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Polarizing Procedures: Transsexual Inmates, Sex Reassignment Surgery, and the Eighth Amendment, 50 J. Marshall L. Rev. 747 (2017)

Jameson Rammell

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POLARIZING PROCEDURES: TRANSSEXUAL INMATES, SEX REASSIGNMENT SURGERY, AND THE EIGHTH AMENDMENT

JAMESON RAMMELL*

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INTRODUCTION

In 2014, the First Circuit heard the case of Michelle Kosilek, a transsexual inmate seeking Sex Reassignment Surgery [SRS].¹ In what appeared to be a monumental decision expanding the rights of transsexual inmates, a three-judge panel upheld an injunction that required the Massachusetts Department of Correction [DOC] to provide Kosilek with SRS.² However, shortly thereafter, the First

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1. *Kosilek v. Spencer*, 740 F.3d 733 (1st Cir. 2014), *withdrawn*, *Kosilek v. Spencer*, No. 12-2194, 2014 U.S. App. LEXIS 2660, at *3 (1st Cir. Feb. 12, 2014).

2. *Kosilek*, 740 F.3d at 773, *withdrawn*, *Kosilek*, 2014 U.S. App. LEXIS 2660, at *3.

Circuit voted to withdraw its opinion and rehear the case en banc.³ The en banc majority struck down the injunction, and Kosilek's request for SRS remained denied.⁴

In a forceful dissent from the en banc majority, Judge Ojetta Thompson criticized the result, and shared her belief that the ruling would one day rest on the wrong side of history.⁵ She identified “[p]rejudice and fear of the unfamiliar” as factors fighting against Kosilek, stating: “I am confident that I would not need to pen this dissent . . . were [Kosilek] not seeking a treatment that many see as strange or immoral . . . this decision will not stand the test of time, ultimately being shelved with the likes of *Plessy v. Ferguson* . . . and *Korematsu v. United States*”⁶

At the heart of these opposing outcomes lies a fundamental disagreement over the medical necessity of SRS—particularly within the framework of the Eighth Amendment's restriction of cruel and unusual punishment.⁷ When claiming that a denial of medical care amounts to cruel and unusual punishment, an inmate must show two things: first, that the deprivation of care was objectively serious, and second, that prison officials acted deliberately indifferent towards a serious risk to the inmate's health or safety.⁸ A substantial risk of future harm, such as an increased risk of suicide, may sustain an inmate's Eighth Amendment claim.⁹

3. *Kosilek*, 2014 U.S. App. LEXIS 2660, at *3. The original opinion was withdrawn after a “majority of the active judges” on the First Circuit voted to rehear the case en banc. *Id.* However, the underlying reasons were not provided. *Id.* The Federal Rules of Appellate Procedure provide that “[a]n en banc hearing or rehearing is not favored and ordinarily will not be ordered unless: (1) en banc consideration is necessary to secure or maintain uniformity of the court's decisions; or (2) the proceeding involves a question of exceptional importance.” FED. R. APP. P. 35. Here, the Court was not attempting to maintain uniformity in its decisions. Rather, the en banc majority opinion begins by stating the “case involves important issues that arise under the Eighth Amendment.” *Kosilek v. Spencer*, 774 F.3d 63, 68 (1st Cir. 2014). Additionally, in her dissent, Judge Thompson explained that “the maintenance of uniformity [was] . . . not in play” and expressed her belief that the rehearing occurred because the court believed the case presented an issue of exceptional importance. *Id.* at 97 (Thompson, J., dissenting).

4. *Kosilek*, 774 F.3d at 96.

5. *Id.* at 113 (Thompson, J., dissenting).

6. *Id.* (citing *Plessy v. Ferguson*, 163 U.S. 537 (1896) (holding that racial segregation in public facilities does not violate the equal protection clause); *Korematsu v. United States*, 323 U.S. 214 (1944) (upholding the internment of Japanese Americans during WWII).

7. Compare *Kosilek v. Spencer*, 740 F.3d 733, 772-73 (1st Cir. 2014) (affirming the district court's ruling that SRS is medically necessary for Kosilek), *withdrawn, with Kosilek*, 774 F.3d at 96 (explaining that a treatment plan that does not contain SRS may still satisfy the Eighth Amendment).

8. *E.g.*, *Kosilek*, 774 F.3d at 82-83.

9. *Id.* at 90 (“[F]uture risk of suicidality is not one that this court takes lightly, and . . . clear risk of future harm may suffice to sustain an Eighth Amendment claim.”) (citing *Helling v. McKinney*, 509 U.S. 25, 35 (1993)).

Under this test, the original three-judge panel agreed with the lower court that denial of SRS would amount to cruel and unusual punishment; identifying the “intense mental anguish” Kosilek experienced over her male genitalia as a serious medical condition that antidepressants and psychotherapy could not fix.¹⁰ The en banc majority disagreed; claiming that a denial of SRS is not harmful enough to violate the Eighth Amendment when prison officials follow a treatment plan designed by a qualified medical professional that—although not including SRS—still treats the underlying condition.¹¹ Today, the decision of the en banc majority still stands. However, in the short span of years that have passed since, a noticeable shift towards expanded rights and protections for transgender individuals has occurred,¹² and Judge Thompson’s prediction seems increasingly prescient.

Nevertheless, intense disagreement over the necessity of SRS continues. Compare the views of Dr. Nick Gorton, a transgender health expert and openly transgender physician,¹³ against those of Dr. Paul McHugh, former psychiatrist-in-chief at Johns Hopkins Hospital: Dr. Gorton believes that denial of SRS “exposes [transsexual patients] to a longer duration of pain, suffering, and decreased social functionality, [and] also unnecessarily places their lives at risk.”¹⁴ He claims that transsexual patients who do not receive sex reassignment therapies are twenty to thirty times more likely to commit suicide than transsexual patients who do receive such treatment.¹⁵

Dr. McHugh disagrees. He has stated: “policy makers and the media are doing no favors either to the public or the transgendered by treating their confusions as a right in need of defending rather than as a mental disorder that deserves understanding, treatment and prevention.”¹⁶ In fact, Dr. McHugh fears SRS can actually lead to severe negative consequences, referencing a study conducted in 2011, which found “about 10 years after having [SRS], the transgendered began to experience increasing mental difficulties . . .

10. *Kosilek*, 740 F.3d at 766, *withdrawn*.

11. *Kosilek*, 774 F.3d at 91–92.

12. *See infra* Part IV (discussing relevant recent events).

13. Regents of the University of California, *Medical Advisory Board: R. Nick Gorton, MD*, TRANSHEALTH.UCSF.EDU (2017), <http://transhealth.ucsf.edu/trans?page=ab-gorton>.

14. The Sylvia Rivera Law Project, *“It’s War in Here”: A Report on the Treatment of Transgender and Intersex People in New York State Men’s Prisons*, SYLVIA RIVERA LAW PROJECT 1, 28 (2007), <http://srjp.org/files/warinhere.pdf>.

15. *Id.*

16. Paul McHugh, *Transgender Surgery Isn’t the Solution: A Drastic Physical Change Doesn’t Address Underlying Psycho-Social Troubles*, WALL ST. J. (June 12, 2014), www.wsj.com/articles/paul-mchugh-transgender-surgery-isn-t-the-solution-1402615120 (last updated May 13, 2016).

. [and] their suicide mortality rose almost 20-fold above the comparable non-transgender population.”¹⁷

These opposing viewpoints demonstrate the uncertainty and polarity of opinions that this issue presents for Departments of Correction around the country, as well as any court where the question is raised. This uncertainty is significant because the outcome of these cases is heavily influenced by whether a court believes SRS is an effective treatment for a legitimate medical condition.¹⁸

This article argues that at present, there is not sufficient certainty within the medical and scientific communities to definitively state that SRS is medically necessary for transsexual individuals, or that it effectively relieves the negative symptoms often associated with gender dysphoria. Because the Supreme Court has held that the Eighth Amendment does not require prison officials to provide the most cutting-edge treatments available, but only an adequate level of treatment, it is not a violation of the Eighth Amendment to deny a transsexual inmate’s request for SRS.

Part I explores the medical and scientific communities’ current understanding of gender dysphoria, the medical treatments available, and where uncertainty still exists. Part II examines the challenges and dangers that transsexual inmates face, as well as the difficulties they present for prison officials. Part III reviews the Eighth Amendment’s restriction of cruel and unusual punishment, and how courts have interpreted this restriction in regard to medical care for inmates. The *Kosilek* decisions are examined in order to demonstrate how the cruel and unusual punishment test is applied. Part IV highlights the significant events that have occurred since *Kosilek*, including the Army’s approval of SRS for inmate Chelsea Manning, and a recent United States District Court decision approving SRS for an inmate in California. Part V is a discussion and analysis of the central question involved in this

17. *Id.* Dr. McHugh has been accused by LGBT advocates of being biased against the LGBT community. See Brynn Tannehill, *Johns Hopkins Professor Endangers the Lives of Transgender Youth*, HUFFINGTON POST: THE BLOG (Mar. 20, 2016, 10:00 AM), www.huffingtonpost.com/brynn-tannehill/johns-hopkins-professor-e_b_9510808.html (claiming Dr. McHugh’s opinions are “based on distortions, omissions, half-truths, outdated research, and motivated entirely by religious based bias.”). However, the 2011 study Dr. McHugh cites does not receive such criticism. In fact, the study concludes with a call for increased follow-up and improved care for transgender individuals—not less. *Cecilia Dhejne et al., Long-Term Follow-Up of Transsexual Persons Undergoing Sex Reassignment Surgery: Cohort Study in Sweden*, 6 PLOS ONE e16885-1, e16885-7 (2011).

18. See Cynthia S. Osborne & Anne A. Lawrence, *Male Prison Inmates with Gender Dysphoria: When Is Sex Reassignment Surgery Appropriate?*, 45 ARCHIVES SEXUAL BEHAV. 1649, 1651 (2016) (“The medical necessity of SRS is a fundamental issue, because U.S. courts have consistently ruled that failure to provide inmates with necessary medical treatment . . . [violates] the Eighth Amendment’s prohibition of cruel and unusual punishment.”).

issue: do transsexual inmates who medically qualify for the procedure have a constitutional right to receive SRS? Part VI concludes that at present, no such right exists.

PART I: UNDERSTANDING GENDER DYSPHORIA

The medical necessity of SRS is a fundamental consideration when determining whether transsexual inmates have a constitutional right to receive the procedure.¹⁹ No such decision can competently be made without an updated and thorough understanding of gender dysphoria.²⁰ In 2013, the American Psychiatric Association [APA] released the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* [DSM-V], which helps to define and diagnose mental disorders.²¹ Among the changes made in the updated fifth edition was the replacement of the diagnostic term “gender identity disorder” with “gender dysphoria.”²² The APA felt it important to note, “gender nonconformity is not in itself a mental disorder,” and intended this change in title as well as changes to the diagnostic criteria²³ to help

19. *Id.*

20. Lila Leonard, *Gender Reassignment Surgery in Prisons: How the Eighth Amendment Guarantees Medical Treatments Not Covered by Private Insurance or Medicare for Law-Abiding Citizens*, 11 RUTGERS J. L. & PUB. POL'Y 626, 629 (2014).

21. Wynne Parry, *Gender Dysphoria: DSM-5 Reflects Shift in Perspective on Gender Identity*, HUFFINGTON POST (June 4, 2013), https://www.huffingtonpost.com/2013/06/04/gender-dysphoria-dsm-5_n_3385287.html; *Gender Dysphoria*, AM. PSYCHIATRIC ASS'N, www.psychiatry.org/psychiatrists/practice/dsm/educational-resources/dsm-5-fact-sheets (last visited Mar. 2, 2017) [hereinafter APA].

22. APA, *supra* note 21.

23. The DSM-V diagnostic criteria for gender dysphoria in adults and adolescents include:

A. A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months' duration, as manifested by at least two of the following:

1. A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics).

2. A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender (or in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics).

3. A strong desire for the primary and/or secondary sex characteristics of the other gender.

4. A strong desire to be of the other gender (or some alternative gender different from one's assigned gender).

5. A strong desire to be treated as the other gender (or some alternative gender different from one's assigned

remove the stigma that all individuals who identify as transgender are mentally ill.²⁴

The DSM-V defines “gender dysphoria” as “the distress that may accompany the incongruence between one's experienced or expressed gender and one's assigned gender.”²⁵ Transsexualism is the most extreme form of gender dysphoria.²⁶ This term “denotes an individual who seeks, or has undergone, a social transition from male to female or female to male, which in many, but not all cases also involves a somatic transition by cross-sex hormone treatment and genital surgery.”²⁷ Therefore, any inmate seeking SRS would be considered transsexual.

Although identifying the prevalence of transsexualism proves to be a difficult task,²⁸ one systematic review of numerous studies estimates the number of transsexual women to be about one in every 14,705 individuals.²⁹ The prevalence among men is lower: about one in every 38,461 individuals.³⁰ Recent studies show statistically significant higher rates of transsexualism than older studies.³¹ This is likely due to various factors, such as the condition becoming less stigmatized and an increasing awareness and availability of treatment options.³² In light of these trends, it seems reasonable to believe that the estimates made by this systematic review, although calculated using the best available data, may significantly underestimate the true prevalence of the condition.

Individuals experiencing gender dysphoria often battle significant mental and emotional challenges.³³ The DSM-V explains that gender dysphoria “is associated with high levels of stigmatization, discrimination, and victimization, leading to negative self-concept.”³⁴ Sadly, this is common in the daily lives of

gender).

6. A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender).

APA, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 452–53 (5th ed., 2013) [hereinafter DSM-V].

24. APA, *supra* note 21.

25. DSM-V, *supra* note 23, at 451.

26. Osborne & Lawrence, *supra* note 18, at 1649.

27. DSM-V, *supra* note 23, at 451.

28. Factors that cause this difficulty include: the evolving classification system; inconsistent use of terminology between studies; and the complexity of general prevalence studies. J. Arcelus, et al., *Systematic review and meta-analysis of prevalence studies in transsexualism*, 30 EUR. PSYCHIATRY 807, 807-08 (2015).

29. *Id.* at 811.

30. *Id.*

31. *Id.*

32. *Id.* at 812.

33. DSM-V, *supra* note 23, at 454–58.

34. *Id.* at 458.

many transgendered individuals.³⁵ The collective impact of such treatment leads to elevated risk for drug and alcohol abuse, and suicide attempts.³⁶ Indeed, a survey of 6,450 transgender individuals in the United States, performed by the National Center for Transgender Equality and the National Gay and Lesbian Task Force [hereinafter Transgender Discrimination Survey] revealed that 41% of respondents had attempted suicide.³⁷

Additional effects of gender dysphoria may include “increased rates of mental disorder comorbidity, school dropout, and economic marginalization, including unemployment, with attendant social and mental health risks.”³⁸ These problems are compounded by structural barriers that impede access to mental and physical healthcare services, such as institutional discomfort or inexperience in working with transgender individuals.³⁹

A. Treatment Options

While there are numerous treatments designed to reduce or eliminate gender dysphoria, the World Professional Association for Transgender Health’s [WPATH] Standards of Care manual is considered by some to be “the most comprehensive and evidence-based set of recommendations for treating the condition.”⁴⁰ WPATH describes one of the manual’s main functions as “[promoting] the highest standards of health care for individuals through the articulation of Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People.”⁴¹ The organization further claims that the Standards of Care “are based on the best available science and expert professional consensus.”⁴² However, it should be noted that while some courts have regarded the Standards of Care as authoritative,⁴³ others have emphasized that they are merely flexible “guidelines.”⁴⁴

35. Jaime M. Grant et al., *Injustice at Every Turn: A Report of the National Transgender Discrimination Survey*, NATIONAL GAY AND LESBIAN TASK FORCE 84 (2011), http://www.thetaskforce.org/static_html/downloads/reports/reports/n_tds_full.pdf.

36. *Id.*

37. *Id.* at 82.

38. DSM-V, *supra* note 23, at 458.

39. *Id.*

40. Transgender Medicine Model NCD Working Group, *Summary of Clinical Evidence for Gender Reassignment Surgeries*, CMS.GOV 1, 2, www.cms.gov/Medicare/Coverage/DeterminationProcess/Downloads/Kalra_comment_01022016_b.pdf (last visited Oct. 23, 2016).

41. THE WORLD PROFESSIONAL ASSOCIATION FOR TRANSGENDER HEALTH, STANDARDS OF CARE FOR THE HEALTH OF TRANSSEXUAL, TRANSGENDER, AND GENDER NONCONFORMING PEOPLE 1 (7th version, 2011) [hereinafter WPATH].

42. *Id.*

43. *See, e.g.,* Kosilek v. Spencer, 740 F.3d 733, 763 (1st Cir. 2014); Norsworthy v. Beard, 87 F. Supp. 3d 1104, 1109 (N.D. Cal. 2015).

44. Kosilek v. Spencer, 774 F.3d 63, 87 (1st Cir. 2014); *see also* Osborne &

Medical and psychological treatment options recommended by WPATH fall into four main types:

1. Changing gender expression and role (“which may involve living part time or full time in another gender role, consistent with one’s gender identity”);
2. Hormone therapy (“to feminize or masculinize the body”);
3. SRS;
4. Psychotherapy (“for purposes such as exploring gender identity, role, and expression; [and] addressing the negative impact of gender dysphoria”).⁴⁵

In addition to (and in some cases as alternatives to) medical and psychological treatments, WPATH recommends additional changes in social support and gender expression that may help alleviate gender dysphoria, including:

- Peer support resources, groups, or community organizations that provide avenues for social support and advocacy;
- Voice and communication therapy to help individuals develop verbal and non-verbal communication skills that facilitate comfort with their gender identity;
- Hair removal through electrolysis, laser treatment, or waxing;
- Breast binding or padding, genital tucking or penile prostheses, padding of hips or buttocks;
- Changes in name and gender marker on identity documents.⁴⁶

While WPATH views SRS as “often the last . . . step in the treatment process for severe gender dysphoria,” it does claim that for some transsexuals the procedure is medically necessary.⁴⁷

While some individuals desire full gender reassignment, including hormonal treatments and SRS, some do not wish to receive SRS, and others do not desire any treatment at all.⁴⁸ For some, whether to undergo SRS is not viewed as a choice.⁴⁹ Rather, they consider SRS “the only possible solution to life-long suffering .

Lawrence, *supra* note 18, at 1650-51 (discussing the shortcomings and critiques of the Standards of Care).

45. WPATH, *supra* note 41, at 9-10.

46. *Id.* at 10.

47. *Id.* at 54-55.

48. Gennaro Selvaggi et al., *The 2011 WPATH Standards of Care and Penile Reconstruction in Female-to-Male Transsexual Individuals*, 2012 *ADVANCES IN UROLOGY* 1, 1-2 (2012).

49. David Valentine, *Sue E. Generous: Toward a Theory of Non-Transsexuality*, 38 *FEMINIST STUD.* 185, 192 (2012).

. . . it is no more of a choice than any other medical procedure that might save a life.”⁵⁰ Others hold a different view. Author and gender theorist Kate Bornstein, who underwent SRS, stated: “I accept the label transsexual as meaning only that I was dissatisfied with my given gender, and I acted to change it. I am transsexual by choice, not by pathology.”⁵¹

The results of the Transgender Discrimination Survey are consistent with this dichotomy. The survey revealed that only 33% of respondents had undergone SRS.⁵² An additional 28% had received hormonal treatments.⁵³ These relatively low numbers may be partially explained by individuals being unable to afford treatment; over 25% of the survey’s respondents reported making less than \$25,000 per year, while genital transition alone may cost over \$20,000, and more comprehensive transitions can cost over \$100,000.⁵⁴ However, the survey revealed that many transgender individuals do not desire SRS at all.⁵⁵ While 53% of biologically born female respondents indicated that they would like to eventually undergo metoidioplasty (creation of testes), only 27% indicated that they would like to undergo phalloplasty (creation of penis).⁵⁶ Sixty-four percent of biologically born male respondents indicated that they would like to undergo vaginoplasty (creation of vagina) while 53% stated they would like to receive breast augmentation surgery.⁵⁷

Most clinicians agree that SRS is not a “cure” for gender dysphoria.⁵⁸ Rather, it is considered a “strategy to diminish the serious suffering of a transsexual Person.”⁵⁹ However, empirical data to support this claim is lacking. Although the current form of the procedure has been practiced for over fifty years, data regarding suicide rates and psychological disorders post-SRS is limited.⁶⁰ Additionally, many of the studies that have been published provide inconsistent results that at times contradict each other.⁶¹ One research team identified four reasons why reliable information

50. *Id.*

51. KATE BORNSTEIN, GENDER OUTLAW: ON MEN, WOMEN, AND THE REST OF US 118 (1994).

52. Grant et al., *supra* note 35, at 52.

53. *Id.*

54. THE PHILADELPHIA CENTER FOR TRANSGENDER SURGERY, www.thetransgendercenter.com/index.php/price-list.html (last visited Nov. 1, 2017); Chris Taylor, *Transgender Surgery Can Cost More Than \$100,000*, TIME (Oct. 29, 2015), <http://time.com/money/4092680/transgender-surgery-costs/>.

55. Grant et al., *supra* note 35, at 52.

56. *Id.*

57. *Id.*

58. Luk Gijs & Anne Brewaeys, *Surgical Treatment of Gender Dysphoria in Adults and Adolescents: Recent Developments, Effectiveness, and Challenges*, 18 ANN. REV. SEX RES. 178, 184 (2007).

59. *Id.*

60. Dhejne et al., *supra* note 17, at e16885-1 to e16885-2.

61. *Id.*

regarding the efficacy of SRS is so difficult to obtain.⁶² First, performing double blind, randomized controlled studies of SRS is not possible because the nature of SRS prevents researchers from providing one group of subjects with a mere placebo procedure.⁶³ Second, because transsexualism is rare, follow-up studies are constrained by the limited number of subjects.⁶⁴ Third, many individuals who have undergone SRS decline to participate in such studies and often relocate following the procedure.⁶⁵ This results in “high drop-out rates and consequent selection bias.”⁶⁶ Fourth, many studies have been hindered by limited follow-up periods.⁶⁷ Collectively, “these limitations preclude solid and generalizable conclusions.”⁶⁸

Additionally, the information that is available seems to merely produce uncertainty over whether SRS is effective in treating the mental and emotional side effects of gender dysphoria. The Transgender Discrimination Survey revealed that perplexingly, those who had undergone SRS had higher rates of attempted suicide than those who had not received the procedure (43% and 39% respectively).⁶⁹ However, the survey did not ask respondents to clarify at what age they had attempted suicide, so it is “difficult to draw conclusions about the risk of suicide over their life spans.”⁷⁰ Perhaps most who had received SRS had attempted suicide prior to surgery rather than after surgery.

Yet, proponents of SRS cite studies showing extremely favorable outcomes and positive results following the procedure.⁷¹ In its Standards of Care manual, WPATH states that “[f]ollow-up studies have shown an undeniable beneficial effect of sex reassignment surgery on postoperative outcomes.”⁷² The most substantial, modern study WPATH cites in support of this claim analyzed eighteen treatment evaluation studies, all of which were conducted after 1990.⁷³ This study concluded that 96% of

62. *Id.*

63. *Id.*

64. *Id.*; Sutcliffe et al., *Evaluation of Surgical Procedures for Sex Reassignment: A Systematic Review*, 62 J. PLASTIC, RECONSTRUCTIVE & AESTHETIC SURGERY 294, 303 (2009).

65. Dhejne et al., *supra* note 17, at e16885-1 to e16885-2.

66. *Id.*

67. *Id.*

68. *Id.*

69. Grant et al., *supra* note 35, at 82.

70. *Id.*

71. *E.g.*, WPATH, *supra* note 41, at 55.

72. *Id.*

73. Gijs & Brewaeys, *supra* note 58, at 185-87. While WPATH does cite to a collective review that examined more studies than Gijs & Brewaeys, this review was published in 1998, and examined follow-up studies conducted between 1961 and 1991, with a much less critical approach than that utilized by Gijs & Brewaeys to identify and disregard less reliable studies. WPATH, *supra* note 42, at 55. Compare Pfäfflin, F., & Junge, A., *Sex reassignment. Thirty Years of*

transsexuals who received SRS reported feeling satisfied with the outcome of the procedure at least one year removed from surgery.⁷⁴ Such overwhelming satisfaction surely seems to support the statement that the procedure has an “undeniable beneficial effect.”⁷⁵ However, the cited study includes the following caution:

Methodologically, however, this conclusion should be carefully qualified. Not one of the reviewed outcome studies was a controlled one. . . . Furthermore, a number of investigators used only a posttest to measure the effects of SRS. In many studies, sound psychometric instruments were not used. Especially disturbing is that many researchers did not directly measure gender dysphoria as the main outcome variable but instead used derivative measures, for example, satisfaction with surgery, sexual and interpersonal relationships, occupational and global functioning, or quality of life in general. . . . In addition to the design problems of the studies, patient numbers are seriously skewed. A large number of patients who received surgery were lost at follow-up.⁷⁶

This methodological uncertainty is problematic because changing an individual’s external genitalia is a unique intervention “not only in psychiatry but in all of medicine.”⁷⁷ While many studies purport to show that SRS effectively relieves gender dysphoria, others report regrets, psychiatric morbidity, and suicide attempts following the procedure.⁷⁸

Although some courts have considered the WPATH Standards of Care to be authoritative,⁷⁹ the above example highlights why courts should be cautious before doing so. While WPATH portrays its standards as scientific, the organization also advocates for the transgender community, and encourages clinicians to do the same.⁸⁰ Advocacy on behalf of vulnerable populations is by no means an unworthy cause. However, Dr. Stephen B. Levine, who helped write the fifth version of the Standards of Care manual,⁸¹ has expressed

International Follow-Up Studies After Sex Reassignment Surgery: A Comprehensive Review, 1961-1991. INT. J. TRANSGENDERISM (1998), with Gijs & Brewaeys, *supra* note 58, at 178.

74. Gijs & Brewaeys, *supra* note 58, at 199.

75. WPATH, *supra* note 42, at 55.

76. Gijs & Brewaeys, *supra* note 58, at 199.

77. Dhejne et al., *supra* note 17, at e16885-1 to e16885-2.

78. *Id.*

79. See e.g., *Kosilek v. Spencer*, 740 F.3d 733, 763–64 (1st Cir. 2014) (claiming the Standards of Care are widely relied upon, trusted, and “generally accepted” in the courts), *withdrawn*; *Norsworthy v. Beard*, 87 F. Supp. 3d 1164, 1192 (N.D. Cal. 2015) (rejecting expert medical testimony for being inconsistent with the Standards of care).

80. See Stephen B. Levine, *Reflections on the Legal Battles Over Prisoners with Gender Dysphoria*, 44 J. AM. ACAD. PSYCHIATRY L. 236, 240 (2016).

81. *Kosilek v. Spencer*, 774 F.3d 63, 77 (1st Cir. 2014). Dr. Levine is currently a Professor of Psychiatry at Case Western Reserve University School of Medicine, and Co-director of the Beachwood, Ohio Gender Identity Clinic. Levine, *supra* note 80, at 236.

concern over WPATH's combination of science and social advocacy.⁸² In his view, this combination is problematic because science is meant to "provide[] a dispassionate view of . . . the facts," while advocacy can cause an organization to become "disinterested in emphasizing the limitations of its position," and to "muster[] the facts that support [its] goal."⁸³ In Dr. Levine's experience, skepticism and alternative viewpoints are not well received within the WPATH organization, and he believes certain elements of WPATH's Standards of Care represent political, rather than scientific positions.⁸⁴

Regardless of the confidence one places in the current body of research supporting SRS, it is undeniable that the transsexual population faces difficult challenges. In addition to efforts to combat the discrimination they face, research analyzing the effectiveness of SRS must improve, and other medical treatments must continue to develop. Although the current body of research supporting SRS suffers from considerable methodological limitations,⁸⁵ research methods are improving, and "controlled outcome studies . . . evaluating the effectiveness of SRS are eagerly awaited."⁸⁶

PART II: TRANSGENDER INMATES: CHALLENGES FACED AND CHALLENGES CREATED

The precise number of transgender inmates in the United States prison system is unknown.⁸⁷ However, based upon court documents and reports from Departments of Correction around the country, there are an estimated 500 to 750 transgender inmates in custody in state facilities and another 50 to 100 in federal facilities.⁸⁸ Since many inmates never receive an official diagnosis, this likely underestimates the actual number of inmates experiencing gender dysphoria.⁸⁹

Much of the abuse and discrimination that transgender individuals experience outside of prison is also prevalent within the prison system.⁹⁰ Traditionally, most of this discrimination and abuse has involved issues of placement, safety, clothing and

82. Levine, *supra* note 80, at 240.

83. *Id.*

84. *Id.*

85. *E.g.*, Mohammad Hassan Murad et al., *Hormonal Therapy and Sex Reassignment: A Systematic Review and Meta-Analysis of Quality of Life and Psychosocial Outcomes*, 72 CLINICAL ENDOCRINOLOGY 214, 214-231. (2010).

86. Gijs & Brewaeys, *supra* note 58, at 215.

87. George R. Brown & Everett McDuffie, *Health Care Policies Addressing Transgender Inmates in Prison Systems in the United States*, 15 J. CORRECTIONAL HEALTH CARE 280, 281 (2009).

88. *Id.*

89. *Id.*

90. The Sylvia Rivera Law Project, *supra* note 14, at 17.

appearance, and access to medical care.⁹¹ During a series of interviews, transgender inmates in the New York prison system recounted some of the horrors they faced while incarcerated:

I have been beaten and raped because [I'm both] a transgender with female breasts and feminine. I have been burned out of a cell block [and] dorm because I wouldn't give an inmate sex. I have been slapped, punched, and even threatened because [I'm] a transgender that told another inmate 'No' when they told me they wanted sex from me I have been harassed verbally and have had others grab my female breasts and ass because they knew I was transgender and figured they can get away with such actions—which they do most of the time due to the fact no one cares what happens to us transgenders inside. . . .⁹²

I have trouble showering safely because that's when others come in the bathroom and always try to see me naked, ask me for sex, or try to take sex from me even though I'm unwilling to do anything sexual with them.⁹³

[I]t's war in here. The administration is against us The correctional officers are the ones who are the most violent. They're the ones to be scared of. . . . I've made complaint after complaint, but no response. No success.⁹⁴

Fortunately, in 2003 Congress passed the Prison Rape Elimination Act [PREA].⁹⁵ In addition to establishing a “zero tolerance” standard for prison rape,⁹⁶ the Act called for the development of “national standards for the detection, prevention, reduction, and punishment of prison rape.”⁹⁷ In 2012, these standards were finally released, and were made binding on the Federal Bureau of Prisons.⁹⁸ While not binding on state agencies, PREA includes significant financial incentives to comply with its standards.⁹⁹ Each state detention facility must be audited at least once every three years, and if the state is not in full compliance with PREA standards, its federal prison grants may be reduced by five percent.¹⁰⁰ If, however, the state's governor guarantees that the five percent will be used to come into compliance with PREA, the funding is preserved.¹⁰¹

91. *Id.*

92. *Id.* at 25.

93. *Id.* at 30.

94. *Id.* at 19.

95. Gabriel Arkles, *Prison Rape Elimination Act Litigation and the Perpetuation of Sexual Harm*, 17 N.Y.U. J. LEGIS. & PUB. POL'Y 801, 802 (2014).

96. 42 U.S.C. § 15602(1) (2012).

97. 42 U.S.C. § 15602(3) (2012).

98. Arkles, *supra* note 95, at 806.

99. *Id.*

100. *Id.*

101. *Id.*

A. Placement and Protection

Some PREA standards are specifically directed at the placement and protection of transgender inmates.¹⁰² For example, prison facilities are required to allow transgender and intersex inmates the opportunity to shower separately from other inmates.¹⁰³ Additionally, placement concerns were addressed by requiring agencies to consider the housing of transgender inmates on a case-by-case basis to ensure that they are placed in a safe environment.¹⁰⁴ When making these housing decisions, prison officials are required to give serious consideration to a transgender inmate's own views regarding his or her safety, and to reassess each transgender inmate's placement and programming at least twice each year.¹⁰⁵

Traditionally, an inmate's external genital anatomy was used to determine their sex classification and placement into either a men's or women's facility.¹⁰⁶ As one prison official summarized: "[a]n inmate with a penis is considered male; one with a vagina is considered female. It doesn't matter whether nature or a surgeon provided the part."¹⁰⁷ In 2016, the Department of Justice specifically rejected this traditional approach by clarifying standard 115.42(e), explaining that "[a]ny written policy or actual practice that assigns transgender or intersex inmates to gender-specific facilities, housing units, or programs based solely on their external genital anatomy violates [PREA]."¹⁰⁸ However, the DOJ recognizes that due to security concerns, deciding where to house a transgender inmate is complicated.¹⁰⁹

B. Security Concerns

The Supreme Court has declared that the "central objective of prison administration [is] safeguarding institutional security."¹¹⁰

102. 28 C.F.R. 115.42 (2012).

103. 28 C.F.R. 115.42(f) (2012).

104. 28 C.F.R. 115.42(c)-(e) (2012).

105. *Id.*

106. Christine Peek, *Breaking Out of the Prison Hierarchy: Transgender Prisoners, Rape, and the Eighth Amendment*, 44 SANTA CLARA L. REV. 1211, 1219 (2004).

107. Sydney Scott, "One Is Not Born, But Becomes a Woman": A Fourteenth Amendment Argument in Support of Housing Male-to-Female Transgender Inmates in Female Facilities, 15 U. PA. J. CONST. L. 1259, 1272 (2013) (quoting Ken Hollen, Assoc. Superintendent, Shelton Corr. Ctr., Wash.).

108. DOJ Bureau of Justice Assistance, *Does a Policy that Houses Transgender or Intersex Inmates Based Exclusively on External Genital Anatomy Violate Standard 115.42(c) & (e)?*, NATIONAL PREA RESOURCE CENTER (Mar. 24, 2016), <https://www.prearesourcecenter.org/node/3927>.

109. *Id.*

110. *Bell v. Wolfish*, 441 U.S. 520, 547 (1979).

The Court explained that “maintaining institutional security and preserving internal order and discipline . . . may require limitation or retraction of the retained constitutional rights of . . . convicted prisoners.”¹¹¹ As such, security considerations become particularly relevant when an inmate claims his or her constitutional rights have been violated, because even if DOC policies and procedures infringe on a constitutional guarantee, security considerations may justify the intrusion.¹¹²

In cases involving transgender inmates, prison officials must balance security concerns against an inmate’s specific needs and requests. For example, when a transgender inmate requests (or has previously undergone) hormone therapy or SRS, prison officials must make a difficult decision regarding where to house the inmate, without exposing the transgender inmate or any other inmate to unacceptable levels of risk or psychological trauma.¹¹³

Similar considerations were involved in *Battista v. Clarke*.¹¹⁴ Sandy Battista, a biologically born male had been convicted of rape and was housed at the Massachusetts Treatment Center for Sexually Dangerous Persons.¹¹⁵ Battista sought an injunction requiring the Massachusetts DOC to provide her with hormone therapy and female clothing.¹¹⁶ The DOC argued that “sexual contacts or assaults by other detainees would be made more likely by female clothing and accessories and the enhancement of breasts due to hormone therapy.”¹¹⁷ The First Circuit acknowledged these security concerns, and recognized that they were important factors to consider.¹¹⁸ The court specifically rejected basing such decisions upon medical judgment alone, stating, “[a]ny professional judgment that decides an issue involving conditions of confinement must embrace security and administration, and not merely medical judgments.”¹¹⁹

Ultimately, the court affirmed the decision of the district court to grant Battista’s injunction.¹²⁰ However, the court implied that its decision might have been different if the DOC had more adequately handled the case by placing greater emphasis on security concerns.¹²¹ Specifically, the court stated that “this would be a much harder case if [the DOC] had proffered a persuasive and untainted professional judgment that—while hormone therapy would help

111. *Id.* at 546–47.

112. *Id.*

113. *See generally* *Battista v. Clarke*, 645 F.3d 449 (1st Cir. 2011).

114. *Id.*

115. *Id.* at 450.

116. *Id.*

117. *Id.* at 451.

118. *Id.* at 454–55.

119. *Id.* at 455 (quoting *Cameron v. Tomes*, 990 F.2d 14, 20 (1st Cir. 1993)).

120. *Battista*, 645 F.3d at 455.

121. *Id.* at 454–55.

Battista—the dangers, security costs and other impediments made it infeasible.”¹²²

Ultimately, determining where to house transsexual inmates presents difficult problems for prison officials, and there are no easy answers.¹²³ However, the expectation that prison officials will follow PREA standards by making housing decisions on a case-by-case basis while also giving serious considering to a transgender inmate’s own views with respect his or her own safety has been made clear.¹²⁴

C. Clothing and Appearance

Concerns over clothing and appearance are not addressed by PREA. Although inmates have a constitutional right to “adequate clothing,”¹²⁵ very few courts have held that transgender prisoners have a constitutional right to wear clothing items that correspond with their stated gender identity.¹²⁶ Often, transgender women held in male prison facilities are denied access to bras and other feminine undergarments, and sometimes not allowed to grow their hair past a certain length.¹²⁷ Likewise, transgender men held in women’s facilities are often expected to keep their face clean-shaven.¹²⁸ These experiences can be psychologically harmful for transgender inmates, and can lead to elevated levels of gender dysphoria.¹²⁹

However, as awareness and understanding of gender dysphoria continues to increase, there appears to be a growing trend

122. *Id.* at 454.

123. See *infra* Part V (discussing potential security concerns, and possible solutions).

124. DOJ Bureau of Justice Assistance, *supra* note 108.

125. *Farmer v. Brennan*, 511 U.S. 825, 832 (1994).

126. See *Konitzer v. Frank*, 711 F. Supp. 2d 874, 908–11 (E.D. Wis. 2010) (finding that denial of inmate’s requests for makeup, women’s undergarments, and facial hair remover may give rise to an Eighth Amendment violation); *Soneeya v. Spencer*, 851 F. Supp. 2d 228, 246 (D. Mass. 2012) (holding that delay in providing female clothing for inmate’s GID treatment constituted deliberate indifference). However, most courts have taken a different stance. See, e.g., *Lopez v. City of New York*, No. 05 Civ. 10321, 2009 WL 229956, at *13 (S.D.N.Y. Jan. 30, 2009) (refusal of inmates request to wear women’s clothing did not violate 14th Amendment); *Nelson v. Anderson*, No. 7:07cv00149, 2007 WL 989980, at *2 (W.D. Va. March 30, 2007) (prison officials violated transgender inmate’s generalized due process rights by forbidding him from drawing his eyebrows on); *Powell v. Cusimano*, 326 F.Supp. 2d 322, 343 (D. Conn. 2004) (rejecting inmate’s equal protection claims concerning prison’s prohibition against hair extensions).

127. AMERICAN CIVIL LIBERTIES UNION & THE NATIONAL CENTER FOR LESBIAN RIGHTS, KNOW YOUR RIGHTS: LAWS, COURT DECISIONS, AND ADVOCACY TIPS TO PROTECT TRANSGENDER PRISONERS 7 (2014), www.aclu.org/files/assets/121414-aclu-prea-kyrs-1_copy.pdf.

128. *Id.*

129. *Id.*

towards allowing transgender inmates to dress and groom themselves consistent with their gender identity.¹³⁰ For example, the King County, Washington jail allows transgender women to order and wear bras and other feminine clothing items made available for female inmates at the commissary.¹³¹ Similarly, in 2012 the Denver, Colorado Sherriff Department implemented policies that allow transgender inmates to wear clothing, groom, and use names and pronouns that are consistent with their gender identity.¹³²

Overall, PREA signifies a substantial shift towards expanded rights and protections for transgender inmates. However, these standards are useless if prison officials fail to implement them.¹³³ Admittedly, trusting prison officials to properly implement PREA may be difficult in light of the Transgender Discrimination Survey, which revealed that it is not uncommon for prison officials to be a source of abuse and harassment for transgender inmates.¹³⁴ However, the DOJ has released training materials acknowledging this concern,¹³⁵ and PREA includes severe disciplinary sanctions for prison staff that violate the Act.¹³⁶ Progress still needs to be made, and transgender inmates remain a highly vulnerable population, but PREA is an important step in the right direction, and slowly but surely, the voices of transgender inmates are being heard.

PART III: THE EIGHTH AMENDMENT AND INMATE MEDICAL CARE

The medical necessity of SRS is fundamental to the decision of whether to grant a transsexual inmate's request for the procedure.¹³⁷ This is due to the manner in which the Supreme Court has interpreted the Eighth Amendment's restriction of cruel and unusual punishment.¹³⁸ The Amendment states: "[e]xcessive bail shall not be required, nor excessive fines imposed, nor cruel and

130. *Id.*

131. *Id.*

132. JODY MARKSAMER & HARPER JEAN TOBIN, *STANDING WITH LGBT PRISONERS: AN ADVOCATE'S GUIDE TO ENDING ABUSE AND COMBATING IMPRISONMENT* 41, 51 (2013), www.transequality.org/sites/default/files/docs/resources/JailPrisons_Resource_FINAL.pdf.

133. For a discussion of the failure of certain courts and detention centers to properly implement PREA to protect vulnerable inmates, see Arkles, *supra* note 95, at 801.

134. Grant et al., *supra* note 35, at 158.

135. DOJ, *Policy Review and Development Guide: Lesbian, Gay, Bisexual, Transgender, and Intersex Persons in Custodial Settings*, NATIONAL PREA RESOURCE CENTER (2013), www.prearesourcecenter.org/sites/default/files/library/lgbtpolicyguideaugust2013.pdf.

136. 28 C.F.R. 115.76 (2012).

137. See Osborne & Lawrence, *supra* note 18, at 1651.

138. See *generally* Farmer v. Brennan, 511 U.S. 825, 834 (1994).

unusual punishments inflicted.”¹³⁹ To determine whether the level of care provided or withheld from an inmate constitutes cruel and unusual punishment, the Supreme Court has developed a two-pronged test.¹⁴⁰ The first prong is an objective standard, requiring that the alleged deprivation be “sufficiently serious.”¹⁴¹ The second prong is a subjective standard, which to be satisfied, requires that prison officials act deliberately indifferent towards a serious risk to an inmate’s health or safety.¹⁴² Both prongs must be satisfied to prevail on an inadequate medical care claim.¹⁴³

A. The Objective Prong

When medical care is at issue, the first prong requires “proof of a serious medical need.”¹⁴⁴ A medical condition or need is objectively serious “if it is one that has been diagnosed by a physician as mandating treatment, or one that is so obvious that even a lay person would easily recognize the necessity for a doctor’s attention.”¹⁴⁵ The objective standard does not create a requirement that inmates receive perfectly tailored medical treatment, or the most cutting-edge treatments available.¹⁴⁶ The Supreme Court has explained that “society does not expect that prisoners will have unqualified access to health care.”¹⁴⁷ In reference to confinement conditions generally, only “deprivations denying the minimal

139. U.S. CONST. AMEND. VIII.

140. *Farmer*, 511 U.S. at 834.

141. *Id.*

142. *Id.* at 834-40; see also James McGrath, *Raising the “Civilized Minimum” of Pain Amelioration for Prisoners to Avoid Cruel and Unusual Punishment*, 54 RUTGERS U. L. REV. 649, 665 (2002).

143. *Kosilek v. Spencer*, 774 F.3d 63, 82 (1st Cir. 2014).

144. *Id.*

145. *Gaudreault v. Salem*, 923 F.2d 203, 208 (1st Cir. 1990); see also e.g., *Monmouth County Correctional Institutional Inmates v. Lanzaro*, 834 F.2d 326, 347 (3d Cir. 1987) (defining serious condition as a condition that “has been diagnosed by a physician as requiring treatment or one that is so obvious that a lay person would easily recognize the necessity for a doctor’s attention.”); *Hunt v. Uphoff*, 199 F.3d 1220, 1224 (10th Cir. 1999) (explaining that a medical need is sufficiently serious “if it is one that has been diagnosed by a physician as mandating treatment or one that is so obvious that even a lay person would easily recognize the necessity for a doctor’s attention.”); *Johnson v. Busby*, 953 F.2d 349 (8th Cir. 1991) (defining serious medical need as “one that has been diagnosed by a physician as requiring treatment, or one that is so obvious that even a layperson would easily recognize the necessity for a doctor’s attention.”). *But see Peralta v. Dillard*, 744 F.3d 1076, 1081 (9th Cir. 2014) (where the court essentially rephrases the *Estelle* standard- defining “serious condition” as a condition which will result in significant injury or the “unnecessary and wanton infliction of pain” if left untreated).

146. E.g., *Kosilek*, 774 F.3d at 82; *United States v. DeCologero*, 821 F.2d 39, 42 (1st Cir. 1987) (“[T]hough it is plain that an inmate deserves adequate medical care, he cannot insist that his institutional host provide him with the most sophisticated care that money can buy.”).

147. *Hudson v. McMillian*, 503 U.S. 1, 9 (1992).

civilized measure of life's necessities are sufficiently grave to form the basis of an Eighth Amendment violation."¹⁴⁸ Lower courts have phrased this standard in different ways.¹⁴⁹ While some have said that the alleged deprivation must be "so inadequate as to shock the conscience,"¹⁵⁰ others have said that prisoners are entitled only to "minimum care."¹⁵¹ Regardless of variations in style, the substance is similar: only "outrageous" deprivations are likely to be remedied.¹⁵²

This is not to say that prison officials satisfy all Eighth Amendment requirements by simply providing *any* form of treatment. The following hypothetical provided by the Fourth Circuit illustrates this point. Imagine a situation in which an inmate suffers a serious injury that "by all objective measures, requires evaluation for surgery."¹⁵³ However, what if prison officials only provided painkillers for the inmate?¹⁵⁴ Would they then "be free to deny him consideration for surgery, immunized from constitutional suit by the fact that they were giving him a painkiller?"¹⁵⁵ The court felt that such minimal treatment would be insufficient, and concluded, "although . . . a prisoner does not enjoy a constitutional right to the treatment of his or her choice, the treatment a prison facility does provide must nevertheless be adequate to address the prisoner's serious medical need."¹⁵⁶ Ultimately, prison officials must provide treatments that are compatible with the "evolving standards of decency that mark the progress of a maturing society."¹⁵⁷

B. The Subjective Prong

To satisfy the second prong, an inmate must show that prison officials acted deliberately indifferent towards a serious risk to the inmate's health or safety.¹⁵⁸ The "serious risk" requirement may be

148. *Id.*

149. *See generally* Carl T. Drechsler, Annotation, *Relief Under Federal Civil Rights Acts to State Prisoners Complaining of Denial of Medical Care*, 28 A.L.R. Fed. 279 (2017) (discussing the variations of this standard in a slightly different context).

150. *E.g.*, *Kosilek*, 774 F.3d at 83 (quoting *Torraco v. Maloney*, 923 F.2d 231, 235 (1st Cir. 1991)).

151. *Maggert v. Hanks*, 131 F.3d 670, 672 (7th Cir. 1997).

152. *See generally* Drechsler, *supra* note 149 (discussing the variations of this standard in a slightly different context).

153. *De'Lonta v. Johnson*, 708 F.3d 520, 526 (4th Cir. 2013).

154. *Id.*

155. *Id.*

156. *Id.*

157. *Estelle v. Gamble*, 429 U.S. 97, 102-03 (1976) (internal citations omitted).

158. *Farmer v. Brennan*, 511 U.S. 825, 834-40 (1994); *see also* McGrath, *supra* note 142, at 665.

satisfied by a clear risk that future harm may occur.¹⁵⁹ Seminal cases involved in the development of this test include *Estelle v. Gamble*¹⁶⁰ and *Farmer v. Brennan*.¹⁶¹ *Estelle* established the “deliberate indifference” standard, which the Supreme Court further clarified in *Farmer*.¹⁶²

Estelle involved an inmate housed in a Texas correctional facility who sustained a back injury while performing prison work.¹⁶³ He claimed prison officials failed to provide adequate medical treatment following his injury, thereby violating the Eighth Amendment.¹⁶⁴ In recounting the history of the Amendment’s restriction of cruel and unusual punishment, the Court stated that punishments involving “the unnecessary and wanton infliction of pain” are repugnant to the Eighth Amendment,¹⁶⁵ and “deliberate indifference to serious medical needs of prisoners constitutes the unnecessary and wanton infliction of pain.”¹⁶⁶

However, the Court ultimately held that the prison officials’ conduct did not rise to the level of deliberate indifference.¹⁶⁷ Prison doctors had diagnosed Estelle with a lower back strain, and proscribed pain relievers, muscle relaxants and bed rest.¹⁶⁸ Although there were additional diagnostic techniques and treatments that could have been pursued, the Court viewed this as “a classic example of a matter for medical judgment,” and added “[a] medical decision not to order an X-ray, or like measures, does not represent cruel and unusual punishment.”¹⁶⁹

Following *Estelle*, lower courts struggled to determine exactly what constituted “deliberate indifference” and developed inconsistent tests for the standard.¹⁷⁰ In *Farmer*, the Supreme Court attempted to alleviate this confusion by adopting a subjective awareness standard.¹⁷¹ For deliberate indifference to be established, an inmate must show that prison officials have a “sufficiently culpable state of mind.”¹⁷² In other words, the

159. See *Helling v. McKinney*, 509 U.S. 25, 35 (1993) (“[P]etitioners have, with deliberate indifference . . . pose[d] an unreasonable risk of serious damage to his future health.”).

160. *Estelle*, 429 U.S. at 97.

161. *Farmer*, 511 U.S. at 825; McGrath, *supra* note 142, at 663-66.

162. *Id.*

163. *Estelle*, 429 U.S. at 98.

164. *Id.* at 101.

165. *Id.* at 102-03 (internal citations omitted).

166. *Id.* at 104 (internal citations omitted).

167. *Id.* at 107-08.

168. *Id.* at 107.

169. *Id.*

170. *Farmer v. Brennan*, 511 U.S. 825, 832 (1994); see also McGrath, *supra* note 142, at 664.

171. *Farmer*, 511 U.S. at 832; see also McGrath, *supra* note 142, at 664.

172. *Farmer*, 511 U.S. at 834.

subjective standard requires that the prison officials “knew of and disregarded an excessive risk to inmate health and safety.”¹⁷³

One additional consideration under the subjective prong is the security concerns of prison officials.¹⁷⁴ As noted above, the Supreme Court has held that even if institutional restrictions infringe upon constitutional rights, the infringement must be evaluated in light of “the central objective of prison administration, [which is] safeguarding institutional security.”¹⁷⁵ Ultimately, as long as prison officials “make judgments balancing security and health concerns that are within the realm of reason and made in good faith, their decisions do not amount to a violation of the Eighth Amendment.”¹⁷⁶

C. *The Test Applied: Kosilek v. Spencer*

Michelle Kosilek, an anatomically male prisoner who self-identifies as female, was convicted of first-degree murder in 1992 for the strangulation of her wife, and was sentenced to life in prison without parole.¹⁷⁷ Since 1994, Kosilek has been held in a medium-security male prison in Massachusetts.¹⁷⁸ While awaiting trial for her wife’s murder, Kosilek made two suicide attempts, and on one occasion attempted self-castration, but abandoned the endeavor when it became painful.¹⁷⁹ Kosilek initially received only “supportive therapy” and filed her first lawsuit seeking expanded treatment for gender dysphoria in 1992.¹⁸⁰ In 2002, a federal district court issued a decision making it clear that the Massachusetts DOC needed to provide additional treatment for Kosilek’s condition.¹⁸¹ Accordingly, her treatment was expanded in 2003 to include additional ameliorative measures, such as hormonal treatment and the provision of female clothing.¹⁸²

Following this expansion of treatment, Kosilek continued to seek SRS.¹⁸³ After receiving input from numerous medical experts, the DOC decided it would not provide her with the procedure.¹⁸⁴ In 2006, another trial commenced in federal district court, which culminated in the granting of Kosilek’s injunction for SRS in

173. McGrath, *supra* note 142, at 665.

174. *See* Kosilek v. Spencer, 774 F.3d 63, 92 (1st Cir. 2014) (quoting Bell v. Wolfish, 441 U.S. 520, 547 (1979)).

175. *Wolfish*, 441 U.S. at 546-47.

176. *Kosilek*, 774 F.3d at 92 (quoting Battista v. Clarke, 645 F.3d 449, 454 (1st Cir. 2011)).

177. *Kosilek*, 774 F.3d at 68-69.

178. *Id.* at 69.

179. *Id.*

180. *Id.*

181. *Id.*

182. *Id.* at 69-70.

183. *Kosilek v. Spencer*, 740 F.3d 733 (1st Cir. 2014), *withdrawn*, *Kosilek v. Spencer*, No. 12-2194, 2014 U.S. App. LEXIS 2660, at *3 (1st Cir. Feb. 12, 2014).

184. *Kosilek*, 774 F.3d at 70–74.

2012.¹⁸⁵ The DOC appealed, and in 2014, a three-judge First Circuit panel [hereinafter *Kosilek I*] upheld the district court's decision.¹⁸⁶ Shortly thereafter, the First Circuit withdrew its opinion, and reheard the case en banc [hereinafter *Kosilek II*].¹⁸⁷ A comparison between these two First Circuit decisions—*Kosilek II* and the withdrawn opinion that it supersedes—demonstrates the impact that the WPATH Standards of Care have when a court considers them to be authoritative rather than flexible guidelines.¹⁸⁸

1. The Objective Prong

That gender dysphoria should be considered an objectively serious medical condition was not disputed in *Kosilek*.¹⁸⁹ Rather, the parties disagreed over whether SRS was a medically necessary component of Kosilek's treatment—"such that any course of treatment not including surgery [was] constitutionally inadequate."¹⁹⁰ Kosilek argued that the only "constitutionally sufficient treatment regimen" was full adherence to the Standards of Care.¹⁹¹ She emphasized the fact that doctors from two separate institutions—both of whom were hired by the Massachusetts DOC—testified that SRS was "medically necessary" and that denial of SRS "would almost certainly lead to a deterioration in Kosilek's mental state and a high likelihood of self-harming behaviors."¹⁹²

Conversely, the DOC argued that full progression through the Standards of Care treatment sequence "is not the only adequate treatment option" and that Kosilek's condition could be appropriately managed with a treatment plan that did not include SRS.¹⁹³ This alternative treatment plan provided Kosilek with "such alleviative measures as psychotherapy, hormones, electrolysis, and the provision of female garb and accessories."¹⁹⁴ In support of this alternative treatment plan, the DOC relied upon the advice of accredited medical professionals and claimed that such treatment "far exceeds a level of care that would be so inadequate as to shock the conscience."¹⁹⁵ The DOC further noted that in practice, their treatment plan had "greatly diminished Kosilek's mental distress and allowed her a fair measure of contentment."¹⁹⁶

185. *Id.* 74-82.

186. *Kosilek*, 740 F.3d at 736, *withdrawn*.

187. *Kosilek*, 774 F.3d at 63.

188. *Compare Kosilek*, 774 F.3d *with Kosilek*, 740 F.3d, *withdrawn*. For a discussion of the WPATH Standards of Care, see *infra* Part I.

189. *Kosilek*, 774 F.3d at 86.

190. *Id.*

191. *Id.*

192. *Id.*

193. *Id.*

194. *Id.*

195. *Id.* (internal quotation marks and citations omitted).

196. *Id.*

A notable point of difference between *Kosilek I* and *Kosilek II* is the contrasting views the courts held of testimony provided by Dr. Chester Schmidt, a licensed psychiatrist and Associate Director of the Johns Hopkins School of Medicine.¹⁹⁷ Dr. Schmidt testified on behalf of the DOC that he believed its treatment plan, which did not include SRS, was adequate.¹⁹⁸ Dr. Schmidt viewed the Standards of Care “as protocols or guidelines” and did not agree with the claim that “sex reassignment surgery is medically necessary in patients with severe gender identity disorder.”¹⁹⁹ The district court that initially granted Kosilek’s injunction rejected Dr. Schmidt’s views.²⁰⁰ It concluded he was “not a prudent professional” because “he does not accept certain fundamental features of the Standards of Care.”²⁰¹

In *Kosilek I*, the court began its review of the objective prong with a consideration of the lower court’s rejection of Dr. Schmidt.²⁰² It did not believe this determination constituted “clear error,” which was the standard of review it employed.²⁰³ The court supported this conclusion by noting, “Dr. Schmidt expressed a good deal of disagreement with the Standards of Care.”²⁰⁴ Additionally, his views regarding the medical necessity of SRS were “not only unsupported by the Standards of Care but also contradicted by the testimony of the other medical providers at trial.”²⁰⁵ By dismissing Dr. Schmidt’s testimony as imprudent, the court was left with a majority of testifying medical experts who offered support for the Standards of Care and believed SRS was a medically necessary procedure for Kosilek.²⁰⁶ Ultimately, the court believed that since there were “three eminently qualified doctors [who] testify without objection, in accord with widely accepted, published standards, that Kosilek suffers from a life-threatening disorder that renders surgery medically necessary” then it could not overrule the lower court’s finding that an objectively serious deprivation had occurred.²⁰⁷

To the contrary, the *Kosilek II* majority believed the lower court’s dismissal of Dr. Schmidt’s testimony was “based on several

197. Compare *Kosilek*, 774 F.3d at 63 (refusing to dismiss Dr. Schmidt’s testimony), with *Kosilek v. Spencer*, 740 F.3d 733 (1st Cir. 2014) (dismissing Dr. Schmidt’s testimony as imprudent), *withdrawn*, *Kosilek v. Spencer*, No. 12-2194, 2014 U.S. App. LEXIS 2660, at *3 (1st Cir. Feb. 12, 2014).

198. *Kosilek*, 774 F.3d at 191.

199. *Kosilek*, 740 F.3d at 748, *withdrawn*.

200. *Kosilek v. Spencer*, 889 F. Supp. 2d 190, 235 (D. Mass. 2012), *rev’d en banc*, *Kosilek*, 774 F.3d 63.

201. *Kosilek*, 889 F. Supp. 2d at 235–36, *rev’d en banc*, *Kosilek*, 774 F.3d 63.

202. *Kosilek*, 740 F.3d at 763, *withdrawn*.

203. *Id.* at 761-764.

204. *Id.* at 763.

205. *Id.* at 764.

206. *Id.* at 764-66.

207. *Id.* at 763, 766.

erroneous determinations.”²⁰⁸ First, the majority took issue with the amount of deference the lower court gave to the Standards of Care, pointing out that the document itself admits that “significant flexibility in their interpretation and application” is proper.²⁰⁹ Additionally, the lower court’s own court-appointed expert testified that the Standards of Care was a “consensus document” forged together through a political process, and that Dr. Schmidt’s views, “however unpopular and uncompassionate in the eyes of some experts . . . is within prudent professional community standards.”²¹⁰ The appointed expert further explained that “[t]reatment stopping short of SRS would be considered adequate by many psychiatrists . . . [and] patients themselves.”²¹¹

The *Kosilek II* majority believed that the central question was whether the decision not to provide SRS was “sufficiently harmful . . . so as to violate the Eighth Amendment.”²¹² The court expressed concern over the potential risk of increased suicidality following denial of SRS, and it agreed with *Kosilek* that a “clear risk of future harm may suffice to sustain an Eighth Amendment claim.”²¹³ However, it found that the DOC’s treatment plan accounted for *Kosilek*’s needs and utilized “methods proven to alleviate *Kosilek*’s mental distress while crafting a plan to minimize the risk of future harm.”²¹⁴ *Kosilek* herself admitted that the current level of treatment had led to a “significant stabilization in her mental state,” and her doctors confirmed that admission.²¹⁵ Accordingly, the majority believed the lower court had “unduly minimize[d] the nature of the DOC’s preferred treatment plan,”²¹⁶ finding that “the DOC has chosen one of two alternatives—both of which are reasonably commensurate with the medical standards of prudent professionals, and both of which provide *Kosilek* with a significant measure of relief.”²¹⁷ Thus, the DOC’s refusal to provide SRS did not violate the Eighth Amendment.²¹⁸

2. The Subjective Prong

Although the *Kosilek II* majority determined that *Kosilek*’s constitutional claim failed because she did not satisfy the objective prong, the court still analyzed the relevant facts under the

208. *Kosilek v. Spencer*, 774 F.3d 63, 86–87 (1st Cir. 2014).

209. *Id.* at 87.

210. *Id.*

211. *Id.*

212. *Id.* at 89.

213. *Id.* at 90.

214. *Id.*

215. *Id.*

216. *Id.* at 89.

217. *Id.* at 90.

218. *Id.*

subjective prong.²¹⁹ It held that this standard presented another burden that Kosilek could not meet.²²⁰ Even if Kosilek could have shown that SRS was the only adequate treatment option, she would have also needed to show that “the DOC was—and continue[d] to be—deliberately indifferent to her serious risk of harm.”²²¹ Effectively, this would require Kosilek to establish that the prison officials knew (or should have known) that SRS was the only adequate treatment for her condition, and still failed to provide the procedure.²²² This was not the case. Because the DOC sought opinions from multiple medical experts, and received alternative treatment plans, “each developed . . . to mitigate the severity of Kosilek’s mental distress,” its choice to not provide SRS did not rise to the level of deliberate indifference.²²³ Ultimately, the majority recognized that although the DOC’s treatment plan was “disfavored by some in the field,” it was still developed by competent medical professionals, and therefore, the denial of Kosilek’s request did not “exhibit a level of inattention or callousness . . . rising to a constitutional violation.”²²⁴

The majority also criticized the lower court for ignoring the DOC’s stated security concerns.²²⁵ It explained that it “takes no great stretch of the imagination” to recognize that housing a post-operative male-to-female transsexual in a male facility could create security concerns.²²⁶ Likewise, housing Kosilek, a biologically born male who had been convicted of murdering his wife, in a women’s facility could also present significant concerns—especially due to the fact that women’s prison facilities often contain a high number of domestic violence survivors.²²⁷

Ultimately, the DOC’s security concerns were found to be reasonable.²²⁸ According to the majority, the lower court failed to give proper deference to the prison officials’ judgment and improperly relied upon its own beliefs.²²⁹ The prison officials had decades of combined experience in the management of penological institutions and were therefore much better suited to make security determinations than the court.²³⁰ As such, the majority provided a

219. *Id.* at 91.

220. *Id.*

221. *Id.*

222. *Id.*

223. *Id.* at 91-92.

224. *Id.*

225. *Id.* at 92-96.

226. *Id.* at 93.

227. *Id.*

228. *Id.* at 93-96.

229. *Id.*

230. *Id.* at 94.

wide level of deference to the prison officials' judgment, and reversed the decision of the lower court.^{231 232}

PART IV: RECENT DEVELOPMENTS

Legal battles involving medical care for transgender inmates have been occurring for decades.²³³ Often, these cases involved a fight to have gender dysphoria recognized as a serious medical condition, and efforts to receive treatment, such as hormone therapy.²³⁴ Progress has at times been slow, but today, many of these battles have been won in courts throughout the country.²³⁵ While efforts to receive SRS have generally been futile,²³⁶ recent events suggest a shift in American law, policy, and opinion that could benefit transsexual inmates seeking SRS.

First, in May of 2014, the U.S. Department of Health and Human Services [HHS] announced that its prior policy, which banned the use of Medicare funding for SRS, was based upon outdated science, and was therefore invalidated.²³⁷ This makes it

231. *Id.* at 93-96.

232. The ultimate result of the *Kosilek* saga aligns with the Supreme Court's reluctance to second-guess a doctor's decision regarding "matter[s] for medical judgment." *Estelle v. Gamble*, 429 U.S. 97, 107 (1976). However, medical testimony may at times warrant second-guessing. While there is no set formula for determining exactly when a medical expert's testimony is outside the bounds of professional prudence, drawing from the standard the Supreme Court has established to govern the admissibility of expert testimony may be beneficial. In *Daubert v. Merrell Dow Pharmaceuticals*, the Court explained that judges play a "gatekeeping role," ensuring that scientific evidence meets a certain standard of reliability before it is admitted at trial. 509 U.S. 579, 597 (1993). The stated goal of this standard is to "ensure that any and all scientific testimony . . . is not only relevant, but reliable." *Id.* at 589. In doing so, a court should not only analyze "what the experts say, but what basis they have for saying it." *Daubert v. Merrell Dow Pharms.*, 43 F.3d 1311, 1316 (9th Cir. 1995). This standard may serve as a useful analytical framework in this setting as well, because ultimately, if an expert's testimony would be considered admissible under a *Daubert* analysis, then it follows that there is some reasonable basis for the expert's position.

233. For a more comprehensive discussion of the history of transgender inmates seeking expanded rights to medical care, see Drechsler, *supra* note 149; see also Kayleigh Smith, *Free to Be Me: Incorporating Transgender Voices into the Development of Prison Policies*, 15 HOUS. J. HEALTH L. & POL'Y 253, 263-73 (2015); Travis Wright Colopy, *Note: Setting Gender Identity Free: Expanding Treatment for Transsexual Inmates*, 22 HEALTH MATRIX 227, 252-58 (2012); Dan Schneider, *Decency, Evolved: The Eighth Amendment Right to Transition in Prison*, 2016 WIS. L. REV. 835, 845-48 (2016).

234. See generally Drechsler, *supra* note 149; Smith, *supra* note 233, at 263-73; Colopy, *supra* note 233, at 252-58; Schneider, *supra* note 233, at 845-48.

235. See Smith, *supra* note 233, at 263-73; see Susan S. Bendlin, *Gender Dysphoria in the Jailhouse: A Constitutional Right to Hormone Therapy*, 61 CLEV. ST. L. REV. 957, 962-68 (2013).

236. See generally Drechsler, *supra* note 149.

237. National Center for Transgender Equality, *Know Your Rights: Medicare*, NATIONAL CENTER FOR TRANSGENDER EQUALITY, www.transequalit

possible for transsexual individuals receiving Medicare services to have the costs of SRS covered.²³⁸ However, this does not function as a blanket approval policy.²³⁹ Rather, deciding whether to fund SRS will be made on a case-by-case basis, like all other services covered under Medicare.²⁴⁰

Similarly, in May of 2016, HHS implemented new provisions to the Affordable Care Act that, amongst other changes, prohibit discrimination on the basis of sex—which was defined to include discrimination based upon gender identity.²⁴¹ Transgender rights activists celebrated this provision as a groundbreaking step towards adequately protecting those affected by gender dysphoria.²⁴² However, on December 31, 2016, the U.S. District Court for the Northern District of Texas issued an injunction on religious liberty grounds prohibiting HHS from enforcing the provision as it relates to issues of gender identity and abortion.²⁴³ Due to this ongoing litigation, as well as the uncertain future of the Affordable Care Act,²⁴⁴ the fate of this provision is unclear. While it does not directly involve incarcerated individuals, it highlights the continued political shift towards expanded rights for the transgender population.

In 2015 a federal district court ordered the California DOC to provide Michelle Norsworthy, a transsexual inmate, with SRS.²⁴⁵ As in *Kosilek I and II*, the court's opinion of the Standards of Care played an important role in its decision. The court noted that the conclusions of the DOC's medical expert were "at odds with the Standards of Care" which "are recognized as authoritative standards of care by the American Medical Association."²⁴⁶ Further, the court believed Norsworthy was likely to succeed on her

y.org/know-your-rights/medicare (last visited Jan. 20, 2017).

238. *Id.*

239. *Id.*

240. *Id.*

241. See Zack Ford, *New Obamacare Regulations Ensure Transgender People's Access To Health Care*, THINKPROGRESS (Sept. 3, 2015), <https://thinkprogress.org/new-obamacare-regulations-ensure-transgender-peoples-access-to-health-care-d3a703a0c2a6#.nypactvrq>. For information regarding the implementation schedule of the provision, as well as its current status, see U.S. Department of Health & Human Services, *Section 1557 of the Patient Protection and Affordable Care Act*, HHS.GOV, www.hhs.gov/civil-rights/for-individuals/section-1557/index.html (last visited Jan. 20, 2017).

242. Ford, *supra* note 241.

243. U.S. Department of Health & Human Services, *supra* note 241; see also American Civil Liberties Union, *Franciscan Alliance v. Burwell*, AMERICAN CIVIL LIBERTIES UNION, www.aclu.org/cases/franciscan-alliance-v-burwell (last updated Jan. 9, 2017).

244. See Margot Sanger-Katz, *What Does Trump's Executive Order Against Obamacare Actually Do?*, N.Y. TIMES: THE UPSHOT (Jan. 21, 2017), www.nytimes.com/2017/01/21/upshot/what-does-the-order-against-the-health-law-actually-do.html?_r=0 (discussing the uncertain future of the Affordable Care Act).

245. *Norsworthy v. Beard*, 87 F. Supp. 3d 1164, 1195 (N.D. Cal. 2015).

246. *Id.* at 1190.

deliberate indifference claim because “[d]espite access to the relevant Standards of Care and evidence that SRS was medically necessary for Norsworthy, Defendants failed to provide her with SRS, or to refer her to a specialist for further evaluation.”²⁴⁷

This case was appealed to the Ninth Circuit; however, one day prior to the scheduled oral arguments, Norsworthy was paroled and the Ninth Circuit dismissed the case as moot.²⁴⁸ Regardless, the decision still made a significant impact. Later that same year the State of California settled a claim with Shiloh Quine, an inmate convicted of first-degree murder, who had been incarcerated since 1980.²⁴⁹ California conceded that Quine suffered from severe gender dysphoria, and that SRS was a medically necessary procedure in her case.²⁵⁰ In doing so, California became the first state to agree to pay for a transgender inmate’s SRS.²⁵¹ Following her procedure, Quine will be moved to a women’s prison facility.²⁵² While a settlement agreement is not precedential, Ilona Turner, the legal director of the Transgender Law Center in Oakland, which handled both Norsworthy and Quine’s cases, stated that she believes the decisions “clearly [mark] where the law is going and where the entire health industry is going.”²⁵³

Finally, in 2016, the Department of Defense overturned its ban of transgender individuals serving in the military.²⁵⁴ The new policy made it clear that service members would be allowed to transition genders.²⁵⁵ Prior to this change, service members who received gender transition services were discharged.²⁵⁶ Earlier that year, the United States Army granted a request for hormone therapy from Chelsea Manning, a transsexual inmate who had been sentenced to thirty-five years in prison for leaking classified government files while serving in the United States Army.²⁵⁷ Shortly thereafter, SRS was recommended for Manning, and the Army indicated that it planned to move forward with that recommendation.²⁵⁸ However, in January of 2017, former President Barack Obama commuted the remainder of Manning’s sentence, moving her release date up to

247. *Id.* at 1189-90.

248. *Norsworthy v. Beard*, 802 F.3d 1090 (9th Cir. 2015).

249. Paige St. John, *In a First, California Agrees to Pay for Transgender Inmate’s Sex Reassignment*, L.A. TIMES (Aug. 10, 2015, 3:30 AM), www.latimes.com/local/california/la-me-inmate-transgender-20150810-story.html.

250. *Id.*

251. *Id.*

252. *Id.*

253. *Id.*

254. Jonah Engel Bromwich, *Chelsea Manning Told She Can Have Gender Reassignment Surgery, Lawyer Says*, N.Y. TIMES (Sept. 13, 2016), www.nytimes.com/2016/09/14/us/chelsea-manning-told-she-can-have-gender-reassignment-surgery-lawyer-says.html.

255. *Id.*

256. *Id.*

257. *Id.*

258. *Id.*

May 2017.²⁵⁹ After her release, the military was no longer responsible for Manning's medical care, and SRS was not provided.²⁶⁰

The military's stance on transgender service members was once again thrust into the forefront of national news on July 26, 2017 when President Donald Trump announced his intention to reinstate the ban on transgender individuals serving "in any capacity in the U.S. Military."²⁶¹ This announcement was immediately met with backlash and protests nationwide, and the fate of the potential policy remains unknown.²⁶²

While these recent trends and events are not binding upon prison facilities throughout the country, they do signal potential change on the horizon. Where courts, such as *Kosilek II*, have indicated that SRS was not the only medically adequate treatment available for inmates suffering from severe gender dysphoria, these recent developments indicate that both medical and social trends increasingly support the notion that SRS is an effective and sometimes necessary treatment for transsexual individuals.

PART V: DISCUSSION

Despite the recent shift towards expanded rights and protections for transsexual individuals, prison officials do not violate the Eighth Amendment by simply refusing a transsexual inmate's request for SRS. Treatment plans that lack the procedure—but still treat the underlying condition—remain constitutionally sufficient if the plan is supported by a qualified medical professional acting in good faith. Arguments to the contrary misconstrue Eighth Amendment requirements and ignore serious problems with the available body of research that has assessed the efficacy of the procedure.

Additionally, prison officials are provided "wide-ranging deference" in making decisions that affect the security and safety of inmates under their care.²⁶³ The placement and protection of transsexual inmates presents challenging issues with no easy answers.²⁶⁴ Providing an inmate with SRS could create further

259. Charlie Savage, *Chelsea Manning to Be Released Early as Obama Commutes Sentence*, N.Y. TIMES (Jan. 17, 2017), www.nytimes.com/2017/01/17/us/politics/obama-commutes-bulk-of-chelsea-mannings-sentence.html.

260. *Id.*

261. President Donald J. Trump (@realDonaldTrump), TWITTER (July 26, 2017, 6:04 AM), <https://twitter.com/realdonaldtrump/status/890196164313833472?lang=en>.

262. Karma Allen, *Protests Erupt Nationwide Following Trump's Transgender Military Ban Announcement*, ABC NEWS (July 27, 2017), <http://abcnews.go.com/US/protesters-rally-trumps-transgender-military-ban/story?id=48876355>.

263. *Bell v. Wolfish*, 441 U.S. 520, 547 (1979).

264. *See supra* Part II (discussing challenges faced by transsexual inmates,

complications.²⁶⁵ Ultimately, due to the uncertainty that continues to surround the efficacy of SRS, coupled with the substantial security considerations that could arise following the procedure, prison officials do not violate the Eighth Amendment by simply denying a transsexual inmate's request for SRS. A closer analysis under the Supreme Court's two-pronged test confirms this conclusion.

A. *The Test Applied*

The first prong is an objective standard that requires a "sufficiently serious" deprivation of medical care.²⁶⁶ The second prong is a subjective standard that is only met if prison officials act deliberately indifferent towards a serious risk to an inmate's health or safety.²⁶⁷ Both prongs must be satisfied to prevail on an inadequate medical care claim.²⁶⁸

1. *The Objective Prong*

The first prong requires "proof of a serious medical need."²⁶⁹ A medical condition or need is objectively serious "if it is one that has been diagnosed by a physician as mandating treatment, or one that is so obvious that even a lay person would easily recognize the necessity for a doctor's attention."²⁷⁰ The Supreme Court has not yet heard a case in which it specifically identified gender dysphoria as a serious medical condition.²⁷¹ However, multiple lower courts throughout the country have found that it meets the requisite criteria.²⁷² Admittedly, there remains disagreement within the medical community over whether transsexualism is anything more than a mental illness,²⁷³ and the cause of the condition remains shrouded in uncertainty.²⁷⁴ However, this is unlikely to prevent a court from viewing transsexualism as a serious medical condition

as well as challenges that such inmates may present for prison officials).

265. See *infra* Part V(A)(2)(a) (discussing potential security concerns that could arise following an inmate receiving SRS).

266. *Farmer v. Brennan*, 511 U.S. 825, 834 (1994).

267. *Id.* at 834-40 (1994); see also McGrath, *supra* note 142, at 665.

268. *Kosilek v. Spencer*, 774 F.3d 63, 82 (1st Cir. 2014).

269. *Id.*

270. *Supra* note 142.

271. See Smith, *supra* note 233, at 263 (discussing relevant cases throughout the country, and identifying courts without relevant precedent or where the results have been "foggy").

272. *Id.* at 263-73.

273. McHugh, *supra* note 16.

274. See Elizabeth R. Boskey, *Understanding Transgender Identity Development in Childhood and Adolescence*, 9 AM. J. SEXUALITY EDUC., 445, 451-53 (2014).

because the Supreme Court has held that unreasonable risk of future harm can sustain an inmate's Eighth Amendment claim.²⁷⁵

Such risk is present here. Many transsexual individuals report that they have attempted suicide,²⁷⁶ and if gender dysphoria is left untreated, suicide rates can increase dramatically.²⁷⁷ Surely a substantially increased risk that an inmate will commit suicide could be considered an unreasonable risk of future harm—and indeed, lower courts have found that to be the case.²⁷⁸ However, this test is a fact-specific inquiry,²⁷⁹ so presumably, a court may not view the condition as objectively serious if the inmate does not manifest severe symptoms, such as suicidal ideation, or if the court finds the inmate's claims regarding symptoms to be falsified.

a. The Medical Necessity of SRS

The next question under the first prong is whether SRS is a necessary treatment for severe gender dysphoria—such that denial of the procedure violates a prisoner's Eighth Amendment rights.²⁸⁰ While inmates are not entitled to receive the most cutting-edge treatments available, prison officials must provide care that aligns with evolving standards of decency.²⁸¹

However, no clear test exists for determining when medical treatment meets this threshold. While the testimony of medical experts is certainly an important consideration, these cases typically involve competing medical opinions.²⁸² As a result, the court must determine whether one expert's opinion is clearly right, or if there is room for reasonable experts to disagree.²⁸³ However, this is a challenging task because judges are not medical experts themselves.²⁸⁴ While the court may appoint its own independent

275. *Helling v. McKinney*, 509 U.S. 25, 35 (1993).

276. Grant et al., *supra* note 35, at 82.

277. Sylvia Rivera Law Project, *supra* note 14, at 28.

278. *E.g.*, *Kosilek v. Spencer*, 774 F.3d 63, 90 (1st Cir. 2014).

279. *E.g.*, *Miller v. Calhoun County*, 408 F.3d 803 (6th Cir. 2005); *Waldrop v. Evans*, 871 F.2d 1030, 1034 (11th Cir. 1989).

280. *See Kosilek*, 774 F.3d at 86 (“That GID is a serious medical need, and one which mandates treatment, is not in dispute in this case. . . . Rather, the parties disagree over whether SRS is a medically necessary component of Kosilek's care, such that any course of treatment not including surgery is constitutionally inadequate.”).

281. *Estelle v. Gamble*, 429 U.S. 97, 102-03 (1976) (internal citations omitted).

282. *E.g.*, *Kosilek*, 774 F.3d at 74-79.

283. *Cf. Id.*; *Bismark v. Fisher*, 213 F. App'x 892, 897 (11th Cir. 2007) (“Nothing in our case law would derive a constitutional deprivation from a prison physician's failure to subordinate his own professional judgment to that of another doctor”); *Estate of Cole by Pardue v. Fromm*, 94 F.3d 254, 261 (7th Cir. 1996); *Bowring v. Godwin*, 551 F.2d 44, 48 (4th Cir. 1977).

284. *See Adam B. Badawi, Influence Costs and the Scope of Board Authority*, 39 IOWA J. CORP. L. 675, 706 (2014) (“[T]here are plenty of fields where judges do not have expertise where they are perfectly comfortable second-guessing

expert, this does not insulate its decision against reversal.²⁸⁵ The lower court in *Kosilek* appointed an independent expert, but still made the “significantly flawed inferential leap” of relying upon its “own— non-medical —judgment.”²⁸⁶

Applying an objective analytical framework, such as the Supreme Court’s *Daubert*²⁸⁷ standard, may help a court remain objective, and reach reliable conclusions.²⁸⁸ The purpose of the *Daubert* standard is to “ensure that any and all scientific testimony . . . is not only relevant, but reliable.”²⁸⁹ While it was designed to govern the admissibility of expert testimony, it is a logical and natural fit in this setting as well. Courts are encouraged to examine “whether the theory or technique employed by the expert is generally accepted in the scientific community; whether it’s been subjected to peer review and publication; whether it can be and has been tested; and whether the known or potential rate of error is acceptable.”²⁹⁰ However, these factors are illustrative rather than exhaustive.²⁹¹ Essentially, a court is supposed to objectively analyze not only “what the experts say, but what basis they have for saying it.”²⁹²

However, this is not a recommendation for independent judicial investigation. Such activity remains highly controversial.²⁹³ Rather, this is suggested only as an objective analytical framework to help courts determine if an expert’s medical testimony falls outside the bounds of professional prudence. If parties to the suit do not present all information needed for such an analysis, the court may appoint an independent expert to fill the remaining gaps.²⁹⁴

decisions. Perhaps the most prominent example is the medical field. Judges are not medical experts . . .”).

285. See *e.g.*, *Kosilek*, 774 F.3d at 88 (where a lower court’s decision was reserved, even though the lower court heard testimony from a court-appointed expert).

286. *Id.* at 84-89.

287. *Daubert v. Merrell Dow Pharms., Inc.*, 509 U.S. 579 (1993).

288. *Infra* note 232.

289. *Daubert*, 509 U.S. at 589.

290. *Daubert v. Merrell Dow Pharms., Inc.*, 43 F.3d 1311, 1316 (9th Cir. 1995).

291. *Id.* at 1316-17.

292. *Id.* at 1316.

293. For a discussion of opposing views on independent judicial investigation, as well as an argument for its expanded use, see Edward K. Cheng, *Independent Judicial Research in the Daubert Age*, 56 DUKE L. J. 1263, 1285-1318 (2007).

294. JOE S. CECIL & THOMAS E. WILLGING, FED. JUDICIAL CTR., COURT-APPOINTED EXPERTS: DEFINING THE ROLE OF EXPERTS APPOINTED UNDER FEDERAL RULE OF EVIDENCE 706 12 (1993) (“[E]xperts are most often appointed to assist in understanding technical issues necessary to reach a decision. The desire for such assistance was attributed by the judges to a lack of knowledge in an essential area, a concern over the technical nature of an issue or issues, or a concern over the need to properly articulate the rationale for a decision.”).

b. The Research Examined

It is improper to reject an expert's medical testimony simply because the expert does not view SRS as a medically necessary treatment for severe gender dysphoria. Drawing from *Daubert* and engaging in an objective, independent validation of the conflicting claims regarding SRS reveals considerable room for reasonable experts to disagree.

One suggested consideration under *Daubert* is general acceptance within the relevant professional community.²⁹⁵ In *Norsworthy*, the court rejected the testimony of the DOC's medical expert, finding it to be "at odds with the Standards of Care" which "are recognized as authoritative standards . . . by the American Medical Association."²⁹⁶ However, pointing to acceptance by organizations such as the American Medical Association [AMA] as definitive proof of general acceptance in the medical community is misleading. For example, while the AMA is often touted as "the voice of doctors,"²⁹⁷ in reality, less than twenty percent of physicians in the United States are members of the organization.²⁹⁸ Further, a survey of physicians conducted in 2011 revealed that seventy-seven percent of respondents did not believe the AMA accurately reflected their medical views.²⁹⁹

Additionally, general acceptance in the medical community is not outcome determinative. Rather, it is merely one suggested consideration under *Daubert*.³⁰⁰ Courts should not only analyze "what the experts say, but what basis they have for saying it."³⁰¹ As such, even if a majority of testifying experts claim SRS is medically necessary, the court should still examine the basis of this claim to make sure it is reasonably supported by empirical evidence.³⁰²

In both *Kosilek* and *Norsworthy*, medical experts testified that SRS was an effective and necessary treatment for an inmate with severe gender dysphoria.³⁰³ Much of this testimony relied upon the

295. *Daubert v. Merrell Dow Pharms., Inc.*, 509 U.S. 579, 594 (1993).

296. *Norsworthy v. Beard*, 87 F. Supp. 3d 1164, 1170, 1190 (N.D. Cal. 2015).

297. Linda Girgis, *Is the AMA Really the Voice of Physicians in the US?*, PHYSICIAN'S WEEKLY (June 9, 2015), www.physiciansweekly.com/is-the-ama-really-the-voice-of-physicians-in-the-us/.

298. *Id.*

299. Igor Volsky, *77 Percent Of Doctors Say AMA Does Not Represent Their Views*, THINKPROGRESS (Sept. 7, 2011), <https://thinkprogress.org/77-percent-of-doctors-say-ama-does-not-represent-their-views-7661936dc34>.

300. *Daubert*, 509 U.S. at 588-89, 594 ("Nothing . . . establishes 'general acceptance' as an absolute prerequisite to admissibility.").

301. *Daubert v. Merrell Dow Pharmaceuticals*, 43 F.3d 1311, 1316 (9th Cir. 1995).

302. *See Daubert*, 509 U.S. at 594-95 ("The inquiry envisioned . . . [is] a flexible one. Its overarching subject is the scientific validity—and thus the evidentiary relevance and reliability—of the principles that underlie a proposed submission.").

303. *Kosilek v. Spencer*, 774 F.3d 63, 74-77 (1st Cir. 2014); *Norsworthy v.*

WPATH Standards of Care.³⁰⁴ However, in both cases the DOC presented testimony from experts who believed SRS was not medically necessary.³⁰⁵ In *Kosilek*, the lower court rejected the testimony of the DOC's medical expert, finding his conclusions to be unreasonable because "he [did] not accept certain fundamental features of the Standards of Care."³⁰⁶ Likewise, in *Norsworthy*, the court dismissed the testimony of the DOC's expert because it was "at odds with the Standards of Care."³⁰⁷

Such findings are improper and ignore serious problems with the available body of research that has assessed the efficacy of SRS. If the beneficial effects of SRS are truly "undeniable"—as WPATH claims them to be³⁰⁸—then perhaps a court is justified in dismissing a medical expert as professionally imprudent if his or her proposed treatment plan does not include the procedure.³⁰⁹ However, available outcome studies critically examining SRS leave considerable room for doubt and disagreement on this point. While some studies show optimistic results,³¹⁰ others present conflicting and worrisome outcomes, including reports of "regrets, psychiatric morbidity, and suicide attempts following the procedure."³¹¹

Even favorable research regarding the efficacy of SRS is concerning. The most comprehensive, modern study cited by WPATH in support of its claim that SRS has "undeniable beneficial effects"³¹² includes a startling summary of shortcomings that plague available research.³¹³ This study narrowed its analysis to include only the best, most reliable research conducted after 1990.³¹⁴ Alarming, even when narrowed to this select group the data remained questionable because none of the studies was able to utilize a control group to compare against an experimental group.³¹⁵ Additionally, "sound psychometric instruments were not used;" results were "seriously skewed" because many initial participants were lost at follow-up; and for many of the studies the main outcome variable was not whether SRS effectively reduced gender dysphoria, which means the central question—whether SRS effectively treats

Beard, 87 F. Supp. 3d 1164, 1170, 1185-90 (N.D. Cal. 2015).

304. See *Kosilek*, 774 F.3d at 74-77; *Norsworthy*, 87 F.Supp. 3d at 1185-90.

305. *Kosilek*, 774 F.3d at 74-77; *Norsworthy*, 87 F.Supp. 3d at 1185-90.

306. *Kosilek v. Spencer*, 889 F. Supp. 2d 190, 235 (D. Mass. 2012) *rev'd en banc*, *Kosilek*, 774 F.3d 63.

307. *Norsworthy*, 87 F. Supp. at 1170, 1190.

308. WPATH, *supra* note 41, at 55.

309. See *Kosilek*, 889 F. Supp. at 235-36 (disregarding expert medical testimony because it conflicted with WPATH's Standards of Care), *rev'd en banc*, *Kosilek*, 774 F.3d 63.

310. Gijs & Brewaeys, *supra* note 58, at 199.

311. See Dhejne et al., *supra* note 17, at e16885-1 to e16885-2.

312. WPATH, *supra* note 41, at 55.

313. Gijs & Brewaeys, *supra* note 58, at 199.

314. *Id.*

315. *Id.*

the condition— was left unanswered.³¹⁶ Ultimately, the study reported that 96% of transsexuals who received SRS reported feeling satisfied with the outcome of the procedure.³¹⁷ However, the poor data used to reach this conclusion leaves ample room for skepticism, and the study’s own authors acknowledged that their findings should be “carefully qualified.”³¹⁸

Admittedly, this research was published in 2007.³¹⁹ With a decade having passed, one could hope that more reliable studies have been produced since; and surely a court should look to the best research available when examining the basis of an expert’s claims. However, more recent studies continue to be plagued by similar methodological shortcomings.³²⁰ Until more reliable data is produced, it remains reasonable for medical professionals to view the Standards of Care as flexible guidelines, and prudent for courts to provide medical experts with a significant level of deference. As a result, simply denying an inmate’s request for SRS cannot definitively be considered a “sufficiently serious” deprivation of medical care, and fails to satisfy the first prong of the Supreme Court’s test.

2. *The Subjective Prong*

The subjective prong requires an inmate to show that prison officials acted with deliberate indifference towards a serious risk to the inmate’s health or safety.³²¹ However, because both prongs must be satisfied to succeed on an Eighth Amendment claim,³²² the subjective prong only becomes relevant if a court determines that denial of SRS constitutes an objectively serious deprivation of care, thereby satisfying the first prong.

Consider *Estelle*, where doctors diagnosed the inmate with a lower back strain, and proscribed pain relievers, muscle relaxants

316. *Id.*

317. *Id.*

318. *Id.*

319. *Id.* at 178.

320. See e.g., Jochen Hess et al., *Satisfaction With Male-to-Female Gender Reassignment Surgery*, 111 DEUTSCHES ARZTEBLATT INT’L 795, 800 (2014) (“response rate of less than 50% must be mentioned as a shortcoming of this study. This may have led to a bias in the results.”); Dhejne et al., *supra* note 17, at e16885-2 (explaining the limitations that “preclude solid and generalizable conclusions” regarding the efficacy of SRS, including: the impossibility of performing double blind, randomized controlled studies of SRS; constrained follow-up studies due to a limited number of subjects; high rates of participant drop-out and consequent selection bias; and limited follow-up periods); Murad et al., *supra* note 85, at 214-31 (identifying “serious methodological limitations” as the reason why the current body of research supporting SRS “is of very low quality.”).

321. *Farmer v. Brennan*, 511 U.S. 825, 834-40 (1994); see also *McGrath*, *supra* note 142, at 665.

322. See *Kosilek v. Spencer*, 774 F.3d 63, 82 (1st Cir. 2014).

and bed rest.³²³ Although other treatments could have been pursued, the Court viewed this as “a classic example of a matter for medical judgment,” and did not view a “medical decision not to order an X-ray, or like measures” to constitute deliberate indifference.³²⁴ Similarly, if under the objective prong the court determines that reasonable medical experts may disagree over the necessity of SRS, then a decision to not provide the procedure will likely be viewed the same way: as a matter for medical judgment that does not rise to the level of deliberate indifference.

If a court does determine that denial of SRS is an objectively serious deprivation of care, then denying a transsexual inmate’s request for the procedure comes under much greater scrutiny.³²⁵ Prison officials must either be unaware that denial of the procedure constitutes a serious deprivation of care, or be able to show that sufficient security considerations justify denial of the procedure.³²⁶ However, a lack of knowledge is unlikely to prevent an injunction from being granted, because deliberate indifference “should be determined in light of the prison authorities’ . . . attitudes and conduct at the time suit is brought and [their attitudes and conduct] *persisting thereafter*.”³²⁷ As such, once a court determines denial of SRS constitutes an objectively serious deprivation of care, prison officials involved in the suit can no longer claim ignorance regarding the necessity of the procedure. In this situation, only substantial security considerations can justify a continued refusal to provide SRS.

a. Security Concerns

An objectively serious deprivation of care may be justified if prison officials can show that providing the procedure is likely to create unreasonable risks for the transsexual inmate or for other inmates housed in the same facility.³²⁸ The Supreme Court has explained that “maintaining institutional security and preserving internal order and discipline . . . may require limitation or retraction of the retained constitutional rights of . . . convicted prisoners.”³²⁹ Accordingly, “even when an institutional restriction infringes a specific constitutional guarantee . . . the practice must be evaluated in the light of the central objective of prison administration” which is to protect and promote security within the prison facility.³³⁰

323. *Estelle v. Gamble*, 429 U.S. 97, 107 (1976).

324. *Id.*

325. *See Norsworthy v. Beard*, 87 F. Supp. 3d 1104, 1189-90 (N.D. Cal. 2015).

326. *Farmer*, 511 U.S. at 844-45; *Battista v. Clarke*, 645 F.3d 449, 454-55 (1st Cir. 2011).

327. *Farmer*, 511 U.S. at 845 (emphasis added).

328. *Bell v. Wolfish*, 441 U.S. 520, 546-47 (1979); *see also Farmer*, 511 U.S. at 844-45; *Battista*, 645 F.3d 449, 454-55 (1st Cir. 2011).

329. *Bell*, 441 U.S. at 546-47.

330. *Id.*

Prison officials are provided “wide-ranging deference” in such matters.³³¹

Providing an inmate with SRS may significantly increase health and safety risks for both the transsexual inmate and other inmates within their facility. For example, if a biologically born male prisoner is provided SRS, thereby receiving female genitalia, prison officials must make a difficult decision regarding where to house the inmate, without exposing that inmate or any other inmate to unacceptable levels of risk or psychological trauma.³³² If left in a male facility, the potential for sexual assault requires “no great stretch of the imagination.”³³³ Transsexual inmates already face intense discrimination and victimization in prison, and providing the procedure may only increase these unfortunate events.³³⁴ Transferring the inmate to a female facility also creates potential health and safety concerns. Many female inmates have been victimized by men during their lives,³³⁵ and placing a biologically born male in a female facility could cause them significant mental and emotional distress.³³⁶

Reversing this hypothetical scenario presents similar problems. If a biologically born female receives male sex organs and is transferred to a male facility, the risk of harassment and sexual assault once again seems clear.³³⁷ If left in a female facility, sexual assault remains a concern. Inmate-on-inmate sexual violence is “at least three times higher” in women’s prison facilities than in men’s facilities.³³⁸ This may be due to female prison infrastructure lagging behind the substantial increase in female incarceration rates.³³⁹ As

331. *Id.* at 547.

332. *Cf. Battista*, 645 F.3d at 454 (“[T]his would be a much harder case if defendants had proffered a persuasive and untainted professional judgment that—while hormone therapy would help Battista—the dangers, security costs and other impediments made it infeasible.”).

333. *Kosilek v. Spencer*, 774 F.3d 63, 93 (1st Cir. 2014) (citing *Farmer*, 511 U.S. at 848–49); *Cf. Will Worley, Transgender woman 'raped 2,000 times' in all-male prison*, INDEPENDENT (Apr. 18, 2016), www.independent.co.uk/news/world/australasia/transgender-woman-raped-2000-times-male-prison-a6989366.html.

334. *Cf. Worley*, *supra* note 333.

335. DOJ: OFFICE OF JUSTICE PROGRAMS, PRIOR ABUSE REPORTED BY INMATES AND PROBATIONERS (1999), www.bjs.gov/content/pub/pdf/parip.pdf.

336. *See Kosilek*, 774 F.3d at 80 (“Kosilek’s presence could create significant disruption in [the women’s facility], given that Kosilek had been convicted for violently murdering her wife, and that a significant portion of women at [the facility] were victims of domestic abuse.”).

337. *Cf. Kosilek*, 774 F.3d at 93; *Worley*, *supra* note 333.

338. DOJ: OFFICE OF JUSTICE PROGRAMS, PREA DATA COLLECTION ACTIVITIES (2012), www.bjs.gov/content/pub/pdf/pdca12.pdf.

339. *See* ACLU, *Facts About the Over-Incarceration of Women in the United States*, AMERICAN CIVIL LIBERTIES UNION, www.aclu.org/other/facts-about-over-incarceration-women-united-states (last visited Mar. 28, 2017).

a result, female prison facilities are often “overcrowded and poorly designed, making them difficult to police.”³⁴⁰

One potential solution may be to avoid these risks altogether by placing transsexual inmates in protective custody or solitary confinement indefinitely. However, the viability of this strategy seems doubtful.³⁴¹ Solitary confinement has seen extensive use, and the results are typically less than ideal.³⁴² It has been shown to cause mental and emotional trauma, and the U.N. has indicated that stays in solitary confinement longer than fifteen days may be considered torture.³⁴³

Perhaps a more reasonable approach would be the creation of separate facilities specifically for transgender inmates. In fact, Rikers Island jail facility, the second largest jail in the nation, recently opened a separate unit for transgender women.³⁴⁴ Yet even this presents unique risks.³⁴⁵ A similar facility for gay and transgender inmates at Rikers was shut down in 2005 after violence-prone inmates started pretending to be gay or transgender in order to gain access to the facility, seeking to “prey on” and “take advantage of a group they perceived as weak.”³⁴⁶

While some of these risks remain somewhat speculative, prison officials must only articulate a reasonable explanation as to why security considerations render the provision of SRS infeasible.³⁴⁷ Additionally, courts are to provide considerable deference to prison officials in matters regarding institutional security.³⁴⁸ The security concerns that may arise if a transsexual inmate is provided SRS are substantial, and present no easy solutions. Prison officials who choose to mitigate risk by providing an alternative treatment plan likely have a reasonable basis for doing so, and therefore, do not violate of the Eighth Amendment.

340. Christina Piccora, *Female Inmates and Sexual Assault*, JURIST (Sept. 14, 2014), www.jurist.org/dataline/2014/09/christina-piccora-female-inmates.php.

341. See Editorial Board, *Solitary Confinement Is Cruel and All Too Common*, N.Y. TIMES: THE OPINION PAGES (Sept. 2, 2015), www.nytimes.com/2015/09/03/opinion/solitary-confinement-is-cruel-common-and-useless.html (discussing the inhumane nature of indefinite solitary confinement, and the shift away from such punishment in the United States).

342. Aviva Stahl, *The Shocking, Painful Trauma of Being a Trans Prisoner in Solitary Confinement*, VICE: BROADLY (Jan. 22, 2016), broadly.vice.com/en_us/article/the-shocking-painful-trauma-of-being-a-trans-prisoner-in-solitary-confinement.

343. Editorial Board, *supra* note 341.

344. Christopher Mathias, *New York's Largest Jail to Open Housing Unit For Transgender Women*, HUFFINGTON POST (Nov. 18, 2014), www.huffingtonpost.com/2014/11/18/rikers-transgender-women_n_6181552.html.

345. Paul Von Zielbauer, *New York Set to Close Jail Unit for Gays*, N.Y. TIMES (Dec. 30, 2005), www.nytimes.com/2005/12/30/nyregion/new-york-set-to-close-jail-unit-for-gays.html.

346. *Id.*

347. *Farmer v. Brennan*, 511 U.S. 825, 844-45 (1994).

348. *Bell v. Wolfish*, 441 U.S. 520, 547 (1979).

PART VI: CONCLUSION

Inmates are not traditionally seen as a group that garners, or perhaps even deserves much sympathy.³⁴⁹ Yet, treating prisoners with respect is rooted deeply in the American tradition,³⁵⁰ and the Court has declared that “it is but just that the public be required to care for the prisoner, who cannot by reason of the deprivation of his liberty, care for himself.”³⁵¹ In severe cases, failure to provide adequate treatment can lead to torture or even death, “the evils of most immediate concern to the drafters of the [Eighth] Amendment.”³⁵² In the world of transsexual inmates, these concerns can be all too real.³⁵³

However, inmates do not have a constitutional right to unqualified access to medical care.³⁵⁴ Rather, the law simply dictates that they receive care that is adequate and compatible with the “evolving standards of decency that mark the progress of a maturing society.”³⁵⁵ This legal standard, in light of the current understanding of SRS, does not create a constitutional right for transsexual inmates to receive SRS. For such a right to exist, the efficacy and necessity of the procedure must be so well established that no medical expert could reasonably believe it was not a necessary treatment for severe gender dysphoria.³⁵⁶ Currently, considerable room for disagreement exists on this point.³⁵⁷ SRS is a unique procedure that has proven difficult to study,³⁵⁸ and the understanding of its overall effectiveness and long-term ramifications is limited.³⁵⁹ While some studies indicate optimistic

349. Kevin H. Wozniak, *American Public Opinion About Prisons*, 39 CRIM. JUST. REV. 305, 305 (2014).

350. Julie Gutman Dickinson, *What Would George Do?*, HUFFINGTON POST, www.huffingtonpost.com/julie-b-gutman/founding-fathers-stance-on-torture_b_1644769.html (last visited Mar. 3, 2017).

351. *Estelle v. Gamble*, 429 U.S. 97, 104 (1976) (quoting *Spicer v. Williamson*, 191 N.C. 487, 490 (1926)).

352. *Estelle*, 429 U.S. at 103.

353. See Sylvia Rivera Law Project, *supra* note 14, at 1, 17, 19, 25, 30 (recounting horrors faced by transsexual inmates); see also Worley, *supra* note 333 (same).

354. *Hudson v. McMillian*, 503 U.S. 1, 9 (1992).

355. *Estelle*, 429 U.S. at 102-03 (internal citations omitted).

356. See *id.* at 107; see also *Bismark v. Fisher*, 213 F. App'x 892, 897 (11th Cir. 2007) (“Nothing in our case law would derive a constitutional deprivation from a prison physician's failure to subordinate his own professional judgment to that of another doctor . . .”); *Estate of Cole by Pardue v. Fromm*, 94 F.3d 254, 261 (7th Cir. 1996); *Bowring v. Godwin*, 551 F.2d 44, 48 (4th Cir. 1977).

357. See *infra* Part IV.

358. Dhejne et al., *supra* note 17, at e16885-1 to e16885-2.

359. See *id.*; Murad et al., *supra* note 85, at 214-31.

results, methodological uncertainties cast doubt over such findings.³⁶⁰

Yet, this may eventually change. As research methods improve and the stigma surrounding transsexualism continues to decrease, more individuals are likely to undergo SRS.³⁶¹ As a result, more patients may be available to participate in follow-up studies. Further, individual states are free to voluntarily provide transsexual inmates with SRS and contribute to a body of research in need of growth and improvement.³⁶² For states that choose to provide an alternative treatment plan, they remain within the bounds of constitutionally adequate medical care as long as qualified medical professionals support the treatment plans they implement.

Ultimately, *Kosilek II* may one day rest on the wrong side of history.³⁶³ However, as the law currently stands, the outcome of the case remains legally sound and transsexual inmates do not have a constitutional right to receive SRS. While this may seem cruel to some,³⁶⁴ it is the correct result when the Supreme Court's two-pronged test is objectively applied. At times, such objectivity may require a court to make difficult decisions that conflict with societal trends or even the judge's personal views. However, this principle is particularly important when difficult cases presenting important constitutional issues arise, for "[a] principle applied only when unimportant is not much of a principle at all."³⁶⁵

360. Dhejne et al., *supra* note 17, at e16885-1 to e16885-2; see also Gijs & Brewaeys, *supra* note 58, at 199.

361. Kate Lyons, *Gender identity clinic services under strain as referral rates soar*, THE GUARDIAN (July 10, 2016), www.theguardian.com/society/2016/jul/10/transgender-clinic-waiting-times-patient-numbers-soar-gender-identity-services ("Trans activists suggest this is the tip of the iceberg and that there could be tens of thousands more considering medical intervention – hormones or surgery . . .").

362. See St. John, *supra* note 249 (discussing California's decision to provide an inmate with SRS).

363. See *Kosilek v. Spencer*, 774 F.3d 63, 113 (1st Cir. 2014) (Thompson, J., dissenting).

364. See Mark Pratt, *U.S. Supreme Court Rejects Transgender Inmate's Appeal for Sex Change Surgery*, LGBTQ NATION (May 4, 2015), www.lgbtqnation.com/2015/05/u-s-supreme-court-rejects-inmates-appeal-for-sex-change-surgery/2/ ("The treatment of [Kosilek] has been cruel and unusual.").

365. *Boumediene v. Bush*, 553 U.S. 723, 806 (2008) (Roberts C.J., joined by Scalia, Thomas, and Alito JJ., dissenting).