Review of International Studies (2023), **49:** 4, 657–675
doi:10.1017/S0260210522000560

RIS

RESEARCH ARTICLE

Capacitating militarised masculinity: Genitourinary injuries, sex/sexuality, and US military medicine

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(Received 27 July 2021; revised 14 September 2022; accepted 10 October 2022)

Abstract

This article examines the soldiering body in relation to the increasing prevalence of genitourinary injuries in military personnel. Feminist scholars have demonstrated that the idealised masculine soldiering body are central to the workings of international politics. The article shows that US militarised masculinity operates through the selective distribution of bodily capacities. The article draws upon critical disability studies, particularly Jasbir Puar's work on capacity and debility, to argue that treatments for genitourinary injuries revolve around the production of seminal capacity. Queer and trans bodies are debilitated in these arrangements through the denial of heterosexual and cisgender capabilities to them. To unpack this argument the article analyses treatments for genitourinary injuries. The article shows that genitourinary injuries destabilise the gender identity of US service members. Through an exploration of surgical treatments, including penis transplants and reconstructive surgeries, and fertility treatments, the article shows how masculine capacitation is achieved for some US service members through the debilitation of others; in particular, queer and trans bodies, and the bodies of Iraqi and Afghan civilians.

Keywords: Militarised Masculinity; Gender; Sexuality; Military Medicine; Feminist Security Studies; Critical Disability Studies; Genital Injuries; Debility; Capacity; Biopolitics

Introduction

The soldiering body is a familiar and yet perennial object of interest to International Relations scholars. It is vital not only to the practice of warfighting, but to the mobilisation and legitimisation of violence around the world. Critical scholarship, particularly feminist and queer work on the politics of embodiment, has shown that the soldier is important to understanding how vital organising principles of international politics such as gender, sex, sexuality, race, and militarism are reproduced and circulated.[1] The figure of the soldier is, however, not static throughout time. Gendered discourses of militarism continually evolve and change in regards to the body of the soldier, and the idealised service member's body has at various times ranged from the hyper-violent, hyper-butch 'Rambo' to a supposedly softer, humanitarian warrior.[2] That the ideal

[1]Marsha Henry, 'Problematizing military masculinity, intersectionality and male vulnerability in feminist critical military studies', *Critical Military* Studies, 3:2 (2017), pp. 182–99; Laleh Khalili, 'Gendered practices of counterinsurgency', *Review of International Studies*, 37:4 (2011), pp. 1471–91; Laura Prividera and John Howard, 'Masculinity, whiteness, and the warrior hero: Perpetuating the strategic rhetoric of U.S. nationalism and the marginalization of women', *Women and Language*, 29:2 (2006), pp. 29–37.

[2]Lauren Greenwood, 'Chameleon masculinity: Developing the British "population-centred" soldier', *Critical Military Studies*, 2:1–2 (2016), pp. 84–102; Paul Higate, '"Soft clerks" and "hard civvies": Pluralising military masculinities', in

image of the soldier (and what is expected of such a body) changes over time demonstrates that these forms of military masculinity require continual critical challenge.

Feminist scholarship stands as the body of literature that has contributed the most to critical analyses of militarism, the soldier, and military masculinities.[3] Feminists have offered insight into the processes by which militarised masculinities are produced, the forms they take, and the violences they inflict.[4] Importantly, feminists have also cautioned that in writing about soldiering bodies we run the risk of solidifying 'military masculinity', contributing to its ability to present militarised subjects as stable, fixed identities and bodies.[5] Challenging the ontological stability of military masculinity offers us a way to identify and apply pressure to the cracks in violent ideals of masculinity, and to the wider power structures that produce soldiers' bodies.

This article therefore seeks to contribute to attempts to disrupt the militarised body as a stable object. In this article, I explore articulations of US military masculinity in reference to genitourinary injuries (GUIs). GUIs offer a central paradox for militarised masculinity; for a mode of being that relies heavily on normative sex/gender binaries, the soldiering body without a normative penis presents a destabilising gender challenge. I show that through techno-medical interventions, militarised masculinity can stretch to encompass non-normative male bodily realities, in the form of service members with GUIs. I argue this happens through the exclusion of queer and trans possibilities. To do so, I draw upon a critical disability studies analysis of genitourinary injuries (GUIs) and their treatment within the US military. I show that the US military manages GUIs through healthcare practices and the governance of bodily capacities. This creation and regulation of bodily capacity allows the concept of military masculinity to stretch to encompass bodies that may otherwise challenge it; as this article argues, however, this leeway is not granted to everyone.

I begin by reviewing the existing literature that draws upon the intersection of militarised masculinity, bodily injuries, and critical disability studies. I then offer an outline of the prevalence of GUIs and situate them in relation to the importance of penile genital capacity for militarised masculinity, introducing the concepts of debility/capacity to frame this discussion. The article then turns to explore how GUIs are treated through military medical care. I show that surgical treatments, namely penis transplant surgeries, work to capacitate cisgender male bodies with penile capacity through the debilitation of trans bodily possibilities. Following this, I look at fertility treatments for GUIs. I argue that fertility treatments capacitate heterosexual military masculinity with the ability to have children. I show how this occurs against the debilitation of queer parental capacity. This article then concludes by reflecting on how capacity/debility allow us to explore the production of militarised masculinity through the governance of bodily capacity. Throughout the article, I argue that this selective capacitation of bodies (re)produces hierarchies of sex, gender and sexuality.

Paul Higate (ed.), *Military Masculinities: Identity and the State* (London, UK: Praeger, 2003), pp. 27–42; Henri Myrttinen, 'Disarming masculinities', *Disarmament Forum*, 4:1 (2003), pp. 37–46; Julia Welland, 'Liberal warriors and the violent colonial logics of "partnering and advising"', *International Feminist Journal of Politics*, 17:2 (2015), pp. 289–307.

[3]Rebecca Adelman, 'Sold(i)ering masculinity: Photographing the coalition's male soldiers', *Men and Masculinities*, 11:3 (2007), pp. 259–85; Federica Caso, 'Sexing the disabled veteran: The homoerotic aesthetics of militarism', *Critical Military Studies*, 3:3 (2017), pp. 217–34; Cara Daggett, 'Drone disorientations', *International Feminist Journal of Politics*, 17:3 (2015), pp. 361–79; Cristina Masters, 'Bodies of technology: Cyborg soldiers and militarized masculinities', *International Feminist Journal of Politics*, 7:1 (2005), pp. 112–32; Rachel Woodward, 'Warrior heroes and little green men: Soldiers, military training, and the construction of rural masculinities', *Rural Sociology*, 65:4 (2000), pp. 640–57.

[4]Brianne Gallagher, 'Burdens of proof: Veteran frauds, PTSD pussies, and the spectre of the welfare queen', *Critical Military Studies*, 2:3 (2016), pp. 139–54; Khalili, 'Gendered practices of counterinsurgency'; Joanna Tidy, 'Gender, dissenting subjectivity and the contemporary military peace movement in body of war', *International Feminist Journal of Politics*, 17:3 (2015), pp. 454–72.

[5]Julia Welland, 'Militarised violences, basic training, and the myths of asexuality and discipline', *Review of International Studies*, 39:4 (2013), pp. 881–902. See also Maria Stern and Marysia Zalewski, 'Feminist fatigue(s): Reflections on feminism and familiar fables of militarisation', *Review of International Studies*, 35:3 (2009), pp. 611–30.

Militarised masculinity and injured bodies

Feminist scholars have worked over several decades to highlight the ways in which the construction of 'the soldier' as a militarised ideal of the embodied subject is built, in part, through understandings of gender/sex/sexuality; arguing that the military (and particularly, for the purposes of this article, the US military) is based upon a set of 'traditional processes and images of masculinity'.[6] Within military practices and discourses, scholars have shown how the creation of the solider-subject is achieved through a 'self-consciously cultivated' process of training through which citizen recruits are turned into 'warrior-soldiers', masculine subjects that are able to kill and follow orders that may well contradict civilian ethical norms and behaviours.[7] These training practices and the resulting military culture is, feminists argue, reliant upon the valorisation of 'masculine' values and ideals (strength, hardness, virility, aggression) against the devaluation of the 'feminine' (softness, emotionality, passivity, etc.). The hierarchical coding of masculinity over and against femininity is often very explicit; for example, the practice of insulting recruits through the use of terms such as pussy, ladies, cunt, as well as homophobic and racialised slurs.[8] Feminists have shown how soldiers are thus expected to perform the role of a hypermasculine subject. This particular type of masculinity is often referred to as militarised masculinity. Feminists have argued that militarised masculinity is best understood in the plural, as the military requires the production of 'different heterosexual violent masculinities', from foot soldiers to officers, all of which draw upon hierarchies of race, ethnicity, and class.[9] This hierarchical understanding of gender constructs an image of the 'ideal' soldier, through a privileging of archetypes of masculinity.

Feminists have also pointed out how, much as with gender relations outside of the military, this is a shifting and unstable set of power relations. While telling a story about militarised masculinities, it is important to identify that such ideals of masculinity are unachievable. Not only can few of us embody this ideal constantly, but the lived experience of soldiering can rarely be so neatly categorised into binary divisions of masculine/feminine, heterosexual/homosexual, etc. Julia Welland, for example, argues that the ambiguity involved in defining and enforcing the boundaries of militarised masculinity works to both sustain and challenge the militarised masculine ideal (e.g., an exorcism of the possibility of queerness sits alongside routine practices of group nakedness).[10] Feminists have argued not only that militarised masculinities exist, but also that there is a danger in presuming they are ontologically stable. To do so is to (re)iterate and (re)produce such identities.[11] Feminist scholars have therefore drawn attention to the knife-edge of failure that militarised masculinities continually dance upon. Militarised masculinities are not identities that are achieved once, and remain complete forever. Instead, militarised masculinities are best understood as a set of disciplinary practices that are consistently attempting (and failing) to produce the militarised masculine ideal subject. This article contributes to feminist attempts to highlight the instability of militarised masculinity. To do so, I offer an exploration of how bodies which threaten the militarised masculine ideal as a result of GUIs can come

[6]William Arkin and Lynne Dobrofsky, 'Military socialization and masculinity', *Journal of Social Issues*, 34:1 (1978), pp. 151–68 (p. 153); see also Joshua Goldstein, *Gender and War: Causes, Constructions and Critique* (Cambridge, UK: Cambridge University Press, 2001); Susan Jeffords, *The Remasculinization of America: Gender and the Vietnam War* (Bloomington, IN: Indiana University Press, 1989).

[7]Sandra Whitworth, 'Militarized masculinity and post traumatic stress disorder', in Jane Parpart and Marysia Zalewski (eds), *Rethinking the Wo/man Question in International Politics* (London, UK: Zed Books, 2008), pp. 109–26 (p. 113).

[8]Whitworth, 'Militarized masculinity'; Gallagher, 'Burdens of proof'.

[9]Maria Baaz and Maria Stern, 'Why do soldiers rape? Masculinity, violence and sexuality in the armed forces in the Congo (DRC)', *International Studies Quarterly*, 53:2 (2009), pp. 495–518 (p. 499). See also Paul Higate, 'Drinking vodka from the "butt-crack": Men, masculinities and fratriarchy in the private militarized security company', *International Feminist Journal of Politics*, 14:4 (2012), pp. 450–69; Khalili, 'Gendered practices of counterinsurgency'.

[10]Welland, 'Militarised violences'.

[11]Ibid.; Aaron Belkin, *Bring Me Men: Military Masculinity and the Benign Façade of American Empire, 1898–2001* (New York, NY: Columbia Press, 2012); Stern and Zalewski, 'Feminist fatigue(s)'.

to be (re)incorporated into militarised masculine frames, through the excoriation of queer/trans 'others'.

In addition to thinking about the construction and instability of militarised masculinity, feminist scholars have also offered powerful analyses of the relationship between militarised masculinity and injury. Jennifer Terry's work is particularly instructive in this regard, exploring the ways in which '[w]ar and medicine are in a relationship of mutual provocation', as 'wounding and illness generate biomedical knowledge and vice versa'.[12] She dubs this the biomedicine-nexus, arguing that practices of militarism are (re)iterated through this relationship, resulting in the tacit acceptance of war and militarist practices in US society. Terry's work is vital in drawing together feminist science studies along with critical disability studies to outline how the biomedical practices that accompany warfare are profoundly political. Through an analysis of bionic prosthetics, pharmaceuticals, and regenerative medicine, Terry shows that the wounding and 'repair' of US service members works to sustain practices of militarism. This article thus extends Terry's arguments into the area of genitourinary injuries specifically to pull out in detail how the perpetuation of militarism through medicine (re)produces sexed and gendered dynamics of power.

Genital injuries themselves have been the subject of discussion by a small number of scholars in international politics. Henri Myrttinen and Chris Hendershot both do excellent work in pulling out the ways in which genitourinary injuries can be considered a form of sexual violence in conflict.[13] Myrttinen shows how violence directed against genitalia can be a form of sexual violence, with varied understandings of what this violence is intended to communicate dependent upon context and between various actors.[14] Hendershot's discussion of GUIs, while also rooted in a consideration of sexual violence, turns attention away from the violent act and towards the violent effects; namely arguing that the sexualisation of genital injuries 'naturalise[s] what it means to be a man or boy', problematically obscuring that the construction of 'normal' and 'natural' male bodies 'is also an injurious process'.[15] In this article, I take up Hendershot's line of inquiry as to the relationship between 'normal' and 'unnatural' male bodies that is effected in the treatment of genitourinary injuries, taking this to a specifically US context to map closely which gendered and sexed 'others' emerge in treatment processes. I argue that an exploration of GUI treatments, and how these 'others' are both made manifest and banished, can help us to understand how something as unstable as militarised masculinity continues to (re)produce. Techno-medical interventions constitute one site through which militarised masculinity is able to stretch – to swallow threats to its ontological stability through medical practices that target (certain) body's capacities. This is, of course, not a new ability of masculinity, which has always been selectively malleable. The aim of this article, however, is to lay out in detail one of the processes through which this selective stretchiness is effected.

In using the language of capacity, this article also draws upon critical disability studies. Critical disability studies is a body of literature that uses critical theories in order to interrogate the production of disability, eschewing binary models for thinking about disability and exploring the history of disability within wider sociopolitical and economic paradigms.[16] Critical disability studies has challenged rights based approaches to disability, arguing that while rights based activism has

[12]Jennifer Terry, *Attachments to War: Biomedical Logics and Violence in Twenty-First Century America* (Durham, NC and London, UK: Duke University Press, 2017), p. 6.

[13]Chris Hendershot, 'Battle-induced urotrauma, sexual violence, and American servicemen', in Marysia Zalewksi, Paula Drumond, Elisabeth Prugl, and Maria Stern (eds), *Sexual Violence Against Men in Global Politics* (London, UK: Routledge, 2020), pp. 43–56; Henri Myrttinen, 'Languages of castration – male genital mutilation in conflict and its embedded messages', in Zalewksi, Drumond, Prugl, and Stern (eds), *Sexual Violence Against Men in Global Politics*, pp. 71–88.

[14]Myrttinen, 'Languages of castration'.

[15]Hendershot, 'Battle-induced urotrauma', p. 44.

[16]Dan Goodley, 'Dis/entangling critical disability studies', *Disability & Society*, 28:5 (2013), pp. 631–44; Helen Meekosha and Russell Shuttleworth, 'What's so "critical" about critical disability studies?', *Australian Journal of Human Rights*, 15:1 (2009), pp. 47–75.

yielded benefits for disabled folks, it has also empowered some disabilities at the expense of those which 'do not fit the respectability and empowerment models of disability progress'.[17] Critical disability studies authors have begun already to unpack how the bodies of disabled and injured service members are crucial sites for the (re)production of masculinity and heterosexuality, and the powerful effects this has for solidifying the masculinity of militarism.[18]

To explore questions about how and why service members with GUIs can be (re)integrated into military masculinity, despite the fact their material bodies actively challenge cisgender heterosexual norms, I adopt critical disability studies' emphasis on capacity/debility. Jasbir Puar's work on debility/capacity is particularly instructive for this article.[19] Puar introduces the terms debility and capacity to enrich conversations around disability. If disability can be understood as a mode of being, Puar looks to see how debility and capacity are created and governed within certain populations in order to produce disability.[20] In doing so, Puar offers an understanding of biopolitical forms of governance as 'capacitation' machines.[21] Biopolitical governance operates as 'an ableist mechanism', which seeks to produce capacity as a property of some bodies through the debilitation of others.[22] The governance of capacity/debility are therefore essential to strategies of population control.

In drawing upon Puar's work, I am not attempting to argue that service members with GUIs can (or should) be understood or discussed as disabled subjects. Instead, I seek to understand how US service members with GUIs are capacitated as heterosexual, masculine bodies and subjects. Focusing on capacity rather than the body itself allows us to recognise the ways that GUI treatments produce normatively sexed/gendered masculine bodies through control of their bodily capacities – a (re)creation of these bodies as having certain possibilities, acquiring capacity through 'circuits of … privilege'.[23] Through this capacitation of service members, this article goes on to show how the challenge that the materiality of bodies with GUIs might pose to the sex/gender binary is neutralised through the concurrent debilitation of queer and trans ways of being.

Feeling whole again: The prevalence and impact of GUIs among US service members

Between 2001 and 2013, 1,463 US service members were identified as having a GUI, meaning an injury to the genitalia or urinary tract.[24] The overwhelming majority of these service members were men – perhaps unsurprising given that the legal ban on women serving in combat roles was only lifted in 2013, meaning that in these years women were vastly outnumbered by male service members.[25] Rates of GUIs among US service members has risen during recent years, particularly during the wars in Iraq and Afghanistan; this can be attributed to both improvements in

[17]Jasbir Puar, *The Right To Maim: Debility, Capacity, Disability* (Durham, NC and London, UK: Duke University Press, 2017), p. xvii. Critical disability studies has been critiqued here for failing to account for the mundane and daily experiences of disabled people; see Simo Vehmas and Nick Watson, 'Moral wrongs, disadvantages, and disability: A critique of critical disability studies', *Disability & Society*, 29:4 (2014), pp. 638–50.

[18]Caso, 'Sexing the disabled veteran'; Russell Meeuf, 'John Wayne as "Supercrip": Disabled bodies and the construction of "hard" masculinity in "The Wings of Eagles"', *Cinema Journal*, 48:2 (2018), pp. 88–113; David Serlin, 'Crippling masculinity: Queerness and disability in U.S. military culture, 1900–1945', *GLQ: A Journal of Gay and Lesbian Studies*, 9:1–2 (2003), pp. 149–79; David Serlin, 'Constructing autonomy: Smart homes for disabled veterans and the politics of normative citizenship', *Critical Military Studies*, 1:1 (2015), pp. 38–46.

[19]Puar, *The Right To Maim*.

[20]Ibid., p. xvii.

[21]Ibid., p. xviii.

[22]Ibid.

[23]Puar, *Right to Maim*, p. 20.

[24]Amy Reed, Jud Janak and Jean Orman, 'Genitourinary injuries among female U.S. service members during Operation Iraqi Freedom and Operation Enduring Freedom: Findings from the Trauma Outcomes and Urogenital Health (TOUGH) project', *Military Medicine*, 183:7–8 (2018), pp. 304–09.

[25]Ibid.

military medicine and technology, reducing the mortality rate of 'renal combat wounds' and meaning GUIs are more survivable; and also to the prevalence of improvised explosive devices in this conflict, which account for the majority (75 per cent) of GUIs in male service members.[26] GUIs comprise one of many possible injuries that can result from the use of ground level explosive devices, and in US service members they are often comorbid with other injuries. A survey of the 1,367 male US service members who sustained GUIs between 2001 and 2013 found that 40.2 per cent also suffered traumatic brain injuries, and 28.7 per cent required lower extremity amputations.[27] This comorbidity is not unusual; Terry notes that polytrauma (within war-related medicine, multiple traumatic injuries caused specifically by explosive devices) is the 'signature injury' of the global war on terror.[28] While this article focuses on the specific impacts and biopolitical management of GUIs, it is important to note that they exist within a much wider (and crowded) scene of war-related injury and disability.

The rising rates of GUIs have meant that these injuries have increasingly attracted the attention of the US Department of Defence (DoD) and various branches of the military.[29] As a result, the US Army Medical Research and Development Command have sponsored the ongoing Trauma Outcomes and Urogenital Health project (with the fittingly masculine acronym TOUGH). GUIs are also included as a specific focus under the Armed Forces Institute of Regenerative Medicine's second programme (AFIRM II).

GUIs can impact toileting and sexual function as well as damaging service member's sense of self, and as such are often represented as 'spiritually and emotionally debilitating' injuries.[30] The psychological impacts of these forms of traumatic injuries have not yet been fully explored in the wider literature.[31] However, preliminary research does indicate higher rates of PTSD, depression, and suicidal behaviours in service members with GUIs as opposed to service members without them.[32] Medical staff and service members report that the status of the external genitalia is often the first thing injured service members ask about.[33] One service member with a GUI reports awakening from an impact blast, realising both his legs had been severed above the knee, and that his first words were 'Hey! Check my nuts!'.[34] This suggests that GUIs (and specifically genital injuries) are greatly feared among service members.[35]

The next section of this article explores what happens when the business of war fighting harms service members' genitalia, throwing them into a space of sexed/gendered trouble. Before doing

[26]Steven Hudak, Allen Morey, Thomas Rozanski, and C. William Fox Jr, 'Battlefield urogenital injuries: Changing patterns during the past century', *Urology*, 65:6 (2005), pp. 1041–6 (p. 1041); Reed et al., 'Genitourinary injuries among female U.S. service members', p. 306.

[27]Judson Janak, Jean Orman, Douglas Soderdahl, and Steven Hudak, 'Epidemiology of genitourinary injuries among male U.S. service members deployed to Iraq and Afghanistan: Early findings from the Trauma Outcomes and Urogenital Health (TOUGH) project', *Journal of Urology*, 197:2 (2017), pp. 414–19 (p. 414).

[28]Terry, *Attachments to War*, p. 57.

[29]Reed et al., 'Genitourinary injuries among female U.S. service members'; Hudak et al., 'Battlefield urogenital injuries'; Molly Williams and James Jezior, 'Management of combat-related urological trauma in the modern era', *Nature Reviews Urology*, 10:9 (2013), pp. 504–12.

[30]Recovering Warrior Task Force US Department of Defense, 'Task Force on the Care, Management and Transition of Recovering Wounded, Ill and Injured Members of the Armed Forces: Business Meeting, Tuesday April 2, 2013', p. 221, available at: {https://rwtf.defense.gov/Portals/22/Documents/Meetings/m14/m14040213transcript.pdf} accessed 9 October 2018.

[31]Sherrie Wilcox, Ashley Schuyler, and Anthony Hassan, 'Genitourinary Trauma in the Military: Impact, Prevention, and Recommendations', available at: {https://cir.usc.edu/wp-content/uploads/2015/03/CIR_Policy-Brief_GU-Trauma_March2015.pdf} accessed 8 June 2021; Williams and Jezior, 'Management'.

[32]Wilcox, Schuyler, and Hassan, 'Genitourinary Trauma'.

[33]Ibid.

[34]David Wood, 'Beyond the battlefield: Afghanistan's wounded struggle with genital injuries', *Huffington Post*, para. 21, available at: {https://www.huffingtonpost.co.uk/entry/beyond-the-battlefield-afghanistan-genital-injuries_n_1335356?ri18n=-true} accessed 6 October 2020.

[35]Denise Grady, '"Whole Again": A Vet Maimed by an I.E.D. Receives a Transplanted Penis', available at: {https://www.nytimes.com/2018/04/23/health/soldier-penis-transplant-ied.html} accessed 9 May 2018; Williams and Jezior, 'Management'.

so a brief note on methodology is needed. As the TOUGH project notes, GUIs were 'rare' as injuries prior to the US invasion of Afghanistan.[36] This does not mean that US service members had never before experienced injuries to this area of their bodies; rather, that these injuries were previously unlikely to be survivable. As such, many of the novel treatments developed specifically for GUIs are still in their infancy. This is particularly true of penile transplants, which I discuss at length below. In order to understand these treatments, in this article I look at both specific treatment cases as well as conducting a critical analysis of discourses from medical professionals, media outlets, and US military institutions around these injuries.

The fact that there are often a small handful of cases and sources to be discussed raises questions about whether we can safely generalise and infer wider attitudes from these cases. I would argue that such an analysis is valuable for two reasons. Firstly, these injuries form part of a broader historical pattern of the capacitation of US military bodies. GUIs map onto a wider history of select injured service members gaining capacity through techno-medical intervention, often at the expense of the debilitation of others.[37] Secondly – and this relates specifically to the section of this article that discusses transplantation medicine – there is great debate within the medical field as to whether transplantations should be carried out if the transplant would not be life-saving. This is due to the complications of receiving a transplant, namely the need for lifelong immuno-suppressants. The discourse around penis transplant surgeries is therefore able to teach us much about what types of injuries we think are worth treating, and *why* they are deserving of treatment. In this article, I show that this justification is expressed through cis-normatives logics of gender, sex, and sexuality.

Troubling injuries and sex/gender capacity

In a social world where the penis and testes are the materialisation of masculinity upon the body, with the penis functioning as 'a symbol of masculinity *par excellence*', GUIs can lead to a fracture within both body and sense of self.[38] The cultural link between gender, sex, and genitalia is so strong that these terms are often treated as synonyms. This is true of both popular culture and scientific literatures, which portray particular genitals as 'male' and 'female', something which trans, intersex, and (some) feminist scholars have worked to challenge.[39] Even the language we have developed to discuss these experiences and wounds points towards the symbolic merging of masculinity with the penis. The physical process of losing the penis and testes are referred to as 'emasculation', a word that joins the Latin for 'change of state' with 'male'. The genitalia is so central to constructions of gender and sex that sustaining damage to the penis or scrotum can also rupture a masculine identity, disqualifying the body from being able to achieve the 'normal' masculine shape.

Importantly, this 'loss' of masculinity refers not only to the loss of the physical tissue, but to the bodily capacities that are lost with it. The damage to the physical matter of the body is important, as it damages the bodily capacity to engage in the iterative acts/relationships that produce gender and sex identities. GUIs threaten men's ability to perform a range of 'masculine'

[36]Trauma Outcomes and Urogenital Health Project, 'Frequently Asked Questions', para. 3, available at: {https://toughprogram.uthscsa.edu/} accessed 14 September 2022.

[37]See Alice Cree and Nick Caddick, 'Unconquerable heroes: Invictus, redemption, and the cultural politics of narrative', 13:3 (2020), pp. 258–78; Puar, *Right to Maim;* Emma Pullen and Michael Silk, 'Disability, masculinity, militarism: The paralympics and the cultural (re-)production of the para-athlete-soldier', *Journal of War & Culture Studies*, 13:4 (2020), pp. 444–61; Serlin, 'Constructing autonomy'; Terry, *Attachments to War*.

[38]Caso, 'Sexing the disabled veteran', p. 223.

[39]Gerald Callahan, *Between XX and XY: Intersexuality and the Myth of Two Sexes* (Chicago, IL: Chicago Review Press, 2009); Myra Hird, 'Gender's nature: Intersexuality, transsexualism and the "sex"/ "gender" binary', *Feminist Theory*, 1:3 (2000), pp. 347–64; Kristen Schilt and Laurel Westbook, 'Doing gender, doing heteronormativity: "Gender normals", transgender people, and the social maintenance of heterosexuality', *Gender & Society*, 23:4 (2009), pp. 440–64; Julia Serano, *Whipping Girl: A Transsexual Woman on Sexism and the Scapegoating of Femininity* (Emeryville, CA: Seal Press, 2007).

bodily activities. These activities centre on the capacity of the penis: urinating standing up, maintaining erections, ejaculation, having penetrative sex, and fathering children. All these masculine bodily capacities are potentially disrupted by GUIs. This can leave service members with feelings of both physical and social emasculation, where they are no longer able to fulfil the corporeal roles and bodily expectations that are associated with masculinity and maleness.[40]

This surfaces in repeated narratives that these injuries stop men from feeling like men, common across literatures and media reporting on genital injury.[41] One service member reported that his GUI had left him struggling to view himself 'as a man'.[42] The crises these injuries commonly portend for men are also frequently acknowledged by members of their medical teams who emphasise how these injuries wound gendered embodiments, damaging the physical (genital) seat of 'your sense of self and identity as a male'.[43] This damage to the body and to the sense of self has led to service members with GUIs being produced as fractured following their injury. As a doctor reported, '[t]hey say, "I want to feel whole again" … [i]t's very hard to imagine what it means if you don't feel whole.'[44] It is genitalia in particular that damages a sense of wholeness, more so than other body parts. As the recipient of a 2018 penis transplant noted – who also underwent a double leg amputation as a result of his injuries – it was the acquisition of a penis that restored a sense of 'wholeness' to his body.[45]

As a result of this loss of genital capacity, the masculinity and gender/sex of these bodies is therefore less certain. It is not so simple as claiming that these bodies are feminised – rather, they are 'reconfigured as "rootless, dismembered"' by their GUIs, thrust into sex/gender ambiguity.[46] They 'upset' binary logics of sex.[47] As a result of these injuries, service members '[g]endered anatomies' therefore become 'hard to decipher'.[48] GUIs challenge their gendered and sexed claim to being a recognisably 'human' subject, a recognisably 'human' life. As feminist, queer, and trans scholarship has argued, conforming to dominant norms of personhood requires us to conform to binary understandings of sex/gender that privilege cisgender subjects/bodies.[49] This is amplified within the context of militarism, as decades of feminist work has shown us the ways in which militaries and the process of military training relies heavily on hyper-masculinised ideals, fetishising bodily strength, hardness, and heterosexual virility.[50] In such a context, GUIs threaten to

[40]Myrttinen, 'Languages', p. 82.

[41]Denise Grady, 'Penis Transplants Being Planned to Help Wounded Troops', available at: {https://www.nytimes.com/2015/12/07/health/penis-transplants-being-planned-to-heal-troops-hidden-wounds.html?_r=0} accessed 5 September 2018; Grady, '"Whole Again"'; Massachusetts General Hospital, 'MGH Genito-Urinary Vascularized Composite Allograft (Penile) Transplant FAQs', available at: {https://www.massgeneral.org/News/assets/pdf/penile-transplant-faq-051616.pdf} accessed 5 September 2018; BBC News, 'Man receives penis transplant in US', available at: {https://www.bbc.co.uk/news/world-us-canada-36304320} accessed 5 September 2018; Williams and Jezior, 'Management'; Wilcox, Schuyler, and Hassan, 'Genitourinary Trauma'; Myrttinen, 'Languages of castration'; Hendershot, 'Battle-induced urotrauma'.

[42]Grady, '"Whole Again"', para. 6.

[43]Grady, 'Penis Transplants Being Planned', para. 17.

[44]Ibid., para. 36.

[45]Susan Rinkunas, 'This Is How A Wounded Veteran Got a Penis Transplant', available at: {https://www.vice.com/en_us/article/mbxnwp/penis-transplant-veteran} accessed 24 January 2020.

[46]Cynthia Weber, *Faking It: U.S. Hegemony in a 'Post-Phallic' Era* (Minneapolis, MN: University of Minnesota Press, 1999), p. 131.

[47]Laura Shepherd and Laura Sjoberg, 'Trans-bodies in/of war(s): Cisprivilege and contemporary security strategy', *Feminist Review*, 101:1 (2012), pp. 5–23.

[48]Sheila Cavanaugh, 'Touching gender: Abjection and the hygenic imagination', in Susan Stryker and Aren Aizura (eds), *The Transgender Studies Reader 2* (New York, NY: Routledge, 2013), pp. 426–42 (p. 433).

[49]Judith Butler, *Bodies That Matter: On the Discursive Limits of Sex* (Oxon, UK: Routledge Classics, 2011); Dean Spade, 'Resisting medicine/remodeling gender', *Berkeley Women's Law Journal*, 18 (2003), pp. 15–37; Stephanie Turner, 'Intersex identities: Locating new intersections of sex and gender', *Gender and Society*, 13:4 (1999), pp. 457–79.

[50]Adelman, 'Sold(i)ering masculinity'; Arkin and Dobrofsky, 'Military socialization'; Synne Dyvik and Lauren Greenwood, 'Embodying militarism: Exploring the spaces and bodies in-between', *Critical Military Studies*, 2:1–2 (2016), pp. 1–6; Christine Williams, 'Militarized masculinity', *Qualitative Sociology*, 17:4 (1994), pp. 415–22; Julia Welland, 'Militarised violences, basic training, and the myths of asexuality and discipline', *Review of International Studies*, 39:4 (2013), pp. 881–902.

disqualify soldiers permanently from being able to occupy corporeal fantasies of the hetero-masculine soldier.

While we might be able to see how service members with GUIs fit with common understandings of disability, the language of disability is often absent from representations of them. This may well be an attempt to keep service members away from the stigma and prejudice attached to disability and being disabled that permeates US society. Instead of the language of disability, discussions of service members focus not on whether the subject is disabled, but instead on what the subject's body can and cannot do. For example, rather than describing service members as having a physical disability, medical, media, and military actors refer instead to their 'reproductive capability', 'reproductive function', 'sexual function', 'ability to have sex, father children [and] urinate normally'.[51] These representations of service members with GUIs frame the conversation not solely around the materiality of the body but focuses instead on questions of capacity, particularly cisgender heterosexual masculine capacities. The ways these bodies are often discussed attempts to focus attention away from what the body has/is (does it have a penis? Is it a male body if not?) and instead onto questions of what the body can do (does it have the capacity to do 'male' things?).

The importance of penile capacity is well understood by the US military, who have invested financially into producing the capacity for erection and ejaculation among its soldiers. In 2015, the Defense Health Agency spent around $84 million on erectile dysfunction medicines, $41 million of which was on Viagra alone.[52] While this makes up less than 1 per cent of the Defense Health Agency's spend for that fiscal year, it's worth noting that it dwarfs the estimated costs of $2.3–8.4 million associated with providing healthcare to trans service members, costs that a former president described as 'tremendous' and cited as a reason to ban trans service members from the military.[53] Drugs classed as 'genitourinary agents' rank 13th in terms of TRICARE's (the programme that provides healthcare for active service members) top drugs by days of supply, and 7th for the Veterans Health Agency (which provides healthcare for veterans); Viagra is TRICARE's 15th most supplied single source active ingredient, and the VHA's 9th.[54] Investment in the seminal capacity of soldiers is also not uncommon outside of the US. Jasbir Puar's work on the Israeli military points to the ways in which the seminal 'capacitation' of soldiers through reproductive services supports broader assemblages of militarism.[55]

Treatment options are often not about restoring damaged genitalia to their previous condition – indeed, this is often impossible – but instead with enabling the bodies of service members to perform as if they *had* normatively functioning genital and reproductive tissues. This is vital for understanding what military-medical assemblages attempt to achieve through treatments for GUIs. It is the capacity and potential of service members' bodies to perform certain roles that is the object of governance in GUI treatments. The article shows that military-medical assemblages are concerned with producing certain penile capacities – the ability to ejaculate and biologically reproduce – in service members, regardless of whether this capacity is achieved through the material body alone, or in conjunction with medical technologies. GUIs show us that the

[51]Recovering Warrior Task Force, 'Task Force', p. 229; TOUGH Project, 'Frequently asked Questions', para. 7; Grady, 'Penis Transplants Being Planned', para 11; Grady, '"Whole Again"', para. 3.

[52]Patricia Kime, 'DoD Spends $84M a Year on Viagra, Similar Meds', available at: {https://www.militarytimes.com/pay-benefits/military-benefits/health-care/2015/02/13/dod-spends-84m-a-year-on-viagra-similar-meds/} accessed 13 November 2018.

[53]Agnes Gereben Schaefer, Radha Iyengar, Srikanth Kadiyala, Jennifer Kavanagh, Charles C. Engel, Kayla M. Williams, and Amii M. Kress, *Assessing the Implications of Allowing Transgender Personnel to Serve Openly* (California: RAND Corporation, 2016); Christopher Ingraham, 'The military spends five times as much on Viagra as it would on transgender troops' medical care', *Washington Post*, available at: {https://www.washingtonpost.com/news/wonk/wp/2017/07/26/the-military-spends-five-times-as-much-on-viagra-as-it-would-on-transgender-troops-medical-care/} accessed 10 June 2021.

[54]Andrew Mulcahy, Brian Phillips, and Christopher Whaley, *Balancing Access and Cost Control in the TRICARE Prescription Drug Benefit* (Santa Monica, CA: RAND Corporation, 2021), pp. 14–15.

[55]Puar, *Right to Maim*, p. 117.

importance of *how* these penile capacities are achieved matters less to the military than *whom* these capacities are assigned to.

In the next section, I look at how current treatments for service members with GUIs attempt to produce these bodies as having seminal capacity, in order to (re)produce service members as cisgender, heterosexual masculine bodies. I look first at developing technologies of penis transplantation, arguing that seminal capacity is achieved here at the debilitation of trans possibilities. I then explore fertility treatments for GUIs, showing how the production of seminal capacity through fertility support is reliant upon the debilitation of queer family arrangements.

Cis bodies, trans bodies, and 'natural' masculine capacity

Surgical treatment options may involve reconstructive surgery or transplantation surgery. Both offer different possibilities and outcomes. Reconstructive surgeries are heavily dependent on the extent of the injuries. Surgeons may attempt to reconstruct the shape of the penis, and can also insert prosthetic devices into the penis to allow erections to be achieved and sustained if this capacity has been lost.[56] Penis transplants are a much more novel form of surgical treatment for GUIs. To date, there have been five penis transplants recorded worldwide, with two taking place in the United States. In 2018, surgeons from The Johns Hopkins Hospital performed the first penis transplant in the US for a wounded service member. This surgery was also noticeable for being one of the most extensive transplant surgeries to date, attaching not only a donated penis but for the first time including the scrotum and lower abdominal wall as part of the transplant.[57]

While to date there has been only one service member with a GUI that has benefited from transplant surgeries, the figure of the wounded soldier has been instrumental in penis transplant technologies and practices. At Massachusetts General Hospital, where penis transplant surgeries are also being developed, the transplantation programme came about as a result of a partnership between military urological surgeons with experience treating the 'devastating genitourinary injuries of wounded warriors' and cancer teams.[58] The transplant programme at Massachusetts also cites one of the main aims of the programme as helping US soldiers who had sustained GUIs in Iraq and Afghanistan.[59] Despite this interest in service members with GUIs, to date these surgeries are in their infancy and are not currently covered under existing military insurance schemes. The DoD has, however, financially invested in the research for penile transplantations, and the surgeons involved in the 2018 procedure were hopeful of the possibility of grants from the Pentagon to fund future operations, perhaps not unreasonably given GUIs new priority in AFIRM II.[60]

Assessing such surgeries through the lens of capacity/debility allows us to recognise two important points. Firstly, that these surgeries aim to (re)affirm the masculinity of service members through the use of transplants to create seminal capacity within the body. These surgeries aim 'to restore a person's sense of identity and manhood' according to the chair of plastic and reconstructive surgery at Johns Hopkins.[61] This restoration of masculinity is achieved through the acquisition of a normative penis, one that looks 'right' and has certain masculine capacities

[56]Williams and Jezior, 'Management'.

[57]Johns Hopkins Medicine, 'Johns Hopkins Performs First Total Penis and Scrotum Transplant in the World', available at: {https://www.hopkinsmedicine.org/news/media/releases/johns_hopkins_performs_first_total_penis_and_scrotum_transplant_in_the_world} accessed 5 August 2018.

[58]Massachusetts General Hospital, 'First Genitourinary Vascularized Composite Allograft (Penile) Transplant in the Nation Performed at Massachusetts General Hospital', para. 16, available at: {https://www.massgeneral.org/News/pressrelease.aspx?id=1937} accessed 5 August 2018.

[59]BBC News, 'Man Receives Penis Transplant in US', para. 15, available at: {https://www.bbc.co.uk/news/world-us-canada-36304320} accessed 5 August 2018.

[60]Grady, '"Whole Again"', paras 17–18.

[61]Ibid., para. 9.

(or is presumed that it will acquire such capacities). These capacities are not only urinary but sexual and seminal, with the stated aim of restoring 'spontaneous erection and orgasm' to service members.[62] This treatment attempts to produce seminal capacity in service members through the curation of the ability to ejaculate, and for semen to exit the body 'normally'. The penis here functions as an essential precondition for the possibility of semen, and whether semen is actually produced/expressed or not is secondary to the ability to mimic ejaculation. As the testes may have been damaged in the original GUI and penis transplants do not include the transplantation of the testes, the ability to physically produce and express semen may not be affected by these surgeries.

Rather, it is the *capacity* to ejaculate, the *potential* of performing this act – regardless of whether semen is present or not – that transplant surgeries attempt to restore. The positioning of penis transplants in particular as an exciting and innovate surgery for soldiers with GUIs produces non-normative phalluses as problems that require fixing. Through penis transplantations, this fix comes in the form of the surgical restoration of an ejaculating penis (or one that can mime this ability). This works to naturalise and solidify a particular genital configuration as 'proper' for masculinity. As the recipient of the 2018 transplant put it, penile transplants give soldiers an opportunity to have 'the real thing'.[63]

Secondly, capacity/debility allows us to recognise that the creation of seminal capacity for cismen service members also entails a debilitation of other bodies whose penises have been created through surgical intervention, and specifically through the denial of similar capacities to trans people. That the genitals involved in penis transplantation are positioned as the 'real thing' establishes a hierarchy of genitalia, in which some bodies – and some masculinities – are perceived as more 'real' than others. Trans bodies in particular exist at the periphery of discourses around penile reconstruction and transplantation, often invoked only to establish the dominance of cis male bodies. When questioned about whether these surgeries may be developed in order to benefit trans people, a bioethicist at Johns Hopkins edged around how this would be managed in transplantation surgeries: '[w]hat do you say to the [next of kin of the] donor? A 23-year-old wounded in the line of duty has a very different sound than somebody who is seeking gender reassignment.'[64] The inference here is that there is a hierarchy of deservingness, when it comes to penises; the romanticism of the patriotic, wounded soldier is more deserving of a penis than a trans person. Of course, this opinion is not unanimous among the medical profession. In 2020, for example, surgeons at Massachusetts General Hospital expressed interest in obtaining approval to carry out the world's first penis transplant for a trans man.[65] However, transgender patients remain explicitly excluded from the so-called 'Baltimore Criteria' of ethical guidelines for penile transplantation.[66] Developed by medical professionals from Johns Hopkins University and the University of Maryland, the ethical criteria restricts candidates for penile transplants to cisgender men, noting that not only is more researched needed into the feasibility of transplants for trans patients, but that substantial prejudice against trans people in the US could 'pose problems in seeking donations in this setting'.[67]

Similarly, some service members have been recorded as rejecting any comparison between their bodies and those of trans people. As one article records, the referral of service members with GUIs at the Walter Reed National Military Medical Center to doctors who specialise in

[62]Ibid., para. 10.
[63]Ibid., para. 31.
[64]Grady, 'Penis Transplants Being Planned', para. 25.
[65]Randy Dotinga, 'Hospital Debates Penis Transplant in Transgender Patient', MedPage Today, available at: {https://www.medpagetoday.com/surgery/transplantation/89033} accessed 7 April 2022.
[66]Ledibabari M. Ngaage, Adekunle Elegbede, Jeremy Sugarman, Arthur J. Nam, Carisa M. Cooney, Damon S. Cooney, Yvonne M. Rasko, Gerald Brandacher, and Richard J. Redett, 'The Baltimore Criteria for an ethical approach to penile transplantation: A clinical guideline', *Transplant International*, 33:5 (2019), pp. 471–82.
[67]Ibid., p. 480.

genital surgeries for trans people is 'an option not well received in the ranks'.[68] As a staff sergeant with a GUI is reported to have 'growled', 'I ain't going to no sex-change doctor.'[69] The use of 'growled' underscores the anger (as well as gruff and aggressive masculinity) generated by the suggestion that cis bodies would ever tarnish themselves by making use of resources designed for trans people.[70]

The creation of a hierarchy of penises here, where some surgical penises are 'realer' than others, demonstrates how the concept of phallic masculinity is able to adapt to encompass cis, heterosexual male subjects through the exclusion of others. That cis male bodies should have ejaculative penises is the natural order of things, requiring no justification, whereas trans bodies and surgeries are positioned as something insulting to compare service members with GUIs to. Cisgender male bodies are therefore produced as natural masculine subjects. Their masculinity is something that can be 'restored' to them, something that pre-existed their injury and naturally belongs to these particular bodies. As a result, the boundaries of the male subject allow service members with transplanted penises into the exclusive and privileged club of cis male masculinity.

This cements a particular distribution of capacitation/debilitation in these settings. The possibility of male bodies existing without penises and seminal capacity are refuted; the realness of penises that are not grown organically is denied. In this way, trans embodiment is excluded from the privileged position of 'real' male bodies, debilitated through attempts to deny their right to possess seminal capacity. The focus on establishing seminal capacity for service members with GUIs works to deny the possibility that men can and do live happy, fulfilling and sexual lives without penises, or with penises that look and function very differently to dominant sexual ideals. Through the focus on penis transplants and surgical treatments, trans bodies and bodily possibilities are rendered invisible, either explicitly devalued or implicitly excluded from being 'real', liveable bodies. This constitutes a form of debilitation for trans bodies and lives.

It is vital that we connect these forms of capacitation and debilitation with wider discourses of transphobia in international politics. Within a North American context, trans folk are subject to enormous and daily amounts of violence as a result of their transness, their perceived 'failure' to perform binary understandings of sex/gender/genitalia. Trans people face both acute and cumulative forms of violence, in terms of interpersonal as well as wider structural violences.[71] Trans studies scholars have demonstrated the ways in which Western healthcare often pathologises trans bodies.[72] Setting these militarised modes of debilitation into a wider, national scene of denial and debilitation of trans bodies reveals to us how not only trans bodies but also therefore trans lives and subjects are produced as less valuable than cisgender subjects and lives. Transplant surgeries reveal that this hierarchy of recognisable, liveable lives is established not only through medical technologies that directly engage with trans folk, but through medical technologies that explicitly do *not* engage with trans folk.

[68]Wood, 'Beyond the battlefield'.

[69]Ibid., para. 29.

[70]Such statements also work to deny that trans people, their bodies and experiences as well as their healthcare requirements, are a useful source of knowledge and learning for cis bodies. The idea that trans people have much to teach us about medicine and care are here refuted, in order to prioritise cis bodies as the 'proper' source not only of penile tissue but as subjects of medical research.

[71]See, for example, Alexis Dinno, 'Homicide rates of transgender individuals in the United States: 2010–2014', *American Journal of Public Health*, 107:9 (2017), pp. 1441–7; Sandy James, Jody Herman, Susan Rankin, Mara Keisling, Lisa Mottet, and Ma'ayan Anafi, *The Report of the 2015 U.S. Transgender Survey* (Washington, DC: National Center for Transgender Equality, 2017); Jessica Xavier, Marilyn Bobbin, Ben Singer, and Earline Buff, 'A needs assessment of transgendered people of color living in Washington, DC', *International Journal of Transgenderism*, 8:2–3 (2005), pp. 31–47.

[72]Emma Inch, 'Changing minds: The psycho-pathologization of trans people', *International Journal of Mental Health*, 45:3 (2016), pp. 193–204; Esther Arjonilla, 'Reframing care practices on transgender health: The international campaign Stop Trans Pathologization', available at: {https://www.academia. edu/5631627/Reframing_Care_Practices_on_Transgender_Health_The_International_Campaign_Stop_Trans_Pathologization} accessed 18 June 2021.

The exclusion of trans bodies from hierarchies of deservingness when it comes to seminal capacity reflects an active choice rather than a passive omission. When service members reject help from surgeons experienced in trans healthcare, when doctors privilege cis service members above trans people, they are not passively omitting trans people from the category of meaningful, recognisable, liveable human lives. Rather they are committing a 'form of discursive violence' against trans people, an act familiar within a military setting that has long sought to actively exclude trans folk, and a wider society that does the same.[73] This violent relationship is effected through the governance of seminal capacity. In actively working to distribute semen among certain bodies, medical technologies are complicit in the eradication of trans possibilities, which are focused to occupy a subordinate position of artificial and unreal modes of living. In attempting to eradicate the spectre of the trans body within penis transplant surgeries, medical technologies that attempt to 'fix' the bodies of service members with GUIs are complicit in wider societal assemblages of transphobic dehumanisation. These assemblages do not afford trans lives the same value, the same easy congruence with 'the human', as cisgender bodies.

The logics at work in penile transplant surgeries thus must be understood as complicit in wider structures of power through which trans bodies are produced as perverse others, as not-normal bodies. These assemblages of penile transplant surgery are nested within wider relations of power that devalue trans bodies and trans lives. These power relations are (re)produced through phallocentric curations of service members' semen.

No kids for queers

Having explored the relationship between surgical treatments and seminal capacity, I now turn to explore how medical treatments, specifically fertility treatments, engage with these dynamics. For soldiers with GUIs there is also the attendant risk of fertility problems. Fertility and virility have long been important to militarised masculinities, given the hyper-focus on the idealised masculine warrior figure as an 'archetypal of heterosexual and rugged masculinity'.[74] In Western societies, masculinity has long been associated with the ability to conceive children, with masculine ideals prescribing that a 'real man can get the sex he wants and impregnate a woman when he so desires'.[75] It is therefore unsurprising that ideas about the potency of sperm are important to militarised masculinity, as sperm is often constructed as the distillation of the masculine self into biological form.[76] Through the capacity to father children, fertile semen allows men to perform the important masculine ability to 'create', to 'extend power' and their own corporeality through the bodies of others.[77] Concerns and anxieties about the effect of war fighting on fertility and fatherhood have been common among Western militaries for years, surfacing most recently prior to GUIs in service members' narratives of Gulf War Syndrome and fears that their military work damaged the fertility of their semen.[78] The crossover between militarism and fertility is even captured in common colloquialisms for male infertility, such as referring to infertility as a man 'shooting blanks'.[79] Here, a fertile man is constructed as a warrior shooting semen (understood as live ammunition), while the infertile man is emasculated through his failure to possess (weaponised) fertile semen.

[73]Shepherd and Sjoberg, 'Trans bodies in/of war', p. 9.

[74]Susie Kilshaw, 'Toxic emissions: The role of semen in GWS narratives', *Anthropology & Medicine*, 14:3 (2007), pp. 251–8 (p. 255).

[75]Liberty Barnes, *Conceiving Masculinity: Male Infertility, Medicine and Identity* (Philadelphia, PA: Temple University Press, 2014), p. 4.

[76]Kilshaw, 'Toxic emissions', p. 256.

[77]Stephen Linstead, 'Dangerous fluids and the organization-without-organs', in John Hassard, Ruth Holliday, and Hugh Willmott (eds), *Body and Organization* (London, UK: SAGE, 2000), pp. 31–51 (p. 33); see also Elizabeth Grosz, *Volatile Bodies: Towards a Corporeal Feminism* (Bloomington, IN: Indiana University Press, 1994), p. 199.

[78]Kilshaw, 'Toxic emissions'.

[79]Barnes, *Conceiving Masculinity*, p. 4.

Whether a GUI impairs the ability to have penetrative sex and ejaculate, or the testes themselves are damaged, there are multiple ways in which a GUI may make biological reproduction difficult, if not impossible for service members. The military does offer some assisted reproductive services for service members who were injured on active duty. These include sperm and egg retrieval, IVF, artificial insemination, blastocyst implantation, and cryopreservation of embryos.[80] For veterans, the VA covers hormonal therapies, 'surgical correction', artificial insemination, and IVF for veterans with service-related injuries and their spouses.[81]

While there is a lack of data as to how service members with GUIs access these services (and indeed, whether they are able to in practice), it is important to note that these fertility treatments are all organised around heterosexual childbearing practices, and the nuclear family. Infertility health cover for those who sustained injuries while on active duty under TRICARE (the DoD's healthcare system) and the VA is only accessible if the partner has a 'lawful spouse'.[82] That the provision of fertility cover only extends to married couples demonstrates that for the military, the nuclear family is the only type of familial arrangement that is worth financially investing in. While of course in the United States same-sex couples can marry, it is impossible not to note the heterosexist presumptions that underlie a decision to set marriage as the access bar for fertility services.[83] LGB marriage rights were only secured across all fifty states in 2015 by the Supreme Court, meaning that prior to this decision access to fertility services for service members with GUIs were premised upon the exclusion of queer couples. Although it is now possible for married queer couples to fulfil the access criteria, that marriage is a requirement for fertility services entrenches heteronormative ideals of marriage as the most deified form of relationship arrangement, and the basic organisational unit of the family.[84] This is exemplified in the Supreme Court's 2015 ruling in favour of marriage equality for LGB couples, which stated that '[n]o union is more profound than marriage, for it embodies the highest ideals of love, fidelity, devotion, sacrifice, and family.'[85] The privileging of marriage within existing fertility provisions therefore not only practically speaking has excluded queer couples prior to 2015, but continues to devalue queer partnerships and childrearing arrangements that exist outside of heterosexist norms.

Investigating what fertility treatments are available to service members with GUIs further underscores the profound privileging of normative, cisgender heterosexual families. The available TRICARE and VA treatments, such as artificial insemination and IVF, presume that a married couple can between them supply both sperm and egg. For many queer couples wishing to have a child that is biologically related to them, a third party is needed to either supply sperm or act as a surrogate for the pregnancy. No provision is made for the acquisition of donor sperm or forms of surrogacy under TRICARE, and there is no provision made for adoption fees or support for couples electing to parent a child that is not biologically related to them (which includes both queer and heterosexual couples). Existing fertility treatments are therefore premised on an understanding that out of a married couple, one partner has ovaries and eggs and one partner has testes and sperm. These treatments thus rule out many queer couples even if they

[80]Defense Health Agency, 'Assisted Reproductive Services', tricare.mil, available at: {https://www.tricare.mil/CoveredServices/IsItCovered/AssistedReproductiveServices} accessed 17 September 2018.

[81]US Department of Veterans Affairs. 'Infertility Treatment', va.gov, available at: {https://www.va.gov/COMMUNITYCARE/programs/veterans/ivf.asp} accessed 30 October 2018.

[82]Defense Health Agency, 'Assisted Reproductive Services', para. 9; see also US Department of Veterans Affairs, 'Infertility Treatment'.

[83]Marriage as an institution has not only been historically designed to exclude LGBT couples, but a plethora of 'other' sexed/racialised/disabled subjects. See Priya Kandaswamy, 'State austerity and the racial politics of same-sex marriage in the US', *Sexualities*, 11:6 (2008), pp. 706–25; Spike Peterson, 'Family matters: How queering the intimate queers the international', *International Studies Review*, 16:4 (2014), pp. 604–08; Sarah Rainey, 'In sickness and in health: Cripping and queering marriage equality', *Hypatia*, 32:2 (2017), pp. 230–46.

[84]Peterson, 'Family matters'.

[85]*Oberfell* v. *Hodges*, 576 U.S. 644 (2015), p. 28.

are married, along with a number of heterosexual couples where one partner may be trans, intersex, or otherwise unable to provide the necessary biological material (for example, as a result of a GUI).

The types of treatment offered also exclude a number of childbearing arrangements familiar to many queer couples, such as surrogacy, which TRICARE takes the time to make explicit that it does not cover, or adoption.[86] As such, fertility treatments offered under the VA and TRICARE do not work to enable veterans simply to raise children. Were this the case, the acquisition of donor sperm, forms of surrogacy, and adoption fees would be covered under existing insurance programmes. However, it is only forms of reproductive technologies that involve sperm and egg from married, cisgender couples that are covered. It is only heterosexual, cisgender modes of living that are granted seminal capacity under existing fertility treatments. Through the production of seminal capacity in certain cishetero couples only, fertility treatments debilitate queer couples and queer modes of childrearing through (re-)enforcement of nuclear, cishetero couples as the natural, normal, and dominant family.

Privileging heterosexual nuclear families within the military fits into a wider historical pattern of governance. As David Serlin argues, the 1944 GI bill and its mortgage provisions constituted 'a mechanic to promote and privilege family life' and to help in 'sustaining heteronormative bliss'.[87] Fertility treatments work in the same way, to ease the pressures infertility brings to bear upon military couples and to conserve the conventional nuclear family.[88] That fertility treatments for service members with GUIs are premised upon the heterosexual couple and the nuclear family demonstrates how the military is highly invested in the governance of service members' semen in particular ways, and in heterosexual orientations. As this article has already argued in regards to surgical treatments, the military medical-bureaucracy invests in endowing soldiers with seminal and ejaculative capacity. This capacity is granted with particular heterosexual goals in mind, as this two-pronged strategy of surgical intervention/fertility treatments demonstrates. The governance of service members' semen revolves around an image of the soldier as a heterosexual, cisgender male; this is who the treatments cater to, and these are the bodies and sexualities that occupy the central place in discourses of GUIs.

In doing so, queer bodies and queer lives are debilitated, produced as unworthy of similar levels of support through their total exclusion from such treatments. The governance of soldiers' semen in the case of fertility treatments validates and reproduces heterosexual biological reproduction and heterosexual forms of life and living as the dominant norm. Queer lives and families are rendered invisible in these discourses. The governance of seminal capacity for the purpose of heterosexual reproduction instantiates family, reproduction, and future as the property of heterosexuality.

This feeds into a wider politics of anti-queerness that associates queerness not with temporal futures, but with the end of them. As Lee Edelman argues when he reminds us that queerness 'is understood as bringing children … to an end', queerness is often figured within dominant heterosexual cultures as anti-life.[89] The exclusion of queer bodies and childbearing/parenting arrangements common to queer communities enacts and supports wider processes of heterosexist debilitation that attempt to deny the possibility of a future to queer communities and lifestyles. Under existing TRICARE and VA frameworks, queer families are debilitated through the restriction of their access to the financial, medical, and technological support it takes to produce a family when a parent has a severe GUI.

By looking at fertility treatments through the lens of capacity/debility, we are able to see how again the boundaries around militarised masculinity are able to be stretched to encompass *some*

[86]Defense Health Agency, 'Assisted Reproductive Services'. It is worth noting that this also automatically rules out many cisgender and heterosexual service members with GUIs too, if they have sustained damage to the testes and sperm retrieval is not an option.

[87]Serlin, 'Constructing autonomy', p. 40.

[88]Hendershot, 'Battle induced urotrauma'.

[89]Lee Edelman, 'The future is kid stuff: Queer theory, disidentification, and the death drive', *Narrative*, 6:1 (1998), pp. 18–30.

masculine bodies, but not others. When a GUI leaves a service member without the masculine capacity to father children, military healthcare systems attempt to offer some remedy to this 'problem', (re)affirming the masculinity of service members with GUIs through producing masculinity capacity. This capacity may not be exercised according to dominant rubrics of masculinity (e.g., fathering children through medically unmediated, penetrative heterosexual sex) but the capacity to biologically reproduce is still supported and enabled. This process is concurrent with the debilitation of other family arrangements, including fertility arrangements common to families with queer parents. This demonstrates that the boundaries of military masculinity can stretch to encompass a select few who fail to meet the criteria. While heterosexual service members with GUIs may be unable to fulfil the fertility and virility requirements of militarised masculinity, their heterosexuality and nuclear family configuration allow the military to (re)masculinise service members, through the technological creation of masculine capacity.

Fertility treatments for GUIs thus partake in a distribution of capacity/debility that protects and values heterosexual forms of life and family at the expense of queer possibilities. This article has argued that surgical treatments for GUIs necessitate the debilitation of trans possibilities in order to protect embodied cisgender forms of life. Fertility treatments perform the same function within the broader parameters of queerness. These treatments actively attempt to distribute and perpetuate heterosexual life, through the replication of heterosexual families. In order for this to happen, queer possibilities and queer forms of family and kinship must become invisible. They are made to fade away from fields of possibilities through an active distribution of resources that prioritises heterosexual capacity.

Racialised bodily hierarchies

While this article is focused on the way in which militarised masculinity stretches to encompass certain non-normative bodies through the exclusion of queer/trans others, it is also of vital importance to note how the management of service members capacities stands in sharp contrast to the lack of care extended to Iraqi and Afghan populations. As Terry notes, the US military has also deployed explosive devices of their own in heavily populated areas; both Iraqi and Afghan combatants and non-combatants have sustained serious levels of blast injuries, yet are often absented in discussions of the impact of blast injuries and genitourinary injuries.[90] The gendered and sexed capacitation that operates upon service members with GUIs is also reliant upon a racialised distribution of life-death that constructs Iraqi and Afghan bodies as available for injury. As Puar notes, biopolitical governance operates through the production of certain populations as 'available for maiming'.[91] While US service members are offered some (profoundly limited/limiting and inadequate) medical response to GUIs, the treatment of Afghan and Iraqi victims of GUIs has been inhibited by the destructive material and economic impact of war upon both countries.

Indeed, the impact of war makes it very difficult to identify the scope of these injuries among Iraqi and Afghan populations in the wake of both conflicts. The difficulty in estimating civilian and combatant casualty injuries is well documented due to the US-led coalition's reticence to release civilian casualty statistics; in a context where, as US General Tommy Franks told the press, 'we don't do body counts', injury and mortality estimates are the subject of much debate.[92] The closest we can get to an appraisal of the numbers of GUIs in Afghan and Iraqi populations,

[90]Terry, *Attachments to War*, p. 62.

[91]Puar, *The Right to Maim*, p. xvii.

[92]Neta Crawford, 'Civilian Death and Injury in Afghanistan, 2001–2011', Watson Institute of International and Public Affairs, p. 2, available at: {https://watson.brown.edu/costsofwar/files/cow/imce/papers/2011/Civilian%20Death%20and%20Injury%20in%20Afghanistan%2C%202001-2011.pdf} accessed 14 April 2022. See also John Bohannon, 'Counting the dead in Afghanistan', *Science*, 331:6022 (2011), pp. 1256–60; see also Jennifer Hyndman, 'Feminist geopolitics revisited: Body counts in Iraq', *The Professional Geographer*, 59:1 (2007), pp. 35–46.

as a direct result of war, is to circle around the edges of the (estimated) number of injuries. In Iraq, around 56 per cent of civilians who were injured in 2014 experienced a disability as a result of these injuries; from 2008 onwards, the prime cause of war-related injuries were primarily blasts and explosions.[93] Between 2003 and 2014, in Baghdad, injuries to the abdomen and pelvis accounted for 12.7 per cent of reported civilian injuries.[94] In Afghanistan, the number of civilian casualties caused by IEDs has risen since 2009.[95] The Afghan National Disability Survey estimates that around 17 per cent of all disabilities in the country are directly related to the war.[96]

None of these figures represent the number of GUIs. But based upon these estimates of civilian casualties, injuries, causes, and disability rates, it is very reasonable to suggest that there are likely substantial numbers of people in Iraq and Afghanistan living with GUIs. This is not including the numbers of Afghan and Iraqi people who would likely have lived with GUIs had their injuries not been fatal. Civilians and armed forces in both these countries are not likely to be wearing the protective body armour or riding in armed vehicles that US forces have access to, and are likely to lack access to a similar level of medical care and resource. Our inability to trace the numbers of people in both countries living with GUIs is not inevitable; instead, it is the result of a set of political choices to *not* collect and monitor these forms of data.

The US invasion of Iraq is particularly instructive here for highlighting that a lack of data is not an inevitable consequence of armed conflict. With regards to Iraq, the US Department of State and the Agency for International Development (USAID) signed contracts with both the World Health Organisation and UNICEF to implement a programme of health surveillance, training, and monitoring post-invasion; these responsibilities were then moved to the Department of Defense, based on the US presumption that US forces would be welcomed by the Iraqi people as 'liberators', and OEF would therefore be completed within three weeks, leaving no need for a prolonged health plan.[97] Following this incredible presumption, the budget for humanitarian aid was cut in half, and various experienced members of the State Department were dismissed from their posts in Iraq following a drive for 'ideological loyalty'; this included the interim minister of health, who was dismissed after declaring Baghdad to be a public health emergency.[98] As a result of the Bush administration's imperial presumption that they would be welcomed as liberators of Iraq, the US rejected opportunities to systematically monitor and assess the health consequences of the US invasion. To this end, the WHO and UNICEF contracts were never implemented, and USAID did not receive any funds for conducting public health surveillance.[99] The opportunity to gather data and information about the injury rates in the Iraqi population were not so much missed as refused.

Highlighting the lack of data in relation to GUIs among Iraqi and Afghan populations demonstrates that various bodily capacities are not being actively produced among Iraqi and Afghan populations in the way they are for US service members. It shows us that these bodies are actively debilitated through the infliction of injury, but also through the debilitation of healthcare systems that would address such injuries, and the denial of visibility to these injuries themselves. It is very difficult for us to even see GUIs among the populations most affected by war because choices

[93]Riyadh Lafta, Sahar Al-Shatari, Megan Cherewick, Lindsay Galway, Charles Mock, Amy Hagopian, Abraham Flaxman, Tim Takaro, Anna Greer, Adam Kushner, and Gilbert Burnham, 'Injuries, death, and disability associated with 11 years of conflict in Baghdad, Iraq: A randomized household cluster survey', *PLoS ONE*, 10:8 e:0131634 (2015), p. 12.

[94]Ibid., p. 9.

[95]Neta Crawford, 'War-Related Death, Injury and Displacement in Afghanistan and Pakistan 2001–2014', Watson Institute of International and Public Affairs, p. 4, available at: {https://watson.brown.edu/costsofwar/files/cow/imce/papers/2015/War%20Related%20Casualties%20Afghanistan%20and%20Pakistan%202001-2014%20FIN.pdf} accessed 19 April 2022.

[96]Ibid., p. 7.

[97]Frederick Burkle Jr and Richard Garfield, 'Civilian mortality after the 2003 invasion of Iraq', *The Lancet*, 381:9870 (2013), pp. 877–9.

[98]Terry, *Attachments to War*, pp. 43–4.

[99]Ibid.; Burkle Jr and Garfield, 'Civilian mortality'.

have been made to render them invisible and silent within the relevant data. While this article focuses on issues of capacity and debility within US forces, it is vital to acknowledge that the hierarchy of bodies established is a profoundly racialised one. The governance and attention granted to US service members' bodies is premised upon an understanding that the US soldiering body is one that is 'worthy' and 'deserving' of capacity. This is not a valuation that is extended to Iraqi and Afghan bodies.

The seminal capacity of US service members is therefore protected and promoted through the exposure of Iraqi and Afghan populations to higher levels of death and debilitation. The arguments about the unequal distribution of risk in both of these wars has been made thoroughly by other scholars, so I will not repeat them here.[100] However, it is important to draw attention to the fact that the absence of information and data around GUIs effects an 'elision' of the role of US imperialism in producing GUIs, erasing a thorough consideration and critique of how wounding and injury similarly affects populations 'over there' in addition to populations 'at home'.[101] This demonstrates how capacitation/debilitation in this context is premised upon a racialised hierarchy that situates Afghan and Iraqi bodies as 'available' for debilitation in contrast to the bodies of select US service members, which are produced as 'available' for (re)capacitation.

Conclusion

As this article has demonstrated, military-medical assemblages attempt to (re)masculinise soldiers with genitourinary injuries through the production of certain genital capacities. This article began by demonstrating that GUIs are produced as an emasculating form of injury that leaves the bodies of service members in ambiguously sexed/gendered positions. To rescue the bodies of service members from occupying such an uncertain space in relation to the sex/gender binary, militaries offer both surgical and fertility based treatments to service members. Both these forms of treatment attempt to produce service members' bodies as having penile capacity, reaffirming service members as men through the creation of masculine bodily capacities. Whether this capacity is produced through surgical interventions or fertility treatments, these forms of capacitation are achieved through the concurrent debilitation of trans and queer bodies and possibilities, which are rendered invisible and impossible in these forms of treatments.

In offering such an analysis, this article has attempted to highlight the value of debility/capacity for exploring militarised masculinities. Debility/capacity make two important offerings to us. Firstly, these logics demonstrate to us that militarised masculinity is produced through the governance of bodily capacities. While the material body of the masculine soldier may differ, military medical assemblages navigate this through the governance of what the body can *do*, rather than what it *is*, in order to (re)construct masculinity. Recognising that the governance of capacity is a vital mode through which military masculinity is constructed and maintained is crucial for avoiding an image of the body as a static entity. Capacity/debility allow us to think the body, and by extension sex, gender, and sexuality, in terms of what bodies can do.

Secondly, capacity/debility reveals the flexibility and stretch gender, sex, and sexuality have. Looking at how both capacity/debility are produced among bodies shows us that militarised masculinity is not as rigid a category as we may sometimes imagine. Even hegemonic masculinities that rely upon binary understandings of sex and gender can stretch to encompass the bodies that challenge them, as this article has demonstrated. Indeed, the fact that military masculinity can accommodate the very bodies that challenge it – masculine soldiering bodies that do not conform to binary understandings of 'maleness' – demonstrates that one of the ways the military

[100]Patricia Owens, 'Accidents don't just happen: The liberal politics of high-tech humanitarian war', *Millennium: Journal of International Studies*, 32:3 (2003), pp. 595–615; Martin Shaw, 'Risk transfer militarism, small massacres and the historic legitimacy of war', *International Relations*, 16:3 (2002), pp. 343–59.

[101]Puar, *Right to Maim*, p. 93.

neutralises threats to militarised masculinity is to absorb them. These bodies have the potential to radically threaten and challenge hegemonic ideals of masculinity. Instead, they are *incorporated* into militarised masculinity.

This malleability and production of capacity is not extended to all bodies and subjects equally. Instead it is achieved through the production and debilitation of 'others'. The boundary between heterosexuality and cisgender masculinity are policed through the debilitation of certain bodies, ways of living and being. The boundary of inclusion/exclusion is redrawn via who is considered a worthy recipient of certain bodily capacities. In this way, the potential threat to undermine associations between sexuality, gender, and genitalia is (re)produced through the distribution of bodily capacity in military healthcare. While the heterosexual cisgender soldier is available for (re)capacitation as a masculine body, understandings of masculinity do not stretch to encompass trans men. The family does not stretch to encompass queer couples or queer kinship and child-rearing. Capacity/debility push us to think of capacitation as a relational process, one that requires the debilitation of others. The question becomes, as Puar puts it, which bodies are deemed 'available and valuable enough' for (re)capacitation – 'and which cannot be?'.[102] In the case of GUI treatments, it is cis male heterosexuality that is capacitated over and against queer/trans bodies and lives. These processes privilege and protect certain bodies, establishing cishet masculinities as the most worthy, the most recognisable, and the most meaningful form of life.

Acknowledgements. I am very grateful to the three anonymous reviewers, along with the editors of *The Review of International Studies*, whose considered and thoughtful advice have improved this article immeasurably and given me much to think about in the future. Before this paper was a paper it benefited from the advice and guidance of Cristina Masters, Laura McLeod, and Maya Zehfuss, and the support of other attendees at a *Review of International Studies* workshop for women early career researchers.

Video abstract: To view the video abstract, please visit: https://doi.org/10.1017/S0260210522000560

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[102]Puar, *Right to Maim*, p. 13.

Cite this article: Hobbs, J. 2023. Capacitating militarised masculinity: Genitourinary injuries, sex/sexuality, and US military medicine. *Review of International Studies* **49,** 657–675. https://doi.org/10.1017/S0260210522000560