and surgeon are less concerned with the cosmetic outcome and that this surgery has been done for functional reasons. Its visual presence replicates the significance of the scar for both Leah and Tonya. Leah's motivation to seek breast reduction surgery originated in the shame she felt about the stretch marks networked across her breasts; in contrast to these, surgical scars were not concerning in the least. Tonya made a decision to never be ashamed of her surgical scars and contradictorily described her scars as "big and disgusting and ugly" but also "actually quite good." She created a regimen of care to minimize the size and improve the appearance of her scars, which included the use of turmeric and rosehips. Melinda also spoke about scarring, saying that while her breast augmentation scars were larger than usual, they were also "not noticeable" and "faded." Figure 2 is markedly different, as the scar left by inserting breast implants into the patient's chest is possibly concealed in the creases underneath her breasts, something which Melinda mentioned when she said that her scars were not apparent. In figure 2, it appears that the patient's breasts have miraculously grown, but are otherwise not substantially different in shape or location.

Intriguingly, the depiction of breasts in figure 2 is revealing of how Melinda discussed her hopes for her breast augmentation surgery, rather than her interactions with her surgeon. Melinda consulted the photograph gallery on her surgeon's website and was reassured that he had operated on women who varied in body and breast size, and that he also performed breast reduction and lifting surgery. She reminisced fondly about her experiences of being pregnant and breastfeeding her daughter, which was a time when her "body changed a lot" because she "had breasts" and felt "more feminine and sexier and curvier." This transformation was almost magical, and facilitated an experience of embodiment that was powerful and different from her self-concept as a "heady" person who didn't previously care that she had small breasts. Melinda's narrative about her breasts growing during pregnancy and childbirth is uncomplicated and does not involve a dramatic change. This was the expectation that she held about her breast augmentation, which she hoped would return her to this former embodiment where her breasts were "small, and natural." Here, figure 2 discloses the wishes informing the decision to undergo breast augmentation surgery, as well as Melinda's satisfaction and happiness with her outcome. Significantly, Melinda said that she "liked [her] breasts all of a sudden," a declaration that echoes the immediacy of the transformation in figure 2.

As representatives of conventional before and after photographs of cosmetic breast surgeries, my analysis of figures 1 and 2 in relation to interview narratives about breast reduction and augmentation indicates that such photographs do hold a disclosive dimension that I had never considered. When read disclosively, looking at before and after photographs of cosmetic breast surgeries is an act of recognition that reveals the body in transformation and the power dynamics of the patient-surgeon relationship. This disclosive dimension exists alongside the instrumental use of before and after photographs as evidence of a surgery, a use which I have argued conceals more than it reveals (73). For example, what continues to be invisible in figures 1 and 2 is the severe pain, swelling, and bruising that Tonya described as "look[ing] like I'd gone through a Mack truck," the dehydration and adverse reaction to pain medication that led Melinda to an emergency room two days after her surgery, and the discomfort Leah experienced when dealing with drainage tubes for the week following her surgery. These examples of what is unseen in before and after photographs of cosmetic breast surgeries suggest that their common use as evidence of a surgery is one that intends to be persuasive through diminishing what is painful and unpleasant about healing.

Before and after photographs of cosmetic breast surgery are "predicated on [a] conceit of immediacy and visual order," revealing a desire to correct and control the disruptive body presented in the before image (Hannabach 356). An analysis of before and after photographs of cosmetic breast surgeries as disclosive is significant in the context of ongoing struggles for authority over the interpretation and creation of medical images at the intersection of science and popular culture (Treichler et al. 9). Reflecting on the disclosive qualities of Figure 1 and Figure 2 through the lens of narratives of cosmetic breast surgeries makes room for an interpretation that considers not just the results of a surgery (evidence), but also the conditions that patients navigate as they establish relationships with surgeons. Ordinary before and after photographs of cosmetic breast surgeries can facilitate a better understanding of patients' hopes for surgery, as well as their experiences of the consultation process, which are inscribed onto the photograph's surface. Reconsidering these photographs through Silverman's insight that photography reveals something about the world compels me toward a more nuanced and changed understanding of Tonya's, Leah's, and Melinda's narratives. Thus, while I continue to interpret these photographs as concealing the process of recovery and healing, I additionally understand them as revealing a partial view of the world of cosmetic surgery to their viewers. Thinking through such photographs not only as evidentiary, but also as disclosive, opens up a potential avenue of analysis for researchers interested in visual culture and embodiment.

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BROKEN

VANESSA GREAVES

Broken

Artist: Vanessa Greaves

Photographer: Jacqueline Juba

Materials: Wire and concrete

ARTIST STATEMENT

This piece embodies both the strength and fragility of the female body. As women, our identity can be connected to our physical beings. Much cultural significance is given to breasts as being symbolic of femininity and sexuality.

But we cannot always control the narratives of our lives. When breasts don't physically conform to what is culturally assigned as beautiful, the impact can be felt to the core.

This piece seeks to illustrate the strength and beauty that is found within, challenging traditional ideas and, in the process, reimagining and redefining the body. With its stark aesthetic, *Broken* invites us to reconstruct our views on the physical breast, embracing beauty and strength in all forms.

RAD ART: A JOURNEY THROUGH RADIATION TREATMENT

SALLY LOUGHRIDGE

When I was diagnosed with breast cancer in 2010, I was startled, frightened, and anxious. After surgery, radiotherapy was recommended for 33 consecutive days (excluding weekends). As an artist, I decided to make a quick, small, and unplanned daily painting immediately after each radiation treatment to help me express, discharge, and cope with the overwhelming and unfamiliar feelings I was experiencing. I did not want cancer to become my identity! After treatment ended, friends and professionals encouraged me to create a book from these private paintings and their accompanying daily log. The American Cancer Society published this material as *Rad Art: A Journey Through Radiation Treatment* in 2012 (Atlanta, GA).

These oil paintings are the first two I created as my radiation course began. My goal was expression, not artwork *per se*. I allowed myself 20 minutes or less for each 5 x 7" painting in order to minimize rational thought. Indeed, the pieces seemed to flow from my brush without forethought or planning. Stirred by each completed painting, I wrote a few words to describe how I was feeling at that moment.

Image credits

"My Right Breast." Copyright 2012 American Cancer Society, Inc. Reprinted with permission.
"My Terrain." Copyright 2012 American Cancer Society, Inc. Reprinted with permission.

Day One: My Right Breast

"I had always thought of my breasts as a matched pair. But since I received a diagnosis of breast cancer, they have become distinctly individual. i am anxious about starting radiation, and I feel protective of my right breast–in a familiar, motherly way. in this first painting, i am startled to see how dark the interior is, full of the mystery and menace of the cancer cells.

One treatment down, thirty-two to go! Six and a half weeks feels like a very long time. I am glad I have started this series of paintings, but I am not sure how my near daily practice of studio painting will fare. I am already looking forward to my first weekend off treatment.

Day Two: My Terrain

"I started this painting full of raw emotions and uncertainty about the radiation process. Do I need it? Will it help me? Will it have long-term side effects? I am angry that I need more treatment, angry that I have cancer.

I loaded my brush with magenta and sculpted a mountainous terrain. The landscape quickly became my profile as I lay on the metal treatment table–arms over my head and knees elevated. I have to assume a very exact position and remain still during the treatment so that the rays can be precisely focused on the target area mapped on my chest. The jagged cloud shapes in the painting are the radiation beams aimed at my breast, coming from a huge, circling, and humming apparatus over the table. I have already begun to count the clicks and movements of the machine."

RUNNING FOR THE FUTURE: REPRODUCTIVE FUTURITY IN CANADIAN BREAST CANCER SURVIVORSHIP DISCOURSE

RACHAEL PACK

Abstract*: This article critically examines the proliferation of images of youthful breast-cancer survivors within Canadian Breast Cancer Foundation's (CBCF) promotional materials, explicating how such images of survivorship are inextricably tied up with the (re)production of gender, sexual, temporal, and citizenship norms. Focusing specifically on the 2013 Run for the Future campaign, I trace how the figure of the prepubescent child and narratives of emerging (hetero)sexuality operate to project a vision of the future, which is marked by the inevitability of both breast cancer and fractured nuclear families. I consider how such imaginations of an unstable future are mobilized to promote participation in the Run for the Cure (the philanthropic event promoted by CBCF's multimedia campaign). Drawing on insights from queer theory, I highlight how the youthful survivor subject is embedded within a discourse of reproductive futu-*

Resume *: Cet article examine de façon critique la prolifération d'images de jeunes survivantes du cancer du sein parmi les documents de la Canadian Breast Cancer Foundation (CBCF), et explique comment de telles images de survie sont inextricablement liées à la reproduction des normes de genre, de sexualité, de temporalité et de citoyenneté. En me concentrant surtout sur la campagne Run for the Future de 2013, je retrace comment l'image de l'enfant prépubère et les récits d'(hétéro)sexualité naissante agissent pour projeter une vision du futur qui est marquée à la fois par l'inévitabilité du cancer du sein et par celle de la fracturation de la famille nucléaire. J'étudie comment ces images d'un futur précaire sont employées pour encourager la participation à la campagne Run for the Cure (un événement philanthropique parrainé par la campagne multimédia de la CBCF). A la lumière de la théorie Queer, je souligne comment le sujet de la jeune survivante s'inscrit dans un discours de futurité re-*

rity in which her nascent citizenship is inextricable from her projected motherhood and heterosexuality. I suggest that the campaign constructs breast cancer as a disease that threatens the integrity and continuance of the heterosexual, nuclear family, and thus constitutes an unavoidable risk that must be addressed by citizens in the name of the future. Ultimately, I argue that participation in the Run for the Cure is styled not as a strategy to protect girls and future women, but rather to safeguard an imagined, desired heterosexual future.

productive dans lequel la citoyenneté naissante est inséparablement liée aux attentes de sa maternité et son hétérosexualité. Je suggère que la campagne présente le cancer du sein comme une maladie qui menace l'intégrité et la survie de la famille nucléaire hétérosexuelle et constitue ainsi un risque inévitable auquel les citoyens doivent faire face au nom du futur. Finalement, j'avance que la participation à Run for the Cure est représentée non pas comme une stratégie destinée à protéger les filles et futures femmes, mais plutôt pour sauvegarder un futur hétérosexuel imaginé et souhaité.

INTRODUCTION

> *I'm proud of my daughter. As a toddler, she was strong and confident, so of course, when she was a teenager, we argued a lot (sigh)… But she grew into this woman who could accomplish anything. Now, it's my turn to be strong for her. Now that she has breast cancer. I'm running for my daughter. (Godsall and Diller, "Delia")*

This passage, from a 2013 promotional video for Canadian Breast Cancer Foundation's (CBCF) annual CIBC Run for the Cure, may appear at first to be unremarkable, similar even to the dozens of public narratives about breast cancer and philanthropic giving that we encounter. However, Delia—the narrator at the heart of this drama—is remarkable; she is a child. The advertisement collapses time and asks the viewer to imagine pre-teen Delia's future as a mother with a daughter of her own, a daughter that has breast cancer. Delia speaks in a soft, distinctly childlike voice of a future—her future—that has not yet been realized with a chilling certainty; her daughter will have breast cancer. In response to this unknowable truth, Delia pledges to participate in the Run for the Cure and to do her part, as a mother and a citizen, to bring a "future without breast cancer" into being.

Figure 1, *Delia*

I came across Delia and her impossible narrative of motherhood and civic participation while conducting my doctoral research, which traced how breast-cancer survivorship discourse operates to shape and reinforce our ideas about what it means to be a woman and responsible citizen. While my study was concerned with the discursive construction of adult breast-cancer survivor subjectivities, I found that children figured prominently in the philanthropic texts produced by the CBCF. While children were frequently present in my archive of texts, none of them were quite like Delia. These children were silent figures, more objects than actors. Their physical and relational proximity to their mothers was designed to draw on the heartstrings of viewers and remind them that the breast-cancer survivors at the heart of these advertisements were first and foremost mothers. So, imagine my surprise when Delia spoke of herself as an agentic—if impossible—subject. This discrepant text demanded investigation.

Delia's video is part of a 2013 video and print campaign united under the slogan "Run for the Future." Each of the 8 print and video advertisements in this series features a child who speaks in the voice of their future adult self about their heterosexual family that has been disrupted by the breast-cancer diagnosis of a daughter or wife. This disorienting campaign is organized around a vision of the future that is suspended in a complex temporal arrangement that blurs the boundaries of the future and the present. The temporal ambiguity threaded through the campaign operates as a powerful discursive strategy that unsettles the viewer and appeals to their sense of morality and responsible citizenship. While both types of child figures—the silent and the speaking—are invoked in breast-cancer philanthropic discourse to construct participation as a moral imperative, the meaning attached to each of these figures is profoundly different.

In this article, I take the figure of the speaking child featured in the 2013 Run for the Future campaign as the object of my analytic attention. Drawing on insights from queer theory, I trace how the figure of the prepubescent child and their narrative of emerging (hetero)sexuality operates to project a vision of the future, which is marked by the inevitability of both breast cancer and fractured nuclear families. I consider how such imaginations of the future of the Canadian nation state are mobilized to promote both participation in the philanthropic event and reproductive futurity. In exploring the temporal dimensions of this unique survivorship discourse, I highlight how the youthful survivor subject is embedded within a discourse of reproductive futurity in which her nascent citizenship is inextricable from her projected motherhood and heterosexuality. I suggest that the campaign constructs breast cancer as a disease that threatens the integrity and continuance of the heterosexual, nuclear family, and thus constitutes an unavoidable risk that must be addressed by citizens in the name of the future. Ultimately, I argue that participation in the Run for the Cure, in this campaign, is styled not as a strategy to protect girls and future women, but rather to safeguard an imagined, desired heterosexual future.

BREAST-CANCER PHILANTHROPY

The Run for the Future campaign is situated within the context of the North American breast-cancer philanthropy, a thriving form of health-consumer activism that calls upon corporations and private citizens to address the problem of breast cancer through the donation of money and time and the purchase of sponsored products (King 46). The unprecedented success of these charitable campaigns and the philanthropic organizations behind them—most notably the American Susan G. Komen Foundation and the Canadian Breast Cancer Foundation—are in large part due to the cheerful, optimistic pink imagery that has become an inextricable part of breast-cancer culture (Ehrenreich 47). This pinkwashing has rendered breast cancer as a palatable disease and a cause that is "blissfully without controversy" (Goldman 70). Pinkwashing and the relentless hope and optimism threaded through philanthropic campaigns has effectively transformed breast cancer into a "rite of passage" and a "normal marker in the life cycle, like menopause or greying hair" (Ehrenreich 48). The unremarkability of breast cancer is particularly dangerous, as it operates to constrain women's possibilities for action by delegitimizing responses of anger, distrust, and critical engagement and reinforcing both traditional femininity and paternalistic relationships with biomedicine (Dubriwny 50).

Breast-cancer philanthropy and mass-participation events like the Run for the Cure have come to occupy a significant place in North-American breast-cancer culture and play a key role in shaping public perceptions of the disease. These events have also transformed the landscape of breast-cancer research, generating tens of millions of dollars each year for cure-oriented biomedical research (Sulik 12). While corporate sponsorship supported the creation of a multi-billion-dollar, breast-cancer research industry, this prominence has come at a high cost—namely its activist potential. Maya Goldenberg argues that, while contemporary breast-cancer activism and cure-oriented fundraising campaigns appear on the surface to be concerned with improving the conditions for women's health, these mainstream campaigns actually operate to support and reinforce the status-quo through an "unquestioning support of the medical model" (151). In effect, the current state of breast-cancer organizing restricts women's field of possibilities for participation and action to the consumer realm and the purchasing of supposedly socially conscious products (King 46). Such acts of consumerism are framed as activism, and meaningful productive ways to address the problem of breast cancer, and thus have become central components of responsible citizenship (Goldenberg 158).

CANADIAN BREAST CANCER FOUNDATION

The CBCF, founded in 1986, is currently the largest charitable funder of breast-cancer research in Canada. In concert with its corporate sponsor, the Canadian Imperial Bank of Commerce (CIBC), CBCF has organized and administrated the Run for the Cure since 1992. Over the years, the Run for the Cure has become the largest, single-day, volunteer-run breast-cancer fundraising event in Canada. The Run is currently held in 63 communities across Canada and attracted 97,040 participants in 2016, raising over 17 million dollars ("About the CIBC Run"). Since the inaugural event in 1992, the Run for the Cure has maintained a strong public presence, through widespread advertising campaigns (e.g., through websites, billboards, bus-shelter ads, television, YouTube, Facebook, and so on) that call for awareness and fundraising. The widely popular Run for the Cure and the CBCF remain the most public and recognizable face of breast cancer in Canada.

In my larger study, I illustrated how CBCF promotional materials over the past decade have almost exclusively represented breast-cancer survivors as young, beautiful women, and often mothers (Pack). I argued that this intense focus on youth and vitality produced the figure of the *Universal Woman At-Risk*, who functions as a symbol of national urgency and constructs breast cancer as problem that must be responded to with conspicuous acts of personal generosity. I suggested that the proliferation of images of young, seemingly healthy breast-cancer survivors enacted a cultural disarmament, disrupting the idea that youth is a time of protection from disease and that the cultivation of health offers a protective shield against the disease. This discursive severing of youth from the expectation of health interrupts cultural conceptions of the life course, enabling the possibility of disease, disability, and death to puncture the everyday. More simply put, the broader archive of CBCF texts address all women as survivors and presumes the emergence of the disease in their future. Counter to public-health narratives of risk reduction (Conway et al. 758), the disease is figured as entirely inescapable. This strategy of address underpins the central marketing strategy of the CBCF and is also visible in the Run for the Future campaign.

This notion of *universal vulnerability* is central to my reading of the Run for the Future campaign. Through its collapsing of time, the advertisements in this series further expands the field of breast-cancer survivorship to incorporate women and girls who have yet to come into maturity or existence, predetermining their diseased futures. This is highly visible in Delia's prediction of her own daughter's present/future diagnosis. The temporal expansion that enables Delia to be simultaneously a child and mother of an adult daughter is made possible through the queering of time, in which both her and her daughter's future have already been destabilized by civic neglect of their reproductive futurism. Time, in this sense, is more than the organized passage of minutes and hours; it is a socially constructed system that operates to regulate, direct, and compel bodies towards particular—"normal"—ends (Freeman 18), which the advertisements suggest civic inaction has already compromised, leading to "queer" dead ends. Adopting this notion of "queer time"—as time that has been directed away from reproductive ends—enables a critical examination of the temporal trajectories and orientations in which the orating child and their pre-diseased loved one are implicated, further revealing the subtle and complex ways that breast-cancer survivor subjectivity is produced and towards what ends.

CHRONONORMATIVE NARRATIVES

The temporal trajectory that underlies the narrative in the video advertisement *Sean* is decidedly normative. *Sean* features a young blonde-haired boy sitting on a swing in a park. Gazing intently at the viewer he states:

> I love my wife. We met in fourth year on campus. It was love at first sight; she'd say second sight. We got married not too long after graduation. Last October we got the bad news. The doctor found a lump in her breast. I'm running for my wife (Godsall and Diller, "Sean").

Sean's narration of an anticipated future in the present, like Delia's, produces a disorientating temporality. The first portion of his narrative maps neatly onto an idealized, anticipatory life trajectory marked by heterosexual romance, advanced education, and family formation. This trajectory is reflective of the dreams and aspirations that many Canadian parents and families hold for their children—the reproduction of the nuclear, heterosexual family and the cultivation of a middle-class life.

Figure 2, *Sean*

While the desire to cultivate a timeline such as Sean's may appear to be natural, this "naturalness" is an effect of the socially constructed rhythms of time that work to shape bodies into forms that synchronize with larger structural and political goals (i.e., capitalism), thus enabling citizens to participate in dominant forms of sociality (Freeman 18). As an effect of chrononormativity (Freeman 5), bodies, like Sean's, that can ease into the desired tempo are incorporated into the fabric of dominant culture and rendered intelligible citizens. This normative timeline, in turn, binds bodies to the rhythm of capitalism and heteronormative notions of the nuclear family and reproduction. Chrononormativity extends beyond the level of individual and infiltrates the national, producing a chronobiopolitical society in which the state and its institutions fuse disciplined bodies to narratives of progress and teleological strategies of living, such as marriage, reproduction, and the accumulation of wealth (Luciano 9). To this effect, Elizabeth Freeman argues that, "in the eyes of the state, the sequence of socioeconomically 'productive' moments is what it means to have a life at all" (5).

The alignment of the first act of Sean's narrative—heterosexual love, post-secondary education, and marriage—with the values of the Canadian, chronobiopolitical state renders him as an intelligible citizen. It is through his participation in these teleological strategies that he and his unnamed wife come to matter to the viewer and the nation. It is precisely Sean's productivity that makes the disruption of his anticipated life course tragic. The emergence of breast cancer and the possibility of losing his wife to the disease threaten to sever his chrononormative life trajectory. This tragedy, however, is made queer by the collapsed temporality of Sean's narrative. Sean, a child, is faced with the prospect of losing his wife, with whom he fell in "love with at first sight," years before he will meet her (Godsall and Diller, "Sean"). His fairy-tale, campus romance and heterosexual family are at risk before they can ever be realized. This pre-emptive interruption of Sean's future has two important discursive effects. First, the presentation of his nameless wife's breast-cancer diagnosis as pre-determined reflects the incorporation of all women and girls (refigured as latent survivors) into the expanded field of breast-cancer survivorship. Second, the curtailing of Sean's (re)productive timeline is made politically compelling through his child body, constructing financial and civic support of the CBCF as a moral imperative.

THE AGENTIC CHILD

The driving force in the drama of breast cancer in the campaign is the child at risk of an interrupted future. It is the plight of the child and potential curtailment of their normative life course that signals the urgent need for civic action and public generosity. The centrality of "the Child", the figure the drives this campaign, is reflective of the “reproductive futurism” that Lee Edelman asserts underpins the heart of heteronormative culture and politics in the Western world (21). Reproductive futurity and its intensive focus on the Child facilitates the reproduction of society itself without difference and, in so doing, upholds and reproduces gender, citizenship, sexual, and temporal norms (Edelman 21). Of course, the Child invoked in this campaign is figurative rather than “real.” The advertisements *Delia* and *Sean* do not call for public investment in the futures of either child or their future families; it is the future itself that requires investment. This political symbol—the Child—is a placeholder for the future and its innocence; adult citizens are charged with the responsibility of ensuring its protection. This responsibility to safeguard the Child and the next generation of innocence is integral to reproductive futurity. From standpoint of heteronormativity, abandoning the Child is akin to embracing the death drive (Edelman 27).

The audience addressed by the Run for the Future campaign, however, is already accused of abandoning the Child. Their neglect and civic inaction has necessitated this queer collapse of time and the deathly acceleration of the child’s life course. The jarring juxtaposition of childhood innocence and the responsibilities of secure citizenship and reproductive futurity are visible in the print ad *Elijah*. The advertisement features a young, black boy with wearing a slate gray t-shirt. Below his relaxed, half-smiling face, the bold statement, “I’M RUNNING FOR MY WIFE” is printed in white, childlike font.

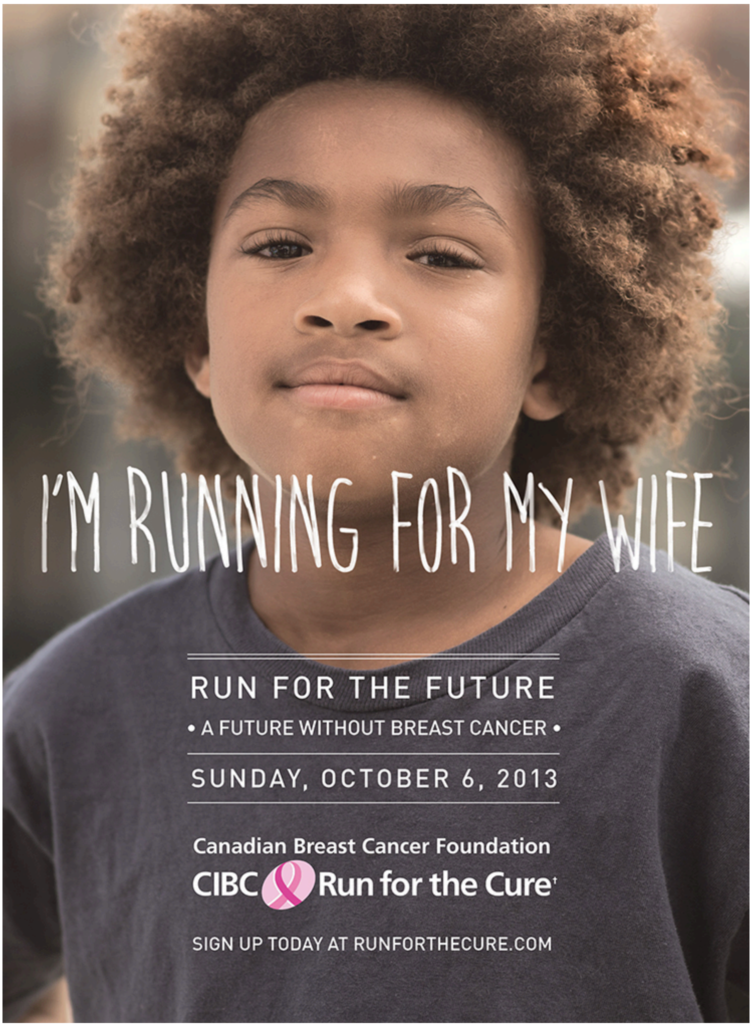

Figure 3, *Elijah*

This white font lays bare the collapse of Elijah's childhood innocence, adult agency, and (hetero)sexuality brought about by the lack of philanthropic effort. He, a child made responsible before his time, is left to take up the role of protecting the future through civic participation. This text at once admonishes the narcissism and irresponsibility of Canadian citizens for their failure to invest in the future and acknowledges the nascent sexuality and agency of children. We, the viewers, are asked to suspend disbelief and view the children simultaneously as innocent, non-sexual beings in need of our protection, and as active participants in politics exercising agency in the name of their own futurity. In so doing, the text produces a strange form of queer time that is appropriated and deployed towards heteronormative ends. But what remains is the fleeting ephemera of childhood agency and sexuality; these traces offer queer possibilities that might subvert or at least complicate the logic of reproductive futurity and the imagined Canadian state.

In contrast to these fleeting possibilities, the heteronormative conservatism of the campaign is laid bare in the absence of the woman for whom the Child pledges to run. Nameless, faceless, she is spectral survivor—a mere idea, rather than a person worthy of investment. Strikingly, personal generosity and participation in the Run for the Cure are disarticulated from any sense of anger or injustice at women's suffering, the high rate of breast-cancer diagnoses, and the devastating effects of biomedical treatments on women's bodies and lives. In other words, the diagnoses of (future) wives and daughters in the campaign are not made tragic because women themselves are suffering, but rather because of the potential severance of their nuclear family and their reproductive possibilities. Suffering, in this campaign, is articulated through concerns about the potential effects of the disease on the nuclear family. In this construction, women's lives come to matter solely through their intimate, reproductive connections to others. In this context, participation in the Run for the Cure can be read as a citizenship practice that articulates one's commitment to the nation by protecting and preserving both women's traditional roles (i.e., as mothers and wives) and the nuclear family—the site through which new citizens are produced and nurtured.

A UNIVERSAL CHILD

The children featured in the Run for the Future campaign appear in all respects to be ordinary; there is nothing remarkable about their appearance. Their clothing, styling, bodies, and locations (i.e., bedroom, park, and so on) are all reflective of childhood. Their ordinary appearance tempers their adult-like patterns of speech and the content of their impossible narrative. Taken together, the children read as uncanny; they are strange and yet familiar. The unsettling ordinariness of these children is by design, as Stockton argues that "normative strangeness" is central to the Child and accounts for its entanglement of whiteness and middle-class sensibilities. This entanglement signals innocence: as Stockton reminds us, "it is a privilege to need to be protected and thus have a childhood" (514).

Although the Child is often imagined to be white and middle-class, the children featured within this campaign are racially diverse. While Delia and Elijah are visually non-white, their narratives of heterosexual marriage and reproduction align neatly with that of Sean. Any difference produced by the racial diversity of the children is thus obscured by the (re)productive teleological markers that pepper their narratives. The uniform timeline that runs through their stories suggests that difference is permissible as long as it fits within the chronobiopolitical order. This sentiment maps neatly onto the Canadian national myth of diversity, inclusion, and equality for all. Echoing Jose Munoz, this single narrative suggests that the only "sovereign princes of futurity" are those that can synchronize their bodies and lives to matchup with a normative timeline (95).

The unremarkable appearance of Delia, Sean, and Elijah and the signals of middle-class whiteness present in their narrative transform them into a compelling visual placeholder for the "average" Canadian child. Effectively, Delia, Elijah, and Sean signal a "universal child": a figure that communicates ubiquitous vulnerability to breast cancer and suggests that no one is safe from the potentially devastating effects of the disease. This universal figure also functions to incorporate both male and female children into the field of breast-cancer survivorship, highlighting their *mutual vulnerability*. While female children are rendered vulnerable through their bodies—the eventual sites for disease emergence—male children are made vulnerable through their assumed intimate connections to their future female partners. Significantly, what are made vulnerable in this configuration are not so much the bodies of girls and future women, but the stability and continuance of the structure of the heterosexual nuclear family.

The dismissal of the material bodies of girls and future women is reflected in the campaign's obfuscation of difference. It is well established that social determinants including race, poverty, and social exclusion are key factors that shape the health and well being of the population (Ratcliff 2). Canada has seen a significant reduction in breast-cancer deaths in the past two decades; early detection of the disease facilitated by widespread screening programs is often credited with this reduction (Jatoi and Miller 252). While on the surface it appears that Canadian women are reaping the benefits of public-health interventions and increased awareness, these population-level statistics cover over some important disparities. Specifically, inadequate and inequitable access to screening is a substantial problem in Canada that disproportionately affects racialized, immigrant, and poor women (Vahabi et al. 679). As a result, these populations have some of the lowest rates of screening utilization and concerning disparities in diagnosis, treatment, and survival exist (Kerner et al. 161). Ensuring equity in breast-cancer care requires more than an outpouring of public generosity; an understanding of the broader structures that yield such disparities is vital. But to recognize that the structure of the Canadian state creates and supports inequality would puncture our national fantasy of equality, inclusion, and multiculturalism. Furthermore, it would demand that we recognize the humanity and value of bodies that do not or cannot synchronize to the normative timeline.

REPRODUCTIVE FUTURITY AND SURVIVORSHIP

As I have argued, the Run for the Future Campaign frames breast cancer as a problem that comes to matter on the national stage through its anticipated disruption of future nuclear families and the heteronormative fabric of Canadian life. The ways that breast cancer is attached to the heterosexual nuclear family in the Run for the Future campaign supports Lauren Berlant's argument that the conditions of women's citizenship are increasingly attached to reproduction and futurity (148). Within this discourse of citizenship, the imagined future that women are charged with bringing into being is one that does not belong to them. Women thus are simply vehicles for (rather than subjects of) the future; the temporal trajectory made available for women is a circular trajectory of birth, marriage, motherhood, and death.

The homophobic implications of this imagining of the future are clear. The vision of a future without breast cancer promised through the CBCF discourse is a heterosexual future in which women's citizenship value is derived from her connections to the nuclear family unit. Further, the youthful breast-cancer survivor invoked within the Run for the Future campaign is a subject firmly situated in reproductive futurity. Her status as wife and potential future mother are central to her value as a citizen about whom we should care and whose future we should attempt to secure through acts of personal generosity. Glaringly absent from this campaign are women independent from the nuclear family—they are outside the boundaries of intelligibility. The non-appearance of women who defy heteronormative and patriarchal norms speaks volumes; these are women whose lives and futures are not worthy of public or personal investment. These women are not visible as citizens within the CBCF's construction of the survivor and its imaginings of the Canadian nation.

What I suggest in this brief analysis is that the Run for the Future campaign operates to do more than appeal to Canadians' sense of moral and civic responsibility and encourage an outpouring of personal generosity to create a "future without breast cancer." Specifically, this campaign and the figure of the Child operate to invoke anxiety in the viewer by threatening the reproductive futurity of the nation and leverage this anxiety into philanthropic giving. Ultimately, this discourse on breast cancer calls upon citizens to act in the interest of securing the continuation of hegemonic society in which only certain bodies and forms of suffering matter, and only certain women (and children) are recognizable and intelligible as at risk and deserving of protection.

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IMAGE NOTES

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IMAGING HUMAN BREAST TUMOURS IN DIFFERENT SPECIES: HOW HUMAN ARE THEY?

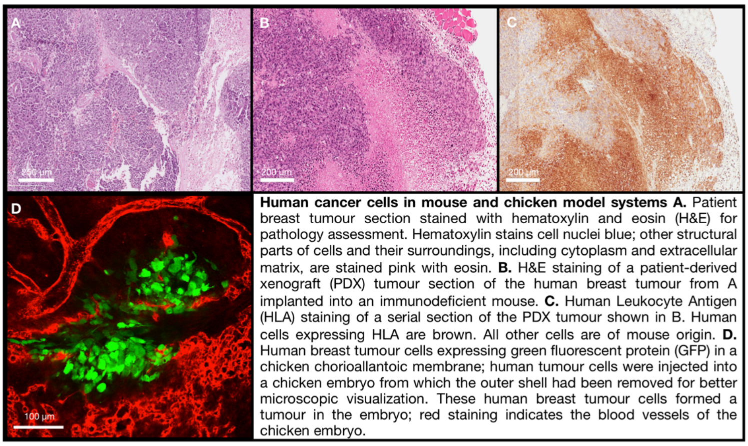
GABRIELLE M. SIEGERS, JULIA SCHUELER, HON SING LEONG, LYNNE-MARIE POSTOVIT

***Abstract**: In a gedankenexperiment, we pose the philosophical question as to whether human breast cancer cells or tissues can still be considered human after transplantation into another species. Alongside medical research images illustrating xenotransplantation, we provide descriptions of how tissues were prepared for imaging. In addition, we discuss how such models enable further understanding of cancer and provide invaluable tools for testing new therapies.*

***Resume** : Dans un gedankenexperminent nous posons la question philosophique de savoir si les tissus et cellules de cancer du sein humain peuvent toujours être considérés comme humains après qu'ils ont été transplantés dans une autre espèce. En plus de photographies de recherche médicale illustrant la xénotransplantation, nous offrons des descriptions expliquant comment des tissus ont été préparés pour la visualisation. Nous débattons en outre de la manière dont de tels modèles permettent une meilleure compréhension du cancer et offrent des outils inestimables pour tester de nouvelles thérapeutiques.*

Cancer researchers use model systems in order to understand mechanisms of cancer initiation and progression, and also to test new treatments. This is done before such treatments are tested in people, and is governed by the Helsinki Declaration (World Medical Association) as well as national animal care committee guidelines (such as those of the CCAC in Canada, OLAW in the USA, and GV-Solas in Germany), which ensure ethical practices are employed in the use of both human tissues and animals in research.

Xenograft (xenos, Greek = foreign) models involve transplanting human cells or tissue into mice that have little to no immune systems (which would reject the transplants). For diagnostic purposes, pieces of breast tumours removed during surgeries are preserved and sent to histology labs for processing. Tumours are embedded in paraffin and sliced very thinly, after which these "sections" are stained with hematoxylin and eosin (H&E) dyes. These allow pathologists to see the sizes and shapes of cells under the microscope, to distinguish cell nuclei from other structures within the cell and also to identify structures outside of cells, termed extracellular matrix. An example of an H&E stained section of a human tumour is shown in panel A. The corresponding H&E section from the model system derived from this very tumour—the patient derived xenograft (PDX, Charles River)—is depicted in panel B. The similarities are striking, and therein lies the power of the PDX. The human tumour piece has been implanted into a mouse, allowed to grow in size, and then pieces thereof are further implanted into more mice. Throughout this process, these tumour pieces retain most characteristics of the original malignancy; this enables creation of a tissue bank that can be used for testing promising anti-cancer drugs and immunotherapies.



Human cancer cells in mouse and chicken model systems A. Patient breast tumour section stained with hematoxylin and eosin (H&E) for pathology assessment. Hematoxylin stains cell nuclei blue; other structural parts of cells and their surroundings, including cytoplasm and extracellular matrix, are stained pink with eosin. **B.** H&E staining of a patient-derived xenograft (PDX) tumour section of the human breast tumour from A implanted into an immunodeficient mouse. **C.** Human Leukocyte Antigen (HLA) staining of a serial section of the PDX tumour shown in B. Human cells expressing HLA are brown. All other cells are of mouse origin. **D.** Human breast tumour cells expressing green fluorescent protein (GFP) in a chicken chorioallantoic membrane; human tumour cells were injected into a chicken embryo from which the outer shell had been removed for better microscopic visualization. These human breast tumour cells formed a tumour in the embryo; red staining indicates the blood vessels of the chicken embryo.

The question arises, however, as to whether human breast cancer cells or breast tumour tissues can still be considered human after they have been transplanted into another species, such as a mouse or chicken embryo. To survive in another species, a human tumour must connect with the blood system of that species, which allows various support cells to enter the tumour and help it thrive. So how human is the tumour at this point?

One defining feature of human cells is their expression of specific proteins called human leukocyte antigens (HLA) on their surface (World Health Organization, Park and Terasaki). Using a technique called immunohistochemistry, we can detect the presence or absence of HLA on cells in tumour sections. HLA expression on the tumour in panel B is shown in panel C: brown staining indicates the presence of human HLA and the lack of stain indicates mouse cells. Thus, the breast tumour, that looks so similar to its all-human counterpart in A, has now become a hybrid of human and mouse.

Another type of xenograft model used in breast cancer research is the chicken chorioallantoic membrane (CAM) model (Nowak-Sliwinka et al.). Egg shells are removed from chicken embryos so that we can visualize them easily using a microscope. Human cancer cell lines are often engineered in the lab to produce a fluorescent protein, so that they can be easily distinguished from the host (mouse or chicken, in this case) and monitored using different types of imaging techniques. These are then injected into the CAM and are used to learn about many aspects of cancer progression. Panel D shows human breast cancer cells that express green fluorescent protein (GFP) that have formed a tumour in a CAM; here, the circulation system of the chicken embryo has been dyed red (rhodamine bound to lectin on the cell surface). Again, the chicken cells and system support human tumour growth, allowing us to study aspects of breast cancer and how metastasis occurs (Leong et al.).

How human are these breast tumours? It is a question worth considering. For now, we can at least say that they are human enough for us to learn more about human breast cancer, and test new treatments that will hopefully lead to better outcomes for breast cancer patients.

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STILL LIFE

DOROTHY WOODMAN AND ALOYS FLEISCHMANN

I waited until Al showed up for the shoot before I removed my prosthesis. While he set up the photography equipment in my dining area, I dashed into the bedroom to wrest it out of the bra's pocket, my fingers absorbing its reflected heat. I wanted it to be warm, to retain memories of my own body as we began, together, to arrange the still life for our shoot. And I had to figure out how to carry it out into my dining area where we would take the photographs. Now outside my clothing it had become strangely public. Just minutes before it was a simulacrum, a half-sister to the mound of tissue, blood and lymph next to it; now it sat on the Ikea cabinet, tipping awkwardly on the polished veneer.

Arranging the fruit I had selected from studied arrangements in the enormous store, we took turns sliding the prosthesis back and forth across the surface, squinting to determine if its aesthetic place had been located. All the while, despite our handling, it cooled, the vestiges of intimacy evap-

A decade ago, Dorothy and I were walking through the courtyard at the University of Alberta. She'd just returned to our doctoral program, and she had been telling me about her experience with cancer. By then our conversation had moved on to pollution and global warming, and I made a wisecrack about us all dying of cancer. I physically stumbled, I recall, at the effort to stop the words that were pouring out of my mouth. Too late. If it registered at all with Dorothy, I'm guessing she filed it under "*faux pas*" and moved on to the next topic. But I've always been like this—my casual banter veers suddenly into the mortality it was meant to avoid. The last time I saw my uncle in law … the final time … he had developed incredibly aggressive lung cancer, the product of working in the New Mexico desert while the army tested nuclear weapons. I made a joke about the ending of *War and Peace*. Reading it was on his bucket list and, sadly, he was halfway through. "Everyone dies," I quipped urorating, and fell back into an anonymous plasticity. Even though I irreverently fling the lopsided bra onto a chair at night, thinking of slingshots as I lob it, the jokiness of the bedroom somehow couldn't slide into the dining space now crowded with Al's photographic equipment. The joke was between me and this body part, and now with its relocation from body chest to dining chest, the seriousness of its new public purpose became a kind of alienation and freedom at the same time.

This collaboration began as a project to disrupt and overdetermine current significations of the breast. Formerly students in the same doctoral program, Al and I reconnected after many years when I contacted him about my quirky project. We would let the prosthesis be a proxy for that iconic, culturally freighted body part that was now a distant memory for me, for indeed, publicly this manufactured product functions very well as "my breast." I wanted, in our collaboration, to experience my/the prosthesis other than a negative (fakery, false consciousbanely. My aunt jumped in to change the subject: "Oh, well now you've given the ending away," she interjected, her eyes wide. But I didn't know the ending. I probably never will.

This wasn't my first rodeo, so as we planned the shoot, I watched my language. I noticed I tended to refer to the prosthesis as an "implant." Because it was silicate? I'm inclined to think of prosthetics as metal rods with plastic casings. Or perhaps it was a defense mechanism, a way of hiding the gravity of Dorothy's experience behind a glittering wall of mass media culture, where implants are simultaneously treated as a concession made by second-rate talents to their unsophisticated audiences *and* a celebration of conspicuous consumption by powerful women. This marketplace logic leaves little room to think about implanted breasts and their illusory fullness as a response to the failure of biology—of meat—to maintain the eternal geometry of an idealized curve. Was I fleeing the mortality of the cold Latinate sound of *prosthesis* for the warmer vowels of *implant*?

ness, a feminist cop-out) or a positive (a fakery that enabled normalcy: the glancing eye could be easily tricked and so could I; in fact, I often tap my breasts to remind myself which one is "mine"). But, in moving this translucent wobbly, off-centre shape here and then there, I just didn't know what to make of it/me.

Yet, my asymmetrical body seemed oddly at ease as Al and I worked together. The distance between half-sisters created a new set of relationships. Their kinship had become expansive; the prosthesis had now become engaged in a whole new set of discourses. Why, then, cannot this be the case for flesh? How are the cremated remains of the original, unceremoniously expelled, now entangled with a miscellany of dust, still me and not/me? The prosthesis, up against my chest, fills up with the revenant of my history. Bearing air and dust motes jostled by strawberries, haunted, it cannot be extricated from my body even as it is turned into an/Other. Yet, as an/Other, it welcomes me into new kinships with myself, encouraging This is not whimsy: the verb-based root of prosthesis is "to add," while the root of implant is "to plant" (also Latinate). The prosthesis lies atop the skin, the implant takes root underneath and grows. I realized how often I had said "flesh out the concept" during the planning phase—how many times my words had wished living tissue over Dorothy's concept, and her prosthesis.

Roland Barthes popularized the idea of *studium* and *punctum*. Photographers often take *studium* to mean a pleasant standard composition, while *punctum* is that jarring pinprick of contrast that gives the photo its contemplative appeal. Yet contrast was always part of standard composition, and most likely always will be. If anything punctuates the clinical blue image for me, it's that perfect focus on the serial numbers of Dorothy's breast. It was dark, and I had to use a very wide aperture for the shot; I originally planned to edit two focal points together but chose to discard the forward-focused image. Or could *punctum* be less a puncture, and more the full frame uncaning me to experience my body as intrinsically fragmented, processual, *off-centre*, an assemblage of parts that slip on and off, into and out of, multiple sites of engagement.

DW

niness that comes out of imitating a squared two-dimensional painting with a camera whose rotational axis kept slipping into unwanted depths? (I should have brought my "heavy" tripod.) And, as we widen out further, as we take in the two people and all the apparatus in that late-afternoon dining room studio, how do I name the difficulty of showing in real time Dorothy's prosthesis is still warm?

AF

CONTRIBUTORS

Abigail B. Bakan is Professor in the Department of Social Justice in Education (SJE), at the Ontario Institute for Studies in Education (OISE), University of Toronto. Her research is in the area of anti-oppression politics, with a focus on intersections of gender, race, class, political economy and citizenship. Her publications include: *Israel, Palestine and the Politics of Race: Exploring Identity and Power in a Global Context* (2020) (with Yasmeen Abu-Laban); *Theorizing Anti-Racism: Linkages in Marxism and Critical Race Theories* (co-edited with Enakshi Dua); and *Negotiating Citizenship: Migrant Women in Canada and the Global System* (with Daiva Stasiulis).

Abigail B. Bakan est professeure dans le Département de Justice Sociale dans l'Enseignement (SJE) à l'Ontario Institute for Studies in Education (OISE) de l'Université de Toronto. Sa recherche se situe dans le domaine de la politique anti-oppression, avec une concentration spéciale sur l'intersection entre les concepts de sexe, de race, de classe, d'économie politique et de citoyenneté. Ses publications incluent: *Israel, Palestine and the Politics of Race: Exploring the Identity and Power in a Global Context* (2020) (en collaboration avec Yasmeen Abu-Laban); *Theorizing Anti-Racism: Linkage in Marxism and Critical Race Theories* (co-édité avec Enakshi Dua); et *Negotiating Citizenship: Migrant Women in Canada and the Global System* (en collaboration avec Daiva Stasiulis)

Josephine Baker is a Cree-Métis woman living in Treaty 6 territory and her ancestral Métis homeland. She is completing her Master of Arts in anthropology at the University of Alberta. She holds a Bachelor of Arts with Distinction in anthropology from the University of Alberta. Her research interests include language and communication, gender, performativity, and subversive practices. Her current research focuses on the role of humor as a communicative practice.

Josephine Baker est une femme métis-cree résidant dans un territoire autochtone régi par le Traité 6 ainsi que dans sa patrie métis ancestrale. Elle termine son Master of Arts en anthropologie à l'Université d'Alberta. Elle détient un Bachelor of Arts with Distinction en anthropologie de l'Université d'Alberta. Ses recherches s'intéressent, entre autres, au langage et à la communication, au genre, à la performativité et aux pratiques subversives. Elle se concentre en ce moment sur le rôle de l'humour en tant que pratique communicative.

Anique Ellis is a Jamaican-born Canadian and an internationally trained educator. She is currently pursuing further studies at the University of Alberta, with special interest in Psychology and Women and Gender Studies. Anique is a lifestyle blogger, and a mother of one son.

Anique Ellis est une Canadienne d'origine jamaïcaine et une éducatrice de formation internationale. Elle poursuit actuellement ses études à l'Université d'Alberta, avec un intérêt spécial pour la psychologie et les études sur les femmes et le genre. Anique est l'auteure d'un blog de style de vie, elle est aussi la maman d'un petit garçon.

Aloys Fleischman is currently a Doctoral Candidate at the Department of English and Film Studies at the University of Alberta, specializing in Indigenous and Japanese Canadian literatures. He was co-editor of *Narratives of Citizenship: Indigenous and Diasporic Peoples Unsettle the Nation-State* (2011), and has published several articles, including "The Rhetorical Function of Comedy in Michael Moore's *Fahrenheit 9/11*" (*Mosaic* 2007). He has worked since 2010 as a fashion, portrait and event photographer, most notably as the official photographer for Saskatoon Pride (2010-2015), receiving the Affinity Credit Union "Community Service Special Merit Award" in 2012.

Aloys Fleischman est actuellement doctorant dans le Département d'Anglais et de Filmologie à l'Université d'Alberta, se spécialisant dans les littératures canadiennes d'origine japonaise et autochtone. Il a co-édité *Narratives of Citizenship: Indigenous and Diasporic Peoples Unsettle the Nation-State* (2011) et publié divers articles dont "The Rhetorical Function of Comedy in Michael Moore's *Fahrenheit 911*"

(*Mosaic* 2007). Depuis 2010, il travaille comme photographe de mode, de portrait et d'actualité, notamment comme le photographe officiel pour Saskatoon Pride (2010-2015,) ce qui lui a valu de recevoir le "Community Service Special Merit Award" de l'Affinity Credit Union en 2012.

Vanessa Greaves is a visual artist from Edmonton, Alberta, Canada who has been inspired to represent her ideas through art from a very young age. She is a recent graduate from the University of Alberta, Bachelor of Arts (Art and Design) with a focus in sculpture. Vanessa has a strong disposition toward working with the mediums of wire and concrete. She is drawn to both the strength and the fragility that these differing materials offer and the richness of possibilities they present. Manipulation of materials and their innate properties guide her work and exploration as an artist.

Vanessa Greaves est une artiste visuelle d'Edmonton, dans la Province d'Alberta au Canada, qui a eu l'inspiration de représenter ses idées à travers l'art depuis un très jeune âge. Elle vient de recevoir un diplôme de Bachelor of Arts (Art and Design) de l'Université d'Alberta avec une spécialisation en sculpture. Vanessa se sent fortement attirée par le travail avec les matériaux du fil de fer et du ciment. Elle aime à la fois la force et la fragilité offertes par ces matériaux ainsi que la richesse de possibilités qu'ils présentent. La manipulation de ces matériaux et leur propriétés intrinsèques guide son travail et son exploration artistiques.

Rachel Alpha Johnston Hurst is Associate Professor of Women's and Gender Studies at St. Francis Xavier University in Antigonish, Nova Scotia. Her research is concerned with the relationships between power, embodiment, and (visual) culture, from the perspectives of psychoanalysis and decolonial thought. She is author of *Surface Imaginations: Cosmetic Surgery, Photography, and Skin* (MQUP, 2015) and co-editor of *Skin, Culture, and Psychoanalysis* (Palgrave, 2013). Her most recent essays have been published in *History of Photography, Feminist Studies, Configurations,* and *Body & Society.* Currently, she is editing a collection of essays titled *Representing Abortion* (under contract with Routledge).

Rachel Alpha Johnston Hurst est professeure agrégée d'Etudes sur les Femmes et le Genre à l'Université St. Francis-Xavier d'Antigonish en Nouvelle-Ecosse. Sa recherche s'intéresse aux relations entre pouvoir, incarnation et culture (visuelle), de la perspective de la psychoanalyse et de la pensée décoloniale. Elle est l'auteure de *Surface Imaginations: Cosmetic Surgery, Photography, and Skin* (MQUP, 2015) et co-éditrice de *Skin, Culture, and Psychoanalysis* (Palgrave, 2013). Ses essais les plus récents ont été publiés dans *History of Photography, Feminist Studies, Configurations,* et *Body and Society*. Elle édite actuellement une collection d'essais intitulée *Representing Abortion* (sous contrat avec Routledge).

Daze Jefferies is a multidisciplinary artist-poet-researcher at Memorial University whose research-creation focalizes upon embodiments, geographies, and histories of trans women (and) sex workers in Ktaqamkuk/Newfoundland, Canada. Her work (an assemblage of poetics, sound, theory, and visuals) has been exhibited and performed at artist-run centres, conferences, festivals, galleries, and theatres nationally. She is co-author of *Autoethnography and Feminist Theory at the Water's Edge: Unsettled Islands* (Palgrave Pivot 2018), and she has recent publications in *Transgender Sex Work and Society* (2018) and *Hustling Verse: An Anthology of Sex Workers' Poetry* (2019).

Daze Jefferies est une artiste-poète-chercheure multidisciplinaire à Memorial University. Sa recherche-création se concentre sur le mode de réalisation, sur les géographies et les histoires de femmes trans (et) travailleuses du sexe de Ktaqamkuk, à Terre-Neuve au Canada. Son oeuvre (assemblage de poésie, de son, de théorie, et de visuel) a été exposée et représentée dans des centres d'artistes, des conférences, des festivals, des galeries, et des théâtres à travers le pays. Elle est co-auteure de *Autoethnography and Feminist Theory at the Water's Edge: Unsettled Islands* (Palgrave Pivot, 2018). Elle a également publié des articles dans *Transgender Sex Work and Society* (2018) et *Hustling Verse: An Anthology of Sex Workers' Poetry* (2019).

Hon Leong obtained a BSc in Biological Sciences and Business (University of Alberta), followed by MSc and PhD degrees at the University of British Columbia. Hon pursued post-doctoral studies at the

London Regional Cancer Centre and Western University (London, ON). Hon has received numerous fellowships and awards, including the Prostate Cancer Canada/Movember Rising Star award (2013). Hon is an Associate Professor at the Mayo Clinic (Rochester, MN, USA) in the Departments of Urology, Physiology and Biomedical Engineering. His laboratory is focused on cancer research in which insights developed in the lab are translated to clinical practice.

Hon Leong a obtenu un BSc en Biological Sciences and Business (à l'Université d'Alberta), suivi d'un MSc et d'un PhD à l'Université de Colombie britannique. Hon a poursuivi ses études post-doctorales au London Regional Cancer Centre et à la Western University (London, Ontario). Hon a reçu de nombreuses bourses et prix universitaires dont le Prostate Cancer Canada/Movember Rising Stars (2013). Hon est professeur agrégé dans les Départements d'Urologie, de Physiology, et de Génie biomédical à la Mayo Clinic de Rochester, dans l'Etat de Minnesota aux USA. Son laboratoire se spécialise dans la recherche sur le cancer dans laquelle les découvertes réalisées en laboratoire sont immédiatement appliquées au traitement clinique.

Sally Loughridge, PhD, is a professional artist, cancer survivor, and retired clinical psychologist, who believes in the power of art to foster understanding and healing. She is the author/illustrator of *Rad Art: A Journey Through Radiation Treatment* (Atlanta, GA: American Cancer Society 2012). She is also the author/illustrator of *Daniel and His Starry Night Blanket*: *A Story of Illness and Sibling Love* (Thomaston, ME: Maine Authors Publishing 2015). As an artist living on the coast of Maine, she is inspired continually by the beauty and ruggedness of Maine's landscape and resourcefulness of her people. www.sallyloughridge.com

Sally Loughridge est une artiste professionnelle, une survivante du cancer, et une psychologue clinique retraitée qui croit que l'art a le pouvoir de favoriser la compréhension et la guérison. Elle est l'auteure-illustratice de *Rad Art: A Journey Through Radiation Treatment* (Atlanta, Géorgie: American Cancer Society 2012). Elle est également l'auteure-illustratrice de *Daniel and His Starry Night Blanket: A Story of Illness and Sibling Love* (Thomaston, Maine, Maine Authors Publishing 2015). Artiste vivant sur la côte du Maine, elle s'inspire continuellement de la beauté sauvage du paysage du Maine et de l'ingéniosité de ses habitants. www.sallyloughridge.com

Rachael Pack is an interdisciplinary scholar of the body, health and gender. She works with feminist, queer, and Foucauldian theories to research a broad variety of topics including representations of health and illness and the culture of medicine. She holds at PhD in Women's Studies and Feminist Research from the University of Western Ontario, and is currently a post-doctoral fellow at the Schulich School of Medicine and Dentistry at University of Western Ontario.

Rachael Pack est une spécialiste interdisciplinaire du corps, de la santé et du genre. Elle travaille avec l'aide des théories féministes, queer et foucauldienne pour examiner une variété de sujets tels que les représentations de la santé et de la maladie ainsi que de la culture de la médecine. Elle détient un doctorat en Etudes sur les femmes et Etudes féministes de l'Université de Western Ontario. Actuellement elle effectue un stage postdoctoral à la Schulich School of Medicine and Dentistry de l'Université de Western Ontario.

Lynne-Marie Postovit earned her Honours BSc (Life Sciences) and PhD (Anatomy and Cell Biology) from Queen's University (Kingston, ON). After postdoctoral studies in Cancer Biology and Epigenomics (Northwestern University, Chicago, USA), Lynne became an Assistant Professor in Anatomy and Cell Biology at Western University (London, ON). Lynne became Full Professor at the University of Alberta, where she held multiple Oncology research chairs, and co-directed the Cancer Research Institute of Northern Alberta. Lynne has received multiple prestigious awards, is a member of the Royal Society of Canada and is now Head of the Department of Biomedical and Molecular Sciences Program at Queen's University.

Lynne-Marie Postovit a reçu ses diplômes de BCs (Science de la vie) avec honneurs et de doctorat en anatomie et biologie cellulaires de Queen's University (à Kingston, en Ontario). Après des études postdoctorales en biologie du cancer et en épigénomique à Northwestern University (à Chicago, aux USA), Lynne est devenue maître-assistante en anatomie et biologie cellulaire à la Western University (de London, Ontario). Lynne a été promue professeure titulaire à l'Université d'Alberta, où elle a occupé de multiples chaires de cancérologie et co-dirigé le Cancer Research Institute of Northern Alberta. Lynne a reçu de nombreux prix prestigieux, elle est membre de la Royal Society of Canada, et elle dirige actuellement le Department of Biomedical and Molecular Sciences Program à Queen's University.

Julia Schüler obtained her Doctor of Veterinary Medicine degree from the Freie Unversität Berlin (Germany), interning at the Tierspital Zürich (Switzerland). Julia then joined Prof. Dr. Heiner Fiebig (founder, Oncotest GmbH) at the Klinik für Tumorbiologie (Freiburg, Germany), developing patient derived xenograft models in immunocompromised mice. After receiving her PhD (University of Berlin, 1999), Julia studied innate immunology as a postdoctoral fellow at the Max-Planck Institute for Immunobiology, Freiburg. She re-joined Oncotest, now Charles River Discovery Research Services, in 2002, holding leading positions in *in vivo* contract research, and research and development. Julia is now a Research Director.

Julia Schüler a obtenu son doctorat de médecine vétérinaire de la Freie Universität Berlin, en Allemagne, avec un stage d'internat au Tierspitsal de Zürich en Suisse. Julia a ensuite rejoint le Professeur- Docteur Heinrich Fiebig (fondateur de la compagnie Oncotest) à la Klinik für Tumorbiologie (de Freiburg en Allemagne) où elle a participé au développement de modèles de xénogreffes dérivées d'un patient humain à des souris immunodéficitaires. Après avoir obtenu son doctorat (à l'Université de Berlin en 1999), Julia a effectué un stage postdoctoral au Max-Planck Institute for Immunology de Freiburg, consacré à l'étude de l'immunologie innée. Elle est ensuite revenue à Oncotest, devenu depuis Charles River Discovery Research Services, en 2002, occupant des positions de direction dans la recherche de contacts *in-vivo*, ainsi que dans la recherche et le développement. Julia est désormais Directrice de Recherche.

Gabrielle M. Siegers obtained her undergraduate degree in Biochemistry and German (University of Guelph), a Master of Arts in German (Queen's University) and a PhD in Molecular Immunology (Max Planck Institute for Immunobiology, University of Freiburg, Germany). Gabrielle trained at the Princess Margaret Hospital (Toronto), Robarts Research Institute and Western University (London, ON). Her research on gamma delta T cell immunotherapy for cancer includes studies in leukemia, prostate cancer, glioblastoma, breast and ovarian cancer. Gabrielle has given invited talks at scientific meetings in Canada, the United States and Germany. She is currently a research associate at the University of Alberta.

Gabrielle M. Siegers a obtenu sa license en biochimie et en allemand de l'Université de Guelph, une maîtrise en allemand de Queen's University et un doctorat en immunologie moléculaire du Max Planck Institute for Immunology à l'Université de Freiburg en Allemagne. Gabrielle a effectué des stages au Princess Margaret Hospital de Toronto, au Robarts Research Institute et à la Western University de London en Ontario. Sa recherche sur l'immunothérapie de la cellule gamma delta T pour le cancer a incorporé des études sur la leucémie, le cancer de la prostate, le glioblastome, le cancer du sein et des ovaires. Gabrielle a été invitée à présenter des communications au Canada, aux Etats-Unis et en Allemagne. Elle est actuellement associée de recherche à l'Université d'Alberta.

Dorothy Woodman is a contract instructor at the University of Alberta and Concordia University of Edmonton. Her research focuses on intersectional analysis of medial topics and themes in a variety of texts that include breast cancer representations, graphic memoirs and comic superheroes with cancer. Publications include "Enhancing Learning Cultures Through Inter-Disciplinarity: A Reading Group Pilot Project of Medicine and English Studies" with Tamar Rubin for *Keeping Reflection Fresh: A Practical Guide for Clinical Educators*; "Breast Reconstructive Surgery" and "Beauty Ideals, 20th-21st Century" for *The Cultural Encyclopedia of the Breast*; and "The Waiting," a poem for *Intima: A Journal of Narrative Medicine*. She is currently working with Reginald Wiebe on *The Cancer Plot: Terminal Immortality in Marvel Comic's Moral Universe*, and with Reisa Klein on "When the Phallus is a 'Dick': The Cultural/Material Turn to Breasts" for the forthcoming *Routledge Companion to Sexuality and Culture*.

Dorothy Woodman est enseignante contractuelle à l'Université d'Alberta et à la Concordia University d'Edmonton. Sa recherche se concentre sur l'analyse de l'intersection entre les questions médicales et les thèmes abordés dans une variété de textes incluant les représentations du cancer du sein, les mémoires graphiques et les superhéroïnes de bandes dessinées atteintes du cancer. Ses publications comprennent : "Enhancing Learning Cultures Through Inter-Disciplinarity: A Reading Group Pilot Project of Medicine and English Studies" en collaboration avec Tamar Rubin pour *Keeping Reflection Fresh: A Practical Guide for Clinical Educators*, "Breast Reconstructive Surgery" et "Beauty Ideals, 20th-21st Centuries" pour *The Cultural Encyclopedia of the Breast*; et "The Waiting," un poème pour *Intima: A Journal of Narrative Medicine.* Elle travaille actuellement avec Reginald Wiebe sur *Cancer Plot: The Terminal Immortality in Marvel Comic's Moral Universe*, et avec Reisa Klein sur "When Phallus is a 'Dick': The Cultural/Material Turn to Breasts" pour le *Routledge Companion to Sexuality and Culture* à paraître prochainement.