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The Constitutional Basis for Inmate Gender Confirmation Surgery

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ABSTRACT

Transgender refers to "people whose gender identity, gender expression, or behavior does not conform to what is socioculturally accepted as, and typically associated with, the legal and medical sex to which they were assigned at birth." Despite representing a small percentage of the U.S. population (0.58%), the transgender community is disproportionately represented in the prison system. Studies suggest that one-in-six transgender people (16%) have been incarcerated in their lifetime, compared to 2.8%–6.6% of the general U.S. population. In total, transgender individuals comprise 0.24% of the U.S. prison and jail population.

Unfortunately, research indicates that the prison system is "ill-prepared to accommodate the needs of transgender inmates." This is especially problematic because the transgender population presents particularized medical needs. For example, gender dysphoria generally describes discomfort or distress resulting from the incongruence between a person's gender identity and sex assigned at birth. For some, however, the distress associated with gender dysphoria may necessitate a formal diagnosis. In these cases, an individual not only exhibits marked incongruence between gender and sex but also "clinically significant distress or impairment" in social, school or occupational, or other important areas of functioning. A formal diagnosis of gender dysphoria facilitates access to necessary gender-affirming care, including hormone therapy and gender confirmation surgery. Failure to provide necessary medical treatment for gender dysphoria can result in depression, suicidality, autocastration, and death.

Although the Eighth Amendment imposes an affirmative duty on prison officials to provide adequate medical care to inmates, the U.S. courts of appeals asymmetrically valorize this constitutional right in the context of gender-affirming care. This Comment argues that transgender inmates presenting gender dysphoria possess a serious medical need that poses a substantial risk of harm. A failure to provide, or a categorical prohibition

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of, necessary forms of gender-affirming care runs afoul of the Eighth Amendment's guarantee of adequate care. Ultimately, this Comment evaluates the Estelle-Farmer *framework—formed by two U.S. Supreme Court opinions that bear on the issue—and proposes an objective inquiry into the medical necessity of a particular form of treatment and a per se rule regarding deliberate indifference. In doing so, this Comment advocates for greater protection of the constitutional rights of transgender inmates and addresses several arguments advanced by opponents of gender-affirming care.*

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I. INTRODUCTION

ON September 29, 2015, Adree Edmo, an inmate in the Idaho Department of Correction, composed a note: "I do not want to die," she wrote, "but I am a woman, and women do not have *these*."[1] She left the note in her prison cell, opened a disposable razor, and disinfected it.[2] With the razor, Edmo carefully sliced into her right testicle.[3] This was Edmo's first—but not last—attempt at autocastration.[4]

Edmo's story is indicative of a troubling reality. While the transgender population is disproportionately represented in the U.S. prison system, prison officials are often ill-prepared to address transgender needs, including housing, clothing, and—most significantly—medical care.[5] The prison system's unpreparedness to adequately care for the transgender population can lead to particularly dangerous outcomes—especially for those, like Edmo, presenting symptoms of gender dysphoria.

Sexual minorities are more likely to be incarcerated, relative to the general population.[6] According to a 2016 study conducted by the Williams Institute, approximately 1.4 million, or 0.58%, of adults in the United States identify as transgender.[7] Although transgender people represent a small percentage of the U.S. population, studies suggest that nearly one-in-six transgender people (16%) have been incarcerated.[8] Evaluated using an intersectional lens, this statistic is even more troubling: 21% of transgender women and 47% of Black transgender people have been incarcerated.[9] By contrast, only an estimated 2.8%–6.6% "of

1. Amanda Peacher & Lacey Daley, *Episode 1: "I'm Not a Monster Like Most People Think*," BOISE STATE PUB. RADIO, at 0:00–1:00 (July 8, 2019), https://www.boisestatepublicradio.org/post/episode-1-im-not-monster-most-people-think [https://perma.cc/JQR7-4Y5U].

2. *Id.*

3. *Id.*

4. *Id.*

5. *See generally* 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 (2015).

6. Ilan H. Meyer, Andrew R. Flores, Lara Stemple, Adam P. Romero, Bianca D.M. Wilson & Jody L. Herman, *Incarceration Rates and Traits of Sexual Minorities in the United States: National Inmate Survey, 2011–2012*, 107 AM. J. PUB. HEALTH 267, 272 (2017).

7. ANDREW R. FLORES, JODY L. HERMAN, GARY J. GATES & TAYLOR N.T. BROWN, WILLIAMS INST., HOW MANY ADULTS IDENTIFY AS TRANSGENDER IN THE UNITED STATES? 3 (June 2016), https://williamsinstitute.law.ucla.edu/wp-content/uploads/Trans-Adults-US-Aug-2016.pdf [https://perma.cc/SBE8-UJH7].

8. NAT'L CTR. FOR TRANSGENDER EQUAL., BLUEPRINT FOR EQUALITY: A TRANSGENDER FEDERAL AGENDA FOR THE NEXT PRESIDENTIAL ADMINISTRATION AND CONGRESS 51 (Oct. 2016), https://www.transequality.org/sites/default/files/docs/resources/NCTE%20Federal%20Blueprint%202016%20web_0.pdf [https://perma.cc/ARF7-8YDN].

9. *Id.*; *see also* NAT'L CTR. FOR TRANSGENDER EQUAL., A BLUEPRINT FOR EQUALITY: PRISON AND DETENTION REFORM 1 (2012), https://www.transequality.org/sites/default/

the general U.S. population" have been incarcerated in their lifetime.[10]

Unfortunately, there are minimal, and often outdated, data on the exact population size of sexual minorities currently in the U.S. prison system.[11] For example, the Bureau of Justice Statistics (BJS) conducts the *National Inmate Survey* (NIS) to collect "data on the incidence and prevalence of sexual assault in correctional facilities" pursuant to the Prison Rape Elimination Act of 2003.[12] The BJS data from the 2011–2012 NIS-3 survey estimated that there were 3,209 transgender inmates in state and federal prisons,[13] as well as an additional 1,709 inmates in local jails.[14] A 2020 study conducted by NBC News determined that states and the District of Columbia house 4,890 transgender inmates.[15] Relying on the BJS data, the Williams Institute estimated in 2016 that transgender people comprise 0.24% of the U.S. prison and jail population.[16]

At the same time, extensive research documents the victimization of transgender people in the U.S. prison system.[17] For example, studies show a "heightened prevalence of . . . severe verbal harassment, purposeful humiliation, physical assault and beatings, unwanted sexual touching, unwarranted strip searches and pat-downs, and forcible penetrative sex from other inmates and custody staff."[18] Beyond this, transgender inmates struggle to secure the housing, clothing, and medical care that align with their particular gender identities.[19]

The purpose of this Comment is threefold: (1) to educate readers regarding the transgender population, the importance of gender-affirming care, and the systemic barriers that prevent access to appropriate medical care within correctional facilities; (2) to demonstrate how the Eighth Amendment constitutionalizes an inmate's right to adequate health care,

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files/docs/resources/NCTE_Blueprint_for_Equality2012_Prison_Reform.pdf [https://perma.cc/ZGN2-JHCP].

10. Kirsty A. Clark, Jaclyn M. White Hughto & John E. Pachankis, *"What's the Right Thing to Do?" Correctional Healthcare Providers' Knowledge, Attitudes and Experiences Caring for Transgender Inmates*, 193 SOC. SCI. & MED. 80, 80 (2017).

11. Meyer et al., *supra* note 6, at 267.

12. *National Inmate Surgery (NIS)*, OFF. JUST. PROGRAMS (May 26, 2009), https://www.bjs.gov/index.cfm?ty=dcdetail&iid=278 [https://perma.cc/U3UL-3HSR].

13. Letter from Lambda Legal Def. & Educ. Fund, Inc. et al. to U.S. Comm'n on C.R. (Mar. 25, 2019), https://docs.house.gov/meetings/JU/JU00/20190402/109200/HHRG-116-JU00-20190402-SD018.pdf [https://perma.cc/UX74-59XC].

14. OFF. JUST. PROGRAMS, U.S. DEP'T OF JUST., SEXUAL VICTIMIZATION IN PRISONS AND JAILS REPORTED BY INMATES, 2011–12 (Dec. 2014), https://www.bjs.gov/content/pub/pdf/svpjri1112_st.pdf [https://perma.cc/5SHU-WHAK].

15. Kate Sosin, *Trans, Imprisoned—and Trapped*, NBC NEWS (Feb. 26, 2020), https://www.nbcnews.com/feature/nbc-out/transgender-women-are-nearly-always-incarcerated-men-s-putting-many-n1142436 [https://perma.cc/Q85P-PMQH].

16. Jody L. Herman, Taylor N.T. Brown, Bianca D.M. Wilson, Ilan H. Meyer & Andrew R. Flores, *Prevalence, Characteristics, and Sexual Victimization of Incarcerated Transgender People in the United States: Results from the National Inmate Survey (NIS-3)*, WILLIAMS INST. (2016), https://williamsinstitute.law.ucla.edu/wp-content/uploads/Trans-Incarceration-Violence-Oct-2016.pdf [https://perma.cc/5KSS-UU7N].

17. Clark et al., *supra* note 10, at 80–81.

18. *Id.*

19. *See generally* Routh et al., *supra* note 5, at 19 (demonstrating the failure of state correctional facilities to provide basic necessities for transgender inmates).

and how the existing *Estelle-Farmer* framework has failed to secure adequate care for transgender inmates presenting gender dysphoria; and (3) to argue in favor of a reconceptualized test that protects the right to gender-confirmation surgery for gender dysphoric inmates.

To do this, Part II educates readers on key terminology pertaining to gender and sex in the transgender population. It then details the treatment of the Lesbian, Gay, Bisexual, and Transgender (LGBT) population by the medical community, focusing on the de-pathologization of sexual minorities. Finally, the Section explores medical needs specific to the transgender community, focusing on gender dysphoria as a pathway to specific treatment.

Part III demonstrates that the Eighth Amendment constitutionalizes the right to inmate health care. This Comment will explore the origins of the Eighth Amendment and the shift towards the evolving standards of decency. Part IV argues that the *Estelle-Farmer* framework—in the context of gender dysphoric inmates—is an unworkable standard that has not consistently protected the rights of transgender inmates. Consequently, the First, Fifth, and Ninth Circuits utilize differing approaches to gender confirmation surgery. Part V reconceptualizes the test, showing that: (1) gender dysphoria is a serious medical need; (2) gender confirmation surgery is a medically necessary form of treatment for gender dysphoria; and (3) categorical prohibition against gender-affirming care is per se deliberate indifference. Finally, Part VI addresses common counterarguments to the provision of gender-affirming care to inmates.

II. TRANSGENDER: A MATTER OF DIVERSITY, NOT PATHOLOGY

This Section provides necessary background on de-pathologization of the transgender community. Specifically, it highlights that a subset of the transgender community may exhibit clinically significant gender dysphoria that serves as a pathway to necessary forms of gender-affirming care.

A. Relevant Terminology

To better understand the transgender community, it is important to distinguish between some commonly misunderstood terms. *Transgender* refers to "people whose gender identity, gender expression, or behavior does not conform to what is socioculturally accepted as, and typically associated with, the legal and medical sex to which they were assigned at birth."[20] Although "sex" and "gender" are often used interchangeably, the distinction between the two is critical. For the purposes of this Comment, *sex* refers to the physical and biological traits that typically catego-

20. Daphna Stroumsa, *The State of Transgender Health Care: Policy, Law, and Medical Frameworks*, 104 Am. J. Pub. Health e31, e31 (2014).

rize individuals as male, female, or intersex.[21] On the other hand, *gender* refers to the psychological, behavioral, social, and cultural aspects of being male or female.[22] *Gender identity*[23] refers to an individual's personal identification as male, female, both, or neither, and *gender expression* refers to an individual's presentation and behavior—including physical appearance, clothing, etc.—as it relates to socially constructed views of gender or gender roles.[24] Accordingly, "[*g*]*ender nonconformity* refers [generally] to the extent to which a person's gender identity, role, or expression differs from the cultural norms prescribed for people of a particular *sex*."[25]

B. Transgender Health Care: From Pathology to Diversity

Psychiatric, psychological, and other medical professionals historically sought to "cure" the LGBT community.[26] Treatment of LGBT persons by medical professionals is a relatively recent invention that coincided with "the conceptualization of homosexuality as a medical-psychological phenomenon."[27] Although "the American Psychiatric Association (APA) removed the diagnosis of 'homosexuality'" in 1973,[28] historically, to be transgender has practically meant the *continued* medicalization or disordering by various medical and psychological organizations.[29] In 1980, the APA classified gender identity disorder (GID) as a formal diagnosis in the third edition of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-3*).[30] A diagnosis for GID remained an official category until the APA published the *DSM-5* in 2013.[31] This shift came after a December 2012 decision by the APA to de-pathologize gender variance.[32] Thus, today, to be transgender is a "[m]atter of [d]iversity, [n]ot [p]athology."[33]

Despite significant changes in the treatment of transgender people in the late-twentieth century, necessary "[h]ealth care [for the transgender

21. Am. Psych. Ass'n, Definitions Related to Sexual Orientation & Gender Diversity in APA Documents 5 (2015), https://www.apa.org/pi/lgbt/resources/sexuality-definitions.pdf [https://perma.cc/PL56-JK7V].

22. *Id.* at 2.

23. *Id.* at 4.

24. *Id.* at 3–4.

25. Eli Coleman et al., *Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People, Version 7*, 13 Int'l J. Transgenderism 165, 168 (2011) (second emphasis added).

26. Jonathan Katz, Gay American History: Lesbians and Gay Men in the U.S.A. 197–205 (1976), *reprinted in* Carlos A. Ball, Jane S. Schacter, Douglas NeJaime & William B. Rubenstein, Cases and Materials on Sexuality, Gender Identity, and the Law 19 (6th ed. 2017).

27. *Id.* at 20.

28. Jack Drescher, *Out of DSM: Depathologizing Homosexuality*, 5 Behav. Sci. 565, 565–66 (2015).

29. *Gender Dysphoria Diagnosis*, Am. Psychiatric Ass'n, https://www.psychiatry.org/psychiatrists/cultural-competency/education/transgender-and-gender-nonconforming-patients/gender-dysphoria-diagnosis [https://perma.cc/3BQ8-Z8DP].

30. Stroumsa, *supra* note 20, at e31.

31. *Id.*

32. *Id.*

33. Coleman et al., *supra* note 25, at 168.

population] has historically been, and continues to be, overlooked by governmental, health care, and academic establishments."[34] This is particularly troubling because transgender people present particularized medical needs. For example, within that population, *some* transgender persons may suffer from gender dysphoria. Research indicates that the failure to provide the necessary medical treatment to counter the symptoms of "gender dysphoria can result in depression, suicidality, auto-castration, and death."[35]

Generally, *gender dysphoria* describes "discomfort or distress that is caused by a discrepancy between a person's gender identity and that person's sex assigned at birth."[36] Not all transgender people present gender dysphoria, however. In fact, "Only *some* gender-nonconforming people experience gender dysphoria at *some* point in their lives."[37] The severity of gender dysphoria can vary significantly. For some, the distress associated with gender dysphoria may necessitate a formal diagnosis.[38] An official diagnosis indicates that an individual not only exhibits a marked incongruence between gender identity and assigned sex, but also that this incongruence manifests in "clinically significant distress or impairment in social, school, or other important areas of functioning."[39] Thus, though all transgender individuals exhibit incongruence between gender and sex, only a subset of the population presents the clinically significant distress or impairment that necessitates a formal diagnosis of gender dysphoria.

The formal diagnosis is not intended to stigmatize the individual but rather to identify the symptoms resulting from gender dysphoria.[40] Significantly, formal diagnoses can facilitate access to necessary health care and effective forms of treatment, including hormone therapy and gender confirmation surgery[41] (GCS).[42] Here, doctors should provide particularized care by consulting the World Professional Association for Transgender Health (WPATH) Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People (SOC).[43]

In short, not all transgender people possess the clinically significant distress to merit a diagnosis of gender dysphoria. An official diagnosis is necessary to secure access to particular forms of treatment, including GCS. The failure to treat gender dysphoria poses a serious risk to an individual's health and may result in death or bodily harm.

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34. Stroumsa, *supra* note 20, at e31.
35. Clark et al., *supra* note 10, at 81.
36. Coleman et al., *supra* note 25, at 166.
37. *Id.* at 168.
38. *Id.*
39. Am. Psychiatric Ass'n, Diagnostic and Statistical Manual of Mental Disorders 452 (5th ed. 2013).
40. *See* Coleman et al., *supra* note 25, at 169.
41. Some cases continue to use Sex Reassignment Surgery (SRS), an outdated term for Gender Confirmation Surgery. For the purposes of this Comment, the author uses GCS to de-emphasize surgery as a necessary part of transition.
42. Coleman et al., *supra* note 25, at 169.
43. *See generally id.* (advocating for the WPATH Standards of Care).

III. CONSTITUTIONALIZING THE RIGHT TO INMATE HEALTH CARE

The Eighth Amendment states, "Excessive bail shall not be required, nor excessive fines imposed, nor cruel and unusual punishments inflicted."[44] However, neither the Supreme Court nor the Founders has defined the exact scope of "cruel and unusual."[45] This Section shows that the prohibition against cruel and unusual punishment grants inmates a constitutional right to adequate health care. A failure by prison administrators to provide adequate care would, in effect, impose a condition of confinement analogous to the very punishment prohibited by the Constitution.

A. EIGHTH AMENDMENT: ORIGINAL MEANING

The Eighth Amendment's historical roots trace back to English law.[46] During the drafting of Virginia's constitution, Section 9 of the Declaration of Rights included a "verbatim copy" of the English Bill of Rights prohibition.[47] Subsequent to the inclusion in the Virginia Constitution, eight states adopted an identical provision, the federal government included the clause in the Northwest Ordinance of 1787, and the provision became the Eighth Amendment to the United States Constitution in 1791.[48] Some legal historians argue that cruel and unusual punishment—as understood by the drafters of the English Bill of Rights—represented *more* than just a reaction to torture, harsh sentences, and assizes.[49] However, the Founding Fathers primarily understood the clause "to outlaw torture and other cruel punishments."[50]

After its adoption, the Eighth Amendment was rarely invoked, primarily because the barbarous treatments used in the United Kingdom were not commonplace in the United States.[51] In fact, early attempts to broaden the meaning of the clause—namely, to extend the prohibition to disproportionate punishment—were futile.[52] For this reason, some early commentators "believed the clause to be obsolete."[53]

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44. U.S. CONST. amend. VIII.

45. Trop v. Dulles, 356 U.S. 86, 99 (1958) ("The exact scope of the constitutional phrase 'cruel and unusual' has not been detailed by this Court.").

46. Furman v. Georgia, 408 U.S. 238, 316 (1972) (Marshall, J., concurring) ("The Eighth Amendment's ban against cruel and unusual punishments derives from English law.").

47. Anthony F. Granucci, *"Nor Cruel and Unusual Punishments Inflicted:" The Original Meaning*, 57 CALIF. L. REV. 839, 840 (1969).

48. *Id.*

49. *Furman*, 408 U.S. at 318; *see also* Granucci, *supra* note 47, at 860.

50. *Furman*, 408 U.S. at 319; *see also* Granucci, *supra* note 47, at 862–65.

51. Granucci, *supra* note 47, at 842.

52. *Id.*

53. *Id.*

B. The Eighth Amendment & Evolving Meaning

The Supreme Court has not limited the amendment's protections to a mere prohibition on the torturous and barbarous punishments that were commonplace in the eighteenth century.[54] For example, in *Weems v. United States*, the Supreme Court found a fifteen-year sentence disproportionate to the convictable offense and, thus, cruel and unusual punishment, signifying that the amendment's protections are not pegged to the original understanding.[55] In doing so, the Court reasoned:

> Time works changes, brings into existence new conditions and purposes. Therefore a principle, to be vital, must be capable of wider application than the mischief which gave it birth. . . . In the application of a constitution, therefore, our contemplation cannot be only of what has been, but of what may be. Under any other rule a constitution would indeed be as easy of application as it would be deficient in efficacy and power. . . . Rights declared in words might be lost in reality.[56]

Significantly, *Weems* stands for the proposition that the Eighth Amendment is dynamic, or "progressive," rather than "fastened to the obsolete"; accordingly, the Eighth Amendment can "acquire meaning as public opinion becomes enlightened by a humane justice."[57]

In essence, *Weems* paved the way for the introduction of the flexible standard for cruel and unusual punishment—the evolving standards of decency—coined by the Warren Court (1958–1969). Although the Warren Court did relatively little to expand the substance of prisoners' rights, this period of Supreme Court history featured several positive strides regarding Eighth Amendment jurisprudence, including: the formal incorporation of "the Eighth Amendment ban on cruel and unusual punishments to the states," the guarantee of legal assistance for prison inmates, the weakening of the historical deference given to state prison administration by federal courts, and more.[58]

In *Trop v. Dulles*, Chief Justice Warren, writing for the majority, concluded that a provision of the Nationality Act of 1940 (depriving an American of U.S. citizenship following a conviction and dishonorable discharge related to military desertion) constituted cruel and unusual punishment within the meaning of the Eighth Amendment.[59] In doing so, the Supreme Court, for the first time, observed that "[t]he basic concept underlying the Eighth Amendment is nothing less than the dignity of man."[60] Noting that the Constitution is comprised of "vital, living princi-

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54. Gregg v. Georgia, 428 U.S. 153, 171 (1976) ("[T]he Amendment has been interpreted in a flexible and dynamic manner.").

55. Weems v. United States, 217 U.S. 349, 362 (1910).

56. *Id.* at 373.

57. *Id.* at 378.

58. John A. Fliter, Prisoners' Rights: The Supreme Court and Evolving Standards of Decency 69 (2001).

59. Trop v. Dulles, 356 U.S. 86, 101, 103 (1958).

60. *Id.* at 100.

ples" rather than "time-worn adages or hollow shibboleths," Chief Justice Warren stated that "[t]he Amendment must draw its meaning from the *evolving standards of decency that mark the progress of a maturing society*."[61] For Warren, the Supreme Court's failure to apply this dynamic rather than static standard would render "the words of the Constitution . . . little more than good advice."[62]

C. Conditions of Confinement: Inmate's Right to Medical Care

Though the Constitution "'does not mandate *comfortable* prisons,' . . . neither does it permit inhumane ones."[63] While the Supreme Court initially confined the Eighth Amendment prohibition to "punishments," the Supreme Court broadened its application in proscribing more than simply "physically barbarous punishments."[64] For example, under the Burger Court, the Supreme Court began to more actively intervene in the administration of prisons by focusing on the "conditions of confinement."[65] Accordingly, beyond curtailing certain forms of punishment, the Eighth Amendment now—in addition to placing restraints on prison officials—also imposes significant duties upon these officials.[66] Among these duties, prison officials must "provide humane conditions of confinement; . . . ensure that inmates receive adequate food, clothing, shelter, and *medical care*[;] and . . . 'take reasonable measures to guarantee the safety of the inmates.'"[67] Thus, "the treatment a prisoner receives in prison and the conditions under which he is confined are subject to scrutiny under the Eighth Amendment."[68]

Today, the denial of adequate medical care in prison constitutes cruel and unusual punishment. Underlying this obligation is the reality that prison inmates—by the very nature of incarceration—rely on prison authorities for their basic needs, including medical needs; without help from prison authorities, these needs will not and cannot be met.[69] For Justice Marshall, the failure at worst "may actually produce physical 'torture or a lingering death,'" which were "the evils of most immediate concern to the

61. *Id.* at 101, 103 (emphasis added).
62. *Id.* at 103–04.
63. Farmer v. Brennan, 511 U.S. 825, 832 (1994) (emphasis added) (quoting Rhodes v. Chapman, 452 U.S. 337, 349 (1981)).
64. Estelle v. Gamble, 429 U.S. 97, 102 (1976).
65. *See* Fliter, *supra* note 58, at 93.
66. *Farmer*, 511 U.S. at 832.
67. *Id.* at 832–33 (emphasis added) (noting prison administrators are under an obligation "to take reasonable measures to guarantee the safety of the inmates" (quoting Hudson v. Palmer, 468 U.S. 517, 526–27 (1984))); *see also* Helling v. McKinney, 509 U.S. 25, 31–32 (1993); Washington v. Harper, 494 U.S. 210, 225–26 (1990) (holding that when an inmate's mental disability poses a threat to the inmate population, the obligation for prison administrators to ensure safety necessarily includes a provision of medical treatment for the mental illness); *Estelle*, 429 U.S. at 104–05 ("[D]eliberate indifference to serious medical needs . . . constitutes [an] 'unnecessary and wanton infliction of pain'" that violates the Eighth Amendment (quoting Gregg v. Georgia, 428 U.S. 153, 173 (1976))).
68. *Farmer*, 511 U.S. at 832 (citing *Helling*, 509 U.S. at 31).
69. *Estelle*, 429 U.S. at 103.

drafters of the Amendment."[70] In lesser cases, denial of care may impose pain and suffering that fails to serve a penological purpose.[71] Therefore, the Constitution imposes an obligation on the State "to care for the prisoner, who cannot by reason of the deprivation of his liberty, care for himself."[72]

In short, consistent with the evolving standards of decency, the Supreme Court applied the Eighth Amendment to conditions of confinement. In doing so, the Court imposed an array of duties on prison officials, most notably, the obligation to provide adequate medical care.

IV. MEDICAL CARE FOR TRANSGENDER INMATES TODAY

Although the Eighth Amendment places an affirmative duty on prison administrators to provide adequate medical care to transgender inmates, research shows that the prison system is "ill-prepared to accommodate the needs of transgender inmates."[73] Consequently, significant obstacles remain for transgender inmates seeking access to care. These obstacles include, but are not limited to, limited prison budgets, personal staff bias, and lack of transgender cultural competence.[74]

Additionally, state legislatures play a critical role in undermining access to necessary care for transgender inmates. For instance, policies for medical care actually *available* for transgender inmates significantly vary among the fifty states.[75] According to a 2015 study, twenty-eight states prohibit transgender inmates from obtaining treatment once incarcerated; only thirteen states allow transgendered inmates to initiate hormone therapy, compared to twenty-one states that allow inmates to *continue* hormone therapy; and seven states allow GCS.[76] Further, the U.S. courts of appeals contribute to the care-related obstacles for transgender inmates because these courts address gender-affirming care differently under the *Estelle-Farmer* framework. Under the current test, the constitutional right to adequate health care is denied to transgender inmates. This Section explains the two-prong test for adequate health care and the division in U.S. courts of appeals as it relates to transgender health care, specifically GCS.

A. INADEQUATE MEDICAL CARE UNDER *ESTELLE-FARMER*

A prison official's "deliberate indifference to [an inmate's] serious medical need[ ] . . . constitutes the 'unnecessary and wanton infliction of

70. *Id.*
71. *Id.* (citing *Gregg*, 428 U.S. at 173).
72. *Id.* at 104.
73. Routh et al., *supra* note 5, at 5 (citing Syndey Tarzwell, *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 (2006)).
74. *Id.* at 5–6, 18.
75. *Id.* at 19.
76. *Id.* at 12–18 & tbl.1. The study excludes ten states because relevant policies or statutes were unlocatable. *Id.* at 18.

pain' . . . proscribed by the Eighth Amendment."[77] For an inmate to prove an Eighth Amendment violation based on failure to provide adequate care, an inmate must show (1) a serious medical need and (2) that prison officials were deliberately indifferent to the medical need.[78] This test contains both an objective and subjective prong.

In *Estelle v. Gamble*, the Supreme Court established this modern standard for inadequate care. There, J.W. Gamble sued the Director of the Texas Department of Corrections and other prison officials for a failure to provide adequate diagnosis and medical care following an injury sustained during a prison work assignment.[79] Over a three-month period, Gamble visited multiple medical personnel on seventeen occasions, in which Gamble received treatment for a back injury, high blood pressure, and other heart problems.[80] The *Estelle* Court "conclude[d] that deliberate indifference to serious medical needs" violates the Eighth Amendment.[81]

Following *Estelle*, circuit courts differed as to whether the deliberate indifference standard was an objective or subjective test.[82] The Supreme Court in *Farmer v. Brennan* defined the deliberate indifference standard in the context of a gender dysphoric inmate, opting for the latter approach.[83] There, prior to conviction at eighteen years old for credit card fraud, Farmer began male-to-female transition, including shifting gender expression, "under[going] estrogen therapy, receiv[ing] silicone breast implants, and submit[ting] to unsuccessful 'black market' testicle-removal surgery."[84] Although the record remains silent regarding Farmer's in-prison appearance, Farmer "claim[ed] to have continued hormonal treatment while incarcerated by using drugs smuggled into prison and . . . [to] wear[ing] clothing in a feminine manner."[85] The *Farmer* Court held that, to be deliberately indifferent, an official must "know[ ] of and disregard[ ] an excessive risk to inmate health or safety."[86] In other words, the official must (1) know of the substantial risk of serious harm and (2) have drawn the inference of harm.[87] Here, the Court remanded to determine whether the prison officials would be liable under this standard.[88]

Ultimately, not every claim alleging inadequate care amounts to an

77. *Estelle*, 429 U.S. at 104 (citing Gregg v. Georgia, 428 U.S. 153, 173 (1976)).

78. *See* LILY CHI-FANG TSAI, SUBSTANDARD MEDICAL CARE IN U.S. PRISONS: IMPROVEMENT THROUGH CIVIL LIABILITY ACTIONS 25–26 (Nicholas P. Lovrich ed., 2014).

79. *Estelle*, 429 U.S. at 107.

80. *Id.* at 99, 107.

81. *Id.* at 104 (citing Gregg v. Georgia, 428 U.S. 153, 173 (1976)).

82. Joel H. Thompson, *Today's Deliberate Indifference: Providing Attention Without Providing Treatment to Prisoners with Serious Medical Needs*, 45 HARV. C.R.-C.L. REV. 635, 637 (2010).

83. *See* Farmer v. Brennan, 511 U.S. 825, 847 (1994).

84. *Id.* at 829.

85. *Id.*

86. *Id.* at 837.

87. *See id.*

88. *Id.* at 848–49, 851.

Eighth Amendment violation.[89] For example, "an inadvertent failure to provide adequate medical care cannot be said to constitute 'an unnecessary and wanton infliction of pain' or to be 'repugnant to the conscience of mankind.'"[90] Instead, an inmate must allege conduct "sufficiently harmful to evidence deliberate indifference to serious medical needs."[91] Further, deliberate indifference applies solely to "action or inaction taken in conscious disregard of a substantial risk of serious harm."[92]

B. Circuit Split Jeopardizes Prisoners' Rights

Although circuit courts have addressed questions pertaining to gender dysphoria and adequate care, relatively few courts have addressed the narrower question of whether the Eighth Amendment guarantees gender confirmation surgery. To highlight the disparity in jurisprudential treatment, this Section highlights the First, Fifth, and Ninth Circuits' differing approaches. These circuits illustrate, respectively, a (1) traditional case-by-case approach that declines to foreclose the possibility of Eighth Amendment protection, (2) categorical ban of GCS, and (3) case-by-case analysis constitutionalizing GCS. Thus, this Section demonstrates the unworkable standard established in *Estelle-Farmer* and that, unfortunately, the Supreme Court has allowed this split to continue.[93]

1. The First Circuit: From Early Recognition to Subsequent Reversal

Michelle Kosilek suffers from a severe form of gender dysphoria, resulting in "constant mental anguish and, at times, abuse," including suicide and autocastration attempts.[94] Throughout her incarceration, Kosilek sought treatment pursuant to the SOC.[95] In *Kosilek v. Maloney* (*Kosilek I*), Kosilek challenged the Department of Corrections (DOC) Commisoner's "blanket policy" that effectively restricted access to hormone therapy for those like Kosilek who had taken "black market" hormones and excluded the possibility of receiving GCS.[96] Though *Kosilek I* noted that the prison did not provide adequate care for Kosilek's serious medical need (gender dysphoria), the court found that Kosilek failed to prove deliberate indifference.[97]

Interestingly, in 2014, Kosilek again alleged inadequate care in violation of the Eighth Amendment in *Kosilek v. Spencer* (*Kosilek II*) after the DOC refused to provide GCS, which the DOC doctors identified as the

89. Estelle v. Gamble, 429 U.S. 97, 105 (1976).
90. *Id.* at 105–06.
91. *Id.* at 106.
92. Thompson, *supra* note 82, at 638.
93. *See, e.g.*, Idaho Dep't of Corr. v. Edmo, 141 S. Ct. 610, 610 (2020) (mem.), *denying cert. to* 935 F.3d 757 (9th Cir. 2019); Gibson v. Collier, 140 S. Ct. 653, 653 (2019) (mem.), *denying cert. to* 920 F.3d 212 (5th Cir.); Kosilek v. O'Brien, 575 U.S. 998, 998 (2015) (mem.), *denying cert. to* 774 F.3d 63 (1st Cir. 2014).
94. Kosilek v. Maloney, 221 F. Supp. 2d 156, 158 (D. Mass. 2002).
95. *Id.* at 159.
96. *Id.* at 160, 176.
97. *Id.* at 195.

"*only adequate*" treatment for Kosilek's severe gender dysphoria.[98] The *Kosilek II* court agreed with the doctors and concluded that Kosilek had a serious medical need for which GCS was the only adequate treatment.[99] Unlike *Kosilek I*, however, this court determined that the DOC acted with deliberate indifference because the decision to deny the procedure was neither made in good faith nor motivated by reasonable safety concerns.[100] Instead, the court found that the DOC feared providing the procedure "would provoke public and political controversy, criticism, scorn, and ridicule."[101] Thus, *Kosilek II* found that the DOC improperly violated the Eighth Amendment in denying Kosilek's GCS.[102] On appeal, the First Circuit panel upheld this decision in *Kosilek III*, noting that the court in *Kosilek II* did not clearly err in finding that (1) "Kosilek has a serious medical need for the surgery" and (2) the DOC's denial was "unsupported by legitimate penological considerations."[103]

Despite this initial success for securing GCS as a form of necessary care, in *Kosilek IV*, the First Circuit reheard the case en banc and overturned the holding and affirmation on appeal.[104] Notably, *Kosilek IV* reframed the question: "[W]hether the decision not to provide [GCS]—in light of the continued provision of all ameliorative measures currently afforded Kosilek and in addition to antidepressants and psychotherapy—is sufficiently harmful to Kosilek so as to violate the Eighth Amendment."[105] In deviating from prior holdings, this panel noted that "Kosilek is provided hormones, facial hair removal, feminine clothing and accessories, and access to regular mental health treatment."[106] As a result of these accommodations, Kosilek received some relief from her depressive state and experienced "significant physical changes and an increasingly feminine appearance."[107]

Regarding the objective prong, the *Kosilek IV* court noted that, in the case before it, GCS was not necessary, given successful treatment and DOC's plan to treat future suicidality.[108] In so holding, the court refused to foreclose the possibility of a different outcome under different facts, stating that the decision will not "foreclose all litigants from successfully seeking [GCS] in the future."[109] Finally, regarding the subjective prong, the panel disagreed with the conclusion that DOC acted "by pretextual or improper concerns with public pressure" in the absence of evidence.[110]

98. Kosilek v. Spencer, 889 F. Supp. 2d 190, 197–98 (D. Mass. 2012) (emphasis added).
99. *Id.* at 238.
100. *Id.* at 245.
101. *Id.* at 203.
102. *Id.*
103. Kosilek v. Spencer, 740 F.3d 733, 772–73 (1st Cir. 2014).
104. Kosilek v. Spencer, 774 F.3d 63, 96 (1st Cir. 2014) (en banc).
105. *Id.* at 89.
106. *Id.* at 90.
107. *Id.*
108. *Id.* at 96.
109. *Id.* at 91.
110. *Id.* at 95–96.

Overall, the First Circuit's approach signifies early success in litigating a transgender inmate's constitutional right to medical care. Although the First Circuit reversed en banc, the court's analysis employs a case-by-case approach to inadequate care analysis. Notably, the First Circuit does not foreclose plausible claims for categorical denial of GCS.

2. The Fifth Circuit: A Categorical Ban Against Gender Confirmation Surgery

By contrast, the Fifth Circuit in *Gibson v. Collier* concluded—over a dissent—that a "state does not inflict cruel and unusual punishment by declining to provide sex reassignment surgery to a transgender inmate."[111] There, Vanessa Lynn Gibson, a transgender woman in the custody of the Texas Department of Criminal Justice, previously received a formal diagnosis for gender dysphoria.[112] For Gibson, gender dysphoria manifests with acute distress, depression, and attempts at self-harm and autocastration.[113] Although suicidality was not *solely* linked to Gibson's gender dysphoria, gender dysphoria was *a* cause of Gibson's suicidality.[114]

In January 2017, Texas Department of Criminal Justice Policy G-51.11 regarding the treatment of offenders with gender dysphoria went into effect.[115] Under the policy, inmates must be "evaluated by appropriate medical and mental health professionals" to determine treatment "on a case-by-case basis as clinically indicated."[116] Relying on this policy, Texas doctors denied Gibson the opportunity for evaluation of whether GCS was medically necessary to treat Gibson's gender dysphoria.[117] Instead, following attempts to commit suicide and autocastrate, the state "started mental health counseling and hormone therapy" for Gibson.[118] Though the treatment had some effect, it did not ameliorate the underlying gender dysphoria or its effects.[119]

Turning to *Estelle-Farmer*, the *Gibson* court acknowledged that Texas did not contest the underlying serious medical need, in light of Gibson's "record of psychological distress, suicidal ideation, and threats of self-harm."[120] Therefore, the court solely focused on whether the State acted with deliberate indifference in denying Gibson medical evaluation to determine the necessity of GCS and in denying the procedure itself.[121] For

111. Gibson v. Collier, 920 F.3d 212, 215 (5th Cir. 2019).
112. *Id.* at 216–17.
113. *Id.*
114. *Id.*
115. *Id.* at 217–18; TEX. DEP'T CRIM. JUST., CORRECTIONAL MANAGED HEALTH CARE POLICY MANUAL G-51.11 (2020), https://www.tdcj.texas.gov/divisions/cmhc/docs/cmhc_policy_manual/G-51.11.pdf [https://perma.cc/824S-W7Z3].
116. CORRECTIONAL MANAGED HEALTH CARE POLICY MANUAL, *supra* note 115.
117. *Gibson*, 920 F.3d at 217–18.
118. *Id.* at 217.
119. *Id.*
120. *Id.* at 219.
121. *Id.* at 219–20.

the court, this question largely turned on whether GCS could be seen as a medically necessary form of treatment for gender dysphoria.[122]

With regard to the subjective prong, *Gibson* found that the State did not act with deliberate indifference.[123] In so holding, the court argued the officials could not act with "malicious intent," or "with knowledge that they were withholding medically necessary care," when "a genuine debate exists within the medical community about the necessity or efficacy of that care."[124] Here, the court—unable to find a "consensus" that amounted to "*universal acceptance*"—"doom[ed] Gibson's claim."[125] Claiming to rely on the First Circuit's analysis in *Kosilek IV*,[126] the court denied Gibson the opportunity to assess whether her *personal* medical need necessitated the use of GCS, noting that evidence of individual need would not affect the outcome of the case.[127]

However, the Fifth Circuit's approach meaningfully differed from the First Circuit's approach in *Kosilek IV*.[128] Notably, *Gibson* foreclosed the opportunity to prove medical necessity itself.[129] Judge Barksdale criticized the Fifth Circuit's reliance on *Kosilek IV* in dissent, observing that particular case "spanned over 20 years, had a very 'expansive' record, and was not decided by summary judgment."[130] Further, Barksdale noted the Fifth Circuit—in dismissing Gibson's claim on summary judgment—failed to account for "developments in the medical community regarding treating gender dysphoria and determining the necessity for" GCS.[131] Put simply, "to reach its broader holding that denying GCS cannot, as a matter of law, violate the Eighth Amendment—in other words, to reject every conceivable Eighth Amendment claim based on the denial of GCS—the Fifth Circuit coopted the record from *Kosilek*."[132]

In short, the *Gibson* majority rejected the deliberate indifference claim. In doing so, the Fifth Circuit refused to find deliberate indifference when the State "d[id] nothing more than refus[e] to provide medical treatment whose necessity and efficacy is hotly disputed within the medical commu-

122. *Id.* at 224 ("[Gibson] cannot establish on remand that such surgery is universally accepted as an effective or necessary treatment for gender dysphoria.").

123. *Id.*

124. *Id.* at 220.

125. *Id.* at 220–21 (emphasis added).

126. Kosilek v. Spencer, 774 F.3d 63 (1st Cir. 2014) (en banc).

127. *Gibson*, 920 F.3d at 224.

128. *Compare id.* ("We do not see how evidence of individual need would change the result in this case, however. Any evidence of Gibson's personal medical need would not alter the fact that sex reassignment surgery is fiercely debated within the medical community."), *with Kosilek*, 774 F.3d at 91 ("[T]he DOC has specifically disclaimed any attempt to create a blanket policy regarding [GCS]. We are confident that the DOC will abide by this assurance, as any such policy would conflict with the *requirement that medical care be individualized based on a particular prisoner's serious medical needs*." (emphasis added)).

129. *See* Samantha Braver, Note, *Circuit Court Dysphoria: The Status of Gender Confirmation Surgery Requests by Incarcerated Transgender Individuals*, 120 COLUM. L. REV. 2235, 2259 (2020).

130. *Gibson*, 920 F.3d at 233 (Barksdale, J., dissenting).

131. *Id.*

132. Edmo v. Corizon, Inc., 935 F.3d 757, 795 (9th Cir. 2019) (per curiam).

nity."[133] Thus, the Fifth Circuit's approach is tantamount to a categorical ban on the use of GCS.

3. The Ninth Circuit: Constitutionalizing Gender Confirmation Surgery on a Case-by-Case Basis

Adree Edmo is a transgender woman currently in the custody of the Idaho Department of Corrections.[134] The incongruity between Edmo's sex assigned at birth and gender identity resulted in severe distress, "limit[ing] [Edmo's] ability to function."[135] As a result, Edmo "twice attempted self-castration to remove her male genitalia, which cause[d] her profound anguish."[136] Consequently, all parties and medical experts agreed that Edmo suffers from gender dysphoria, that it is a serious medical need, and that GCS is among the necessary forms of treatment.[137] "[T]he district court concluded that GCS is medically necessary for Edmo and ordered the State to provide the surgery."[138] This decision relied on testimony from Edmo's medical experts—arguing *for* medical necessity—and dismissed the State's experts who "lacked relevant experience" and could not justify why they deviated from accepted treatment guidelines.[139]

Regarding the objective prong of *Estelle-Farmer*, the court noted that not even the State could justifiably rebut the fact that "Edmo's gender dysphoria is a sufficiently serious medical need to trigger the State's obligations under the Eighth Amendment."[140] In doing so, the *Edmo* court relied on the *DSM-5* and Edmo's testimony to show how gender dysphoria—and accompanying symptoms—have severely impacted Edmo's ability to function.[141] Specifically, the court observed, "her gender dysphoria causes her to feel 'depressed,' 'disgusting,' 'tormented,' and 'hopeless,' and it has caused past efforts and active thoughts of self-castration."[142] Accordingly, the court concluded that the State had an obligation to provide adequate care to counter Edmo's gender dysphoria.[143]

The State, however, failed to provide adequate care, and the court determined that Edmo clearly demonstrated how the "'course of treatment' chosen to alleviate her gender dysphoria 'was medically unacceptable under the circumstances.'"[144] In rejecting the State's expert testimony, the court noted that these experts "lack meaningful experience directly treating people with gender dysphoria," specifically: "having treated indi-

133. *Gibson*, 920 F.3d at 226.
134. *Edmo*, 935 F.3d at 767.
135. *Id.*
136. *Id.*
137. *Id.*
138. *Id.*
139. *Id.*
140. *Id.* at 785.
141. *Id.*
142. *Id.*
143. *Id.* at 786.
144. *Id.*

viduals with gender dysphoria, having evaluated individuals for GCS, and having treated them post-operatively."[145] Further, the court treated the State's testimony skeptically because it "ran contrary to the established standards of care in the areas of transgender health care."[146]

Turning to the subjective prong, the court determined the State acted with deliberate indifference in its treatment of Edmo.[147] The State, on appeal, argued it could not have acted with deliberate indifference because it (1) did not act with "malice, intent to inflict pain, or knowledge that [the] recommended course of treatment was medically inappropriate" and (2) "provided some care."[148] With respect to the first argument, the *Edmo* court concluded that "[t]he State misstated the standard."[149] Under *Farmer*, Edmo simply had to show that an official acted or failed to act despite knowledge of a substantial risk of harm.[150] Despite the State's knowledge of Edmo's self-castration attempts, it failed to adjust its treatment plan.[151] Accordingly, Edmo showed the State failed to take steps to mitigate the substantial risk of harm.[152] With respect to the second argument, the court stated, "The provision of some medical treatment, even extensive treatment over a period of years, does not immunize officials from the Eighth Amendment's requirements."[153]

Therefore, the Ninth Circuit upheld the district court's conclusion that the State violated Edmo's Eighth Amendment right when it failed to provide medically necessary GCS despite a substantial risk of ongoing and future harm.[154] Like the First Circuit's decision in *Kosilek*, this required a factual assessment of Edmo's condition, the prison's knowledge of the continued risk of Edmo's gender dysphoria, and the administration's failure to act in light of this knowledge. Notably, however, unlike *Kosilek*, "important factual differences between [the] cases yield different outcomes."[155] Subsequently, a rehearing en banc was denied despite the fact *Edmo* effectively became the first circuit court to constitutionalize an inmate's right to GCS.[156]

In short, the approaches embraced by the First, Fifth, and Ninth Circuits highlight the unworkability of the existing standard in producing predictable outcomes. Consequently, these differing standards jeopardize transgender inmates' rights to receive medically necessary care. For this

145. *Id.* at 787–88.
146. *Id.* at 788.
147. *Id.* at 797.
148. *Id.* at 793 (alteration in original).
149. *Id.*
150. *Id.* (citing Lemire v. Cal. Dep't Corr. & Rehab., 726 F.3d 1062, 1074 (9th Cir. 2013)).
151. *Id.*
152. *See id.*
153. *Id.*
154. *Id.* at 780–81.
155. *Id.* at 794.
156. Edmo v. Corizon, Inc., 949 F.3d 489, 490 (9th Cir. 2020) (rehearing en banc denied) (O'Scannlain, J., respecting denial of rehearing en banc).

reason, the Supreme Court must reconsider the application of the *Estelle-Farmer* framework in GCS cases.

V. RECONCEPTUALIZING THE *ESTELLE-FARMER* FRAMEWORK

Responding to the circuit split, this Section addresses both the objective and subjective prongs of *Estelle-Farmer* in the context of GCS. Ultimately, it argues that gender dysphoria per se constitutes a serious medical need under Eighth Amendment jurisprudence. Further, advancement in medical science demonstrates that there is a consensus regarding the efficacy of GCS as a necessary form of treatment in severe cases of gender dysphoria. Accordingly, this Section argues (1) that gender dysphoric inmates have a constitutional right to GCS, implicit in the right to adequate medical care, and (2) that categorical prohibitions against this form of treatment are per se deliberately indifferent. Thus, this Comment proposes a refined question under the *Estelle-Farmer* framework to account for administrative interests without jeopardizing the constitutional rights of transgender inmates: Under the facts of any particular case, is gender confirmation surgery necessary to mitigate the serious risk of harm posed by the inmate's gender dysphoria?

A. Gender Dysphoria Poses a Serious Medical Need Per Se

The Supreme Court in *Hudson v. McMillian*[157] limited inadequate health care claims to those in which the needs presented are "serious" "[b]ecause society does not expect that prisoners will have unqualified access to health care."[158] The Court has not defined what constitutes a "serious" need, however, leaving that decision to lower courts.[159] A consequence of this framework is that "what one court may consider to be a serious medical need, another may reject."[160] The First, Third, Sixth, Tenth, and Eleventh Circuits assess whether the condition is one: "(1) that has been diagnosed by a physician as requiring treatment; (2) that is so obvious that a lay person would recognize the necessity for a doctor's attention; or (3) for which the delay of or inadequacy of treatment would result in a substantial risk of harm."[161] On the other hand, the Second and Ninth Circuits consider: "(1) the existence of an injury that a reasonable doctor or patient would find important and worthy of comment or treatment; (2) the presence of a medical condition that significantly affects an individual's daily activities; or (3) the existence of chronic or substantial pain."[162]

157. 503 U.S. 1 (1992).
158. *Id.* at 9; *see also* Haley Loutfy, *Health Care Behind Bars: Constructing a Uniform Deliberate Indifference Standard to Prevent the Use of the Eighth Amendment as Broad Prison Reform*, 45 Lincoln L. Rev. 77, 89 (2018).
159. Loutfy, *supra* note 158, at 80.
160. *Id.* at 81.
161. *Id.* at 82.
162. *Id.* at 83.

Over time, courts have found that a wide range of conditions constitute serious medical needs, including: arthritis and hepatitis C;[163] stomach masses, constipation, and testicular cysts;[164] severe chest pain and a subsequent heart attack;[165] and more.[166] Under *Estelle*, a serious medical need is not limited to physical conditions; instead, a serious medical need may be a "psychiatric or psychological condition."[167] Notably, some courts have concluded that psychological needs—especially those resulting in *suicidality*—constitute serious medical needs.[168]

Gender dysphoria falls within the purview of recognized serious medical needs. Specifically, gender dysphoria is a diagnosable mental condition accompanied by clinically significant "discomfort or distress" resulting from the incongruity "between a person's gender identity and that person's sex assigned at birth."[169] Additionally, severe gender dysphoria can result in depression, suicidality, autocastration, and death.[170] Therefore, to be diagnosed with gender dysphoria is to be diagnosed with a serious medical need. In effect, it is the equivalent of having a recognized mental condition that causes symptoms also recognized as serious needs.

This conclusion is supported by court precedent.[171] For example,

163. Roe v. Elyea, 631 F.3d 843, 861 (7th Cir. 2011); Christy v. Robinson, 216 F. Supp. 2d 398, 413 (D. N.J. 2002).

164. MacLeod v. Kern, 424 F. Supp. 2d 260, 265 (D. Mass. 2006).

165. Mata v. Saiz, 427 F.3d 745, 752–56 (10th Cir. 2005).

166. TSAI, *supra* note 78, at 94; *see also* Laura R. Givens, *Why the Courts Should Consider Gender Identity Disorder a Per Se Serious Medical Need for Eighth Amendment Purposes*, 16 J. GENDER, RACE & JUST. 579, 601–02 (2013).

167. Meriwether v. Faulkner, 821 F.2d 408, 413 (7th Cir. 1987) (citing Partridge v. Two Unknown Police Officers, 791 F.2d 1182, 1187 (5th Cir. 1986)); *see also* Wellman v. Faulkner, 715 F.2d 269, 272–73 (7th Cir. 1983); Ramos v. Lamm, 639 F.2d 559, 574 (10th Cir. 1980); Inmates of Allegheny Cnty. Jail v. Pierce, 612 F.2d 754, 763 (3d Cir. 1979); Bowring v. Godwin, 551 F.2d 44, 47 (4th Cir. 1977).

168. *See* Lord v. Beahm, 952 F.3d 902, 904 (7th Cir. 2020) ("All agree that suicide is an objectively serious medical condition."); Luckert v. Dodge Cnty., 684 F.3d 808, 817 (8th Cir. 2012); Comstock v. McCrary, 273 F.3d 693, 702 (6th Cir. 2001) ("While the right to medical care for serious medical needs does not encompass the right 'to be screened correctly for suicidal tendencies,' we have long held that prison officials who have been alerted to a prisoner's serious medical needs are under an obligation to offer medical care to such a prisoner.").

169. Coleman et al., *supra* note 25, at 166.

170. Clark et al., *supra* note 10, at 81.

171. *See* Kosilek v. Spencer, 774 F.3d 63, 90–91 (1st Cir. 2014) (en banc); De'lonta v. Johnson, 708 F.3d 520, 525 (4th Cir. 2013) (finding that prison officials have a duty to protect De'lonta from debilitating effects of her gender dysphoria, namely protection against continued self-mutilation); Gibson v. Collier, 920 F.3d 212, 217 (5th Cir. 2019); Fields v. Smith, 653 F.3d 550, 555 (7th Cir. 2011) (explaining that the lower court determined that gender dysphoria is a serious medical need, a point uncontested by the State); Meriwether v. Faulkner, 821 F.2d 408, 413 (7th Cir. 1987) ("There is no reason to treat transsexualism differently than any other psychiatric disorder. Thus . . . plaintiff's complaint does state a 'serious medical need.'"); White v. Farrier, 849 F.2d 322, 325 (8th Cir. 1988) ("[T]ranssexualism is a serious medical need."); Edmo v. Corizon, Inc., 935 F.3d 757, 795 (9th Cir. 2019); Rosati v. Igbinoso, 791 F.3d 1037, 1039–40 (9th Cir. 2015) (holding that Rosati stated a plausible Eighth Amendment claim for inadequate care of her severe gender dysphoria); Kosilek v. Spencer, 889 F. Supp. 2d 190, 229 (D. Mass. 2012); Kosilek v. Maloney, 221 F. Supp. 2d 156, 195 (D. Mass. 2002).

neither party questioned whether gender dysphoria constituted a serious medical need in *Gibson v. Collier* because of the "record of psychological distress, suicidal ideation, and threats of self-harm."[172] Similarly, in *Edmo v. Corizon, Inc.*, the State did not dispute whether gender dysphoria constituted a serious medical need.[173] In that case, the Ninth Circuit strongly stated that the particular conclusion could not even be disputed by the State.[174] Consequently, by arguing gender dysphoria, inmates implicate their rights to the Eighth Amendment guarantee of adequate care.

B. Gender Confirmation Is a Necessary Form of Treatment for Gender Dysphoria

The Supreme Court routinely considers the opinions of the medical and broader scientific community when assessing cruel and unusual punishment.[175] For example, in *Atkins v. Virginia*, the Supreme Court determined that the death penalty for those who are cognitively disabled is unconstitutional.[176] There, the Court relied on "clinical definitions of mental retardation" to demonstrate "abundant evidence" that the cognitively disabled "often act on impulse rather than pursuant to a premeditated plan," such that it "diminish[es] their personal culpability."[177] Moreover, the Supreme Court in *Roper v. Simmons* concluded that the Eighth Amendment prohibits the use of the death penalty for offenders under eighteen.[178] In doing so, the Court relied on "scientific and sociological studies" that demonstrated that those under the age of eighteen (1) are subject to more negative influences and outside pressures and (2) possess diminished culpability for the severity and consequences of their actions.[179] Finally, in *Hall v. Florida*, the Supreme Court again relied on scientific measurement (IQ score) of a defendant's abilities to invalidate a Florida statute that "create[d] an unacceptable risk that persons with intellectual disability will be executed."[180]

In sum, the judiciary generally looks to medical consensus when assessing questions of medical necessity or adequate care. This applies even when a court evaluates the needs of a transgender inmate.[181] Here, the

172. *Gibson*, 920 F.3d at 219.
173. *Edmo*, 935 F.3d at 785.
174. *Id.*
175. *See, e.g.*, Atkins v. Virginia, 536 U.S. 304, 318–20 (2002); Roper v. Simmons, 543 U.S. 551, 569 (2005); Hall v. Florida, 572 U.S. 701, 709 (2014).
176. *Atkins*, 536 U.S. at 319, 321.
177. *Id.* at 318.
178. *Roper*, 543 U.S. at 578–79.
179. *Id.* at 569.
180. *Hall*, 572 U.S. at 704.
181. *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."); Fields v. Smith, 653 F.3d 550, 553–54 (7th Cir. 2011) (outlining the standards of care dictating the treatment for gender dysphoria); Keohane v. Fla. Dep't of Corr. Secr'y, 952 F.3d 1257, 1296 (11th Cir. 2020) (Wilson, J., dissenting) (relying on medical community standards of care for gender dysphoric patients).

medical community accepts that gender dysphoria—and most significantly, its accompanying symptoms—can be alleviated through treatment.[182] Once an individual receives a formal diagnosis, treatment necessitates medical professionals to "assist people with such distress to explore their gender identity and find a gender role that is comfortable for them."[183] Accordingly, care is *necessarily* individualized.[184]

In providing care, the WPATH's SOC are the foundational guidelines for gender-affirming care. Indeed, the SOC outline what the medical community views as adequate care for transgender patients. Notably, many courts recognize that the SOC are the leading source for transgender health care, and these courts frequently rely on them for legal analysis.[185] For example, in *Edmo v. Corizon, Inc.*, the court observed that "most courts agree" that the SOC are the "internationally recognized guidelines for the treatment of individuals with gender dysphoria."[186]

According to the SOC, the two avenues for alleviating gender dysphoria are (1) social support changes and (2) psychological or medical treatment.[187] Together, these forms of treatment fall under the umbrella of gender-affirming care for transgender patients. The social support changes include: in-person and online peer support resources and community-based groups for transgender people and their families; voice therapy to accord with perceptions of gender identity; hair removal treatment; formal, legal changes in name and gender markers; and breast binding or padding, genital tucking, penile prostheses, or hip padding.[188] The social modifications may be in addition to or an alternative to psychological and medical treatment, depending on the needs of the particular individual.[189] Some individuals may require psychological or medical treatment to alleviate gender dysphoria. These options include: psychotherapy to address the negative impact of gender dysphoria on mental health and internalized transphobia; changes in gender expression and role; hormone therapy to feminize or masculinize the body; and surgery to modify primary, secondary, or both kinds of characteristics.[190]

Some question the necessity of GCS and its protection under the Eighth Amendment. These opponents generally deny the necessity of GCS for two reasons. First, opponents point to fringe disagreement in the

182. *See* Coleman et al., *supra* note 25, at 170–71.

183. *Id.* at 168.

184. *See id.*

185. *Edmo*, 935 F.3d at 788 n.16 ("WPATH [SOC] . . . 'are the internationally recognized guidelines for the treatment of individuals with gender dysphoria.'"); De'lonta v. Johnson, 708 F.3d 520, 522–23 (4th Cir. 2013) (describing the SOC as "the generally accepted protocols for the treatment of" gender dysphoria); *Fields*, 653 F.3d at 553–54 (explaining "accepted standards of care" for patients with gender dysphoria).

186. *Edmo*, 935 F.3d at 769.

187. Coleman et al., *supra* note 25, at 171–72.

188. *Id.*

189. *Id.* at 171.

190. *Id.*

medical community to undermine the medical consensus. Second, opponents argue that gender confirmation cannot be medically necessary if alternative forms of treatment exist and yield positive results.

For example, despite the overwhelming medical support for GCS, the Fifth Circuit nevertheless questioned the universality of the SOC in *Gibson v. Collier* in the context of GCS.[191] There, the court argued that the SOC merely represent "one side in a sharply contested medical debate over" GCS.[192] Consequently, the Fifth Circuit claims that "it is indisputable that the necessity and efficacy of [GCS] is a matter of significant disagreement within the medical community."[193] In doing so, the Fifth Circuit deviated from the consensus among both court opinions[194] and apparent medical authority.[195] Thus, the Fifth Circuit is an outlier in its failure to recognize the consensus surrounding the SOC.[196]

On the other hand, individualized care does not undermine medical necessity. Particularized care is common in the medical community, with doctors evaluating presenting conditions and recommending a course of treatment to respond to those individual needs. The use of alternative treatments for an individual does not undermine the necessity of a specific treatment for the condition itself. For example, a cancer patient who can be successfully treated through surgical removal does not invalidate chemotherapy and radiation therapy as necessary forms of treatment for the generalized condition of cancer. Thus, case-by-case treatment does not undermine necessary treatment for conditions, generally.

When assessing gender dysphoria, prison officials should rely on the SOC, the leading guideline on transgender health care. Care must be individualized, ranging from changes in gender expression to GCS. Put simply, "[s]ome patients may need hormones, a possible change in gender role, but not surgery; others may need a change in gender role along with surgery but not hormones."[197] Significantly, medical professionals overwhelmingly agree that hormone therapy and GCS are among the array of medically necessary treatments for gender dysphoria. Therefore, GCS is a

191. Gibson v. Collier, 920 F.3d 212, 221 (5th Cir. 2019).

192. *Id.*

193. *Id.* at 216.

194. Edmo v. Corizon, Inc., 935 F.3d 757, 769, 795 (9th Cir. 2019).

195. Significant medical authority supports the conclusion that GCS is a medically necessary procedure to treat gender dysphoria. For example, major professional associations have indicated the support for gender-affirming care, including the American Medical Association; the American Medical Student Association; the American Psychiatric Association; the American Psychological Association; the American Family Practice Association; American College of Obstetricians and Gynecologists; the Endocrine Society; the National Association of Social Workers; the American Academy of Plastic Surgeons; the American College of Surgeons; Health Professionals Advancing LGBTQ Equality; the HIV Medicine Association, the Lesbian, Bisexual, Gay, and Transgender Physician Assistant Caucus; and Mental Health America. *See Edmo*, 935 F.3d at 795; *see also* Stroumsa, *supra* note 20, at e33.

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

197. Coleman et al., *supra* note 25, at 171.

medically necessary form of treatment for gender dysphoria, which is a recognizable serious medical need.

C. Categorical Bans of Necessary Care Are Per Se Deliberately Indifferent

Policies that categorically preclude the use of medically necessary forms of treatment are per se deliberately indifferent because they amount to conscious decisions to refuse necessary care or to provide a lesser form of treatment. Therefore, categorical prohibitions are tantamount to deliberate indifferent decisions.

Under *Farmer v. Brennan*, the deliberate indifference standard lies "somewhere between the poles of negligence at one end and purpose or knowledge at the other."[198] Therefore, while deliberate indifference is "*more* than mere negligence," a plaintiff need not show "acts or omissions for the very *purpose* of causing harm or with [the] knowledge that harm will result."[199] According to the Supreme Court in *Farmer*, a higher purpose standard does not apply to challenges against conditions of confinement.[200] Thus, the *Farmer* Court noted,

> [A] prison official cannot be found liable under the Eighth Amendment for denying an inmate humane conditions of confinement unless the official knows of and disregards an excessive risk to inmate health or safety; the official must both be aware of facts from which the inference could be drawn that a substantial risk of serious harm exists, and he must also draw the inference.[201]

Notably, however, this test does not require a showing of an act or omission "believing that harm actually *would* befall an inmate."[202] Instead, a claimant simply must show that an "official acted or failed to act despite his knowledge of a *substantial risk of serious harm*."[203] Therefore, the Eighth Amendment protects against the risk of future harm, meaning that the plaintiff need not have suffered the harm yet.[204]

Accordingly, "The knowledge of the need for medical care and intentional refusal to provide that care . . . constitute deliberate indifference."[205] In addition, some courts have found that the decision to provide less efficacious care constitutes deliberate indifference.[206]

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198. Farmer v. Brennan, 511 U.S. 825, 836 (1994).
199. *Id.* at 835 (emphasis added).
200. *See id.* at 835–37.
201. *Id.* at 837.
202. *Id.* at 842.
203. *Id.* (emphasis added).
204. *See* Helling v. McKinney, 509 U.S. 25, 33 (1993).
205. Ancata v. Prison Health Servs., Inc., 769 F.2d 700, 704 (11th Cir. 1985) (citing Robinson v. Moreland, 655 F.2d 887, 889–90 (8th Cir. 1981)); *accord* Ramos v. Lamm, 639 F.2d 559, 575 (10th Cir. 1980) ("Deliberate indifference to serious medical needs is shown when prison officials have prevented an inmate from receiving recommended treatment or when an inmate is denied access to medical personnel capable of evaluating the need for treatment.").
206. Berry v. Peterman, 604 F.3d 435, 441 (7th Cir. 2010) ("[A] doctor's choice of the 'easier and less efficacious treatment' for an objectively serious medical condition can still

Courts have questioned categorical bars to medically necessary treatments for gender dysphoria.[207] For example, in *Fields v. Smith*, gender dysphoric inmates challenged a Wisconsin statute that prohibited both the provision of hormone therapy and GCS.[208] There, the court took issue with the fact that the Wisconsin statute "ban[ned] treatment to *all* prisoners," regardless of whether hormones and GCS *were deemed medically necessary* by medical professionals.[209] Accordingly, the court firmly stated, "It is well established that the Constitution's ban on cruel and unusual punishment does not permit a state to deny effective treatment for the serious medical needs of prisoners."[210] In reaching this conclusion, the *Fields* court constructed a hypothetical statute limiting cancer treatment for inmates to therapy and painkillers.[211] Using this hypothetical, the court determined that it would clearly be seen as unconstitutional.[212] Therefore, the provision of *some* treatment is insufficient where a serious medical need cannot be treated because of a blanket prohibition against the necessary *form* of treatment.[213] For *Fields*, the refusal to provide this treatment was constitutionally invalid as it served no "penological" purpose and was tantamount to torture.[214]

The failure to treat gender dysphoria poses an undeniable substantial risk of harm. As noted, the medical community identified ongoing depression, suicidality, autocastration, and death as potential outcomes for failure to treat gender dysphoria.[215] Consequently, these symptoms may result in torture or lingering death for an untreated inmate. Like other cases concerning adequate medical care, a failure to treat gender dysphoria presents the very harm that the Eighth Amendment is in-

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amount to deliberate indifference for purposes of the Eighth Amendment."); McCarthy v. Maitland Place, 313 F. App'x. 810, 814–15 (6th Cir. 2008) (finding that a conscious decision to provide less efficacious treatment can constitute deliberate indifference); McElligott v. Foley, 182 F.3d 1248, 1255 (11th Cir. 1999) ("We have also held that deliberate indifference may be established by a showing of grossly inadequate care as well as by a decision to take an easier but less efficacious course of treatment."); Chance v. Armstrong, 143 F.3d 698, 703 (2d Cir. 1998) ("[A] physician may be deliberately indifferent if he or she consciously chooses 'an easier and less efficacious' treatment plan.").

207. *See* Fields v. Smith, 653 F.3d 550, 553 (7th Cir. 2011); Soneeya v. Spencer, 851 F. Supp. 2d 228, 247, 252 (D. Mass. 2012) (holding that a DOC policy that placed a categorical ban against laser hair removal, cosmetic surgery, and GCS to treat gender dysphoric inmates violated the Eighth Amendment by refusing to provide necessary evaluation and care for medical needs).

208. *Fields*, 653 F.3d at 557.

209. *Id.* (emphasis added); *see also* Fields v. Smith, 712 F. Supp. 2d 830, 866–67 (E.D. Wis. 2010) ("The statute applies irrespective of an inmate's serious medical need or the DOC's clinical judgment . . . . The reach of this statute is sweeping inasmuch as it is applicable to any inmate who is now in the custody of the DOC or may at any time be in the custody of the DOC, as well as any medical professional who may consider hormone therapy or [GCS] as necessary treatment for an inmate.").

210. *Fields*, 653 F.3d at 556.

211. *Id.*

212. *Id.*

213. *Id.*

214. *Id.*

215. Clark et al., *supra* note 10, at 81.

tended to prevent. For this reason, gender dysphoria clearly presents a serious medical need.

To mitigate these symptoms, doctors follow the triadic approach established by the SOC, including: living in the preferred gender role, hormone therapy, and GCS.[216] The knowledge of gender dysphoria—specifically, the severity of its symptoms—and the intentional refusal to provide medical evaluations for necessary treatment is deliberate indifference. Further, categorical prohibitions against particular forms of treatment present constitutional concerns. Specifically, a prohibition against GCS deprives all inmates of access to a form of treatment that may be of medical necessity. Instead, it signals a decision to provide a lesser form of treatment instead of what a doctor may deem a medical necessity in a particular case. Under the proposed standard, categorical prohibitions against the evaluation for and use of GCS would constitute deliberate indifference.

VI. ADDRESSING COUNTERARGUMENTS

Under this Comment's proposed rule, courts should consider whether GCS is a medically necessary procedure to mitigate the substantial risks presented by an inmate's particular case of gender dysphoria. In doing so, the court will rely on the understanding that (1) gender dysphoria is a substantial medical need; (2) GCS is considered a medically necessary form of treatment; (3) in determining adequate care, medical necessity should be assessed on a case-by-case basis in recognition of the fact that care for gender dysphoria is *individualized*; and (4) the categorical denial of treatment deemed medically necessary itself is per se deliberately indifferent.

This Section addresses two common arguments advanced by opponents of extending constitutional protection to gender-affirming care: (1) the proposed rule empowers inmate choice in health care; and (2) cost is a legitimate factor in denying access to GCS. This Comment ultimately argues that these critiques fail to fulfill the Eighth Amendment's call to provide adequate care.

A. This Rule Does Not Empower Inmate Choice of Treatment

Historically, the Supreme Court has held that the Constitution neither requires comfortable prisons nor permits inhumane ones.[217] Accordingly, "Prison conditions may be 'restrictive and even harsh.'"[218] Further, courts have held that mere disagreement regarding the form of treatment an inmate *should* receive does not result in a constitutional violation.[219]

216. Coleman et al., *supra* note 25, at 170–71.
217. Farmer v. Brennan, 511 U.S. 825, 832 (1994).
218. *Id.* at 833 (quoting Rhodes v. Chapman, 452 U.S. 337, 347 (1981)).
219. Keohane v. Fla. Dep't of Corr. Secr'y, 952 F.3d 1257, 1274 (11th Cir. 2020); Lamb v. Norwood, 899 F.3d 1159, 1163 (10th Cir. 2018).

One concern associated with this proposed rule is that it empowers inmates to exercise choice over their treatment through threats of suicidality or autocastration. This would be tantamount to valorizing disagreements regarding choice of treatment. In addition, this critique relates to a broader argument that denying access to a *form* of treatment is not the same as denying access to *care* itself. In this vein, the provision of *some* treatment—even treatment inconsistent with patient needs—is sufficient to constitute adequate care. This misstates the question underlying claims for inadequate care. The threshold question is whether an inmate possesses a serious medical need that poses a substantial risk of harm. Consequently, the question is not what form of treatment the patient may *prefer* but rather what form of treatment is *recommended* by a healthcare professional.

To help answer this question, the SOC outline criteria for gender-affirming surgery.[220] In assessing whether an inmate qualifies for GCS, doctors consider different factors depending on the type of procedure required. The criteria for breast/chest surgery or breast augmentation, for example, include: persistent, well-documented gender dysphoria; capacity to make an informed decision; age of majority in the country; and control of medical or mental health conditions, if present.[221] With respect to genital surgery, the threshold is higher: persistent, well-documented gender dysphoria; capacity to make an informed decision; age of majority; control of medical and mental health conditions, if present; and twelve months of hormone therapy, unless hormones are not clinically indicated.[222] Some procedures require an additional twelve-month period of living in a gender role congruent with gender identity.[223] Therefore, inmates cannot dictate the course of their treatment simply by alleging mental health, suicidality, or autocastration concerns. Instead, to qualify for particular forms of treatment, an individual must satisfy the threshold criteria for the recommended procedure.

Though some of these prerequisites are relatively easy to satisfy, demonstrating a persistent, well-documented case of gender dysphoria is not. To satisfy this prerequisite, an inmate cannot simply exhibit incongruence between gender and sex.[224] Instead, a diagnosis of gender dysphoria is contingent upon clinically significant distress or impairment that interferes with critical areas of functioning.[225] This diagnosis itself provides the serious medical need that triggers the Constitution's guarantee of adequate care to mitigate the substantial risk of harm.

The concerns about inmate control over treatment plans do not align with the reality of medical treatment for gender dysphoria. Specifically, the critique overemphasizes the role of the inmate and de-emphasizes the

220. Coleman et al., *supra* note 25, at 201–02.
221. *Id.*
222. *Id.* at 202.
223. *Id.*
224. AM. PSYCHIATRIC ASS'N, *supra* note 39, at 452–53.
225. *Id.*

presenting symptoms and documented medical history necessary to secure hormone therapy and GCS. In cases of severe gender dysphoria, the question of care is not one of choice. The recommended procedures are neither elective nor cosmetic. They are medically necessary to respond to the underlying condition, gender dysphoria, and to mitigate the ongoing risks of accompanying symptoms. Accordingly, the denial of access to adequate medical care is not "part of the penalty that criminal offenders pay for their offenses against society."[226] The provision of adequate care is consistent with the evolving standards of decency. Therefore, the denial of necessary care—including, but not limited to, the denial of GCS—serves no legitimate penological purpose.

B. Cost Is an Illegitimate Interest in Denying Access to Necessary Care

Cost is a commonly cited factor by opponents of providing gender-affirming care to prison inmates. Some argue that limited prison budgets necessarily require prison administrators to make financial trade-offs when assessing what form of treatment should be offered for a serious medical need. In this regard, prison officials sometimes provide lesser forms of care to save the cost associated with GCS itself. This argument improperly elevates cost concerns over substantial medical needs and, by extension, deprives prisoners of adequate care in violation of the Eighth Amendment.

A strict reliance on cost to avoid the provision of medically necessary care is inconsistent with Eighth Amendment jurisprudence. Cost may be considered in light of prison administration. However, the cost assessment must be between two equally effective forms of medical treatment. If the choice is between a costly but effective form of treatment and a cheap but ineffective form of treatment, cost would serve as a barrier preventing access to *adequate* care itself.

Underlying the Court's reasoning to protect inmates from poor conditions of confinement is the belief that society *justly* bears a cost to provide adequate care, else the conditions are tantamount to torturous punishment.[227] For example, in *Spicer v. Williamson*, the court outlined the common law view that society is obligated to provide care for prison inmates: "The prisoner[,] by his arrest[,] is deprived of his liberty for the protection of the public. It is but *just* that the public be required to care for the prisoner, who cannot, by reason of the deprivation of his liberty, care for himself."[228] Further, *Estelle v. Gamble* tied this societal obligation to the provision of adequate *medical* care: prison inmates rely on officials to respond to their medical needs, and a failure for authorities to

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

227. *See* Estelle v. Gamble, 429 U.S. 97, 103 (1976); Farmer v. Brennan, 511 U.S. 825, 832–34 (1994).

228. Spicer v. Williamson, 132 S.E. 291, 293 (N.C. 1926) (emphasis added).

treat these needs risks perpetuating pain and suffering.[229] According to the *Estelle* court, this "unnecessary suffering is inconsistent with contemporary standards of decency."[230]

Notably, some courts have addressed the cost concern in the context of gender dysphoric inmates.[231] In *Kosilek II*, the District Ct. of Massachusetts stated, "It is not, however, permissible to deny an inmate adequate medical care because it is costly."[232] Accordingly, the court observed that prison officials have paid for various expensive procedures—CAT scans, dialysis, etc.—to treat serious medical needs.[233] Further, *Fields v. Smith* addressed the cost concern when invalidating a Wisconsin statute that prohibited the use of taxpayer funds for hormone therapy or GCS.[234] There, the Seventh Circuit noted that the DOC pays for "other significant surgeries" that "may be more expensive" than GCS, including coronary bypass and kidney transplants.[235] In doing so, the court affirmed the district court's conclusion that the "DOC might actually incur *greater* costs by refusing to provide hormones."[236] These additional costs may include "other expensive treatments or enhanced monitoring by prison security."[237]

Further, several studies indicate that the provision of gender-affirming care is actually a cost-saving mechanism in the long-term.[238] For example, a study conducted by the Johns Hopkins Bloomberg School of Public Health "analyze[d] the cost-effectiveness of health insurance coverage for medically necessary and preventive services compared to no coverage."[239] In the study, researchers found the provision of care to be cost-effective at the five- and ten-year marks.[240] The study noted that "[w]hile justice, legality, and a desire to avoid discrimination should drive decisions about benefit coverage," the economic argument is ultimately an

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

230. *Id.* at 103.

231. *See, e.g.*, Kosilek v. Spencer, 774 F.3d 63, 81 (1st Cir. 2014) (en banc); Fields v. Smith, 653 F.3d 550, 555–56 (7th Cir. 2011); Maggert v. Hanks, 131 F.3d 670, 672 (7th Cir. 1997); Campbell v. Kallas, No. 16-cv-261-jdp, 2020 WL 7230235, at *8 (W.D. Wis. Dec. 8, 2020); Kosilek v. Maloney, 221 F. Supp. 2d 156, 161 (D. Mass. 2002).

232. *Kosilek*, 221 F. Supp. at 161.

233. *Id.*

234. *Fields*, 653 F.3d at 555–56.

235. *Id.* at 555.

236. *Id.*

237. *Id.* at 555–56.

238. AM. MED. ASS'N, HEALTH INSURANCE COVERAGE FOR GENDER-AFFIRMING CARE OF TRANSGENDER PATIENTS 3 nn.15, 17–19 (2019), https://www.ama-assn.org/system/files/2019-03/transgender-coverage-issue-brief.pdf [https://perma.cc/4HRW-FT35]; 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, 398 (2015); Routh et al., *supra* note 5, at 18 ("The costs of other medical procedures that state DOC are required to provide (e.g., major surgery or continual hormone therapy) cost substantially more than short-term psychotherapy.").

239. Padula et al., *supra* note 238, at 395.

240. *Id.* at 398.

attractive one.[241] In addition, the American Medical Association adopted the position that gender-affirming care is cost-effective relative to "costs associated with untreated gender dysphoria."[242] Therefore, there is a growing consensus that increasing accessibility to medically necessary treatment actually mitigates costs by reducing the risks of suicidality and autocastration and any accompanying costs.

The cost-saving argument has been employed to counter the cost concern in court. For example, in an amicus brief filed for *Edmo v. Corizon, Inc.*, the Williams Institute articulated this point, arguing that cost projections using conservative assumptions highlight that Corizon would actually incur negligible costs by providing this form of treatment—an outcome "unlikely to affect future health care plan costs."[243] Significantly, the Williams Institute argued that the asserted cost concern fails to account for the significant costs "incurred to treat the prisoner's gender dysphoria in the *absence* of surgery as a treatment option."[244] This is particularly evidenced in cases like *Edmo*, where the Idaho DOC incurred costs associated with Edmo's continued suicidality and autocastration attempts. Accordingly, the Williams Institute argued that to truly account for cost, prison authorities should offer gender-affirming care to reduce unnecessary, incidental costs associated with the denial of treatment.[245]

Ultimately, the cost-saving arguments supporting the denial of GCS are unpersuasive. These arguments fail to adequately consider the research showing that the provision of gender-affirming care is actually cost-effective in the long-term. Specifically, those arguing in favor of cost-saving strategies discount the costs associated with ongoing treatment for severe gender dysphoria and security-related monitoring costs. Beyond this, cost-saving proponents, in effect, use cost as an absolute barrier to a form of treatment that may be considered medically necessary. In this regard, the cost factor serves to deny inmates what is considered adequate care itself in violation of the Eighth Amendment.

In short, the common counterarguments are unpersuasive. Although Eighth Amendment jurisprudence limits inmate choice over treatment and acknowledges cost constraints, neither articulated concern applies in the context of gender-affirming care. As noted, inmates must satisfy the SOC's prerequisites to be diagnosed with gender dysphoria and to qualify for the forms of treatment. Further, cost may only be used when deciding between equally effective forms of treatment. Categorical prohibitions of medically necessary, albeit disfavored, forms of treatment are not valid under cost concerns.

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241. *Id.* at 399.

242. AM. MED. ASS'N, *supra* note 238, at 3.

243. Brief of Amicus Curiae Jody L. Herman in Support of Appellee Adree Edmo and Urging Affirmance at 5–6, Edmo v. Corizon, Inc., 935 F.3d 757 (9th Cir. 2019) (No. 19-35019), http://williamsinstitute.law.ucla.edu/wp-content/uploads/Amicus-Edmo-9th-Cir-Apr-2019.pdf [https://perma.cc/UF7R-WVHB].

244. *Id.* at 19 (emphasis added).

245. *Id.* at 21–22.

VII. CONCLUSION

"The degree of civilization in a society can be judged by entering its prisons."[246]

The primary issue underlying this Comment is neither one of policy nor morals. Instead, it is a constitutional question regarding the scope of existing Eighth Amendment jurisprudence. The answer is clear: transgender inmates presenting gender dysphoria are entitled to gender-affirming care, including gender confirmation surgery, under the prohibition against cruel and unusual punishment. Categorial prohibitions against the provision of gender-affirming care run afoul of this constitutional guarantee.

The Eighth Amendment places an affirmative duty on prison officials to provide inmates with adequate medical care.[247] For transgender inmates, however, this constitutional duty is often unmet. Authorities frequently cite administrative, cost, policy, and taxpayer concerns to skirt the constitutional guarantee. The danger of denying care for the transgender community is clear and the risks are dire; the failure to treat gender dysphoria may result in depression, suicidality, autocastration, or death.[248]

Denial of gender-affirming care obfuscates the call of the Eighth Amendment itself. The Supreme Court has historically noted that the Bill of Rights "withdraw[s] certain subjects from the vicissitudes of political controversy, to place them beyond the reach of majorities and officials and to establish them as legal principles to be applied by the courts."[249] Accordingly, the Eighth Amendment and its guarantee against cruel and unusual punishment "may not be submitted to [a] vote," subject to the whims of politics.[250] So too does the Eighth Amendment withdraw questions concerning the provision of gender-affirming care from the vicissitudes of political controversy and resolution by electoral victory.

Ultimately, the principle "underlying the Eighth Amendment is nothing less than the dignity of man."[251] For this to mean anything, the prohibition against cruel and unusual punishment must derive its meaning from the "evolving standards of decency that mark the progress of a maturing society."[252] A failure by courts to apply this dynamic standard would render the Constitution and its protections "little more than good advice."[253] Consequently, the Constitution obligates the State "to care

246. JOSEPH EPSTEIN, YALE UNIV., THE YALE BOOK OF QUOTATIONS 210 (Fred R. Shapiro ed. 2006) (quoting FYODOR DOSTOYEVSKI, THE HOUSE OF THE DEAD (Constance Garnett trans. 1948) (1862)).

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

248. Clark et al., *supra* note 10, at 81.

249. Kosilek v. Spencer, 889 F. Supp. 2d, 190, 203 (D. Mass. 2012) (quoting W. Va. State Bd. of Educ. v. Barnette, 319 U.S. 624, 638 (1943)).

250. *Id.* (quoting Furman v. Georgia, 408 U.S. 238, 268 (1972) (Brennan, J., concurring)).

251. Trop v. Dulles, 356 U.S. 86, 100 (1958).

252. *Id.* at 101.

253. *Id.* at 103–04.

for the prisoner, who cannot by reason of the deprivation of his liberty, care for himself."[254] Affording dignity to the incarcerated is central: "By protecting . . . those convicted of heinous crimes, the Eighth Amendment reaffirms the duty of the government to respect the dignity of *all* persons."[255]

The Eighth Amendment applies equally to the transgender and cisgender populations. The transgender community—a minority status within the U.S. population and the U.S. prison population—has been and continues to be misunderstood. The Eighth Amendment does not permit prison authorities to rely on misperceptions about the transgender community to deny access to necessary care. Nor does it empower the State to deny medically necessary forms of treatment because it is politically disfavored. Just as the Eighth Amendment guarantees cisgender inmates access to adequate care, it guarantees transgender inmates access to adequate care.

This constitutional guarantee is particularly important for transgender inmates exhibiting gender dysphoria. The denial of gender-affirming care serves no penological purpose. It inflicts ongoing suffering with well-known risks on a vulnerable population. At worst, with increased risk of suicidality and autocastration, the denial of care may result in torture or lingering death for the inmate—the evils of most immediate concern for the drafters of the Eighth Amendment. At the same time, prohibitions of gender-affirming care may increase the administrative and taxpayer costs to treat the consequences of these ill-informed policies. These realities run counter to the Eighth Amendment's intended purpose. Ultimately, through the Eighth Amendment, the Constitution valorizes the dignity of transgender persons. In doing so, it ensures access to necessary gender-affirming care when the serious medical need—gender dysphoria—is present.

The right to adequate medical care may be deep-rooted in Eighth Amendment jurisprudence, but the Supreme Court cannot allow this guarantee to lose its meaning. In *Weems v. United States*, the Supreme Court noted that courts must not only consider what may have been, but what may be.[256] A failure to do so would render the Constitution "deficient in efficacy and power," and the rights protected therein would be "lost in reality."[257] Moving forward, courts must remain informed by the existing consensus regarding the transgender community and valorize the right to gender-affirming care enshrined in the Eighth Amendment.

254. Estelle v. Gamble, 429 U.S. 97, 104 (1976).
255. Roper v. Simmons, 543 U.S. 551, 560 (2005) (emphasis added).
256. *See* Weems v. United States, 217 U.S. 349, 373 (1910).
257. *Id.*