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Theo Erbenius

Jenny Gunnarsson Payne

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Unlearning Cisnormativity in the Clinic: Enacting Transgender Reproductive Rights in Everyday Patient Encounters

By Theo Erbenius¹ and Jenny Gunnarsson Payne²

Abstract

In recent years, transgender reproduction has become increasingly visible in public debates in Sweden. Heated debates and years of activism and advocacy ultimately led to a change in law in 2013. In the new law, the previously controversial demands for patients to be unmarried and sterile had been removed from the legal framework. As a consequence, transgender patients also became entitled to fertility preservation through assisted reproductive technologies (ARTs). This gave rise to a new patient group of fertility patients with specific medical and psychosocial needs.

Drawing on qualitative in-depth interviews with healthcare professionals in a Stockholm clinic for reproductive medicine, we discuss the professionals' strategies for *unlearning* cisnormativity and what Riggs has called 'mundane transphobia' in the clinic. We also analyze the processes of *relearning* that the healthcare professionals (more or less successfully) went through. Our findings demonstrate that there is still room for improvement when it comes to meeting the specific needs of transgender fertility patients, but the clinic staff had taken a number of actions. They had gone through training with an LGBTQ organization, they had changed some of their materials such as medical posters and forms to less binary counterparts, and they had developed a number of mental strategies for being better prepared in patient meetings. One major conclusion of our study is that the reason for the remaining problems was largely associated with the fact that re-learning clinical everyday practices takes both time and continuous efforts, rather than there being any reluctance by staff to learn new habits. A major problem pointed out by the staff was that the legal reform increased the number of patients without increasing the clinic's budget, and that this had required a 'creative reallocation' of funds from other patient groups.

Keywords: transgender rights; transgender reproduction, assisted reproduction; cis-normativity; qualitative interviews.

Introduction

In recent years, transgender reproduction has become increasingly visible in public debates in Sweden and elsewhere. Best-known on an international scale is probably the case of Thomas

¹ Theo Erbenius is an independent scholar with a Master's degree in Ethnology from Södertörn University in Sweden. His current position is at Arkiv Sörmland where he develops methods to collect and preserve young people's digital memories to the future. He has published on issues of gender in *Anthropology & Medicine*.

² Jenny Gunnarsson Payne is associate professor of Ethnology and research leader at the Centre for Baltic and East European Studies (CBEES), Södertörn University, in Sweden. She has published widely on issues of gender, sexuality and reproduction, and is co-editor of *Transnationalising Reproduction: Third-party Conception in a Globalised World* (Routledge 2018, with Róisín Ryan-Flood). She currently leads the research project *Reproducing (In)Justice: Towards a Theory of Relational Reproductive Justice and Surrogacy in Baltic, Central and Eastern Europe*. She has published in journals such as *Signs: Journal of Women in Culture and Society*, the *European Journal of Women's Studies* and *Gender, Place and Culture*.

Beatie, a North-American transman who became famous for his pregnancy. Although the issue of pregnant men is still far from uncontroversial in many contexts, the increased recognition of transgender people as (potential) parents represents a major cultural shift in parts of the western world. In Sweden, this shift was reflected in the law change in 2013 when the old *Law (1972:119) on determination of sex identity in special cases* (Lag (1972:119) om fastställande av könstillhörighet i vissa fall) was revised. Since 1972, when it was instigated as the first law of its kind globally, it had stipulated that any person applying for legal gender affirmation needed to be over 18 years old, a Swedish citizen, unmarried and sterile. According to the preparatory works of this law, sterility was judged necessary to prevent transgender individuals with changed legal gender markers from having children (Proposition 1972:6, 50). By 2013 the demands to be unmarried and sterile were removed from the legal framework. This meant that transgender individuals in need of legal gender affirmation no longer had to be sterilized, but also that they became entitled to fertility preservation through assisted reproductive technologies (ARTs). This gave rise to a whole new patient group – the transgender fertility patient.

Aim and objectives

The revision of Law 1972:119 in 2013 (SFS 2013:405) constituted a radical break with previous norms concerning transgender and reproduction. This article investigates how the aftermath of this radical break translated into everyday clinical practices in a specific unit for reproductive medicine in Stockholm. Drawing on qualitative in-depth interviews with healthcare professionals, we discuss the professionals' strategies for *unlearning* cisnormativity and what Riggs has called 'mundane transphobia' in the clinical setting. We further analyze the processes of *relearning* that the healthcare professionals (more or less successfully) went through.

Previous research: From cultural representations to reproductive care

The international media attention on Thomas Beatie's pregnancy has often been referred to as a watershed moment for transgender reproduction. Particular importance is sometimes assigned to an episode of the Oprah Winfrey talk show, where Beatie was interviewed. Damien Riggs has argued that Winfrey in this episode repeatedly reproduced expressions of *mundane transphobia*: a range of gender-normative rhetorical tropes that articulate Beatie as 'not quite a man', or 'not a real man' (Riggs, 2014).

Henry von Dousa, Jennifer Power and Jennifer Riggs (2015) have also investigated how transmen themselves renegotiate cultural conceptions of pregnancy and fatherhood in online media such as blogs, and how this is done in a way that does not articulate biology and identity as inherently connected. Gunnarsson Payne has demonstrated how the online genre of blogs served an important role in disseminating personal narratives of the consequences of the Swedish sterilization requirement by co-articulating transgender sterilization with discourses of involuntary childlessness and eugenic sterilization, thereby rendering transgender reproduction culturally intelligible (Gunnarsson Payne, 2013). Michael Toze has shown that the 'cultural unthinkability' of pregnant men has influenced healthcare practices in the UK, for instance by unnecessarily encouraging hysterectomies (2018). Our research investigates how increased cultural intelligibility (normalization) of transgender parenthood among a group of medical practitioners affected their attitudes towards this patient group (Gunnarsson Payne and Erbenius, 2018).

In the field of bioethics a growing number of studies argue for transgender patients' access to fertility preservation and ARTs (see e.g. Chen et al., 2017). That this is also desired by patients themselves is confirmed in a review of empirical studies on transgender care including 51 European and North American studies that demonstrate that transgender persons often are or want to become parents. It also shows that discrimination in their contact with authorities is not an uncommon experience for transgender parents (e.g. in adoption, custody) (Stotzer, Herman and Hasenbush, 2014). A US survey-based study showed that many transgender persons are prepared to go through pregnancy, even though there is a need for more trans-friendly healthcare and better information on fertility preservation and ARTs (Light et al. 2014). Another study points to a number of barriers that pregnant men face in the US healthcare system, that could be addressed by for example electronic medical records, better training of staff, especially about the post-partum period (Berger et al., 2015; see also James-Abra et al., 2015). One Swedish study with transmen's experiences of fertility preservation shows that treatments may negatively impact on the patients' gender dysphoria, but that the patients experienced that they had strategies to cope with the added distress (Armund et al., 2017).

Background and context: Transgender care and assisted reproduction in Sweden

Before the law change in 2013, transgender persons had to choose between legal gender affirmation and future biological parenthood. Even though sterilization is no longer legally required, the patients who do opt for having their reproductive organs (ovaries, testicles) removed will still become sterile as a result. Cross-hormonal treatments also affect fertility negatively. Thus, access to ARTs such as cryopreservation of eggs and sperm and IVF-treatments are central to transgender reproductive rights.

In 2003, however, the very meaning of sterility was questioned when the *Legal Advisory Board* at *The National Board of Health and Welfare* refused to approve a request for legal gender affirmation from a sterilized transgender person on the grounds that the applicant had frozen their gametes and hence was not deemed 'sterile enough'. This initiated a process of judgments and appeals that ultimately led to the judgment that the applicant's frozen gametes had to be destroyed before the application could be approved (Judgment 2004; 2005). The *Legal Advisory Board's* decision made biological parenthood impossible for people in need of legal gender affirmation. But in 2013 the law was revised, and transgender persons were now granted the same juridical rights to use ARTs as cisgender persons.

It is important to consider that the legal restrictions for transgender persons to access ARTs were lifted at a time when Swedish legislation had become increasingly inclusive. Unlike in some other countries, IVF and similar technologies are largely normalized and uncontroversial (Gunnarsson Payne and Korolczuk, 2016). Helena Tinnerholm Ljungberg (2015) has charted the gradual change in access to ARTs through four reforms that each constitutes a break with previous understandings of reproduction and parenthood. 1) In 1985 it became possible for cis- heterosexual couples to receive medical assistance with insemination (Lag 1984:1140). 2) In 1989, cis-heterosexual couples gained access to IVF on condition that they used their own gametes (Law 1988:711). 3) In 2003 it became possible for cis-heterosexual couples to use *either* donated sperms *or* donated eggs during IVF treatment (SFS 2002:252), and 4) in 2005 same-sex (lesbian) couples were also granted access to ARTs (Riksdagen, 2005). Since Tinnerholm Ljungberg's study was published, more 'inclusionary reforms' have been passed in parliament. Since the sterilization requirement for legal gender affirmation was removed in 2013 (SFS 2013:405), transgender people

have had the same rights to fertility preservation and the use of ARTs as cisgender persons. In 2016 single women were granted access to ARTs as the first non-couple group (Riksdagen, 2016), and from January 2019, embryo donation will be permitted.

Theoretical framework

The underlying theoretical framework for this article is Glynos and Howarth's (2007) model of practices and regimes. Within this model a regime consists of a hegemonic structure that regulates society through social (naturalized) practices. What is 'taken for granted' differs across time and space, and can range from 'working nine to five' to the use of sterilization as a requirement for gender affirmation. Political practices consist of those actions which challenge the prevailing consensus. With regard to the Swedish healthcare system, the 'arms and legs' of the regime consist of the government as well as regional and municipal politicians. Through the roles of lawmaker (the government) and financiers (government, county councils and municipalities) they set the boundaries for what is legally and economically feasible in the Swedish healthcare system. The social practices that make the system 'tick' consist, for example, of the various care chains that regulate and structure the day to day activities on each ward. What Glynos and Howarth call political practices can consist of politically outspoken transgender rights movements outside the clinics, as well as hospital personnel that protest against consensus treatments. As we will see, care chains are developed through interactive processes between legislators, healthcare providers, patients, political protest movements and economic conditions. Seen through Glynos and Howarth's model of practices and regimes this can be described as an ongoing process of public contestations and absorptions of new ideas that surface through the friction between social and political practices and regimes. For example, the removal of the sterilization requirement in 2013 did not just happen, it was caused by the kaleidoscopic transgender rights movement's political practices (Erbenius, 2015). In this paper, we will examine how the resulting shift in perspective within the regime's framework regarding transgender parenthood has or has not been absorbed and structured into new social practices in the form of new or modified care chains for transgender fertility patients.

Methodological and ethical considerations

Empirically this article draws on a larger body of data, mainly collected by Erbenius over the years 2015 and 2017. In total, the body of data consists of seven qualitative interviews with professionals working with transgender issues, four court cases (two of which are referred to in this article), online materials such as blogs and websites, an observation of an educational half-day on transgender care, plus information materials and medical forms. For the purposes of this article, we focus specifically on interviews with three medical professionals working in transgender care and reproductive medicine at the Karolinska University Hospital in Huddinge, Stockholm (Sweden).

The interviews lasted between 30 and 80 minutes (60 on average). They were recorded, transcribed and coded in the software MAXQDA. Most interviewees are anonymized, but Kenny Rodriguez-Wallberg is quoted using her real name. The reason for not anonymizing her is that she has been active in public debates on transgender issues and/or assisted reproduction in Sweden for many years. Therefore she is extremely easy to trace. Considering that Kenny is interviewed in her professional capacity, we concluded that appearing under her own name would not compromise

her personal integrity. Although the others also respond in their professional roles, they are not as public as Kenny, which is why we applied the precautionary principle and anonymized them. These are: ‘Beatriz’ (midwife at the unit for reproductive medicine) and ‘Agneta’ (associate professor and specialist in gynaecology, unit for reproductive medicine). All interviewees had the opportunity to read and consent to the use of their quotes before publication.

The experiences of the first transgender fertility patients

To get a better sense of the development at the unit for reproductive medicine between 2013 and the present, we refer to a text by Emelie Åsell from 2013, published online. She was then chair of the youth section of the Swedish Federation for Lesbian, Gay, Bi, Transgender and Queer Rights (RFSL Ungdom) and had joined a transgender man on his first visit to the fertility clinic. Åsell made several interesting observations during the tour which provide insights into how the first patients were treated.

On the positive side was the staff's willingness to re-learn, and the visible effort they put into avoiding offensive ways of speaking and behaving. But it was also apparent, according to Åsell, that the staff ‘lacked the necessary language and tools. Papers, questionnaires, referrals and so on were not adapted to transgender people as a group’ (Åsell, 2013, n.p.). For example, the patient referral forms were addressed to cisgender couples: ‘On the first row it said that “You and your partner are welcome on a doctor’s visit”, but “your partner” was crossed out with a ballpoint pen. A few lines down it said that “the woman” who will undergo the treatment should fill out a “declaration of health before the visit”’ (Ibid., 2013). When Åsell and the transgender man first arrived at the reception, they were received with confusion since the staff at work were unaccustomed to welcoming transgender patients. Once inside the doctor’s office Åsell discovered that the health declarations which all patients had to fill in were pink for women and blue for men: ‘They first said they were sorry for not having a suitable form for him [the transman], and then came to the conclusion that he needed to use the pink form since it was the one that dealt with uteruses, eggs, menstrual cycles and other things they need to know’. The doctor then warned them that the words ‘woman’ and ‘eggs’ would be used since the doctor in question did not know how to express what needed to be said in other words. Åsell stated that it is possible to say ‘men with eggs’, a tip the doctor received with gratitude. Finally, the doctor took out a brochure with the heading *Women's Reproductive Body*, and said: ‘Oops, maybe we should tape over or cut out that part’. From Åsell’s account, it is clear that the staff at the unit for reproductive medicine had a sympathetic attitude towards transgender people, but that they lacked the necessary *experience*, *words* and *working material* to treat the new patients in a professional and non-discriminatory way. We now analyze if and how the clinic dealt with these shortcomings.

The initial education and its unforeseen problems

Kenny, the head physician at the reproductive unit, describes how the clinic started to get referrals of transgender patients in 2013. Because they did not have any previous experience with transgender patients they decided to prepare themselves through collaborating with ENID (a unit for transgender care), RFSL Ungdom and with the new patient group themselves. Through these collaborations the staff at the reproductive unit increased their knowledge about transgender people and got the opportunity to reflect on their own use of cisgender normative terminology, approaches and attitudes. The educational goal was, according to Kenny, to make the staff feel

confident in how to interact with and treat the new patients. When asked how the staff had reacted to the news that they would start treating transgender patients, Kenny said that the reactions were mainly positive, but that some members of staff expressed a worry about 'being a bad professional' since they lacked experience in meeting and treating the new patient group.

In our interviews with the staff at the unit for reproductive medicine, it was evident that the preparatory education also had some unforeseen adverse effects. More specifically it seems that RFSL Ungdom's lectures actually increased the staff's fear of making mistakes. Beatriz describes how she thinks the initial encounter with the new patient group would have gone better if RFSL Ungdom had not scared them so much:

When the first patients were to arrive, they were maybe around ten that would visit us over a two-week period. Oh God, we were so scared of saying [the] wrong [things], and we had been trained by RFSL on how to act: 'You are not allowed to say menstruation, [...] you are not allowed to talk about... down there...'. Well you know, all this... So I believe we made all mistakes possible in the beginning.

Put differently, it seems that a heightened awareness regarding what is or is not 'correct' behavior increased the fear of doing 'wrong'. To make matters more confusing for the staff, at times what they thought was 'wrong' turned out to be 'right'. Beatriz illustrated this with an example, in which she asked a transgender patient if they bled. The patient answered: 'Well yes, I menstruate every 28th day'. The patient had no problem talking about menstruation. This did not match Beatriz' preconceived idea regarding what was or was not considered sensitive by transgender males. Beatriz described the patients as very different: some were sensitive to being called by the wrong pronoun, and others not. In the interviews with members of the staff it became clear that the relationship between the team and patients became more relaxed over time. According to Beatriz, this was partly because the patients as a group became less sensitive to mistakes made by the staff. But it was also the result of the staff growing more experienced in treating transgender patients.

A collaboration between doctors and patients

Since the unit for reproductive medicine is a research-driven unit, they sought cooperation with the transgender patient group. The purpose of the joint venture was for the clinic to learn more about the new patient group and in the process improve its caregiving capabilities. The study concluded that although there were many similarities between treating transgender and cisgender patients, there were also several important differences. One valuable lesson for the staff was that some patients had been taking cross-sex hormones for quite some time before arriving at the clinic. For the fertility-preserving treatment to work, the patients had to stop these hormone therapies for an average of three to six months before it was possible to initiate treatments like cryopreservation of oocytes (eggs). A second finding was that it was common among the new patient group to suffer from gender dysphoria, and that the clinic needed to take this into account while treating them. For example, when a transgender man quits taking cross-sex hormones the patients' endogenous hormones become dominant again. This in turn awakens the menstrual cycle, something that many of the transgender male patients perceived as traumatic. The clinic also found out that gynecological examinations could cause a lot of distress among the transgender patients. For

example, collecting eggs is done through the vaginal opening, and before that is possible, it is necessary to examine the ovaries with an ultrasound probe which is inserted through the vagina. Kenny said that some patients took months before they could imagine having this sort of procedure done, and she stressed the importance of waiting until the patient was mentally prepared for this and decided that they wanted to proceed. A third lesson was that patients often handled the negative experiences that came up during the fertility treatment by focusing on the purpose of treatment (to save one's fertility for the future), through support from friends and family, and by thinking of other things than the fertility treatment (Armund et al., 2017, 387-388).

Language problems and mental strategies

One of Åsell's remarks in 2013 was that the staff at the unit for reproductive medicine lacked the necessary language to interact with transgender patients in a non-discriminatory way. During our interviews with the staff in 2017, it became apparent that this was a smaller but still lingering problem. This is problematic since 25% of the transgender persons that had been in contact with the Swedish healthcare system during the previous year felt that they had been discriminated against (SOU 2017:92, 305–307). The language problems that surfaced during the interviews can be divided into two categories. The first concerns the choice of right pronoun. The second focuses on various characteristics that are associated with transgender people. The most obvious example from category one was that Beatriz managed to describe one and the same patient with no less than four different pronouns: "Somebody, she was a bit older, they were a bit older. He had a male partner". Some examples from category two are how staff described the transgender patients as too young; confused; sensitive; irritable; unreachable; vulnerable and/or exaggerated. A concrete example was gynecologist Agneta's remark that 'they tend to exaggerate their femininity'. However, it should be noted that the staff also associated the patient group with positive characteristics such as being tranquil, stable and ordinary. It is also clear that the team was excited about being part of this societal development. With regard to the problematic use of language it has to be said that they were aware of the problem and were actively working to improve their interaction with transgender patients.

The majority of the clinic's patients were cis-people, and the same was true of the staff. This means that the staff had to change their vocabulary as they switched from a cis- to a trans-normative context, and vice versa. To facilitate this switching, over time the staff developed various individual strategies. We call the two most common strategies *resetting* and *mental preparation*. The goal of the first strategy was to let go of all preconceived ideas regarding the patients as a group. This is helpful since it minimizes the risk of being dumbfounded, a reaction that otherwise may happen when there is a mismatch between the staff's image of reality and that reality itself. If the first strategy was about letting go of various preconceptions, the second strategy was about creating a coherence between the staff's preconceptions and the patient's self-image before their actual meeting. At times this was done through *batching* the transgender patients. It is not clear in our data if this way of booking was planned or happened more by chance. What is certain, however, is that it seemed helpful to the staff as it meant fewer changes between different mental modes. Another strategy to 'get prepared' was to *scan* the waiting room to identify if the incoming patient was a cis- or a transgender person. However, this somewhat questionable strategy was not so effective because it was not always possible to identify who is trans- or cisgender from appearances. The act of preparing mentally before seeing the patients could also be hampered by the fact that patient records often do not state how patients experience their gender identity, or if

they want to be called by a different name than their birth name. This, in turn, made it more difficult for the staff to align their preconceptions, language and behaviour with the patients' wants and needs.

The transparency of cisnormative images, forms and transgender patients

Another problem that was apparent when Åsell visited the unit for reproductive medicine in 2013 was their use of cisnormative forms and posters. During our interviews with the staff, we found that the clinic had become more aware of the fact that some of the images and posters could be perceived as provocative from a transgender perspective. One example of this was how Kenny in a lecture at Karolinska University Hospital reflected on an anatomical image that previously had been in use at the clinic. The image³ is a close-up showing the hip region of a person and where, among other things, the ovaries are located: 'I show this picture for a reason. It has been widely criticized by transgender people who have seen it because it shows curves on the body belonging to a female body, and the eggs do not have to be female, the eggs are only gametes that one can use to have children in the future'. In our interview Kenny further stated that: 'On all possible images with fertility treatments, there is always a female body with curves. A fact that we had not responded to since we had not seen it. But they could see it instantly'. A possible explanation for the image's 'invisibility' is the cisnormative assumption that there is an intrinsic interconnection between women, pregnancy, and childbirth. This, then, constitutes a social logic that is so taken for granted that it is more or less invisible. The clinic chose to solve the problem of cis-stereotypical images and posters simply by not using them in their work with transgender people. However, the clinic still uses a similar cisnormative image in a brochure about cryopreservation of oocytes that is downloadable from their website (Karolinska, 2017, 4). The image depicts a vaginal ultrasound examination and the intended recipient of the survey, a person with curves standing in a feminine pose dressed in a skirt. The use of that image makes it questionable if the clinic really has sharpened its gaze enough regarding cisnormative images.

Let us now turn our eyes towards the pink and blue health declaration forms that Åsell described as problematic during her visit in 2013. The pink and blue forms attributed to women and men are still in use, but the clinic has designed a new white form intended for transgender patients. Through analyzing each form as a piece of materialized culture it is possible to construct a shadow image of each form's intended recipient. Our analysis, based on the questions ask on the health declarations, informs us that a man is a person that identifies with a male pronoun, likes blue as a color, risks having inguinal hernias, has testicles and produces sperm, and can give rise to pregnancy. A woman is a person who identifies herself with the female pronoun, likes the color pink, risks having thrombus and gynecological problems, can menstruate, become pregnant and give birth to children. According to their form transgender people do not identify with any pronoun (since none is used), prefer no color (alternatively like white), risk having thrombus and gynecological problems, are at times operated on, can menstruate, become pregnant and give birth to children. This analysis makes apparent that the male and female forms are intended for cisgender persons, and that the form for transgender persons is intended for transgender males but not for transgender females. One possible explanation for the lack of a specific form for transgender females is that they often can extract their sperm through masturbation, while transgender males need hormone therapy and operational interventions from the staff to retrieve their eggs. One may

³ <https://www.hopkinsmedicine.org/healthlibrary/GetImage.aspx?ImageId=161349> (last accessed 30 September 2018).

ask, however, what form is used for those transgender females who, due to gender dysphoria, need help to extract their sperm directly from the testicles? Based on the health declarations we received from the unit reproductive medicine, it seems that the form for cisgender men was their only option. And if so, the problem regarding health declarations for transgender people is only half solved.

An interconnected problem is that transgender patients are not mentioned on the clinic's website⁴. If we, for example, look under the heading 'forms to print,' we find the already discussed health declarations for cisgender men and woman, but no forms for transgender persons. If we consider the following four facts: the health declaration for transgender people does not have an addressed recipient; has no color; there is no separate form for transgender females; and the health declaration in use for transgender people is not accessible through the clinic's website, one might argue that transgender people as a group have almost been made invisible. That the website does not mention transgender people as a patient group but addresses other patient groups' needs, for example interpreting, and that single women have had access to ARTs since 2016 makes the pattern even more explicit.

Inadequate funding and transgender (non)parenthood

The care provided to transgender patients is part of the clinic's larger program for fertility preservation measures. The program was initiated in the mid-1990s, and the underlying care chain was developed with cancer patients in mind. Since 2013 transgender people have also been offered fertility protection measures since they, like cancer patients, risk losing their reproductive capability due to gender-affirming healthcare.

In Sweden, it is common that county councils offer cancer- and transgender patients one round of fertility-preserving treatment free of charge. The limited number of procedures is understandable when it comes to cancer patients since it is often most urgent for them to start treating the cancer itself. According to Agneta the problem with providing just one treatment is that the chances for transgender men to become parents in the future depends in part on how many eggs the clinic is able to retrieve during the one fertility treatment. Agneta explained that since cryopreservation of oocytes is a somewhat new technology, it is not really known how many eggs a person needs to freeze to maximize the likelihood of saving their fertility for the future, but she estimated the number to be around 15-20 eggs. Because it is not uncommon that fertility treatment results in a lower egg count, Agneta considered the fertility treatments given to transgender people at this point in time to be more for appearances' sake.

In our interviews it became clear that the main underlying problem for the clinic was financial, or as Beatriz put it: 'We get new assignments, but we do not get any more money'. Both Kenny and Agneta shared this view: 'We do not have more doctors, but we have received new patients who require resources, so we have been able to do ... well, as good as we have been able to.' The lack of financial resources means that the waiting time for fertility treatment among transgender people has grown very long indeed. And since it is not possible to take cross-sex hormones before and during the procedure, this waiting causes a lot of frustration and suffering. Attempts have been made to speed up the waiting time through reallocating funds intended for other patient groups to transgender fertility patients. As we interpret it, this is a kind of creative emergency solution, but what is needed is for politicians to improve the underlying economic

⁴<https://www.karolinska.se/reproduktionsmedicin> (last accessed 30 September 2018).

reality for the better. If transgender people's ability to reproduce was previously limited by legal constraints, it is still significantly limited through economic non-prioritization.

Concluding remarks

In this article, we have discussed how the juridical revision in 2013 (SFS 2013:405) that gave transgender people the right to biological parenthood and access to ARTs, has been implemented at one fertility clinic. Drawing on qualitative in-depth interviews with healthcare professionals this article has investigated professionals' strategies of unlearning what Riggs has called 'mundane transphobia' in the clinical setting, as well as their ongoing work on improving the clinic's caregiving capabilities. In their effort to improve the quality of care, the clinic worked simultaneously on four different but interconnected fronts:

1. The clinic initiated the process of adjusting existing (cisnormative) care chains to the transgender patients' needs through collaborating with the new patient group. The clinic thus learned, among other things, that they needed to take into account transgender patients' use of cross-sex hormones, and that fertility preservation treatments can trigger gender dysphoria among many of the patients.
2. The professionals' second focus was to 'update' their cisnormative language use. To achieve this, they invited ENID and RFSL Ungdom to conduct a series of lectures for the staff working at the clinic. Although the lectures increased staff's awareness of what was and was not appropriate behaviour, it also increased their fear of making mistakes. That said, the professionals gained in confidence over time. The staff still have some problems with e.g. pronoun use but are aware of the problems and have developed various strategies to facilitate the transition between the cis- and transnormative frameworks that they work within.
3. Through collaborating with the patient group and with RFSL Ungdom, the professionals learnt that they had a problem with stereotypical cis images and lacked specific health declaration forms for the transgender patients. The issue regarding images was 'solved' through avoidance of use (with transgender patients) rather than through replacement. The clinic continues to have a lingering problem with a cisnormative image in their online material. During our visit to the clinic, we found that a form intended for transgender males had been created, but not for transgender females.
4. The fourth, and probably the most significant problem, is that the clinic has not received any extra funding for the transgender patients. Since there has been a constant lack of money to pay for the treatments, the clinic has not been able to receive as many patients as they otherwise would. This has led to increased waiting times for the transgender patients. To handle this situation, the clinic had to reallocate funds from other patient groups. Although a creative emergency move, it is not a sustainable solution. More funding needs to be allocated through political decisions.

In sum, we conclude that much effort has been made in the years between the new law of 2013 and the time of this study to improve the quality of care for transgender fertility patients. Importantly, some issues that remain to be solved are connected to lack of funding rather than staff

efforts. Considering the calls for staff training that have been requested in previous research on transgender healthcare, we would like to add that while such training has indeed been an important part of the work at the unit for reproductive medicine at the Karolinska University Hospital, their experience also shows that this needs to be complemented with adequate funding and new materials (e.g. forms, posters) – but also that the processes of unlearning cisnormativity and relearning new strategies takes both time and continuous efforts to integrate into everyday clinical practice.

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