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TRANSGENDER RIGHTS & THE EIGHTH AMENDMENT

JENNIFER LEVI* & KEVIN M. BARRY†

ABSTRACT

The past decades have witnessed a dramatic shift in the visibility, acceptance, and integration of transgender people across all aspects of culture and the law. The treatment of incarcerated transgender people is no exception. Historically, transgender people have been routinely denied access to medically necessary hormone therapy, surgery, and other gender-affirming procedures; subjected to cross-gender strip searches; and housed according to their birth sex. But these policies and practices have begun to change. State departments of corrections are now providing some, though by no means all, appropriate care to transgender people, culminating in the Ninth Circuit’s historic decision in Edmo v. Corizon, Inc. in 2019—the first circuit-level case to require a state to provide transition surgery to an incarcerated transgender person. Other state departments of corrections will surely follow, as they must under the Eighth Amendment. These momentous changes, which coincide with a broader cultural turn away from transphobia and toward a collective understanding of transgender people, have been neither swift nor easy. But they trend in one direction: toward a recognition of the rights and dignity of transgender people.

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INTRODUCTION

On June 15, 2020, in *Bostock v. Clayton County*, the U.S. Supreme Court issued a landmark decision for the lesbian, gay, bisexual, transgender, and queer (“LGBTQ”) movement.¹ In an opinion with sweeping consequences, the Court interpreted Title VII of the Civil Rights Act’s prohibition on “sex” discrimination to include discrimination based on transgender status.² According to the Court, “The statute’s message for our cases is . . . simple and momentous: An individual’s homosexuality or

1. *Bostock v. Clayton Cnty.*, 140 S. Ct. 1731, 1737 (2020).

2. *Id.*

transgender status is not relevant to employment decisions. That’s because it is impossible to discriminate against a person for being homosexual or transgender without discriminating against that individual based on sex.”³ As the Court’s dissenters rightly predicted, *Bostock*’s holding “is virtually certain to have far-reaching consequences,” given that over one hundred federal statutes and the Federal Equal Protection Clause prohibit sex-based discrimination.⁴

As legal barriers to transgender equality fall, this Article addresses one barrier that *Bostock* did not directly reach: the denial of medical care to incarcerated transgender people in violation of the Eighth Amendment.⁵ The past two decades have witnessed a dramatic shift in corrections facilities providing some, though by no means all, appropriate care to transgender people, culminating in the Supreme Court’s denial of certiorari on October 13, 2020 in *Edmo v. Corizon, Inc.*—the first circuit-level case to require a state department of corrections to provide transition surgery to an incarcerated transgender person.⁶

This Article traces the historic strides that incarcerated transgender people have made under the Eighth Amendment, from the rejection of policies that house transgender people based on their birth sex, to the requirement that prison officials provide transgender people with access to hormone therapy, social transition, and, most recently, transition surgery.⁷ Changes in prison practices and policies toward incarcerated transgender people, although neither swift nor easy, trend in one direction: toward a recognition of the rights and dignity of transgender people. These

3. *Id.* at 1741.

4. *Id.* at 1778 (Alito & Thomas, JJ., dissenting). Although *Bostock* was a Title VII case, courts routinely look to Title VII when interpreting other sex discrimination statutes and the Equal Protection Clause. *See, e.g.,* Grimm v. Gloucester Cnty. Sch. Bd., 972 F.3d 586, 616–17 (4th Cir. 2020) (applying Title VII case law to Title IX and equal protection claims); Adams *ex rel.* Kasper v. Sch. Bd. of St. Johns Cnty., 968 F.3d 1286, 1305 (11th Cir. 2020) (same); Whitaker *ex rel.* Whitaker v. Kenosha Unified Sch. Dist. No. 1 Bd. of Educ., 858 F.3d 1034, 1047 (7th Cir. 2017) (“Although not as often as some of our sister circuits, this court has looked to Title VII when construing Title IX.”); Glenn v. Brumby, 663 F.3d 1312, 1316–18 (11th Cir. 2011) (applying Title VII case law to equal protection claims); Smith v. City of Salem, 378 F.3d 566, 577 (6th Cir. 2004) (same); Back v. Hastings on Hudson Union Free Sch. Dist., 365 F.3d 107, 117–21 (2d Cir. 2004) (same).

5. Because *Bostock* has been interpreted to apply to discrimination based on transgender status under the Equal Protection Clause, it has important implications for incarcerated transgender people who are denied medically necessary care. *See, e.g.,* Grimm, 972 F.3d at 616–617 (applying Title VII case law to Title IX and equal protection claims); Adams *ex rel.* Kasper, 968 F.3d at 1305 (same).

6. *Edmo v. Corizon, Inc.*, 935 F.3d 757 (9th Cir. 2019), *reh’g denied*, 949 F.3d 489 (9th Cir. 2020) (en banc), *cert. denied sub nom.* Idaho Dep’t of Corr. v. Edmo, 141 S. Ct. 610 (2020). Transition surgery refers to a range of procedures that change one’s primary and/or secondary sex characteristics, including surgery on the breasts or chest, external or internal genitalia, and facial features. *See* discussion *infra* Section II.A.1.

7. *See infra* Parts II–III.

momentous changes in the prison context coincide with a broader cultural turn away from transphobia and toward a collective understanding of transgender people and the medical care essential to transgender people's health and well-being.⁸

Part I of this Article provides a snapshot of the historic progress that transgender people have made in recent decades, both culturally and under the law.⁹ From sustained mass media attention to expressions of solidarity from celebrities and faith, business, and political leaders, transgender people's voices are resonating throughout American culture. And the momentous legal gains achieved during the administration of President Barack Obama, although temporarily halted in some cases during his successor's term, continue under President Joe Biden. Part II turns to the success of incarcerated transgender people in securing their rights under the Eighth Amendment, which is emblematic of the historic progress of transgender people.¹⁰ In recent years, courts have ruled in favor of incarcerated transgender people who were denied access to medically necessary care, including hormone therapy, commissary items, and gender-appropriate strip-searches and housing. Part III discusses the most recent and consequential development in the rights of incarcerated transgender people: the Ninth Circuit's historic decision in *Edmo v. Corizon, Inc.*, which affirmed a district court order requiring a state department of corrections to provide transition surgery to an incarcerated transgender woman.¹¹ The Conclusion of this Article offers some closing remarks.¹²

I. THE PROGRESS OF TRANSGENDER PEOPLE IN CULTURE AND IN LAW

The past decades have witnessed dramatic shifts in the visibility, acceptance, and integration of transgender people across all aspects of culture. Nearly a century of sensationalized media depictions of transgender people have been replaced by “an explosion of mainstream media representations of trans issues actually produced by and inclusive of trans people,” and by user-generated, trans-inclusive content on social media.¹³ Summer camps, books, and other resources have helped parents support their transgender children.¹⁴ LGBTQ peer support groups, in person and on social

8. *See infra* Part I.

9. *See infra* Part I.

10. *See infra* Part II.

11. *See infra* Part III.

12. *See infra* Conclusion.

13. SUSAN STRYKER, *TRANSGENDER HISTORY: THE ROOTS OF TODAY'S REVOLUTION* 195 (2d ed. 2017).

14. *Id.* at 199.

media, have helped transgender youth find and build community.¹⁵ Medical and social science have informed society's understanding of gender identity and the transgender community.¹⁶ Workplaces and schools have adopted policies that support transgender health and safety.¹⁷ An overwhelming majority of Americans support allowing transgender people to serve openly in the U.S. military.¹⁸ Many faith communities have begun to welcome and support transgender people.¹⁹ And private businesses have publicly expressed solidarity with transgender people, most notably by cancelling planned business investments, conferences, concerts, and sporting events—including the 2017 NCAA men's basketball playoffs—in response to a North Carolina law that stripped transgender people of local civil rights protections and required that they use bathrooms based on their birth sex rather than their lived identities.²⁰

Additionally, transgender-led grassroots activism, nascent in the 1950s, has grown into a powerful social and political force, helping to shape national policies that affect transgender people and influencing other grassroots movements, most notably Black Lives Matter, which have embraced and advanced the rights of transgender people.²¹ A national conversation about gender has changed the way we talk, with growing acceptance of gender-neutral honorifics and pronouns; the way we express ourselves, with youth fashion trends that blur the line between traditional men's and women's clothing; and the accommodations we use, with the

15. Colt Keo-Meier & Lance Hicks, *Youth*, in *TRANS BODIES, TRANS SELVES: A RESOURCE FOR THE TRANSGENDER COMMUNITY* 446, 460–61 (Laura Erickson-Schroth ed., 2014).

16. See, e.g., WORLD PRO. ASS'N FOR TRANSGENDER HEALTH, *STANDARDS OF CARE FOR THE HEALTH OF TRANSEXUAL, TRANSGENDER, AND GENDER-NONCONFORMING PEOPLE* 5 (7th ed. 2012) [hereinafter *WPATH STANDARDS*], https://www.wpath.org/media/cms/Documents/SOC%20v7/SOC%20V7_English2012.pdf?t=1613669341 [<https://perma.cc/7FK3-WH7L>]; Genny Beemyn, *U.S. History*, in *TRANS BODIES, TRANS SELVES: A RESOURCE FOR THE TRANSGENDER COMMUNITY* 501, 501–32 (Laura Erickson-Schroth ed., 2014).

17. See, e.g., HUM. RTS. CAMPAIGN FOUND., *CORPORATE EQUALITY INDEX 2021* 6, 18 (2021) [hereinafter *HRC INDEX*], https://hrc-prod-requests.s3-us-west-2.amazonaws.com/CEI-2021_FINAL.pdf?mtime=20210128123716&focal=none [<https://perma.cc/A7GQ-3L8T>]; U.S. DEP'T OF EDUC., *EXAMPLES OF POLICIES AND EMERGING PRACTICES FOR SUPPORTING TRANSGENDER STUDENTS 1–15* (2016), <https://www.justice.gov/opa/file/851001/download> [<https://perma.cc/XL6P-WS74>].

18. Justin McCarthy, *In U.S., 71% Support Transgender People Serving in Military*, GALLUP (June 20, 2019), <https://news.gallup.com/poll/258521/support-transgender-people-serving-military.aspx> [<https://perma.cc/UQ2G-UQP3>].

19. See Delfin Bautista, Quince Mountain, & Heath Mackenzie Reynolds, *Religion and Spirituality*, in *TRANS BODIES, TRANS SELVES: A RESOURCE FOR THE TRANSGENDER COMMUNITY* 62, 65–71 (Laura Erickson-Schroth ed., 2014) (discussing inclusion of transgender people in Christianity, Islam, Judaism, and Hinduism); see also Christina Morales, *Hundreds of Religious Leaders Call for End to L.G.B.T.Q. Conversion Therapy*, N.Y. TIMES (Dec. 16, 2020), <https://www.nytimes.com/2020/12/16/world/conversion-therapy-pledge.html> [<https://perma.cc/5NXP-J8LC>].

20. STRYKER, *supra* note 13, at 223; Public Facilities Privacy & Security Act of 2016, N.C. GEN. STAT. § 115C-521.2 (2016), *repealed by* An Act to Reset, 2017 N.C. Sess. Laws 4.

21. STRYKER, *supra* note 13, at 210.

proliferation of all gender restrooms.²² Further, support for transgender people has come from the very highest levels of government: in 2015, the country's first African-American president, Barack Obama, became the first president to use the word "transgender" in a State of the Union; in 2012, then vice president, now president, Joe Biden called transgender discrimination "the civil rights issue of our time",²³ and transgender representation continues to expand in statehouses, courthouses, agencies, mayorships, and city councils throughout the country.²⁴

The progress of transgender people is also evident in law. In recent years, transgender people have successfully challenged laws and practices that have historically excluded and otherwise discriminated against them. Specifically, transgender people have relied on federal, state, and local anti-discrimination laws, as well as federal and state constitutional law, to challenge discrimination in the workplace, such as termination, harassment, and the denial of equal employment benefits;²⁵ discrimination in schools, such as the refusal to permit transgender boys to use the boys' communal use restroom or girls to use the girls' one;²⁶ and discrimination in healthcare, such as the exclusion of transition-related care in state Medicaid plans and the denial of coverage of appropriate care by healthcare providers.²⁷ In 2010, transgender people successfully argued before the U.S. Tax Court that hormone therapy and transition-related surgeries are tax-deductible medical expenses.²⁸ And in 2015, transgender people successfully claimed protection under the Americans with Disabilities Act for discrimination based on gender dysphoria.²⁹

In addition to these court victories, transgender people have successfully advocated for federal, state, and local legislation and administrative policies that further the rights of transgender people. At the federal level, Congress passed the Matthew Shepard and James Byrd, Jr., Hate Crimes Prevention Act of 2009, which allows federal criminal prosecution of hate crimes motivated by the victim's actual or perceived sexual orientation or gender identity.³⁰ The following year, Congress passed

22. *Id.* at 201, 220.

23. *Id.* at 218; Alexandra Jaffe, *Obama Makes Historic Transgender Reference in SOTU*, CNN: POLITICS (Jan. 20, 2015, 11:55 PM), <https://www.cnn.com/2015/01/20/politics/obama-transgender-sotu/index.html> [<https://perma.cc/T8J5-UYRW>].

24. STRYKER, *supra* note 13, at 224.

25. *See, e.g.*, *Bostock v. Clayton Cnty.*, 140 S. Ct. 1731, 1737 (2020).

26. *See, e.g.*, *Grimm v. Gloucester Cnty. Sch. Bd.*, 972 F.3d 586, 593–94 (4th Cir. 2020).

27. *See, e.g.*, *Flack v. Wis. Dep't of Health Servs.*, 328 F. Supp. 3d 931, 934 (W.D. Wis. 2018).

28. *O'Donnabhain v. Comm'r*, 134 T.C. 34, 76–77 (2010).

29. *Blatt v. Cabela's Retail, Inc.*, No. 5:14-cv-04822, 2017 U.S. Dist. LEXIS 75665, at *8–11 (E.D. Pa. May 18, 2017).

30. *Matthew Shepard and James Byrd, Jr., Hate Crimes Prevention Act of 2009*, 18 U.S.C. § 249.

the Patient Protection and Affordable Care Act of 2010, which among other things, prohibits sex discrimination by health providers.³¹ Under the Obama administration, the State Department updated its requirements for amending federal identity documents such as passports and social security cards, aligning these requirements with a contemporary understanding of the medical needs of transgender people.³² Heralding the Supreme Court's holding in *Bostock* in 2020, the Equal Employment Opportunity Commission ruled in 2012 that employment discrimination against a transgender person is sex discrimination under Title VII of the Civil Rights Act of 1964.³³ In 2014, the Department of Health and Human Services invalidated its 1989 determination denying Medicare coverage of transition surgery.³⁴ In 2015, the Obama administration barred federal contractors from discriminating based on gender identity and sexual orientation.³⁵ In 2016, the Departments of Justice and Education released joint guidance to protect the rights of transgender students in school.³⁶ On January 20, 2021, the day of his inauguration, President Biden issued a sweeping executive order requiring all federal agencies to review their regulations and policies and revise them to comply with *Bostock*'s holding that discrimination "because of . . . sex" includes discrimination based on gender identity and sexual orientation.³⁷ Five days later, on January 25, 2021, President Biden revoked the Trump administration's ban on transgender people serving in the U.S.

31. 42 U.S.C. § 18116(a); see also *Section 1557 of the Patient Protection and Affordable Care Act*, U.S. DEP'T OF HEALTH & HUM. SERVS., <https://www.hhs.gov/civil-rights/for-individuals/section-1557/index.html> [<https://perma.cc/NM4W-62RM>].

32. See Kylar W. Broadus & Shannon Price Minter, *Legal Issues*, in *TRANS BODIES, TRANS SELVES: A RESOURCE FOR THE TRANSGENDER COMMUNITY* 174, 178–80 (Laura Erickson-Schroth ed., 2014).

33. *Macy v. Holder*, EEOC Decision No. 0120120821, 2012 EEOPUB LEXIS 1181, at *33–34 (Apr. 20, 2012).

34. *NCD 140.3, Transsexual Surgery*, DEP'T OF HEALTH & HUM. SERVS. (May 30, 2014), <https://www.hhs.gov/sites/default/files/static/dab/decisions/board-decisions/2014/dab2576.pdf> [<https://perma.cc/72TE-JXDV>].

35. Secretary Thomas E. Perez, *Another Step Toward Equality for LGBT Workers*, OBAMA WHITE HOUSE (Apr. 8, 2015, 10:57 AM), <https://obamawhitehouse.archives.gov/blog/2015/04/08/another-step-toward-equality-lgbt-workers> [<https://perma.cc/XXG3-WDEC>].

36. U.S. DEP'T OF JUST. & U.S. DEP'T OF EDUC., *DEAR COLLEAGUE LETTER ON TRANSGENDER STUDENTS* (May 13, 2016), <https://www2.ed.gov/about/offices/list/ocr/letters/colleague-201605-title-ix-transgender.pdf> [<https://perma.cc/DYW5-HA5R>]. In 2017, the Trump administration rescinded this guidance, citing, inter alia, a federal district court's holding "that the term 'sex' unambiguously refers to biological sex" and stating that "there must be due regard for the primary role of the States and local school districts in establishing educational policy." U.S. DEP'T OF JUST. & U.S. DEP'T OF EDUC., *DEAR COLLEAGUE LETTER 1* (Feb. 22, 2017), <https://www.justice.gov/crt/page/file/942021/download> [<https://perma.cc/M32L-B4NH>].

37. Exec. Order No. 13988, 86 Fed. Reg. 7023 (Jan. 20, 2021); see also *Executive Order on Preventing and Combating Discrimination on the Basis of Gender Identity or Sexual Orientation*, WHITE HOUSE (Jan. 20, 2021), <https://www.whitehouse.gov/briefing-room/presidential-actions/2021/01/20/executive-order-preventing-and-combating-discrimination-on-basis-of-gender-identity-or-sexual-orientation> [<https://perma.cc/2UY7-PKA2>].

military and restriction of service members' access to transition surgery, reaffirming the Department of Defense's conclusion in 2016 that permitting transgender people to serve openly is consistent with military readiness and strength through diversity.³⁸ In February 2021, Housing and Urban Development became the first of what no doubt will be many federal agencies to issue a memorandum notifying grantees and the public that, consistent with the *Bostock* opinion, it will administer and enforce federal sex discrimination statutes to prohibit discrimination on the basis of transgender status.³⁹

Legal reform at the state and local levels has been equally momentous: approximately twenty-one states and 330 municipalities prohibit discrimination in employment, housing, and public accommodations based on sexual orientation and gender identity; twenty-four states prohibit health insurance exclusions for transition-related care; twenty states prohibit conversion therapy for LGBTQ minors; twenty-seven states prohibit discrimination in adoption based on sexual orientation and gender identity; twenty states prohibit school bullying on the bases of sexual orientation and gender identity; twenty-three states require neither transition surgery nor a court order to change the gender marker on one's birth certificate, with fourteen of these states permitting residents to designate their gender as "X"; and thirty-eight states do not require proof of transition surgery, a court order, or an amended birth certificate to change the gender marker on one's driver's license, with twenty of these states permitting residents to designate their gender as "X."⁴⁰

38. Exec. Order No. 14004, 86 Fed. Reg. 7471 (Jan. 25, 2021); see also *Executive Order on Enabling All Qualified Americans to Serve Their Country in Uniform*, WHITE HOUSE (Jan. 25, 2021), <https://www.whitehouse.gov/briefing-room/presidential-actions/2021/01/25/executive-order-on-enabling-all-qualified-americans-to-serve-their-country-in-uniform> [<https://perma.cc/H3DR-L4CV>]. In 2017, the Trump administration halted the use of agency "resources to fund sex reassignment surgical procedures for military personnel . . ." *Doe v. Trump*, 275 F. Supp. 3d 167, 184 (D.D.C. 2017) (quoting section 2(b) of Military Service by Transgender Individuals Memorandum, 82 Fed. Reg. 41319 (Aug. 25, 2017)).

39. *HUD to Enforce Fair Housing Act to Prohibit Discrimination on the Basis of Sexual Orientation and Gender Identity*, U.S. DEP'T OF HOUS. & URB. DEV. (Feb. 11, 2021), https://www.hud.gov/press/press_releases_media_advisories/HUD_No_21_021 [<https://perma.cc/87AF-CQNM>].

40. *Local Nondiscrimination Ordinances*, MOVEMENT ADVANCEMENT PROJECT, https://www.lgbtmap.org/equality-maps/non_discrimination_ordinances [<https://perma.cc/NKZ4-7K84>]. See generally *Snapshot LGBT Equality by State*, MOVEMENT ADVANCEMENT PROJECT, <https://www.lgbtmap.org/equality-maps> [<https://perma.cc/Q3X7-S53X>].

II. ACCESS TO APPROPRIATE MEDICAL CARE IN PRISON IS EMBLEMATIC OF THE PROGRESS TRANSGENDER PEOPLE HAVE MADE

Another important measure of the progress of transgender people can be found in U.S. prisons, which are disproportionately populated by transgender people, including transgender people of color who are subjected to over-policing and often prosecuted for survival crimes.⁴¹ Like others in prison, incarcerated transgender people “are held in conditions that threaten their health, safety, and human dignity on a daily basis.”⁴² For transgender people, these abuses include the denial of access to transition-related medical care and safe, gender-appropriate housing.⁴³ Although progress in the prison context has been slow, it has been inexorable, with courts increasingly recognizing the rights of incarcerated transgender people.⁴⁴

This Part traces this evolution in the law, from cases requiring that prison officials provide incarcerated transgender people with access to hormone therapy and commissary items, to the rejection of policies that house transgender people based on their birth sex.⁴⁵ Before discussing this evolution, some background on gender identity and the treatable medical

41. *Transgender Incarcerated People in Crisis*, LAMBDA LEGAL, <https://www.lambdalegal.org/know-your-rights/article/trans-incarcerated-people> [<https://perma.cc/SAD3-NH6G>]; see also Pooja Gehi, *Gendered (In)Security Migration and Criminalization in the Security State*, 35 HARV. J. L. & GENDER 357, 367 & n.50 (“[P]ervasive discrimination . . . causes transgender people of color to be more likely to engage in criminalized work in order to meet their basic needs. These crimes are often poverty-related ‘survival crimes,’ including turnstile jumping, dealing and/or possession of drugs (or prescription controlled substances), welfare-related crimes, petty theft, . . . loitering,” and “prostitution”).

42. *Prisoners’ Rights*, AM. C.L. UNION, <https://www.aclu.org/issues/prisoners-rights> [<https://perma.cc/648D-3Q5F>].

43. See *infra* Part II. For helpful background regarding the challenges that incarcerated transgender people experience, see generally DAVID B. CRUZ & JILLIAN T. WEISS, *GENDER IDENTITY AND THE LAW*, ch. 12 (2021); SUSAN GLUCK MEZEY, *BEYOND MARRIAGE* 59–71 (2017); ALLY WINDSOR HOWELL, *TRANSGENDER PERSONS AND THE LAW*, ch. 12 (1st ed. 2013); Broadus & Minter, *supra* note 32, at 207–09; Judson Adams, Halle Edwards, Rachel Guy, Maya Springhawk Robnett, Rachel Scholz-Bright & Breanna Weber, *Transgender Rights and Issues*, 21 GEO. J. GENDER & L. 479, 515–18 (2020); Yvette K. W. Bourcicot & Daniel Hirotsu Woofter, *Prudent Policy Accommodating Prisoners with Gender Dysphoria*, 12 STAN. J.C.R. & C.L. 283, 317–19 (2016); Douglas Routh, Gassan Abess, David Makin, Mary K. Stohr, Craig Hemmens & Jihye Yoo, *Transgender Inmates in Prisons A Review of Applicable Statutes and Policies*, 61 INT’L J. OFFENDER THERAPY & COMPAR. CRIMINOLOGY 645, 662 (2015); *Classification and Housing of Transgender Inmates in American Prisons*, 127 HARV. L. REV. 1746, 1747–50 (2014); AM. C.L. UNION & NAT’L CTR. LESBIAN RTS., *KNOW YOUR RIGHTS: LAWS, COURT DECISIONS, AND ADVOCACY TIPS TO PROTECT TRANSGENDER PRISONERS* 4–9 (Dec. 1, 2014) [hereinafter *KNOW YOUR RIGHTS*], https://www.nclrights.org/wp-content/uploads/2014/12/KnowYourRights_GuidetoProtectTransgenderPrisoners.pdf [<https://perma.cc/ED59-UWY8>]; Sydney Tarzwell, Note, *The Gender Lines Are Marked with Razor Wire Addressing State Prison Policies and Practices for the Management of Transgender Prisoners*, 38 COLUM. HUM. RTS. L. REV. 167, 190–212 (2006) (compiling state policies for the management of incarcerated transgender people).

44. See *infra* Part III.

45. See *infra* Sections II.B.1–3.

condition of gender dysphoria is instructive.

A. BACKGROUND: GENDER IDENTITY, GENDER DYSPHORIA, AND
TRANSITION-RELATED CARE

The term “gender identity” is a well-established concept in medicine, referring to one’s internal sense of their own gender.⁴⁶ All human beings develop an understanding of themselves of belonging to a particular gender, such as male or female, early in life.⁴⁷ Gender identity is often referred to as a person’s brain sex.⁴⁸ This is, in part, because studies focused on determining the origins of a person’s gender identity have shown that the human brain is significantly influenced by exposure to hormone levels before birth.⁴⁹ Brain studies that correlate brain patterns of transgender individuals with nontransgender individuals who have the same gender identity further contribute to the body of research that supports a biological basis for gender identity.⁵⁰

At birth, infants are classified as male or female.⁵¹ For most people,

46. See Declaration of George Richard Brown, MD, DFAPA in Support of Plaintiffs’ Motion for Preliminary Injunction ¶ 14, *Doe v. Trump*, 275 F. Supp. 3d 167 (D.D.C. 2017) (No. 17-cv-1597) [hereinafter Declaration of George Richard Brown]; see also *Edmo v. Corizon, Inc.*, 935 F.3d 757, 768 (9th Cir. 2019) (per curiam) (discussing the meaning of gender identity); AM. PSYCHIATRIC ASS’N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 451 (5th ed. 2013) [hereinafter DSM-5] (same).

47. Affidavit of Randi Ettner, Ph.D. ¶ 4, Petition for Declaratory Ruling Regarding Health Insurers’ Categorization of Certain Gender Confirming Surgeries as Cosmetic (Conn. Comm’n on Hum. Rts. & Opportunities Jan. 28, 2020) [hereinafter Affidavit of Randi Ettner].

48. See Declaration of George Richard Brown, *supra* note 46, ¶¶ 8–9, 15.

49. *Id.*; see, e.g., CHRISTINE MICHELLE DUFFY, GENDER IDENTITY AND SEXUAL ORIENTATION DISCRIMINATION IN THE WORKPLACE: A PRACTICAL GUIDE 16–77 (2014) (discussing medical studies pointing to biological etiology for transgender identity); Randi Kaufman, *Introduction to Transgender Identity and Health*, in THE FENWAY GUIDE TO LESBIAN, GAY, BISEXUAL, AND TRANSGENDER HEALTH 331, 337–38 (2d ed. 2008) (“The predominating biological theory suggests that a neurohormonal disturbance takes place in the brain during embryological development. While the genitalia of the human embryo become differentiated as male or female during the [twelfth] week of fetal development, the gender identity portion of the brain differentiates around the [sixteenth] week. If there is a hormonal imbalance during this four-week period, gender identity may not develop along the same lines as the genitalia.”); Milton Diamond, *Biased-Interaction Theory of Psychosexual Development* “How Does One Know if One Is Male or Female?,” 55 SEX ROLES 589, 597 n.14 (2006) (“During prenatal development the nervous system, the brain in particular, is programmed along a track that is usually concomitant with the development of other sex appropriate structures like genitals and reproductive organs. The brain, however, as in other [i]ntersex conditions, can develop along one sex/gender path while other organs develop along another. Put simply, the brain can develop as male while other parts of the body develop as female.”); see also Second Statement of Interest of United States of America at 3–4, *Blatt v. Cabela’s Retail, Inc.*, No. 5:14-cv-04822, 2017 U.S. Dist. LEXIS 75665 (E.D. Pa. May 18, 2017) (compiling studies supporting a physical basis for transgender identity); Aruna Saraswat, Jamie D. Weinand & Joshua D. Safer, *Evidence Supporting the Biologic Nature of Gender Identity*, 21 ENDOCRINE PRAC. 199, 199–202 (2015) (providing a review of scientific data and concluding that “current data suggest a biologic etiology for transgender identity”).

50. Declaration of George Richard Brown, *supra* note 46, ¶¶ 8–9, 15.

51. Affidavit of Randi Ettner, *supra* note 47, ¶ 5.

their gender identity matches the sex they were assigned at birth.⁵² Generally, persons born with the typical physical characteristics of males have a male gender identity, and those with the typical physical characteristics of females have a female gender identity.⁵³ However, for transgender individuals, this is not the case. An individual whose gender identity is different from their assigned birth sex is transgender.⁵⁴

If unaddressed, the incongruence between a transgender person's birth sex and their gender identity results in gender dysphoria, a serious medical condition.⁵⁵ The Diagnostic and Statistical Manual of Mental Disorders ("DSM") by the American Psychiatric Association is the generally recognized authoritative handbook on the diagnosis of mental health conditions relied upon by mental health professionals in the United States, Canada, and other countries.⁵⁶ The content of the DSM reflects a science-based, peer-reviewed process by experts in the field.⁵⁷ According to the fifth edition of the DSM ("DSM-5"), published in 2013, gender dysphoria is characterized by the following traits: (1) a marked incongruence between one's gender identity and one's assigned birth sex, which is often accompanied by a strong desire to be rid of one's primary and secondary sex characteristics and/or to acquire primary/secondary sex characteristics of another gender; and (2) clinically significant and persistent distress resulting from this incongruence.⁵⁸ The eleventh revision of the World Health Organization's International Classification of Diseases and Related Health Problems ("ICD") likewise recognizes the parallel medical condition of "gender incongruence," which is characterized "by a marked and persistent incongruence" between one's experienced gender and assigned sex, "which often leads to a desire to 'transition', in order to live and be accepted as a person of the experienced gender, through hormonal treatment, surgery or other health care services to make the individual's body align, as much as desired and to the extent possible, with the experienced gender."⁵⁹

People with gender dysphoria may live for a significant period of their

52. *Id.*

53. *Id.*

54. *Id.* ¶ 6; *see also* Edmo v. Corizon, Inc., 935 F.3d 757, 768 (9th Cir. 2019) (discussing transgender identity); DSM-5, *supra* note 46, at 451 (same).

55. Declaration of George Richard Brown, *supra* note 46, ¶¶ 17, 37; *see also* Edmo, 935 F.3d at 768 (discussing gender dysphoria); DSM-5, *supra* note 46, at 451 (same).

56. *See* Declaration of George Richard Brown, *supra* note 46, ¶ 16. *See generally* WPATH STANDARDS, *supra* note 16, at 1–3.

57. *See id.*

58. DSM-5, *supra* note 46, at 452–53.

59. HA60 Gender Incongruence of Adolescence or Adulthood, ICD-11 FOR MORTALITY & MORBIDITY STAT. (May 2021), <https://icd.who.int/browse11/l-m/en#/http%3a%2f%2fid.who.int%2fid%2fententy%2f90875286> [https://perma.cc/A43C-2XFS].

lives in denial of the symptoms of gender dysphoria.⁶⁰ Others may not initially understand the emotions associated with gender dysphoria or may lack the language or resources to find support for the distress they experience until well into adulthood.⁶¹ Without treatment, individuals with gender dysphoria experience a range of debilitating psychological symptoms such as anxiety, depression, suicidality, and other attendant mental health issues.⁶² Without support for their transition, they may become socially isolated and carry a burden of shame and low self-esteem “attributable to the feeling of being inherently ‘defective.’”⁶³ This can lead to stigmatization and, over time, it can damage the development of a healthy personality and disrupt social and interpersonal relationships.⁶⁴

1. WPATH’s Authoritative Standards of Care

While serious and potentially debilitating, gender dysphoria is also highly treatable.⁶⁵ The standards of care for treatment of gender dysphoria are set forth in the World Professional Association for Transgender Health (“WPATH”) Standards of Care (“WPATH Standards”).⁶⁶ Developed in the 1970s by pioneering physician Harry Benjamin, the WPATH Standards, now in their seventh edition, are the internationally recognized guidelines for the treatment of gender dysphoria.⁶⁷ The WPATH Standards “articulate a professional consensus about the psychiatric, psychological, medical, and surgical management of gender dysphoria” and inform medical treatment in the United States and throughout the world.⁶⁸

Every medical professional association to take up the question,

60. Affidavit of Randi Ettner, *supra* note 47, ¶ 10.

61. *Id.*

62. See, e.g., *Edmo v. Corizon, Inc.*, 935 F.3d 757, 769 (9th Cir. 2019) (“Left untreated, [gender dysphoria] . . . can lead to debilitating distress, depression, impairment of function, substance use, self-surgery to alter one’s genitals or secondary sex characteristics, self-injurious behaviors, and even suicide.”); DSM-5, *supra* note 46, at 451 (“[M]any individuals are distressed if the desired physical interventions by means of hormones and/or surgery are not available.”).

63. Affidavit of Randi Ettner, *supra* note 47, ¶ 10.

64. *Id.*

65. Declaration of George Richard Brown, MD, DFAPA in Support of Opposition to Defendant’s Motion to Dismiss and Motion to Dissolve the Preliminary Injunction ¶ 39, *Doe v. Trump*, 275 F. Supp. 3d 167 (D.D.C. 2017) (No. 17-cv-1597) [hereinafter Declaration of George Richard Brown Supporting Opposition] (“Gender dysphoria is a treatable and curable condition.”); see also *Edmo*, 935 F.3d at 769 (“Gender dysphoria is a serious but treatable medical condition.”).

66. See WPATH Standards, *supra* note 16.

67. See Declaration of George Richard Brown, *supra* note 46, ¶ 22; Aaron Devor, *History of the Association*, WORLD PRO. ASS’N FOR TRANSGENDER HEALTH, <https://www.wpath.org/about/history> [<https://perma.cc/8ZR5-B4GS>]. The seventh version of the WPATH Standards was published in 2011; previous versions were published in 2001, 1998, 1990, 1981, 1980, and 1979. See WPATH Standards, *supra* note 16, at n.1, 110.

68. *Mission and Vision*, *supra* note 85; Affidavit of Randi Ettner, *supra* note 47, ¶ 11.

including the American Medical Association, the Endocrine Society, the American Psychological Association, the American Psychiatric Association, the World Health Organization, the American Academy of Family Physicians, the American Public Health Association, the National Association of Social Workers, the American College of Obstetrics and Gynecology, and the American Society of Plastic Surgeons, has endorsed treatment protocols in accordance with the WPATH Standards of Care.⁶⁹ According to the AMA,

An established body of medical research demonstrates the effectiveness and medical necessity of mental health care, hormone therapy and [transition] surgery as forms of therapeutic treatment for many people diagnosed with [Gender Identity Disorder] . . . Health experts in [gender dysphoria], including WPATH, have rejected the myth that such treatments are “cosmetic” or “experimental” and have recognized that these treatments can provide safe and effective treatment for a serious health condition.⁷⁰

At least four Circuit Courts of Appeals, the U.S. Tax Court, and numerous federal district courts have likewise concluded that the WPATH Standards “represent[] the consensus of the medical and mental health communities regarding the appropriate treatment for transgender and gender dysphoric individuals.”⁷¹ As the Ninth Circuit recognized in *Edmo*, and as

69. See *Edmo v. Corizon, Inc.*, 935 F.3d 757, 769 (9th Cir. 2019); see, e.g., AM. MED. ASS’N HOUSE OF DELEGATES, RESOLUTION 122 (A-08) (2008), <http://www.imatyfa.org/assets/ama122.pdf> [<https://perma.cc/L8RN-ALUW>]; Wylie C. Hembree, Peggy Cohen-Kettenis, Henriette A. Delemarrevan de Waal, Louis J. Gooren, Walter J. Meyer III, Norman P. Spack, Vin Tangpricha & Victor M. Montori, *Endocrine Treatment of Transsexual Persons An Endocrine Society Clinical Practice Guideline*, 94 J. CLINICAL ENDOCRINOLOGY & METABOLISM 3132, 3135 (2009); AM. PSYCH. ASS’N COUNCIL OF REPRESENTATIVES, TRANSGENDER, GENDER IDENTITY, AND GENDER EXPRESSION NON-DISCRIMINATION (2008), <https://www.apa.org/about/policy/transgender.pdf> [<https://perma.cc/TV74-JQAG>].

70. AM. MED. ASS’N HOUSE OF DELEGATES, *supra* note 69, at 1 (footnote omitted). In 2013, the American Psychiatric Association removed the diagnosis of “gender identity disorder” from the fifth edition of its Diagnostic and Statistical Manual of Mental Disorders and added a new and distinct diagnosis: gender dysphoria. See DSM-5, *supra* note 46, at 451; see also *Doe v. Mass. Dep’t of Corr.*, No. 17-12255, 2018 U.S. Dist. LEXIS 99925, at *16 (D. Mass. June 14, 2018) (expressing agreement with plaintiff’s argument that “the decision to treat ‘Gender Dysphoria’ in DSM-V as a freestanding diagnosis is more than a semantic refinement” and that “[r]ather, it reflects an evolving re-evaluation by the medical community of transgender issues and the recognition that [gender dysphoria] involves far more than a person’s gender identification”). Like the plaintiff in *Doe v. Massachusetts Department of Correction*, who was originally diagnosed with gender identity disorder as a teenager and with gender dysphoria after 2013, most people diagnosed with gender dysphoria will satisfy the clinical criteria for gender dysphoria. See *id.* at *6–8.

71. *Edmo*, 935 F.3d at 769; see *Grimm v. Gloucester Cnty. Sch. Bd.*, 972 F.3d 586, 595 (4th Cir. 2020) (“[T]he Standards of Care . . . represent the consensus approach of the medical and mental health community . . . and have been recognized by various courts, including this one, as the authoritative standards of care.”); *Adams ex rel. Kasper v. Sch. Bd. of St. Johns Cnty.*, 968 F.3d 1286, 1293 (11th Cir. 2020) (stating plaintiff’s medical and social transition as reflecting the “accepted standard of care for transgender persons suffering from gender dysphoria.”); *De’lonta v. Johnson*, 708 F.3d 520, 522–23 (4th

the state conceded in that case, “the WPATH Standards of Care ‘provide the best guidance,’ and ‘are the best standards out there.’ ‘There are no other competing, evidence-based standards that are accepted by any nationally or internationally recognized medical professional groups.’ ”⁷²

Pursuant to the WPATH Standards, many transgender individuals undergo a medically-indicated and supervised gender transition, which allows transgender individuals to live their lives consistent with their gender identity.⁷³ Because the essence of gender dysphoria is the incongruence of the body and one’s identity, the goal of gender transition is to enable the person to comfortably live in their affirmed gender in order to eliminate the debilitating symptoms of gender dysphoria.⁷⁴ If this goal is impeded, it will undermine an individual’s core identity and psychological health.⁷⁵

The WPATH Standards recommend an individualized approach to gender transition, consisting of one or more of the following evidence-based treatment options for gender dysphoria: social transition, hormone therapy, psychotherapy, and transition surgery.⁷⁶ Despite incorporation of the word “social” in its description, social transition is part of the medical course of gender transition.⁷⁷ It refers to changes in an individual’s gender expression and role, which involve living in the gender role consistent with one’s gender identity.⁷⁸ Hormone therapy refers to “the administration of exogenous endocrine agents to induce feminizing or masculinizing changes,” such as a

Cir. 2013) (“The Standards of Care, published by the World Professional Association for Transgender Health, are the generally accepted protocols for the treatment of [gender dysphoria.]” (footnote omitted)); *Fields v. Smith*, 653 F.3d 550, 553–54 (7th Cir. 2011) (discussing “[t]he accepted standards of care” for gender dysphoria, including social transition, hormone therapy, and surgery), *aff’g*, 712 F. Supp. 2d 830, 844 (E.D. Wis. 2010) (“The [WPATH] Standards of Care are ‘a document that articulates professional consensus about the treatment of gender [dysphoria]’ ”); *O’Donnabhain v. Comm’r*, 134 T.C. 34, 65 (2010) (“The [WPATH] standards are widely accepted in the psychiatric profession, as evidenced by the recognition of the standards’ triadic therapy sequence as the appropriate treatment for [gender dysphoria] and transsexualism in numerous psychiatric and medical reference texts.”); *Monroe v. Meeks*, No. 18-cv-00156, 2020 U.S. Dist. LEXIS 37128, at *9 (S.D. Ill. Mar. 4, 2020) (“[T]his Court finds that the WPATH Standards of Care are an appropriate benchmark for treating gender dysphoria at this time. . . . Notably, Defendants still have not put forth a single expert to contest the WPATH Standards of Care or offer an opinion about the appropriate level of care for transgender inmates.”); *accord Norsworthy v. Beard*, 87 F. Supp. 3d 1164, 1170 (N.D. Cal.), *appeal dismissed*, 802 F.3d 1090 (9th Cir. 2015); *Soneeya v. Spencer*, 851 F. Supp. 2d 228, 231–32 (D. Mass. 2012); *Glenn v. Brumby*, 724 F. Supp. 2d 1284, 1289 n.4 (N.D. Ga. 2010), *aff’d*, 663 F.3d 1312 (11th Cir. 2011).

72. *Edmo*, 935 F.3d at 769; *see also id.* at 791 (discussing “the widely accepted, evidence-based criteria set out in the WPATH’s Standards of Care”).

73. Affidavit of Randi Ettner, *supra* note 47, ¶ 12; *see* WPATH Standards, *supra* note 16, at 9–10.

74. Affidavit of Randi Ettner, *supra* note 47, ¶ 13.

75. *Id.*

76. *Id.* ¶ 12; *see* WPATH Standards, *supra* note 16, at 9–10.

77. *See* WPATH Standards, *supra* note 16, at 9–10.

78. *Id.* *See generally* Heath Mackenzie Reynolds & Zil Garner Goldstein, *Social Transition, in TRANS BODIES, TRANS SELVES: A RESOURCE FOR THE TRANSGENDER COMMUNITY* 124, 124–54 (Laura Erickson-Schroth ed., 2014).

deepened voice, growth in facial and body hair, cessation of menses, physical alteration to sex-related physiology, and decreased percentage of body fat compared to muscle mass in transgender men, and alterations to a person's genital appearance and functionality, and increased percentage of body fat compared to muscle mass in transgender women.⁷⁹ Psychotherapy (individual, couple, family, or group) "is not intended to alter a person's gender identity," but rather is intended to help people "achieve long-term comfort in their gender identity expression" by exploring gender identity, role, and expression; addressing the negative impact of gender dysphoria and stigma on mental health; alleviating internalized transphobia; enhancing social and peer support; improving body image; or promoting resilience.⁸⁰

Lastly, and of most significance to this Article, transition surgery refers to a range of procedures that change one's primary and/or secondary sex characteristics, including surgery on the breasts or chest, external or internal genitalia, and facial features.⁸¹ According to the WPATH Standards, although many transgender individuals

find comfort with their gender identity, role, and expression without surgery, for many others surgery is essential and medically necessary to alleviate their gender dysphoria. . . . For [these individuals], . . . relief from gender dysphoria cannot be achieved without modification of their primary and/or secondary sex characteristics to establish greater congruence with their gender identity. . . . Follow-up studies have shown an undeniable beneficial effect of [transition surgery] on postoperative outcomes such as subjective well-being, cosmesis, and sexual function.⁸²

79. WPATH Standards, *supra* note 16, at 33, 36.

80. *Id.* at 29.

81. *Id.* at 57.

82. *Id.* at 54–55 (citing studies). A small handful of controversial figures outside of the professional medical community, most notably Dr. Paul McHugh, have attempted to cast doubt on the medical consensus supporting transition surgery. *See, e.g.*, Brief of Dr. Paul R. McHugh, M.D. as Amicus Curiae Supporting Petitioner at 26, R.G. & G.R. Harris Funeral Homes, Inc. v. EEOC, 139 S. Ct. 1599 (2019) (No. 18-107) (arguing that "[t]here is no good evidence that this dramatic surgery produces the benefits espoused by the [American Medical Association]"). Dr. McHugh is a member of the American College of Pediatricians, a "fringe anti-LGBTQ hate group" according to the Southern Poverty Law Center, and is "well-known for his strongly held view[s] that [transition] surgery is 'religiously abhorrent,' " a moral "abomination," and a "collaborat[ion] with madness." *Kosilek v. Spencer*, 889 F. Supp. 2d 190, 221 (D. Mass. 2012); *American College of Pediatricians*, S. POVERTY L. CTR., <https://www.splcenter.org/fighting-hate/extremist-files/group/american-college-pediatricians> [<https://perma.cc/ZS2N-36WC>]; Katherine Pratt, *The Tax Definition of "Medical Care" A Critique of the Startling IRS Arguments in O'Donnabhain v. Commissioner*, 23 MICH. J. GENDER & L. 313, 316–17 (2016). As advisor to the Vatican, Dr. McHugh urged the Catholic Church to condemn transition surgery as necessary treatment for gender dysphoria and, as chief of psychiatry at Johns Hopkins Hospital from 1975 to 2001, McHugh played a central role in ending Johns Hopkins's first-of-its-kind transgender surgery program in 1979. Amy Ellis Nutt, *Long Shadow Cast by Psychiatrist on Transgender Issues Finally Recedes at Johns Hopkins*, WASH. POST (Apr. 5, 2017), https://www.washingtonpost.com/national/health-science/long-shadow-cast-by-psychiatrist-on-transgender-issues-finally-recedes-at-johns-hopkins/2017/04/05/e851e56e-0d85-11e7-ab07-07d9f521f6b5_story.html [<https://perma.cc/Q5D5-LHEJ>]. More recently, Dr.

Importantly, decades of research have demonstrated that attempting to treat gender dysphoria by forcing transgender people to live in accordance with their sex assigned at birth—to “convert” them out of being transgender—is ineffective, unethical, and dangerous.⁸³ The mainstream medical community overwhelmingly condemns this “conversion therapy.”⁸⁴

2. WPATH’s Organization and Drafting Process

Formed in 1979, WPATH is the leading international organization focused on transgender health care.⁸⁵ The organization has over two thousand members throughout the world and is comprised of physicians, psychiatrists, psychologists, social workers, social scientists, and legal professionals who are dedicated to the treatment of gender dysphoria.⁸⁶ WPATH’s leadership is composed of renowned health professionals across the globe, including plastic surgeons, psychologists, psychiatrists, and other health professionals who have spent years treating people with gender

McHugh has published several articles in non-peer-reviewed religious magazines and journals, discrediting the efficacy of transition surgery and claiming, contrary to established science, that neither gender identity nor sexual orientation is biologically determined. *See id.*; *see also* O’Donnabhain v. Comm’r, 134 T.C. 34, 67 n.47 (2010) (discussing “Surgical Sex” in *First Things*, a magazine published by the Institute on Religion and Public Life). Dr. McHugh’s work has been widely denounced by medical professionals throughout the country—from the National Institutes of Health to dozens of his own colleagues at Johns Hopkins—who have characterized his claims as “pure balderdash” and “dated, now-discredited theories.” Nutt, *supra*. In 2017, Johns Hopkins reversed the course set by Dr. McHugh four decades ago by opening a transgender health service and providing needed medical care once again. *Id.*

83. WPATH Standards, *supra* note 16, at 32 (“Treatment aimed at trying to change a person’s gender identity and lived gender expression to become more congruent with sex assigned at birth has been attempted in the past, yet without success, particularly in the long-term. Such treatment is no longer considered ethical.” (citations omitted)).

84. *Id.*; *see also* Letter from U.S. Pro. Ass’n for Transgender Health Bd. of Dirs. to U.S. Surgeon Gen., Jerome M. Adams 1 & nn.1–4 (Aug. 26, 2019), https://www.wpath.org/media/cms/Documents/USPATH/2019/FINAL%20USPATH%20Letter%20to%20Surgeon%20General%208_26_2019.pdf [<https://perma.cc/A6V9-VBGY>] (“It has long been established that psychiatric intervention is likely not successful, and is instead likely harmful, in the approach to treating youth with gender dysphoria.” (citing studies)); *Conversion “Therapy” Laws*, MOVEMENT ADVANCEMENT PROJECT (July 13, 2021), https://www.lgbtmap.org/equality-maps/conversion_therapy [<https://perma.cc/CSG8-XMPG>] (documenting twenty states with laws banning conversion therapy for minors). *See generally* *Hearing on Proposed House Bill 6695 Before the Pub. Health Comm.*, 2017 Leg., Reg. Sess. (Ct. 2017) (statement of Quinnipiac Univ. Sch. of L. Civil Justice Clinic in support of proposed House Bill 6695), <https://www.cga.ct.gov/2017/PHdata/Tmy/2017HB-06695-R000307-Quinnipiac%20University%20School%20of%20Law%20Civil%20Justice%20Clinic%20-TMY.PDF> [<https://perma.cc/TU8H-8QCN>] (discussing harmful consequences of, and medical and legal communities’ opposition to, conversion therapy).

85. *See* Declaration of George Richard Brown, *supra* note 46, ¶ 9; *see also* *Mission and Vision*, WORLD PRO. ASS’N FOR TRANSGENDER HEALTH, <https://www.wpath.org/about/mission-and-vision> [<https://perma.cc/H449-RKHR>]. WPATH was originally named the Harry Benjamin International Gender Dysphoria Association, after one of the first physicians to treat patients with gender dysphoria. *History*, WORLD PRO. ASS’N FOR TRANSGENDER HEALTH, <https://www.wpath.org/about/history> [<https://perma.cc/6E27-HTEU>].

86. *See* Declaration of George Richard Brown, *supra* note, 46, ¶ 9; *Member Search Results*, WORLD PRO. ASS’N FOR TRANSGENDER HEALTH, <https://www.wpath.org/member/search/results?showAll=1> [<https://perma.cc/RZR2-MDHL>].

dysphoria.⁸⁷ Since its founding over forty years ago, WPATH has published the Standards of Care, which are now in their seventh edition.

Like other professional health organizations, WPATH goes through a lengthy, rigorous process to generate professional consensus documents that are relied on by health professionals.⁸⁸ WPATH's process for developing and revising the latest version of the Standards of Care, Version 7, is illustrative. Although Version 7 was published in 2011, the revision process began five years earlier, in 2006, with the establishment of a "work group."⁸⁹ The work group examined each section of Version 6 of the Standards of Care, "review[ed] the relevant literature, identifi[ed] where research was lacking and needed, and recommend[ed] potential revisions to the [WPATH Standards] as warranted by new evidence."⁹⁰ Over the next several years, "invited papers were written, subjected to peer review, and published for public comment in the *International Journal of Transgenderism*."⁹¹

In 2010, WPATH's Board of Directors established a Revision Committee composed of "a diverse group of dozens of experts and clinicians," who debated the background papers.⁹² The Board then appointed a subset of that committee, the Writing Group, to draft Version 7 of the Standards of Care, in consultation with the full Revision Committee and "an International Advisory Group of transsexual, transgender, and gender-

87. See Declaration of George Richard Brown, *supra* note 46, ¶ 9. For example, WPATH Board member Dr. Randi Ettner, one of the authors of the seventh version of the WPATH Standards and a licensed clinical and forensic psychologist, has evaluated, diagnosed, and treated over three thousand individuals with gender dysphoria and mental health issues related to gender variance from 1980 to the present. Affidavit of Randi Ettner, *supra* note 47, ¶ 2; see also *Edmo v. Corizon, Inc.*, 935 F.3d 757, 776 (9th Cir. 2019). Dr. Ettner has also authored or edited numerous peer-reviewed publications on the treatment of gender dysphoria and transgender health care more broadly, including the leading textbook used in medical schools on the subject, and she currently trains medical and mental health providers on treating people with gender dysphoria. See *Edmo*, 935 F.3d at 775. Similarly, Dr. George Brown, also a WPATH Board member and co-author of the seventh version of the WPATH Standards, is a licensed psychiatrist, medical school professor, and chief of psychiatry at James H. Quillen Veterans Affairs Medical Center in Johnson City, Tennessee. Declaration of George Richard Brown, *supra* note 46, ¶¶ 2–3; see also *O'Donnabhain*, 134 T.C. at 42. Since 1983, Dr. Brown has evaluated and treated between 600 and 1,000 individuals with gender dysphoria in a clinical setting and has reviewed the cases of over 5,100 other individuals with gender dysphoria as an academic researcher. See Declaration of George Richard Brown, *supra* note 46, ¶ 5. He has also published numerous papers in peer-reviewed medical journals and written several book chapters on topics related to gender dysphoria, including those in the Merck Manuals, one of the most widely used medical reference texts in the world. See *O'Donnabhain*, 134 T.C. at 42.

88. See discussion *infra* Section II.A.2.

89. WPATH Standards, *supra* note 16, at 109.

90. *Id.*

91. Brief for the World Pro. Ass'n for Transgender Health as Amicus Curiae Supporting Petitioner, at 7, *Kosilek v. O'Brien*, 774 F.3d 63 (1st Cir. 2014) (No. 14-1120) [hereinafter WPATH Amicus Brief]; see WPATH Standards, *supra* note 16, at 109.

92. WPATH Amicus Brief, *supra* note 91, at 7; see WPATH Standards of Care, *supra* note 16, at 109.

nonconforming individuals” who “g[a]ve input on the revision.”⁹³ At a two-day, face-to-face meeting, the Writing Group “reviewed all recommended changes and debated and came to consensus on various controversial areas.”⁹⁴ Decisions were made “based on the best available science and expert consensus,” and were incorporated into the draft of Version 7, which was circulated among the broader Revision Committee and the International Advisory Group for comment.⁹⁵ After three iterations of review and revision, the Writing Group presented the final draft of Version 7 to the WPATH Board of Directors, which approved the WPATH Standards on September 14, 2011.⁹⁶

WPATH’s comprehensive process for drafting the WPATH Standards is consistent with that of other professional organizations whose authoritative consensus documents are routinely relied upon by courts and agencies.⁹⁷ The American Psychiatric Association, for example, publishes and periodically updates its Diagnostic and Statistical Manual of Mental Disorders (“DSM”), now in its fifth edition.⁹⁸ Similar to the Standards of Care, the “development and revision process for the Fifth Edition of the DSM spanned fourteen years and involved multiple phases including extensive research and literature review, field trials, data analysis, and drafting among work groups in consultation with leadership.”⁹⁹ Courts have widely credited the DSM as “the diagnostic Bible of mental disorders,” as have agencies.¹⁰⁰ Similarly, the World Health Organization publishes and periodically updates the ICD, which is widely relied upon by both courts and U.S. public health officials at the federal, state, and local levels.¹⁰¹ The

93. WPATH Standards, *supra* note 16, at 110.

94. *Id.*

95. *Id.*

96. *Id.*

97. *See* *Edmo v. Corizon, Inc.*, 935 F.3d 757, 786 (9th Cir. 2019) (“Accepted standards of care and practice within the medical community are highly relevant in determining what care is medically acceptable and unacceptable.”).

98. *See* DSM-5, *supra* note 46.

99. WPATH Amicus Brief, *supra* note 91, at 8.

100. *Lee v. Barnhart*, 117 F. App’x 674, 678 (10th Cir. 2004) (unpublished); *see, e.g.*, *Hall v. Florida*, 572 U.S. 701, 704 (2014) (stating that the DSM is “one of the basic texts used by psychiatrists and other experts”); *United States v. Wooden*, 693 F.3d 440, 452 n.4 (4th Cir. 2012) (“The DSM is widely recognized as ‘the authoritative reference used in diagnosing mental disorders.’” (quoting *Young v. Murphy*, 615 F.3d 59, 61 n.1 (1st Cir. 2010))); Revised Medical Criteria for Evaluating Mental Disorders Rule, 81 Fed. Reg. 66138, 66160–78 (Sept. 26, 2016) (relying on the DSM-5 to evaluate claims involving mental disorders under the Social Security Act); *Attention-Deficit/Hyperactivity Disorder (ADHD)*, CTRS. FOR DISEASE CONTROL & PREVENTION, <https://www.cdc.gov/ncbddd/adhd/diagnosis.html> [<https://perma.cc/9FVP-N3C6>] (referencing the DSM-5 in the Centers for Disease Control’s (“CDC”) explanation of ADHD diagnosis).

101. *See, e.g.*, *Madej v. Maiden*, 951 F.3d 364, 375 (6th Cir. 2020) (affirming the district court’s exclusion of expert testimony regarding multiple-chemical-sensitivity diagnosis, in part, because “the diagnosis remains unrecognized by the American Medical Association and unlisted in the World Health

development and revision process for the current version of the ICD, now in its eleventh edition, spanned over ten years and involved a systematic review of the available scientific literature and relevant information on health policies and health professionals' experience with the ICD-10, as well as field-testing and extensive drafting among working groups.¹⁰²

3. The WPATH Standards' Application to Correctional Facilities

Importantly, the WPATH Standards explicitly apply “in their entirety . . . to all transsexual, transgender, and gender nonconforming people, irrespective of their housing situation.”¹⁰³ This includes transgender people who are incarcerated. According to the WPATH Standards, “[p]eople should not be discriminated against in their access to appropriate health care based on where they live, including institutional environments such as prisons,” and such healthcare “should mirror that which would be available to them if they were living in a non-institutional setting within the same community. . . . All elements of assessment and treatment as described in the [WPATH Standards] can be provided to people living in institutions.”¹⁰⁴

Notably, both the U.S. Department of Justice National Institute of Corrections and the National Commission on Correctional Health Care, “a leading professional organization in health care delivery in the correctional context,” whose standards are widely relied upon by courts, have endorsed the WPATH Standards.¹⁰⁵

Organization's International Classification of Diseases”); *Granville House, Inc. v. Dep't of Health & Hum. Servs.*, 715 F.2d 1292, 1300 (8th Cir. 1983) (“[C]ounsel for the [U.S.] government stated that the ICD was widely used throughout [the U.S. Department of Health and Human Services] as a reference manual for disease classification purposes”); *International Classification of Diseases, (ICD-10CM/PCS) Transition—Background*, CTRS. FOR DISEASE CONTROL & PREVENTION, https://www.cdc.gov/nchs/icd/icd10cm_pcs_background.htm [<https://perma.cc/768B-AZ2Y>] (relying on ICD for purposes of compliance with HIPAA).

102. WORLD HEALTH ORG., PRODUCTION OF ICD-11: THE OVERALL REVISION PROCESS 2 (2007), <https://www.who.int/classifications/icd/ICDRevision.pdf> [<https://perma.cc/4PMV-URFT>].

103. WPATH Standards, *supra* note 16, at 67; *see also* *Edmo v. Corizon, Inc.*, 935 F.3d 757, 789 (9th Cir. 2019).

104. WPATH Standards, *supra* note 16, at 67; *see also id.* (“Access to these medically necessary treatments should not be denied on the basis of institutionalization or housing arrangements”); *Edmo*, 935 F.3d at 771 (“The next update to the WPATH Standards of Care will likewise apply equally to incarcerated persons.”).

105. *Edmo*, 935 F.3d at 771 (discussing the National Commission on Correctional Healthcare); BRENDA V. SMITH & JAIME M. YARUSSI, U.S. DEP'T OF JUST., NAT'L INST. OF CORR., POLICY REVIEW AND DEVELOPMENT GUIDE: LESBIAN, GAY, BISEXUAL, TRANSGENDER, AND INTERSEX PERSONS IN CUSTODIAL SETTINGS nn.30–38 (2d ed. 2015), https://info.nicic.gov/sites/info.nicic.gov/lgbti/files/lgbti-policy-review-guide-2_0.pdf [<https://perma.cc/5CPV-HZTY>] (discussing WPATH's “internationally accepted protocols for the treatment of youth and adults with gender dysphoria”); *Transgender and Gender Diverse Health Care in Correctional Settings*, NAT'L COMM'N ON CORR. HEALTH CARE (Nov. 1, 2020), <https://www.ncchc.org/transgender-and-gender-diverse-health-care> [<https://perma.cc/AN2Y-Z892>] (endorsing WPATH Standards to guide correctional health professionals in addressing the needs of transgender people); *see also* *Grochowski v. Clayton Cnty.*, 961 F.3d 1311, 1315 (11th Cir. 2020)

B. ACCESS TO TRANSITION-RELATED CARE IN CORRECTIONAL FACILITIES

Before discussing the progress of incarcerated transgender people in securing medically necessary care and appropriate housing, a summary of the Eighth Amendment analysis is instructive.

1. The Eighth Amendment Analysis

The Eighth Amendment prohibits “cruel and unusual punishments.”¹⁰⁶ This prohibition encompasses both “deliberate indifference to [the] serious medical needs” of incarcerated people, that is, the failure to provide adequate medical care, as well as “deliberate indifference to a substantial risk of serious harm” to incarcerated people, that is, the failure to protect incarcerated people from violence at the hands of other inmates.¹⁰⁷

i. Inadequate Medical Care

As Justice Thurgood Marshall, writing for the majority, stated over forty years ago in *Estelle v. Gamble*, “broad and idealistic concepts of dignity, civilized standards, humanity, and decency” embodied in the Eighth Amendment “establish the government’s obligation to provide medical care . . . for the prisoner, who cannot by reason of the deprivation of [their] liberty, care for [themselves].”¹⁰⁸ To establish a claim of inadequate medical care under the Eighth Amendment, an incarcerated person must make two showings. First, the person must show a “serious medical need.”¹⁰⁹ For those with gender dysphoria, this is not a difficult showing. State departments of corrections regularly concede that “gender dysphoria is a sufficiently serious medical need to trigger the State’s obligations under the Eighth

(discussing the “best practices issued by the National Commission on Correctional Healthcare”); *Schuenemann v. United States*, No. 05-2565, 2006 U.S. App. LEXIS 4350, at *14 (3d Cir. Feb. 23, 2006) (discussing “the standards set forth by the National Commission on Correctional Healthcare . . . the national governing body responsible for overseeing the delivery of prison health care . . .”); *accord* *Gates v. Cook*, 376 F.3d 323, 336–42 (5th Cir. 2004); *Women Prisoners of the D.C. Dep’t of Corr. v. District of Columbia*, 93 F.3d 910, 935 (D.C. Cir. 1996).

106. U.S. CONST. amend. VIII.

107. *Farmer v. Brennan*, 511 U.S. 825, 835–36 (1994); *Estelle v. Gamble*, 429 U.S. 97, 104 (1976). For helpful discussions of Eighth Amendment inadequate medical care and failure-to-protect claims brought by incarcerated transgender people, see *CRUZ & WEISS*, *supra* note 43, at 669–819; *MEZEY*, *supra* note 43, at 59–71, and *KNOW YOUR RIGHTS*, *supra* note 43.

108. *Estelle*, 429 U.S. at 102–04 (internal quotation marks omitted) (footnote omitted) (quoting *Spicer v. Williamson*, 132 S.E. 291, 293 (N.C. 1926)); *see also id.* at 103 (“An inmate must rely on prison authorities to treat [their] medical needs; if the authorities fail to do so, those needs will not be met. In the worst cases, such a failure may actually produce physical ‘torture or a lingering death,’ . . . the evils of most immediate concern to the drafters of the [Eighth] Amendment. In less serious cases, denial of medical care may result in pain and suffering which no one suggests would serve any penological purpose.” (citations omitted)).

109. *Edmo v. Corizon, Inc.*, 935 F.3d 757, 785 (9th Cir. 2019).

Amendment.”¹¹⁰

Second, the person must show that the prison officials’ response to the need was deliberately indifferent.¹¹¹ When an incarcerated person seeks treatment for gender dysphoria, this step of the analysis is where the battle lines are drawn. The analysis has two components: (1) the course of treatment that officials chose was medically unacceptable under the circumstances—that is, they denied well-established care, such as hormone therapy, social transition, or surgery; and (2) the official chose the medically unacceptable course of treatment in conscious disregard of an excessive risk to the plaintiff’s health.¹¹²

ii. Failure to Protect

The Supreme Court formally recognized the Eighth Amendment’s failure-to-protect theory in 1994 in *Farmer v. Brennan*, a case in which an incarcerated transgender woman, Dee Farmer, was beaten and brutally raped by her male cellmate.¹¹³ According to the Supreme Court,

[P]rison officials have a duty . . . to protect prisoners from violence at the hands of other prisoners. . . . [G]ratuitously allowing the beating or rape of one prisoner by another serves no “legitimate penological objectiv[e],” . . . any more than it squares with “evolving standards of decency.” Being violently assaulted in prison is simply not “part of the penalty that criminal offenders pay for their offenses against society.”¹¹⁴

To succeed on a failure-to-protect claim, an incarcerated person must show that they are “incarcerated under conditions posing a substantial risk of serious harm” and that prison officials acted with “deliberate indifference” to their safety.¹¹⁵

110. *Id.* (stating that the State did not contest that gender dysphoria was a serious medical need, “[n]or could it”); *see, e.g.*, *Gibson v. Collier*, 920 F.3d 212, 219 (5th Cir. 2019) (“Here, the State of Texas does not appear to contest that Gibson has a serious medical need, in light of [her] record of psychological distress, suicidal ideation, and threats of self-harm.”); *Lamb v. Norwood*, 899 F.3d 1159, 1162 (10th Cir. 2018) (“The seriousness of Michelle’s medical need is uncontested for purposes of summary judgment.”); *see also* *O’Donnabhain v. Comm’r*, 134 T.C. 34, 62 (2010) (collecting circuit cases finding “serious medical need”).

111. *Edmo*, 935 F.3d at 786.

112. *Id.*; *see also* *Lemire v. Cal Dep’t of Corr. & Rehab*, 726 F.3d 1062, 1074 (9th Cir. 2013) (stating that incarcerated person “must show that prison officials ‘kn[ew] of and disregard[ed]’ the substantial risk of harm, but the officials need not have intended any harm to befall the inmate; ‘it is enough that the official acted or failed to act despite his knowledge of a substantial risk of serious harm’ ” (quoting *Farmer v. Brennan*, 511 U.S. 825, 842 (1994))).

113. *Farmer*, 511 U.S. at 829–30.

114. *Id.* at 833–34 (citations omitted) (quoting *Hudson v. Palmer*, 478 U.S. 517, 548 (1984); *Estelle v. Gamble*, 429 U.S. 97, 102 (1976); *Rhodes v. Chapman*, 452 U.S. 337, 347 (1981)).

115. *Farmer*, 511 U.S. at 834; *see also id.* at 837, 842 (stating that a prison official is deliberately indifferent when they “know[] of and disregard[] an excessive risk to inmate health or safety,” and that “a factfinder may conclude that a prison official knew of a substantial risk from the very fact that the risk was obvious”).

2. Access to Hormone Therapy

According to the WPATH Standards, feminizing and masculinizing hormone therapy is a medically necessary treatment for gender dysphoria, “induc[ing] physical changes that are more congruent with a patient’s gender identity.”¹¹⁶ Historically, some state departments of corrections refused to provide incarcerated transgender people with hormone therapy. They did so in two primary ways: through general policies that categorically banned hormone therapy or prohibited such therapy for those who were not receiving it prior to incarceration; and through individualized assessments conducted by treating physicians who asserted, erroneously, that hormone therapy was not safe or effective.¹¹⁷ Over the past two decades, the tide has shifted.

Numerous courts have concluded that categorical bans on hormone therapy, and so-called “freeze-frame” policies that prohibit hormone therapy for those who were not receiving it prior to incarceration, violate the Eighth Amendment because such policies are deliberately indifferent to the individual medical needs of incarcerated people.¹¹⁸ In 2001, in *Allard v. Gomez*, for example, the Ninth Circuit reversed a grant of summary judgment to the California Department of Corrections for refusing to provide hormone therapy to an incarcerated transgender woman on the basis of a “department-wide policy . . . that denied such therapy for gender [dysphoria], regardless of the medical recommendations for treatment of any given individual.”¹¹⁹ In 2011, when state legislators in Wisconsin enacted legislation that categorically banned hormone therapy (and transition surgery) for incarcerated people—without an exception for medical necessity—the Seventh Circuit held that the statute violated the Eighth Amendment on its face and as applied to the plaintiffs who had been receiving such therapy.¹²⁰ “Just as the legislature cannot outlaw all effective cancer treatments for prison inmates,” the Seventh Circuit stated, “it cannot outlaw the only effective treatment for a serious condition like [gender dysphoria].”¹²¹ In 2013, in *De’lonta v. Johnson*, the Fourth Circuit held that

116. WPATH Standards, *supra* note 16, at 36; *see also id.* at 36–38 (discussing physical effects of masculinizing and feminizing hormones); *see also O’Donnabhain*, 134 T.C. at 70, 71 (concluding, *inter alia*, that hormone therapy “treat[s] disease” and is not “a cosmetic procedure[.]”).

117. *See* KNOW YOUR RIGHTS, *supra* note 43, at 6–7; *see also infra* Section II.B.

118. *See infra* Section II.B.2.

119. *Allard v. Gomez*, 9 F. App’x 793, 794 (9th Cir. 2001) (unpublished); *see also South v. Gomez*, No. 99-15976, 2000 U.S. App. LEXIS 3200, at *5–6 (9th Cir. Feb. 25, 2000) (holding that prison officials violate Eighth Amendment by abruptly terminating an incarcerated transgender person’s hormone therapy).

120. *Fields v. Smith*, 653 F.3d 550, 559 (7th Cir. 2011).

121. *Id.* at 557; *see also Diamond v. Owens*, 131 F. Supp. 3d 1346, 1373–74 (M.D. Ga. 2015) (holding, *inter alia*, that plaintiff stated a claim that the State’s blanket denial of hormone therapy violated the Eighth Amendment); *Barrett v. Coplan*, 292 F. Supp. 2d 281, 285–86 (D.N.H. 2003) (holding that

the plaintiff, an incarcerated transgender woman, stated a claim that the state department of corrections violated the Eighth Amendment by terminating her hormone therapy pursuant to a blanket ban on such therapy.¹²² And in 2018, in *Hicklin v. Precynthe*, a federal district court in Missouri invalidated a state department of corrections freeze-frame policy and directed the state to provide the plaintiff medically necessary care, including hormone therapy.¹²³

This shift away from policies that exclude hormone therapy is consistent with the current position of the Federal Bureau of Prisons. In response to litigation brought by a transgender woman incarcerated in federal prison,¹²⁴ the Bureau, in 2011, agreed to eliminate its freeze-frame policy that permitted incarcerated individuals with gender dysphoria “to receive only the level of treatment they received in the community prior to incarceration.”¹²⁵ The current policy, Federal Bureau of Prisons Program Statement 6031.04, “[r]ecognizes the need to treat prisoners according to their needs, rather than blanket rigid policies,” by requiring that people in Bureau custody with a possible diagnosis of gender dysphoria “receive a

plaintiff stated a claim that the State’s “blanket policy . . . of not considering hormone or surgical treatment for people with [gender dysphoria], without regard to the individualized medical need presented by the individual patient suffering from the condition, prevented her from being considered for appropriate treatment for her serious medical needs” in violation of the Eighth Amendment); *Brooks v. Berg*, 270 F. Supp. 2d 302, 312 (N.D.N.Y. 2003) (denying summary judgment to the State for denying hormone therapy to incarcerated transgender woman on the basis of freeze-frame policy, and stating that “[p]rison officials cannot deny [transgender] inmates all medical treatment simply by referring to a prison policy which makes a seemingly arbitrary distinction between inmates who were and were not diagnosed with [gender dysphoria] prior to incarceration”), *vacated in part on other grounds*, 289 F. Supp. 2d 286 (N.D.N.Y. 2003); *cf. Keohane v. Fla. Dep’t of Corr. Sec’y*, 952 F.3d 1257, 1267, 1271 (11th Cir. 2020) (stating that, during litigation, the State “formally rescinded its freeze-frame policy”—“pursuant to which it refused [plaintiff’s] early requests for hormone treatment”—and “replaced it with a new one that properly attends to inmates’ individualized medical needs”); *Soneeya v. Spencer*, 851 F. Supp. 2d 228, 251 (D. Mass. 2012) (denying summary judgment to the State for refusing to provide, inter alia, transition surgery to incarcerated transgender woman on the basis of blanket ban that “determine[d], without exception, that certain accepted treatments for [gender dysphoria] are never medically necessary for inmates”).

122. *De’lonta v. Johnson*, 708 F.3d 520, 525–26 (4th Cir. 2013).

123. *Hicklin v. Precynthe*, No. 4:16-cv-01357, 2018 U.S. Dist. LEXIS 21516, at *49–50 (E.D. Mo. Feb. 9, 2018); *see also Lynch v. Lewis*, No. 7:14-CV-24, 2014 U.S. Dist. LEXIS 62885, at *1–2 (M.D. Ga. May 7, 2014) (holding that plaintiff stated a plausible claim that the denial of hormone therapy pursuant to freeze-frame policy violated the Eighth Amendment); *Houston v. Trella*, No. 04-CV-1393, 2006 U.S. Dist. LEXIS 68484, at *17–18 (D.N.J. Sept. 22, 2006) (denying summary judgment to the State and holding that a categorical denial of hormone treatment violated the Fifth and Eighth Amendments); *cf. Colwell v. Bannister*, 763 F.3d 1060, 1068–70 (9th Cir. 2014) (denying summary judgment to the State and holding that a blanket policy of denying cataract surgery in which a person has at least one “good eye” violated Eighth Amendment); *Brock v. Wright*, 315 F.3d 158, 166–67 (2d Cir. 2003) (denying summary judgment to the State and holding that a blanket policy of denying treatment of keloid scars to alleviate moderate chronic pain violates Eighth Amendment).

124. *See Adams v. Fed. Bureau of Prisons*, 716 F. Supp. 2d 107, 110 (D. Mass. 2010).

125. Statement of Interest of United States at 17 n.29, *Diamond v. Owens*, 131 F. Supp. 3d 1346 (M.D. Ga. 2015) (No. 5:15-cv-50).

current individualized assessment and evaluation.”¹²⁶ According to the policy, treatment options, “including, but not limited to: those elements of the real life experience consistent with the prison environment, hormone therapy, and counseling[,] . . . will not be precluded solely due to level of services received, or lack of services, prior to incarceration.”¹²⁷ Likewise, numerous states have administrative policies explicitly requiring that incarcerated transgender people receive hormone therapy and other medically necessary transition-related care.¹²⁸

In addition to invalidating blanket bans and freeze-frame policies for hormone therapy, courts have also rejected the outdated assumptions of some medical professionals that hormone therapy was “danger[ou]s,” “controversial,” and not medically necessary.¹²⁹ As the science surrounding the treatment of gender dysphoria has progressed, recent cases reiterate the consensus position of the medical community that hormone therapy is safe, effective, and medically necessary for the treatment of gender dysphoria.¹³⁰

126. *Id.* at 17; U.S. DEP’T OF JUST., FED. BUREAU OF PRISONS, PROGRAM STATEMENT NO. 6031.04: PATIENT CARE 41–42 (June 3, 2014) [hereinafter *TRANSGENDER PATIENT CARE*].

127. *TRANSGENDER PATIENT CARE*, *supra* note 126, at 41–42; *see also* U.S. DEP’T OF JUST., FED. BUREAU OF PRISONS, CHANGE NOTICE, NO. 5200.04 CN-1: *TRANSGENDER OFFENDER MANUAL* 9 (May 11, 2018) [hereinafter *TRANSGENDER OFFENDER MANUAL*] (requiring that incarcerated transgender people receive “hormone or other necessary treatment”).

128. *See, e.g.*, R.I. DEP’T OF CORR., STANDARD OPERATING PROCEDURE: IDENTIFICATION, TREATMENT AND MANAGEMENT OF TRANSGENDER AND INTERSEX INMATES 11 (2018) (“Hormone Treatment and Sexual Reassignment Surgery . . . Transgender inmates will receive all medical care, treatment and the maintenance of any ongoing procedures related to the transition process utilizing the standards of care afforded to all [Rhode Island Department of Corrections] inmates. . . .”); MASS. DEP’T OF CORR., IDENTIFICATION, TREATMENT AND CORRECTIONAL MANAGEMENT OF INMATES DIAGNOSED WITH GENDER DYSPHORIA 10 (2017) (providing that people with gender dysphoria receive medical care, including hormone therapy, “utilizing the most current version of the standards of care referenced by WPATH”); *see also* Douglas Rourth et al., *supra* note 43, at 18.

129. *E.g.*, *Supre v. Ricketts*, 792 F.2d 958, 960, 963 (10th Cir. 1986) (holding that refusal to provide hormone therapy did not violate Eighth Amendment based, in part, on “the medical community[’s] . . . disagree[ment] among themselves as to the best form of treatment for plaintiff’s condition,” including treating physicians’ assertions that such therapy was “controversial” and “danger[ou]s”); *accord* *Brown v. Zavaras*, 63 F.3d 967, 970 (10th Cir. 1995); *see also* *Praylor v. Tex. Dept. of Crim. Just.*, 430 F.3d 1208, 1209 (5th Cir. 2005) (finding no Eighth Amendment violation for refusal to provide hormone therapy based, in part, on “the lack of medical necessity for the hormone”). In a separate line of cases, courts have consistently found no Eighth Amendment violation for the failure to provide hormone therapy where there was no underlying diagnosis of gender dysphoria. *See* *Smith v. Hayman*, 489 F. App’x 544, 547 (3d Cir. 2012) (unpublished) (no “definitive [gender dysphoria] diagnosis”); *Maggert v. Hanks*, 131 F.3d 670, 671 (7th Cir. 1997) (“The psychiatrist does not believe that [plaintiff] suffers from gender dysphoria.”); *Long v. Nix*, 86 F.3d 761, 764 (8th Cir. 1996) (“The experts thus agreed that [plaintiff] is not a transsexual” and is not “eligible for hormone therapy or sex-change surgery”); *White v. Farrier*, 849 F.2d 322, 328 (8th Cir. 1988) (“[H]ere there is a question as to whether [plaintiff] is a transsexual and whether any treatment is required.”).

130. *See, e.g.*, *Kothmann v. Rosario*, 558 F. App’x 907, 911 (11th Cir. 2014) (unpublished) (“[W]e hold that [the plaintiff] has alleged facts sufficient to show that [prison officials] knew that hormone treatment was the recognized, accepted, and medically necessary treatment for [plaintiff’s] gender

3. Facilitation of Social Transition

According to the WPATH Standards, social transition—that is, changing one’s “gender expression and role . . . which may involve living part time or full time in another gender role, consistent with one’s gender identity”—is a medically necessary treatment for gender dysphoria.¹³¹ Social transition often includes “wearing clothing and having a hairstyle that reflects [one’s] gender identity,” as well as gender-affirming procedures such as “[h]air removal through electrolysis, laser treatment, or waxing.”¹³² Although clothing, makeup, and hair removal items “may appear superficial or not medical,” they “in fact play a prominent role in the treatment of [gender dysphoria] and allow the patient to move from a discordant and uncomfortable life that interferes with their functioning into a safer and more comfortable gendered ecology.”¹³³ Social transition also includes using and being referred to by names and pronouns congruent with one’s gender identity and, in the prison context, having access to gender-appropriate strip searches and housing.¹³⁴ Along with state statutes and administrative policies

dysphoria], yet knowingly refused [plaintiff’s] repeated requests for such treatment and thus was deliberately indifferent to a serious medical need.”); *Fields v. Smith*, 653 F.3d 550, 555–56 (7th Cir. 2011) (characterizing as dicta statements in decades-old cases that suggested that hormone therapy was an “esoteric,” medically unnecessary treatment and concluding that the defendant “did not produce any evidence that another treatment could be an adequate replacement for hormone therapy. Plaintiffs’ witnesses repeatedly made the point that, for certain patients with [gender dysphoria], hormone therapy is the only treatment that reduces dysphoria and can prevent the severe emotional and physical harms associated with it.”) (citing *Maggert v. Hanks*, 131 F.3d 670 (7th Cir. 1997) and *Meriwether v. Faulkner*, 821 F.2d 408 (7th Cir. 1987)); *Battista v. Clarke*, 645 F.3d 449, 452, 455 (1st Cir. 2011) (affirming a preliminary injunction ordering prison officials to provide hormone therapy to incarcerated transgender person where officials “concede[d] that [the plaintiff] suffer[ed] from [gender dysphoria] and need[ed] treatment and that hormone therapy ha[d] been recommended as medically necessary,” and engaged in “delays, poor explanations, missteps, changes in position and rigidities . . . to an extreme”); see also *Keohane v. Fla. Dep’t of Corrs. Sec’y*, 952 F.3d 1257, 1271 (11th Cir. 2020) (“[The State’s] own doctors have concluded—and testified under oath—that [plaintiff’s] hormone therapy *is* medically necessary.”); *Mitchell v. Kallas*, 895 F.3d 492, 501–02 (7th Cir. 2018) (denying summary judgment to the State based on “material disputes about whether [prison officials] balanced the pros and cons of starting [plaintiff] on hormones, or if they just looked at the calendar and reflexively dismissed her request.”); *Phillips v. Mich. Dep’t of Corrs.*, 731 F. Supp. 792, 800 (W.D. Mich. 1990) (holding that prison officials’ termination of hormone therapy to incarcerated transgender woman deprived her of “healing medical treatment” in violation of the Eighth Amendment), *aff’d*, No. 90-1289, 1991 U.S. App. LEXIS 10204 (6th Cir. 1991).

131. WPATH Standards, *supra* note 16, at 9–10.

132. *Id.* at 10, 16.

133. *Konitzer v. Frank*, 711 F. Supp. 2d 874, 910 (E.D. Wis. 2010) (quoting plaintiff’s expert, Dr. Randi Ettner); see also *id.* at 890 (“[The WPATH Standards] do[] not specify a list of particular ingredients that will create the image that [a person with gender dysphoria] needs to establish a level of well-being. [They do], however, provide a guideline, and in that guideline, the thrust of it is to help . . . people [with gender dysphoria] consolidate an identity that is ego-syntonic and causes them to feel comfortable and safe in this world, therefore, the real-life experience, so they get practice in living 24 hours a day, seven days a week in their preferred gender.” (quoting Dr. Ettner)).

134. WPATH Standards, *supra* note 16, at 9–10, 32, 67 (stating that health care for incarcerated transgender people “should mirror that which would be available to them if they were living in a non-institutional setting,” and discussing gender-appropriate pronoun usage and gender-segregated

requiring prison officials' facilitation of social transition,¹³⁵ Eighth Amendment litigation has been critical to removing barriers to social transition in prison.

i. Access to Commissary Items and Other Gender-Affirming Care

Some state departments of corrections have prevented incarcerated transgender people from socially transitioning by prohibiting them from purchasing gender-affirming clothing from the prison commissary and refusing to provide gender-affirming procedures such as hair removal.¹³⁶ When incarcerated transgender people have challenged these denials, courts have in almost all cases ruled in their favor.¹³⁷

As the district court concluded in *Hicklin v. Precynthe*, “the case law is clear—‘gender-affirming’ canteen items,” such as clothing and makeup, “and permanent hair removal are not merely cosmetic treatments but, instead, medically necessary treatments to address a serious medical disease.”¹³⁸ In *Hicklin*, the district court granted a preliminary injunction directing prison officials to provide the plaintiff, an incarcerated transgender woman, “with care that her doctors deem to be medically necessary treatment for her gender dysphoria,” including, inter alia, “access to permanent body hair removal, and access to ‘gender-affirming’ canteen items.”¹³⁹ Likewise, in *Monroe v. Baldwin*, a class action brought by six incarcerated transgender women, the district court concluded that “[s]ocial transition is ‘an important component of medical treatment,’ ”¹⁴⁰ and held that there was evidence that prison officials “prevent[ed] Plaintiffs’ social transitions” in violation of the Eighth Amendment by, inter alia, “denying them access to female

correctional facilities); *see also* *Monroe v. Baldwin*, 424 F. Supp. 3d 526, 547 (S.D. Ill. 2019) (ordering the State to “develop a policy to allow transgender inmates medically necessary social transition, including individualized placement determinations, avoidance of cross-gender strip searches, and access to gender-affirming clothing and grooming items”); Affidavit of Randi Ettner, Ph.D., ¶ 35, *Doe v. Mass. Dep’t of Corr.*, 2019 U.S. Dist. LEXIS 112313 (D. Mass. July 8, 2019) (No. 17-12255) (“Being referred to by the appropriate female name and being respectfully treated as a woman are crucial to the psychological well-being of a gender dysphoric woman. Absent respectful and appropriate interactions, psychological symptoms and disorders develop. . . . It is extremely distressing for a transgender woman to be . . . strip-searched by male guards who touch and grope her.”).

135. *See, e.g.*, MASS. GEN. LAWS ANN. ch. 127, § 32A (West 2018) (requiring that incarcerated people be addressed by staff in a manner consistent with their gender identity, have access to items, clothing, and educational materials consistent with their gender identity, and have the right to be searched by a staff member of the same gender identity); accord CONN. GEN. STAT. ANN. § 18-81ii (West 2020); CAL. PENAL CODE § 2606 (West Supp. 2022); R.I. DEP’T OF CORR., *supra* note 128, at 5, 12.

136. *See* KNOW YOUR RIGHTS, *supra* note 43, at 7; *see also infra* Part III.

137. *See infra* Part III.

138. *Hicklin v. Precynthe*, No. 4:16-CV-01357, U.S. Dist. LEXIS 21516, at *43 (E.D. Mo. Feb. 9, 2018).

139. *Id.* at *48.

140. *Monroe v. Baldwin*, 424 F. Supp. 3d 526, 545 (S.D. Ill. 2019).

commissary items.”¹⁴¹ The court granted a preliminary injunction ordering prison officials to “develop a policy to allow transgender inmates medically necessary social transition, including . . . access to gender-affirming clothing and grooming items.”¹⁴² In *Soneeya*, the district court similarly enjoined a state department of corrections from enforcing a policy that categorically prohibited, *inter alia*, “[f]eminization or masculinization procedures such as laser hair removal and/or electrolysis for permanent facial, chest or other body hair removal.”¹⁴³ And in *Konitzer v. Frank*, the district court denied summary judgement to a state department of corrections and held that the plaintiff, an incarcerated transgender woman, had provided sufficient evidence to show that prison officials’ blanket ban of “modest makeup, female undergarments, [and] facial hair remover or growth items” denied her medically necessary care in violation of the Eighth Amendment.¹⁴⁴

ii. Gender-Appropriate Strip Searches and Pronoun Usage

Prison officials have also undermined transgender people’s social transition by denying them access to gender-appropriate strip searches and misgendering them in violation of the Eighth Amendment.¹⁴⁵ The law is clear that, absent emergency circumstances, “cross-gender” strip-searches involving intimate physical contact violate the Eighth Amendment.¹⁴⁶ This

141. *Id.* at 527, 545.

142. *Id.* at 547.

143. *Soneeya v. Spencer*, 851 F. Supp. 2d 228, 240 (D. Mass. 2012).

144. *Konitzer v. Frank*, 711 F. Supp. 2d 874, 909 (E.D. Wis. 2010); *see also* *Iglesias v. True*, 403 F. Supp. 3d 680, 685 (S.D. Ill. 2019) (holding that an incarcerated transgender woman made out a plausible claim that prison officials violated the Eighth Amendment by denying her medically necessary care for gender dysphoria, including laser hair removal); *Diamond v. Owens*, 131 F. Supp. 3d 1346, 1360, 1364 (M.D. Ga. 2015) (holding that plaintiff, a transgender woman, stated a claim that prison officials denied her medically necessary treatment in violation of the Eighth Amendment by ridiculing and disciplining her “for her female gender expression,” including her feminine “eyebrow adornments”); *Alexander v. Weiner*, 841 F. Supp. 2d 486, 492 (D. Mass. 2012) (holding that plaintiff stated a claim that prison officials denied her medically necessary care in violation of Eighth Amendment by repeatedly ignoring her doctors’ prescriptions for “laser hair removal and/or electrolysis”). *But compare* *Keohane v. Fla. Dep’t of Corr. Sec’y*, 952 F.3d 1257, 1274 (11th Cir. 2020) (vacating the district court’s order directing prison officials to permit plaintiff to socially transition and holding that prison officials’ denial of access to female clothing and grooming standards did not violate Eighth Amendment because, “unlike with respect to hormone therapy, the testifying medical professionals were—and remain—divided over whether social transitioning is medically necessary to Keohane’s gender-dysphoria treatment”), *with id.* at 1295–97 (Wilson, J., dissenting) (arguing that the district court correctly found that prison officials had a “categorical, blanket ban” on social transitioning, and that the State’s medical providers who determined that social transitioning was not medically necessary for plaintiff “were incompetent and incredible”).

145. *See* *KNOW YOUR RIGHTS*, *supra* note 43, at 7, 12.

146. *See* *Shaw v. District of Columbia*, 944 F. Supp. 2d 43, 56, 58–59 (D.D.C. 2013) (stating that “a reasonable officer would know that treating a female detainee as plaintiff was treated,” including having her searched by male prison officials, “exposed her to a substantial risk of serious harm, and, therefore, would know that those actions violated her constitutional rights”); *id.* at 57 (applying Eighth Amendment analysis to search of a pretrial detainee, given that “the due process rights of a pretrial detainee are at least as great as the Eighth Amendment protections available to a convicted prisoner” (quoting *Revere v. Mass. Gen. Hosp.*, 463 U.S. 239, 244 (1983))). In addition to the Fifth and Eighth

prohibition applies to male prison officials' strip-searches of transgender women.¹⁴⁷ As the district court stated in *Shaw v. District of Columbia*, a transgender woman's "'clearly established rights' include the same rights as any other female detainee."¹⁴⁸ Additionally, courts have required prison officials to address misgendering by training prison officials regarding proper name and pronoun usage.¹⁴⁹

In *Monroe*, for example, the district court concluded that there was evidence that prison officials "prevent[ed] Plaintiffs' social transitions" by, *inter alia*, conducting cross-gender strip searches and also "misdgendering inmates," which, the court stated is "traumatic" for a person with gender dysphoria.¹⁵⁰

The court granted a preliminary injunction ordering prison officials to immediately . . . develop a policy to allow transgender inmates medically necessary social transition, including . . . avoidance of cross-gender strip searches, and . . . advis[ing] the Court what steps, if any, [prison officials have] taken to train all correctional staff on transgender issues, including the harms

Amendments, cross-gender strip searches may violate the Fourth Amendment. *See, e.g., id.* at 58 (holding that transgender woman who was detained pretrial stated a claim that prison officials violated her clearly established Fourth Amendment rights not to be searched by male prison staff); *Byrd v. Maricopa Cnty. Sheriff's Dep't*, 629 F.3d 1135, 1146 (9th Cir. 2011) ("This litany of cases over the last thirty years has a recurring theme: cross-gender strip searches in the absence of an emergency violate an inmate's right under the Fourth Amendment to be free from unreasonable searches.").

147. *See, e.g., Monroe v. Baldwin*, 424 F. Supp. 3d 526, 547 (S.D. Ill. 2019) (ordering prison officials to avoid cross-gender strip searches of incarcerated transgender people); *Shadle v. Frakes*, No. 8:16CV546, 2017 U.S. Dist. LEXIS 53731, at *2-3 (D. Neb. Apr. 7, 2017) (permitting incarcerated transgender woman to sue prison officials for, *inter alia*, subjecting her to male staff strip-searches); *Shaw*, 944 F. Supp. 2d at 57, 60 (holding that transgender woman who was detained pretrial stated a claim that prison officials violated her clearly established due process rights under the Fifth Amendment not to be searched by male prison staff); *see also Meriwether v. Faulkner*, 821 F.2d 408, 418 (7th Cir. 1987) (holding that forcing transgender people to regularly "strip before guards and other inmates" may violate the Eighth Amendment where it is "maliciously motivated, unrelated to institutional security, and hence 'totally without penological justification'" (quoting *Rhodes v. Chapman*, 452 U.S. 337, 346 (1981))); *cf. Sarratt v. Stirling*, No. 8:16-cv-03486, 2019 U.S. Dist. LEXIS 63399, at *3, 7 (D.S.C. Mar. 21, 2019) (denying injunctive relief to an incarcerated transgender woman who was "subjected to body cavity searches by male corrections officers" based on testimony from prison warden that, in response to litigation, he "directed that female staff members perform patdown searches of Plaintiff unless there is some type of emergent situation where a female officer is not available and [a] search has to be done immediately"). *But see Naisha v. Metzger*, 490 F. Supp. 3d 796, 804 (D. Del. 2020) (stating that "there is no precedent to support the existence of [a] right" for "a transgender inmate to be strip searched by an officer of the gender with which the inmate identifies").

148. *Shaw*, 944 F. Supp. 2d at 58.

149. *See, e.g., Monroe*, 424 F. Supp. 3d at 547 (granting an preliminary injunction ordering State to advise the court regarding training of prison staff on transgender issues); *Hampton v. Baldwin*, No. 3:18-CV-550, 2018 U.S. Dist. LEXIS 190682, at *52 (S.D. Ill. Nov. 7, 2018) (granting an preliminary injunction ordering prison officials to "train all correctional staff on transgender issues"); *cf. Tay v. Dennison*, 457 F. Supp. 3d 657, 683-84, 690-91 (S.D. Ill. 2020) (holding that incarcerated transgender woman demonstrated a likelihood of success on the merits of her equal protection claim with regard to, *inter alia*, "constant[] misgender[ing]").

150. *Monroe*, 424 F. Supp. 3d at 545.

caused by misgendering and harassment—by both [prison] staff and other inmates.¹⁵¹

iii. Access to Appropriate Placement

Incarcerating transgender women in men’s prisons and transgender men in women’s prisons undermines the process of social transition and also poses obvious and horrifying risks to transgender people’s health and safety, including sexual assault and violence.¹⁵² In recognition of these substantial risks to transgender people’s health and safety, the WPATH Standards caution against housing transgender people “on the sole basis of the appearance of the external genitalia,” and state that housing assignments for incarcerated transgender people should instead “take into account their gender identity and role, physical status, dignity, and personal safety.”¹⁵³ Despite these obvious risks and the consensus position of the medical community, prisons officials have historically denied incarcerated transgender people access to gender-appropriate placement—instead housing them according to their assigned sex at birth, or placing them in administrative segregation, that is, solitary confinement.¹⁵⁴ As the result of

151. *Id.* at 546–47.

152. *See, e.g., Meriwether*, 821 F.2d at 417 (“Given her transsexual identity and unique physical characteristics, her being housed among male inmates in a general population cell would undoubtedly create, in the words of the district court, ‘a volatile and explosive situation.’ Under such circumstances it is unlikely that prison officials would be able to protect her from the violence, sexual assault, and harassment about which she complains.” (quoting the district court)); *see also* 42 U.S.C § 30301(12) (acknowledging the “epidemic character of prison rape and the day-to-day horror experienced by victimized inmates”); *see also* Darren Rosenblum, “Trapped” in *Sing Transgendered Prisoners Caught in the Gender Binarism*, 6 MICH. J. GENDER & L. 499, 523–24 (2000) (stating that “[m]ale prisons have an infamous history of creating and reinforcing barbarous hierarchies of economic, social, and sexual subjugation of the weak to the strong, hierarchies that affect and victimize all male prisoners,” with transgender women often “forced into the victim role”). Despite the dearth of case law and scholarship regarding incarcerated transgender men, *see id.* at 512–13, emerging research suggests that transgender men experience different, but overlapping, forms of discrimination as compared with incarcerated transgender women. *See* Shana Tabak & Rachel Levitan, *LGBTI Migrants in Immigration Detention: A Global Perspective*, 37 HARV. J.L. & GENDER 1, 27 n.107 (2014) (“Anecdotal evidence indicates that transgender men housed in women’s prisons face physical and sexual violence, but more often from guards than from other inmates.”); SYLVIA RIVERA L. PROJECT, “IT’S WAR IN HERE”: A REPORT ON THE TREATMENT OF TRANSGENDER AND INTERSEX PEOPLE IN NEW YORK STATE MEN’S PRISONS 32 (2007), <https://srp.org/files/warinhere.pdf> [<https://perma.cc/HV37-AG9D>] (“As is the case in men’s prisons, authorities in women’s prisons target transgender, gender non-conforming, and intersex people in those facilities with verbal harassment, humiliation, excessive strip searches, and isolation, and refuse to recognize their gender identities.”).

153. WPATH Standards of Care, *supra* note 16, at 68 (“Placement in a single-sex housing unit, ward, or pod on the sole basis of the appearance of the external genitalia may not be appropriate and may place the individual at risk for victimization.”).

154. *See* KNOW YOUR RIGHTS, *supra* note 43, at 10; *see also* *Farmer v. Haas*, 990 F.2d 319, 320 (7th Cir. 1993) (stating that, since the early 1990s, “[t]he practice of the federal prison authorities . . . [has been] to incarcerate persons who have completed sexual reassignment with prisoners of the transsexual’s new gender, but to incarcerate persons who have not completed it with prisoners of the transsexual’s original gender”).

legislation and litigation, these historical practices have begun to change, although at a frustratingly slow pace for those subject to them.¹⁵⁵

Under the Prison Rape Elimination Act of 2003 (“PREA”), the federal government, and every jail or prison receiving federal dollars, must make an “individualized determination[]” about whether an incarcerated transgender person would be safer housed in a men’s or women’s facility.¹⁵⁶ States like California, Connecticut, Massachusetts, and Rhode Island, and localities such as Denver, Colorado and Chicago, Illinois, similarly require, through statute or administrative policy, an individualized determination regarding the housing of incarcerated transgender people.¹⁵⁷ Although, in practice, these formal shifts in federal, state, and local policy often go ignored by prison officials,¹⁵⁸ they are an important step towards appropriate housing for incarcerated transgender people.

Eighth Amendment litigation has also opened the doors to gender-appropriate housing for incarcerated transgender people.¹⁵⁹ A growing

155. See *infra* Part III.

156. 28 C.F.R. § 115.42(b) (2021); see also *id.* § 115.42(c) (“In deciding whether to assign a transgender or intersex inmate to a facility for male or female inmates, and in making other housing and programming assignments, the agency shall consider *on a case-by-case basis* whether a placement would ensure the inmate’s health and safety, and whether the placement would present management or security problems.” (emphasis added)). The PREA established a National Prison Rape Elimination Commission to “carry out a comprehensive legal and factual study of the pen[o]logical, physical, mental, medical, social, and economic impacts of prison rape in the United States” and to recommend to the Attorney General “national standards for enhancing the detection, prevention, reduction, and punishment of prison rape.” 42 U.S.C. § 30306(d)(1), (e)(1). The PREA standards are binding on the Federal Bureau of Prisons. *Id.* § 30307(b). Generally speaking, states that do not certify full compliance with the PREA standards are subject to the loss of five percent of any Department of Justice grant funds that they would otherwise receive for prison purposes. *Id.* § 30307(e)(2)(A). During the Obama administration, the Federal Bureau of Prisons, consistent with the PREA Standards, directed federal prisons to house transgender people “by gender identity when appropriate.” TRANSGENDER OFFENDER MANUAL, *supra* note 127, at 6. In 2018, the Trump administration changed this directive to state that housing transgender people by gender identity “would be appropriate only in rare cases.” *Id.* The Biden administration has since revised the policy to direct placement of transgender people based on a case-by-case assessment ensuring that a placement does not “jeopardize” the person’s well-being. U.S. DEP’T OF JUST., FED. BUREAU OF PRISONS, PROGRAM STATEMENT, NO. 5200.08: TRANSGENDER OFFENDER MANUAL 6 (Jan. 13, 2022), <https://www.bop.gov/policy/progstat/5200-08-cn-1.pdf> [<https://perma.cc/RTF2-RJY2>].

157. See, e.g., MASS. GEN. LAWS ANN. ch. 127 § 32A (West 2021) (“A prisoner of a correctional institution, jail or house of correction that has a gender identity . . . that differs from the prisoner’s sex assigned at birth, with or without a diagnosis of gender dysphoria or any other physical or mental health diagnosis, shall be . . . housed in a correctional facility with inmates with the same gender identity.”); accord CAL. PENAL CODE § 2606 (West Supp. 2022); CONN. GEN. STAT. Ann. § 18-81ii (West 2020); see also Broadus & Minter, *supra* note 32, at 207 (discussing policies in Denver, Colorado; Chicago, Illinois; Portland, Maine; and the District of Columbia, which require a case-by-case determination of gender-appropriate housing for transgender people).

158. See Broadus & Minter, *supra* note 32, at 207; see also GLUCK MEZEY, *supra* note 43, at 62.

159. See *infra* Part III. In addition to the Eighth Amendment, transgender litigants have successfully claimed that incarceration based on birth sex violates their rights under the Equal Protection and Due

number of courts have concluded that prison officials may fail to protect transgender people from a substantial risk of serious harm in violation of the Eighth Amendment when they incarcerate transgender women—who are “highly vulnerable” to sexual assault—in correctional facilities inconsistent with their gender identity.¹⁶⁰ For example, in 2004 in *Green v. Bowles*, the Sixth Circuit reversed a grant of summary judgment to the state in a case in which prison officials placed a transgender woman in an all-male protective custody unit, where she was repeatedly assaulted.¹⁶¹ According to the Sixth Circuit, the plaintiff presented sufficient evidence to show that she was “vulnerable” to assault based on her “physical appearance” and transgender status, and that prison officials failed to protect her in violation of the Eighth Amendment.¹⁶²

In 2015, in *Diamond v. Owens*, a federal district court in Georgia similarly held that the plaintiff, an incarcerated transgender woman who was repeatedly sexually assaulted in prison, stated a claim that prison officials violated the Eighth Amendment by housing her in maximum security male facilities, despite the “obvious” risk of sexual assault.¹⁶³ And in 2020, in *Tay*

Process Clauses as well as under federal disability rights laws. *See, e.g.*, *Doe v. Mass. Dep’t of Corr.*, No. 17-12255, 2018 U.S. Dist. LEXIS 99925, at *26–30 (D. Mass. June 14, 2018) (holding that incarcerated transgender woman stated claim that her incarceration in men’s prison violated due process, equal protection, and disability rights laws); *Tay v. Dennison*, 457 F. Supp. 3d 657, 689 (S.D. Ill. 2020) (granting preliminary injunction ordering state department of corrections to “come up with an individualized housing plan” for a transgender woman incarcerated in men’s prison—including consideration of transfer to women’s correctional facility—based on violations of Equal Protection Clause and Eighth Amendment).

160. *See infra* notes 162–65.

161. *Green v. Bowles*, 361 F.3d 290, 293–94 (6th Cir. 2004).

162. *Green*, 361 F.3d at 293–94 (6th Cir. 2004).

163. *Diamond v. Owens*, 131 F. Supp. 3d 1346, 1378 (M.D. Ga. 2015); *accord* *Zollicoffer v. Livingston*, 169 F. Supp. 3d 687, 690–91, 696 (S.D. Tex. 2016) (holding that incarcerated transgender woman who was physically and sexually assaulted in men’s prison stated claim that prison officials were deliberately indifferent to a substantial risk of serious harm when they denied her repeated requests to be transferred to a safer housing area); *id.* at 691 (“Transgender inmates in particular face a shockingly high rate of sexual abuse in prison. The [Bureau of Justice Statistics] reported that 34.6% of transgender inmates reported being the victim of sexual assault. That is nearly nine times the rate for all prisoners, which is 4.0%. The vulnerability of incarcerated transgender people to sexual abuse is no secret. For example, the National Institute of Corrections has stated that ‘research on sexual abuse in correctional facilities consistently documented that men and women with nonheterosexual orientations, transgender individuals, and people with intersex conditions were highly vulnerable to sexual abuse.’”); *Lojan v. Crumbsie*, No. 12 CV 0320, 2013 U.S. Dist. LEXIS 15590, at *13 (S.D.N.Y. Feb. 1, 2013) (denying motion to dismiss failure-to-protect claim and finding that Plaintiff stated a valid claim as she “allege[d] that officials . . . acted with deliberate indifference to her safety because jail officials knew that she was a likely victim [T]he argument that more than mere knowledge of Plaintiff’s transgender status was required to put Defendant on notice of Plaintiff’s vulnerability is spurious”); *Green v. Hooks*, No. 6:13-cv-17, 2013 U.S. Dist. LEXIS 124806, at *3–4 (S.D. Ga. July 18, 2013) (holding that incarcerated transgender person who was sexually assaulted in prison stated claim that prison officials were deliberately indifferent to substantial risk of serious harm when they placed her in the general population of an all-male prison, and in protective custody with a male inmate); *Shaw v. District of Columbia*, 944 F. Supp. 2d 43, 59–60 (D.D.C. 2013) (denying motion to dismiss where police officers placed the

v. Dennison, the district court reserved a ruling on whether the plaintiff, an incarcerated transgender woman, should be transferred to a women's prison until after trial, but it ordered the state department of corrections to "come up with an individualized housing plan for [p]laintiff in accordance with its affirmative duty to protect her from a substantial risk of harm."¹⁶⁴ According to the district court, the department "should consider [plaintiff's] assertion that being housed in a men's prison is the primary cause of her suffering because, as a trans woman, she is especially vulnerable to physical and sexual violence from her male counterparts," and "whether the reason . . . that she has not been able to receive treatment for her Gender Dysphoria is because she is in a male prison . . . and whether in a women's facility, she would not be subjected to the same risk of sexual and physical assault."¹⁶⁵

Several courts have acknowledged that inappropriate gender-segregated housing constitutes not only a failure to protect under the Eighth Amendment, but also a failure to provide adequate medical care—namely, access to social transition. In *Monroe*, for example, the district court granted a preliminary injunction ordering prison officials "to immediately . . . cease the policy and practice of depriving gender dysphoric prisoners of medically necessary social transition, including by mechanically assigning housing based on genitalia and/or physical size or appearance," and to "develop a policy to allow transgender inmates medically necessary social transition, including individualized placement determinations."¹⁶⁶

Relatedly, prison officials' placement of incarcerated transgender people in solitary confinement for their own safety does not remedy the Eighth Amendment violation.¹⁶⁷ Rather, as at least one circuit court and

plaintiff, a transgender woman, "in a single cell in the male area of the Central Cellblock" despite "the risk to transgender detainees [that] was obvious, well-documented, and known to [d]efendants"); *Smith v. Hayman*, No. 09-2602, 2010 U.S. Dist. LEXIS 15612, at *25 (D.N.J. Feb. 19, 2010) (permitting plaintiff's claim to proceed on grounds that "[p]laintiff's publicized transsexualism would appear to place h[er] at risk of serious harm from other inmates if housed in the same cell with another male, especially after plaintiff has requested women's clothing and amenities"); *Doe v. Yates*, No. 1:08-cv-01219, 2009 U.S. Dist. LEXIS 106545, at *13–14 (E.D. Cal. Nov. 16, 2009) (holding that incarcerated transgender person who was sexually assaulted in men's prison stated claim that prison officials were deliberately indifferent to substantial risk of serious harm when they housed her with "male aggressors" and "threatened her with disciplinary action if she refused to take these other inmates as cell mates"); see also Statement of Interest of United States, *supra* note 125, at 5 n.10 (reserving right to weigh in on, inter alia, the constitutionality of the State's housing transgender woman in maximum security men's prison).

164. *Tay v. Dennison*, 457 F. Supp. 3d 657, 688 (S.D. Ill. 2020) (alteration in original).

165. *Id.* at 689; accord *Hampton v. Baldwin*, 2018 WL 5830730, at *16 (S.D. Ill. Nov. 7, 2018).

166. *Monroe v. Baldwin*, 424 F. Supp. 3d 526, 546–47 (S.D. Ill. 2019); see also *Iglesias v. True*, 403 F. Supp. 3d 680, 685 (S.D. Ill. 2019) (holding that an incarcerated transgender woman made out a plausible claim that prison officials violated the Eighth Amendment by denying medically necessary care for her gender dysphoria, including transfer to a woman's correctional facility).

167. See *infra* Part III.

numerous district courts have held, such confinement may violate the Constitution by denying the person “adequate recreation, living space, educational and occupational rehabilitation opportunities, and associational rights for nonpunitive reasons” in light of other feasible alternatives¹⁶⁸—such as transfer to a gender-appropriate facility.¹⁶⁹ Solitary confinement may also run afoul of the Prison Rape Elimination Act (“PREA”) standards, which explicitly prohibit the involuntary segregation of transgender people unless “a determination has been made that there is no available alternative means of separation from likely abusers,” and which further provide that segregation “shall not ordinarily exceed a period of [thirty] days.”¹⁷⁰

As a result of these legislative and litigation developments, some incarcerated transgender people are now being housed in gender-appropriate facilities, either upon entry into prison or after requesting transfer. For example, at least two transgender women in federal custody at the female prison in Fort Worth, Donna Langan and Linda Thompson, have been transferred to a federal woman’s prison.¹⁷¹ Furthermore, at least eight

168. *Meriwether v. Faulkner*, 821 F.2d 408, 416 (7th Cir. 1987); *id.* at 415 (stating that segregation of transgender person “may constitute cruel and unusual punishment in violation of the Eighth Amendment”); *see, e.g.*, *Medina-Tejada v. Sacramento Cnty.*, No. CIV S-04-138, 2006 U.S. Dist. LEXIS 7331, at *25–26 (E.D. Cal. Feb. 24, 2006) (denying summary judgment to the County because it had not shown why automatic administrative segregation of transgender detainees—which included “significant limitations on, or total denials of, recreational activities, exercise, phone calls, visitation privileges, out-of-cell time, access to religious services, and access to the law library”—was not “excessive in relation to the alleged safety purpose in keeping her segregated and why this purpose could not have been achieved by alternative and less harsh methods”); *Tates v. Blanas*, No. CIV S-00-2539, 2003 U.S. Dist. LEXIS 26029, at *28 (E.D. Cal. Mar. 6, 2003) (holding, after trial, that prison officials’ automatic placement of all transgender detainees in administrative segregation—which included routine shackling and the denial of opportunities to socialize, attend religious services, and shower—violated the plaintiff’s constitutional rights, and stating that “[t]he duty to protect [the plaintiff] from harm may not be used to justify actions not reasonably related to accomplishing that purpose. . . . The necessary consequence of [such segregation] is to needlessly deprive transgender pretrial detainees of basic human needs and of privileges available to all other inmates, and to needlessly subject transgender inmates to harsh conditions, as discussed earlier in this opinion”); *cf. Jones v. Union Cnty. Sheriff’s Off.*, No. 3:18-CV-00509, 2019 U.S. Dist. LEXIS 190588, at *17 (W.D.N.C. Nov. 4, 2019) (observing that “a policy of segregating incarcerated transgender people may potentially raise constitutional concerns, depending on the conditions of the segregation, which are not alleged here”).

169. *See infra* notes 171–72 (discussing placement of incarcerated transgender people in gender-appropriate facilities); *see also* Affidavit of James Aiken ¶¶ 10, 18–19, *Doe v. Mass. Dep’t of Corr.*, No. 17-12255, 2018 U.S. Dist. LEXIS 99925, at *26–30 (D. Mass. June 14, 2018) (stating that housing a transgender woman “in a male correctional facility creates an unnecessary perilous endangerment for her,” and opining that the plaintiff’s “safety requires that she be transferred to a women’s correctional facility to abate this clear, present and known endangerment issue,” and that such a transfer would not “create[] any security or management concern solely because she is a woman who is transgender as there is nothing inherently dangerous about being a transgender person”).

170. 28 C.F.R. § 115.43(a), (c) (2021).

171. Lauren McGaughy, *After Texas Suit, Trump Administration Reverses Prison Policies Protecting Transgender Inmates*, DALLAS MORNING NEWS (May 15, 2018, 4:30 PM), <https://www.dallasnews.com/news/2018/05/15/after-texas-suit-trump-administration-reverses-prison-policies-protecting-transgender-inmates> [<https://perma.cc/8NAY-NQY8>] (discussing incarceration of transgender women,

transgender women in state custody have likewise been transferred to state women's prisons: Shiloh Quine in California, Adree Edmo in Idaho, Strawberry Hampton and Janiah Monroe in Illinois, Angelina Resto in Massachusetts, Sonia Doe in New Jersey, Jai Diamond in New York, and Kanautica Zayre-Brown in North Carolina.¹⁷² Given the privacy and safety considerations of all people in prison, these publicly known names suggest the tip of a larger iceberg.

III. ACCESS TO TRANSITION SURGERY IN CORRECTIONAL - FACILITIES -

Time and again, the restrictive and artificial lines that corrections facilities have drawn around transition-related medical care have been erased. From policies and practices that denied incarcerated transgender people hormone therapy, commissary items, gender-appropriate strip searches, and other gender-affirming care, to prison officials' refusal to house transgender people in gender-appropriate correctional facilities, barriers to accessing appropriate medical care have gradually given way.¹⁷³

As this Part will discuss, medically necessary transition surgery is no exception to this trend, nor are there any legal or medical reasons why it should be. In recent years, some state departments of corrections have begun to provide transition surgery to incarcerated transgender people.¹⁷⁴ Other state departments of corrections will surely follow, as they must under the

Donna Langan and Linda Thompson, at a federal female prison in Fort Worth).

172. *Doe v. Massachusetts Department of Correction*, GLBTQ LEGAL ADVOCS. & DEFS. (Apr. 2019), <https://www.glad.org/cases/doe-v-massachusetts-department-correction> [<https://perma.cc/DB56-FBD5>] (Resto); Matt Masterson, *IDOC Transfers Another Transgender Inmate to Women's Prison*, WINDOW TO THE WORLD (Apr. 3, 2019, 3:08 PM), <https://news.wttw.com/2019/04/03/idoc-transfers-another-transgender-inmate-womens-prison> [<https://perma.cc/8A2Z-3QWX>] (Monroe and Hampton); Joe Hernandez, *N.J. to Move Transgender Woman Out of Men's Prison After Lawsuit*, WHYY (Aug. 29, 2019), <https://whyy.org/articles/nj-to-move-transgender-woman-out-of-mens-prison-after-lawsuit> [<https://perma.cc/9973-TWF9>] (Doe); *NC Transgender Inmate Moved to Women's Facility After Advocates Call for Transfer*, ABC NEWS (Aug. 16, 2019), <https://abc11.com/transgender-inmate-womens-facility/5469820> [<https://perma.cc/CT35-EJ2Z>] (Zayre-Brown); Kate Sosin, *How a Women's Facility Gave This Trans Prisoner a Future*, THEM. (July 3, 2019), <https://www.them.us/story/jai-diamond-trans-women-prison> [<https://perma.cc/EL7Q-BG7X>] (Diamond); *Quine v. Beard*, TRANSGENDER L. CTR., <https://transgenderlawcenter.org/quine-v-beard> [<https://perma.cc/8BZY-JKRE>] (Quine); see also Matthew Clarke, *Two Transgender Prisoners Transferred to Women's Prison*, PRISON LEGAL NEWS (Mar. 5, 2019), <https://www.prisonlegalnews.org/news/2019/mar/5/two-transgender-prisoners-transferred-womens-prison> [<https://perma.cc/P6XW-ZW7J>] (discussing transfers of Resto and Hampton); cf. *Guy v. Espinoza*, No. 1:19-CV-00498, 2020 U.S. Dist. LEXIS 9893, at *11 (E.D. Cal. Jan. 21, 2020) (recommending dismissal with prejudice of claims that prison officials' policy of housing transgender women in women's prison violated the constitutional rights of non-transgender women), *dismissed*, No. 1:19-CV-00498, 2020 U.S. Dist. LEXIS 33838 (E.D. Cal. Feb. 27, 2020) (adopting findings and recommendations of magistrate judge).

173. See *supra* Part II.

174. See *infra* notes 198–99 and accompanying text.

Eighth Amendment. As with other barriers to transgender health and safety in prison, access to transition surgery will be neither swift nor easy. But change will come—bringing with it a more humanized understanding of gender dysphoria and the medical care essential to transgender people’s health and well-being. Given the recent and important developments in access to transition surgery for incarcerated transgender people, this Part discusses the issue in some detail.

A. THE TRANSITION SURGERY CIRCUIT CASES: FROM *KOSILEK* TO *EDMO*

The dramatic evolution in the law regarding access to transition surgery traces an arc that began decades ago in the case of *Kosilek v. Spencer*, and culminated in 2019, in the case of *Edmo v. Corizon*.¹⁷⁵ In 1992, Michelle Kosilek, an incarcerated transgender woman, sued the Massachusetts Department of Corrections for failing to provide her with treatment for gender dysphoria—namely, hormone therapy and transition surgery—in violation of the Eighth Amendment.¹⁷⁶ The district court found that Ms. Kosilek “had proven the existence of a serious medical need and had shown that her then-current treatment plan,” which consisted of only “supportive therapy,” was inadequate, but ultimately concluded that there was no Eighth Amendment violation.¹⁷⁷ According to the court, prison officials “[were] unaware that a failure to provide additional treatment to Kosilek might result in serious harm,” and their “failure to provide treatment was rooted, at least in part, in ‘sincere security concerns.’”¹⁷⁸ Importantly, the district court warned prison officials “that a failure to provide treatment in the future, now that the [State] was on notice of the potential for harm if only ‘supportive therapy’ was provided, could amount to an Eighth Amendment violation.”¹⁷⁹

In 2003, after revising its policy of “freezing” an incarcerated person’s treatment at whatever level that person was receiving prior to incarceration, prison officials began providing additional ameliorative treatment to Ms. Kosilek, including gender-appropriate clothing and personal effects, electrolysis, and hormone therapy.¹⁸⁰ In 2005, however, prison officials denied Ms. Kosilek transition surgery against the recommendations of multiple doctors hired by the state department of corrections, who testified that transition surgery was medically necessary and, without it, Ms. Kosilek

175. See *Kosilek v. Spencer*, 774 F.3d 63 (1st Cir. 2014); *Edmo v. Corizon, Inc.*, 935 F.3d 757 (9th Cir. 2019).

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

177. *Id.* (discussing the district court’s opinion).

178. *Id.*

179. *Id.*

180. *Id.* at 69–70.

would likely attempt suicide as she had twice done in the past.¹⁸¹ Trial commenced on May 30, 2006, with three rounds of testimony from numerous officials and medical experts over the following two years, and additional legal argument over the course of three more years.¹⁸² On September 4, 2012, the district court held that prison officials' refusal to provide transition surgery to Ms. Kosilek violated the Eighth Amendment.¹⁸³ According to the district court, prison officials "understood and accepted the [department of correction] doctors' view that Kosilek is at substantial risk of serious harm and that [transition] surgery is the only adequate treatment for [her] condition," and the officials' "purported security concerns [we]re a pretext to mask the real reason for the decision to deny [her transition] surgery—a fear of controversy, criticism, ridicule, and scorn."¹⁸⁴

In a 2-1 ruling, a three-judge panel of the First Circuit affirmed the district court.¹⁸⁵ However, on December 16, 2014, the First Circuit, sitting en banc, reversed the district court, with a 3-2 majority and two sharply-worded dissents. Rejecting Ms. Kosilek's Eighth Amendment claim, the majority pointed to several "unique circumstances" in the case, including prison officials' purported security concerns and the credited testimony of the State's medical experts—three prominent critics of the WPATH Standards¹⁸⁶—who expressed doubts regarding the authoritativeness of the Standards and the medical necessity of transition surgery.¹⁸⁷ In her dissenting opinion, Judge Thompson wrote, "I am confident that I would not need to pen this dissent, over twenty years after *Kosilek*'s quest for constitutionally adequate medical care began, were she not seeking a treatment that many see as strange or immoral. Prejudice and fear of the unfamiliar have undoubtedly played a role in this matter's protraction."¹⁸⁸ Judge Thompson went on to predict the case would not stand the test of time, "ultimately being shelved with the likes of *Plessy v. Ferguson*."¹⁸⁹

181. *Id.* at 74.

182. *See id.* at 74–81.

183. *Id.* at 81–82.

184. *Kosilek v. Spencer*, 889 F. Supp. 2d 190, 197–98 (D. Mass. 2012), *rev'd*, 774 F.3d 63 (1st Cir. 2014).

185. *Kosilek v. Spencer*, 740 F.3d 733, 773 (1st Cir.), *withdrawn*, 774 F.3d 63 (1st Cir. 2014).

186. Tellingly, numerous courts, before and after *Kosilek*, have explicitly found all three individuals to be "outliers in the field of gender dysphoria treatment" and have given "virtually no weight" to their testimony. *Infra* note 254.

187. *See Kosilek v. Spencer*, 774 F.3d 63, 91 (1st Cir. 2014) ("Certain facts in this particular record—including the medical providers' non-uniform opinions regarding the necessity of SRS, Kosilek's criminal history, and the feasibility of postoperative housing—were important factors impacting the decision."); *id.* at 76–79 (recounting testimony questioning the WPATH Standards of Care).

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

189. *Id.*

Judge Thompson's comments proved prescient.

On September 1, 2017, Adree Edmo, an incarcerated transgender woman, sued the Idaho Department of Corrections for refusing to provide her with medically necessary transition surgery in violation of the Eighth Amendment.¹⁹⁰ Prison officials had provided Ms. Edmo with hormone therapy since 2012, but her gender dysphoria persisted, and she twice attempted self-castration.¹⁹¹ After a three-day evidentiary hearing, during which the court heard from medical experts for Ms. Edmo and the State, the district court held that Idaho Department of Correction's failure to provide transition surgery to Ms. Edmo violated the Eighth Amendment.¹⁹²

On August 23, 2019, a unanimous panel of the Ninth Circuit affirmed the district court, holding "that Edmo has a serious medical need, that the appropriate medical treatment is [transition surgery], and that prison authorities have not provided that treatment despite full knowledge of Edmo's ongoing and extreme suffering and medical needs."¹⁹³ In its decision, the Ninth Circuit explicitly distinguished *Kosilek*, stating that, in contrast to that case, the State of Idaho did "not so much as allude to" security concerns, and its medical experts agreed that the WPATH Standards were "the appropriate benchmark regarding treatment for gender dysphoria" and that "in certain circumstances, [transition surgery] can be a medically necessary treatment for gender dysphoria."¹⁹⁴ On February 10, 2020, the Ninth Circuit, over the objection of several Ninth Circuit judges, denied the State's petition for rehearing en banc.¹⁹⁵

In July 2020, Ms. Edmo finally received transition surgery after the U.S. Supreme Court refused to stay the district court's injunction ordering the State to provide the surgery.¹⁹⁶ "So much pressure and inner turmoil is gone," Ms. Edmo said. "I feel whole and connected in myself. The surgery itself was literally life-changing. I'm extremely grateful that I finally received the treatment."¹⁹⁷ Ms. Edmo is among a growing group of incarcerated people who have won the right to receive medically necessary

190. *Edmo v. Corizon, Inc.*, 935 F.3d 757 (9th Cir. 2019), *reh'g denied*, 949 F.3d 489 (9th Cir. 2020) (en banc).

191. *Id.* at 773–74.

192. *See id.* at 780 (discussing the district court's decision).

193. *Edmo*, 935 F.3d at 767.

194. *Id.* at 767, 794.

195. *Edmo v. Corizon, Inc.*, 949 F.3d 489, 490 (9th Cir. 2020) (en banc) (denying rehearing).

196. *Idaho Dep't of Corr. v. Edmo*, 141 S. Ct. 610 (2020) (denying petition for writ of certiorari); *Edmo v. Idaho Department of Correction*, NAT'L CTR. FOR LESBIAN RTS., <https://www.nclrights.org/our-work/cases/edmo-v-idaho-department-of-correction> [<https://perma.cc/XL8X-6QEF>].

197. *Edmo v. Idaho Department of Correction*, *supra* note 196.

transition surgery.¹⁹⁸ As her case demonstrates, there is an emerging trend toward the provision of medically necessary transition surgery to people who are incarcerated.¹⁹⁹

Only two other circuit court cases have addressed the denial of transition surgery under the Eighth Amendment: the Fifth Circuit's decision in *Gibson* and the Tenth Circuit's decision in *Lamb*.²⁰⁰ Both cases bear little weight. Unlike *Kosilek* and *Edmo*, *Gibson* and *Lamb* were litigated by pro se plaintiffs and were resolved on concededly "sparse" records by district courts in prediscovery proceedings—without benefit of any expert evidence about the medical standard of care for gender dysphoria or evidence about the plaintiffs' individual medical condition or need for surgery.²⁰¹ The district courts ruled against the plaintiffs on summary judgment in both cases, and the circuit courts of appeals affirmed.²⁰²

In *Gibson*, a bitterly-divided three-judge panel of the Fifth Circuit, relying heavily on *Kosilek*, held that Texas prison officials' blanket ban on transition surgery did not violate the Eighth Amendment because "there is no consensus in the medical community about the necessity and efficacy of [transition surgery] as a treatment for gender dysphoria."²⁰³ In dissent, Judge

198. In 2017, Shiloh Quine became the first incarcerated transgender person to receive transition surgery as part of a settlement with the California Department of Corrections and Rehabilitation. See, e.g., *Quine v. Beard*, No. 14-cv-02726, 2017 U.S. Dist. LEXIS 65276, at *2 (N.D. Cal. Apr. 28, 2017) ("Under the Agreement, [the California Department of Corrections and Rehabilitation] agreed to provide [transition] surgery to Plaintiff."). And in 2020, after more than twenty years of litigation, the Massachusetts Department of Corrections agreed to provide Michelle Kosilek with transition surgery. Defendant's Updated Status Report at 1, *Kosilek v. Turco*, No. 18-cv-11838 (D. Mass. Apr. 30, 2020); see also Aviva Stahl, *Transgender Prisoners: What an Inmate's Surgery Means for Trans Rights*, ROLLING STONE (Nov. 9, 2017), <https://www.rollingstone.com/culture/culture-features/transgender-prisoners-what-an-inmates-surgery-means-for-trans-rights-196781> [<https://perma.cc/F2ZG-Z34D>] (stating that, in California, "five [incarcerated] individuals have been approved for surgeries").

199. See, e.g., *Monroe v. Baldwin*, 424 F. Supp. 3d 526, 546 (S.D. Ill. 2019) (stating that class action plaintiffs "provided plenty of evidence that [state department of corrections] continuously fails to provide adequate treatment to inmates with gender dysphoria," including "never evaluat[ing] a single inmate for surgical intervention"); *Iglesias v. True*, 403 F. Supp. 3d 680, 685 (S.D. Ill. 2019) (holding that an incarcerated transgender woman made out a plausible claim that prison official violated the Eighth Amendment by denying her medically necessary care for gender dysphoria, including transition surgery); *Norsworthy v. Beard*, 87 F. Supp. 3d 1164, 1170 (N.D. Cal.) (granting a preliminary injunction ordering the state department of corrections "to provide Plaintiff with access to adequate medical care, including [transition] surgery"), *appeal dismissed*, 802 F.3d 1090 (9th Cir. 2015) (remanding to the district court); *Soneeya v. Spencer*, 851 F. Supp. 2d 228, 251 (D. Mass. 2012) (denying summary judgment to the State for refusing to provide incarcerated transgender woman access to, inter alia, transition surgery).

200. See *Gibson v. Collier*, 920 F.3d 212 (5th Cir. 2019); *Lamb v. Norwood*, 899 F.3d 1159 (10th Cir. 2018).

201. See *Gibson*, 920 F.3d at 221; *Lamb*, 899 F.3d at 1163.

202. See *supra* note 201.

203. *Gibson*, 920 F.3d at 221; see *id.* at 218 (stating that prison's "[p]olicy does not designate [transition] surgery . . . as part of the treatment for [gender dysphoria]"); *id.* at 238 (Barksdale, J., dissenting) (stating that the State refused to have the plaintiff evaluated "not due to a conflicting medical opinion, but instead based on a blanket policy"). Shockingly, the Fifth Circuit deliberately misgendered

Rhesa Hawkins Barksdale argued that the majority had improperly relied on a procedurally deficient and “inadequate summary-judgment record,” as well as medical testimony in *Kosilek* that had since been deemed “not credible” by multiple courts.²⁰⁴ In *Lamb*, the Tenth Circuit, in a pithy four-page decision, unanimously affirmed the district court’s grant of summary judgment against the plaintiff, who conducted no discovery and submitted no expert testimony.²⁰⁵

B. A NEW BREAK FOR TRANSGENDER RIGHTS

The Ninth Circuit’s holding in *Edmo*, decided nearly thirty years after Ms. Kosilek first sued prison officials to obtain access to transition surgery, marks a new era for the rights of incarcerated transgender people.²⁰⁶ *Edmo*’s holding makes clear that there is no justification for denying transgender people all appropriate medical care, including surgery.²⁰⁷ There is no reason in either law or policy for prison officials to pick and choose among the medical needs of transgender people—or anyone else.²⁰⁸

Edmo offers four important takeaways regarding access to transition surgery: (1) the professional standards that guide treatment for gender dysphoria generally, and transition surgery specifically, enjoy a widespread

the plaintiff, a transgender woman, throughout its opinion, and, adding insult to injury, attempted to support its action by relying on Supreme Court precedent affirming the civil rights of women under the Equal Protection Clause). *See id.* at 217 n.2 (citing *Frontiero v. Richardson*, 411 U.S. 677, 686 (1973), for proposition that “sex . . . is an immutable characteristic determined solely by . . . birth”).

204. *Gibson*, 920 F.3d at 233–35, 242 (Barksdale, J., dissenting) (distinguishing *Kosilek*); *see also id.* at 233 (“In the last four years [since *Kosilek*], have there been any developments in the medical community regarding treating gender dysphoria and determining the necessity for [transition surgery]? We do not know because . . . we have no expert testimony or any evidence as to the medical necessity outside of the WPATH Standards of Care.”).

205. *Lamb*, 899 F.3d at 1164. In contrast to *Gibson*, the Tenth Circuit in *Lamb* “specifically amended the opinion to delete language suggesting that there is no medical consensus on how to treat gender dysphoria and that scientific advances in understanding gender dysphoria need not be considered.” Respondent’s Brief in Opposition at 23, Idaho Dep’t of Corr. v. *Edmo*, 141 S. Ct. 610 (2020) (No. 19-1280). Compare *Lamb v. Norwood*, 895 F.3d 756, 759–60 (10th Cir. 2018), with *Lamb*, 899 F.3d at 1162, 1162 n.9 (“[S]cience has advanced since 1986, resulting in new forms of treatment for gender dysphoria. . . . In the past decades, (surgical) care for people diagnosed with gender dysphoria is increasingly provided in specialized, interdisciplinary health-care facilities following the Standards of Care.”).

206. *See Edmo v. Corizon, Inc.*, 935 F.3d 757, 767 (9th Cir. 2019).

207. *See supra* note 198 and accompanying text (citing cases ruling in favor of incarcerated transgender people seeking transition surgery).

208. *See supra* Part II (discussing various courts’ rulings in favor of transgender people who were denied access to hormone therapy and social transition); *see also Colwell v. Bannister*, 763 F.3d 1060, 1068–70 (9th Cir. 2014) (denying summary judgment to the State and holding that a blanket policy of denying cataract surgery in which a person has at least one “good eye” violates Eighth Amendment); *Brock v. Wright*, 315 F.3d 158, 166–67 (2d Cir. 2003) (denying summary judgment to the State and holding that a blanket policy of denying treatment of keloid scars to alleviate moderate chronic pain violates Eighth Amendment).

medical consensus; (2) these standards are backed by sixty years of scientific evidence; (3) arguments that attempt to undermine the WPATH standards or misinterpret them as not applying to incarcerated people are without merit; and (4) providing incarcerated transgender people with access to transition surgery has broader implications for culture and law that extend well beyond the prison gates.²⁰⁹ We discuss each in turn.

1. Transition Surgery Has Attained Widespread Acceptance in the Medical Community and Beyond

As the Ninth Circuit in *Edmo* and numerous courts have held, the “weight of opinion in the medical and mental health communities agrees that [transition surgery] is safe, effective, and medically necessary in appropriate circumstances” for the treatment of gender dysphoria.²¹⁰ It is neither experimental nor cosmetic.²¹¹ Support for this consensus can be found in the

209. See *infra* Section III.B.

210. *Edmo*, 935 F.3d at 770; see, e.g., *Norsworthy v. Beard*, 87 F. Supp. 3d 1164, 1171 (N.D. Cal. 2015) (“Studies have shown that [transition surgery] is a safe and effective treatment for individuals with gender dysphoria.”); *O’Donnabhain v. Comm’r*, 134 T.C. 34, 69 (2010) (“The evidence is clear that a substantial segment of the psychiatric profession has been persuaded of the advisability and efficacy of hormone therapy and [transition] surgery as treatment for [gender dysphoria], as have many courts.”); WPATH Standards, *supra* note 16, at 54–55 (stating that, for many transgender individuals, “surgery is essential and medically necessary to alleviate their gender dysphoria. For th[is] . . . group, relief from gender dysphoria cannot be achieved without modification of their primary and/or secondary sex characteristics to establish greater congruence with their gender identity.” (citation omitted)); DSM-5, *supra* note 46, at 451 (discussing physical interventions, including surgery, that alleviate gender dysphoria); *NCD 140.3, Transsexual Surgery*, *supra* note 34, at 20 (noting “a consensus among researchers and mainstream medical organizations that [transition] surgery is an effective, safe and medically necessary treatment for [gender dysphoria]”).

211. See, e.g., *Edmo*, 935 F.3d at 770 (“[Transition] surgery is not considered experimental or cosmetic; it is an accepted, effective, medically indicated treatment for [gender dysphoria].” (quoting *De’lonta v. Johnson*, 708 F.3d 520, 523 (4th Cir. 2013))); WPATH Standards, *supra* note 16, at 58 (“[M]ost professionals agree that genital surgery and mastectomy cannot be considered purely cosmetic.”); WORLD PRO. ASS’N FOR TRANSGENDER HEALTH, POSITION STATEMENT ON MEDICAL NECESSITY OF TREATMENT, SEX REASSIGNMENT, AND INSURANCE COVERAGE IN THE U.S.A. 3 (2016), <https://www.wpath.org/media/cms/Documents/Web%20Transfer/Policies/WPATH-Position-on-Medical-Necessity-12-21-2016.pdf> [<https://perma.cc/A7JA-WDZ3>] (“The medical procedures attendant to gender affirming/confirming surgeries are not ‘cosmetic’ or ‘elective’ or ‘for the mere convenience of the patient.’ These reconstructive procedures are not optional in any meaningful sense, but are understood to be medically necessary for the treatment of the diagnosed condition.”); STATE OF CONN. COMM’N ON HUM. RTS. & OPPORTUNITIES, DECLARATORY RULING ON PETITION REGARDING HEALTH INSURERS’ CATEGORIZATION OF CERTAIN GENDER-CONFIRMING PROCEDURES AS COSMETIC 8 (2020), <https://ctchro.files.wordpress.com/2020/04/declaratory-ruling.pdf> [<https://perma.cc/PZ7K-VGX8>] (“[N]o treatment for gender dysphoria can be deemed cosmetic. . . . This is because procedures altering the appearance of transgender patients for treatment of gender dysphoria are not for the purpose of ‘enhancing’ cosmetic beauty—they are medically indicated for the purpose of bringing a transgender patient’s appearance in accordance with their gender identity to eliminate the stress caused by incongruence of the same. . . . [T]he goal is to ‘modify . . . characteristics from [one sex to another] in order to allow a person to live and function in their affirmed gender, thereby reducing or eliminating their gender dysphoria.’”) (quoting Dr. Randi Ettner); *O’Donnabhain*, 134 T.C. at 70–71 (concluding that transition surgery was not “cosmetic surgery” for tax purposes); *NCD 140.3, Transsexual Surgery*, *supra* note 34, at 20 (“[T]he [National Coverage Determination]’s reasons for asserting that [transition] surgery

long line of leading professional organizations that endorse the WPATH Standards, including the National Commission on Correctional Healthcare,²¹² and in the inclusion of transition surgery in prominent surgical text books and psychiatric reference texts.²¹³

Longstanding decisions by multiple federal agencies further support this consensus, as do a number of state department of corrections policies.²¹⁴ In 2011, the Internal Revenue Service acquiesced in the 2010 decision of the U.S. Tax Court that transition surgery is not “cosmetic surgery” and is a deductible medical expense under the Internal Revenue Code.²¹⁵ On May 30, 2014, an impartial adjudicative board in the U.S. Department of Health & Human Services invalidated its 1989 determination denying Medicare coverage of transition surgery and concluded, based on decades of studies, that surgical care to treat gender dysphoria is safe, effective, and not experimental.²¹⁶ The board’s decision specifically noted that there was sufficient evidence to prove “a consensus among researchers and mainstream medical organizations that transsexual surgery is an effective, safe[,] and medically necessary treatment for [gender dysphoria].”²¹⁷ Ever since the adjudicative board’s decision, Medicare has provided coverage for transition-related surgery based on patients’ individual needs.²¹⁸ In 2016, the

was experimental are no longer valid.”).

212. See *Transgender and Gender Diverse Health Care in Correctional Settings*, *supra* note 105 (discussing provision of “gender-affirming surgical procedures . . . when determined to be medically necessary for a patient” consistent with WPATH Standards).

213. See *O’Donnabhain*, 134 T.C. at 65–66 (“[E]very psychiatric reference text that has been established as authoritative in this case endorses [transition] surgery as a treatment for [gender dysphoria] in appropriate circumstances. No psychiatric reference text has been brought to the Court’s attention that fails to list, or rejects, the triadic therapy sequence or [transition] surgery as the accepted treatment regimen for [gender dysphoria].”); *NCD 140.3, Transsexual Surgery*, *supra* note 34, at 21 (discussing the inclusion of transition surgeries “in prominent surgical text books” as evidence of consensus).

214. See *infra* notes 215–20 and accompanying text.

215. See *O’Donnabhain*, 134 T.C. at 61, *action on dec.*, 2011-47 (Nov. 21, 2011).

216. See *NCD 140.3, Transsexual Surgery*, *supra* note 34, at 24; *id.* at 21, 24 (concluding that the National Center for Health Care Technology’s assertion in 1981 report that transition surgery “must be considered still experimental” because “[t]he safety and effectiveness of transsexual surgery as a treatment of transsexualism is not proven and is questioned” was “not reasonable in light of the unchallenged new evidence”).

217. *Id.* at 20; see also *id.* at 22 (stating that the “unchallenged new evidence” demonstrated, *inter alia*, that transition surgery “has been performed thousands of times with surgeons around the world and has been proven to be a medically necessary and successful treatment, saving many lives and significantly improving the lives of those who undergo this surgery”).

218. See *id.* at 20. The determination of whether transition surgery is medically necessary for individual Medicare recipients is made by private health care insurers (Medicare Administrative Contractors) on a case-by-case basis. See CTRS. FOR MEDICARE & MEDICAID SERVS., DECISION MEMO FOR GENDER DYSPHORIA AND GENDER REASSIGNMENT SURGERY, No. CAG-00446N § IX (2016), <https://www.cms.gov/medicare-coverage-database/details/nca-decision-memo.aspx?NCAId=282> [<https://perma.cc/7RKG-TCCP>]. In 2016, the Centers for Medicare & Medicaid Services (“CMS”), an agency within DHHS, refrained from issuing national standards (that is, a National Coverage Determination) for determining the medical necessity of transition surgery for Medicare recipients—noting that this

Department of Defense approved procedures permitting active-duty transgender service members to receive “cross-sex hormone therapy or other medical procedures,” including surgery, while serving.²¹⁹ Additionally, numerous state departments of corrections explicitly require prison officials to provide incarcerated transgender people with access to transition-related care, including surgery.²²⁰

Further support for this consensus can be found in public and private healthcare plans’ coverage of transition surgery.²²¹ In addition to Medicare coverage for transition surgery,²²² the overwhelming majority of Medicaid programs—forty states and the District of Columbia—have either removed or never adopted exclusions of transition surgery in their Medicaid programs.²²³ Additionally, the federal Office of Personnel Management prohibits the exclusion of transition surgery in federal employee health

population includes many older adults and people with disabilities, whose health outcomes may differ from those of the general population based on their “unique and complex needs.” *Id.* §§ VII(8)(b)(11), VIII(c), IX. The CMS decision clarified that transition surgery “may be a reasonable and necessary service for certain [Medicare] beneficiaries with gender dysphoria,” but “[t]he current scientific information is not complete for CMS to make a [national coverage determination] that identifies the precise patient population for whom the service would be reasonable and necessary.” *Id.* § VII(8)(b)(3). *But see* *Gibson v. Collier*, 920 F.3d 212, 223 n.7 (5th Cir. 2019) (erroneously arguing that CMS “found that there was insufficient expert medical evidence to support [transition] surgery with respect to Medicare and Medicaid patients”). Importantly, CMS’s conclusion does not undermine the medical necessity of transition surgery; indeed, the appropriateness of most medical and surgical care provided to patients is determined on an individualized basis, taking into account each patient’s unique clinical circumstances, and not by national standards. *See, e.g.*, CTRS. FOR MEDICARE & MEDICAID SERVS., *supra* note 218, § IX (“We are not making a national coverage determination relating to counseling, hormone therapy treatments, or any other potential treatment for gender dysphoria.”).

219. U.S. DEP’T OF DEF., INSTRUCTION 1300.28, IN-SERVICE TRANSITION FOR TRANSGENDER SERVICE MEMBERS 1, 16 (2016), https://dod.defense.gov/Portals/1/features/2016/0616_policy/DoD-Instruction-1300.28.pdf [<https://perma.cc/Z6XN-8TZF>].

220. *See, e.g.*, CAL. CORR. HEALTH CARE SERVS., GUIDELINES FOR REVIEW OF REQUESTS FOR GENDER AFFIRMING SURGERIES 1–4 (2018), <https://documentcloud.adobe.com/link/track?uri=urn%3Aaaid%3Ausc%3A4dace6e8-5ad9-481f-912c-91f7ebd25398#pageNum=1v> [<https://perma.cc/8N L9-JGE4>] (providing process for referral and review of requests for transition surgery); R.I. DEP’T OF CORR., *supra* note 128, at 11 (stating that “[t]ransgender inmates will receive all medical care, treatment and the maintenance of any ongoing procedures related to the transition process”—including transition surgery—“utilizing the standard care afforded to all [Rhode Island Department of Corrections] inmates. . . .”); *see also* Rourth et al., *supra* note 43, at 18 (compiling state policies).

221. *See infra* notes 222–29 and accompanying text. Transition-related care, including surgery, has long been covered by national health plans outside of the United States, including in Argentina, Brazil, Canada, Cuba, Iran, and the following European countries: Austria, Belgium, the Czech Republic, Denmark, Finland, France, Germany, Hungary, Ireland, Italy, Latvia, the Netherlands, Poland, Portugal, Spain, Sweden, and the United Kingdom. *See* TRANSGENDER LEGAL DEF. & EDUC. FUND, MEMORANDUM TO PLAN ADMINISTRATORS RE: LIABILITY FOR TRANSGENDER HEALTH CARE EXCLUSIONS IN EMPLOYER HEALTH PLANS 10–11 (2021).

222. *NCD 140.3, Transsexual Surgery*, *supra* note 34, at 1 (eliminating exclusion for transition-related surgery).

223. *See Healthcare Laws and Policies Medicaid*, MOVEMENT ADVANCEMENT PROJECT, www.lgbtmap.org/equality-maps/healthcare_laws_and_policies [<https://perma.cc/2VUR-FL6Q>].

plans,²²⁴ and seventeen states and the District of Columbia cover transition surgery in state employee health plans.²²⁵

As for private healthcare coverage, twenty-four states and the District of Columbia prohibit the exclusion of transition surgery in private insurance.²²⁶ Over ninety-one percent of the 1,142 private-sector businesses surveyed in the Human Rights Campaign’s 2021 Corporate Equality Index, and over seventy-one percent of Fortune 500 businesses, cover transition surgery in employer-sponsored health insurance plans.²²⁷ Insurance companies have overwhelmingly eliminated exclusions for transition surgery from individual health insurance plans,²²⁸ and all major insurance companies administer employer-sponsored health insurance plans that cover transition surgery.²²⁹

2. Transition Surgery Is Supported by a Significant Body of Medical Evidence

As alluded to by the Ninth Circuit in *Edmo*, the broad consensus in support of transition surgery derives from a robust body of medical evidence, dating back more than sixty years, which overwhelmingly demonstrates transition surgery’s safety and efficacy.²³⁰

As the U.S. Tax Court concluded in *O’Donnabhain*, the medical literature provides “ample proof of [transition surgery’s] positive therapeutic

224. U.S. OFF. OF PERS. MGMT., FEHB PROGRAM CARRIER LETTER NO. 2015-12, COVERED BENEFITS FOR GENDER TRANSITION SERVICES (2015), <https://www.opm.gov/healthcare-insurance/healthcare/carriers/2015/2015-12.pdf> [<https://perma.cc/9V4V-Q242>] (“[N]o carrier participating in the Federal Employees Health Benefits Program may have a general exclusion of services, drugs or supplies related to gender transition or ‘sex transformations.’”).

225. *Healthcare Laws and Policies State Employee Benefits*, MOVEMENT ADVANCEMENT PROJECT, http://www.lgbtmap.org/equality-maps/healthcare_laws_and_policies [<https://perma.cc/2VUR-FL6Q>].

226. *Healthcare Laws and Policies Private Insurance*, MOVEMENT ADVANCEMENT PROJECT, http://www.lgbtmap.org/equality-maps/healthcare_laws_and_policies [<https://perma.cc/2VUR-FL6Q>].

227. HRC INDEX, *supra* note 17, at 6, 18.

228. *See* OUT2ENROLL, SUMMARY OF FINDINGS: 2018 MARKETPLACE PLAN COMPLIANCE WITH SECTION 1557, at 1–3, <https://www.out2enroll.org/out2enroll/wp-content/uploads/2017/11/Overview-of-Trans-Exclusions-in-2018-Marketplace-Plans-1.pdf> [<https://perma.cc/SX3U-H4B5>] (surveying 500 individual health insurance plans across eighteen states and finding that ninety percent of such plans did not exclude transition-related care).

229. *See* TRANSGENDER LEGAL DEF. & EDUC. FUND, *supra* note 221, at 9–10.

230. *See* *Edmo v. Corizon, Inc.*, 935 F.3d 757, 771–72 (9th Cir. 2019) (citing scientific studies supporting necessity and efficacy of transition surgery); *see also* Declaration of George Richard Brown Supporting Opposition, *supra* note 65, ¶¶ 13–14 (“Sixty years of clinical experience and data have demonstrated the efficacy of treatment for the distress resulting from gender dysphoria . . .” (citing a multi-country, long-term follow-up study)). The earliest recorded transition surgeries using modern surgical techniques took place in Germany in the 1920s and 1930s at Dr. Magnus Hirschfeld’s Institute for Sexual Science, and evidence of alterations to male genitals dates back to ancient times. *See* Beemyn, *supra* note 16, at 506; Dallas Denny, *Transgender Communities*, in TRANSGENDER RIGHTS 175 (2006).

outcomes.”²³¹ In 1981, two years after the formulation of the original Standards of Care by the Harry Benjamin International Gender Dysphoria Association (now WPATH), Dr. Ira Pauly, an American psychiatrist, published the results of a large retrospective study of people who had undergone transition surgery.²³² The results were overwhelmingly positive. “Among 83 [Female-to-Male] patients, 80.7% had a satisfactory outcome ([that is], patient self-report of ‘improved social and emotional adjustment’), 6.0% unsatisfactory. Among 283 [Male-to-Female] patients, 71.4% had a satisfactory outcome, 8.1% unsatisfactory.”²³³

The 1981 study “included patients who were treated before the publication and use of the Standards of Care.”²³⁴ Since the Standards of Care have been in place, moreover, “there has been a steady increase in patient satisfaction and decrease in dissatisfaction with the outcome of [transition] surgery,” with the “vast majority of follow-up studies . . . show[ing] an undeniable beneficial effect of [transition] surgery on postoperative outcomes such as subjective well being, cosmesis, and sexual function,” and no patient regret from having had surgery—even among those who “develop[ed] severe surgical complications post-surgery.”²³⁵

Recent studies confirm the necessity and efficacy of transition surgery. According to a 2014 study, “a significant body of evidence shows that treatment can alleviate symptoms among those who do experience distress. A meta-analysis of more than 2,000 patients in seventy-nine studies published between 1961 and 1991 found “[f]avorable effects of therapies that included both hormones and surgery . . . Most patients reported improved psychosocial outcomes, ranging between [eighty-seven percent] for [male-to-female] patients and [ninety-seven percent] for [female-to-male] patients.”²³⁶ Moreover, these “[s]atisfaction rates have increased over time: studies have been reporting a steady improvement in outcomes as the field becomes more advanced.”²³⁷ Indeed, a 2010 study found that “almost all patients were satisfied with [transition surgery] at [five] years, and [eighty-six percent] were assessed by clinicians at follow-up as stable or

231. *O’Donnabhain v. Comm’r*, 134 T.C. 34, 68 (2010) (citing psychiatric reference texts).

232. *See* WPATH Standards, *supra* note 16, at 107.

233. *Id.*

234. *Id.*

235. *Id.*; *see also id.* at 108 (“[M]ost [patients] reported being satisfied with the cosmetic and functional results of the surgery.” (citing studies)); *see also Edmo*, 935 F.3d at 771 (“Scientific studies show that the regret rate for individuals who undergo [transition surgery] is low, in the range of one to two percent.” (citing studies)).

236. M. Joycelyn Elders, George R. Brown, Eli Coleman, Thomas A. Kolditz & Alan M. Steinman, *Medical Aspects of Transgender Military Service*, 41 *ARMED FORCES & SOC’Y* 199, 175 (2014).

237. *Id.*; *see also* WPATH Standards, *supra* note 16, at 108 (“Patients operated on after 1986 did better than those before 1986; this reflects significant improvement in surgical complications.”).

improved in global functioning.”²³⁸

Most studies of the outcomes of surgeries and other transition-related treatments have been retrospective—that is, the studies analyzed health outcomes for those who had already undergone surgery and other transition-related treatments.²³⁹ Although fewer in number, there have been several prospective studies that analyzed health outcomes for individuals before and after undergoing surgery and other transition-related treatments. For example, a 2005 study, which evaluated 325 consecutive adult and adolescent subjects seeking transition-related care, “affirm[ed] the results from retrospective studies that a combination of hormone therapy and surgery improves gender dysphoria and other areas of psychosocial functioning.”²⁴⁰ Specifically, the study found that surgery and hormone therapy reduced gender dysphoria and body dissatisfaction and also improved psychological function.²⁴¹ Additionally, a 2016 study, which analyzed thirty-eight prior studies in order to determine the psychiatric outcome for individuals following surgery and other transition-related treatments, concluded that people who undergo such treatments report mental health conditions at rates similar to nontransgender people.²⁴² According to the report:

longitudinal studies investigating the same cohort of trans people pre- and post-interventions showed an overall improvement in psychopathology and psychiatric disorders post-treatment. In fact, the findings from most studies showed that the [quality-of-life] scores of trans people following [gender-confirming medical interventions] were similar to those of the general population.²⁴³

3. Arguments Defending Denials of Access to Transition Surgery Do Not Withstand Scrutiny

The Ninth Circuit’s decision in *Edmo* rightly rejected several meritless arguments advanced by states to avoid their medical treatment obligations under the Eighth Amendment.²⁴⁴ Specifically, the WPATH Standards’ requirement that coexisting mental health concerns *unrelated* to a person’s gender dysphoria be well-controlled prior to undergoing surgery²⁴⁵ poses no

238. WPATH Standards, *supra* note 16, at 109.

239. *See id.* at 107.

240. *Id.* at 109.

241. *Id.*

242. *See* Cecilia Dhejne, Roy Van Vlerken, Gunter Heylens & Jon Arcelus, *Mental Health and Gender Dysphoria: A Review of the Literature*, 28 INT’L REV. PSYCHIATRY 44, 53 (2016).

243. *Id.*

244. *See infra* notes 245–54 and accompanying text.

245. WPATH Standards, *supra* note 16, at 105–06. These mental health concerns include “psychotic conditions and other serious mental illnesses” such as “bipolar disorder, dissociative identity

barrier to incarcerated transgender people who experience anxiety, depression, self-harm, and suicidality as a result of gender dysphoria.²⁴⁶ As the Ninth Circuit correctly concluded, “[c]oexisting medical or mental health issues resulting from a person’s gender dysphoria are not an impediment” to surgery; indeed, transition surgery *ameliorates* these symptoms of gender dysphoria.²⁴⁷

Additionally, the WPATH Standards’ requirement that people socially transition twelve months prior to undergoing surgery also poses no barrier to incarcerated transgender people, who can and often do socially transition in prison.²⁴⁸ For example, Adree Edmo changed her legal name and the sex on her birth certificate while incarcerated and consistently presented as female.²⁴⁹ Michelle Kosilek likewise presented as female, wearing gender-appropriate clothing, as did Dee Farmer, the plaintiff in the Supreme Court’s 1994 decision that established an Eighth Amendment violation for prison officials’ failure to protect.²⁵⁰ Indeed, the Eighth Amendment, as well as some state laws—not to mention the WPATH Standards themselves—demand access to social transition in prison.²⁵¹ Several of those state laws, moreover, explicitly require that incarcerated transgender people receive transition surgery.²⁵²

Lastly, the decades-old testimony relied on by the First Circuit in *Kosilek* and recycled by the Fifth Circuit in *Gibson* (and also by several

disorder, [and] borderline personality disorder,” which can impair a person’s ability to discern reality. *Id.* at 61; *Edmo v. Corizon, Inc.*, 935 F.3d 757, 776 (9th Cir. 2019) (discussing “thought disorders” and “impaired reality testing” in connection with qualification for transition surgery).

246. See DSM-5, *supra* note 46, at 454–55 (stating that the “development of depression, anxiety, and substance abuse . . . may be a consequence of gender dysphoria,” and that “[a]dolescents and adults with gender dysphoria before gender reassignment are at increased risk for suicidal ideation, suicide attempts, and suicides”); see also *Edmo*, 935 F.3d at 769 (“Left untreated . . . [gender dysphoria] can lead to debilitating distress, depression, impairment of function, substance use, self-surgery to alter one’s genitals or secondary sex characteristics, self-injurious behaviors, and even suicide.”).

247. *Edmo*, 935 F.3d at 771; see *id.* at 776–77 (stating that transition surgery would “eliminate much of the depression and the attendant symptoms [of gender dysphoria] that [the plaintiff] is experiencing,” and that plaintiff’s suicide attempts and cutting behaviors did not “indicate[] that [the plaintiff] has inadequately controlled mental health concerns,” but rather indicated the need for transition surgery (quoting plaintiff’s expert, Dr. Randi Ettner)); *id.* at 778 (stating that transition surgery would alleviate the risk of self-castration attempts (quoting plaintiff’s expert, Dr. Gorton)); accord *Kosilek v. Spencer*, 774 F.3d 63, 73 (1st Cir. 2014) (“[T]he likelihood that [the plaintiff] would become suicidal if denied surgery was, to the [plaintiff’s] doctors, not a contraindication to her eligibility, but instead was a symptom that could be alleviated by provision of [transition surgery].”); see also DSM-5, *supra* note 46, at 451 (“[M]any [individuals with gender dysphoria] are distressed *if* the desired physical interventions by means of hormones and/or surgery are not available.” (emphasis added)).

248. WPATH Standards, *supra* note 16, at 106.

249. See *Edmo*, 935 F.3d at 772.

250. See *Kosilek*, 774 F.3d at 70; *Farmer v. Brennan*, 511 U.S. 825, 829 (1994).

251. See *supra* notes 130–72 (discussing access to social transition).

252. See *supra* note 128 (discussing state administrative policies requiring that incarcerated transgender people receive hormone therapy and other medically necessary transition-related care).

Ninth Circuit judges in their unsuccessful bid to rehear *Edmo* en banc), which suggested that there was no medical consensus to support transition surgery, is, according to the Ninth Circuit, “incorrect, or at best outdated.”²⁵³ Several courts have gone further, characterizing the sources of that testimony as “outliers in the field of gender dysphoria treatment” and “not credible,” and giving “virtually no weight” to their testimony.²⁵⁴

4. Providing Access to Transition Surgery Has Broader Cultural and Legal Significance

State departments of corrections’ provision of access to transition surgery not only meets the health needs of transgender people in satisfaction of the Eighth Amendment, but it also has important implications for the progress of transgender people, beyond the prison gates, in culture and in law.

First, because transgender people of color are disproportionately represented in criminal justice facilities,²⁵⁵ the denial of essential care, including surgery, has a deeply troubling racial dimension. One account of the community suggests that nearly one-half of all Black transgender people have been incarcerated.²⁵⁶ Black transgender lives matter, especially in this context.²⁵⁷ By providing access to transition surgery, state departments of corrections, in this modest way, support racial justice, rather than standing as a bulwark against it.

Second, the denial of access to transition surgery often reflects a mistrust, or even disdain, for science by crediting the outdated views of a

253. *Edmo*, 935 F.3d at 795.

254. *Edmo v. Idaho Dep’t of Corr.*, 358 F. Supp. 3d 1103, 1126 (D. Idaho 2018) (“Under these circumstances, the Court gives virtually no weight to the opinions of Defendants’ experts”); *see also* *Norsworthy v. Beard*, 87 F. Supp. 3d 1164, 1188 (N.D. Cal. 2015) (“The Court gives very little weight to the opinions of Levine, whose report misrepresents the Standards of Care; overwhelmingly relies on generalizations about gender dysphoric prisoners, rather than an individualized assessment of Norsworthy; contains illogical inferences; and admittedly includes references to a fabricated anecdote.”); *O’Donnabhain v. Comm’r*, 134 T.C. 34, 64, 74 (2010) (“Since Dr. Schmidt did not [interview the plaintiff], his analysis is entitled to considerably less weight . . . Respondent has not shown that Dr. Schmidt’s concept of medical necessity is widely accepted, and it strikes the Court as idiosyncratic and unduly restrictive.”); *see also* *Gibson v. Collier*, 920 F.3d 212, 234–35 (5th Cir. 2019) (Barksdale, J., dissenting) (“The courts in *Edmo* and *Norsworthy* found those doctors not credible in the light of their misrepresentations and refusal to subscribe to the medically-accepted standards of care—WPATH.”).

255. *See Transgender Incarcerated People in Crisis*, LAMBDA LEGAL, <https://www.lambdalegal.org/know-your-rights/article/trans-incarcerated-people> [<https://perma.cc/SAD3-NH6G>].

256. *Id.*; *see also* STRYKER, *supra* note 13, at 208.

257. *See* Isabella Grullón Paz & Maggie Astor, *Black Trans Women Seek More Space in the Movement They Helped Start*, N.Y. TIMES (June 27, 2020), <https://www.nytimes.com/2020/06/27/us/politics/black-trans-lives-matter.html> [<https://perma.cc/8DHK-GNHW>]. *See generally* Kortney Ryan Ziegler & Naim Rasul, *Race, Ethnicity, and Culture*, in *TRANS BODIES, TRANS SELVES: A RESOURCE FOR THE TRANSGENDER COMMUNITY*, *supra* note 15, at 29 (discussing institutionalized racism experienced by transgender people of color).

diminishing cohort of discredited doctors on the fringe of gender dysphoria treatment over the consensus view of the national and international medical community that transition surgery is essential medical care.²⁵⁸ By providing access to transition surgery, state departments of corrections help to expose and undermine the outdated myth, founded on no science, that transition surgery is controversial, experimental, or frivolous,²⁵⁹ and show transition surgery for what it is: a mainstream, successful treatment for a serious medical condition.

Third, the denial of access to transition surgery runs counter to the overwhelming national trend supporting coverage of such treatment in public and private healthcare.²⁶⁰ States that provide access to transition surgery to incarcerated transgender people are in harmony with the federal government's coverage of transition surgery under Medicare and federal employee health plans.²⁶¹ They are also consistent with states that cover transition surgery under Medicaid and state employee health plans, and with states that require coverage of transition surgery in private insurance plans.²⁶² These states are also in line with the many private businesses that provide transition surgery coverage for their employees, and with the overwhelming number of insurance companies that provide and administer health insurance that covers transition surgery.²⁶³

Fourth, the denial of access to transition surgery is historically rooted in stigma, that is, in prejudice and stereotypes toward transgender people and ignorance and neglect of their medical needs.²⁶⁴ In *Diamond v. Owens*, for

258. See *supra* note 82 (discussing Dr. Paul McHugh).

259. *NCD 140.3, Transsexual Surgery*, *supra* note 34, at 23 (stating that views in opposition to transition surgery in 1981 “fall far outside the mainstream psychological, psychiatric, and medical professional consensus” and are “completely unscientific”).

260. See *supra* notes 220–28 and accompanying text (discussing coverage of transition surgery in public and private healthcare plans).

261. *NCD 140.3, Transsexual Surgery*, *supra* note 34, at 1 (eliminating exclusion for transition-related surgery); see U.S. OFF. OF PERS. MGMT., *supra* note 224 (“[N]o carrier participating in the Federal Employees Health Benefits Program may have a general exclusion of services, drugs or supplies related to gender transition or ‘sex transformations.’”).

262. See *supra* notes 223, 225–59 and accompanying text (discussing state coverage of transition surgery in public and private health plans).

263. See *supra* notes 228–29 and accompanying text (discussing coverage of transition surgery in individual health insurance plans and employer-sponsored health insurance plans).

264. See, e.g., *NCD 140.3, Transsexual Surgery*, *supra* note 34, at 24 (discussing opposition to Medicare's coverage of transition surgery in 1981 because it was not considered “social[ly] acceptab[le]”); JOANNE MEYEROWITZ, *HOW SEX CHANGED* 12 (2002) (observing the popular belief that people who undergo transition are “social frauds” who “misrepresent themselves, deceive themselves (and presumably others) as they attempt to pass as something they are not”); see also *Grimm v. Gloucester Cnty. Sch. Bd.*, 972 F.3d 586, 616–17 (4th Cir. 2020) (discussing history of discrimination against transgender people); *Flack v. Wis. Dept. of Health Servs.*, 328 F. Supp. 3d 931, 953 (W.D. Wis. 2018) (same); cf. *Henderson v. Thomas*, 913 F. Supp. 2d 1267, 1317–18 (M.D. Ala. 2012) (declaring unconstitutional Alabama's policy of segregating HIV-positive prisoners because it was based on

example, a prison warden refused to permit an incarcerated transgender woman to socially transition, stating that “he didn’t like [the plaintiff’s] eyebrows and ‘we aren[’]t going to do that[.] ‘This is a man’s facility.’”²⁶⁵ And in *Kosilek*, the plaintiff presented evidence that prison officials’ refusal to provide transition surgery to an incarcerated transgender person were motivated by fears that providing transition surgery would invite political controversy and public ridicule.²⁶⁶ By providing access to transition surgery, state departments of corrections reduce this stigma and align prison practices with the common sense of the public—an overwhelming majority of whom support transgender rights generally and access to transition surgery, in particular.²⁶⁷

Lastly, the denial of access to transition surgery is often based on misplaced concerns about costs of care.²⁶⁸ For example, the Governor of Idaho stated in a press releases that “[t]he hard working taxpayers of Idaho should not be forced to pay for [Adree Edmo’s] gender reassignment surgery . . . We cannot divert critical public dollars away from our focus on keeping the public safe and rehabilitating offenders.”²⁶⁹ Similarly, in

“outdated and unsupported assumptions about HIV” and reflected an “intentional bias against HIV-positive people,” and chiding corrections officials for declaring that, “[W]e live in Alabama. . . . Prejudices . . . die hard in Alabama,” in response to the question of why the policy was continued after the facts of HIV transmission had become known).

265. *Diamond v. Owens*, 131 F. Supp. 3d 1346, 1364 (M.D. Ga. 2015).

266. *See Kosilek v. Spencer*, 889 F. Supp. 2d 190, 198 (D. Mass. 2012). The district court in *Kosilek* credited this evidence, holding that purported security concerns were “a pretext to mask the real reason for the decision to deny [Ms. Kosilek] sex reassignment surgery—a fear of controversy, criticism, ridicule, and scorn.” *Id.* at 198. The First Circuit, sitting en banc, reversed, concluding that the district court’s assumption that the Department of Corrections Commissioner’s “acting in response to ‘public and political criticism’ . . . necessarily carried over to her successors and governed their actions [wa]s unsupported by the record.” *Kosilek v. Spencer*, 774 F.3d 63, 94–95 (1st Cir. 2014).

267. Winston Luhur, Taylor N.T. Brown & Andrew R. Flores, *Public Opinion of Transgender Rights in the United States*, WILLIAMS INST. (Aug. 2019), <https://williamsinstitute.law.ucla.edu/publications/public-opinion-trans-rights-us> [<https://perma.cc/5JDH-VPDF>] (reporting that seventy-three percent of respondents believed that transgender people should be protected from discrimination, and seventy-one percent believed transgender people should have access to transition surgery).

268. Although cost is a common reason that states deny transition surgery, it is not a legitimate one. *See, e.g., Ancata v. Prison Health Servs., Inc.*, 769 F.2d 700, 705 (11th Cir. 1985) (“Lack of funds . . . cannot justify an unconstitutional lack of competent medical care and treatment for inmates.”); *Kosilek*, 889 F. Supp. 2d at 210–11 (citing cases in Second, Third, Fifth, Seventh, Ninth, and Eleventh Circuits for proposition that cost is no defense for inadequate medical care under Eighth Amendment); *see also Fields v. Smith*, 653 F.3d 550, 555 (7th Cir. 2011) (rejecting argument that gender dysphoria treatment could lawfully be excluded from healthcare coverage due to cost); *accord Toomey v. Arizona*, No. CV-19-00035, 2019 U.S. Dist. LEXIS 219781, at *6–9 (D. Ariz. Dec. 23, 2019); *Boyden v. Conlin*, 341 F. Supp. 3d 979, 1000–03 (W.D. Wis. 2018); *Flack v. Wis. Dept. of Health Servs.*, 328 F. Supp. 3d 931, 954–55 (W.D. Wis. 2018); *Hicklin v. Precynthe*, No. 4:16-cv-01357, 2018 U.S. Dist. LEXIS 21516, at *49–50 (E.D. Mo. Feb. 9, 2018); *Stockman v. Trump*, No. EDCV 17–1799, 2017 U.S. Dist. LEXIS 221323, at *15 (C.D. Cal. Dec. 22, 2017); *Soneeya v. Spencer*, 851 F. Supp. 2d 228, 243 (D. Mass. 2012).

269. Press Release, Idaho Off. of the Governor, Idaho Appeals Ruling in Transgender Inmate Surgery Case (Jan. 9, 2019), <https://gov.idaho.gov/pressrelease/idaho-appeals-ruling-in-transgender-inmate-surgery-case> [<https://perma.cc/3ZL4-NKCY>]; *see also Balla v. Idaho State Bd. of Corr.*, 119 F.

Massachusetts, the Lieutenant Governor publicly opposed using tax revenues to provide transition surgery to Michelle Kosilek; a state senator introduced legislation to prohibit the department of corrections from paying for transition surgery; state legislators wrote letters to the commissioner of the department of corrections “express[ing] ‘outrage’ at the request that taxpayers fund a ‘sex-change’ operation for Kosilek,” noting the strained state budget and threatening to reduce the department’s funding if surgery were provided; and local media consistently published articles and editorials “specifically opposing the expenditure of taxpayer funds to provide such treatment.”²⁷⁰

Numerous studies show that the cost of covering transition surgery is inconsequential or cost-neutral because transgender people comprise a relatively small percentage of the inmate population, and not all transgender people undergo all available treatments.²⁷¹ Indeed, departments of

Supp. 3d 1271, 1278–79 (D. Idaho 2015) (finding that clinical supervisor for Idaho State Corrections Institute instructed clinicians “to not diagnose inmates with gender identity disorder . . . so that [the prison] would not have to pay for gender identity disorder treatment”).

270. *Kosilek*, 889 F. Supp. 2d at 246.

271. *See, e.g.*, *Flack v. Wis. Dep’t of Health Servs.*, 395 F. Supp. 3d 1001, 1021–22 (W.D. Wis. 2019) (stating that analyses of transition-related health care exclusion in state Medicaid plan “reveal such small estimated savings . . . that they are both practically and actuarially immaterial. Defendants estimate that removing the [exclusion] and covering gender-confirming surgeries would cost between \$300,000 and \$1.2 million annually, which actuarially speaking amounts to one hundredth to three hundredth of one percent of the State’s share of Wisconsin Medicaid’s annual budget”); *Boyden*, 341 F. Supp. 3d at 1000–01 (“From an actuarial perspective, there appears to be no dispute that the cost of coverage is immaterial at 0.1% to 0.2% of the total cost of providing health insurance to state employees, even adopting defendants’ cost estimation. . . . [T]he court is hard-pressed to find that a reasonable factfinder could conclude that the cost justification was an ‘exceedingly persuasive’ reason or that this miniscule cost savings would further ‘important governmental objectives.’ ”); *see also* TRANSGENDER LEGAL DEF. & EDUC. FUND, *supra* note 221, at 13 (citing studies discussing negligible costs of transition-related healthcare coverage in North Carolina and Alaska, and in U.S. military context); HUM. RTS. CAMPAIGN FOUND., CORPORATE EQUALITY INDEX 2020, at 18 (2020), <https://hrc-prod-requests.s3-us-west-2.amazonaws.com/CEI-2020.pdf?mtime=20200806234745&focal=none> [<https://perma.cc/F6QB-B9CT>] (“According to businesses’ reporting to the HRC Foundation, making [transition-related care] . . . accessible comes at an overall negligible cost to the employers’ overall health insurance plans. This holds true across industries.”); Brief of Jody L. Herman as Amicus Curiae Supporting Appellee at 18, *Edmo v. Idaho Dep’t of Corr.*, 935 F.3d 757 (9th Cir. 2019) (No. 19-35017) [hereinafter *Herman Amicus Brief*] (analyzing negligible costs of providing transition-related healthcare coverage to incarcerated transgender people in California based on analysis of claims data from city of San Francisco, private employers, and U.S. military); William V. Padula, Shiona Heru & Jonathan D. Campbell, *Societal Implications of Health Insurance Coverage for Medically Necessary Services in the U.S. Transgender Population A Cost-Effectiveness Analysis*, 31 J. GEN. INTERNAL MED. 394, 394 (2015) (“Health insurance coverage for the U.S. transgender population is affordable and cost-effective, and has a low budget impact on U.S. society.”); JODY L. HERMAN, WILLIAMS INSTITUTE, COSTS AND BENEFITS OF PROVIDING TRANSITION-RELATED HEALTH CARE COVERAGE IN EMPLOYEE HEALTH BENEFIT PLANS 2 (2013), <http://williamsinstitute.law.ucla.edu/wp-content/uploads/Herman-Cost-Benefit-of-Trans-Health-Benefits-Sept-2013.pdf> [<https://perma.cc/7HHY-HVPQ>] (“Employers report very low costs, if any, from adding transition-related coverage to their health benefits plans or from actual utilization of the benefit after it has been added—with many employers reporting no costs at all.”); CAL. DEP’T OF INS., ECONOMIC IMPACT ASSESSMENT: GENDER NONDISCRIMINATION IN HEALTH INSURANCE (2012),

corrections regularly cover the treatment of far more prevalent and expensive medical conditions.²⁷² Furthermore, some studies suggest that coverage for transition surgery in fact reduces costs, given the substantial costs that may result from untreated gender dysphoria, including those arising from the development of depression, anxiety, and substance abuse, attempted or completed self-surgeries, and suicide attempts.²⁷³ By providing access to transition surgery, state departments of corrections acknowledge that the cost of providing transition surgery is merely “budget dust”;²⁷⁴ it is negligible when compared to the total cost of providing healthcare to states’ incarcerated populations and may, in fact, reduce cost in the long run by avoiding foreseeable and dire medical results.

CONCLUSION

Prison healthcare is notoriously inadequate, and nowhere is this more evident than in the context of transgender healthcare. Historically, transgender people have routinely been denied access to medically necessary hormone therapy, surgery, and other gender-affirming procedures; subjected to cross-gender strip searches; and housed according to their birth sex. But these policies and practices have begun to change. The past two decades have witnessed a dramatic shift in prisons providing some, though by no means all, appropriate care to transgender people.

This Article has traced the historic strides that incarcerated transgender people have made under the Eighth Amendment, from the rejection of policies that house transgender people based on their birth sex, to the requirement that prison officials provide transgender people with access to

lawcenter.org/wp-content/uploads/2013/04/Economic-Impact-Assessment-Gender-Nondiscrimination-In-Health-Insurance.pdf [https://perma.cc/3TTV-WV7Z] (stating that transition-related healthcare coverage “will cost little or nothing in the short run and may produce longer-term cost savings and improved health benefits for transgender people”); CITY & CNTY. OF S.F. HUM. RTS. COMM’N, SAN FRANCISCO CITY AND COUNTY TRANSGENDER HEALTH BENEFIT 1–2 (2006), <http://www.tgender.net/taw/SanFranciscoTGBenefitUpdateMar3106.pdf> [https://perma.cc/R8XZ-4GZP] (stating that transition-related healthcare coverage in employee health plans “has proven to be appropriately accessed and undeniably more affordable than other, often routinely covered, procedures. . . . Unlike the fears expressed, none of the concerns came to pass. . . . [T]he benefit costs much less to provide than the reduced rate currently being charged.”).

272. See, e.g., *Kosilek*, 889 F. Supp. 2d at 247 (“The DOC provides many prisoners with Hepatitis B medication that costs \$18,000 a year. Other prisoners receive dialysis, which is also costly.”).

273. See, e.g., Herman Amicus Brief, *supra* note 271, at 20 (stating that, by improving the overall health and well-being of transgender people, transition-related healthcare coverage “can result in cost-savings”); CAL. DEP’T OF INS., *supra* note 271, at 9 (“The evidence suggests that there may be potential cost savings resulting from the adoption of the proposed regulation [that prohibits the denial of coverage for transition-related care] in the medium to long term, such as lower costs associated with the high cost of suicide and attempts at suicide, overall improvements in mental health and lower rates of substance abuse . . .”).

274. Declaration of Raymond Edwin Mabus, Jr. in Support of Plaintiff’s Motion for Preliminary Injunction ¶ 41, *Doe v. Trump*, 275 F. Supp. 3d 167 (D.D.C. 2017) (No. 17-cv-1597).

hormone therapy, social transition, and, most recently, transition surgery. These momentous changes, which coincide with a broader cultural turn away from transphobia and toward a collective understanding of transgender people, have been neither swift nor easy. But they trend in one direction: toward a recognition of the rights and dignity of transgender people, as they must under the Eighth Amendment.²⁷⁵

275. See *Estelle v. Gamble*, 429 U.S. 97, 103 (1976) (“The [Eighth] Amendment ‘embodies broad and idealistic concepts of dignity, civilized standards, humanity, and decency . . .’ against which we must evaluate penal measures.” (quoting *Jackson v. Bishop*, 404 F.2d 571, 579 (8th Cir. 1968))).