CAN REPRODUCTIVE TRANS BODIES EXIST?

Chase Strangio†

"I assume you're here about a hysterectomy . . . "

Those were the first words my gynecologist ever spoke to me. Before she sat down, before she said hello, she looked at my chart and assumed I was in her office for a major surgery that would end my ability to carry a child at age twenty-seven. After months of delay, I had scheduled the appointment to address the severe pelvic pain that I had been dealing with for months. The dread of that feeling of walking into a gynecologist's office and facing the inquisitive looks had caused me to ignore the near-constant pain. "What is he doing here?" "Is that really a woman?" "What a freak." The whispers. The stares. The internalized self-hate.

"Umm . . . no. I am not here for a hysterectomy," I replied. An inauspicious beginning for an already fraught relationship—and this was the "trans-friendly" gynecologist recommended by the LGBT health center.

My medical records clearly indicated to my gynecologist that I was transgender (some identifying medical procedures and medical interventions), and her assumption was that I therefore wanted a hysterectomy. That might have been a completely fair assumption from a medical perspective—that a trans man coming in for a visit with a gynecologist would ask about a hysterectomy. The problem is not that she asked; it was that without knowing anything about me she assumed that the only possible reason for my visit was to remove my reproductive organs. This type of engagement with a trans patient sends at least two concerning

† Chase Strangio is a Staff Attorney with the LGBT & HIV Project at the ACLU. He received his JD from Northeastern University School of Law and a BA from Grinnell College. He also volunteers paying bail with the Lorena Borjas Community Fund.

messages: the first is that trans people do not need access to preventive care and only visit the doctor when discussing health care related to transition; and the second is that trans people are assumed not to desire the capability to biologically make children. Both messages have strong eugenic undertones contributing to the negative health outcomes for the trans community and the coerced sterilization of trans people.[1]

For me, this experience—an incredibly common one for transmasculine people—was also a stark reminder of how precarious trans bodies are in our public imagination. We simply do not exist in so many spaces. We are the men who become pregnant, need gynecological care, want abortions; the women who need prostate care, produce sperm, can get their partners pregnant; the men, women, and non-binary people who may need care that defies every expectation of how bodies look, perform, and have sex.

The cost of not existing is felt very differently across axes of race, immigration status, disability, poverty, and gender presentation. For me—a white trans man; a lawyer; a person with access to wealth and resources—it means that I may choose not to become pregnant or that I worry about the embarrassment of being scrutinized at the gynecologist. For my trans sisters of color, it means devastating rates of murder, forced sterilization, incarceration.[2] For all of us, we are told that our bodies are not meant to reproduce and that we cannot and should not parent the kids we make and the kids we raise. These messages are the result, in part, of legal systems that compel narratives of identity and embodiment that fail to account for the complexity and beauty of people's bodies and capabilities.

It is easy to attempt to explain the tenuousness of trans bodies in our medical and legal discourse by focusing on the way and extent to which reproductive rights advocacy fails to account for reproductive trans bodies. It is true that a reproductive rights and health discourse that presumes that only women can become

---

1 *See* NAT'L LATINA INST. FOR REPROD. HEALTH, AT THE MARGINS OF CARE: THE NEED FOR INCLUSIVE HEALTH CARE FOR TRANSGENDER & GENDER NON-CONFORMING LATINAS 1 (2013), http://latinainstitute.org/sites/default/files/NLIRH-FactSheet-GenderedCare-EngR3new.pdf [https://perma.cc/7A5H-HZKD].

2 Zach Stafford, *Transgender Homicide Rate Hits Historic High in US, Says New Report*, GUARDIAN (Nov. 13, 2015), http://www.theguardian.com/us-news/2015/nov/13/transgender-homicide-victims-us-has-hit-historic-high [https://perma.cc/WB7P-6LBL] ("The Human Rights Campaign report documented 21 transgender homicide victims so far in 2015, almost all of them transgender women of color . . . .").

pregnant or that all women share certain reproductive capacities is trans exclusionary at best, and anti-trans at worst. However, the negative outcomes for trans people that flow from the current state of reproductive rights advocacy are not unique to that context.[3] In fact, the very same consequences flow from the advocacy strategies pursued by the transgender rights movement.

As advocates for trans people, we have similarly failed to name and protect reproductive trans bodies. Over the course of the past several years, as the transgender "movement" has gained visibility in connection to and independently from a broader gay and lesbian movement, narratives of transgender experience have proliferated. These narratives have employed different devices to make politically coherent the experiences of trans and gender non-conforming people. Often we hear stories of people "born in the wrong body" or "never quite fitting in" until medical intervention brought their internal senses of self into congruence with their bodies.[4] Individual trans people and advocacy movements have utilized those narratives but have, at the same time, critiqued the ways transgender identity and experience have been medicalized[5] and how the processes for accessing health care force us as trans patients and advocates to reproduce the very pathologizing

---

[3] Cheryl Chastine, *Cisgender Women Aren't the Only People Who Seek Abortions, and Activists' Language Should Reflect That*, RH REALITY CHECK (Mar. 18, 2015, 12:09 PM), http://rhrealitycheck.org/article/2015/03/18/cisgender-women-arent-people-seek-abortions-activists-language-reflect/ [https://perma.cc/V3E8-WXF6].

[4] *See, e.g.*, Schroer v. Billington, 424 F. Supp. 2d 203, 205 (D.D.C. 2006) ("At birth, plaintiff was classified as male and christened 'David John Schroer.' From a young age, she was socialized to wear traditionally masculine attire and to think of herself as a boy. However, this designation did not match her gender identity . . . .") (internal citations omitted); *see also* Petition at 3, O'Donnabhain v. Comm'r of Internal Revenue, 134 T.C. 34 (T.C. 2010) (No. 6402-06), https://www.glad.org/uploads/docs/cases/in-re-rhiannon-odonnabhain/odonnabhain-tax-court-petition.pdf [https://perma.cc/K9R4-AVYY] ("Since childhood, Ms. O'Donnabhain had experienced extreme discomfort with her anatomical sex and felt a deep sense of inappropriateness in the gender role of that sex. She had feelings that something was not right in her body from as early as six or seven years old, but wasn't able to put a label on the feelings."); JAY PROSSER, SECOND SKINS: THE BODY NARRATIVES OF TRANSSEXUALITY 68 (Columbia Univ. Press 1998) ("Transsexual subjects frequently articulate their bodily alienation as a discomfort with their skin or bodily encasing: being trapped in the wrong body is figured as being in the wrong, or an extra, or a second skin, and transsexuality is expressed as the desire to shed or step out of this skin.").

[5] In this context, medicalization refers to the process by which narratives of selfhood are given meaning and coherence through psychiatric and medical discourses with their concurrent pathologizing impulse. We become defined through our illness and cured through medical intervention. *See generally* MICHEL FOUCAULT, HISTORY OF SEXUALITY, VOLUME 1: AN INTRODUCTION (1978).

discourses of trans experience that we critique.[6]

While embodiment is a central part of trans experience and the desire for re-embodiment or changed embodiment is important for the self-actualization of many trans-identified people, as advocates for transgender people we have failed to account for and embrace the many ways we inhabit our bodies.[7] Even as we critique the medical model and its pathologizing impulse, when we seek surgeries to modify our bodies and tell stories of gendered actualization we necessarily rely on some idea of sexed embodiment as being natural or "right" in an internal sense. For example, when I tell my therapist that I want a mastectomy because it fits my gender, I am reifying maleness. My identity takes on meaning through a digression from expected female sexed embodiment, and masculinity conflates with male chest reconstruction. Even as I denounce the narrative I am forced to tell of always having felt like "a boy,"[8] there is something about the maleness of a flat chest that I seek—something not only about its flatness, but also about its maleness. As this narrative is collectivized through our desire for the recognition of the legitimacy of our transness as something real and politically cognizable and our "need" for affirming care as something legitimate, we reinforce ideas about how sexed bodies look and operate within a binary.

By examining both reproductive and trans rights discourse, this article poses the question of whether reproductive trans bodies can exist in the law. The purpose is not to answer the question one way or the other but rather to expose how all our movements are susceptible to critique and ultimately, our advocacy strategies will never wholly capture the multitude of people's experiences. Rather than focus on the ways in which our legal and political strategies fall short, I propose an emphasis on collaborative engagement. The goal at this stage is not necessarily to change the legal

---

6 *See* Dean Spade, *Resisting Medicine, Re/Modeling Gender*, 18 BERKELEY WOMEN'S L.J. 15, 23-24 (2003) ("The medical model, ultimately, was what I had to contend with in order to achieve the embodiment I was seeking. I learned quickly that to achieve that embodiment, I needed to perform a desire for gender normativity, to convince the doctors that I suffered from GID and wanted to 'be' a 'man' in a narrow sense of both words.").

7 *Id.*; *see also* PROSSER, *supra* note 4, at 33 (responding to Judith Butler, Prosser explains, "In its representation of sex as a figurative effect of straight gender's constative performance, *Gender Trouble* cannot account for a transsexual desire for sexed embodiment as *telos*.").

8 *See* Spade, *supra* note 6, at 23-24 (discussing his own experience deploying this narrative).

paradigm, but rather to speak publicly and boldly about all bodies and to honor sexed embodiment outside of the gender binary. Once we name and embrace who we are beyond the legal and political narratives we may be forced to tell, we might shift the conditions for trans people and in time shift our advocacy narratives.

I. What to Make of That Uterus? – Reproductive Trans Bodies in Reproductive Rights and Trans Rights Discourse

For my gynecologist, the existence of my uterus was presumed to be my problem. If I wanted to be a man, in her mind, then certainly I wouldn't want to keep that organ that signified womanhood. She assumed that I desired a coherently sexed body. Underneath that assumption is a strand of political discourse that seeks to expel from the categories of "womanhood" and "manhood" those bodies that possess reproductive capacities different from those traditionally associated with the "opposite gender." The anxiety is that if we accept that a body without breasts and with a uterus, for example, could desire to carry a child, we might destabilize the advocacy projects of both the reproductive rights and the transgender rights movements. This section explores how both reproductive rights and trans rights advocacy are wary of fully embracing transgender bodies.

A. Transgender People and Sex

Despite the difficulty of developing meaningful definitions to capture the range of transgender experiences, it is still useful and important to identify some general contours for these categories and terms to ground a discussion of trans experience. For the past number of years at least, the commonly used definition of the term "transgender" has been something to the effect of "an umbrella term referring to individuals with a gender identity or expression that differs from the gender identity or expression associated with the person's assigned sex at birth."[9] Concerned that this definition creates a problematic and completely artificial distinction between "gender identity" and "sex," I prefer to understand "transgender" as a term referring to individuals with a gender that differs from the gender assigned to them at birth, including individuals with a

9 *See, e.g.*, *GLAAD Media Reference Guide – Transgender Issues: Transgender Specific Terminology*, GLAAD, http://www.glaad.org/reference/transgender [https://perma.cc/Z78G-U7CS].

gender other than male or female.[10] Though a transgender person may also be "gender non-conforming," the two terms are not coextensive for every person. I use the term "gender non-conforming" to encompass a broader range of persons who express their gender in a manner that is not traditionally associated with their assigned gender, whether or not they identify as transgender.

When discussing health care for transgender people, both advocates and medical providers rely on the terms gender identity, gender, and sex. Gender identity often refers to one's subjective sense of belonging to a particular gender (usually assumed to be male or female).[11] The most common way of distinguishing gender from sex in medical and legal discourse has been to define gender as a culturally and socially constructed set of behaviors associated with sex, whereas sex is "assigned at birth based upon sexual characteristics of the external genitalia."[12] However, once interrogated, this distinction becomes tenuous and the idea of sexual difference is exposed as a construct itself in which binary sexual difference is produced through our discourses of gender.[13] For example, while we may locate bodily differences among different people, those differences are ascribed meaning through social process. Properly understood, what we had thought of in the past as biological sex in the sense of a noun, might be better understood as a verb—one is sexed through a process of attaching significance to different body parts.

B. Trans Bodies in Reproductive Rights

The movements to expand access to abortion and reproduc-

---

10 *See, e.g.*, Dean Spade, *Documenting Gender*, 59 HASTINGS L.J. 731, 751 (2008) ("[Administrative policies concerning gender changes] emerged from a growing awareness of the existence of a group of people, currently called 'transgender' people, who live their lives identifying as and expressing a different gender than the one assigned to them at birth.").

11 *Id.*

12 Robert Garofalo et al., *Overlooked, Misunderstood and At-Risk: Exploring the Lives and HIV Risk of Ethnic Minority Male-to-Female Transgender Youth*, 38 J. ADOLESCENT HEALTH 230, 230 (2006).

13 *See* P.-L. Chau & Jonathan Herring, *Defining, Assigning and Designing Sex*, 16 INT'L J. L. POL'Y & FAM. 327, 328 (2002) ("'[T]he hierarchical division of humanity into two transforms an anatomical difference (which is itself devoid of social implications) into a relevant distinction for social practice.' In other words the 'biological fact' of sex is only a 'fact' of any interest because of the cultural importance attached to it."); *see generally* JUDITH BUTLER, GENDER TROUBLE: FEMINISM AND THE SUBVERSION OF IDENTITY 12 (1990) ("[T]here is no recourse to a body that has not always already been interpreted by cultural meanings; hence, sex could not qualify as a prediscursive anatomical facticity. Indeed, sex, by definition, will be shown to have been gender all along.").

tive health have long and complicated histories in the law. The purpose of this section is not to explore the various doctrinal strategies for challenging restrictions on health access and discrimination against those who are or may become pregnant. Rather it is to highlight some of the background legal realities that have compelled an emphasis on equality principles within the reproductive rights landscape and to situate the trans rights critique within that larger framework.

In a 2015 piece for *The Nation*, Katha Pollitt urged the reproductive rights movement to resist a push from, according to Pollitt, trans advocates to abandon a focus on "women" in favor of gender-neutral terminology.[14] "Who has abortions?" Pollitt began. "For most of human history, the answer was obvious: women have abortions. Girls have abortions. Not any more. People have abortions. Patients have abortions. *Men* have abortions."[15] The piece went on to position the demands of "young people" in opposition to the needs of "half of humanity and 99.999 percent of those who get pregnant."[16] The question, for Pollitt and many others, is how can something as tenuous as reproductive health care for (non-transgender) women abandon its core constituency. In another piece, Pollitt wrote: "It has taken humanity thousands of years to acknowledge womanhood as something to identify with proudly, to see women as bearers of rights. I wouldn't be so quick to throw that away."[17]

The idea that somehow the needs of the transgender community result in the "throwing away" of womanhood has come to frame the question of how trans bodies interact with reproductive rights advocacy. In a more hostile piece for *The New York Times*, journalist Elinor Burkett, wrote incredulously of the idea that "self-described transgender persons" would claim that "[a]bortion rights and reproductive justice is not a women's issue . . . ."[18] In her formulation, transgender advocates think about abortion not as a "women's issue" but as a "uterus owner's issue." This is, of course, factually true but Burkett's description of the advocacy by trans

---

14 Katha Pollitt, *Who Has Abortions?*, NATION (Mar. 13, 2015), http://www.thenation.com/article/who-has-abortions/ [https://perma.cc/UJ75-THK6].

15 *Id.*

16 *Id.*

17 Katha Pollitt et al., *Does Talking About 'Women' Exclude Transgender People from the Fight for Abortion Rights?*, NATION (Apr. 22, 2015), http://www.thenation.com/article/letters-505/ [https://perma.cc/6YTJ-DHZU].

18 Elinor Burkett, *What Makes a Woman?*, N.Y. TIMES (June 6, 2015), http://www.nytimes.com/2015/06/07/opinion/sunday/what-makes-a-woman.html.

people is quite reductive, and according to Burkett, it is this reframing that "undermin[es] women's identities, and silenc[es], eras[es] or renam[es women's] experiences . . . ."[19] For Burkett, what is clear is that the existence of trans people has the potential to "erase" non-transgender people—non-transgender (or cisgender) women, in particular.[20] Trans people don't even have to claim space within reproductive rights or women's rights advocacy to threaten it with their very existence.

Both Pollitt and Burkett craft (or invent) narratives of trans identity and advocacy that are aimed at or would have the effect of undermining the interests of cisgender women, but neither accounts for the actual experiences or goals of transgender people. The reality is that "womanhood" as a lived reality and a political concept should not be subject to a scarcity notion—there is enough womanhood to go around, and one person's experience of and claim to womanhood does nothing to undermine or take away another woman's experience of the same. The idea that a transwoman's claim to womanhood harms or erases non-transgender women is just as logically incoherent as the claim that marriages between same-sex couples would undermine the completely unrelated marriages of different-sex couples.[21] It is not a zero sum game. And while it is tempting to devote an entire article to the distortions and inaccuracies that Burkett and Pollitt put forth, I do not think engaging on this terrain is useful. Further, as offensive as their framing is for trans people (myself included), the concerns both authors cite about undermining the already precarious access to reproductive health care are real and important. Though there may be some ill-intentioned people at the margins,[22] for most reproductive rights and women's rights activists, the resistance to a trans-inclusive reproductive rights discourse is grounded in a fear of losing access to reproductive health care for everyone and not in a goal of singling out transgender people for exclusion.

The idea of shifting from talking about "pregnant women" to

---

19 *Id.*

20 *Id.*

21 Brief for Texas Eagle Forum & Steven F. Hotze, M.D., as Amici Curiae Supporting Respondents, Obergefell v. Hodges, 135 S. Ct. 2584 (2015) (No. 14-556).

22 There are varying degrees of insidious rhetoric when it comes to excluding transgender people from women's and reproductive rights discourse and advocacy. On the extreme end are trans exclusionary radical feminists (TERFs) like Cathy Brennan and Janice Raymond who do not believe that transgender people exist at all and make public efforts to denounce transgender people, using the wrong names and pronouns and opposing access to health care for transgender people. *See, e.g.*, JANICE RAYMOND, THE TRANSSEXUAL EMPIRE (Beacon Press 1979).

"pregnant people" can evoke traumatic memories of the Supreme Court's refusal to protect pregnant people from discrimination under a sex discrimination theory forty years ago. In *Geduldig v. Aiello*, the Supreme Court considered whether discrimination on the basis of pregnancy constituted sex discrimination for purposes of equal protection.[23] The case involved a challenge to California's disability insurance program that excluded from coverage work loss related to pregnancy.[24] The Court rejected the argument that pregnancy discrimination constituted sex discrimination, reasoning in a now infamous footnote:

> The California insurance program does not exclude anyone from benefit eligibility because of gender but merely removes one physical condition—pregnancy—from the list of compensable disabilities. While it is true that only women can become pregnant it does not follow that every legislative classification concerning pregnancy is a sex-based classification like those considered in [*Reed v. Reed*, 404 U.S. 71 (1971), and *Frontiero v. Richardson*, 411 U.S. 677 (1973)]. Normal pregnancy is an objectively identifiable physical condition with unique characteristics. Absent a showing that distinctions involving pregnancy are mere pretexts designed to effect an invidious discrimination against the members of one sex or the other, lawmakers are constitutionally free to include or exclude pregnancy from the coverage of legislation such as this on any reasonable basis, just as with respect to any other physical condition. The lack of identity between the excluded disability and gender as such under this insurance program becomes clear upon the most cursory analysis. The program divides potential recipients into two groups—pregnant women and nonpregnant persons. While the first group is exclusively female, the second includes members of both sexes.[25]

Though the decision was essentially overruled by Congress when it passed the Pregnancy Discrimination Act in 1978, the legal holding that pregnancy discrimination is not sex discrimination still stands.[26] Relying on *Geduldig*, the Court has since held that restrictions on abortion access likewise do not constitute sex discrimination.[27]

---

23 Geduldig v. Aiello, 417 U.S. 484, 494 (1974).

24 *Id.* at 492.

25 *Id.* at 496 n.20.

26 Newport News Shipbuilding & Dry Dock Co. v. E.E.O.C., 462 U.S. 669 (1983).

27 *See, e.g.*, Bray v. Alexandria Women's Health Clinic, 506 U.S. 263, 271 (1993) ("Respondents' case comes down, then, to the proposition . . . that since voluntary abortion is an activity engaged in only by women, to disfavor it is *ispso facto* to discrimi-

The Court's refusal to recognize discrimination based on pregnancy and restrictions on access to abortion as sex discrimination is particularly concerning for those who may become pregnant because the substantive due process line of cases have failed to adequately protect the rights of those who are or may become pregnant. In the immediate aftermath of the Court's decision in *Roe v. Wade*, Congress and the states acted swiftly to restrict abortion access.[28] Restrictions continued, and in 1992, the Court was again confronted with the question of whether and to what extent the decision to terminate a pregnancy was protected by the Constitution. That year, in *Planned Parenthood of Southeastern Pennsylvania v. Casey*, the Court reaffirmed the central holding of *Roe* that the decision to end a pregnancy before the viability of a fetus is protected by due process and that any restriction amounting to an undue burden on this liberty interest is unconstitutional.[29] But abortion restrictions continued to proliferate and the legal test set up in *Casey* and its progeny has been ineffective at halting—and has actively contributed to—the continued assault on the availability of safe and legal abortions. This term, the Court will again consider the contours of the "undue burden" test in *Whole Woman's Health v. Hellerstedt*, a case challenging Texas laws that would, according to petitioners, "cause a significant reduction in the availability of abortion services while failing to advance the State's interest in promoting health."[30] If the Court upholds the targeted regulation of abortion providers ("TRAP") laws in Texas, the impact will be felt most severely by low-income people across the country whose access to safe and legal abortion will all but disappear.[31]

---

nate invidiously against women as a class. Our cases do not support that proposition.").

28 Before the close of 1973, Congress passed a law that exempted any individual or entity receiving federal funds from any requirement to perform an abortion where such performance would be contrary to the individual's or the institution's religious beliefs. Public Health Service Act, Pub. L. No. 93-45, § 401, 87 Stat. 91, 95-96 (1973) (codified as amended at 42 U.S.C. § 300a-7 (2012)). More restrictions followed, such that now at least forty-four states permit health care institutions to refuse to provide abortion services, and forty-four states permit individual health care providers to refuse. GUTTMACHER INST., STATE POLICIES IN BRIEF AS OF OCTOBER 1, 2014: REFUSING TO PROVIDE HEALTH SERVICES (2014), https://www.guttmacher.org/sites/default/files/pdfs/spibs/spib_RPHS.pdf [http://perma.cc/66QB-FAVN].

29 Planned Parenthood of Se. Penn. v. Casey, 505 U.S. 833, 876-77 (1992).

30 Brief for Petitioners, Whole Woman's Health v. Cole, No. 15-274 (S. Ct. *petition for cert. filed* Sept. 2, 2015), http://www.scotusblog.com/wp-content/uploads/2016/01/15-274-ts-reprint.pdf [https://perma.cc/XX5B-D23Q].

31 *See, e.g.*, Miriam Zoila Pérez, *Everything You Need to Know About the Biggest Abortion Case In Our Lifetime*, COLOR LINES (Jan. 22, 2016), http://www.colorlines.com/articles/everything-you-need-know-about-biggest-abortion-case-our-lifetime [https://

The decision to center cisgender women in the conversations about pregnancy and abortion access has been compelled by the Court's holdings in *Geduldig*, *Roe*, and *Casey* in which the Court has gone out of its way to obscure the concrete and measurable harms to those forced to carry an unwanted or unsafe pregnancy to term. The shift to an equality discourse that foregrounds the experiences of women in reproductive rights and health advocacy is a logical one. The alternative would have been to risk ceding the conversation to the abstract principles of liberty and the balancing of burdens, which have completely failed to protect all people who may become pregnant from restrictive and dangerous laws restricting abortion access. As Justice Ginsburg notes in her dissent in *Gonzales v. Carhart*, "legal challenges to undue restrictions on abortion procedures do not seek to vindicate some generalized notion of privacy; rather, they center on a woman's autonomy to determine her life's course, and thus to enjoy equal citizenship stature."[32]

Given this history, it is understandable why the women's rights movement would be wary of decentering "women" from such campaigns as "Stand With Women" or "Stop the War on Women" because the framing does not include the experiences of trans people. There is an urgent need to halt the harms flowing to cisgender women from abortion restrictions and pregnancy discrimination,[33] and it is strategic and important for the reproductive rights and women's rights movements to highlight the harms of these restrictions on their constituencies. That is why Pollitt writes, "Once you start talking about 'people,' not 'women,' you lose what abortion means historically, symbolically and socially. It becomes hard to understand why it isn't simply about the right to life of the 'unborn.'"[34] It does make sense within the political landscape and

---

perma.cc/DAR6-UGNB]; Brief for Planned Parenthood Federation of America et al. as Amici Curiae Supporting Petitioners, Whole Women's Health v. Cole, No. 15-274, (S. Ct. Jan. 4, 2016), http://www.scotusblog.com/wp-content/uploads/2016/01/Planned-Parenthood-Federation-of-America.pdf [https://perma.cc/D8TN-G97Y].

32 Gonzales v. Carhart, 550 U.S. 124, 172 (2007) (Ginsburg, J., dissenting).

33 Each year brings new proposals to restrict abortion access in the states, with the cost born disproportionately by people living in rural places, people living in poverty, and people of color. *See, e.g.*, CTR. FOR REPROD. RIGHTS, 2015 STATE OF THE STATES: FIGHTING BACK BY PUSHING FORWARD, http://www.reproductiverights.org/sites/crr.civicactions.net/files/documents/USPS-Year-End-Report-Vs-6.pdf [https://perma.cc/MWY8-Q8M4] (discussing the 400 bills and forty-seven newly enacted restrictions on access to reproductive health care in 2015); *see also Crisis in the South*, CTR. FOR REPROD. RIGHTS, http://www.reproductiverights.org/feature/crisis-in-the-south [https://perma.cc/YZ45-V325] (discussing the impact of abortion restrictions on women who are marginalized).

34 Pollitt, *supra* note 14.

given the constraints under which we are operating that we talk about "women" when we talk about pregnancy and abortion. The problem and the challenge is that an emphasis on cisgender women and the experiences of cisgender women can quickly and uncritically translate into a set of narratives that fail to account for the existence of transgender people at all.

This erasure of reproductive trans bodies has shown up uncritically in much of the legal scholarship engaging with questions of reproductive autonomy, pregnancy discrimination, and reproductive health.[35] The standard post-*Geduldig* formulary becomes: "Given the indisputable facts that only women become pregnant, that generally only women who have recently been pregnant and given birth lactate, that only women who are lactating are able to breastfeed, and that only women who are breastfeeding need to pump or manually express milk from their breasts, the chain of causation from sex to pregnancy to lactation to breastfeeding to expressing milk would appear to be fairly clear."[36] Even in a symposium entitled "Pregnant Man?"[37] scholars essentially disavowed trans existence. The language in the scholarship seemed to gratuitously exclude the trans experience: "simply because biology prevents a man from being pregnant (Thomas Beatie apart);"[38] "Breast-feeding is a function only women can perform;"[39] "It also is interesting that pregnancy, that one thing that only women (defined biologically) can do, is the source of such angst."[40]

Scholarship also erases the existence of women who are transgender and unable to become pregnant by conflating the definition of womanhood with an ability to be or become pregnant. As one author wrote of *Geduldig*:

> It contains an obvious fallacy. While it is true that not all women are pregnant at any one time, all women, as a class, are susceptible to pregnancy (and bear in the United States an average of two children apiece). But even if pregnancy were a risk for only a small subclass of women, the sex discrimination issue would

---

35 *See, e.g.*, Sylvia A. Law, *Rethinking Sex and the Constitution*, 132 U. PA. L. REV. 955, 983 (1984) ("Criticizing *Geduldig* has since become a cottage industry. Over two dozen law review articles have condemned both the Court's approach and the result.").

36 L. Camille Hébert, *The Causal Relationship of Sex, Pregnancy, Lactation, and Breastfeeding and the Meaning of "Because of . . . Sex" Under Title VII*, 12 GEO. J. GENDER & L. 119, 119 (2011).

37 Darren Rosenblum et al., *Pregnant Man?: A Conversation*, 22 YALE J.L. & FEMINISM 207, 277 (2010).

38 *Id.*

39 *Id.*

40 *Id.* at 232.

> still be a live one.[41]

None of these formulations are true, and more insidiously, all of these formulations make it more difficult for transgender people to stake our own claims to bodily autonomy and reproductive health. What becomes of the transgender woman who cannot become pregnant or the transgender man who is pregnant? They are quite literally written out of existence.

The legal history of pregnancy and abortion restrictions is helpful for understanding why and how trans people are marginally situated in reproductive rights advocacy and discourse. The law constrains the narrative that advocates can deploy to resist and destabilize the harms set up through legal restrictions and discrimination. By neutralizing possible discrimination arguments in *Roe*, *Geduldig*, and *Casey*, the Court framed the terms of the debate over reproductive health access in abstract principles rather than real world consequences. The reality for trans people in reproductive rights discourse is that our bodies complicate the coherence of a narrative that is already fragile because of the fraught and unsettled nature of the legal protection at stake. This is true of all legal work, and some bodies and some people are always excluded or made more vulnerable. So what do we do? The answer is not simple, but we might better understand the problem if we look at how the trans advocacy movement has similarly contributed to the erasure of reproductive trans bodies.

C. Reproductive Trans Bodies in Trans Rights Advocacy

In some of the same ways that reproductive rights advocacy has refused to account for and accommodate the realities of trans bodies, so too have advocates for transgender rights. If the trans movement is to critique the ways in which we have been excluded from reproductive rights discourse, we must do so with a full recognition of our own complicity in the same exclusionary practices. Just as reproductive rights advocates have been forced to make certain linguistic and strategic choices in advocacy because of the restrictions in place, trans advocates have made similar choices with attendant costs and benefits in response to legal restrictions and social pressures. This section explores the ways in which trans advocacy challenges to restrictions on insurance coverage for transgender health care and access to accurate identification for

---

41 Diane L. Zimmerman, Geduldig v. Aiello*: Pregnancy Classifications and the Definition of Sex Discrimination*, 75 COLUM. L. REV. 441, 448 (1975) (emphasis omitted).

transgender people have contributed to the erasure of reproductive trans bodies.

Though the past few years have witnessed tremendous advances for transgender people, restrictions on health and identification access continue to threaten the health and well being of the trans community. Despite a medical consensus that "gender-affirming" health care—like hormone therapy and surgery—is medically necessary and safe, many public and private insurance programs exclude such care from coverage.[42] While that care is excluded, many government record-keeping bodies continue to require proof of surgical transition in order to update the record of a person's gender.[43] What this means is that a transgender woman in Alabama, for example, may have a medical need for genital surgery, but unless she can pay the $50,000 to cover the cost of the care out of pocket, she will not be able to receive the care.[44] At the same time, in order to update the gender listed on her Alabama driver's license to reflect her female gender, she will have to prove that she has had the surgical procedure that she cannot have because of the exclusions in place.[45] This person will then have poor health outcomes because she is wrongly identified as male on her identification and unable to obtain needed care to treat her medical condition. She will also be vulnerable to violence because every time she uses her driver's license she will be outed as transgender in a climate where transgender people—particularly transgender women—face harassment and physical abuse for simply existing.[46]

Given the consequences for trans people that flow from insurance coverage restrictions and onerous policies for updating iden-

---

42 *See* Pooja S. Gehi & Gabriel Arkles, *Unraveling Injustice: Race and Class Impact of Medicaid Exclusions of Transition-Related Health Care for Transgender People*, 4 SEXUALITY RES. & SOC. POL'Y 7, 7 (2007).

43 *See generally ID Documents Center,* NAT'L CTR. FOR TRANSGENDER EQUAL., http://www.transequality.org/documents [https://perma.cc/ZV8T-ZRZJ] (compiling policies in various jurisdictions).

44 JODY L. HERMAN, THE WILLIAMS INSTITUTE, COSTS AND BENEFITS OF PROVIDING TRANSITION-RELATED HEALTH CARE COVERAGE IN EMPLOYEE HEALTH BENEFITS PLANS 5 (2013), http://williamsinstitute.law.ucla.edu/wp-content/uploads/Herman-Cost-Benefit-of-Trans-Health-Benefits-Sept-2013.pdf [https://perma.cc/7K9N-PX4X] (estimating cost per claimant for trans health care at around $50,000).

45 *See ID Documents Center: Alabama,* NAT'L CTR. FOR TRANSGENDER EQUAL., http://www.transequality.org/documents/state/Alabama [https://perma.cc/S6RH-7HRV] ("[D]ocumentation signed by a surgeon verifying that the applicant has completed gender reassignment surgery [is required].").

46 *See generally* JAIME M. GRANT ET AL., INJUSTICE AT EVERY TURN: A REPORT OF THE NATIONAL TRANSGENDER DISCRIMINATION SURVEY 2 (2011) (finding pervasive discrimination in areas including education, economic security, housing, treatment by police, and health care).

tification documents, it is no surprise that the trans movement has focused on increasing access to both health care coverage and identification documents. The problem is that when we advocate with the insurance industry and the government to broaden access to gender-affirming surgeries we often become trapped in a "medical necessity" discourse that reinforces binary sexual difference. We also bump up against our strategies for removing surgical standards for updating identification documents to accurately reflect our genders with government record keepers. While in the former context we argue that gender-affirming health care is necessary to make our bodies coherent, in the latter we contend that internal self-identification as male or female regardless of medical intervention is "sufficient" to make our gender identities "real." These two strategies reflect the ambivalent and confused relationship that trans advocacy has with the body, and the tension between them can have the effect of placing trans bodies (and all bodies) in precarious and impossible positions.

One example of the hazards of strategies for removing trans exclusions from health insurance coverage can be found in the successful challenges to the New York State Medicaid program's exclusions on coverage for gender-affirming health care. In the first case challenging this exclusion, *Casillas v. Daines*, the plaintiff argued that to deny her access to sex reassignment procedures contravened state Medicaid law requiring coverage for "medically necessary procedures."[47] To make out this claim, the plaintiff had to establish, among other things, that she had a medical diagnosis of gender identity disorder ("GID"),[48] what is now known as gender dysphoria, for which surgical intervention was medically necessary. The complaint explains how this necessity for female sexed embodiment came about: first, "Ms. C was a biological male at birth, but has identified as a woman since 1974;" then, she was diagnosed with GID and she began to live "as a woman" including bringing her physical body into conformity with her internal sense of her womanness; ultimately, Ms. C "*needs* gender reassignment surgery in order to *achieve the capacity* to live a life without terrible suffer-

---

47 Complaint ¶ 39, Casillas v. Daines, 580 F. Supp. 2d 235 (S.D.N.Y. 2008) (No. 07 Civ. 04082).

48 Gender Identity Disorder is a condition defined by the American Psychiatric Association as "a condition characterized by a strong and persistent cross gender identification and discomfort about one's assigned sex, unrelated to either a perceived cultural advantage of being the other sex or a concurrent physical intersex condition, which results in clinically significant distress or impairment in social, occupation or important areas of functioning." AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 576 (4th ed. 1994).

ing."[49] Though advocates were careful not to fully flesh out the more problematic narrative ("I am a woman inside, therefore I need this surgery to become a woman on the outside"), that subtext is clear in the story the plaintiff is compelled to tell. When seeking recognition from the insurance excluder—whether that be the government or a private company—the medical necessity standard constrains us to a narrative about sexed embodiment wherein to be a woman, one must attain womanly embodiment with all of its attending physicality and meaning.[50]

Our trans advocacy strategies reproduce norms of sexed embodiment that make it harder to embrace and celebrate the range of bodies our communities inhabit. For example, in *O'Donnabhain v. Commissioner of Internal Revenue*, a transgender woman sued the Internal Revenue Service for excluding from her deductions medical expenses related to her gender transition.[51] Under IRS rules, a medical expense can be deducted from one's taxable income so long as it is not "experimental" or "cosmetic." The IRS had determined that Ms. O'Donnabhain's expenses related to her gender transition were cosmetic and therefore not deductible, and she sued in Tax Court.[52] To establish her medical need for the procedures for which she sought deductions, Ms. O'Donnabhain's complaint, like Ms. Casillas', explains how she "grew up with a medical condition in which her self-identification as female did not align with her male anatomical sex."[53] Her surgeries, the complaint explains, were directed to "cure" her GID (a "disease" within the

---

[49] Complaint, Casillas v. Daines, *supra* note 47, ¶ 56 (emphasis added).

[50] This narrative can be found in almost every case challenging exclusions on health care coverage for transgender people. *See, e.g.*, Amended Complaint ¶ 38, Norsworthy v. Beard, 87 F. Supp. 3d 1104 (N.D. Cal. 2015) (No. 3:14-cv-00695-JST), http://transgenderlawcenter.org/wp-content/uploads/2014/12/First-Amended-Complaint.pdf [https://perma.cc/K6U7-9WMD] ("Plaintiff is a 'biological female' based upon her hormone levels and chemical castration, yet is being forced to live every minute of every day in a body with male genitalia that does not match her biology or deeply rooted identity."); Amended Complaint ¶ 108, Manning v. Carter, No. 1:14-cv-1609-CKK (D.D.C. May 5, 2015), https://www.aclu.org/sites/default/files/field_document/041_amended_complaint_2015.10.05.pdf [https://perma.cc/S9YG-QV8Q] ("She is forced to cut her hair in a masculine manner undermining her ability to be affirmed in her female gender."); Verified Complaint ¶ 5, Diamond v. Owens, No. 5:15-cv-00050 (MTT), 2015 WL 5341015 (M.D. Ga. Feb. 19, 2015), https://www.splcenter.org/sites/default/files/d6_legacy_files/downloads/case/complaint_2.pdf [https://perma.cc/944T-JCJA] ("As a result of her continued denial of care, Ms. Diamond's body has been violently transformed, she has been forced to transition back from a man to a woman, and she has experienced physical symptoms of withdrawal.").

[51] O'Donnabhain v. Comm'r of Internal Revenue, 134 T.C. 34 (2010).

[52] *See* Petition, O'Donnabhain v. Comm'r of Internal Revenue, *supra* note 4.

[53] *Id.* at 3.

meaning of the Tax Code)—whereby her body could align with her self-identified female gender.[54] The narrative sets up a binary of male and female, which is anatomically defined, and presumed to pre-exist its articulation.[55] To be the "woman" that she feels she is, Ms. O'Donnabhain's body must be transformed. Our citation of this norm produces and re-produces womanhood: the story is not simply descriptive of what the complainant feels but also productive of what a woman *is*. But what happens to the woman who has a penis or has no breasts—can she be a woman within this framework? Can her medical care be justified? Does this not leave out the members of the trans community whose body and identity is not as coherently sexed within that framework?

Not only do we produce binary sexed embodiment through our advocacy discourse, but we also then afford the Court the opportunity to codify sexed norms of how bodies look and operate. In *O'Donnabhain*, the Court ultimately concludes that because Ms. O'Donnabhain has gender identity disorder, most of her gender reassignment procedures were medically necessary within the meaning of the Tax Code and therefore are deductible. But the Court excepts from that determination Ms. O'Donnabhain's breast augmentation, which it determines was cosmetic.[56] Because her surgeon noted that an "examination of [Ms. O'Donnabhain's] breasts reveal [sic] approximately B cup breasts with a very nice shape,"[57] the Court concludes "[the breast augmentation] surgery was not necessary to the treatment of GID in petitioner's case because petitioner already had *normal* breasts before her surgery."[58] It should be terrifying to think of our genders being subjected to judicial fact-finding whereby our medical and survival needs might turn on whether a fact finder believes our breasts or other sexed body parts are "normal." When we pursue relief through the law, we necessarily participate in a process whereby bodies are sexed in accordance with a norm. Not only do we participate in the production of that norm, but we create opportunities for the state to fur-

---

54 *Id.* at 7.

55 *See* BUTLER, *supra* note 13, at 33 (challenging our understanding of sex as the natural state upon which the cultural/constructed gender norms were inscribed) ("No longer believable as an interior 'truth' of dispositions and identity, sex will be shown to be a performatively enacted signification (and hence not 'to be'), one that, released from its naturalized interiority and surface, can occasion the parodic proliferation and subversive play of gendered meanings.").

56 *O'Donnabhain*, 134 T.C. 34 at 73.

57 *Id.* at 72.

58 *Id.* (emphasis added).

ther entrench the bounds of what constitutes "normal" sexed embodiment.

While the trans community has voiced concern over the way in which medicalization demeans our bodies and experiences, we must consider our own role in creating these discourses through the repeated citation of these narratives in our advocacy. Diagnostic criteria and standards of "authentic" trans experience displace processes of self-identification and place power in the hands of medical providers as gatekeepers. In his reflection on seeking a double mastectomy (or "top surgery"), Dean Spade expresses concern over the power of diagnostic criteria to reify "the transsexual" as a category: "By instructing the doctor/parent/teacher to focus on the transgressive behavior, the diagnostic criteria for GID establishes surveillance and regulation effective for keeping both non-transsexuals and transsexuals in adherence to their roles."[59] Citing Bernice Hausman, Spade goes on to explain how "transsexuals must seek and obtain medical treatment in order to be recognized as 'transsexuals.' Their subject position depends upon a necessary relation to the medical establishment and its discourses."[60] This is true and part of the problem, but as advocates we then fail to account for how we, through the collectivization of our medicalized identities to seek recognition from the government and access to care, re-entrench binary norms of sexual difference. To explain our identities in the medicalized language available to us and in ways that the government will understand and recognize, we partake in a project of (re-)producing what it means to have a sexed body.

On an ideological level this complicity in binary sexing is concerning, but even more so our articulations of selfhood invoke standards of sexed embodiment that are self-eliminating. We seek to access insurance coverage for our "medically necessary" procedures, and in so doing reinforce, for example, womanness as inextricably tied to the state of not having a penis—the thing that must be removed for a woman's identity to be actualized. At the same time, our community includes women with penises who are then unable to access other—also needed—medical care such as prostate exams, testicular exams, and reproductive health support. We further take away from those women the legal recognition of their medical need for care like breast augmentation or facial feminization surgery. Those procedures are either viewed as cosmetic, or

---

59 Spade, *supra* note 6, at 25.
60 *Id.* at 19.

the patient is viewed as undeserving of care because they, for example, might not want or need genital surgery and, therefore, are not "really" women within the framework we have set up.

II. What Does This Mean and What Can We Do?

Whether in the reproductive rights or the trans rights space, the cost to trans people of advocacy strategies that lose sight of our bodies and bodily capabilities reinforce presumptions that all bodies are coherently sexed and that trans bodies, in particular, are not able to reproduce or desiring of reproduction. The presumption that a body is coherently sexed is, in turn, literally killing trans people through a variety of mechanisms.[61]

Even as exclusions on health care coverage for transition-related health care like hormone therapy and surgery are struck down and repealed, the government and insurance industries continue to regulate medical procedures in accordance with sex. For example, in the same regulation that had precluded coverage for gender-affirming care under New York State's Medicaid program, New York continues to regulate access to hysterectomies on sexed terms.[62] Hysterectomies are not covered where the sole purpose of the procedure is to prevent further pregnancies but are available and reimbursable under certain conditions where "the *woman* was sterile before the hysterectomy was performed."[63] The language does not explicitly preclude coverage for a person not classified as "a woman." However, in practice, the coding of a recipient's sex as male will preclude access to coverage for procedures associated with femaleness.[64] This includes hysterectomies, gynecological exams, obstetric exams, and mammograms. Where a person with a

---

61 I use the term "coherently sexed" to refer to the presumption that once someone is identified as a particular gender (male or female) they will both have and desire one set of body parts associated with that sex. For a man who is transgender, this means that he is assumed to neither have nor desire any reproductive organs associated with women.

62 *See* N.Y. Comp. Codes R. & Regs. tit. 18, § 505.2(h)(2)(ii)(a) (2015) (presuming the person in need of a hysterectomy is "a woman").

63 *Id.* (emphasis added).

64 This observation is based on my own experiences as an advocate for low-income transgender Medicaid recipients in New York, as well as on conversations with other advocates who have noticed similar patterns of coverage denial. *See also* Dorothy Cornwell, *Proposed Rule on ACA Nondiscrimination: Coverage for Transgender Individuals*, 57 No. 12 DRI for Def. 49, 54 (2015) ("Many commenters responding to the HHS request for information noted that transgender individuals are routinely denied coverage for medically appropriate sex-specific health services due to their gender identity or because they are enrolled in their health plans as one sex because the health services are generally associated with another sex.").

uterus and breasts has a double mastectomy and is classified as male for purposes of Medicaid, that person may not be able to access gynecological care under the state's Medicaid scheme.[65] Similar problems arise for people classified as female but who need prostate care, testicular care, and other care that is limited to those coded as male.[66]

This mismatch between how a person's gender is classified and what the insurer believes to be a gender-limited procedure has long-term negative health consequences for people whose bodies do not conform to a coherent model of binary sexual difference.

In addition to mismatched coding preventing needed care, there are emotional and physical consequences for some people for entering physician's offices that are widely viewed as sex-specific.[67] Like my own experiences described above, when a person who is read and perceived as male but who happens to have a uterus goes to the gynecologist, the experience can invite traumatic gazes from other patients and physicians. For this reason, many people avoid or delay going to the doctor.[68] As the National Latina Institute for Reproductive Health observed:

> Because reproductive health screenings are heavily gendered, simple procedures such as pap smears and prostate exams are difficult to obtain without fear of humiliation and discrimination. Patients cannot trust that most providers will have any expertise in health issues that affect them, and there are documented cases of physicians refusing to treat transgender patients with reproductive cancers.[69]

Failure to receive regular cervical, uterine, and ovarian exams will ultimately increase the likelihood of people with these organs developing malignancies.

The data that exists confirms that transgender people experience extreme discrimination in health care settings causing them to delay or avoid receiving care. The National Center for Transgender Equality reports that "[o]ne in three transgender people, and 48% of transgender men, have delayed or avoided preventive health care such as pelvic exams or STI screening out of fear of

---

65 *See* Lisa Gillespie, *Despite Obamacare Promise, Transgender People Have Trouble Getting Some Care*, KAISER HEALTH NEWS (July 22, 2015), http://khn.org/news/despite-obamacare-promise-transgender-people-have-trouble-getting-some-care/ [https://perma.cc/W2R5-YVBU] (discussing the barriers to health care faced by transgender people due to the coding of services along the gender binary).

66 *See id.*

67 NAT'L LATINA INST., *supra* note 1.

68 *Id.*

69 *Id.*

discrimination or disrespect."[70] Additionally, transgender young people, including those who are at risk of unintended pregnancy, are hesitant to go to family planning clinics, increasing the likelihood of complications and poor health outcomes.[71] Most transgender boys and men, as high as 93.8%, who have sex with cisgender men report a lack of adequate medical information about their sexual health needs.[72] This means that in sexual relationships that could result in pregnancy, for example, people are not receiving the information or health care that they need. This lack of information makes the trans community particularly vulnerable to negative reproductive health outcomes.

In addition to the administrative incoherence and discrimination that makes health care access more difficult for transgender people, the reiteration of norms that do not account for our varied bodies also contributes to the climate where trans bodies are policed and killed. If we establish in law and social discourse that bodies must be coherently sexed to be legitimate, we make spaces for the harassment and violence levied upon those whose bodies transgress those expectations. These expectations are connected to why we see upticks in violence, and particularly deadly violence, in the transgender community, particularly among transgender women of color.[73] For strangers, transgender bodies can be understood to be deceptive in nature, causing people to lash out against a transgender partner. This is the narrative that, for example, Lance Corporal Joseph Scott Pemberton told of killing Jennifer Laude, a transgender woman, while he was on duty in the Philippines.[74] The two had met in a nightclub and went back to Pemberton's hotel room where, he recounted at trial, he discovered that she had a penis, became enraged, and killed her.[75] This same dynamic can play out in intimate partnerships as well, where "abuse is in large part about controlling and enforcing gender norms within rela-

---

70 NAT'L CTR. FOR TRANSGENDER EQUAL., TRANSGENDER SEXUAL AND REPRODUCTIVE HEALTH: UNMET NEEDS AND BARRIERS TO CARE (2012), http://www.transequality.org/sites/default/files/docs/resources/Factsheet_TransSexualandReproHealth_April2012.pdf [https://perma.cc/8K6N-KCJN].

71 *Id.*

72 *Id.*

73 Katy Steinmetz, *Why Transgender People Are Being Murdered at a Historic Rate*, TIME (Aug. 17, 2015), http://time.com/3999348/transgender-murders-2015/ [https://perma.cc/63FG-4WTL].

74 *See* Floyd Whaley, *U.S. Marine Guilty in Killing of Transgender Woman in Philippines*, N.Y. TIMES, Dec. 2, 2015, at A6, http://www.nytimes.com/2015/12/02/world/asia/us-marine-joseph-pemberton-guilty-in-killing-of-transgender-woman-in-philippines.html [https://perma.cc/CJC7-TKN9].

75 *Id.*

tionships [and] transgender people, by virtue of their failure to conform to such norms, are particularly vulnerable to [such] abuse."[76] We make space for such violence by creating legal norms that reinforce the notion that a woman cannot have a penis or that a body that does not cohere to our ideas of proper sexed embodiment is deviant and undesirable.

What this all means, I think, is that even if the entire reproductive rights movement stopped centering cisgender women in its advocacy, I am not convinced that we would see a change in the material conditions for transgender people. It would be symbolically important and more inclusive, sure, but it would not necessarily change my experience at the gynecologist, and it certainly would not end the violence and discrimination faced by transgender people of color. Instead of focusing on those changes in language—important as they are—I propose that we start by more robustly centering trans bodies in LGBT and trans rights work in ways that may have a greater impact on the life chances of transgender people.

This means talking about the fact that, for example, a transgender person who is a woman might have and embrace both breasts and a penis. Or that a transgender man may desire to become pregnant and that such desire and the act of being pregnant makes him no less of a man. These principles are central to our movement, but in our advocacy for health care access or restroom access or accurate identification we are often afraid that naming and embracing our bodies will jeopardize our work. But in reality, the reverse is true. We are jeopardizing our work and constraining our successes by not engaging with our bodies. If we do not normalize the way we inhabit our bodies, the ways that we have sex, and the ways that our bodies are targeted, we will not be successful in making space for our full communities to thrive.

III. Conclusion

Our work as advocates and particularly as legal advocates will inevitably spread costs and benefits across our many constituencies and communities. The nature of legal work, as a mentor once reminded me, is that you will always have blood on your hands. When you interface with a violent and flawed system, your interventions will be violent and flawed. So to advocate for trans people to receive life saving health care will likely entrench binaries that ex-

76 Leigh Goodmark, *Transgender People, Intimate Partner Abuse, and the Legal System*, 48 Harv. C.R.-C.L. L. Rev. 51, 55 (2013).

clude health care for members of our communities. That does not mean we do nothing, but it should caution us in our critiques and we should look to model collaboration before centering critique and frustration. Is the reproductive rights movement flawed? Yes. Is our own movement equally flawed? Definitely.

The impulse to question the connection between trans and reproductive justice is a critical one, but I worry we are focusing on the wrong aspects of intersection. We can and must destabilize the meaning of sex and the sexing of our bodies. To do this, we have to recognize and engage with our bodies in all of our work. Our bodies are not simply vehicles crossing from one side of a coherently sexed gender binary to the other. We must name our existence in its child-bearing, sperm-producing, and menstruating capacities. The cost of not doing so is more than theoretical. Reiteration of the presumptive norm of sexed embodiment as male and female, and their respective bodily formations, makes our lives and bodies as trans people impossible. If we are to survive, we must exist.