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REPRODUCTION AND GENDER SELF-DETERMINATION: FERTILE GROUNDS FOR TRANS LEGAL ADVOCACY

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ABSTRACT

Current medical constructions of trans identities reflect heterosexist understandings of gender expression—understandings that deny access to gender-affirming healthcare to those who fail to perform normative binary genders. As medical providers establish norms for how to "properly" be trans, the state codifies these norms, basing trans existence on rigidly defined and harshly enforced understandings of binary gender. When this construction of transness is codified on an institutional level, such as with gender reclassification rules for government identification, it forces trans people to conform their bodies to cisgender norms, and dangerously disrupts trans people's bodily autonomy and diminishes their control over their reproductive choices.

This Article contends that the gender conformity that the state requires of trans people parallels the violence that the state has inflicted on low-income non-trans women of color. As welfare policies have sought to constrain indigent Black women's reproductive and sexual autonomy, courts use legal gender determination to force trans people to conform to heterosexist sexual and family structures—a project that works to constrain their reproductive freedoms. This Article connects the decades-long struggle of non-

* I would like to thank Dr. Khiara M. Bridges for her stewardship as both a professor and mentor and without whom this work would not have been possible.

† The institution of higher learning that facilitated my critical lens on trans experiences is my global trans community. I grew up and continue to benefit from class-based access to medical care, and I have been cis-passing for the majority of my trans life. So I may have ended up believing of myself, and people like me, the same untruths that I challenge in this Article; I may have never internalized the life-altering harms that result from state-coerced gender conformity, while the more marginalized people in my community are forced to reckon with them. I am humbled, grateful, and hopeful that this work will encourage the agents of trans legal advocacy to center gender self-determination for all trans people, beyond those whose gender identities happen to align more with gender-normativity.

trans women of color for reproductive justice with that of trans people's right to self-identify without medical intervention. In doing so, this Article calls for legal trans advocates to coalition build with existing reproductive justice movements to nurture a trans jurisprudence that rejects heterosexist notions of trans identity and instead embraces the multiplicity of trans embodiment and queer family structures that we, as trans people, can create.

TABLE OF CONTENTS

INTRODUCTION

One page, three panels, and a stock photograph of a smiling white woman at the center of it all. A single pamphlet geared towards cisgender women was the entirety of the reproductive education the San Francisco transgender community health clinic could provide to trans men who, like me, were embarking on their medical transition journeys. On the inside flap, the pamphlet read, "Why should women cryopreserve embryos?" My physician, a trans man, watched with knowing and sad eyes as my shoulders slumped. "Sorry," he sighed, "we just don't receive funding to assist with trans reproductive options." Whether from a lack of funding or a lack of capacity, the transgender clinic could do nothing more for me than to pass off my reproductive needs to a privatized fertility company that never thought that my body belonged on their pamphlet, let alone in their building. My appointment at the community health clinic ended with addresses for local cryopreservation banks and empathetic cordialities. The pamphlet found gainful employment separating the pages of my law school textbooks.

So useful was it, in fact, that I later used its straight edges to create a perfect red rectangle around a block of text in Justice Ginsberg's *United States v. Virginia* opinion. "Inherent differences," she wrote, "are no longer accepted as a ground for race and national origin classifications. Physical differences between men and women, however, are enduring."[1] The lines drew me back to that moment in the clinic where I learned that a trans man's reproductive capacity could only exist inside of a freezer. Whether or not Justice Ginsberg knew it, the assumed border dividing men and women's bodily capacities severs the mind-body connection of so many trans people.[2]

Not only did I intrinsically struggle to see my body as worthy of "manhood," but I had to perform an inflated sense of body dysphoria to convince doctors and therapists that I deserved to medically transition. The doctor expected me to perform a desperate monologue. To be worthy of a testosterone prescription, I needed to present a wish list of physical adjustments to my body that would help me bridge the gap between my body and the "physical differences between men and women"[3] that Ginsberg contemplated. Abundant facial hair, baritone in my voice, a structured chest, rougher skin . . . . Of course, these bodily changes were the qualifications I needed to cross the manufactured gender boundary. Gender normativity demanded that I surrender any lingering desire for my body to carry a pregnancy and give birth, and that I pledge my fealty to masculinity before the medical establishment.

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1. United States v. Virginia, 518 U.S. 515, 533 (1996) (using intermediate level of scrutiny on government gender classifications). The exploitation of Justice Ginsburg's "physical differences" precedent by lawmakers opposed to trans rights has already made its way to the Senate floor. During the confirmation hearing for Justice-designate Ketanji Brown Jackson, Senator Marsha Blackburn asked the Supreme Court nominee if she "agree[s] with Justice Ginsburg that there are physical differences between men and women that are enduring[.]" Blackburn demanded that Brown Jackson define "woman," which resulted in a firm 'I don't know." Blackburn then chided Brown Jackson: "The fact that you can't give me a straight answer about something as fundamental as what a woman is underscores the dangers of the kind of progressive education that we are hearing about." In a final declaration of disdain towards trans people, Blackburn bemoaned that admitting trans competitors into sports tells "our girls that their voices don't matter [and] that they're second-class citizens." "This exchange is neither the first nor the last time *Virginia* will be construed to legitimize state enforcement of the gender binary. *See* Myah Ward*, Blackburn to Jackson: Can You Define 'The Word Woman'?*, POLITICO, https://www.politico.com/news/2022/03/22/blackburn-jackson-define-the-word-woman-00019543 [https://perma.cc/9KBK-TYAV].
2. Like many communities formulating a collective sense of self and resisting oppression, the trans community uses ever-evolving terms to describe our non-normative identities. I use "trans" to indicate people who identify as transsexual, transgender, nonbinary, or any other place within the transgender spectrum.
3. *Virginia*, 518 U.S. at 533.

The "physical differences" framework does nothing to protect *anyone*, especially trans people, from socially coerced gender expression, much less from forced decision-making about how or whether to have a baby. But what alternative conceptualization of my body would grant me access to testosterone without compelling me to regurgitate mainstream narrations of masculinity and femininity? In what world is a trans body like mine a legitimate site for realizing human possibilities that make me feel whole, including perhaps the experience of biologically reproducing?

In this Article, I aim to answer these questions by exploring the systems of power that constrain the bodily autonomy of trans people by connecting trans experiences to those of indigent women of color in the United States.[4] Trans activists and scholars have explored how the medicalization of trans identities forces trans people to conform to rigid disciplinary gender norms,[5] how trans legal advocacy has reproduced notions of sexed embodiment that idealize cisgender body norms,[6] how these norms are codified in governmental and administrative gender reclassification policies,[7] and how these gendered models of citizenship necessitate coerced sterilization of trans people.[8] This Article adds to the

4. I use the umbrella term "women of color" to refer to Black, Native, Latinx, and Asian women. The term was coined by women of color in 1977 at the National Women's Conference in Houston, Texas and has become a visible organizing principle in the United States for women who are most disadvantaged by white supremacy. When I use "Black," I am specifically talking about population-level interventions that target Black women. *See* Angela Davis, *Women of Color and Their Struggle for Reproductive Justice*, *in* UNDIVIDED RIGHTS: WOMEN OF COLOR ORGANIZE FOR REPRODUCTIVE JUSTICE 1, 3 (Jael Silliman et al. eds., 2004).

5. *See* Judith Butler, *Undiagnosing Gender*, *in* TRANSGENDER RIGHTS 274, 281 (Paisley Currah et al. eds., 2006); Shannon Price Minter, *Do Transsexuals Dream of Gay Rights? Getting Real About Transgender Inclusion*, *in* TRANSGENDER RIGHTS 141, 151; Dean Spade, *Compliance is Gendered: Struggling for Gender Self-Determination in a Hostile Economy*, *in* TRANSGENDER RIGHTS 217, 221 (Paisley Currah et al. eds., 2006) [hereinafter *Compliance is Gendered*]; DEAN SPADE, NORMAL LIFE 54 (2009) [hereinafter NORMAL LIFE]; and Dean Spade, *Resisting Medicine/Remodeling Gender*, 18 BERKELEY WOMEN'S L.J. 15, 19-23 (2003) [hereinafter *Resisting Medicine/Remodeling Gender*].

6. *See* Taylor Flynn, *The Ties That (Don't) Bind: Transgender Family Law and the Unmaking of Families*, *in* TRANSGENDER RIGHTS 32, 37 (Paisley Currah et al. eds., 2006); Dean Spade, *Undermining Gender Regulation*, *in* NOBODY PASSES: REJECTING THE RULES OF GENDER AND CONFORMITY 64, 66 (Mattilda ed., 2006) [hereinafter *Undermining Gender Requlation*]; and Chase Strangio, *Can Reproductive Trans Bodies Exist?*, 19 CUNY L. REV. 223, 240 (2016).

7. *See* Dean Spade, *Documenting Gender*, 59 HASTINGS L.J. 731, 754 (2008) [hereinafter *Documenting Gender*]; NORMAL LIFE, *supra* note 5, at 79.

8. *See* Julian Honkasalo, *In the Shadow of Eugenics: Transgender Sterilization and the Struggle for Self-Determination*, *in* THE EMERGENCE OF TRANS: CULTURES, POLITICS, AND EVERYDAY LIVES, 17, 17 (Ruth Pearce et al. eds., 2020); Laura Nixon, *The Right*

existing literature by both reconceptualizing reproductive autonomy as an issue affecting people of all genders, not just cisgender women, and by developing the intersection between the lived struggle for reproductive autonomy faced by trans people and cisgender women of color. At the forefront of this effort is the reality that being socially deprived of morality and humanity precedes and produces a struggle for reproductive autonomy. Establishing this intersection helps better calculate what is at stake and helps inform how resources and advocacy strategies should be allocated in gender justice movements. Ultimately, this analysis demands that trans legal advocacy invest in the collective commitment to gender self-determination, as modeled by the reproductive justice movement.

In Part I, I draw upon French philosopher Michel Foucault's theory of disciplinary power, the creation and maintenance of categories of people as identifiable and governable subjects, to critique the medical construction of trans identities.[9] Medical industries serve as a disciplinary mode of power that force trans people to constrain their identities and presentation into two distinct and rigid gender categories.[10] As a result, the medical industry reproduces the very binaries that many of us aim to deconstruct. Part II highlights the legal and statutory codification of this medical construction of trans identities, focusing specifically on medical evidentiary requirements for gender reclassification on government-issued identifying documents. Because many people do not wish to or cannot afford to undergo medical intervention, an overwhelming majority of trans people have inaccurate gender markers on their government-issued IDs. A visually mismatched gender designation on an identifying document heightens trans visibility, thus exposing trans people to increased exclusion and violence in sex-segregated facilities and in any instance where someone needs to produce identifying documents. Part III explains how the systems outlined above have informed court decisions that render trans reproductive bodies invisible, and thus not worthy of protection. Part IV explores the roles of "choice" and compulsion in the removal of trans reproductive organs and in bodily autonomy more generally. Lastly, Part V explores a reproductive justice intervention and calls for trans legal advocates to coalition build with

to (Trans) Parent: A Reproductive Justice Approach to Reproductive Rights, Fertility, and Family-Building Issues Facing Transgender People, 20 WM. & MARY J. WOMEN & L. 73, 93 (2013); Jemima Repo, *Governing Juridical Sex: Gender Recognition and the Biopolitics of Trans Sterilization in Finland*, 15 POL. & GENDER 83, 90 (2018).

9. MICHEL FOUCAULT, HISTORY OF SEXUALITY: AN INTRODUCTION 43 (Robert Hurley trans., Random House 1978).

10. *See* NORMAL LIFE, *supra* note 5, at 52.

existing reproductive justice movements. Trans legal advocacy should maximize the value of the decades of organizing women of color have done to resist state limitations on their bodily and reproductive autonomy. This partnership would put the weight and strength of the two movements behind a shared commitment to gender self-determination.

I. DISCIPLINARY POWER AND THE MEDICAL CONSTRUCTION OF TRANS IDENTITIES

Disciplinary power refers to the creation and maintenance of categories of people as identifiable and governable subjects.[11] For example, nineteenth-century European doctors and scientists developed the notion that people who engaged or desired to engage in certain sexual acts had a particular type of childhood, physiology, and personality, and they began classifying people based on their sexuality.[12] What had, until then, been seen as individual criminal infractions became understood as a manifestation of a deeper immutable nature. As Foucault explains, "[t]he sodomite had been a temporary aberration; the homosexual was now a species."[13] Of course, this process has occurred not only in the realm of sexuality, but also in race, status, gender, and other social markers of identity. The creation and maintenance of such categories of people (i.e., the homosexual, the criminal, the welfare dependent mother) establish guidelines and norms that are enforced through institutions, such as the medical industry and schools. These arms of enforcement diagnose and evaluate their subjects and prosecute violations of these norms.[14] In this way, the creation of categories of people establishes and enforces the state's conception of "proper" ways of being, rendering human bodies governable.

Foucault's notion of disciplinary power has informed studies on the creation and governance of trans bodies. In October 2008, legal scholar Dean Spade wrote a commentary for the Los Angeles Lawyer about myths regarding trans identity that adversely affect trans people.[15] The first myth: trans people do not exist. The second myth: trans peo-

11. Foucault, *supra* note 9, at 43.
12. *Id.*
13. *Id.*
14. NORMAL LIFE, *supra* note 5, at 54.
15. Dean Spade, *Trans Formation: Three Myths Regarding Transgender Identity Have Led to Conflicting Laws and Policies that Adversely Affect Transgender People*, L.A. LAWYER, Oct. 1 2008, at 34.

ple can only be understood or recognized through medical authority.[16] Trans identities have historically been pathologized as a mental disorder, inextricably linking trans people to the medical industry. According to the World Professional Association of Transgender Health's (WPATH) Standards of Care, the international clinical guidelines for transgender healthcare, it is the responsibility of a qualified mental health professional to be the "first contact" with a trans person seeking medical intervention and to ascertain an individual's eligibility and readiness for gender-related medical interventions, such as hormones and surgeries.[17] The result is that—in addition to validating our identities to ourselves and our networks of family and friends—we must also seek validation from a medical industry that is demonstratively misinformed about our existence in order to exercise agency over our bodies. WPATH currently recommends that trans people receive a psychological assessment and obtain a referral from the mental health professional who performed the assessment in order to begin hormone therapy.[18] For surgical procedures, WPATH recommends that trans individuals have one referral by a mental health professional for chest/breast surgery ("top surgery") and two referrals by mental health professionals for genital surgery ("bottom surgery").[19] These referral requirements indicate that gender realness—the sincerity and validity of a trans person's gender identity—must be verified by medical professionals. Perhaps if the medical construction of trans identities was not so horribly misguided, this reliance on the medical community would not be so concerning.

Foucault explains that disciplinary power "centers on the body" to render individuals as both useful and docile.[20] By focusing on the body, disciplinary power controls how we view our bodies, how our actions make us into certain types of people, and how to practice techniques to modify ourselves to better fit the norms.[21] This pattern is reproduced in the medical construction of trans identities. As a medical identity,

16. *Id.* at 35.
17. Sarah L. Schulz, *The Informed Consent Model of Transgender Care: An Alternative to the Diagnosis of Gender Dysphoria*, 58 J. OF HUMANISTIC PSYCH. 72, 74 (2018). WPATH is an international organization that establishes the Standards of Care for the provision of health and mental health services for transgender people. The Standards of Care are the international clinical guidelines that aim to articulate professional consensus about psychiatric, psychological, medical, and survival treatment of transgender individuals. *Id.*
18. WORLD PRO. ASS'N FOR TRANSGENDER HEALTH, STANDARDS OF CARE FOR THE HEALTH OF TRANSSEXUAL, TRANSGENDER, AND GENDER NONCONFORMING PEOPLE 25-26 (2012).
19. *Id.* at 26-28.
20. NORMAL LIFE, *supra* note 5, at 53.
21. *Id.*

"transsexualism" was historically defined in very rigid heteronormative terms, and access to gender affirming healthcare has been conditioned on compliance with overtly homophobic and sexist standards.[22] Only trans people who conformed to stereotypical gender norms and were deemed capable of "passing" in their new sex were able to obtain treatment.[23] In other words, our access to transition-related services traditionally depended on how successfully we could hide our trans status and approximate a "normal heterosexual life."[24] For example, trans people who were also lesbian, gay, or bisexual—that is, female-to-male trans people who are attracted to men or male-to-female trans people who are attracted to women—were not seen as "real" trans people.[25] If their gender expressions came to match their gender identities, then they would find themselves involved in same-sex relationships, which the medical industry found to be an impermissible state of being for trans people.

This rigidity is persistent. It dictates our experiences not only with medical doctors, but also with mental health providers, the very professionals who are charged with ensuring our mental and emotional safety in a world that constantly tries to deny our humanity. In a series of excerpts about trans interactions with mental health providers, Spade reveals that mental health institutions promote regulatory, binary gender expression and deny access to gender-affirming healthcare to those who fail to perform normative binary genders.[26] Judith Butler put it best:

> A therapist is asked to worry about whether you will be able, psychologically, to integrate into an established social world characterized by large-scale conformity to accepted gender norms, but the therapist is not asked to say whether you are brave enough to have enough community support to live a transgendered life when the threat of violence and discrimination against you will be heightened.[27]

The diagnostic criteria and standards for "authentic" trans experience displace processes of self-identification and empower medical providers as gatekeepers.[28] Because the recognition of trans identities is condi-

22. Minter, *supra* note 5, at 151.
23. *Id.*
24. *Id.*
25. *Id.*
26. *Resisting Medicine/Remodeling Gender*, *supra* note 5, at 19-23.
27. Butler, *supra* note 5, at 281.
28. Strangio, *supra* note 6, at 240.

tioned on successful performance of rigidly defined and harshly enforced understandings of binary gender and heterosexuality, we have been forced to present ourselves in narratives that are not entirely our own in order to access gender-affirming healthcare. For many trans people, reciting symptoms such as "persistent discomfort" with one's assigned sex and being "preoccupied with their wish to live as a member of the other sex" could be the easiest way to ensure access to transition-related healthcare.[29] One would be ill-advised to say that he/she/they believe that the norms that govern recognizable and respectable gender identities are changing, and that cultural efforts to broaden these norms have made him/her/them feel that transitioning is possible and desirable. This effectively limits our ability to assert narratives that challenge the gender norms from which many of us aim to break free.

The diagnosis presumes that normative constructions of masculinity and femininity are valid. It assumes that trans people feel distress and discomfort only because we are in a wrongly sexed body, and not because of an established world order of forced conformity to accepted gender norms. Gender-related treatment therefore centers around making sure our bodies conform to the "new" gender category. Gender and sexuality theorists have problematized the prevalence of the "born in the wrong body" model in books and television, arguing that it privileges gender reassignment surgery as the culmination of a process of self-discovery conforming to the gender binary.[30]

Unfortunately, the "born in the wrong body" model persists beyond media, informing the way our bodies interact with the medical community. In 2017, National Geographic partnered with journalist Katie Couric to create "Gender Revolution," a documentary film about gender identity. The documentary was largely preoccupied with the surgical manifestations of change and spent little time exploring the interpersonal journeys and structural hardships that trans people face. In one scene, the film follows a trans woman waking up from a vaginoplasty. Her surgeon greets her post-op with, "congratulations, you're a woman!" unconcernedly associating "real" womanhood with vaginas. This discourse normalizes ubiquitous aims to conform our bodies to a binary-sexed embodiment.[31] In this instance, it reinforced the sexed principle

29. These are requirements for a diagnosis of "Gender Identity Disorder" (GID) in the DSM IV. *See* WILLIAM N. ESKRIDGE JR., NAN D. HUNTER, COURTNEY G. JOSLIN, SEXUALITY, GENDER, AND THE LAW 109 (4th ed. 2017) [hereinafter Eskridge].

30. Jennifer Putzi, *"None of this 'trapped-in-a-man's-body' bullshit": Transgender Girls and Wrong-Body Discourse in Young Adult Fiction*, 36 TULSA STUDIES IN WOMEN'S LITERATURE 423, 423 (2017).

31. *Gender Revolution: A Journey with Katie Couric*, NAT'L GEOGRAPHIC, 2017.

of woman-ness being inextricably tied to the state of not having a penis, and conversely, maleness to not having a vagina.

The medical establishment's accordance to this sexed embodiment sets a troubling precedent for trans bodily autonomy. It paves the way for the most common medical misunderstanding for gender related care: the belief that all trans people want to, and should, undergo genital surgery as a primary form of medical treatment. This flies directly in the face of the fact that appropriate gender-confirming healthcare drastically differs according to the needs of each individual trans person. At the point of one 2009 study, 80 percent of trans women and 98 percent of trans men had not undergone genital surgery.[32] There are several reasons that motivate the decision not to alter one's genitals. Most obviously, people have different aims and desires for their bodies, and they express gendered characteristics in the ways that make the most sense to those needs and desires.[33] Furthermore, many public and private insurance programs exclude such care from coverage, making gender affirming surgeries prohibitively expensive to all but the most well-resourced trans people.[34]

In summary, the medical establishment has helped to create and perpetuate state gender coercion by privileging gender reassignment surgeries as the culmination of a process of gender self-discovery. The obsession with lacerating trans people's genitals directly reinforces the gender binary by constricting the many ways in which trans people can live in and exhibit their bodies. In order to be "fully" trans, you need to go under the knife. This popular conception of our bodies forges a psychological and spiritual disconnection with our physical selves by insisting that our bodies are necessarily unaligned with our gendered sense of self. When this construction of transness is codified on an institutional level, such as with gender reclassification rules for government identification, it has the potential to dangerously disrupt our bodily autonomy and control over our reproductive capacities.

II. POPULATION MANAGEMENT: GOVERNMENT IDENTIFICATION

As medical providers establish norms for proper trans being, the state codifies these norms through *population-level interventions*, predi-

32. NORMAL LIFE, *supra* note 5, at 80.

33. *Documenting Gender*, *supra* note 7, at 754.

34. *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).

cating trans existence on rigidly-defined and harshly-enforced understandings of binary gender.[35] Gender reclassification rules used by ID-issuing and other administrative agencies and institutions pose the most obvious example of the codification of medical evidentiary requirements.[36] A myriad of institutions will only recognize a trans person's gender identity if the person can prove that they have undergone medical intervention. These agencies include state health departments issuing birth certificates, departments of motor vehicles issuing drivers' licenses and nondriver IDs, the Social Security Administration issuing health records, the Department of State issuing passports, and welfare and Medicaid authorities issuing benefits cards.[37] Some states and agencies want evidence of particular surgeries, while others ask for surgery simpliciter, but do not specify which; and some require a doctor's letter confirming that the person is trans.[38]

The most invasive gender identification policies require surgery to verify one's belonging to a particular gender category. Currently, nine states—Alabama, Georgia, Iowa, Kentucky, Louisiana, Oklahoma, South Carolina, Tennessee, and Texas—require proof of surgery, court order, or an amended birth certificate in order to update the gender marker on a person's state driver's license.[39] Eleven states and one territory—Alabama, Arizona, Arkansas, Georgia, Guam, Kentucky, Louisiana, Michigan, Missouri, Nebraska, North Carolina, and Wisconsin—have statutes that require proof of surgery in order to update the gender marker on a person's birth certificate.[40] In many cases, surgical requirements can include removing one's reproductive organs—the removal of trans men's ovaries and uterus or trans women's penis and testes—resulting in sterilization.[41] These data points thus distill into real, lived experiences in which trans people must choose between undergoing surgical sterilization or facing state-sanctioned rejection of their gender identity.

35. Population-level intervention—referred to by Spade as "population-management power"—includes interventions that impact the population as a whole, usually by claiming to promote the health or security of the nation, and produce clear ideas about the characteristics of who the national population is and which "societal others" should be characterized as a "drain" on or "threats" to that population. *See* NORMAL LIFE, *supra* note 5, at 57.
36. *Documenting Gender*, *supra* note 7, at 733-34.
37. *Id.*
38. NORMAL LIFE, *supra* note 5, at 79.
39. *See generally ID Documents Center,* NAT'L CTR. FOR TRANSGENDER EQUAL., http://www.transequality.org/documents (compiling policies in various jurisdictions).
40. *Id.*
41. *Id.*

One cannot observe state-enforced sterilization without considering America's historical entanglement with eugenics. In the early 1900s, states began vicious campaigns to discourage and prevent the birth of children with "bad" genetic profiles.[42] Efforts to maintain white "racial purity" informed publicly-funded efforts to control the fertility of those deemed "unfit" or "defective."[43] The state's goal was to push "defective" people out of existence, either through institutionalization, sterilization, or both. These legislative efforts culminated in the Supreme Court's decision in *Buck v. Bell*, which upheld the legality of coerced sterilizations for the "feebleminded" with the egregious declaration that "three generations of imbeciles are enough."[44]

The medical and sterilization requirements for trans people, however, are paradoxically attached to legal gender *recognition*, not extermination.[45] Rather than writing trans people out of existence, compulsory medical intervention and sterilization requirements emerge precisely to recognize the existence of trans people and their right to alter their official identity records. Spade refers to this phenomenon as "state gender coercion," the idea that "the state should determine people's gender identities using binary gender as the standard."[46] Much like how Black women on welfare were encouraged to accept sterilization in exchange for a continuation of relief benefits, trans people are forced to alter their bodies and to extinguish their reproductive capacities in exchange for inclusion in political existence and life.[47]

An obvious concern with compulsory medical intervention is the reality that many trans people do not wish to alter their bodies medically.[48] Yet, another concern is that, although legal membership in a sexual category is predicated upon access to medical interventions, those medical interventions are often prohibitively expensive. Despite the govern-

42. *See* ADAM COHEN, IMBECILES: THE SUPREME COURT, AMERICAN EUGENICS, AND THE STERILIZATION OF CARRIE BUCK 5 (2016).
43. *See, e.g.*, *id.* at 4; Davis, *supra* note 4, at 7.
44. Buck v. Bell, 274 U.S. 200, 207 (1927).
45. *See* Repo, *supra* note 8, at 90.
46. *See Undermining Gender Regulation, supra* note 6, at 66.
47. Welfare and coerced sterilization are historically linked. In the 1960s, state legislatures considered many punitive sterilization bills targeting the growing number of Black people receiving Aid to Families with Dependent Children (AFDC). In 1958, Mississippi state legislator David Glass proposed legislation that would force sterilization upon welfare mothers. The bill passed by the House but was dropped in Senate after a national protest. *See* DOROTHY ROBERTS, KILLING THE BLACK BODY: RACE, REPRODUCTION, AND THE MEANING OF LIBERTY 94 (1997).
48. Like all people, trans people experience gender differently from one another, and we seek gendered characteristics in the ways that make the most sense to those needs and desires.

mental consensus that proof of transition-related procedures such as surgery are necessary to update a person's legal gender marker, many public and private insurance programs exclude such care from coverage.[49] This mismatch between necessity and access makes accurate gender markers on governmental records extremely inaccessible to most low-income trans people. The result is that many trans people, depending on where they live and what kind of medical evidence they can or want to produce, have incorrect or outdated gender markers on their identifying documents. In 2015, a study by the National Center for Transgender Equality found that 68 percent of the 27,715 adult trans participants did not have their preferred name and gender designation on any identifying documents and only 11 percent had accurate name and gender designation on all identifying documents.[50]

The legal fiction that gender must match certain sex organs manufactures a legal reality in which trans people *need* government recognition in order to access basic necessities and to shield themselves from violence. It is disaffirming to assume that trans people look to state-issued documentation to cultivate a genuine feeling of gender alignment. For many of us, self-validation and confirmation is achieved primarily through the support of blood families, chosen families, friends, and community.[51] As Spade notes, "[w]e get our identities not from the government regarding us and surveilling us, but from our communities, from knowing who we are . . . ."[52] There exists an obvious divergence between how the government regulates us and how we view ourselves. Yet, human and spiritual needs do not overcome the practical necessity to be recognized by the government in order to access basic necessities and to shield ourselves from violence.

49. *See* Gehi & Arkles, *supra* note 34, at 7.

50. NAT'L CTR. FOR TRANSGENDER EQUALITY, 2015 UNITED STATES TRANSGENDER SURVEY EXECUTIVE SUMMARY 7 (2015).

51. I would be remiss to omit the fact that inaccurate identity documents can still negatively impact trans people's mental health. Compared to those with no gender-affirming identification, those with their preferred name and gender on all documents are 32% less likely to be classified as seriously psychologically distressed, 22% less likely to have seriously considered suicide in the past year, and 25% less likely to have made a suicide plan in the last year. *See* Ayden I. Scheim, Amaya G. Perez-Brumer, & Greta R. Bauer, *Gender-Concordant Identity Documents and Mental Health Among Transgender Adults in the USA: a Cross-Sectional Study*, 5 LANCET PUB. HEALTH J. 196, 196 (2020).

52. Adwoa Gyimah-Brempong & Bill Radke, *X May Be a Gender Option on Driver's Licenses Soon. But Why is Gender Being Tracked at All?*, NPR: KUOW (Aug. 14, 2019), https://www.kuow.org/stories/the-government-can-t-decide-your-gender-identity-so-why-should-they-track-it [https://perma.cc/PS3S-8Z9J].

Consider that all institutions and programs that exist to aid or control indigent people and people of color in the United States are sex-segregated.[53] Institutions that provide essential services, as well as those that coercively control individuals—such as homeless shelters, group homes, drug treatment facilities, foster care facilities, domestic violence shelters, juvenile justice facilities, housing for the mentally ill, immigration detention facilities, jails, and prisons—are all gender segregated.[54] Trans people who do not have the desire or means to obtain medical treatment or surgeries to confirm a gender different from the one they were assigned at birth are thus subject to exclusion from facilities that purport to help them and face the risk of heightened visibility, violence, and abuse in carceral institutions.

Inaccurate gender markers also make trans people vulnerable to economic marginalization, social isolation, and physical assault. Possessing identity documents with incorrect gender markers can "out" people as trans in the hiring process, exposing them to employment discrimination.[55] People whose identifying documents do not match their gender identity also face heightened vulnerability to being outed in situations that require the production of identifying documents, such interactions with police and other public officials when traveling, or even when attempting to go to age-restricted venues or buy age-restricted products.[56] As Spade summarizes, accurate IDs "are not about the states

53. *See Compliance is Gendered, supra* note 5, at 220.

54. *See* NORMAL LIFE, *supra* note 5, at 81.

55. Notwithstanding the recent Supreme Court decision in *Bostock v. Clayton County*, 140 S.Ct. 1731 (2020) (holding that an employer who fires an individual merely for being gay or transgender violates Title VII of the Civil Rights Act of 1964), trans people can still face discrimination in the workplace. An examination of categories of identity that have been included in anti-discrimination laws and statutes over the last several decades indicates that these kinds of reforms have not eliminated bias, exclusion, or marginalization in the workplace. Discrimination and violence against people of color have persisted despite law changes that declared them illegal. Dean Spade explains that this is the result of two things: "[First], anti-discrimination laws are not adequately enforced. Most people who experience discrimination cannot afford to access legal help, so their experiences never make it to court. [Second], the Supreme Court has severely narrowed the enforceability of these laws over the last thirty years, making it extremely difficult to prove discrimination short of a signed letter from a boss or landlord stating, 'I am taking this negative action against you because of your [insert characteristic].' Even in cases that seem as obvious as that, people experiencing discrimination often lose. Proving discriminatory intent has become central, making it almost impossible to win these cases when they are brought to court." SPADE, NORMAL LIFE, *supra* note 5, at 40-41.

56. Ayden Scheim, *Gender-Concordant Identity Documents and Mental Health Among Transgender Adults in the USA*, 5 THE LANCET PUBLIC HEALTH 196, 196 (2020).

recognizing who we really are . . . they're about survival."[57] So long as legal gender recognition is predicated on medical evidentiary requirements, trans people will be unable to access accurate gender identity documents, exposing them disproportionately to a suite of external pressures.

Gender reclassification policies are a population-level intervention that codify the disciplinary power of the medical industry. While there is an increasing recognition of legal membership in one's "new" gender category nationwide, it is only for those trans people who have undergone medical intervention. In this way, the state mobilizes government agencies to predicate trans people's rights on the medical disciplinary construction of trans identities. As long as legal gender recognition remains predicated on medical evidentiary requirements that emphasize binary sexed embodiment, a majority of trans people will remain unable to access accurate gender-identity documents. By making gender reassignment surgery a prerequisite for legal gender recognition, the vast majority of trans people who do not want or are not able to afford such medical intervention remain unprotected.

III. TRANS REPRODUCTIVE BODIES

Medical intervention could be understood as an entry ticket for inclusion in political existence. In exchange for surgeries and injections, the state agrees to recognize trans people's membership into a new sex category. While the state may profess to humanize trans people nominally by changing an "M" to an "F" or an "F" to an "M" on a document, it continues to exclude our bodies from reproductive discourse.

In *Geduldig v. Aiello*, the Supreme Court considered whether discrimination on the basis of pregnancy constituted sex discrimination under the Equal Protection Clause of the Fourteenth Amendment.[58] The case involved a challenge to a California disability insurance law that exempted certain pregnancy-related conditions from its coverage. The Court rejected the argument that pregnancy discrimination constituted sex discrimination, reasoning that the policy "divides potential recipients into two groups—pregnant women and nonpregnant persons."[59] "While the first group is exclusively female," the Court argued,

57. Gyimah-Brempong & Radke, *supra* note 52.

58. Geduldig v. Aiello, 417 U.S. 484 (1974) (reviewing California's disability insurance program, which exempted work loss due to normal pregnancies from insurable coverage).

59. *Geduldig*, 417 U.S. at 496 n.20.

"the second includes members of both sexes."[60] Under *Geduldig*, since women can be both pregnant and not pregnant, discrimination on the basis of pregnancy is not sex discrimination.[61] Relying on *Geduldig*, the Court has since held that restrictions on abortion access likewise do not constitute sex discrimination.[62]

This begs the question: What becomes of trans men who are pregnant? We are invisible. It is clear that in *Geduldig*, the Court only conceptualized non-trans bodies.[63] The Court notes that "only women can become pregnant," writing trans men and gender nonbinary people who were assigned female at birth out of legal existence.[64] If the Court considered trans bodies in *Geduldig*, it would only strengthen its conclusion that pregnancy discrimination does not substantiate sex discrimination. In a selectively "woke" Court—one where the Justices recognize the reproductive capacities of trans men while failing to strike down pregnancy discrimination laws—men would also be in both the "pregnant" and "not pregnant" groups. This recognition of trans reproductive bodies would further weaken the Fourteenth Amendment as a tool to combat pregnancy discrimination. Regardless, the language in *Geduldig* sends a dangerous message to the larger society: because "only [cisgender] women can become pregnant," we, as trans people, are not capable or worthy of reproduction.[65]

60. *Geduldig*, 417 U.S. at 496 n.20.

61. Articles criticizing the *Geduldig* opinion for this reason include Sylvia A. Law, *Rethinking Sex and the Constitution*, 132 U. PA. L. REV. 955, 983 (1984); Katherine Bartlett, *Pregnancy and the Constitution: The Uniqueness Trap*, 62 CAL. L. REV. 1532, 1536 (1974); and Harriet Hubacker Coleman, *Barefoot and Pregnant – Still Equal Protection for Women in Light of* Geduldig v. Aiello, 16 S. TEX. L.J. 211 (1975). Still, some scholars believe that the Court in *Geduldig* did not reject the principle that pregnancy regulation can be sex regulation and, as such, can be discriminatory. Instead, the Court held that state regulations affecting pregnancy are not *always* suspect of sex discrimination, thus requiring that a rational basis analysis will be used. *See* MICHELE GOODWIN, POLICING THE WOMB: INVISIBLE WOMEN AND THE CRIMINALIZATION OF MOTHERHOOD 181 (2020).

62. *See, e.g.*, Bray v. Alexandria Women's Health Clinic, 506 U.S. 263, 270 (1993).

63. I use the word "non-trans" instead of "cisgender" here and throughout this Article to center the experiences of trans people and challenge the assumption that cisgender identities are the norm.

64. *Geduldig*, 417 U.S. at 496 n.20.

65. *Geduldig*, 417 U.S. at 496 n.20.

IV. TRANS REPRODUCTIVE DESIRES: CHOICE OR COMPULSION?

In 2002, on the 75th anniversary of the Supreme Court's *Buck v. Bell* decision upholding Virginia's eugenic sterilization law, Virginia Governor Mark Warner issued a formal apology for the state's decision to forcibly sterilize thousands of Virginians.[66] The apology reflects a collective American consciousness of the horrors of coerced sterilization. Justice Oliver Wendell Holmes's infamous declaration that "three generations of imbeciles is enough" may go down in history as one of the most reprehensible moments in American jurisprudence.[67]

Yet the coercive sterilization of trans people is still openly debated. In March 2019, The Economist tweeted, "Should transgender people be sterilised before they are recognised?"[68] In less than ten words, one of the world's largest news agencies invited its nearly 25 million followers to pontificate about people's right to retain their reproductive organs. Although the publication company later retracted the tweet, it highlights a grave dehumanization of trans bodies.[69] What is a deeply personal relationship between an individual and their bodily autonomy and reproductive capacity turns into a spectacle, inviting opinions from medical communities and the general public. Since state-enforced sterilization is usually theorized in relation to reproductive heterosexuality and understood as a past historical practice that targeted the assumed hereditary degeneracy of heterosexual populations, the practice of present-day, state-enforced trans sterilization is often overlooked.[70]

It is important to explore why the sterilization of trans people does not ring the same alarms as the sterilization of non-trans people. A forgiving hypothesis—which I will call the "choice" hypothesis—suggests that medical providers and policymakers believe that trans people *choose* to self-sterilize in order to conform our bodies to the sex opposite of what we were assigned at birth. Thus, the medical industry's apathy towards trans reproductive choices could stem from a misguided belief that we ourselves do not value our reproductive capacity. A less forgiving hypothesis—which I call the "compulsory" hypothesis—suggests

66. *Virginia Governor Apologizes for Law that Forced Sterilizations*, L.A. TIMES (May 3, 2002), https://www.latimes.com/archives/la-xpm-2002-may-03-na-sorry3-story.html [https://perma.cc/W34L-XAPG].

67. Buck v. Bell, 274 U.S. 200, 207 (1927).

68. The Economist (@TheEconomist), TWITTER (Mar. 19, 2019 5:27 PM).

69. Harron Walker, *The Economist Says Tweet About Sterilizing Trans People Was a Mistake*, OUT MAGAZINE (Mar. 20, 2019), https://www.out.com/news/2019/3/20/economist-says-tweet-about-sterilizing-trans-people-was-mistake [https://perma.cc/T9RX-58NK].

70. *See* Honkasalo, *supra* note 8, at 17.

that medical doctors and society at large believe that trans people are unfit for reproduction and parenthood. Under the compulsory hypothesis, limits on our reproductive choices do not result from misunderstandings of our reproductive desires, but rather reflect an overall belief that trans people *should not* reproduce. This normative stance could be based upon an assumption that trans people will be incompetent parents or will threaten conventional standards of sex and sexuality. The "choice" and "compulsory" hypotheses are not mutually exclusive. An understanding of both paints a better picture of the forces that obscure trans reproductive desires and limit trans reproductive choices.

A. *Choice*

Lawyer and activist Chase Strangio had scheduled a gynecologist appointment to address severe pelvic pain that he had been living with for months. The first words his gynecologist said to him as she entered the room were, "I assume you're here about a hysterectomy"—a major surgery that would permanently take away his ability to carry a child.[71] Without knowing anything about Strangio's relationship to his body and reproductive hopes, the gynecologist assumed that the only possible reason for his visit was to remove his reproductive organs. In this way, the very doctors who are tasked with caring for people who are pregnant or trying to become pregnant render our reproduction indecent.

The "choice" hypothesis suggests that legal and medical attitudes about trans reproduction stem from the misguided belief that trans people choose to self-sterilize in order to conform their bodies to the opposite sex. Similar to the way that racist and classist policymakers cannot imagine that indigent cisgender women of color would elect to have children for the same reasons as wealthy cisgender women, a transphobic medical community could not imagine that trans people would elect to have children.[72] In reality, like all people, trans people may value having children that are genetically related to them. The first major clinical study on reproductive desire in trans men found that a majority of trans

71. Strangio, *supra* note 6, at 223.

72. Roberts describes several stereotypes of Black motherhood that have propelled policies that regulate Black women's fertility. These images include Jezebel and the immoral Black mother, Mammy and the negligent Black mother, the matriarch and the Black unwed mother, and the welfare queen and the devious Black mother. All of these stereotypes devalue Black women's reproductive desires as deceitful and fraudulent. It ignores the possibility and reality that indigent Black mothers may want to bear children for the same reasons as wealthy white mothers. *See* Roberts, *supra* note 47, at 8-19.

men *do* wish to preserve their fertility, have children, and establish a family in the future.[73] A 2002 online survey measuring reproductive desire amongst European trans women showed similar results.[74] Healthcare providers should not assume that trans people want to rid themselves of their reproductive capacities. Indeed, healthcare providers should *listen* to trans people and provide them with care in accordance with their individual reproductive desires.[75]

If we are to critique the way reproductive desires and wants are excluded from our identities, "we must do so with a full recognition of [trans legal advocacy's] complicity in the same exclusionary practices."[76] Legal advocacy strategies for trans rights have contributed to the erasure of reproductive trans bodies. Given the consequences for trans people that flow from insurance coverage restrictions and onerous policies for updating identifying documents, it is no surprise that the trans movement has focused on increasing access to both health care coverage and identifying documents.[77] The problem, however, is that legal advocacy is often trapped in a "medical necessity" discourse that reinforces binary sexual differences.[78]

In *Casillas v. Daines*, the plaintiff, a trans woman, challenged the New York State Medicaid program's exclusion of coverage of gender-affirming healthcare. She argued that denying her access to sex reassignment procedures violated the state Medicaid law requiring coverage for "medically necessary procedures."[79] To make her claim, the plaintiff had to establish that she had a medical diagnosis of "gender identity disorder" for which surgical correction was medically necessary. The claim explains that the plaintiff, who was assigned male at birth and identifies as a woman, "needs gender reassignment surgery in order to achieve the capacity to live a life without terrible suffering."[80] The plaintiff's position reinforces the narrative that, in order to live one's life fully as a woman, once must attain the entirety of sexed physicality that non-trans women hold. This narrative—one where advocates reinforce the binary sexual differences that are so stifling to trans existence in the first

73. Katrien Wierckx et al., *Reproductive Wish in Transsexual Men*, 27 HUMAN REPROD. 483, 486 (2012).
74. Honkasalo, *supra* note 8, at 26-7.
75. *See* Nixon, *supra* note 8, at 93.
76. *See* Strangio, *supra* note 6, at 235.
77. *Id.* at 237.
78. *Id.*
79. Complaint ¶ 39, Casillas v. Daines, 580 F. Supp. 2d 235 (S.D.N.Y. 2008).
80. Complaint ¶ 56, *Casillas*, 580 F. Supp. 2d 235.

place—can be found in almost every case challenging exclusions in healthcare coverage for transgender people.[81]

Trans advocacy strategies reproduce norms of sexed embodiment that make it harder for trans people to identify and honor choices regarding our reproductive capacities. The conception of "choice" thus obscures the social and legal context in which individuals make choices and discounts the ways in which the state regulates populations, disciplines individual bodies, and exercises control over sexuality, gender, and reproduction.[82]

B. *Compulsion*

"Choice" implies that trans people's right to determine what happens to their bodies is legally protected, ignoring the fact that economic and institutional constrains often restrict our bodily "choices." The "compulsory" hypothesis does a better job highlighting these social, economic, and institutional barriers, maintaining that measures to sterilize and limit trans reproduction reflect an overall belief that trans people *should not* reproduce and raise children. The United States has always been shaped by explicit incentives that coerce people into

81. *See, e.g.*, Amended Complaint ¶ 38, Norsworthy v. Beard, 87 F. Supp. 3d 1104 (N.D. Cal. 2015) ("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), ("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, 2015 WL 5341015 (M.D. Ga. Feb. 19, 2015) ("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."); Strangio, *supra* note 6, at 238 n.50.

82. In a 1973 editorial post-*Roe v. Wade*, the National Council of Negro Women provided a cautionary note highlighting the key words "if she chooses." In the note, the Council cautions against *Roe v. Wade* being used to increase forced sterilizations of Black women, pointing to an example of a young Black pregnant woman who was arrested and convicted in North Carolina and was told that her punishment would be to have a forced abortion. "We must be ever vigilant," they said, "that what appears on the surface to be a step forward, does not in fact become yet another fetter or method of enslavement." *See* Davis, *supra* note 4, at 5. *See also* ANANNYA BHATTACHARJEE & JAEL SILLIMAN, POLICING THE NATIONAL BODY: RACE, GENDER, AND CRIMINALIZATION, AT xi (2002) (discussing the limitations of the mainstream reproductive rights movement's focus on "choice").

normative gender and sexual structures, identities, and behaviors.[83] Feminist and race scholars have provided vital insight into how public relief systems have operated through moralistic understandings of sexuality and family structure in order to force recipients into compliance with sexist and heterosexist notions of womanhood and motherhood.[84] This analysis can be extended to examine the effects that compliance with sexist and hetero-supremacist notions of identity constrain trans people's ability to express their gender, sexuality, and reproduction.

While serving as Secretary of Labor under President Lyndon B. Johnson, Daniel Patrick Moynihan authored the "Moynihan Report," where he infamously demonized Black families—and especially Black women—for failing to adhere to white middle-class norms. He found that the increasing number of households headed by single women, the increasing number of "illegitimate" births, and increasing welfare dependency in Black families destroy the stability of the family structure.[85] Black families' matriarchal structure are "so out of line with the rest of the American society," he argued, that they "seriously retard the progress of the group as a whole."[86] Moynihan claimed that indigent Black women were over-endowed with the power of a matriarch and, so empowered, they threatened traditional American patriarchal values. His report reflects concerns regarding Black families' perceived nonnormative gender and sexual behavior and the belief that these family structures challenge and offend the standards of the white middle-class nuclear family.

These concerns have permeated American social welfare policies, invigorating the state to formulate welfare policies that surveil and control Black women's reproductive and sexual behavior. As policymakers

83. The United States has embarked on several population-level interventions, such as eugenics and anti-natalist welfare policies, to control and constrict the sexuality and reproductive capacity of indigent and non-white women. Consider, for example, that women on welfare often have their homes subject to search for evidence of intimacy with men under what is known as the "man in the house" rules. *See, e.g.*, *AFDC Income Attribution: The Man-In-The-House and Welfare Grant Reductions*, 83 HARV. L. REV. 1370, 1376 (1970). If evidence of a man is discovered in the house, the family's aid could be cut off unless the woman agreed to sterilization. *See* HARRIET A. WASHINGTON, MEDICAL APARTHEID: THE DARK HISTORY OF MEDICAL EXPERIMENTATION ON BLACK AMERICANS FROM COLONIAL TIMES TO THE PRESENT 205 (2006).

84. *See, e.g.*, KHIARA M. BRIDGES, THE POVERTY OF PRIVACY RIGHTS 187 (2017); Roberts, *supra* note 47.

85. *See*, *e.g.*, Cathy J. Cohen, *Punks, Bulldaggers, and Welfare Queens: The Radical Potential of Queer Politics?*, *in* BLACK QUEER STUDIES: A CRITICAL ANTHOLOGY 21, 40 (E. Patrick Johnson & Mae G. Henderson eds., 2005); Roberts, *supra* note 47, at 16.

86. DANIEL PATRICK MOYNIHAN, U.S. DEP'T OF LAB., THE NEGRO FAMILY: THE CASE FOR NATIONAL ACTION 123-35 (1965).

began manufacturing a dichotomy between the working poor and the imagined "lazy, Cadillac-driving, steak-eating" welfare queen, they began passing "family cap" laws to disincentivize procreation in Black families that rely on the state for financial assistance.[87] Family cap laws deny additional financial support for growing families, thus discouraging welfare beneficiaries from bearing additional children.[88] Welfare policies also surveil Black women's sexual morality. In *Wyman v. James*, the Court upheld the constitutionality of New York's policy of requiring beneficiaries of Aid to Families with Dependent Children (AFDC) to submit to home visits as a condition of eligibility.[89] In addition to the type of home visits contemplated in *Wyman*, the homes of women on welfare have also been subject to search for evidence of intimacy with men under what was known as the "man in the house" rules.[90] Until 1968, if evidence of a man was discovered in the house, the family's aid could be cut off unless the woman agreed to sterilization, guaranteeing that there would be no additional children for the state to support.[91]

Welfare policies have limited indigent Black women's reproductive and sexual autonomy, forcing them to obey rigid gender and family norms. Similarly, courts use legal gender determination to force trans people to conform to heterosexual sex and family structures. Courts meticulously scrutinize trans parties' sexual anatomy and capacity for heterosexual sexual performance in order to determine their legal gender, divorcing them from their sovereignty and reproductive autonomy.[92] In *M.T. v. J.T.*, for example, a New Jersey Court found that a trans woman, J.T., was legally female because, in important part, "her vagina had a 'good cosmetic appearance' and was 'the same as a normal female vagina after a hysterectomy.'"[93] For the court, it was important not only that J.T.'s genitals look "normal," but also that she is capable of having heterosexual sex.[94] The court notes that she has "a vagina and a labia which

87. Myths of the Black "welfare queen" arose during Ronald Reagan's campaign for presidency. Images of a lazy Black mother on public assistance who deliberately breeds children at the expense of taxpayers to fatten her monthly check were used to limit the distribution of public assistance to indigent, non-white families. *See* Roberts, *supra* note 46, at 17; *see also* Cohen, *supra* note 85, at 42.

88. Bridges, *supra* note 84, at 187.

89. Wyman v. James, 400 U.S. 309 (1971).

90. *AFDC Income Attribution: The Man-In-The-House and Welfare Grant Reductions*, *supra* note 83, at 1376.

91. WASHINGTON, *supra* note 83, at 205.

92. Flynn, *supra* note 6, at 37.

93. M.T. v. J.T., 355 A.2d 204, 206 (N.J. Sup. Ct. App. Div. 1976).

94. Flynn, *supra* note 6, at 38.

[are] 'adequate for sexual intercourse' and could function as any female vagina, that is, for 'traditional penile/vaginal intercourse.'"[95]

Trans men are subjected to the same scrutiny. *Kantaras v. Kantaras* involved a custody dispute between Michael Kantaras, a trans man, and his ex-wife Linda Kantaras. In order to receive custody, Michael had to rebut Linda's claim that he was legally female, and thus, a nonbiological lesbian parent—and a legal stranger— to their children.[96] The court's deliberation on Michael's legal gender was devoted almost entirely to a single issue: whether Michael had a penis deemed sufficient for penetration. Linda's attorney barraged Michael with questions regarding his genitals—whether he could urinate standing up, whether he used a dildo, and whether he could have (in her words) "normal sex."[97]

In both of these cases, the courts determined a trans person's legal gender by examining their ability to perform "normal [heterosexual] sex." Of course, if a trans person is to reconstruct their genitals to the normative genitals of the opposite sex, absent any preemptive fertility treatment, such as harvesting eggs or banking sperm, they are foregoing their reproductive capacity. Putting these pieces together, courts were determining trans people's right to marriage or parenthood depending on whether they had foregone their reproductive capacities and conformed their body closely enough to the cisgender archetype of their "new" sex.

Policymakers disguise their heterosexist, classist, and racist beliefs of proper family structures in concerns for child development. Race scholars have revealed social biases implying that indigent Black mothers are unable to raise their children with the right moral fiber.[98] Legal scholar Dorothy Roberts discusses a historian, Philip Bruce, who tied Black women's sexual promiscuity to dangerous mothering. In his view, Black girls' mothers raised them to follow their own moral depravity: "[T]heir mothers do not endeavor to teach them, systematically, those moral lessons that they peculiarly need as members of the female sex."[99] The congressional findings for the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA)—a 1996 bill implement-

95. *M.T.*, 355 A.2d at 206.

96. *See* Kantaras v. Kantaras, 884 So. 2d 155 (Fla. Dist. Ct. App. 2004) (invalidating parties' marriage on ground that transgender father is legally female).

97. Flynn, *supra* note 6, at 38.

98. *See* BRIDGES, *supra* note 84, at 45 (discussing the moral construction of poverty and the assumptions of unfit motherhood); *see also* Roberts, *supra* note 47, at 8 (discussing racist understandings of "biological impairment" and "deviant lifestyles" that Black mothers transfer onto their children).

99. ROBERTS, *supra* note 47, at 11.

ed to make major changes to American social welfare policy—also reveal that the Act's authors believed that children born to single mothers on welfare are damaged, dysfunctional, unintelligent, and predisposed to criminality and economic dependence.[100]

Similarly, courts disguise transphobic beliefs of proper child-rearing in concerns for the child's development. In *J.L.S. v. D.K.S.*, a trans woman who was her children's biological father had transitioned post-divorce and was not permitted to see her children for nearly two years. The trial court prohibited physical contact with the children for one year and ordered that she "not cohabit with other transsexuals" (one of her roommates was trans) or "sleep with another female" (she identifies as a lesbian).[101] On appeal, the court rejected her argument that the order violated her right to privacy, citing the need to protect the children's "moral development."[102] Some courts have gone so far as to say that gender transitions terminate parental rights altogether. In Nevada, the Supreme Court upheld a ruling that terminated the parental rights of Suzanne Daly, a trans woman who was her child's biological father. The Nevada Supreme Court said that Suzanne had shown herself to be a "selfish person whose own needs, desires, and wishes were paramount" to parenthood, concluding that Suzanne had in fact terminated her own parental rights as a father by discarding fatherhood and "assuming the role of a female."[103]

The state has continuously used its powers to impose moralistic understandings of sexuality and family structure on its subjects. Public relief systems have been mobilized to force recipients into compliance with racist, sexist, and heterosexist notions of womanhood and motherhood. Similarly, legal gender determinations—which have directly affected the validity of trans marriages and parental rights—have been used to coerce trans bodies into compliance with binary notions of gender, sex, and personhood. Trans people who do not conform their bodies to the binary have a limited ability to enjoy the full rights of ordinary citizens with respect to having and raising a child. Taking both hypotheses in consideration, it is evident that trans people's reproductive wishes and potentials are severely impacted by pervading myths about their desire to reproduce and the state's interest in limiting their reproductive capacity.

100. BRIDGES, *supra* note 84, at 196.
101. J.L.S. v. D.K.S., 943 S.W.2d 766 (Mo. Ct. App. 1997).
102. *J.L.S.*, 943 S.W.2d at 766.
103. Daly v. Daly, 715 P.2d 56 (Nev. 1986).

V. A REPRODUCTIVE JUSTICE INTERVENTION

Everywhere that trans people appear in the law, there exists a heavy reliance on medical evidence, as opposed to self-identification, to establish our gender validity. Although state-coerced gender and body conformity poses a distinct harm for trans people, it has been produced and reproduced to undermine the reproductive autonomy of non-trans women of color for decades, if not centuries.[104] Many women of color recognize this history and have since cultivated and birthed what is known as the reproductive justice movement. Distinctive from reproductive rights, a law-focused movement, reproductive justice is a social justice-aimed movement that emphasizes intersecting social identities (such as gender, race, and class) and community-developed solutions to reproductive inequalities.[105]

Fundamental to the reproductive justice framework is the understanding that oppressions are linked, and that justice demands resistance to systems that combine various interlocking forms of subjugation. As reproductive justice pioneer Loretta Ross puts it, "[o]ur ability to control what happens to our bodies is constantly challenged by poverty, racism, environmental degradation, sexism, homophobia, and injustice in the United States."[106] In this way, reproductive justice should be, and in many ways already is, in constant conversation with radical movements, including trans liberation politics.

Even if it is not expressly enumerated, reproductive justice frameworks have been fighting for gender self-determination since conception.[107] Reproductive justice encompasses the right to not have a child,

104. Characterizing women of color as sexually promiscuous and too irresponsible to make their own reproductive decisions and be good mothers serves as the rationale for enacting and legitimizing discriminatory policies, programs, and laws. For example, the 1950s image of the lazy "welfare queen" was rejuvenated during the 1970s and 80s to fuel cutbacks in public assistance. Images of hyper-fertile Mexican women crossing the border to bear their children on United States soil so that their children could secure social benefits helped to pass restrictive legislation such as Proposition 187 in California, which denied undocumented immigrants educational and health benefits. *See* Davis, *supra* note 4, at 15.

105. *See* Zakiya Luna & Kristin Luker, *Reproductive Justice*, 9 ANN. REV. L. SOC. SCI. 327, 327 (2013).

106. Davis, *supra* note 4, at 4.

107. I do not use the word "self" to conform to the contemporary rights discourse, which emphasizes individualism and civil and political rights while neglecting the economic, social, sexual, and cultural rights that address group or collective needs. Instead, I use the word "gender self-determination" in the way Spade does, "as a tool to express opposition to coercive mechanisms of the binary gender system." *See Compliance is Gendered*, *supra* note 5, at 235 n.9.

but also expands reproductive discourse to include the right to have a child and the right to raise one's child with dignity.[108] When reproductive justice calls for the right to have a child and raise one's child with dignity, it is necessarily fighting for gender self-determination. Since childbirth is a highly gendered act and process, the decision to have and raise children is an extension of gender self-determination. Conversely, gender self-determination also demands increased abortion access. That is, because childbirth is a highly gendered act, gender self-determination also necessitates that cisgender women should be able to prevent their bodies from being gendered in the particular way that childbirth demands. State efforts to control reproductive autonomy go hand in hand with attempts to control the gender and sexuality of indigent, nonwhite, and trans people. Thus, when reproductive justice challenges the population-level interventions, such as welfare policies, that aim to limit indigent women of color's ability to reproduce, they are rallying against state-enforced constraints on gender self-determination.

Foundational to reproductive justice, therefore, is an analysis of how heterosexist models of citizenship have been mobilized to affect the ability of all people to determine and express our gender, sexuality, and reproduction. In combatting state policies that aim to control the sexual and reproductive autonomy of non-trans people of color, reproductive justice has been fighting for gender self-determination for all people. Unfortunately, trans legal advocacy as it stands in the courts is in many ways in conflict with the principles of reproductive justice. By acquiescing to the law's body modification checklists, trans legal advocates reproduce the very harms that the reproductive justice movement aims to eradicate.[109] Much like forced sterilization, trans people are being coerced to conform their bodies and self-sterilize in order to achieve legal gender recognition.[110] Although medical intervention can be an important step for someone's personal gender alignment, the codification of binary medical norms undermines our bodily autonomy, reproduc-

108. *See* Luna & Luker, *supra* note 105, at 9.

109. *See supra* note 76 and accompanying text.

110. In the twentieth century, many Indigenous, Black, Latinx, and other women of color were denied the right to have children through systematic and widespread sterilization policies adopted by the United States government and private doctors. For example, in the 1960s and 70s, Latinx women were sterilized without their knowledge or consent. Women who spoke only Spanish were asked to sign consent forms in English and were sometimes pressured to do so even during labor and childbirth. *See* Davis, *supra* note 4, at 9. *See also* NO MÁS BEBÉS (PBS 2015); Madrigal v. Quilligan, 639 F.2d 789 (9th Cir. 1981) (discussing a federal class action lawsuit brought on behalf of ten Latinx women who were subject to sterilization abuse at the Los Angeles County USC Medical Center).

tive control, and ability to realize gender self-determination. To combat this, trans legal advocacy must challenge both the stereotypes and the policies that undermine trans bodily and reproductive autonomy.

Drawing from reproductive justice advocacy, we as trans people need to uplift narratives that center people of color, queerness, and gender fluidity, and destabilize the perceived supremacy of whiteness, heterosexuality, maleness, and gender binarism.[111] This strategy focuses on exposing disciplinary norms as constructed fallacies and proposing alternative ways of being legitimate. As Strangio notes, "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 nonbinary people who may need care that defies every expectation of how bodies look, perform, and have sex."[112] Uplifting these truths will help reclaim our agency by honoring the ways in which we can inhabit our bodies and opposing narratives that use our bodies to reinforce the binary.

Critical trans advocacy must also challenge population-level policies that coerce us into expressing gender identity through a narrowly defined binary. This requires trans advocates to push for the removal of medical evidentiary requirements for changing gender designation on government-issued identifying documents. It even requires advocates to explore the possibility of eliminating gender markers on these documents altogether. Challenging these disciplinary norms of trans identity steers us away from the dangers of building trans politics on the basis of gender normativity and binary sexed embodiment. The absence of medical intervention requirements creates space for processes of gender-alignment and self-identification that support multiple forms of embodiment.

By honoring the multitude of ways we can inhabit our bodies, trans advocacy could embrace the foundations of the reproductive justice movement and reveal a collective commitment to gender self-determination. Gender self-determination is linked to the practices and theories of self-determination embodied by various and ongoing anticolonial, Black Power, and prison abolition movements. It focuses on col-

111. Evelin Shen, director of Asians and Pacific Islanders for Reproductive Health, talks about the need to confront stereotypes to make activism possible. She says, "Asian women are supposed to be docile and obedient. This model is not compatible with fighting for women's rights." *See* Davis, *supra* note 4, at 14. For women of color, challenging these myths and stereotypes is part of the process of reclaiming their humanity and redefining their own identities. *Id.*

112. Strangio, *supra* note 6, at 224.

lectivizing the struggle against both interpersonal and state violence.[113] This broader quest for liberation demands that trans legal advocates abandon the assumption that if we win rights for the most sympathetic members of our community, the rest will be protected over time. As Roberts states, "there is something drastically wrong with a conception of reproductive freedom that allows this wholesale exclusion of the most disadvantaged from its reach."[114] True liberation demands that we fight for gender self-determination for *all* people regardless of their positions in a capitalist economy.[115] In addition to removing medical evidentiary requirements for legal gender recognition, this includes demanding an end to sex-segregated state facilities to eliminate the use of gender as a barrier to access institutions that provide essential services. Opposition to these population-level controls are foundational to a legal commitment to gender self-determination.

CONCLUSION

"Inherent differences," Ginsberg wrote, between men and women can remain "cause for celebration," but not for "artificial restraints on an individual's opportunity."[116] Paradoxically, a belief in the "inherent differences" are precisely what restrain trans people's opportunities and legal rights. Whether the case touches on the legitimacy of a trans person's marriage, the custody of a trans person's children, a trans person's carceral rights, or any dispute with a trans litigant, judges routinely exalt invasive medical evidence as the factor determining the trans person's rights. Gender identity is measured by medical intervention and validated by governmental designation. It transcends the courtroom, finding its way into the everyday lives of trans people and our thoughts about our reproductive legitimacy.

Medical evidence remains one of the only legal shields to protect trans people in the courtroom and the primary way to assert the legitimacy of one's gender identity in the administrative state. While courts require medical intervention in order to recognize trans people's membership in a "new" gender category, they simultaneously render trans reproductive bodies invisible. Similar to how the state uses social welfare programs to coerce recipients into compliance with sexist and heter-

113. *See* Eric A. Stanley, *Gender Self-Determination*, 1 TSQ: TRANSGENDER STUD. Q. 89, 90 (2014).
114. Davis, *supra* note 4, at 15.
115. *Compliance Is Gendered*, *supra* note 5, at 232.
116. United States v. Virginia, 518 U.S. 515, 533 (1996).

onormative constructions of womanhood and motherhood, courts use the medical industry to render trans bodies governable: namely, unwanting and incapable of reproduction. Trans advocates should combat the disciplinary constructions of trans identities and the population-level interventions that enforce binary gender norms. Through a reproductive justice and self-determination framework, we can nurture a nascent jurisprudence that embraces the multiplicity of trans embodiment and the non-normative family structures that we, as trans people, can create. ♣

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