EIGHTH AMENDMENT JURISPRUDENCE AND TRANSGENDER INMATES: THE "WPATH" TO EVOLVING STANDARDS OF DECENCY

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INTRODUCTION

In recent years, the challenges facing those with the mental illness gender dysphoria have become apparent in the American legal

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system.[1] Disagreement regarding whether "sex" in civil-rights statutes protects one's *chosen* gender identity from discrimination receives the most attention, but there is another challenge equally as daunting—access to mental healthcare for inmates suffering from gender dysphoria.[2]

An early manifestation of tension between medical treatment that prisons provide and additional medical treatment that inmates desire is found in *Estelle v. Gamble*.[3] J. W. Gamble was an inmate of the Texas Corrections Department when he "was injured on November 9, 1973, while performing a prison work assignment."[4] Gamble saw medical personnel on "17 occasions during a 3-month span [who] treated his injury and other problems."[5] However, an X-ray, which Gamble felt was necessary to diagnose and treat his lower-back pain, was not ordered as part of his treatment.[6] Still feeling pain even after other treatments, Gamble initiated the district-court action alleging medical indifference to his pain in violation of the Eighth Amendment.[7]

A near-unanimous Court found that constitutionally violative "deliberate indifference to serious medical needs" by prison officials could be determined with a two-part test.[8] The first part, a subjective test, examines whether prison officials acted with more than "an inadvertent failure to provide adequate medical care."[9] The implication is, therefore, that "a complaint that a physician has been negligent in diagnosing or treating a medical condition does not state a valid claim of medical mistreatment under the Eighth Amendment."[10] The second part, an objective test, requires "acts or omissions sufficiently harmful to evidence deliberate indifference to

1. *See* AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS, 451–59 (5th ed. 2013).

2. *See* 42 U.S.C. § 2000e-(2) ("It shall be an unlawful employment practice for an employer—(1) to fail or refuse to hire or to discharge any individual, or otherwise to discriminate against any individual with respect to his compensation, terms, conditions, or privileges of employment, because of such individual's race, color, religion, sex, or national origin."); Bostock v. Clayton Cnty., Ga., 140 S. Ct. 1731, 1734 (2020).

3. 429 U.S. 97, 102–04 (1976).

4. *Id.* at 98.

5. *Id.* at 97.

6. *See id.*

7. *See id.*

8. *Id.* at 104.

9. *Id.* at 105.

10. *Id.* at 106.

serious medical needs."[11] The implications of this test are that there must exist both an objective sufficient harm and an objective serious medical need that must be remedied with medically necessary treatment.[12]

Inmates with gender dysphoria have applied this same philosophy of prison officials' response to the medical needs resulting from gender dysphoria. The medical treatment that the subsequent actions have sought as remedy is known as sex-reassignment surgery (SRS). Three sister circuits and their respective cases, those of Kosilek, Gibson, and Edmo, are examined below in their facts, outcomes, and methodologies.[13] While all cases have been disposed of and denied certiorari by the Supreme Court,[14] the stream of action still flows—and the debate rages on.[15]

Issues critical to the debate are readily found in reviewing the cases. A primary point of contention regarding whether prisons must provide SRS to inmates with gender dysphoria is whether SRS is medically necessary. The scope of "medical necessity" in regard to Eighth Amendment requirements is medical care that provides the "minimal civilized measure of life's necessities."[16] Minimal standards of society are noted by federal-court jurisprudence to be found in comparative state legislation and action. The analyses of such legislation and action, via regulation and administrative rules regarding both prison guidelines and medical guidelines, indicate that SRS is provided by states spottily at best, and therefore, does not reach the "consensus" required to deem SRS a medically necessary treatment.[17]

As with any well-reasoned, good-faith community disagreement, there are a number of states, agencies, and federal courts that disagree, and the source of their disagreement originates from a manual for transgender healthcare published by the World

11. *Id.*
12. *See id.*
13. *See infra* Part I.
14. *See generally* Kosilek v. Spencer, 774 F.3d 63 (1st Cir. 2014), *cert. denied*, 135 S. Ct. 2059 (2015); Gibson v. Collier, 920 F.3d 212 (5th Cir. 2019), *cert. denied*, 140 S. Ct. 653 (2019); Edmo v. Corizon, Inc., 935 F.3d 757 (9th Cir. 2019), *cert. denied*, No. 19-1280, 2020 WL 6037411 (U.S. Oct 13, 2020) (mem.).
15. *See* Idaho Dep't of Corr. v. Edmo, 140 S. Ct. 2800, 2800 (2020) (mem.) (denying request for stay although Justice Thomas and Justice Alito would grant the application).
16. *See* Farmer v. Brennan, 511 U.S. 825, 834 (1994) (quoting Rhodes v. Chapman, 452 U.S. 337, 347 (1981)).
17. *See infra* Section II.A.

Professional Association for Transgender Health (WPATH).[18] However, a deep dive into the sources used by WPATH to propagate its Standards of Care (Standards) reveals that the sources often blatantly disagree with the WPATH interpretation.[19] For a manual that has been given almost controlling weight in many venues regarding an issue of the utmost importance—mental health—this is alarming. The findings of medical disagreement regarding SRS and the incongruency between WPATH evidence and its guidelines lead to the conclusion that scrutiny of the Standards is warranted.[20]

This Article in no way seeks to reinvent federal-court jurisprudence—that is a task beyond the scope of these writings. Rather, this Article uses existing jurisprudence to identify the appropriate modes for remedying errant judicial application in future decisions. The lives of Kosilek, Gibson, and Edmo are but three examples of the intersection of law and the place of transgender people *within* the law. The principles that undergird their Eighth Amendment challenges as well as the constitutionally required path forward structure the lives of thousands more transgender Americans seeking repose under the protections of the United States Constitution.

I. A BROAD OVERVIEW OF THE CIRCUIT SPLIT

Naturally, one should endeavor to understand the law in the context of the lives it affects. For inmates suffering from gender dysphoria, the challenge of receiving desired medical care while incarcerated has, at the least, proven difficult.[21] Below are three examples of instances transgender inmates have challenged their respective penitentiaries for the relief of providing SRS in light of the emotional distress caused by their biological genitalia.

While there are plenty more examples among federal circuit courts, *Kosilek*, *Gibson*, and *Edmo* remain representative of the fundamental ways that judges have tackled the Eighth Amendment question in regard to gender-dysphoric inmates.[22] These insightful writings are necessary starting points for understanding the gravity of the decisions that the Supreme Court could soon review.

18. *See infra* Section II.B.
19. *See infra* Section II.B.
20. *See infra* Section II.B, Part III.
21. *See infra* Sections I.A–C.
22. *See* Battista v. Clarke, 645 F.3d 449, 452 (1st Cir. 2011); Allard v. Gomez, 9 F. App'x 793, 794 (9th Cir. 2001); White v. Farrier, 849 F.2d 322, 325 (8th Cir. 1988); Meriwether v. Faulkner, 821 F.2d 408, 412 (7th Cir. 1987).

A. *Kosilek v. Spencer*—First Circuit

Robert Kosilek,[23] now called Michelle Kosilek, "was convicted of first-degree murder and sentenced to a term of life imprisonment"[24] for "strangl[ing] with a rope and a wire" his then-wife, Cheryl McCaul, in 1992.[25] Kosilek sued the Massachusetts Department of Corrections (MDOC) in 1992 for "failure to provide direct treatment" for his gender dysphoria.[26] From 1994 through the appeal, Kosilek had been housed at the medium-security, all-male Massachusetts Correctional Institute (MCI) at Norfolk.[27] Kosilek was only receiving "supportive therapy" to cope with the distress caused by his gender dysphoria.[28] Insufficient to quell his distress and having been denied for SRS, Kosilek sued for "both damages and injunctive relief requiring the DOC to provide h[im] with [SRS]."[29]

In evaluating the standard ordained by *Estelle v. Gamble*, the district court explored whether "(1) [Kosilek] has a serious medical need; (2) which has not been adequately treated; (3) because of [MDOC] deliberate indifference; and (4) that deliberate indifference is likely to continue in the future."[30] The district court ultimately found that Kosilek had established a serious medical need that had not been adequately treated, though it did not find that the Commissioner of

23. For purposes of streamlining the inconsistent use of pronouns, and deference to precedent, Kosilek, Gibson, and Edmo will be referred to by the pronouns consistent with biological sex. *See Farmer*, 511 U.S. at 829–32 (using male pronouns for a biologically male, preoperative transsexual who "projects feminine characteristics"); *see also* HARRY BENJAMIN, THE TRANSSEXUAL PHENOMENON 73 (1966) (noting, as the primary source for transgender research and inspiring the later-discussed WPATH Standards of Care, "speaking of a 'male' when there are (or were) testicles and a penis, and of a 'female' when there are (or were) ovaries and a vagina").

24. Kosilek v. Spencer, 774 F.3d 63, 68 (1st Cir. 2014).

25. Commonwealth v. Kosilek, 668 N.E.2d 808, 811 (Mass. 1996).

26. *See Kosilek*, 774 F.3d at 68–69. The First Circuit uses the term "gender identity disorder" to retain congruence with previous litigation in an effort to keep clear a very fact-intensive endeavor. *See id.* at 69 n.1. As this Subsection is simply summarizing the case, it will defer to the DSM-5 phraseology change of "replac[ing] the diagnostic name 'gender identity disorder' with 'gender dysphoria.'" *See* AM. PSYCHIATRIC ASS'N, GENDER DYSPHORIA 1 (2013).

27. *See Kosilek*, 774 F.3d at 81 (weighing Commissioner Dennehy's contemplation that "housing Kosilek at MCI–Framingham would pose a significant risk of destabilizing that environment" as part of the relief requested in the appeal by Kosilek).

28. *Id.* at 69.

29. *Id.*

30. Kosilek v. Maloney, 221 F. Supp. 2d 156, 184 (D. Mass. 2002).

MDOC was able to "infer[] that there would be a substantial risk of serious harm to Kosilek."[31]

However, MDOC enacted a concerted policy shift that would allow prisoners to "receive additional treatment beyond the level of that received before entering prison, when such care was medically required."[32] Medical recommendations were made by the University of Massachusetts Correctional Health Program, and Kosilek began "significant ameliorative treatment."[33]

Dr. Seil, overseeing Kosilek's treatment, "recommended that Kosilek be considered for SRS after one year of hormonal treatment" and "real-life experience" as the desired sex consistent with the Harry Benjamin Standards of Care.[34] Having attempted suicide twice while in holding for the district-court trial, Kosilek once again expressed a desire to pursue suicide if he could not only have his male genitalia removed but also have them replaced with female genitalia.[35]

MDOC then forwarded this recommendation to the institution's medical consultant, Dr. Cynthia Osborne.[36] Dr. Osborne noted that Kosilek had previously been diagnosed with antisocial personality disorder and "expressed belief that threats of self-harm or suicide should serve as a contraindication to surgery, and that such threats were not a valid or clinically acceptable justification for surgery."[37] Dr. Osborne contradicted Dr. Seil's assessment that such surgery was medically necessary in part by consulting the Standards of Care used to evaluate Kosilek.[38] The Harry Benjamin Standards cite as part of

31. *Id.* at 162, 190 (adding that MDOC's broad policy decision was at least partially rooted in "sincere security concerns").

32. *Kosilek*, 774 F.3d at 69.

33. *Id.* at 69–70 (detailing treatments "provid[ing] female, gender-appropriate clothing and personal effects, and electrolysis was performed to permanently remove h[is] facial hair. Kosilek also began a course of hormonal treatments recommended by an endocrinologist. These treatments resulted in 'breast development and shrinkage of h[is] testicles.' All of the treatments described continue to be offered to Kosilek to the present day.").

34. *See id.* at 70; Walter Meyer III et al., *The Harry Benjamin International Gender Dysphoria Association's Standards of Care for World Professional Association for Gender Identity Disorders, Sixth Version*, 13 J. PSYCH. & HUM. SEXUALITY 1, 3–4 (2001).

35. *See Kosilek*, 774 F.3d at 69, 71.

36. *See id.* at 71.

37. *Id.* at 72.

38. *See id.*

the criteria for genital surgery "satisfactory control of problems such as sociopathy, substance abuse, psychosis and suicidality."[39]

Dr. Osborne was also not convinced that the "real life" experience could be fulfilled given the vast social differences of incarcerated life versus life outside of prison.[40] As a result, security and housing concerns were once again raised given conflicting reports of Kosilek's preparedness for such a consequential procedure.[41] On June 10, 2005, MDOC acknowledged safety and security concerns as well as Dr. Osborne's evaluation to the district court and noted that while the "significant ameliorative treatment" would continue, MDOC would not pursue SRS.[42]

After extensive testimony, the district court ruled that Kosilek had a serious medical need and that MDOC was deliberately indifferent to that need and simply used security and conflicting medical concerns as a pretext to avoid public and political backlash.[43] Believing MDOC would continue to deny Kosilek SRS, "the district court granted an injunction requiring that the [M]DOC provide Kosilek with SRS."[44]

Thus, the case was appealed to the First Circuit, which found that the Eighth Amendment proscribes medical care that falls below American society's *minimum* standards of decency—and the extensive historical treatment of Kosilek's illness precluded the "deliberate indifference" claim.[45] MDOC was to continue "significant ameliorative treatment" as well as form contingency plans should suicide ideation erupt—though providing SRS was not required of the prison.[46]

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39. Meyer III et al., *supra* note 34, at 19. It is important to note that Version 7 of the Standards of Care abandons these exemplified conditions. *See* Gennaro Selvaggi et al., *The 2011 WPATH Standards of Care and Penile Reconstruction in Female-to-Male Transsexual Individuals*, 2012 ADVANCES UROLOGY 1, 6, tbl.2 (2012) (noting that new to Version 7 "sociopathy, substance abuse, psychosis, and suicidal tendencies" were removed as eligibility-disqualifying factors due to Version 7's "[n]o difference between eligibility and readiness").

40. *See Kosilek*, 774 F.3d at 72.

41. *See id.* at 73.

42. *Id.* at 69, 74.

43. *See id.* at 81–82.

44. *Id.*

45. *See id.* at 96 (citing Estelle v. Gamble, 429 U.S. 97, 102–05 (1976)).

46. *See id.*

B. *Gibson v. Collier*—Fifth Circuit

Scott Lynn Gibson, now called Vanessa Lynn Gibson, was convicted on two counts of aggravated robbery.[47] While incarcerated, Gibson further committed, and was convicted of, the additional crimes of aggravated assault, possession of a deadly weapon, and murder.[48] Gibson is slated to serve through May 2031 with eligibility for parole in April 2021.[49] During wardship under the Texas Department of Criminal Justice (TDCJ), Gibson requested, beyond the hormone therapy that the prison had acceded to, SRS and was denied.[50] Gibson claimed the TDCJ exercised deliberate indifference in this judgment and commenced legal action.[51]

The Fifth Circuit "accept[ed] Gibson's invitation to reach his deliberate indifference claim on the merits, rather than reverse based on any procedural defects in the district court proceedings" as it "would be a waste of time and resources for everyone involved (and give false hope to Gibson) to remand for procedural reasons."[52] The standard to be met was identical to the standard in *Kosilek*: (1) "Gibson must first demonstrate a serious medical need," and (2) "show that the Department acted with deliberate indifference to that medical need."[53]

The State of Texas did not contest that Gibson had a serious medical need "in light of his record of psychological distress, suicidal ideation, and threats of self-harm."[54] As the existence of the medical need was not in contest, Gibson then "must show that officials acted with malicious intent—that is, with knowledge that they were withholding medically necessary care."[55] Per *Estelle*, the deprivation of care must manifest as an "unnecessary and wanton infliction of pain."[56] The Fifth Circuit noted that no Eighth Amendment claim invoking "an unnecessary and wanton infliction of pain" can be made "if a genuine debate exists within the medical community about the

47. *See* Gibson v. Collier, 920 F.3d 212, 216–17 (5th Cir. 2019).
48. *See id.* at 217.
49. *See Offender Information Details: Scott Lynn Gibson*, TEX. DEP'T OF CRIM. JUST., https://offender.tdcj.texas.gov/OffenderSearch/offenderDetail.action?sid=05374437 [https://perma.cc/8PMN-PBKS] (last visited Jan. 11, 2021).
50. *See Gibson*, 920 F.3d at 217.
51. *See id.* at 218.
52. *Id.* at 218–19.
53. *Id.* at 219.
54. *Id.*
55. *Id.* at 220.
56. *Id.* at 219 (quoting Estelle v. Gamble, 429 U.S. 97, 104 (1976)).

necessity or efficacy of that care."[57] Gibson accepted this standard and that "he must demonstrate 'universal acceptance by the medical community.'"[58]

The Fifth Circuit, however, permitted an easier burden for Gibson to satisfy by quoting from *Kosilek* that "[n]othing in the Constitution mechanically gives controlling weight to one set of professional judgments."[59] The doctrinal consequence is "where, as here, there is robust and substantial good faith disagreement dividing respected members of the expert medical community, there can be no claim under the Eighth Amendment."[60] Gibson acknowledged the controversy within the medical community but "would *prefer* a policy that provides [SRS]."[61]

The Fifth Circuit echoed the First Circuit in *Kosilek*: for the correctional facility to "cho[ose] one of two alternatives—both of which are reasonably commensurate with the medical standards of prudent professionals . . . is a decision that does not violate the Eighth Amendment."[62] Gibson persisted in requesting a remand so that he may plead his individual case for the medical necessity of SRS per WPATH Standards of Care.[63] However, the Fifth Circuit noted that individual need cannot be shown since a declaration of individual necessity still falls victim to Gibson's admission that SRS is controversial within the medical community and therefore cannot be considered a medically necessary standard of care.[64]

C. *Edmo v. Corizon, Inc.*—Ninth Circuit

Mason Edmo, now called Adree Edmo, was convicted in 2012 for sexually abusing a fifteen-year-old boy at a house party[65]—Edmo was twenty-one years of age at the time of the criminal offense and is

57. *Id.* at 220.
58. *Id.*
59. *Id.* (quoting Kosilek v. Spencer, 774 F.3d 63, 96 (1st Cir. 2014)).
60. *Id.* (citing *Kosilek*, 774 F.3d at 96).
61. *Id.* (emphasis added) (internal quotation marks omitted).
62. *Kosilek*, 774 F.3d at 90.
63. These standards of care are similar to those previously referred to as the "Harry Benjamin Standards of Care" in *Kosilek*. *See* Meyer III et al., *supra* note 34, at 1. The organization formally changed its name starting with the 7th edition of the Standards of Care. *See* WORLD PRO. ASS'N FOR TRANSGENDER HEALTH, STANDARDS OF CARE FOR HEALTH OF TRANSSEXUAL, TRANSGENDER, AND GENDER-NONCONFORMING PEOPLE 1 (2012).
64. *See Gibson*, 920 F.3d at 224.
65. *See* Edmo v. Corizon, Inc., 935 F.3d 757, 772 (9th Cir. 2019).

set to be released in July 2021.[66] The Ninth Circuit began by noting that Edmo was afflicted by gender dysphoria and "ha[d] twice attempted self-castration to remove h[is] male genitalia."[67] A note of particular importance in this case, and for the overall analysis to be conducted later, is that both Edmo and the State of Idaho "agree[d] that the appropriate benchmark regarding treatment for gender dysphoria is the [WPATH Standards]."[68] The State of Idaho and its healthcare contractor, Corizon, Inc., also did "not seriously dispute that in certain circumstances" SRS "can be a medically necessary treatment for gender dysphoria."[69]

The Ninth Circuit then detailed the WPATH guidelines for diagnosing gender dysphoria and the congruence with Edmo's particular situation.[70] Edmo has identified "as female since age 5 or 6" and been so affirmed in this view to be willing to receive multiple disciplinary actions for presenting as female.[71] The prison provided, since Edmo's incarceration, hormone therapy that achieved hormonal confirmation, meaning that the maximum effects of the hormones had been realized (e.g., "breast growth, body fat redistribution, and changes in h[is] skin.").[72]

However, Edmo's distress had not subsided.[73] Also afflicted by major depressive disorder, anxiety, drug and alcohol addiction, trauma, and suicidality, Edmo saw a psychiatrist, though not his treating clinician, as he did "not believe [the clinician] [was] qualified to treat h[is] gender dysphoria."[74] Edmo subsequently attempted castration in 2015 and reported continued thoughts of castration afterward.[75] In 2016, Edmo was evaluated for SRS.[76] Given that he "looked pleasant and had a good mood" to prison staff, the Idaho Department of Corrections (IDOC) did not believe SRS was medically

66. *See IDOC Offender Search Details: Mason Dean Edmo*, IDAHO DEP'T OF CORR., https://www.idoc.idaho.gov/content/prisons/offender_search/detail/94691 [https://perma.cc/M82T-DT4V] (last visited Jan. 11, 2021).
67. *Edmo*, 935 F.3d at 767.
68. *Id.*
69. *See id.*
70. *See id.* at 769–70.
71. *See id.* at 772.
72. *See id.*
73. *See id.*
74. *See id.* at 772–73.
75. *See id.* at 772.
76. *See id.* at 773.

necessary in Edmo's case.[77] This decision was uniformly agreed upon by four separate doctors for the facility.[78]

Later in 2016, Edmo once again attempted castration and was "feeling angry/frustrated that []he was not receiving the help desired related to h[is] gender dysphoria."[79] Edmo continued hormone-therapy treatments and routinely practiced bodily mutilation as a "self-medicat[ion]."[80] On April 6, 2017, Edmo filed a *pro se* complaint where the district court found that Edmo failed on an Eighth Amendment claim—then, the Ninth Circuit reviewed.[81]

Using the *Estelle* criteria, the Ninth Circuit found that Edmo succeeded on an Eighth Amendment claim as a matter of district-court-found fact.[82] In its analysis, the Ninth Circuit noted that "[a] difference of opinion between a physician and the prisoner—or between medical professionals—concerning what medical care is appropriate does not amount to deliberate indifference."[83] However, the Ninth Circuit qualified this by creating an exception if the "chosen course of treatment 'was medically unacceptable under the circumstances.'"[84] Per the district-court findings, the course of treatment provided by IDOC was insufficient to assuage Edmo of the distress that plagued him, and Edmo should succeed on his Eighth Amendment claim.[85]

After establishing this standard, the Ninth Circuit then ardently compared its ruling against *Gibson*, where the most tension was generated.[86] The Ninth Circuit wrote that the Fifth Circuit in *Gibson* "relies on an incorrect, or at best outdated, premise: that '[t]here is no medical consensus that [SRS] is a necessary or even effective treatment for gender dysphoria.'"[87] The reason being, as the State of Idaho had not opposed, that medical consensus is exemplified by the

77. *See id.*

78. *See id.* at 773–74 (nuancing that while four doctors agreed, one of the doctors had never personally treated gender dysphoria and was therefore not qualified by IDOC policy to assess Edmo's appropriateness for SRS).

79. *Id.* at 774.

80. *See id.*

81. *See id.* at 775.

82. *See id.* at 802.

83. *See id.* at 786 (quoting Snow v. McDaniel, 681 F.3d 978, 987 (9th Cir. 2012), *overruled on other grounds by* Peralta v. Dillard, 744 F.3d 1076 (9th Cir. 2014)).

84. *Edmo*, 935 F.3d at 786 (quoting Jackson v. McIntosh, 90 F.3d 330, 332 (9th Cir. 1996)).

85. *See id.* at 786–87.

86. *See id.* at 794–97.

87. *Id.* at 795.

WPATH Standards of Care deigning that SRS may be medically necessary in "appropriate circumstances."[88] To the Ninth Circuit, Edmo exemplified such a circumstance.[89]

II. RELEVANT ISSUES

There are a number of considerations to be gleaned from this diverse set of circuit-court opinions. The First Circuit in *Kosilek* painstakingly took to evaluating the various expert reports that MDOC and Kosilek, via the doctors contracted with MDOC, used to justify their respective claims.[90] The crux of the problem was simple: The clear medical disagreement among the professionals gave rise to genuine safety and security concerns for the staff and inmates at MCI-Norfolk.[91] Given the lack of consensus and sincere institutional concern for safety, Kosilek had not succeeded in proving that MDOC was "deliberately indifferent" to providing medically necessary care.[92]

A very different approach was taken by the Fifth Circuit in *Gibson*. Judge Ho, writing for the Fifth Circuit, took to examining SRS itself as medically necessary or not.[93] However, the Fifth Circuit reviewed meaningfully different facts than those of the First Circuit.[94] Gibson had conceded that consensus regarding the medical need of a treatment was paramount and that "universal acceptance by the medical community" was a high burden.[95] Though the Fifth Circuit did not hold Gibson to this self-imposed standard, the sentiment regarding consensus remained, Gibson conceded this point, and the Fifth Circuit held that well-reasoned members of the medical community disagreed on the necessity of SRS as seen in *Kosilek*.[96] The result was a doctrinal one: SRS generally understood as a medical treatment cannot *ever* be medically necessary because it lacks medical-community consensus.[97]

The Ninth Circuit, just as the First Circuit, sought to resolve this issue on a matter of fact. In determining the necessity of treatment, the Ninth Circuit deferred to factual determinations at the district-court

88. *See id.*
89. *See id.* at 786 (examining the medical necessity of SRS for Edmo specifically).
90. *See* Kosilek v. Spencer, 774 F.3d 63, 68 (1st Cir. 2014).
91. *See id.* at 74.
92. *See id.* at 91.
93. *See* Gibson v. Collier, 920 F.3d 212, 216 (5th Cir. 2019).
94. *See id.* at 216–18.
95. *See id.* at 220.
96. *See id.* at 220, 216.
97. *See id.*

level to evaluate whether SRS was appropriate.[98] Like the Fifth Circuit, however, the Ninth Circuit then took to evaluating the given facts through a doctrinal perspective that adjudicated the claim on the basis of whether the inmate's distress was eased as a result of the treatment.[99] The consequence of this, as the Ninth Circuit described of the district court's findings, was that if Edmo was not satisfied by the treatment received, regardless of the objective nature of the treatment, then Edmo could succeed on an Eighth Amendment claim through a subjective valuation of the inmate's desires that must have been met in order to end the unconstitutional emotional distress of not having one's preferred treatment provided by one's prison system.[100]

A. Defining the Standard of Minimum Care

As the judicial perspectives of *Kosilek*, *Gibson*, and *Edmo* would entail, there are two crucial questions to be asked in evaluating the Eighth Amendment claim: (1) how is the minimum-care standard defined, and (2) is this definition of minimum standard of care met by SRS?

1. *Federal-Court Jurisprudence*

The Eighth Amendment succinctly states that "[e]xcessive bail shall not be required, nor excessive fines imposed, nor cruel and

98. *See* Edmo v. Corizon, Inc., 935 F.3d 757, 803 (9th Cir. 2019).

99. *See id.* at 767, 793, 797–98.

100. The Ninth Circuit engaged in a pas de deux with circular logic in an attempt to conceal this conclusion. The court feigned an examination of the medical community's opinion on SRS in raising the WPATH Standards to dispositive weight by virtue that they "are the best standards out there" while simultaneously acknowledging that "[t]here are no other competing, evidence-based standards . . . ." *See id.* at 769. Status as "the best" due to a lack of any alternative improperly gives the Standards a monopoly over what medical remedies federal courts may be obligated to provide as relief to petitioners. *See id.* Of course, this deduction is not an exaggeration. It is dogma explicitly endorsed by the court. *See id.* at 787. The Ninth Circuit decreed that the State of Idaho's experts "lacked expertise and incredibly applied (or did not apply, in the case of the State's treating physician) the WPATH Standards of Care," and as such, were rightfully given "virtually no weight." *Id.* Elevating the WPATH Standards to determinative heights under the guise of consensus while summarily dismissing opposing medical opinion for the grave sin of not comporting with the Standards is inescapably contradictory. However, is it the dance that must be done to justify the subjective, inmate-driven determination that "[SRS] is medically necessary *because* Edmo's current treatment has been inadequate, as evidenced by h[is] self-castration attempts." *See id.* (emphasis added).

unusual punishments inflicted."[101] The latter clause is referred to as the Cruel and Unusual Punishments Clause, and the Supreme Court has repeatedly "read with the gloss of the experience of those who framed" these words as implicating that "[t]he [Eighth] Amendment must draw its meaning from the evolving standards of decency that mark the progress of a maturing society."[102]

In order for this clause to have any significance, however, it must first apply *to* "punishments." Defining "punishments" has proven to be more contentious than one might first conceive. Thomas Landry describes three contemporary definitions of punishments: (1) "strictural" punishments refer only to the imposed penal sentence and are devoid of events or conditions in prison, (2) "experiential" punishments are anything a prisoner may experience—from the formal sentencing to events and conditions in prison regardless of governmental intention of those events and conditions, and (3) "subjectivist" punishments, which include the terms of the formal penal sentencing as well as events and conditions in prison so long as they are attributable to the subjective intent of a governmental actor.[103] It is beyond the realm of this Article to discuss the merits of these definitions, and the Article instead continues, as the Supreme Court has, with the subjectivist definition.[104]

Evolving standards in regard to medical care are among these subjectivist conditions, and they are explicated most clearly in *Estelle v. Gamble*.[105] In *Estelle*, the majority held that "[i]t 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."[106] As the "deprivation of his liberty" would inhibit the prisoner's ability to obtain medical treatment for "serious medical needs," the conclusion was simply that a lack of necessary medical care would constitute an impermissible "unnecessary and wanton infliction of pain."[107]

From this judicially prescribed right to medical treatment while incarcerated bore a natural question on the behalf of those resistant to

101. U.S. CONST. amend. VIII, § 1, cl. 3.

102. United States v. Rabinowitz, 339 U.S. 56, 70 (1950) (Frankfurter, J., dissenting); Trop v. Dulles, 356 U.S. 86, 101 (1958).

103. *See* Thomas K. Landry, *"Punishment" and the Eighth Amendment*, 57 OHIO ST. L.J. 1607, 1610 (1996).

104. *See id.* (observing that the "[subjectivist] definition now commands a majority on the Supreme Court").

105. 429 U.S. 97, 104–07 (1976).

106. *Id.* at 104 (quoting Spicer v. Williamson, 132 S.E. 291, 293 (N.C. 1926)).

107. *Id.*; Gregg v. Georgia, 428 U.S. 153, 173 (1976).

providing medical care for inmates: Why not just ignore the medical problems so that no action on the right to medical treatment could ensue? This avoidance is understood as "deliberate indifference."[108] The Court in *Estelle* graciously provided a nonexhaustive list of exemplar behaviors that could constitute deliberate indifference to "serious medical needs."[109] Among them: nonprofessionally rooted judgements of medical treatment, intentionally denying or delaying necessary medical care, and interfering with the treatment once administered.[110]

In order to establish deliberate indifference, two distinct tests must be met.[111] The first test is a subjective metric.[112] In elaborating on the subjective test in *Estelle* as something more than "inadverten[ce]," the Court in *Wilson v. Seiter* held that when "the pain inflicted is not formally meted out *as punishment* by the statute or the sentencing judge, some mental element must be attributed to the inflicting officer before it can qualify [as a violation of the Eighth Amendment]."[113] Using these parameters, the Court in *Farmer v. Brennan* defined the subjective test as satisfied by more than negligence but less than malice.[114]

The second test is an objective metric analogous to "the deprivation of a single, identifiable human need such as food, warmth, or exercise."[115] The Court in *Rhodes v. Chapman* restated that "judgment[s] should be informed by objective factors to the maximum possible extent."[116] The "objective indicia" that a court was to look for could be "derived from history, the action of state legislatures, and the sentencing by juries."[117] Additionally, the Court clearly indicated that

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108. *See Estelle*, 429 U.S. at 104–05.

109. *See id.* at 104.

110. *See id.* at 104–05.

111. *See* Wilson v. Seiter, 501 U.S. 294, 298 (1991) (describing deliberate indifference as requiring satisfaction of both a "subjective component" and an "objective component").

112. *See Estelle*, 429 U.S. at 105–06.

113. *See id.*; *Wilson*, 501 U.S. at 300.

114. *See* 511 U.S. 825, 826, (1994) (declaring "[d]eliberate indifference entails something more than negligence, but is satisfied by something less than acts or omissions for the very purpose of causing harm or with knowledge that harm will result").

115. *Wilson*, 501 U.S. at 304–05 (nuancing that "[n]othing so amorphous as 'overall conditions' can rise to the level of cruel and unusual punishment when no specific deprivation of a single human need exists").

116. 452 U.S. 337, 346 (1981); *see also* Rummel v. Estelle, 445 U.S. 263, 274–75 (1980) (quoting Coker v. Georgia, 433 U.S. 584, 592 (1977)).

117. *See Rhodes*, 452 U.S. at 346–47.

the nature of these objective measures could change over time—as could the actions of state legislatures.[118]

These tests are further constrained by the limiting principle espoused that prisons are only required "to meet prisoners' basic health needs" and that treatment does "not have [to] be[] the best that money c[an] buy."[119] The point of inquiry, then, is what constitutes the "minimal civilized measure of life's necessities."[120]

The *Estelle* court also provides guidance in this regard. The "contemporary standards of decency" that guide the Eighth Amendment's application are "manifested in modern legislation."[121] Simply put, the minimum standards of care that prison systems are obligated to follow are ordained by a holistic analysis of state governments. In the American dual-federalist system, then, it is entirely possible, if there is no clear consensus, that there are fifty-one different minimum standards of medical care.

2. *The Standards of Society Through State Actions*

Michael H. Slutsky noted in his 1975 review of the variety of state laws establishing the standards of medical care in the states that "on the whole, the coverage of such regulations is scanty . . . and thus each prison facility is free to establish its own standards."[122] This was the position adopted by the vast majority of states that Slutsky documented and therefore positioned to be *the* defining standards of medical care.[123] However, the inquiry into the actual medical standards propagated by the relevant administrative entities was hardly pursued.[124] To illustrate the incredibly high threshold of objective minimal standards of care, let us first examine a clear example of life-or-death medical need not meeting this test.

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118. *See id.* at 347.

119. *See* Brown v. Plata, 563 U.S. 493, 501 (2011); Mayweather v. Foti, 958 F.2d 91, 91 (5th Cir. 1992); *see also* Brown v. Beck, 481 F. Supp. 723, 726 (S.D. Ga. 1980).

120. *See* Farmer v. Brennan, 511 U.S. 825, 834 (1994) (quoting Rhodes v. Chapman, 452 U.S. 337, 347 (1981)).

121. Estelle v. Gamble, 429 U.S. 97, 103 (1976) (citing state laws as the evidence of this "modern legislation").

122. Michael H. Slutsky, *The Rights of Prisoners to Medical Care and the Implications for Drug-Dependent Prisoners and Pretrial Detainees*, 42 U. CHI. L. REV. 705, 709 (1975).

123. *See id.*

124. *See id.* at 708–09.

In January 2002, the California Department of Corrections (Cal DOC) financed and conducted its first inmate heart transplant.[125] The spokesman for Cal DOC referenced federal-court decisions regarding deliberate indifference to serious medical needs and rationalized that as the inmate would die without the heart transplant, Cal DOC was obligated to provide the treatment.[126] The reasoning was simple enough: If there is a medical treatment, especially one that life and death hinge upon, then an inmate has a constitutional right to that medical treatment.[127]

However, this is a much different standard than the one propagated by *Estelle*.[128] The Court's directive is not to "provide [inmates] with the most sophisticated care that money can buy," but rather "that an inmate deserves *adequate* medical care."[129] As illuminated by the Court in *Rhodes*, the measure of adequacy is fulfilled by the objective "minimal civilized measure of life's necessities."[130] To evaluate this standard, as the *Rhodes* Court suggests, let us once again turn to the acts of state legislatures.[131] Contemporary with the 2002 Cal DOC heart transplant, a study from 1998 illustrated that only twenty-five of forty-nine states and the Federal Bureau of Prisons even offered organ transplants broadly, not speaking to hearts specifically.[132] Undoubtably, the necessity of cardiac functionality had not faded as a precondition to human life by 2002. Does this mean that half of the states in the nation were acting unconstitutionally?

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125. *See Prisoner Gets $1M Heart Transplant*, CBS NEWS (Jan. 31, 2002, 8:31 AM), https://www.cbsnews.com/news/prisoner-gets-1m-heart-transplant/ [https://perma.cc/DT5J-Z7EP].

126. *See id.* (referencing the Court in *Estelle* and Jackson v. McIntosh, 90 F.3d 330 (9th Cir. 1996) (holding that the prison must provide the kidney transplant as the withholding could be attributed to improper personal animus thereby constituting deliberate indifference)).

127. *See id.*

128. *See* Carrie S. Frank, *Must Inmates Be Provided Free Organ Transplants?: Revisiting the Deliberate Indifference Standard*, 15 GEO. MASON U. CIV. RTS. L.J. 341, 345 (2005).

129. United States v. DeCologero, 821 F.2d 39, 42 (1st Cir. 1987).

130. Rhodes v. Chapman, 452 U.S. 337, 347 (1981).

131. *See id.* at 346–47.

132. *See* DEBORAH LAMB-MECHANICK & JULIANNE NELSON, PRISON HEALTH CARE SURVEY: AN ANALYSIS OF FACTORS INFLUENCING PER CAPITA COSTS 50 (n.d.). Many of the states' relevant policies regarding organ transplants have remained unchanged, so the proportion of states denying organ transplants should be considered to be roughly equivalent as the Lamb-Mechanick and Nelson study shows. *See, e.g.*, ILL. ADMIN. CODE tit. 20, § 415.80 (2005).

Not necessarily, but why? The permissibility of prisons' refusal to fund medically necessary treatments, such as heart transplants, is owed to the objective test for deliberate indifference.[133] Cause for deliberate indifference can only be found by deliberate denial of treatments that fall within the purview of society's minimum standards of care.[134] These objective standards of care, as the *Rhodes* Court explicates, can be found in examining relevant state regulations, and, in the case of organ transplants, only about half of the states' prisons financed organ transplants broadly.[135] If every single one of these states had provided heart transplants, then that would still leave the standards of care regarding heart transplants split between obligatory and not. As the Court stated in *Estelle*, "[T]he primary concern of the drafters was to proscribe 'torture[s]' and other 'barbar[ous]' methods of punishment."[136] By definition of the objective standard, depriving inmates of medical treatments that do not reach society's minimum standards of care cannot be "tortur[ous]" and "barbar[ous]"—nor can the deprivation constitute deliberate indifference.[137]

The same principle applies to SRS for gender-dysphoric inmates.[138] Of the fifty states, their respective correctional administrative agencies, and Washington D.C., five states explicitly acknowledge or provide a path for SRS upon exhibited medical need based on "community standards."[139] Eight states provide for elective

133. *See* Fernandez v. United States, 941 F.2d 1488, 1493 (11th Cir. 1991) (upholding the Federal Bureau of Prisons's guideline of requiring a prisoner to establish his ability to pay for an organ-transplant procedure prior to granting a medical furlough).

134. *See* Estelle v. Gamble, 429 U.S. 97, 106 (1976).

135. *See Rhodes*, 452 U.S. at 347; LAMB-MECHANICK & NELSON, *supra* note 132, at 50.

136. *See Estelle*, 429 U.S. at 102.

137. *See supra* notes 116–117 and accompanying text.

138. *See* Kosilek v. Spencer, 774 F.3d 63, 96 (1st Cir. 2014); Gibson v. Collier, 920 F.3d 212, 216 (5th Cir. 2019); White v. Farrier, 849 F.2d 322, 325 (8th Cir. 1988) (noting that in regard to SRS that "the [Supreme] Court has expanded the reach of the eighth amendment to parallel society's evolving standards of decency. Denial of medical care that results in unnecessary suffering in prison is inconsistent with contemporary standards of decency and gives rise to a cause of action . . . .") (citation omitted).

139. *See* ALA. DEP'T OF CORR., ADMIN. REGUL. NO. 602 (2007) ("Sexual Reassignment Therapy: A treatment for transsexuals in which hormone medications or surgical procedures are utilized to alter a person's physical appearance, in an attempt to adopt the physical characteristics of the opposite gender."); CAL. CORR. HEALTH CARE SERVS., CCHCS/DHCS CARE GUIDE: TRANSGENDER 29 (2020) (detailing criteria to be met for SRS to be considered); MASS. DEP'T OF CORR., IDENTIFICATION, TREATMENT, & CORR. MGMT. OF INMATES DIAGNOSED WITH GENDER

therapies that by regulatory text do not *disallow* SRS.[140] Two states explicitly preclude SRS as an obligatory medical treatment.[141] Thirty-four states and D.C. institute policies describing that mental-health services be made available for medical necessities, medical need, or some other baseline equivalent guided by the minimal legal obligation.[142]

DYSPHORIA § 652.09(A) (2016) ("[S]ex reassignment surgery, removal or augmentation of breasts, removal of testicles, etc. shall be evaluated on a case-by-case basis."); MICH. DEP'T OF CORR., POL'Y DIRECTIVE NO. 04.06.184: GENDER DYSPHORIA § Q (2017) ("Surgical procedures for initiation, advancement, or maintenance of sex reassignment shall be considered on a case by case basis."); WIS. DIV. OF ADULT INSTS., POL'Y & PROCS. NO. 500.70.27 § D (2018) ("Health care staff who receive an initial request from an inmate for hormonal therapy or surgical procedures shall forward the request to the PSU Supervisor."). The state of New Jersey was excluded in this survey for not having made public any policies indicative of mental health care provided to inmates.

140. *See* COLO. DEP'T OF CORR., ADMIN. REGUL. § 700–03(IV)(C)(1) (2019) ("Certain treatment services (e.g. elective therapy treatment, preventive treatment, etc.) will be provided only in specific facilities where resources permit and all mental health services must be ordered by a psychiatric provider or a mental health clinician."); ME. DEP'T OF CORR., POL'YS & PROCS. NO. 18.6 § (3)(e) (2013) ("[E]lective therapy services and preventive treatment, where resources permit."); NEB. DEP'T OF CORR. SERVS., MENTAL HEALTH SERVS. §115.23(III)(A)(4) (2019) ("Elective therapy services based on QMHP determination of level of care (LOC)."); N.M. DEP'T OF CORR., POL'YS & PROCS. CD–180400 § B (2018) ("Elective therapy services and preventive treatment where resources permit."); N.Y. BD. OF CORR., ADMIN. CODE § 2–01(d) ("[E]lective therapy services and preventive treatment where resources permit."); OHIO DEP'T OF REHAB. & CORR., POL'YS: MENTAL HEALTH TREATMENT NO. 67–MNH–15 § I(1)(e) (2020) ("Elective therapy services and preventive treatment inclusive of various mental health treatment groups and individual therapy."); VA. DEP'T OF CORR., OPERATING PROC. NO. 730.1 § (IV)(2)(e) (2018) ("Elective therapy services and preventive treatment where resources permit."); WYO. DEP'T OF CORR., POL'Y & PROC. NO. 4.313 § (IV)(A)(5) (2019) ("[E]lective therapy (*i.e.*, short-term individual, group therapy, *etc.*) and preventative treatment where resources permit.").

141. *See* CONN. DEP'T OF CORR., ADMIN. DIRECTIVE NO. 8.1 § 10(B) (2014) ("Exclusions. The contracted health services provider shall be under no obligation to provide or pay for the following types of services: . . . Sex change surgery."); IOWA DEP'T OF CORRS., POL'Y & PROCS. NO. HSP-704 § (IV)(C)(1)(B) (2020) ("The DOC does not provide aesthetic or cosmetic surgical services.").

142. *See* ALASKA DEP'T OF CORR., MED. & HEALTH CARE SERVS. NO. 807.13 § (V)(A) (2009); ARIZ. DEP'T OF CORR., MENTAL HEALTH TECH. MANUAL CH. 3 § 10(2.5.1.1) (2019) ("[C]linically appropriate treatment options to include: Psychological treatment that addresses ambivalence and/or dysphoria regarding gender."); ARK. BD. OF CORR., ADMIN. RULES § 833(V) (1990); D.C. DEP'T OF CORR., POL'Y & PROCEDURE § 6000.3A(2) (2017); DEL. DEP'T OF CORR., CH. 11: BUREAU OF HEALTHCARE, SUBSTANCE ABUSE, & MENTAL HEALTH SERVS. §§ A–01(V) (2020), G–02(VI) (2019); FLA. DEP'T OF CORR., MENTAL HEALTH SERVS. RULE 33–404.102

Of course, as the Fifth Circuit declared in *Gibson*, "universal acceptance by the medical community" is not necessary to demonstrate medical consensus.[143] However, surely consensus requires more than five states at worst, and thirteen states at best, to demonstrate broad principles of the efficacy of SRS as a required treatment on an individualized basis for inmates. Perhaps, then, consensus can be found in organized medical administrations that every state in the nation participates in.

The purpose of Medicaid is to "provid[e] health care to the indigent in quantity and quality equivalent to *the standard of care available to the general population*."[144] Medicaid coverage can therefore exemplify society's standard of care. As such, the contents

§§ 1, 5 (2018); GA. DEP'T OF CORR., MENTAL HEALTH RECEPTION SCREEN § 508.14(I) (2019); HAW. DEP'T OF PUB. SAFETY, CORR. ADMIN. POL'Y & PROCS., CH. 10 § A.01 (2003); IDAHO DEP'T OF CORR., STANDARD OPERATING PROC. NO. 327 § 3 (2017); ILL. DEP'T OF CORR., HEALTH CARE § 415.40 (2005); IND. DEP'T OF CORR., MANUAL OF POL'YS & PROCS. NO. 01–02–101 § II (2018); KAN. DEP'T OF CORR., INTERNAL MANAGEMENT POL'Y & PROC. § 10–122D (2015); KY. DEP'T OF CORR., POL'YS & PROCS. NO. 13.13 § II (2020); LA. DEP'T OF CORR., INFORMATIONAL HANDBOOK FOR FRIENDS & FAMILIES OF PEOPLE IN PRISON 27; MD. DEP'T OF PUB. SAFETY AND CORR. SERVS., EXECUTIVE DIRECTIVE NO. OPS 131.0001 (2016); MINN. DEP'T OF CORR., POL'YS, DIRECTIVES, & INSTRUCTIONS MANUAL § 202.045(E) (2020); MISS. DEP'T OF CORR., INMATE HANDBOOK CH. IV.I.A (2011); MO. DEP'T OF CORR., THERAPY & TREATMENT (n.d.); MONT. DEP'T OF CORR., HEALTH SERVS. OPERATIONAL PROC. MSP HS G-04.0: MENTAL HEALTH SERVS. (2017); N.C. DEP'T OF PUB. SAFETY, PRISONS, POL'Y & PROCS. § .0201 (2017); NEV. DEP'T OF CORR., ADMIN. REGUL. § 643.02 (2013); N.D. DEP'T OF CORR. & REHAB., CORR. FACILITY STANDARDS 19 (2021); OKLA. DEP'T OF CORR., INMATE MED. MENTAL HEALTH & DENTAL CARE § 14I(A) (2020) ("The purposes of health standards are to: Provide constitutionally required health care for inmates."); N.H. DEP'T OF CORR., ORG. RULES § 502.01(e); OR. DEP'T OF CORR., ADULT IN CUSTODY SERVS. (n.d.); PA. DEP'T OF CORR., POL'Y DIRECTIVE § 13.08.01 (2019); R.I. DEP'T OF CORR., POL'Y & PROC. § 18.43–3 (2019); S.C. DEP'T OF CORR., CARE & CUSTODY OF TRANSGENDER INMATES & INMATES DIAGNOSED WITH GENDER DYSPHORIA § 1 (2017); S.D. DEP'T OF CORR., INMATE MEDICALLY NECESSARY HEALTH CARE NO. 1.4.E.2 §§ III–IV (2019); TENN. DEP'T OF CORR., ADMIN. POL'YS & PROCS. § 113.30 (2018); TEX. DEP'T OF CRIM. JUST., OFFENDER HEALTH SERVS. PLAN 16 (2019); UTAH DEP'T OF CORR., INSTITUTIONAL OPERATIONS DIVISION MANUAL §§ FD18/12.00–12.03 (2013); VT. DEP'T OF CORR., ADMIN. RULE § 05-049 (2005); WASH. DEP'T OF CORR., POL'YS NO. 630.500 (2017); W. VA. DIV. OF CORR., OFFENDER ORIENTATION MANUAL 12 (2006).

143. *See* Gibson v. Collier, 920 F.3d 212, 220 (5th Cir. 2019).

144. Guzman v. Shewry, 552 F.3d 941, 951 (9th Cir. 2009); *see also* Three Lower Cntys. Cmty. Health Servs., Inc. v. Maryland, 498 F.3d 294, 297 (4th Cir. 2007) (citing 42 U.S.C. § 1396) ("The purpose of the Medicaid program is to enable States 'to furnish . . . medical assistance on behalf of families with dependent children . . . whose income and resources are insufficient to meet the costs of *necessary medical services*.'") (emphasis added).

of the relevant states' Medicaid policies illuminate whether SRS is among those standards.

Seventeen states and D.C. require that Medicaid cover SRS in cases of medical necessity.[145] Four states prohibit the discrimination of Medicaid coverage based on gender identity, though do not

145. *See* CAL. DEP'T OF HEALTH & HUMAN SERVS. AGENCY, ALL PLAN LETTER 13-011 (Sept. 25, 2013) ("[T]ransgender services are available to Medi-Cal beneficiaries. The term 'transgender services' refers to the treatment of 'gender identity disorder', which may include . . . gender reassignment surgery that is not cosmetic in nature."); COLO. DEP'T OF HEALTH CARE POL'Y & FIN., MED. ASSISTANCE § 8.735.5.E (Dec. 11, 2020); HUSKY HEALTH CONN., PROVIDER POL'YS & PROCS.: GENDER AFFIRMATION SURGERY 1 (2015); D.C. DEP'T OF HEALTH CARE FIN., BULLETIN 13-IB-01-30/13 REVISED (2014) ("The benefits afforded to individuals seeking treatment for gender dysphoria, including gender reassignment surgeries should not be construed as newly-mandated Medicaid benefits."); Press Release, Ill. Dep't of Healthcare & Family Servs., Fulfilling Gov. Pritzker's commitment to healthcare equity, Medicaid to provide for gender affirming surgery (Apr. 5, 2019); ME. DEP'T OF HEALTH & HUMAN SERVS., MAINECARE BENEFITS MANUAL CH. 2 §§ 90.04–.05 (Sept. 16, 2019); MD. DEP'T OF HEALTH & MENTAL HYGIENE, MANAGED CARE ORGANIZATIONS TRANSMITTAL NO. 110 (Mar. 10, 2016); *MassHealth Guidelines for Medical Necessity Determination for Gender Affirming Surgery*, MASS.GOV https://www.mass.gov/guides/masshealth-guidelines-for-medical-necessity-determination-for-gender-affirming-surgery [https://perma.cc/4HLJ-6Q7Q] (last visited Jan. 11, 2021); *Provider Manual: Gender-Confirming Surgery*, MINN. DEP'T OF HUMAN SERVS. (Oct. 8, 2020), https://mn.gov/dhs/ [https://perma.cc/A5AM-BZTH] (choose "Policies and procedures" from the "Partners and providers" dropdown; then select "Health care"; then select "MHCP Provider Manual"; then select "Physician and Professional Services" from the "Table of Contents"; finally, click on "Gender Conforming Surgery"); MONT. DEP'T OF PUB. HEALTH & HUMAN SERVS., HEALTHCARE PROGRAM NOTICE (2017); NEV. DEP'T OF HEALTH & HUMAN SERVS., WEB ANNOUNCEMENT 1532 (May 8, 2018); N.H. HEALTHY FAMILY MEMBER SERVS., MEDICAID CARE MANAGEMENT PROGRAM MEMBER HANDBOOK 56 (2019); N.Y. COMP. CODES R. & REGS. TIT. 18 § 505.2 (2016); PA. DEP'T OF HUMAN SERVS., MED. ASSISTANCE BULLETIN NO. 99-16-11 (2016); R.I. OFF. OF THE HEALTH INS. COMM'R, GUIDANCE REGARDING PROHIBITED DISCRIMINATION ON THE BASIS OF GENDER IDENTITY OR EXPRESSION 1 (2015); DEP'T OF VT. HEALTH ACCESS, GENDER AFFIRMATION SURGERY FOR THE TREATMENT OF GENDER DYSPHORIA 1 (2020); WASH. ADMIN. CODE § 182-531-1675 (2015); WIS. DEP'T OF HEALTH SERVS., FORWARD HEALTH: TRANSGENDER SURGERY POL'Y 1 (2019). It is worth noting that because this Article is pursuing a question of communal standards that the Wisconsin community originally forbad "[t]ranssexual surgery" until a federal court ruled it violative of the Affordable Care Act's prohibition of medical discrimination in Medicaid based on sex. *See* Flack v. Wis. Dep't of Health Servs., 328 F. Supp. 3d 931, 951 (W.D. Wis. 2019) (ruling that "plaintiffs have made a persuasive evidentiary showing . . . that the Challenged Exclusion prevents them from getting medically necessary treatments on the basis of both their natal sex *and* transgender status, which surely amounts to discrimination on the basis of sex in violation of the ACA").

necessarily provide for SRS.[146] Ten states explicitly forbid SRS from being covered under Medicaid.[147] Eighteen states have no explicit policy regarding SRS and defer to generalized community standards of care.[148]

Surely then, these ratios of providing to not providing SRS do not command a consensus. Of course, the beauty of a dual-federalist system is that states and the federal government are often free to have differing policies for administering healthcare.[149] However, even the federal government has not consistently applied a policy on whether SRS can be medically necessary.[150]

On May 30, 2014, the Department of Health and Human Services (HHS) Department Appeals Board oversaw an appeal regarding Medi*care* coverage of SRS.[151] The board concluded that "[t]he new evidence indicates that transsexual surgery is an effective

146. *See* HAW. REV. STAT. ANN. § 432D-26.3 (West 2016); MICH. DEP'T HEALTH & HUMAN SERVS., MEDICAID PROVIDER MANUAL OVERVIEW 14 (2021); S. 4568, 217th Leg. Assemb., 2d Ann. Sess. § (1)(b)(4)(a) (N.J. 2017) (prohibiting discrimination of "health care services related to gender transition if coverage is available for those services under the contract when the services are not related to gender transition"); OR. HEALTH AUTH., OR. HEALTH PLAN HANDBOOK 21 (Jan. 2020).

147. *See* ALASKA ADMIN. CODE tit. 7, § 110.405 (2020); ARIZ. ADMIN. CODE § R9-22-205(B)(4) (2020); GA. DEP'T OF COMM. HEALTH, AMOUNT, DURATION, & SCOPE OF MED. AND REMEDIAL CARE AND SERVS. PROVIDED TO THE CATEGORICALLY NEEDY 1(c) § (7) (Aug. 1991); MO HEALTHNET, MO. PHYSICIAN'S MANUAL 226–28 (2019); NEB. DEP'T OF HEALTH & HUMAN SERVS., NEBRASKA MED. ASSISTANCE PROGRAM SERVICES § 10-004.01; OHIO DEP'T OF MEDICAID, RULE 5160-2-03 § 7 (2015); TENN. DEP'T OF FIN. & ADMIN., TENNCARE MEDICAID § 1200-13-13-.10(3)(b) (Apr. 2019); TEX. MEDICAID & HEALTHCARE P'SHIP, TEX. MEDICAID PROVIDER PROCS. MANUAL § 1.12 (Nov. 2020); W. VA. DEP'T HEALTH & HUMAN SERVS., POLICY MANUAL CH. 100 - GENERAL INFORMATION 12–13; WYO. DEP'T OF HEALTH, MEDICAID HANDBOOK 17; APPROPRIATIONS, 2019 Ia. Legis. Serv. Ch. 85 (H.F. 766) (West) (allowing providers to choose whether to cover SRS).

148. *See* CHRISTY MALLORY & WILLIAM TENTINDO, MEDICAID COVERAGE FOR GENDER-AFFIRMING CARE 6 (2019) (listing Alabama, Arkansas, Delaware, Florida, Idaho, Indiana, Kansas, Kentucky, Louisiana, Mississippi, New Mexico, North Carolina, North Dakota, Oklahoma, South Carolina, South Dakota, Utah, and Virginia among "states [that] have no express statute or administrative policy addressing coverage for gender-affirming care under their Medicaid programs"). Other states in this list were referenced for other categories discussed.

149. *See* Richard P. Nathan, *Federalism and Health Policy*, 24 HEALTH AFFAIRS 1458, 1459 (2005).

150. *See* Daphna Stroumsa, *The State of Transgender Health Care: Policy, Law, and Medical Frameworks*, 104 AM. J. PUB. HEALTH e31, e33–e34 (2014).

151. *See* DEP'T OF HEALTH & HUMAN SERVS., DEPARTMENTAL APPEALS BD., NCD 140.3, TRANSEXUAL SURGERY 1 (2014), https://www.hhs.gov/sites/default/files/static/dab/decisions/board-decisions/2014/dab2576.pdf [https://perma.cc/CG6K-QZN8].

treatment option in appropriate cases."[152] The Appeals Board arrived at this decision primarily by consulting three doctors, Dr. Bowers, Dr. Hsiao, and Dr. Ettner to "review[] five studies in the [aggrieved party] exhibits."[153] These five studies were explicitly presented in rebuttal to a 1981 aggregated research report that the three doctors considered "outdated and irrelevant based on current medical practices and procedures."[154]

Crucial for dispelling one of the alleged reasons given by Medicare providers for not providing SRS, that the surgery was experimental, the Appeals Board relied on Dr. Ettner's "state[ment] that 'there are numerous long-term follow-up studies on surgical treatment demonstrating that surgeries are effective and have low complication rates.'"[155] In terms of the safety of SRS, the Appeals Board relied on Dr. Ettner's analysis of the studies brought by the aggrieved party that "the complication rate is low and most complications can be overcome by adequate correctional interventions."[156] In regard to the question if SRS was efficacious in treating gender dysphoria, Dr. Ettner noted that the studies showed that "[m]any patients report a dramatic improvement in mental health following surgery, and patients have been able to become productive members of society, no longer disabled with severe depression and gender dysphoria."[157] More is discussed regarding comparative interpretive results in Subsection II.B.2.a.[158]

Additionally, on August 30, 2016, the Centers for Medicaid and Medicare Services (CMS) released a Decision Memo regarding Medicare coverage of SRS procedures and reviewed over thirty-three studies of the effects and outcomes of SRS.[159] Other peer analyses of the studies ranged "from 1979 to 2015" and "[o]ver half of the studies were published after 2005."[160] CMS determined that "there is not

152. *See id.* at 15.

153. *See id.* at 13. It is worth noting that this Dr. Ettner is the same Randi Ettner referred to in the WPATH Standards of Care at *supra* note 63 on the cover page listing writers of the Standards, as well as a caregiver and expert witness in the case of *Edmo*.

154. *Compare id.* at 12, *with infra* Subsection II.B.2.b.

155. DEP'T OF HEALTH & HUMAN SERVS., *supra* note 151, at 18.

156. *See id.* at 14 (internal quotation marks omitted).

157. *Id.* at 16 (internal quotation marks omitted).

158. *See infra* Subsection II.B.2.a.

159. *See* TAMARA SYREK JENSEN ET AL., DECISION MEMO FOR GENDER DYSPHORIA AND GENDER REASSIGNMENT SURGERY (CAG-00446N) 46 (2016) [hereinafter CMS MEMO].

160. *Id.* at 8.

enough high quality evidence to determine whether gender reassignment surgery improves health outcomes for Medicare beneficiaries with gender dysphoria and whether patients most likely to benefit from these types of surgical intervention can be identified prospectively."[161] While acknowledging the clear lack of consensus, CMS left the research question open by acknowledging the possibility that "[SRS] *may* be a reasonable and necessary service for certain beneficiaries with gender dysphoria," but that "[t]he current scientific information is not complete," and the subject warrants further examination.[162]

These determinations occurred approximately two years apart while HHS and CMS were controlled by the *same* political administration, yet the agencies reached diametrically opposed results regarding a bright-line SRS rule. Why? It is important to note that the HHS Appeals Board limited the SRS inquiry to the studies brought by the aggrieved party while the CMS Decision Memo analyzed a plethora of studies without party-presentation limitation.[163] Knowing the different scopes of studies reviewed, the disparity in results is to be expected, as petitioners are free to identify only studies that support their position.[164]

The incongruences in state laws, administrative-agency determinations, Medicaid allotment, and Medicare necessity determinations, however, are clear indications that SRS is not a consensus accepted by the medical community as a medically necessary treatment for gender-dysphoric patients—failing the objectivity test of *Rhodes*.

B. The Wayward "WPATH"

Even given this knowledge, there is a recurring theme regarding the standards of care for patients, incarcerated or not, with gender dysphoria. The World Professional Association for Transgender Health, formerly known as the Harry Benjamin International Gender Dysphoria Association, has been repeatedly cited from *Kosilek* to

161. *Id.* at 48.

162. *See id.* at 41 (emphasis added).

163. *Compare id.* at 6, *with* DEP'T OF HEALTH & HUMAN SERVS., *supra* note 151, at 13.

164. *See* DEP'T OF HEALTH & HUMAN SERVS., *supra* note 151, at 13 (describing that the studies Dr. Hsiao reviewed that were part of the aggrieved party's selected exhibits).

Edmo[165]—endeavoring to discover agreed-upon medical standards. WPATH touts that "[t]he [Standards] are based on the best available science and expert professional consensus."[166] The Standards have also been cited by at least three states in helping determine their respective correctional-healthcare guidelines.[167] This reliance is understandable as a primary function of the organization is to "promote the *highest* standards of health care for individuals through the articulation of Standards of Care (SOC) for the Health of Transsexual, Transgender, and Gender Nonconforming People."[168]

The *highest* standard of health care, however, is not the constitutional mandate.[169] Nor are these higher standards rooted in standard practice. The Standards note that "Version 7, represents a significant departure from previous versions . . . based upon significant cultural shifts, advances in clinical knowledge, and appreciation of the many health care issues that can arise for transsexual, transgender, and gender-nonconforming people beyond hormone therapy and surgery."[170] Version 6 of the Standards was published in 2001 while Version 7 was published in 2012. Approximately a decade for societal standards of care to change is a rapid turnaround that warrants a closer examination of the changes,

165. *See* Kosilek v. Spencer, 774 F.3d 63, 77 (1st Cir. 2014); Gibson v. Collier, 920 F.3d 212, 218 (5th Cir. 2019); Edmo v. Corizon, Inc., 935 F.3d 757, 768 (9th Cir. 2019); *see also* De'lonta v. Johnson, 708 F.3d 520, 522–23 (4th Cir. 2013) (stating that WPATH standards of care "are the generally accepted protocols for the treatment of GID"); Rosati v. Igbinoso, 791 F.3d 1037, 1040 (9th Cir. 2015) ("Although Rosati lacks a medical opinion recommending SRS, []he plausibly alleges that this is because the state has failed to provide h[im] access to a physician competent to evaluate h[im] [according to WPATH Standards]."); Glenn v. Brumby, 724 F. Supp. 2d 1284, 1289 n.4 (N.D. Ga. 2010) ("[T]here is sufficient evidence that statements of WPATH are accepted in the medical community.").

166. WORLD PRO. ASS'N FOR TRANSGENDER HEALTH, *supra* note 63, at 1.

167. *See supra* note 145 (referring to California, Massachusetts, and Wisconsin). Arkansas, Delaware, Maryland, New Mexico, Pennsylvania, and Rhode Island reference the National Commission on Correctional Health Care (NCCHC) Standards, which rely heavily on the WPATH Standards for transgender-inmate healthcare. *See* NAT'L COMM'N ON CORR. HEALTH CARE, POSITION STATEMENT: TRANSGENDER AND GENDER DIVERSE HEALTH CARE IN CORRECTIONAL SETTINGS 2–5 (2020) (citing WPATH and outlining guidelines that are analogous to the WPATH Standards).

168. WORLD PRO. ASS'N FOR TRANSGENDER HEALTH, *supra* note 63, at 1 (emphasis added).

169. *See* Farmer v. Brennan, 511 U.S. 825, 834 (1994) (quoting Rhodes v. Chapman, 452 U.S. 337, 347 (1981)) (observing that a deliberate-indifference claim must show deprivation of the "minimal civilized measure of life's necessities").

170. WORLD PRO. ASS'N FOR TRANSGENDER HEALTH, *supra* note 63, at 1 n.2.

but more importantly, an examination of the sources used to support the most current Standards.[171]

1. *Changing American Society at Breakneck Speeds*

Among the changes between Version 6 and Version 7 is an almost inconsequentially placed nuance to the eligibility criteria for SRS. In Version 6, the "readiness criteria for genital surgery . . . impl[y] satisfactory control of problems (such as sociopathy, substance abuse, psychosis, or suicidality)."[172] It is worth noting that the identification of these exemplary comorbidities is the precise evidence that Dr. Osborne in *Kosilek* used in making her determination against SRS.[173] Additionally, Version 7 continues to cite to the very source detailing the Version 6 requirement as substantiating the Version 7 criteria while a significant difference between the versions persists.

Kosilek, Gibson, and Edmo were all exhibiting at least one of "sociopathy, substance abuse, psychosis, or suicidality" before their respective federal court dispositions.[174] In fact, the existence of these conditions—namely, suicidality—was instrumental for the petitioners in arguing that SRS was medically necessary because without it they would once again be drawn to suicidal tendencies.[175] However, the predecessor to the current Standards elicits that surgery would be appropriate *only* if suicidality were controlled.[176] The current Standards accept this argument, in part, by explicitly ordaining that "[i]f significant medical or mental health concerns are present, they must be well controlled" as a criterion for breast, chest, or genital surgery.[177] However, the sample conditions from Version 6 did not

171. *See generally* Meyer III et al., *supra* note 34.

172. STAN MONSTREY ET AL., PRINCIPLES OF TRANSGENDER MEDICINE AND SURGERY 98, 100 (Randi Ettner et al. eds., 2007).

173. *See* Kosilek v. Spencer, 774 F.3d 63, 79 (1st Cir. 2014).

174. *See id.* at 79 (noting that "given Kosilek's high risk of suicide if denied the surgery, SRS was the only adequate treatment plan"); Gibson v. Collier, 920 F.3d 212, 217 (5th Cir. 2019) (noting that "Gibson has averred that, if he does not receive sex reassignment surgery, he will castrate himself or commit suicide"); Edmo v. Corizon, Inc., 935 F.3d 757, 787 (9th Cir. 2019) (noting that "if Edmo does not receive GCS, there is little chance that h[is] gender dysphoria will improve and []he is at risk of committing self-surgery again, suicide, and further emotional decompensation").

175. *See supra* note 174.

176. *See supra* note 172 and accompanying text.

177. WORLD PRO. ASS'N FOR TRANSGENDER HEALTH, *supra* note 63, at 58–59.

make their way into Version 7.[178] Rather than facilitative of petitioners' arguments, the presence of extreme mental distress leading to suicidality could terminate petitioners' claims of SRS necessity upon rational review of the very source writers that the Standards consider authoritative.[179] Another requirement change between Version 6 and Version 7 is the "real-life experience" component prior to genital surgery.[180] Rather than a "real-life experience," Version 7 only requires that "patients have lived continuously for at least 12 months in the gender role that is congruent with their gender identity."[181] Within the prison setting, however, there are reasons to believe "prisons cannot provide the range of services mentally ill prisoners need in the necessary quantity and quality" such as a "real-life experience."[182] Among them being that "[t]he stress of incarceration can cause morbidity among [the mentally ill], resulting in more severe symptoms and more disruptive behavior."[183] There is additional reason to doubt that inmates may be able to "live[] continuously for at least 12 months in the gender role that is congruent with their gender identity" as prison protocol and safety concerns often prevent complete congruence in the inmates' preferred gender and what the prisons can accommodate.[184] A survey conducted by six researchers notes that "[a]fter suicide, regret could be considered one of the worst possible complications" of SRS and that a "[m]ain

178. *See id.* at 59 (excluding the list of contraindicative mental ailments).

179. *See generally* A.J. Kuiper & P.T. Cohen-Kettenis, *Gender Role Reversal Among Postoperative Transsexuals*, 2 INT'L J. TRANSGENDERISM 10 (1998) (arguing that "[h]ow can the risk of false-positive decisions [resulting in postoperative regret] possibly be reduced? . . . [By] caution in the treatment of gender dysphoric individuals if there is a combination of several risk factors such as stress-related late onset of the gender conflict, fetishistic cross-dressing, *psychological instability and/or social isolation*") (emphasis added). Together, Kuiper and Cohen-Kettenis author twenty-one of the sources cited in the WPATH Standards.

180. *See* Selvaggi et al., *supra* note 39, at 1, 6, tbl.2.

181. *See* WORLD PRO. ASS'N FOR TRANSGENDER HEALTH, *supra* note 63, at 21.

182. *See* Jamie Fellner, *A Corrections Quandary: Mental Illness and Prison Rules*, 41 HARV. C.R.-C.L. L. REV. 391, 394 (2006).

183. Kenneth L. Appelbaum et al., *The Role of Correctional Officers in Multidisciplinary Mental Health Care in Prisons*, 52 PSYCHIATRIC SERVS. 1343, 1343 (2001); *see also* Selvaggi et al., *supra* note 39, at 8 (suggesting that the two terms are intended to be similar: "[a]fter 1-2 years of 'living in an identity congruent gender role' (named 'real-life experience' in the 6th version of the [Standards])).")

184. *See* WORLD PRO. ASS'N FOR TRANSGENDER HEALTH, *supra* note 63, at 21; Edmo v. Corizon, Inc., 935 F.3d 757, 776 (9th Cir. 2019) (showing "Edmo has lived for more than one year 'as a woman to the best of h[is] ability in a male prison'"); Gibson v. Collier, 920 F.3d 212, 217 n.2 (5th Cir. 2019) (listing Gibson as an inmate in a male prison, where women would not be).

reason[] for regret" is the "'real-life experience' [being] mostly skipped."[185]

As a result, it is entirely possible that in the end, "medical staff and facilities at prisons are universally and notoriously inadequate for providing even minimally adequate care" that is necessary to treat certain illnesses—even assuming that SRS qualifies as a medically necessary treatment.[186]

The Standards' version changes as well as the inevitable confusion of them as "flexible clinical guidelines," though yet treated as sanctimoniously rigid guides to gender-dysphoric inmate healthcare by petitioners, lead to further skepticism that the guides are based off of communal standards of care.[187] In the eleven-year gap between these two publications, did the significance of assuaging severe, comorbid mental distress such a suicidality and the significance of encouraging a trial of what the patient would experience via the "real-life experience" "before undergoing irreversible surgery" fade?[188]

For the preponderance of states that simply defer to communally accepted standards of care, a rational review of the breakneck speed and contradictory source justifications for these standards yields a whimpering no.[189] As a result, one can arrive at the simple conclusion that can help direct further litigation regarding inmates suffering from gender dysphoria seeking SRS: The word of WPATH is not dispositive and should be examined as critically as the relevant medical testimony found in the facts of all of the cases presented in this Article. As the First Circuit in *Kosilek* declared, and the Fifth Circuit in *Gibson* echoed, "Nothing in the Constitution mechanically gives controlling weight to one set of professional judgments."[190]

185. *See* Marta R. Bizic et al., *Gender Dysphoria: Bioethical Aspects of Medical Treatment*, 2018 BIOMED RSCH. INT'L 1, 4–5 (2018).

186. *See* Marc J. Posner, *The* Estelle *Medical Professional Judgment Standard: The Right of Those in State Custody to Receive High-Cost Medical Treatments*, 18 AM. J.L. & MED. 347, 366 (1992).

187. *See* WORLD PRO. ASS'N FOR TRANSGENDER HEALTH, *supra* note 63, at 35.

188. *See* Selvaggi et al., *supra* note 39, at 8; WORLD PRO. ASS'N FOR TRANSGENDER HEALTH, *supra* note 63, at 21.

189. *See supra* notes 139–142 and accompanying text.

190. *See, e.g.*, Kosilek v. Spencer, 774 F.3d 63, 96 (1st Cir. 2014) (quoting Cameron v. Tomes, 990 F.2d 14, 20 (1st Cir. 1993)); *Gibson*, 920 F.3d at 220 (quoting *Cameron*, 990 F.2d at 20).

2. *An Examination of the Substantive Errors of the Standards of Care*

WPATH is no exception, particularly when the sources WPATH cites for substantiating its positions often are not as efficacious as the editors thought. There are two notable points in this regard: observed medical-community disagreement and the sources of the Standards.

a. Observed Medical-Community Disagreement

SRS is a broad term that can indicate many different types of procedures.[191] It is worth noting, however, that the federal courts have approached SRS as a one-size-fits-all term that encompasses all of these surgeries.[192] As such, it is not unreasonable to evaluate the merits of the principle regarding SRS's potential medical necessity through analyses of the individual procedures.

As discussed, federal courts have been asked to determine whether SRS is medically necessary, and via the objective test, this task begins and ends with agreed-upon community standards of care.[193] WPATH states that the Standards "are based on the best available science and expert professional consensus."[194] However, well-established scientists who generally praise WPATH simply disagree with the notion of professional consensus in regard to some surgeries sanctioned by the Standards, and WPATH acknowledges this broadly.[195] Dr. Gennaro Selvaggi and Dr. James Bellringer write that "[i]n female-to-male gender dysphoria, no technique is recognized as the standard for penile reconstruction . . . ."[196] As Table

191. WORLD PRO. ASS'N FOR TRANSGENDER HEALTH, *supra* note 63, at 62–63 (listing examples of "orchiectomy, penectomy, vaginoplasty, clitoroplasty, and labiaplasty[,]. . . . [h]ysterectomy, salpingo-oophorectomy, vaginectomy, metoidioplasty, scrotoplasty, urethroplasty, placement of testicular prostheses, and phalloplasty").

192. *See generally, e.g.*, *Kosilek*, 774 F.3d at 63 (using the term "SRS" one hundred and ten times); Gibson v. Collier, 920 F.3d 212 (5th Cir. 2019) (using the term "sexual reassignment surgery" sixty-four times); Edmo v. Corizon, Inc., 935 F.3d 757 (9th Cir. 2019) (using the analogous term "GCS" for gender-confirmation surgery one hundred and seventy-four times).

193. *See supra* Subsection II.A.2.

194. *See* WORLD PRO. ASS'N FOR TRANSGENDER HEALTH, *supra* note 63, at 1.

195. *See id.* at 55 (noting that "[s]ome people, including some health professionals, object on ethical grounds to surgery as a treatment for gender dysphoria, because these conditions are thought not to apply").

196. Gennaro Selvaggi & James Bellringer, *Gender Reassignment Surgery: An Overview*, 8 NATURE REVS. UROLOGY 274, 281 (2011).

Three of Dr. Selvaggi and three other doctors' survey of female-to-male surgical techniques demonstrates, there are at least six different techniques that can be used in penile reconstruction, each of varying limitations and benefits.[197]

Among these listed techniques is a phalloplasty procedure known as "radial forearm free-flap."[198] The limitations associated with this technique are "[u]rinary tract problems[,] [m]ultiple stages[,] [s]tiffener required, or permanent erection if bone is used[,] [d]onor-site morbidity[,] [and] [m]icrosurgical skills required."[199] This operation is not a one-time surgery for the treatment of gender dysphoria; it is simply the first treatment in the predictably long line of others—a "surgery necessitating several steps and [a] high number of revisions."[200] Donor-site morbidity is defined as "any event that require[s] a modification of the postoperative management."[201] Examples of donor-site morbidity as it pertains to radial forearm free-flap surgery are "nerve injury, delayed wound healing, [] decreased hand strength[,] [and] . . . skin graft failure."[202]

The physical consequences of such a surgery cannot be understated and informing patients of the potential complications is in line with ethical medical practice.[203] "If the patient's goal is a neophallus of good appearance, standing micturition, sexual sensation, and/or coital ability, patients should be clearly informed that surgery would require several separate stages, with technical difficulties, and high likelihood of additional operations."[204] Of course, this *is* the goal for female-to-male patients as:

197. *See* Selvaggi et al., *supra* note 39, at 9.

198. Corinne O'Keefe Osborn, *Phalloplasty: Gender Confirmation Surgery*, HEALTHLINE, https://www.healthline.com/health/transgender/phalloplasty [https://perma.cc/B88B-GNT3] (Sept. 18, 2018) ("A phalloplasty is the construction or reconstruction of a penis. The phalloplasty is a common surgical choice for transgender and nonbinary people interested in gender confirmation surgery.").

199. *See* Selvaggi et al., *supra* note 39, at 9.

200. *See id.* at 8.

201. O. Lauthe et al., *The Indications and Donor-Site Morbidity of Tibial Cortical Strut Autografts in the Management of Defects in Long Bones*, 100-B BONE & JOINT J. 667, 667 (2018).

202. Alexandra Kovar et al., *Donor Site Morbidity in Phalloplasty Reconstructions: Outcomes of the Radial Forearm Free Flap*, 7 PLASTIC RECONSTRUCTION SURGERY GLOB. OPEN 1, 1 (2019).

203. *See* Cruzan by Cruzan v. Dir., Missouri Dep't of Health, 497 U.S. 261, 269 (1990) (observing that "[t]he informed consent doctrine has become firmly entrenched in American tort law").

204. *See* Selvaggi et al., *supra* note 39, at 8.

> [i]n gender reassignment, the aim is to restore health, intended as physical, mental, and social well-being to transsexuals individuals; in order to restore health, (genital) surgery is trying to restore function (i.e., urinating in a [sic] the desired male or female manner, practicing sexual intercourse, possibly achieving orgasm; (better) passibility in the preferred gender).[205]

As Dr. Selvaggi and his peers state, the most efficacious way to achieve these goals is by the highly complicated, error-prone, and lengthy process of surgical intervention.[206] Though of course, which surgery to intervene with is not agreed upon, but given Dr. Selvaggi's table of limitations and benefits and the motivations behind surgery, the signs point to the most complicated—phalloplasty radial forearm free-flap.[207] If one is convinced that the signs do *not* point to the notably complicated reconstructive surgeries, however, the Standards indicate that as opposed to reconstructive surgery, "[a]esthetic or cosmetic surgery is mostly regarded as not medically necessary."[208] Regardless, SRS fails to be a consensus-agreed-upon medically necessary treatment. Further, it is worth noting that the follow-up procedures to SRS are arguably largely aesthetic in nature and as such would clearly, even by WPATH Standards, not be covered as medically necessary, thereby depriving female-to-male gender-dysphoric inmates of an important step in this procedure.[209]

The psychological consequences of reconstructive surgery also cannot be understated. The likely avenue of thought for an advocate of SRS in reading this now is: The goal of the surgery is to assuage mental distress, and if the price of that is physical distress that the patient is willing to assume, then that is permissible. However, there is little reason to believe that psychological distress will dispel. Dr. Selvaggi, Dr. Bellringer, and their associates also note that "[a]fter the gender reassignment process has been completed, transsexual individuals still need health assistance for life . . . [and] they might eventually require corrective surgery or psychological assistance, even long after the gender reassignment."[210]

If the call of petitioners is to judicially require that SRS take place so that petitioners may cease the burden of severe distress that befalls them because of their born gender, what sense does it make to grant such a request if the requested remedy has a significant chance

205. *See id.* at 10.
206. *See id.*
207. *See id.* at 9.
208. *See* WORLD PRO. ASS'N FOR TRANSGENDER HEALTH, *supra* note 63, at 58.
209. *See id.* at 64.
210. *See* Selvaggi et al., *supra* note 39, at 8.

of generating not only physical anguish but further psychological distress? None. The likelihood that SRS has in generating additional psychological burdens is further substantiated by statistics indicating that "[e]x-prisoners with serious mental illness are two to three times more likely to recidivate than other prisoners."[211] Dr. Selvaggi and associates have acknowledged this effect, and the general uncertainty regarding the procedure, as "scientific progress in penile reconstruction is slow, with a lack of controlled studies, high loss to followup, and lack of validated assessment measures."[212]

This is an important example to give because it illustrates the sheer uncertainty of at least some types of SRS surgery and indicates *why* the Supreme Court defers to state standards of care—because for many sizable groups of state and local leaders, these uncertainties and conflicting medical advices do not warrant formal codification as medical necessity.[213]

The prerogative of federal courts is to examine the communal medical objectivity of SRS broadly[214]—not the individual medical decisions regarding specific procedures—as "[c]ourts have uniformly held that supervision of inmates of federal institutions rests with the proper administrative authorities and that courts have no power to supervise the management . . . of such institutions."[215] The discussed individual procedures surely do not pass muster as communally agreed-upon medical treatments, so the term aggregating the individual procedures under one umbrella, SRS, surely does not either.

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211. *See* David B. Kopel & Clayton E. Cramer, *Reforming Mental Health Law to Protect Public Safety and Help the Severely Mentally Ill*, 58 HOW. L.J. 715, 751 (2015).

212. *See* Selvaggi et al., *supra* note 39, at 8.

213. *See supra* notes 140–142, 146–148.

214. *See* Gibson v. Collier, 920 F.3d 212, 225 (5th Cir. 2019).

> An entire agency of the federal government—the Food and Drug Administration—is devoted to making categorical judgments about what medical treatments may and may not be made available to the American people. So imagine an inmate seeks a form of medical treatment that happens to be favored by some doctors, but has not (at least not yet) been approved by the FDA. Could the inmate challenge this deprivation on the ground that it is a categorical prohibition on medical treatment, rather than an individualized assessment? Surely not.

Id.; Edmo v. Corizon, Inc., 935 F.3d 757, 797 (9th Cir. 2019) (citing Kosilek v. Spencer, 774 F.3d 63, 90 (1st Cir. 2014)) (categorizing the First Circuit's broad adjudication reasoning in its determination that "either of two courses of treatment (one included [SRS] and one did not) were medically acceptable").

215. *See* Sutton v. Settle, 302 F.2d 286, 288 (8th Cir. 1962).

b. Sources of the Standards

The unique situation that arises because of the clear medical disagreement regarding, at the very least, *some* types of SRS begs the question as to why WPATH chose to declare both consensus and then that the consensus was on a single, notable side of the medical debate. The instinct is then that perhaps, like Dr. Ettner in the HHS Appeals Board opinion, that WPATH is operating off of a different set of sources than other scholars and considering those definitive.[216]

Even though Dr. Ettner believed that medical data from 1981 and prior was flatly "outdated and irrelevant based on current medical practices and procedures,"[217] this evaluation of sources will not hold the WPATH Standards' pre-1982 sources to the same unforgiving standard.[218] Rather, the sources will be evaluated against the claims that WPATH attributes to them.

Perhaps the most shocking of these incongruencies is found in a series of studies by Michael G. Gelder, M.D. and Isaac M. Marks, M.D. examining the effects of faradic, or electrical, aversion therapy in male "[t]ranssexuals[,]" "[u]ncomplicated transvestites[,]" "[s]adomasochists[,]" and "[f]etishists[.]"[219] WPATH cited this report as support for the claim that "[t]reatment aimed at trying to change a person's gender identity and expression to become more congruent with sex assigned at birth has been attempted in the past without success" and as a result "[s]uch treatment is no longer considered ethical."[220]

The actual study, however, found that "[a]ll except two patients showed moderate to marked improvement in their deviant behavior at the end of the treatment."[221] Gelder and Marks defined male "deviant behavior" as "cross-dressing[,] . . . imagining . . . sadistic sexual fantasies[,] . . . [and] transsexualism" with the improvement of these deviations as the cessation of these acts and thoughts.[222] The study observed that "deviant sexual fantasies diminished in frequency or

216. *See* DEP'T OF HEALTH & HUMAN SERVS., *supra* note 151, at 22–23.

217. *See id.* at 12.

218. *See id.*

219. *See* Michael G. Gelder, M.D. & Isaac M. Marks, M.D., *Aversion Treatment in Transvestism and Transsexualism*, *in* RICHARD GREEN, M.D. & JOHN MONEY, PH.D, TRANSSEXUALISM AND SEX REASSIGNMENT 398 (1969); *see also* Isaac Marks et al., *Sexual Deviants Two Years After Electric Aversion*, 117 BRIT. J. PSYCHIATRY 173, 173 (1970).

220. *See* WORLD PRO. ASS'N FOR TRANSGENDER HEALTH, *supra* note 63, at 16.

221. *See* Gelder et al., *supra* note 219, at 394.

222. *See id.* at 386–87, & 394.

disappeared completely where previously they usually lasted for hours . . . ."[223]

It is important to note, however, that the results for the most extreme cases, manifesting as severe transsexualism, were less clear cut.[224] Marks, Gelder, and Bancroft considered two possibilities in a later study. The first of which was "[t]he development of transsexualism after some years of transvestist activity" indicating that "transsexualism is an index of severity."[225] The alternate explanation was that "transsexualism may indicate an additional and earlier disturbance of gender identity formation in childhood" resulting from "experiences learnt"—experiences that the study showed could be persuaded against via electric aversion.[226]

The results were generally sustained as "occasional deviant thoughts . . . were usually transient and accompanied by little sexual feeling."[227] Additionally, Gelder and Marks note contrarily to the "theoretical dangers of aversion treatment"—"decreas[ing] normal heterosexual feelings and even produc[ing] impotence"—that "if a change did occur following the treatment, it was a *heightened* heterosexual feeling and performance."[228]

Of course, these studies do not necessarily advocate for electric aversion therapy as an active treatment, but in no part of the study cited by WPATH is there any indication that electric aversion therapy is necessarily "without success."[229] Academic honesty is an important

223. *See id.* at 394; *see also* Marks et al., *supra* note 219, at 184 (noting that "[a]fter treatment, deviant acts and fantasies diminished considerably in transvestites, fetishists and sadomasochists. Deviant attitudes changed correspondingly.").

224. *See* Gelder et al., *supra* note 219, at 403 (summarizing that "faradic aversion therapy is a valuable treatment for patients with transvestism, but is less useful in patients in whom transsexualism is pronounced" due to "the lack of motivation for psychic change shown by most transsexuals."); *see also* Marks et al., *supra* note 219, at 184 (noting that "[i]mprovement was transient or absent in the patients who had strong transsexual feelings."). Given the WPATH concession that only "[s]ome people experience gender dysphoria at such a level that the distress meets criteria for a formal diagnosis that might be classified as a mental disorder," it would be inaccurate to say that those with diverse severities of gender dysphoria can be monolithically grouped under the highest severity group observed by Marks. *See* WORLD PRO. ASS'N FOR TRANSGENDER HEALTH, *supra* note 63, at 5.

225. Marks et al., *supra* note 219, at 182.

226. *See id.* at 182–83.

227. Gelder et al., *supra* note 219, at 396 (reporting that "[o]ne transvestite said: 'As soon as I thought of cross-dressing it just went away; I was surprised. I had expected sexual arousal but there wasn't any.'").

228. *Id.* (emphasis added).

229. WORLD PRO. ASS'N FOR TRANSGENDER HEALTH, *supra* note 63, at 16.

part of ordaining medical standards even if the "overall goal of the [Standards] is to . . . assist transsexual, transgender, and gender-nonconforming people with . . . achieving lasting personal comfort with their gendered selves."[230] A goal opposed to the results of a cited study is no excuse for misrepresenting that study.

Further, WPATH's broad advice against "[t]reatment aimed at trying to change a person's gender identity and expression to become more congruent with sex assigned at birth" does not comport with the practice of Harry Benjamin, in honor of whom WPATH was originally named.[231] As a matter of good practice and principle, Benjamin:

> feel[s] that is it wise to point out to the male transsexual how much trouble he will save for himself if he succeeds in accepting himself in the role of his anatomical sex, possibly with the help of some psychotherapy, and/or hormonal treatment. In this way he would avoid an expensive major operation, with the results always being uncertain. The same applies analogously to the female transsexual.[232]

No less jarring is a research survey used by WPATH to substantiate the very crucial claim, which has arisen before numerous federal courts, that "for many [transsexual, transgender, and gender-nonconforming people] surgery is essential and medically necessary to alleviate their gender dysphoria."[233] The survey, conducted by J. Joris Hage, M.D., Ph.D. and Refaat B. Karim, M.D., Ph.D. not only finds, but also advocates that "[o]ne may rightly defend the view that transgender behavior should be de-medicalized for the same reasons that homosexuality was de-medicalized."[234] Demedicalization is the process by which illnesses are taken out of the realm of medical abnormalities and then treated as natural occurrences.[235]

The implications of this direction of medical care, or lack thereof, compared to the position of WPATH are transformative. The Standards advocate for the medical acceptance and medical necessity

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230. *Id.* at 1.

231. *Id.* at 16.

232. Gelder et al., *supra* note 219, at 305.

233. *See* WORLD PRO. ASS'N FOR TRANSGENDER HEALTH, *supra* note 63, at 54.

234. *See* J. Joris Hage & Refaat B. Karim, *Ought GIDNOS Get Nought? Treatment Options for Nontranssexual Gender Dysphoria*, 105 PLASTIC & RECONSTRUCTIVE SURGERY 1222, 1224 (2000).

235. *See* Drew Halfmann, *Recognizing Medicalization and Demedicalization: Discourses, Practices, and Identities*, 16 HEALTH 186, 187 (2011) (noting that medicalization "mean[s] defining behavior as a medical problem or illness *and* mandating or licensing the medical profession to provide some sort of treatment for it," and that "[m]ost scholars define *demedicalization* simply as the obverse of medicalization").

of SRS, but the primary support for such a claim is a survey advocating for the demedicalization of transgender behavior entirely.[236] Hage and Karim also note that this position is not to simply be overpowered by the definitive weight of WPATH opinions.[237] Rather, "the medicalization of gender dysphoria is a subject of *growing* tension between providers and consumers" with WPATH expected to follow suit.[238]

If the very sources that WPATH uses to justify a claim of medical necessity concede to "growing tension" between medicalization and demedicalization, surely this tension does not weigh in the favor of medical consensus on the necessity of SRS. Additionally, if the trend is indeed heading toward the demedicalization of gender dysphoria, then the WPATH Standards indicating that for some "surgery is essential and medically necessary" no longer hold up, and SRS is definitively not medically necessary nor *ever* required by the Eighth Amendment's Cruel and Unusual Punishments Clause.[239]

III. THE REQUIRED COURSE GOING FORWARD

The evidence presented in this Article enables for five determinative takeaways: (1) as illuminated by state action as measured by administrative regulation and prison healthcare administration, SRS does not reach the threshold of consensus; (2) general-population standards of healthcare as exemplified in both Medicaid and Medicare coverage show that SRS fails the objective test of *Estelle* and cannot be considered a medically necessary treatment fulfilling the minimum standards of care; (3) that the

236. *See* WORLD PRO. ASS'N FOR TRANSGENDER HEALTH, *supra* note 63, at 54–55.

237. *See* Hage & Karim, *supra* note 234, at 1224–25.

238. *See id.* at 1224 (emphasis added); *see also* LOREN S. SCHECHTER & BAUBACK SAFA, GENDER CONFIRMATION SURGERY 310 (2018) (positing that a gender-dysphoria diagnosis may not even be a requirement in the 8th Version of the Standards of Care as it has been argued that the exclusion of the surgery to medical need is not in line with other surgeries which may be pursued simply by desire: "individuals seek[ing] surgery to bring the body into alignment with the gender identity" while "not experience[ing] gender dysphoria").

239. *See* Dean Spade, Commentary, *Resisting Medicine, Re/modeling Gender*, 18 BERKELEY WOMEN'S L.J. 15, 23, 28–29 (2003) (stating as a transgender activist and law professor that Spade's "goal for trans law and policy remains demedicalization"); WORLD PRO. ASS'N FOR TRANSGENDER HEALTH, *supra* note 63, at 54.

whirlwind speeds at which the federal government has flatly declared medically necessary and not medically necessary in regard to SRS show that there is clearly not consensus regarding the indispensability of SRS; (4) clear medical disagreement regarding at least some individual treatments that may fall under the umbrella term "SRS" are conceded to be debatable; and (5) that the Standards put forth by WPATH are intellectually dishonest, founded on evidence that does not comport with the Standards themselves, and openly motivated by political considerations that have seemingly led to the latter two faults.

All of these findings indicate that SRS is not medically necessary as it does not enjoy consensus within the medical community as medically necessary and that the WPATH Standards, though treated as dogma by numerous states, agencies, and federal judges, lack the rigor and logical muster to be treated as such.[240]

How then, does the legal community proceed forward with these findings in mind? The first is that federal courts defer to the states in matters of ordaining the medical necessity of treatment. Of course, deference does not mean, by established jurisprudence, that a state has free reign to ordain jurisprudentially unusual low standards of care, and when challenged, use the affirmative defense of "we are the state; we make the standards."

Rather, the totality of state action is a better metric in deciding whether there is reasonable agreement regarding various procedures.[241] This measure is not a new idea and has been regularly practiced by the Supreme Court.[242] Deference to states, and not WPATH, makes sense as "[o]ur Constitution principally entrusts '[t]he safety and the health of the people' to the politically accountable officials of the *States* 'to guard and protect.'"[243] Even when states "'undertake[] to act in areas fraught with medical and scientific uncertainties,' their latitude 'must be especially broad.'"[244]

240. *See supra* note 165.

241. *See supra* note 116 and accompanying text.

242. *See, e.g.*, Gregg v. Georgia, 428 U.S. 153, 175 (1976) (citing Furman v. Georgia, 408 U.S. 238, 383 (1972) (Burger, C.J., dissenting)) (claiming "[t]his is true in part because the constitutional test is intertwined with an assessment of contemporary standards and the legislative judgment weighs heavily in ascertaining such standards. '[I]n a democratic society legislatures, not courts, are constituted to respond to the will and consequently the moral values of the people.'").

243. S. Bay United Pentecostal Church v. Newsom, 140 S. Ct. 1613, 1613 (2020) (Roberts, C.J., concurring) (emphasis added) (citing Jacobson v. Massachusetts, 197 U.S. 11, 38 (1905)).

244. *Id.* (quoting Marshall v. United States, 414 U.S. 417, 427 (1974)).

Even when the inevitable next case regarding whether or not prisons are required to provide and fund SRS arises, the unelected federal judiciary "lacks the background, competence, and expertise to assess public health and is not accountable to the people."[245]

This judicial course–correction assumes that the medical standards of care for gender-dysphoric patients do not succumb to the growing calls for demedicalization of the condition.[246] If such calls are answered, then the contention over whether prisons must provide SRS becomes moot, as gender dysphoria would no longer be within the purview of medicine. Regardless, the jurisprudentially and critically examined path forward is clear—the only legitimate arbiters of the medical standards of care are the fifty states and the District of Columbia.

CONCLUSION

For the lives affected by the struggle between gender-dysphoric inmates' medical requests and federal jurisprudence, the outcome is a denial of SRS, and predictably so. As Justice Holmes professed, "The law is the witness and external deposit of our moral life."[247] In a dual-federalist society, it is unsurprising that the moral life reflects differently among different states with people of different ideas—it is simply diversity. The Eighth Amendment, even by its most expansive construction, relies on the least common denominator among the states, and the people of the various states are not aligned behind SRS.

As the inspiration for the World Professional Association for Transgender Health, once named after him, Harry Benjamin wrote, "Legal reforms notoriously take place at a snail-like pace."[248] Yet, in the fifty-year period between his writing and now, the lives of transgender and gender-dysphoric Americans have changed substantially.[249] This change is likely due to what has been observed by state action surveyed in this Article—local advocacy and policy

245. *See id.* at 1614 (citing Garcia v. San Antonio Metro. Transit Auth., 469 U.S. 528, 545 (1985)).

246. *See supra* notes 234–239 and accompanying text.

247. Oliver Wendell Holmes, *The Path of the Law*, 10 HARV. L. REV. 457, 459 (1897).

248. *See* HARRY BENJAMIN, THE TRANSSEXUAL PHENOMENON 81 (1966).

249. *See* Genny Beemyn, *Transgender History in the United States*, *in* LAURA ERICKSON-SCHROTH, TRANS BODIES, TRANS SELVES 1, 40–41 (2014) (listing various ways in which the understanding of the lives of transgender people have changed throughout American history).

change. Rarely are the artifices of our legal life administered from the top-down.[250] Rather, the instrumentality of local systems takes precedence in creating reforms desired by interested groups.[251]

For transgender people and those with gender dysphoria, the future of legal protections is entirely within control. State action is not a one-way street. While this Article demonstrates, through states, that SRS is not by "consensus" "medically necessary," the very category that damns SRS as a federal constitutional right—the state—can also become the progenitor of new rights that grant protections indicative of the "external deposit[ion] of our moral life."[252]

250. *See* David Schleicher, *Federalism and State Democracy*, 95 TEX. L. REV. 763, 763 (2017) (observing that "[s]tate and local governments, it is said, are closer to the people, promote more innovation, and produce outputs that are a better fit for the diverse set of preferences that exist in a large nation").

251. *See generally* JEFFREY S. SUTTON, 51 IMPERFECT SOLUTIONS: STATES AND THE MAKING OF AMERICAN CONSTITUTIONAL LAW 202 (2018) (opining that "[i]f change is to come in [the balancing of state and federal legal relief], it's likely to come from the state courts, not the federal courts").

252. *See* Holmes, *supra* note 247, at 459.