

## The risky womb and the unthinkability of the pregnant man: Addressing trans masculine hysterectomy

### Abstract

In April 2017, the European Court of Human Rights ruled that requiring trans people to undergo sterilisation in order to grant legal gender recognition was a breach of human rights. In the UK, sterilisation has never been a legal requirement for trans people. However, hysterectomy and salpingo-oophorectomy have been strongly encouraged for trans masculine people on medical grounds, although the clinical evidence for current recommendations is weak. Within this article I analyse the issue from a feminist perspective and argue that current presumptions in favour of surgical intervention are influenced by the history of medical interventions to 'fix' bodies perceived as female, coupled with a strong social taboo against the pregnant man. As a consequence, medical and legal frameworks are not necessarily facilitating optimal outcomes for the individual. I suggest that practices in this regard should be critically examined, with a view to developing more tailored, person-centred practices and facilitating informed choice.

**Keywords:** Transgender, hysterectomy, fertility, pregnancy, trans man, sterilisation

### Background

Trans masculine people are men or non-binary people who were originally assigned female at birth. Although some trans masculine people also have intersex conditions,

the majority will have been born with reproductive anatomy which is typically perceived as female, including a womb and ovaries. At present, many European countries require that trans people are sterilised prior to legal recognition (TGEU, 2016). However, a ruling by the European Court of Human Rights in April 2017 determined that this was incompatible with human rights ("Affaire A.P., Garçon et Nicot c. France," 2017). In the UK, the Gender Recognition Act (2004) does not create a legal requirement for sterilisation, but NHS England (2013) protocol recommends that trans masculine people who are taking testosterone should undergo hysterectomy and salpingo-oophorectomy within five years of commencing testosterone, even if they do not propose to have other masculinising surgeries.

Medical intervention for trans people has historically been subject to gatekeeping, with a strong focus upon establishing that those who seek medical intervention meet clinical thresholds (Bockting, Robinson, Benner, & Scheltema, 2004; Coleman, 2016; Singh & Burnes, 2010). There is a longstanding principle that more reversible interventions, such as social transition and hormone therapy, should be undertaken before irreversible interventions, such as surgery (Benjamin, 1966; Coleman et al., 2012; Richards & Seal, 2014). Surgical intervention for trans people has therefore implicitly been treated as a 'last resort', only offered when there is no doubt that it is required. However, current UK practice regarding hysterectomies for trans masculine people taking testosterone deviates from these principles. For this population group, surgical intervention is treated as a preferred option, to be done "just in case" of a relatively unproven risk. Within this paper, I argue that this derives from three interlinked assumptions: that reproductive anatomy perceived as female inherently confers risk; that relatively little justification is needed to remove such anatomy; and that trans masculine people will not – or should not – become pregnant. I suggest

that this has implications as other jurisdictions in Europe move beyond legally-mandated sterilisation.

### **Feminism, the body and trans masculinity**

The medicalisation of the womb, fertility and childbirth are archetypal feminist discussions (Groneman, 1994; Rich, 1980; J.M. Ussher, 1991; Young, 2005). These debates raise questions about the ways in which bodies and organs that are socially coded as female are viewed within medical frameworks. Yet this creates a very immediate dilemma: the bodies I wish to discuss are bodies of men and non-binary people, which have organs typically seen as female. One potential solution to this dilemma would be to resort to the traditional sex/gender split, in which male and female are purely labels for certain types of body (Oakley, 1972). Then there would be no contradiction in talking about men or non-binary people having female bodies. However, this reifies binaristic essentialist divides between sex and gender and between male and female which I find largely unhelpful (Butler, 2004). More significantly, I consider it to be inauthentic to my own experiences and, I suspect, to the experiences of many other trans masculine people. Being trans may result in bodily experiences which cannot be easily mapped onto binary biological categories of 'male' and 'female': for example, physiological experiences which arise from having 'male' levels of testosterone in bodies with a womb and ovaries. Riggs (2013) suggest that trans masculine people's self-representations typically seek to describe an embodied experience of pregnancy and parenthood, without being constrained by binaristic notions of 'man', 'woman', 'father' and 'mother'. Rubin (2003) describes related difficulties in finding a way of paralleling some similarities between the experiences of trans men and gender non-conforming women, while also respecting

trans men's embodied identities as men. Simply describing trans masculine people's bodies as 'female' is unauthentic and for many, unacceptable.

The difficulty of finding non-essentialist, trans-inclusive ways of talking about bodies and experiences is scarcely new for feminism. Stone's (1991) 'Posttranssexual manifesto' is often presented as the starting point of modern transfeminist studies. Stone critiques the ways in which trans experience have been framed both by medical categorisation and pre-existing discourses of gender, and asserts the voice of trans people as active subjects. Paradoxical constraints are placed upon trans experiences: trans people are expected to perform gender in a way which meets medical and legislative requirements; yet simultaneously criticised for upholding gender norms (Butler, 2004; Serano, 2007; Spade, 2006; Stone, 1991) Califia (1997) and Serano (2013) point out that the social scrutiny trans people are submitted to is situated within wider structures of gender inequality: femininity is denigrated compared to masculinity, and so trans women are typically subject to a higher level of scrutiny and prejudice than trans men. However, within this article I consider an alternative angle to this inequality: how trans men and non-binary people are affected by social attitudes towards bodily anatomy which is perceived as female. In this context, it is relevant to observe that feminist accounts of the control of the 'female' body often detail ways in which people perceived as gender non-conforming have been forced back to the category of woman through pathologisation and medical intervention (Groneman, 1994; Terry, 1995). There are links between ways in which female bodies and trans masculine bodies have been subject to medical intervention, precisely because in the eyes of many, they are the same thing.

In addressing this issue as a feminist issue, I recognise that there are gendered structures of oppression with direct, material consequences, which result from expecting people to conform to binary categories and privileging that which is categorised as male over that which is considered female. Accordingly, within this article, I describe the reproductive system which consists of womb, ovaries, fallopian tubes and vagina as being anatomy which is typically seen as female. However, my acknowledgement that certain types of anatomy are socially perceived as female is not intended to deny or undermine the gendered experiences of trans masculine people, and the ways in which they understand their own bodies.

Taking a feminist stance in this article also allows me to engage with an epistemological dilemma. Trans masculine hysterectomies are rarely discussed in academic literature (Colebunders et al., 2016; Rachlin, Hansbury, & Pardo, 2010). But I am a trans man, who has belongs to trans masculine communities for over a decade. I got advice from friends about my own hysterectomy, and I have given advice to others. There is an academic convention that there is no need to cite what is common knowledge. However, my own 'common knowledge' about trans masculine hysterectomy is almost entirely missing from the academic literature. Feminist scholarship has often explicitly recognised the value of experiential knowledge, especially where certain types of knowledge has been systematically excluded, or rendered untellable in frameworks of analysis which do not address intersections of marginalisation (Crenshaw, 1991; Letherby, 2003; Stanley & Wise, 1993). Hence, while this account primarily aims to analyse and critique public discourses on trans masculine hysterectomy, in places I signal that my own experiential knowledge indicates that the public discourse may be incomplete. I therefore explore this subject through an analytic autoethnographic approach, in

which I critically analyse how the social world which I am a member of is affected by medical practices, legal constraint, and social discourse (Anderson, 2006)

### **The medical case for the 'risky' trans masculine womb**

Recommendations regarding hysterectomies are often focused upon risks believed to derive from testosterone therapy. The NHS England (2013:17) protocol for treating trans people states: "Continuous use of testosterone therapy in trans-men with an intact uterus increases their risk of developing endometrial hyperplasia and malignancy. Trans-men should be informed of this before commencing testosterone therapy and be strongly recommended to have a hysterectomy and bilateral salpingo-oophorectomy after receiving continuous testosterone therapy for 2-5 years." Similarly, guidance from the endocrinologist at Charing Cross Gender Identity Clinic, the largest in the UK, states: "We also normally recommend hysterectomy after 2 years of treatment to prevent any risk of problems in the womb occurring." (Seal, undated). Neither of these documents provide further references.

In contrast, the Standards of Care issued by the World Professional Association for Transgender Health (WPATH) discusses the potential side effects from masculinising hormone therapy, and categorises ovarian, uterine [endometrial] and cervical cancer as "no increased risk or inconclusive" (Coleman et al., 2012). Wesp (2017), reviewing the literature, concludes that while there is a hypothetical basis for positing an increased risk to trans masculine people of endometrial hyperplasia or cancer, only one such case has been documented. She adds that there is also no evidence that trans masculine people are at increased risk of ovarian cancer. Wesp (2017) therefore concludes that hysterectomy should not be recommended purely for prevention of either uterine or ovarian cancer. Feldman (2016) reaches broadly

similar conclusions, and additionally notes that there is no evidence that testosterone affects the risk of cervical cancer. However Feldman (2016) does offer a low-grade recommendation that oophorectomy and/or hysterectomy be considered where there are particular concerns about ovarian, cervical or uterine cancer, especially if the patient is older, not concerned about fertility, unwilling to undergo screening, and surgery would not pose a health risk.

Feldman's reference to age is particularly significant. Demographic data on trans populations is poor, and subject to methodological variation. However, gender clinics within Europe typically report that the majority of their trans masculine patients seek and receive treatment before they are thirty (De Cuypere et al., 2007; Dhejne, Öberg, Arver, & Landén, 2014; Gómez-Gil, Trilla, Salamero, Godás, & Valdés, 2009; Kreukels et al., 2012; Simonsen, Hald, Giraldi, & Kristensen, 2015). Recent UK data suggests that trans masculine people make up two-thirds of referrals to gender clinics for those under 18, but only a small fraction of referrals over the age of 65 (Bouman et al., 2016; Tavistock and Portman Gender Identity Service, 2016). It therefore appears that the NHS England (2013) recommendation to undertake hysterectomy two to five years after commencing testosterone would largely apply to patients aged in their twenties or thirties. However, endometrial cancer is primarily diagnosed in those aged over 65, and is rare in young adults, with only 18 cases of endometrial cancer diagnosed among people under the age of 30 in the UK each year (Cancer Research UK, 2016c). Even if there was overwhelming evidence that testosterone substantially increased the risk of endometrial cancer (which at present there is not), it seems questionable whether this baseline rate of incidence is sufficient to justify recommending hysterectomy for trans masculine people still in their twenties.

Cervical and ovarian cancer are not cited in the NHS England guidance, but could also be considerations in surgical intervention. Historically, trans masculine people were believed to be at a heightened risk of ovarian cancer, on the somewhat tenuous basis of an observation that the ovaries of trans masculine people appeared to resemble those patients with polycystic ovary syndrome (PCOS) ovaries, and PCOS was potentially linked with cancer (Feldman, 2016; Mueller & Gooren, 2008; Wesp, 2017). This has now been disrupted on the dual grounds that trans masculine ovaries are no longer thought to resemble those of PCOS-sufferers, and PCOS is not conclusively associated with ovarian cancer (Feldman, 2016; Mueller & Gooren, 2008; Wesp, 2017). Ovarian cancer, although most common in older adults, does occur among young people in their twenties and thirties (Cancer Research UK, 2016b). Cervical cancer also occurs relatively commonly among younger adults (Cancer Research UK, 2016a). Evidence from outside the UK suggests that trans masculine people are less likely to have smear tests, and more likely to have inconclusive results (Feldman, 2016; Hsiao, 2017; Peitzmeier, Reisner, Harigopal, & Potter, 2014). However, some trans masculine people may have a relatively low risk of cervical cancer, for example if they have never been exposed to the HPV virus (Feldman, 2016). A HPV vaccine programme was introduced in the UK in 2008, which is likely to mean that current and future cohorts of young trans masculine people will have a reduced risk of cervical cancer (Cuzick, Castaón, & Sasieni, 2010; Mesher et al., 2013). Although trans masculine people can be affected by ovarian and cervical cancer, there does not appear to be strong evidence that trans masculine people are inherently at greater risk than other groups. Insofar as there is an increased risk, this may be largely due to structural factors, such as poor access to inclusive and affirmative gynaecological care (Peitzmeier et al., 2014). Potential



unwillingness to undergo smear tests, or poor access to gynaecological care are not normally considered justifications for a hysterectomy. Ovarian and cervical cancers are not cited by NHS England (2013) in justifying its current policy on hysterectomy and salpingo-oophorectomy, and Feldman (2016) does not conclude that these issues necessitate prophylactic surgery.

The current guidelines therefore justify surgery in terms of a 'risk' which is largely unsupported by evidence. This is despite the fact that the practice of trans healthcare otherwise errs towards non-intervention. Hysterectomy with salpingo-oophorectomy is a significant medical procedure with irreversible consequences, most notably for fertility. In addition, the surgery carries some risk of complications, although data on complications in trans masculine people is limited (Colebunders et al., 2016; Rachlin et al., 2010). The structure of gender identity services may be one factor in the emphasis on 'risks' which are in fact minimal in younger people. The pathway of care is designed on the basis of all treatments taking place within a concurrent period of time, with the patient discharged at the end (NHS England, 2013). Accordingly, the pathway does not facilitate a twenty year-old transitioning, deciding to retain his womb and ovaries for now, and reconsider the risks when he is in his forties. However, this structural issue does not seem to be enough on its own to account for the strong assertion of risk based upon little evidence.

### **Other medical factors promoting surgery**

'Risk' is the formal reason given in the UK for recommending hysterectomy for trans masculine people. However, it is not the only reason why trans masculine people decide to undergo this procedure. For some, knowing that they have a womb and ovaries is part of a sense of distress ('dysphoria') with their anatomy, and hence

removal of these organs is an important part of their transition (Rachlin et al., 2010). It has also been suggested that a hysterectomy and salpingo-oophorectomy may allow trans masculine people to reduce the amount of testosterone they need to take, although the evidence is poor (GIRES, 2008; Rachlin et al., 2010). My own perception from talking to trans masculine people is that other physiological problems such as pain, cramping or bleeding is often a catalyst for deciding to proceed with hysterectomy. However, these issues are poorly documented in the literature, with the exception of Rachlin et al. (2010). It is unclear how common such problems are, and whether surgery is the only solution.

Rachlin et al. (2010) appear to have conducted the only recent piece of research addressing the question of why trans masculine people undergo hysterectomy and salpingo-oophorectomy. They use a convenience sample of 134 trans masculine people, apparently mostly but not exclusively from the US. Participants could cite multiple reasons for undergoing hysterectomy and salpingo-oophorectomy, and were also asked to rank them. Overall, the five most important factors were preventative healthcare; feelings of gender incongruence; resolution of other medical problems; requirements relating to legal recognition; and to stop extreme bleeding and cramping. A number of other physiological and social factors were also cited. The study also highlights the impact of surgery. Although few participants experienced regrets, and none entirely regretted their decision to have surgery, a high proportion reported medical complications, and around half reported some degree of change in sexual sensation or experience, although mostly for the better.

Rachlin et. al's (2010) findings are not necessarily transferable to a UK context.

Some of the factors listed, such as the need for a hysterectomy in order to gain legal recognition, are inapplicable in the UK. In addition, many of Rachlin et. al's (2010)

participants could not access state or insurance funding which fully covered the cost of surgery. On average, participants paid around \$10,000 for hysterectomies.

Individuals in some countries may not receive paid sick leave for transition-related surgeries. It seems likely that this financial burden would tend to result in a higher proportion of patients undergoing surgery in response to an immediate need than would be found in a UK sample, where state-funded surgery is available.

Clearly there are circumstances where individuals decide to have a hysterectomy and salpingo-oophorectomy because their reproductive anatomy is causing them distress, either due to anatomic dysphoria, or due to gynaecological concerns. It is not my intention to suggest that trans people should not have the right to make such decisions. However, at present there seems to be remarkably little data as to why hysterectomies are being undertaken in the trans masculine population, and whether other alternatives could be offered in some cases.

### **Placing trans masculine hysterectomy in a feminist context**

The presumption that a womb and ovaries in a trans masculine individual pose a risk, and that hysterectomy is an appropriate solution for various gynaecological problems, can be placed within a wider cultural context. The notion that reproductive anatomy typically seen as female is inherently risky can be traced throughout much of Western medical history. The ancient Greeks believed that the womb could wander freely through the body, causing disease (Faraone, 2011; Micale & Porter, 1995; J.M. Ussher, 1991). The assumption that internal reproductive anatomy was core to women's health – and hence that women's illness was often located in these organs – underpinned the development of modern gynaecology (Moscucci, 1993; J.M. Ussher, 1991). Even today, it is suggested that many hysterectomies are

performed unnecessarily to resolve conditions which could be addressed in other ways (Cloutier-Steele & West, 2003; Djukic, Lekovic, Jovic, & Varjadic, 2016; Edozien, 2005). The description of ovarian cancer as 'insidious' or as a 'silent killer' has similarly focused attention on the notion that internal reproductive anatomy may be harbouring undetectable disease, and may have contributed to a failure to recognise the symptoms that do occur (Jasen, 2009). As such, there is already a prominent social discourse of risk related to internal reproductive anatomy.

Associated with the history of presumed risk is a medical interventionist approach to 'correcting' gender diversity. Late Victorian sexologists sought to medically classify and correct gender and sexual diversity in people assigned female at birth. Although such pathologisation was typically understood at the time as relating to lesbians, the concept of lesbian at the time included both gender non-conformity and physiological masculinisation (Groneman, 1994; Terry, 1995). Terry (1995) describes attempts to classify lesbians' bodies as physiologically distinct, through looking for signs of physical masculinisation. Case studies described in the 1886 *Psychopathia Sexualis* as extreme cases of 'acquired homosexuality' in women seem to relate to experiences which today might be seen as trans masculine (Krafft-Ebing, 2016). Surgical interventions were undertaken in the assumption that they would 'fix' individuals to the category of women, including oophorectomy, hysterectomy and clitorectomy (Groneman, 1994; J.M. Ussher, 1991). Today, intersex children, and sometimes adults, continue to be subjected to surgery in the hope of 'fixing' their identity to female, with both reproductive potential and sexual satisfaction deemed sacrificeable for this aim (Anderson, 2015; Carpenter, 2016; Chase, 2006).

The threshold for intervention with regard to trans masculine bodies may have been set particularly low because, as I will outline in the second half of this paper, it has

typically been assumed that trans masculine people either cannot or will not bear children. Reproductive ability is closely associated with social constructions of whether a body should be considered female or male (Burkitt, 1999; Jane M Ussher, 2006) As such, the combination of perceived 'riskiness', a desire to 'fix' gender and the perception of the trans masculine body as being either a non-reproductive female body, or a transgressively productive male body, together creates a context in which hysterectomy becomes an obvious 'solution'.

### **Medico-legal denial of the pregnant man**

A discussion about hysterectomy is inevitably also a discussion about fertility and reproduction. Evidence regarding the impact of testosterone on trans masculine fertility is limited. It seems to have been previously assumed that testosterone therapy would inevitably cause infertility. Thus one trans community-produced publication from 2005 states that after approximately two years of testosterone therapy, trans masculine people would become permanently infertile (Blustin, 2005). NHS England (2013) recommends discussion on fertility prior to hormone therapy. Recent publications are more equivocal, noting that data is limited but there are multiple documented cases of trans masculine people ceasing testosterone therapy and conceiving, sometimes after several years (De Sutter, 2016; Light, Obedin-Maliver, Sevelius, & Kerns, 2014; Terrence Higgins Trust, 2012). Accidental pregnancy remains a potential risk for those taking testosterone (Light et al., 2014; Reisner, Perkovich, & Mimiaga, 2010; Terrence Higgins Trust, 2012). Undergoing hysterectomy and salpingo-oophorectomy therefore means that a trans masculine person moves from being potentially capable of bearing children to definitely being unable to do so.

Medical structures have historically drawn upon gender and sexuality stereotypes in order to determine which forms of trans identity should receive diagnostic endorsement (Califia, 1997; Davy, 2011; Spade, 2006). Thus Benjamin (1966), who was highly influential in establishing medical criteria for transition, stated that trans men would be attracted to feminine women, and desperately desire to be husbands and fathers. Benjamin does provide an account of a trans man who became pregnant. However, Benjamin presents this as a strategic technique: the trans man did *not* desire to give birth, or to engage in vaginal sex, but was merely willing to undergo these experiences to achieve his ultimate aim of being a father. A trans masculine person who willingly enters into an enjoyable, sexual relationship with a man and/or gave birth, may therefore risk his maleness being challenged, and access to treatment denied. More (1998:325) quotes a trans man who states that the gender clinic he attended saw his engagement in vaginal sex, and his decision to continue with pregnancy, as an indicator that he was 'salvageable' as a woman. The assumption that gender is defined through sexual practice has therefore served to restrict the sexuality and self-expression of trans people.

In several European countries, the medical discourse on hysterectomies is interconnected with the fact that sterilisation is a specific precondition of legal gender recognition: it is not legally possible for a man to be pregnant (Carastathis, 2015; TGEU, 2016). In the UK, the Gender Recognition Act (2004) does not require trans people to undergo medical treatment prior to being recognised in their new gender, although an explanation must be provided if no surgery has been undertaken. It is therefore perfectly possible for someone to receive legal recognition as a man while still being capable of becoming pregnant. However, UK legislation fundamentally fails to recognise the parental status of a pregnant man.

In the Gender Recognition Act (2004) parental status is excluded from gender recognition as follows: “The fact that a person’s gender has become the acquired gender under this Act does not affect the status of the person as the father or mother of a child.” The explanatory notes add: “This provides that though a person is regarded as being of the acquired gender, the person will retain their original status as either father or mother of a child. The continuity of parental rights and responsibilities is thus ensured.” The phrasing here is brief and somewhat ambiguous. However, the references to “original” and “continuity” in the explanatory notes indicate that what is being discussed is the ongoing parental status of a trans person regarding a child born *before* they received gender recognition. It is unclear whether these provisions are intended to apply to children born after the parent’s gender recognition, or indeed whether this possibility was even considered.

Recognition of non-binary people is not granted by this legislation.

Four years after the Gender Recognition Act, the Human Fertility and Embryology Act (HFEA) (2008), redefined parental categories, including greater legal recognition for some same-sex couples. Some aspects of this redefinition benefited some trans people, for example by expanding parental rights for those whose partners conceive through donor insemination, albeit in gendered terms. However, the HFEA fundamentally ignores the possibility of trans masculine pregnancy, defining the “mother” as the “woman” who has carried the child. The parental status of someone who is legally a man but carries a child is not addressed. Since non-binary gender is not recognised in the UK, non-binary parenthood also remains unaddressed.

There has been greater discussion of trans fertility preservation in the medical literature in recent years, but primarily from a technological perspective. For trans masculine people, the solution which is most commonly proposed is egg freezing,

taking place prior to both starting testosterone and having surgery (Johnson & Finlayson, 2016; Richards & Seal, 2014) However, egg-freezing is not necessarily an ideal solution for trans masculine people wanting a family. Egg freezing is a relatively new technology, with limited data on outcomes (Baldwin, Culley, Hudson, & Mitchell, 2014; Richards & Seal, 2014). Embryo freezing has a more established success rate, but gives a second parent rights over the embryo (Ben-Naftali & Canor, 2008; De Sutter, 2016; Dickens, 2016). The egg retrieval procedure may be unacceptable to some trans masculine people, since it involves cessation of testosterone therapy, commencement of oestrogen therapy and invasive gynaecological procedures (Armund, Dhejne, Olofsson, & Rodriguez-Wallberg, 2017; De Sutter, 2016; Frederiksen, Mehlsen, Matthiesen, Zachariae, & Ingerslev, 2016; Richards & Seal, 2014). Egg-retrieval, storage and implantation is expensive, and subject to variable NHS local funding policies, meaning many trans masculine people are financially unable to access it (Devine, 2015; Kerr, 2013; Krajewska, 2015). Finally, to actually use stored eggs or embryos, a surrogate is required. However, surrogacy law in the UK raises a number of practical barriers. For example, surrogates in the UK cannot be paid beyond expenses, necessitating an altruistic volunteer; the surrogate parent can decide not to surrender the child; and the legislation only allows for couples making use of surrogates, rather than single parents (Horsey, 2016; Norton, Crawshaw, Hudson, Culley, & Law, 2015). For many trans masculine people, egg-freezing is therefore not a viable solution. One reason why egg-freezing may be championed for trans masculine people, despite its drawbacks, is that it is a process which removes reproduction from the body of the individual. The eggs are extracted in a clinic, fertilised in a laboratory and placed inside a surrogate. Society does not



need to publicly address the spectacle of the pregnant man, and the potential challenge it poses to heterosexual, binary-gendered notions of reproduction.

Although it is recommended that fertility advice be offered to trans masculine people, it is unclear whether this always takes place, or the quality of such advice. In the UK, gender identity clinics (GICs) are predominantly staffed by mental health professionals (NHS England, 2015), who may lack expertise in reproductive medicine. In addition, GICs are commissioned nationally, with seven clinics covering all adults in England (NHS England, 2013). In contrast, reproductive services are commissioned locally, and notoriously subject to a 'postcode lottery' (Devine, 2015; Kerr, 2013; Krajewska, 2015). This may make it difficult for GICs to advise on the options practically available to a specific patient. General practice and local fertility services may also lack expertise in advising trans masculine people on fertility.

Another factor which is typically not directly addressed in the literature is that reproductive technologies evolve rapidly. The first IVF baby was born less than forty years ago. The removal of ovaries and womb in a twenty year old not only means they cannot use the reproductive technologies of today, but may also limit access to reproductive technologies which may be available in twenty years time.

At present, therefore, while UK legislation and medical practice does not explicitly prohibit male pregnancy, it tends to disregard it. Legally, there is no parental category covering a man or non-binary person who has given birth, and medical structures are not necessarily well set up for pragmatic, individualised decisions about fertility options.

### **The social unthinkability of the pregnant man**

Medical and legal denials of the possibility of a pregnant man occur in the context of broader social discourses which position male pregnancy as both novel and shocking. There are academic and media accounts of trans masculine pregnancy dating back at least to the late 1990s (Califia, 2000; Devor, 1997; Karaian, 2014; More, 1998). Yet in 2008, Thomas Beattie was widely described in the media as the world's 'first' pregnant man (Currah, 2008; Jones, 2012; M. Moore, 2008). The UK media has announced at least two different UK 'first' pregnant men, one in 2012 and one in 2017 (Box-Turnbull, 2012; Forster, 2017; C. Moore & Dinham, 2017; Park, 2012). The continuing sensationalised – and demonstrably false - claims of novelty indicates that male pregnancy currently remains outside the frame of social recognition.

Trans masculine pregnancy has often been controversial even among trans people. Green (2004) describes hostility within the trans community to a couple who has a child in 1999. My own recollection is that Thomas Beattie's pregnancy was commented on negatively in UK trans masculine communities in 2008. UK trans communities seem to me to be more supportive towards trans masculine pregnancy today, but there remains criticism of those who are seen as deliberately seeking publicity around being pregnant. This hostility seems to be underpinned by a concern about social validation: how can anyone take us seriously as men, if some of us get pregnant?

There is justification for such concerns. Trans masculine people in the media often do need to explicitly confront perceptions that pregnancy invalidates expressed identity, and that it is simply impossible to be a pregnant man (Riggs, 2013, 2014). As I outlined earlier, medical assessment processes have often assumed that a 'true' trans man would never seek to become pregnant. Lesbian and gay parenting has

been subject to repeated scrutiny and legal restriction over concerns that traditional mother and father roles are required for psychological wellbeing of the child, or that same-gender parents may transmit homosexuality or gender non-conformity to the child (Clarke, 2001; Hicks, 2003, 2005). Trans masculine parenting may raise similar concerns, heightened by the physiological nature of transition. For example, Thomas Beatie was questioned about whether his exposure to testosterone could harm his child (Riggs, 2014). These concerns were in part offset by a medical account that Beatie's testosterone levels were 'normal' (presumably meaning within a typical female range), and by Beatie's self-presentation as a 'normal' man who simply wanted to have a family with his infertile wife (Halberstam, 2010; Riggs, 2014). Explicit accounts of the pregnant man as 'normal' may be strategically desirable within a social context that positions his experiences as shocking, dangerous or simply unthinkable.

There is little literature discussing pregnancy or fertility among non-binary people. However, the widespread association of sexuality and fertility with masculinity and femininity may have contributed to a stereotype that non-binary people are asexual. Thus Barrett (2007:43) described non-binary people as being largely unable or unwilling to engage in interpersonal relationships. More recently, other clinicians have presented a rather more nuanced and inclusive view of non-binary identities, including highlighting the need for fertility advice (Richards et al., 2016). The broader lack of legal or social recognition for non-binary people may introduce particular challenges in having their gender identity recognised while pregnant.

## **Conclusions**

The UK has never specifically mandated sterilisation for trans people, but its current medico-legal framework encourages hysterectomy for trans masculine people, and discourages pregnancy. I have argued that this framework can be understood from a feminist perspective as being rooted within a perception that internal reproductive anatomy is inherently risky, and within a strong social taboo regarding male pregnancy. Following the ECHR ruling that state-mandated sterilisation breaches human rights, examining discourses and practices within the UK is timely and useful in order to recognise and address other constraints upon trans people's rights to bodily integrity and individual decisions about fertility and family.

For some trans masculine people, hysterectomy will be appropriate to their needs. Many trans masculine people struggle to access suitable gynaecological care (Peitzmeier et al., 2014; Rachlin et al., 2010). It is not my intention to argue that hysterectomy and salpingo-oophorectomy should never be performed on trans masculine people, nor that additional barriers should be created. However, current presumptions in favour of hysterectomy appear to be poorly evidenced in the medical literature. Guidance offered to patients needs to reflect emerging research in this area, and acknowledge current uncertainty about medical risk.

The ruling that mandatory sterilisation is a breach of human rights is welcome. However, the UK situation demonstrates that, even in the absence of overt legal requirements, medical, legal and social discourses can together position trans masculine fertility as risky, undesirable and unrecognised. There is a danger that in the absence of robust critique, social stereotypes about gender, sexuality and parenthood may influence care and constrain patient autonomy. Feminist critiques of the regulation of female bodies can be expanded to offer a mechanism for analysing the ways in which trans masculine bodies are also regulated and medicalised. This is

crucial for developing new legal and medical frameworks which facilitate trans people's bodily autonomy and reproductive choices.

Trans reproduction and fertility is an emergent area of social discourse, and one which is embedded in normative beliefs about the interconnection of gender, sex and sexuality. It is only relatively recently that transfeminist thought has provided a challenge to medical pathologisation, and explicitly articulated trans people's agency and rationality. Nonetheless, in the UK and in many other jurisdictions, medical care for trans people remains subject to psychological evaluation and oversight.

Highlighting the gendered assumptions which underpin decision-making about trans masculine bodies, fertility and reproductions expands transfeminist debates about the interconnection between gender inequality and trans experience. It also has implications for psychological and healthcare practice in supporting trans people to make individualised decisions regarding bodily interventions and reproduction.

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