

COMMENT

**DECENCY, EVOLVED: THE EIGHTH AMENDMENT
RIGHT TO TRANSITION IN PRISON**

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The United States is beginning to change how it treats transgender people within its prison system. Both state and federal corrections officials, policymakers, and judges are grappling with difficult questions about how to provide medical care, housing, and other basic services to transgender inmates without undermining prison security—or sparking a lawsuit. And with transgender rights becoming a more frequent topic of debate in American culture, these issues are unlikely to disappear.

Transgender prisoners, meanwhile, are stuck in a virtual purgatory of identity while they await access to numerous forms of necessary medical care; namely, those prisoners experiencing the condition known as gender dysphoria. Barring substantive changes to prison health care policies from the top, however, the most direct way for this group to obtain relief from this system may be through the courts. But by what means?

The Eighth Amendment may hold the key. This Comment argues that all prisons have a constitutional obligation to provide transgender prisoners with access to treatments like hormone replacement therapy and sex reassignment surgery in response to a diagnosed case of gender dysphoria. By weaving Chief Justice Warren’s famous “evolving standards of decency” benchmark into contemporary Eighth Amendment case law, this Comment provides a workable, clear-cut standard for assessing a transgender inmate’s claim that he or she has been unconstitutionally denied access to medical care.

Introduction	836
I. Transgenderism and the Prison System	838
A. What Does it Mean to Be “Transgender?”	838
B. Medical Treatment in the Modern Prison System	840
C. The Courts Weigh In.....	844
II. Establishing a Constitutional Right to Transition in Prison	848
A. “Cruel and Unusual” Over Time	849
B. Failure to Provide Transitional Care Constitutes “Deliberate Indifference”	856
C. Addressing Corrections Officials’ Concerns	862
D. Differentiating Between Gender Dysphoria and Other Ailments	867
Conclusion.....	869

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INTRODUCTION

Ten years ago, the national attitude towards transgender prisoners ranged from indifferent to indignant.¹ Inmates seeking to undergo hormone replacement therapy (HRT) or sex reassignment surgery (SRS)² were routinely met with firm opposition from corrections officials, as well as politicians eager to stop taxpayer dollars from being used on ‘frivolous’ medical treatments.³ One Wisconsin state senator even called arguments to provide such medical care “absurd” in a 2006 interview with the Associated Press: “I think the founders of our country—when they wrote [the Eighth Amendment]—they were envisioning preventing people from being burned in oil or burned at the stake, not simply refusing to use taxpayer dollars to allow inmates to get a sex change or breast implants or whatever else.”⁴

But recent events suggest that the national attitude towards transgender inmates has been shifting. In 2015, the Department of Justice filed its first-ever brief arguing that blanket prohibitions on HRT/SRS for transgender inmates are unconstitutional;⁵ states as disparate as Oregon⁶ and Georgia⁷ have started to revisit their policies

1. See, e.g., Aaron T. Norton & Gregory M. Herek, *Heterosexuals’ Attitudes Toward Transgender People: Findings From a National Probability Sample of U.S. Adults*, 68 *SEX ROLES* 738, 742–45 (2013) (finding fairly negative attitudes towards transgender people in general in a 2005 study of over 2,000 non-transgender adults); *infra* note 76.

2. This article uses phrase the “sex reassignment surgery” to describe the procedure used to modify a transgender person’s primary or secondary sex characteristics. See 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, 199 (2011).

3. See, e.g., Ryan Smith, *Pretty in Prison: Cross-Dressing Wife-Killer Wants Smooth Legs*, CBS NEWS (Aug. 10, 2009, 12:50 PM), <http://www.cbsnews.com/news/pretty-in-prison-cross-dressing-wife-killer-wants-smooth-legs/> [<https://perma.cc/5YBD-J2U5>].

4. *Transgendered inmates push for state-funded sex-change surgery*, ASSOCIATED PRESS (Aug. 19, 2006, 9:43 AM), http://usatoday30.usatoday.com/news/nation/2006-08-19-transgendered_x.htm [<https://perma.cc/G4U9-TLD5>]. This comment by republican Rep. Mark Gundrum was made right after Wisconsin became the first state in the country to ever ban providing transgender inmates with access to HRT and SRS under any circumstances, discussed *infra* Section I.

5. See generally Statement of Interest of the United States, *Diamond v. Owens*, 131 F. Supp. 3d 1346 (M.D. Ga. Apr. 3, 2015).

6. Kate Wilson, *Kristina Olvera Says She is a Woman. The Prison System Says He is a Man*, WILLAMETTE WEEK (Apr. 15, 2014), http://www.wweek.com/portland/article-22429-kristina_olvera_says_she_is_a_woman_the_prison_system_says_he_is_a_man.html [<https://perma.cc/NYX8-F526>].

7. Deborah Sontag, *Georgia Says It Will Allow Hormones for Transgender Inmates*, N.Y. TIMES (Apr. 9, 2015), <http://www.nytimes.com/2015/04/10/us/georgia->

for providing hormone therapy to new inmates, which prevent them from receiving HRT unless they were doing so pre-incarceration; California has become the first state to officially provide SRS for its inmates;⁸ and in 2014, the Obama administration lifted the 33-year old blanket ban on using Medicare to cover the cost of SRS, including for prisoners.⁹ The lack of outrage—and in some cases approbation¹⁰—surrounding these changes is decidedly different than many would have thought possible a few years ago.

Nonetheless, transgender prisoners continue to face extraordinary barriers to receiving adequate medical care. Poor literacy in transgender issues among corrections officials, legislators, and even the judiciary continue to contribute to policies for providing HRT and SRS that have crept instead of leapt, leaving many inmates to suffer in a purgatory of identity behind bars. To combat such misunderstanding and get this vulnerable population the medical care it needs, inmates will need something stronger than individual lawsuits and celebrity support:¹¹ they need the protection of the Eighth Amendment and its flexible “evolving standards of decency” standard.¹²

This Comment argues that the Eighth Amendment guarantees transgender prisoners the unencumbered right to access HRT, SRS, and all forms of transitional care while incarcerated. Part I of this Comment reviews the medical, legal, and prison policy-related issues surrounding transgender prisoners’ access to health care. Part II presents the central argument of this Comment: that the Eighth Amendment guarantees transgender inmates access to adequate medical care. In addition, Part II describes how corrections officials’ security and cost concerns about such treatment can be alleviated through simple changes in prison policy, or are otherwise unfounded. This Comment concludes that providing transgender prisoners access to the medical care they deserve would finally put an end to a longstanding cruel and unusual punishment for this minority-within-a-minority.

says-it-will-allow-hormones-for-transgender-inmate.html [https://perma.cc/G24K-F3JS].

8. Richard Pérez-Peña, *California Is First State to Adopt Sex Reassignment Surgery Policy for Prisoners*, N.Y. TIMES (Oct. 21, 2015), <http://www.nytimes.com/2015/10/22/us/california-is-first-state-to-adopt-sex-reassignment-surgery-policy-for-prisoners.html> [https://perma.cc/LQQ2-KZV2].

9. Ariana Eunjung Cha, *Ban lifted on Medicare coverage for sex change surgery*, WASH. POST (May 30, 2014), http://www.washingtonpost.com/national/health-science/ban-lifted-on-medicare-coverage-for-sex-change-surgery/2014/05/30/28bcd122-e818-11e3-a86b-362fd5443d19_story.html [https://perma.cc/D6XG-V84F].

10. Sontag, *supra* note 7.

11. *Id.*

12. *Estelle v. Gamble*, 429 U.S. 97, 102 (1976) (quoting *Trop v. Dulles*, 356 U.S. 86, 101 (1958)).

I. TRANSGENDERISM AND THE PRISON SYSTEM

The problem of transgender inmates' access to medical care requires an understanding of three interlocking parts: transgenderism as a lived identity, the structure of the prison health care system, and the Eighth Amendment. The latter element is analyzed more fully in Section II. For the purposes of this section, it will be sufficient to explain the contours of Eighth Amendment jurisprudence in the context of those other two elements—what it means to be “transgender” and how prisons address the unique health and security issues that arise with transgender prisoners.

A. *What Does it Mean to Be “Transgender?”*

There are two fundamental ways to understand transgenderism. One way recognizes the transgender experience as an issue of personal identity.¹³ The other sees it as a medical condition that can be “treated” through a combination of therapy, HRT, and SRS.¹⁴ This Comment focuses on the latter conception of transgenderism because of its relationship to Eighth Amendment jurisprudence.¹⁵

Defined broadly, a transgender person is someone whose gender identity and expression¹⁶ differs from the gender linked to his or her

13. Outside of the law, the main difference between these two conceptions of transgenderism is one of framing and moral implication (i.e. viewing transgender people as struggling with an incongruity between their gender identity and biological sex versus viewing transgender people as sick). See generally Judith Butler, *Undiagnosing Gender*, in TRANSGENDER RIGHTS 274, 274–75 (Paisley Currah et al. eds., 2006). I use the ‘pathological’ framework here because to do otherwise would foreclose any use of the Eighth Amendment.

14. By using the words “condition” and “treatment” I do not mean to imply that transgenderism is comparable to a disease. The concerns of transgender advocates regarding the ‘pathologization’ of transgenderism are duly noted. See Esinam Agbemenu, *Medical Transgressions in America’s Prisons*, 30 COLUM. J. GENDER & L. 1, 29–33 (2015); Silpa Maruri, *Hormone Therapy for Inmates: A Metonym for Transgender Rights*, 20 CORNELL J.L. & PUB. POL’Y 807, 814 (2011).

15. Arguments for obtaining equal treatment for transgender people by encouraging an abandonment of the traditional ‘gender binary’ in favor of a Constitutional right to sexual autonomy are crucial and worth noting. See, e.g., Agbemenu, *supra* note 14, at 35–37 (discussing the possibility and challenges of a Due Process Clause-based right to personal autonomy in one’s gender identity); Maruri, *supra* note 14, at 815–19 (same); Danielle Weatherby, *From Jack to Jill: Gender Expression as Protected Speech in the Modern Schoolhouse*, 39 N.Y.U. REV. L. & SOC. CHANGE 89 (2015) (arguing that “a transgender student’s expressive conduct . . . is speech that falls within the protective umbrella of the First Amendment”).

16. Defined as “an individual’s internal sense” of their own gender versus the way in which “a person represents or expresses [their] gender identity to others,” respectively. *Transgender Terminology*, NAT’L CTR. FOR TRANSGENDER

biological birth sex.¹⁷ The separate medical condition associated with this is called “gender dysphoria,” described by the Diagnostic and Statistical Manual of Mental Disorders (DSM-V) as distress caused by an incongruity between a person’s birth-designated gender and her true gender identity.¹⁸ Not all transgender individuals necessarily experience gender dysphoria, and those who do may experience it to wildly different degrees.¹⁹ Some experience only minor but persistent discomfort; others will experience such severe psychic pain that it truly qualifies as a mental disorder,²⁰ one that in its worst instances can lead to self-mutilation and suicide.²¹

Regardless of the extent of the pain or discomfort experienced, it is beyond doubt that the medical world accepted gender dysphoria as a legitimate condition requiring some form of treatment a long time ago.²² However, questions about when and how to go through the transition process are deeply personal for a transgender person, and cannot be as easily reduced to a simple diagnosis as the DSM would suggest.²³ The medical community’s gold standard for addressing each person’s unique transition process is the Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People (Standards of Care), produced by the World Professional Association for Transgender Health (WPATH).²⁴ WPATH is a self-described “international, multidisciplinary, professional association” that aims to promote “evidence-based care” in transgender health.²⁵ This guide to providing “flexible directions for the treatment of [Gender Identity Disorder]” and the provision of HRT and SRS has been cited in multiple cases²⁶ relating to transgender health and is

EQUALITY (Jan. 2014), http://www.transequality.org/sites/default/files/docs/resources/TransTerminology_2014.pdf [<https://perma.cc/QL4Z-E2K8>].

17. *Id.*

18. AM. PSYCHIATRIC ASS’N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 451 (5th ed. 2013) [hereinafter DSM-V].

19. Coleman et al., *supra* note 2, at 168.

20. *Id.*

21. See, e.g., *Fields v. Smith*, 712 F. Supp. 2d 830, 835, 864 (E.D. Wis. 2010), *supplemented* (July 9, 2010), *aff’d*, 653 F.3d 550 (7th Cir. 2011).

22. DSM-V, *supra* note 18 at 452–55; see also *Norsworthy v. Beard*, 87 F. Supp. 3d 1164, 1170 (N.D. Cal. 2015).

23. DSM-V, *supra* note 18, at 451–53.

24. Coleman et al., *supra* note 2, at 165–66; see *infra* note 27.

25. Coleman et al., *supra* note 2, at 166.

26. See, e.g., *Kosilek v. Spencer*, 774 F.3d 63, 70 & n.3, 86, 88 (1st Cir. 2014) (en banc); *Norsworthy*, 87 F. Supp. 3d at 1109–10; *Fields*, 712 F. Supp. 2d at 836.

widely considered a leading source on the subject within the medical community.²⁷

The Standards of Care describes the process by which a transgender person transitions into their true gender identity as multifaceted, a progression whose outcomes range from changing one's gender expression—which may involve “living part time or full time in another gender role”—to undergoing surgery to change primary and secondary sex characteristics.²⁸ The full range of transitional options includes receiving HRT and SRS, psychotherapy, group support, and changing one's legal name.²⁹ Whatever goals an individual might have, the Standards of Care stresses that its role is to serve as comprehensive guidelines, rather than an instruction manual for providing transitional care. However, it is firm on one relevant point: “The [Standards of Care] in their entirety apply to all transsexual, transgender, and gender-nonconforming people, irrespective of their housing situation. People should not be discriminated against in their access to . . . health care based on where they live, including institutional environments such as prisons”³⁰

B. Medical Treatment in the Modern Prison System

Transgender prisoners face two major barriers to engaging in the transition process while incarcerated. The primary barrier is prisons' unwillingness to allow them to engage in any of the remedial methods recommended by the Standards of Care. The second barrier is obtaining placement in housing that aligns with their gender identity.

How prevalent are these problems in our prisons? Unfortunately, statistics about the size of the prison system's transgender population are scarce.³¹ In a way, this makes sense: it would be prohibitively difficult for researchers to go into every state and federal prison in the United States to count the transgender inmates, who may be unwilling

27. *De'lonta v. Johnson*, 708 F.3d 520, 522–23 (4th Cir. 2013) (“The Standards of Care . . . are the generally accepted protocols for the treatment of [gender dysphoria.]”); *Norsworthy*, 87 F. Supp. 3d at 1170 (“The World Professional Association for Transgender Health . . . has developed Standards of Care . . . which are recognized as authoritative standards of care by the American Medical Association, the American Psychiatric Association, and the American Psychological Association.”); *O'Donnabhain v. Comm'r*, 134 T.C. 34, 65 (2010) (calling the Standards of Care “widely accepted” within the psychiatric profession).

28. *Coleman et al.*, *supra* note 2, at 171.

29. *Id.* at 171–72.

30. *Id.* at 206 (citing George R. Brown, *Recommended Revisions to the World Professional Association for Transgender Health's Standards of Care Section on Medical Care for Incarcerated Persons with Gender Identify Disorder*, 11 INT'L J. TRANSGENDERISM 133 (2009)).

31. *Maruri*, *supra* note 14, at 809–10.

to “out” themselves in the first place for fear of harassment (or worse). One 2007 study pegged the total transgender prison population in the U.S. at 750, but cautioned strongly that these figures may be a gross underestimate due to issues in self-reporting and sampling within prisons.³²

Ultimately, the size of the at-risk population here is less important than the fact that they are at-risk. About one one-in-seven transgender individuals reported being incarcerated during their lifetime in a 2001 study, compared to about one-in-thirty-seven Americans.³³ Of that group, over one-third reported harassment by their fellow inmates and prison staff, and about one-seventh reported being sexually assaulted.³⁴ A more recent Department of Justice study of American prisons and jails produced even direr figures, finding that over one-third of imprisoned transgender people were sexually abused at least once during their term of confinement.³⁵ As such, the protection of this vulnerable population’s constitutional right to adequate medical care is not merely an academic question, but has very real implications for the safety of our nation’s jails and prisons.

In contemporary correctional institutions, medical care is typically provided by licensed health professionals who are either employed by the prison itself or are a contracted employee of a local hospital.³⁶ Although the quantity and quality of care will vary³⁷ from institution to institution and state to state, inmates do not always have the opportunity

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

33. JAIME M. GRANT ET AL., NAT’L TRANSGENDER DISCRIMINATION SURVEY, INJUSTICE AT EVERY TURN: A REPORT OF THE NATIONAL TRANSGENDER DISCRIMINATION SURVEY 163 (2001), http://www.endtransdiscrimination.org/PDFs/NTDS_Report.pdf [<https://perma.cc/5DTA-PGU6>]. In addition, nearly half of transgender African Americans reported being imprisoned at least once in their lives. *Id.*

34. *Id.* at 167.

35. ALLEN J. BECK, *Sexual Victimization in Prisons and Jails Reported by Inmates, 2011-12: Supplemental Tables: Prevalence of Sexual Victimization Among Transgender Adult Inmates*, BUREAU OF JUST. STATISTICS 9 (2014), http://www.bjs.gov/content/pub/pdf/svpjri1112_st.pdf [<https://perma.cc/P5BG-Y3UJ>].

36. The latter option has become increasingly prevalent. See *National Survey of Prison Health Care*, NAT. CTR. FOR HEALTH STATS. 5–7 (2016); ALEXANDRA GATES ET AL., HEALTH COVERAGE AND CARE FOR THE ADULT CRIMINAL JUSTICE-INVOLVED POPULATION, KAISER FAMILY FOUND. 3 (2014); Doug Jones, *A Cruel and Unusual System: The Inherent Problems of the Practice of Outsourcing Health Care of Prisons and Jails*, 27 CHICANA/O-LATINA/O L. REV. 179, 181 (2008) (“The most commonly outsourced prison services are medical and mental health care.”).

37. John V. Jacobi, *Prison Health, Public Health: Obligations and Opportunities*, 31 AM. J.L. & MED. 447, 453 (2005); GATES ET AL., *supra* note 36.

to see a doctor at will, except in response to an emergency.³⁸ Instead, they must request access to a doctor, who may only be allowed to *recommend* a course of treatment for a particular malady (out of a dual loyalty to both their prisoner-patients and the prison itself).³⁹ As discussed *infra*,⁴⁰ prisons are not required to provide the best possible treatment that a doctor might recommend for a patient—prisons are only required to provide a minimum standard of acceptable care that is compatible with “contemporary standards of decency.”⁴¹

This is where transgender inmates typically run into trouble when seeking medical care.⁴² Most states still do not have formal policies for providing medical treatment to transgender inmates.⁴³ Until recently, even if inmates *were* allowed to see a prison doctor who, subsequently, could diagnose them with gender dysphoria, there was little guarantee that they would be allowed to actively take steps to express their gender identity, consistent with their doctors’ recommendations and the Standards of Care. Whether a person asked to dress in different clothing, receive HRT, or undergo SRS, prison administrators—not the patient or their doctor—retained control over the process and enjoyed deference in its execution.⁴⁴ In recent years, some correctional agencies have shown flexibility in providing inmates with access to some forms of transitional care⁴⁵ (though often in response to lawsuits or, recently, the threat of federal intervention).⁴⁶ But by forcing them to rely on

38. In many cases, access to a doctor may be further limited by a lack of qualified physicians and mandatory medical fees (such as co-pays) that have been authorized by at least thirty-five states and the federal government. See Michele Westhoff, *An Examination of Prisoners’ Constitutional Right to Healthcare: Theory and Practice*, 20 HEALTH LAW. 1, 7 (Aug. 2008); LAUREN-BROOKE EISEN, CHARGING INMATES PERPETUATES MASS INCARCERATION 3 (2015).

39. See Jörg Pont et al., *Dual Loyalty in Prison Health Care*, 102 AM. J. PUB. HEALTH 475 (2012); Jacobi, *supra* note 37, at 456.

40. See *infra* Section II.A.

41. *Hudson v. McMillian*, 503 U.S. 1, 9 (1992); *Estelle v. Gamble*, 429 U.S. 97, 103 (1976).

42. Although the troubles may be more widespread and pervasive than this Comment is able to cover. See generally *Transgender Prisoners in Crisis*, LAMDA LEGAL, http://www.lambdalegal.org/publications/trt_transgender_prisoners_in_crisis [https://perma.cc/U7SM-LZUQ] (last updated 2015); Agbemenu, *supra* note 14, at 2.

43. Jennifer Sumner & Valerie Jenness, *Gender Integration in Sex-Segregated U.S. Prisons: The Paradox of Transgender Correctional Policy*, in HANDBOOK OF LBGT COMMUNITIES, CRIME, AND JUSTICE 229, 237 (Dana Peterson & Vanessa R. Panfil, eds., 2014); Agbemenu, *supra* note 14, at 13.

44. Compare *Bell v. Wolfish*, 441 U.S. 520, 547 (1979), with *Whitley v. Albers*, 475 U.S. 312, 322 (1986) (deference does not extend to “actions taken in bad faith and for no legitimate purpose”).

45. See *supra* notes 6–9 and accompanying text.

46. Memorandum from Newton E. Kendig, Assistant Dir. Health Servs. & Charles E. Samuels, Jr., Assistant Dir. Corr. Programs, to Chief Executive Officers (May 31, 2011); see also Sontag, *supra* note 7.

prison officials, whose primary concerns may differ from a Hippocratic Oath-bound doctor's, transgender inmates are still hamstrung in their ability to obtain this care.⁴⁷

The second issue transgender inmates face in being allowed to express their true gender identity is housing-related. American prisons almost universally segregate men and women into different institutions,⁴⁸ and have thus far shown little enthusiasm for the idea of sending transgender inmates into housing congruent with their gender identity.⁴⁹ This creates an untenable safety risk, particularly for Male-to-Female inmates.⁵⁰ Those who remain in male housing are subject to a thirteen times higher risk of sexual assault than the general prison population.⁵¹ However, the only alternative state prison administrators have been willing to pursue is solitary confinement,⁵² which comes with its own host of physical and psychological risks.⁵³

To this end, some states have begun examining methods for keeping transgender prisoners safe on a case-by-case basis without resorting to solitary confinement.⁵⁴ Pennsylvania, in particular, has done so in part as a response to claims that a failure to make individualized housing decisions for transgender admittees violates the Prison Rape Elimination Act (PREA).⁵⁵ San Francisco has also begun

47. Agbemenu, *supra* note 14, at 24.

48. Maruri, *supra* note 14, at 811–12; Lara Hoffman, *Separate but Unequal – When Overcrowded: Sex Discrimination in Jail Early Release Policies*, 15 WM. & MARY J. WOMEN & L. 591, 598 (2009).

49. Cf. *Kosilek v. Spencer*, 774 F.3d 63, 73–74 (1st Cir. 2014) (describing the apparent “infeasibility” of housing a postoperative transgender inmate in either a male or female institution in Massachusetts).

50. Sometimes stylized as “MtF,” or “FtM” in the case of Female-to-Male transition.

51. Julie Bolcer, *CeCe McDonald Prison Confinement Raises Concerns*, ADVOCATE (June 11, 2012, 12:14 PM), <http://www.advocate.com/politics/transgender/2012/06/11/cece-mcdonald-prison-confinement-raises-question> [<https://perma.cc/WER9-JWVB>].

52. See, e.g., *id.*; but see Elizabeth Daley, *Pennsylvania Improving Policies for Housing Trans Prisoners*, ADVOCATE (Sept. 23, 2015, 3:49 PM), <http://www.advocate.com/transgender/2015/9/23/pennsylvania-improving-policies-housing-transgender-prisoners> [<https://perma.cc/7E64-4ZDS>].

53. The most significant risks being the exacerbation of existing mental illness, self-harm, and in some cases suicide. See, e.g., Fatos Kaba et al., *Solitary Confinement and Risk of Self-Harm Among Jail Inmates*, 104 AM. J. PUB. HEALTH 442, 444–46 (2014); see also Samantha Melamed, *Pa. prisons overhaul policies for transgender inmates*, PHILA. INQUIRER (Sept. 24, 2015), http://articles.philly.com/2015-09-24/entertainment/66826544_1_transgender-women-solitary-confinement-prisons [<https://perma.cc/XL45-YE4Y>].

54. Melamed, *supra* note 53.

55. *Id.*; 28 C.F.R. § 115.42(c) (2014) (providing that correctional agencies “shall consider on a case-by-case basis whether a placement would ensure the inmate’s health and safety”).

to pursue such changes on similar grounds in its county jails.⁵⁶ Still, most institutions maintain a rigid housing placement policy that uses a person's biological birth sex as the primary consideration.⁵⁷

Taken together, the consequences of these practices can be enormous for transgender prisoners. A failure by correctional authorities to address an inmate's legitimate case of gender dysphoria can lead to self-mutilation, suicidal ideation, and even suicide, if left untreated.⁵⁸ In cases where a transgender person has begun transitioning prior to incarceration, the withdrawal of HRT-related hormones may cause a host of painful physical and psychological side effects, from unwanted facial hair growth to nausea and depression.⁵⁹ And the failure to properly manage a transgender inmate's housing situation—either through inaction or overuse of solitary confinement—can lead to abuse at the hands of her fellow inmates, sexual assault, or permanent psychological damage.⁶⁰ At the risk of being redundant: providing this medical care is not an obscure intellectual debate. For transgender prisoners it can be a very real matter of life and death.

C. *The Courts Weigh In*

Prisoners who are denied medical care face a steep climb to receiving a court-ordered injunction against prison officials requiring them to provide treatment. The Eighth Amendment protects prisoners from cruel and unusual punishment, which creates an ongoing obligation to provide medical care to those punished with incarceration.⁶¹ However, the Supreme Court has held that only prison officials' "deliberate indifference" to a prisoner's "serious illness or injury" will rise to the level of a constitutional violation.⁶²

This "deliberate indifference" standard requires a two-part inquiry to determine if an inmate's right to medical care has been violated. First, a prisoner must have a "serious medical need" requiring treatment; second, a prison official must know of and disregard an

56. Keith Burbank, *San Francisco Moves Toward Housing Transgender Inmates*, S.F. BAY (Sept. 11, 2015, 10:48 AM), <http://sfbay.ca/2015/09/11/san-francisco-moves-toward-housing-transgender-inmates/> [<https://perma.cc/PLD6-QJUQ>].

57. Agbemenu, *supra* note 14, at 11 (the assumption of a male-female biological sex-based binary "underscores virtually every aspect of the [prison] system's structure"); Hoffman, *supra* note 48; Maruri, *supra* note 14, at 811–12.

58. See *supra* notes 20–21 and accompanying text.

59. See, e.g., *Fields v. Smith*, 712 F. Supp. 2d 830, 835 (E.D. Wis. 2010), *aff'd* 653 F.3d 550 (7th Cir. 2011).

60. *Supra* notes 32–324 and accompanying text; Kaba et al., *supra* note 53.

61. U.S. CONST. amend. VIII; *Estelle v. Gamble*, 429 U.S. 97, 103 (1976).

62. *Estelle*, 429 U.S. at 104–05. Rather, a violation creating a cause of action under 42 U.S.C. § 1983.

excessive risk to an inmate's health or safety.⁶³ If these prongs are satisfied, prison administrators may offer penological justifications for their failure to provide medical care, and a court may still deny the prisoner's request upon weighing the importance of those justifications against the risks of not providing the requested medical care.⁶⁴ The Supreme Court has never enunciated a bright-line rule for weighing these harms and administrative concerns, but has made clear that at least *some* intrusion into matters of prison administration is reasonable to rectify an ongoing Eighth Amendment violation.⁶⁵

The first major federal case to address the issue of transgender prisoners' access to transitional care using the "deliberate indifference" standard was *Supre v. Ricketts*.⁶⁶ Shauna Supre was an MtF transgender inmate arrested for auto theft and escape in 1978.⁶⁷ In 1980, Supre began to engage in "various forms of mutilation" of her genitals after the Colorado Department of Corrections denied her requests to begin estrogen therapy.⁶⁸ She then sued the Department for violating her civil rights under 42 U.S.C. § 1983.⁶⁹

Although the Department eventually relented to Supre's demands, the Tenth Circuit was asked to decide who the "prevailing party" was in the case, in order to determine the payment of attorney's fees under 42 U.S.C. § 1988.⁷⁰ The Court found that Supre had failed to show the Department's conduct was "required by the Constitution" under *Estelle's* deliberate indifference standard.⁷¹ In the Court's view, the Department had made a reasonable choice under the circumstances

63. *Farmer v. Brennan*, 511 U.S. 825, 835–37 (1994).

64. The Supreme Court has said that "among" the kinds of deprivations that constitute deliberate indifference include those that are "totally without penological justification." *Rhodes v. Chapman*, 452 U.S. 337, 346 (1981). This slippery formulation puts unjustified deprivations of necessary medical care squarely in the domain of deliberate indifference, while leaving to the lower courts the job of determining which justifications are insufficient in comparison to the harm caused.

65. *Brown v. Plata*, 563 U.S. 493, 511 (2011) ("Courts may not allow constitutional violations to continue simply because a remedy would involve intrusion into the realm of prison administration."). Elsewhere in *Plata*, Justice Kennedy also notes that "conditions of confinement" issues such as these rarely come with clear-cut, uncontroversial solutions that have no downside for prison administrators. *Id.* at 525–29.

66. 792 F.2d 958 (10th Cir. 1986).

67. *Id.* at 960.

68. *Id.*

69. *Id.*

70. *Id.* at 960, 962.

71. *Id.* at 963; *Estelle v. Gamble*, 429 U.S. 97, 102–03 (1976).

to not provide *Supre* with HRT, creating a case of negligence or medical malpractice, at most.⁷²

Prior to *Supre* courts saw little litigation surrounding the provision of HRT in prisons, and not a single reported lawsuit surrounding the provision of SRS. Those cases that did address HRT typically dealt with concerns about the use of tax dollars to pay for it.⁷³ After *Supre*, state and federal courts maintained an uneven track record of providing medical care to transgender inmates, sometimes saying ‘yes’ to their claims and sometimes saying ‘no.’⁷⁴ Yet no court addressed the central question raised by *Supre*: when *is* a prisoner constitutionally entitled to receive *any* treatment for gender dysphoria?

In 2011 and 2014, the Seventh and First Circuits provided outlines for the debate over this question, beginning with the case *Fields v. Smith*.⁷⁵ In 2006, Wisconsin had become the first state in United States history to outlaw the provision of HRT or SRS to inmates in the state prison system.⁷⁶ The blanket ban was enacted without input from medical professionals within the Wisconsin Department of Corrections (DOC) and resulted in several inmates then receiving HRT losing access to their previously-approved medical care.⁷⁷ The cessation of hormone treatments caused a range of negative reactions in the patients, including voice deepening, mood swings, hot flashes, depression, and nausea.⁷⁸ Those inmates then sued the DOC.⁷⁹

72. This holding was not only suspect for its Constitutional defects—as I explain *infra*—but also for misapplying circuit precedent regarding the repayment of attorney’s fees under § 1988. *Supre*, 792 F.2d at 965 (Seymour, C.J., dissenting).

73. See, e.g., *Doe v. State, Dep’t of Pub. Welfare*, 257 N.W.2d 816 (Minn. 1977); *G.B. v. Lackner*, 80 Cal. App. 3d 64 (1978).

74. Compare *Meriwether v. Faulkner*, 821 F.2d 408 (7th Cir. 1987) (reversing a district court’s dismissal of a transgender prisoner’s Eighth Amendment claim based on a failure to provide hormone therapy), with *Praylor v. Tex. Dep’t of Crim. Justice*, 430 F.3d 1208 (5th Cir. 2005) (per curiam) (denial of inmate’s request for hormone therapy is not deliberate indifference under the Eighth Amendment).

75. 712 F. Supp. 2d 830 (E.D. Wis. 2010); *Wisconsin Transgender Inmates Win Appeal Over Treatments*, ST. PAUL PIONEER PRESS (Aug. 4, 2011), <http://www.twincities.com/2011/08/04/wisconsin-transgender-inmates-win-appeal-over-treatments-2/> [https://perma.cc/4FH3-8ZLP]

76. It is worth noting that the bill passed through the state legislature with overwhelming bipartisan support and no perceivable public opposition, and was quickly signed into law by then-Governor Jim Doyle, a Democrat. WIS. ASSEMB. JOURNAL, 97th Session, 498 (2005); WIS. SEN. JOURNAL, 97th Session, 490–91 (2005); 2005 Wis. Act 105.

77. *Fields*, 712 F. Supp. at 835.

78. *Id.*

79. *Id.* at 834.

The district court struck down the Wisconsin statute on both Eighth Amendment and Equal Protection grounds.⁸⁰ First, the court found that Fields and her co-plaintiffs had demonstrated “serious medical need[s],” as established by the Standards of Care and a host of case law recognizing the serious effects of gender dysphoria.⁸¹ Second, the court found that the Wisconsin law was a blatant attempt to preempt the relationship between inmate-patients and their doctors, by barring “doctors and other . . . medical personnel from providing [HRT and SRS] that they may determine to be medically necessary.”⁸² Despite the DOC’s protests that the inmates were seeking special treatment for a unique condition that would disrupt security in the state prisons, the court in *Fields* was adamant that “prison officials may not substitute their judgments for a medical professional’s prescription.”⁸³ On appeal, the Seventh Circuit upheld the district court’s factual findings and legal conclusions *in toto*.⁸⁴

The district court’s claim about judgment-substitution begs a host of new questions: namely, which medical professional’s prescription? What doctor gets to decide what care is appropriate for an inmate seeking treatment? Can prisons simply ‘doc shop’ until they find someone willing to deny an inmate HRT or SRS?⁸⁵

The First Circuit confronted these problems in *Kosilek v. Spencer*.⁸⁶ The nuances of Michelle Kosilek’s journey (beginning with a brutal murder in the late 1980s and ending with two high-profile lawsuits over her right to transitional care) are too complex to fully recount here.⁸⁷ Suffice it to say, Kosilek experienced the same problem as the plaintiffs in *Supre* and *Fields*: she wanted access to transitional medical care, specifically SRS, and state prison administrators did not want to give it to her.⁸⁸ The wrinkle in her case, however, would come down to whether the administrators had reasonably relied on one medical opinion over another in deciding to deny her SRS, after receiving medical advice both in favor of and against it.⁸⁹

While the district court and First Circuit originally found that prison officials had displayed “deliberate indifference” to Kosilek and relied on unreasonably imprudent medical advice, the First Circuit

80. *Id.* at 869.

81. *Id.* at 844–52, 863.

82. *Id.* at 866.

83. *Id.* at 866 (internal quotation omitted).

84. *See generally Fields v. Smith*, 653 F.3d 550 (7th Cir. 2011).

85. *See infra* note 133 and Section II.C.

86. 774 F.3d 64 (1st Cir. 2014).

87. *Id.* at 68–74; *see generally Kosilek v. Maloney*, 221 F. Supp. 2d 156 (D. Mass. 2002).

88. *Kosilek*, 774 F.3d at 74.

89. *Id.* at 68–74.

reversed itself upon rehearing the case en banc.⁹⁰ The court acknowledged that Kosilek’s condition constituted a serious medical condition, but refused to hold that the medical opinion used by the Massachusetts DOC to deny Kosilek SRS was objectively unreasonable.⁹¹ The court also reversed the finding that prison administrators’ security concerns were unreasonable, chief among them worries about (1) placing a convicted wife-killer in an all-female inmate population, and (2) creating a precedent of giving prisoners access to medical care upon threats of self-harm or suicide.⁹² Focusing on case law that gives corrections officials wide deference in matters of security, the court found that there was not enough solid evidence of the Massachusetts DOC being motivated by “pretextual or improper concerns” to merit granting Kosilek an injunction.⁹³

Although it did move to cabin⁹⁴ the constitutional consequences of its en banc decision—a review that the dissent did not think should have happened in the first place⁹⁵—the message to transgender prisoners like Michelle Kosilek was straightforward: transitioning in prison is a privilege, the exercise of which is mostly out of your hands.⁹⁶ Fortunately for those prisoners, the First Circuit is not the final authority on what constitutes sufficient medical care. The Constitution is.

II. ESTABLISHING A CONSTITUTIONAL RIGHT TO TRANSITION IN PRISON

A prison’s failure to provide a transgender prisoner with the opportunity to access transitional care—up to and including SRS—constitutes deliberate indifference by corrections officials and violates the Eighth Amendment. First, this section will review the history of the Eighth Amendment and its elastic “evolving standards of decency” standard, then explain how it applies to transgender prisoners seeking medical care. Second, it will demonstrate that the two-part analysis used to evaluate a prisoner’s Eighth Amendment claim of insufficient

90. See *Kosilek v. Spencer*, 740 F.3d 733, 736 (1st Cir.), *rev’d en banc*, 774 F.3d 68 (1st Cir. 2014); *Kosilek v. Spencer*, 889 F. Supp.2d 190, 239–40 (D. Mass. 2012).

91. *Kosilek*, 774 F.3d at 91–92 (“The choice of a medical option that, although disfavored by some in the field, is presented by competent professionals does not exhibit a level of inattention or callousness to a prisoner’s needs rising to a constitutional violation.”).

92. *Id.* at 92–96.

93. *Id.* at 94–96.

94. *Id.* at 90 n.12.

95. *Id.* at 97 (Thompson, J., dissenting).

96. *Id.* at 96.

medical care requires providing transgender inmates with access to transitional care in all but the rarest circumstances. Finally, it will address four recurring concerns expressed by corrections officials in resisting the provision of this health care: threats to inmate safety, the difficulty of housing transgender prisoners, cost, and the risk of walking down a ‘slippery slope.’

A. “Cruel and Unusual” Over Time

The Eighth Amendment borrowed its prohibition on “cruel and unusual punishment” from the English Declaration of Rights of 1688.⁹⁷ In adopting the measure into the Bill of Rights, the Constitution’s Framers were primarily concerned with preventing torture and other “barbarous” punishments of the day.⁹⁸ More specifically, they were concerned with preventing physical harms that offended contemporary standards of decency in punishment.⁹⁹ However, the Amendment was adopted with little debate in Congress, leaving legislatures and courts free to speculate about what it actually prohibited.¹⁰⁰

The Supreme Court was not squarely tasked with defining “cruel and unusual” for well over 100 years after the Bill of Rights’ ratification, other than in death penalty cases.¹⁰¹ In *Weems v. United States*,¹⁰² the Court overturned the conviction of an American bureaucrat named Paul Weems who was convicted of falsifying public documents in the Philippines and sentenced to fifteen years’ imprisonment and hard labor.¹⁰³ In overturning Weems’ sentence, Justice McKenna focused on an idea suggested (but never endorsed) by prior Supreme Court decisions and legal scholars like Thomas Cooley:

97. *Trop v. Dulles*, 356 U.S. 86, 99–100 (1958).

98. *Gregg v. Georgia*, 428 U.S. 153, 169–70 (1976).

99. The focus on bodily security can be seen in early versions of the Amendment adopted in the Colonies. For example, Massachusetts Bay Colony adopted the first such clause in American history, which read: “For bodily punishments we allow amongst us none that are inhumane Barbarous or cruel.” Mass. Body of Liberties, § 46 (1641); *see also Furman v. Georgia*, 408 U.S. 236, 328–29 (1972) (Marshall, J., concurring).

100. The comments that *were* made provide little guidance: one member felt that the Amendment was too indefinite to be effective, while another complained that it tied the government’s hands too tightly in doling out punishments. 1 ANNALS OF CONG. 782–83 (1789) (Joseph Gales ed., 1790), <https://memory.loc.gov/cgi-bin/ampage?collId=llac&fileName=001/llac001.db&recNum=393>.

101. *Weems v. United States*, 217 U.S. 349, 369 (1910) (“No case has occurred in this court which has called for an exhaustive definition.”).

102. 217 U.S. 349 (1910)

103. *Id.* at 357–58, 363–64. This punishment was known as *cadena temporal*. In addition to imprisonment and hard labor, *cadena temporal* also mandated “ancillary” punishments such as lifetime government surveillance and a lifetime ban from public office. *Id.* at 363–65.

“The [Eighth Amendment] of the Constitution . . . [is] progressive, and is not fastened to the obsolete but may acquire meaning as public opinions becomes enlightened by a humane justice.”¹⁰⁴ McKenna acknowledged that he was stepping into a realm in which the Court had been bashful to tread in the past.¹⁰⁵ However, he refused to ignore the severity of the punishment by invoking legislative discretion, holding that Weems’ lengthy sentence was not imposed “under the spirit of constitutional limitations” created by the Eighth Amendment.¹⁰⁶

The Supreme Court would eventually come around to this view in earnest. In 1958, Chief Justice Earl Warren’s plurality opinion in *Trop v. Dulles*¹⁰⁷ solidified the concept of a responsive Eighth Amendment in the Court’s jurisprudence, holding that the Amendment’s interpretation “must draw its meaning from the evolving standards of decency that mark the progress of a maturing society.”¹⁰⁸ Although the Court would not formally adopt this rationale until 2008,¹⁰⁹ the idea animated much of the Court’s Eighth Amendment jurisprudence in the fifty years following *Trop*. For instance, Justice Stewart referenced Warren’s maxim in overturning a death sentence in *Witherspoon v. Illinois*,¹¹⁰ saying that a jury could not properly “maintain a link between contemporary community values and the penal system” when jurors expressing reservations about the death penalty were excluded through voir dire.¹¹¹

Over a decade later, Justice Powell acknowledged that Warren’s formulation applied to the *conditions* of a prisoner’s confinement, as well.¹¹² The reason for this does not require a great stretch of the imagination. The Eighth Amendment outlaws “cruel and unusual punishment,” and the punishment of ‘confinement in a prison for X period of time’ can take a variety of forms—some might be considered inhumane, and some not.¹¹³ Because the Court had already found the

104. *Id.* at 378.

105. *Id.* at 378–79.

106. *Id.* at 381.

107. 356 U.S. 86 (1958).

108. *Id.* at 100–01. Justice Warren cites and draws some of his reasoning from some of the most soaring rhetoric found in *Weems*. 217 U.S. at 373.

109. *Kennedy v. Louisiana*, 554 U.S. 407, 419–20 (2008). That is to say: it was not formally recognized as an operative principle by a majority opinion until that time.

110. 391 U.S. 510 (1968).

111. *Id.* at 519 n.15.

112. *Rhodes v. Chapman*, 452 U.S. 337, 346 (1981) (“No static ‘test’ can exist by which courts determine whether conditions of confinement are cruel and unusual . . .”).

113. U.S. CONST. amend. VIII. For instance, consider two people convicted of burglary: one is incarcerated in a sprawling, under-crowded prison with ample free space and access to medical care, the other in an overcrowded prison infested with rats

Eighth Amendment’s prohibition to be a flexible one, there was no reason for the specifics of a punishment like incarceration to be immune from contemporary community standards of what is “cruel and unusual.”¹¹⁴ Although the Constitution “does not mandate comfortable prisons . . . neither does it permit inhumane ones,” and thus courts retain the ability to prohibit unconscionable conditions of confinement when objective indicia of contemporary values shows that a type of punishment is no longer tolerable.¹¹⁵ This is, as it were, the reason that prisons have a constitutional obligation to provide prisoners with medical care at all.¹¹⁶

The requirement that the protections of the Eighth Amendment square with the reality of our national conscience bears directly on the argument that transgender prisoners cannot be denied access to adequate medical care. Just as our common understanding of what constitutes a “cruel” punishment has changed over time,¹¹⁷ so has the sense of what deprivations a prisoner may suffer while incarcerated.¹¹⁸ In the area of transgender health, this vast attitude shift has taken place in three distinct spheres: medical, legal, and public.

Until the release of the DSM-V in 2013, the consensus view of transgenderism (judging by the content of its predecessors, the DSM-I through IV) in the psychiatric profession rested on the assumption that it was strictly a deviant psychological condition experienced by all transgender people as a matter of personality.¹¹⁹ This monolithic view was consistent with the original 1952 DSM’s original negative view towards all non-heteronormative expressions of gender and sexuality, including homosexuality.¹²⁰ However, the framing adopted by the

and no doctor within 100 miles. Even though both inmates are “incarcerated” as a punishment, the *nature* and *severity* of their punishments are drastically different.

114. *Rhodes*, 452 U.S. at 346–47.

115. *Farmer v. Brennan*, 511 U.S. 825, 832 (1994); *Rhodes*, 452 U.S. at 346–47.

116. *Estelle v. Gamble*, 429 U.S. 97, 103–04 (1976).

117. *Compare Gregg v. Georgia*, 428 U.S. 153 (1976) (holding that the death penalty is not *per se* unconstitutional for the crime of murder), *with Thompson v. Oklahoma*, 487 U.S. 815 (1988) (holding that the death penalty is unconstitutional as applied to crimes committed by people under the age of sixteen), *Roper v. Simmons*, 543 U.S. 551 (2005) (holding that the death penalty is unconstitutional as applied to all crimes committed by minors), *and Kennedy v. Louisiana*, 554 U.S. 407, 421 (2008) (holding that the death penalty is cruel and unusual if applied to any crime against a child short of murder).

118. *See, e.g., Brown v. Plata*, 563 U.S. 493, 538–39 (2011); *Hope v. Pelzer*, 536 U.S. 730, 737–38 (2002).

119. *See* AM. PSYCHIATRIC ASS’N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 451–60 (4th ed. 1994); DSM-V, *supra* note 18.

120. The DSM classified homosexuality as a “sociopathic personality disorder” until 1973. *Obergefell v. Hodges*, 135 S. Ct. 2584, 2596 (2015); Robert L. Spitzer,

DSM-V demonstrates that the medical community has come around to the notion that “gender dysphoria” is not something that someone *is*, but a distress that some transgender people *experience*.¹²¹ Altogether, it is clear that modern medicine has long since accepted the idea that transgenderism is a real phenomenon which can cause legitimate pain and suffering—so much so that the American Medical Association even adopted a resolution saying so in 2008.¹²²

The legal profession has also made significant strides in its acceptance of transgenderism in the past two decades. Some of this shift has been subtle, such as the willingness of courts to refer to transgender plaintiffs by their chosen name (rather than their birth-assigned name) and correct gender pronoun.¹²³ In at least one instance—that of WikiLeaks document-leaker Pfc. Chelsea Manning¹²⁴—a court

The Diagnostic Status of Homosexuality in DSM-III: A Reformulation of the Issues, 138 AM. J. PSYCHIATRY 210, 210–15 (Feb. 1981).

121. Cf. DSM-V, *supra* note 18 (replacing term “gender dysphoria” with “gender identity disorder” and describing it); Am. Psych. Ass’n, *Gender Dysphoria* (2013) (describing changes in the DSM-V as an attempt to “better characterize” the experience of transgender people, and noting that “gender nonconformity is not in itself a mental disorder. The critical element of gender dysphoria is the presence of clinically significant distress associated with the condition.”).

122. Am. Med. Ass’n H. of Del., Res. 122, 110th Cong. (2008). As did the American Psychological Association in 2008. Am. Psych. Ass’n, *Resolution on Transgender, Gender Identity, and Gender Expression Non-Discrimination* (2008), <http://www.apa.org/about/policy/transgender.aspx> [<https://perma.cc/B5RJ-5M68>].

123. Compare *Supre v. Ricketts*, 792 F.2d 958, 959 n.1 (10th Cir. 1986) (Using the plaintiff’s birth name and stating that “[a]lthough plaintiff considers himself to be a woman, male pronouns will be used throughout this opinion), and *Praylor v. Tex. Dep’t of Crim. Justice*, 430 F.3d 1208, 1209 (5th Cir. 2005) (referring to a transgender woman using masculine pronouns), with *Rosati v. Igbinoso*, 791 F.3d 1037, 1038 & n.1 (2015) (per curiam) (using a transgender female plaintiff’s name and stating that “[l]ike the parties, we refer to Rosati in the feminine), and *Kosilek v. Spencer*, 774 F.3d 63, 69, 71 (1st Cir. 2014) (referring to the transgender female plaintiff with feminine pronouns). Notably, Tenth Circuit Judge Stephanie Seymour, dissenting thirty years ago in *Supre v. Ricketts*, did refer to Shauna Supre by her chosen name and with female pronouns, and appears to call out the author of the majority opinion for not doing so. 792 F.2d at 964 n.1.

124. Sabrina Toppa, *Chelsea Manning Can No Longer Be Called ‘He’ by the Military, Court Rules*, TIME (March 6, 2015, 6:55 PM), <http://time.com/3734882/chelsea-manning-he-military/> [<https://perma.cc/LJ3K-7W66>]. Media organizations reporting on Chelsea Manning’s case following her decision to come out as transgender eventually—though not universally—shifted to the use of female pronouns and the name “Chelsea” rather than her birth name, “Bradley.” See Christopher Carbone, *What the Media Learned from Chelsea Manning*, ADVOCATE (Nov. 4, 2013, 3:04 AM), <http://www.advocate.com/print-issue/current-issue/2013/11/04/what-media-learned-chelsea-manning> [<https://perma.cc/8ZXL-XW5N>]; cf. Ruth Tam, *Use of preferred gender pronouns indicates expanding acceptance of transgender people*, WASH. POST (Sept. 5, 2013), <https://www.washingtonpost.com/lifestyle/style/use-of-preferred-gender-pronouns-indicates-expanding-acceptance-of-transgender-people/2013/09/05/25ffdb7e-1595-11e3->

has ordered the United States government to refer to a transgender defendant by her correct gender pronoun in its legal filings, signaling an increased acceptance among the judiciary of the difference between birth gender and gender identity that is *crucial* to understanding the transgender experience.¹²⁵

Other changes have been much more pronounced. The judiciary has begun to review transgender prisoners' claims of deliberate indifference with increased sympathy over the past decade, far from the casual dismissals of demands for HRT and SRS in years past.¹²⁶ In 2012, the Department of Health and Human Services became the first federal agency to propose recognizing gender identity as a form of sex discrimination.¹²⁷ There are now two sitting transgender judges in the United States,¹²⁸ and transgender attorneys have become members of the bar in numerous states, arguing jury trials, engaging in complex civil litigation, and even presenting oral arguments in state supreme courts.¹²⁹ As time goes on and transgender Americans become further

804b-d3a1a3a18f2c_story.html [https://perma.cc/QJ53-A4CU]. This is arguably its own independent, objective indication of changing public sentiment towards transgender people.

125. See also *Norington v. Mitcheff*, No. 3:11-CV-282 RM, 2012 WL 6600101, *1 n.1 (N.D. Ind. Dec. 18, 2012). The pronoun issue is subtle, as stated, but not minor. The Standards of Care refers to the use of gender-accurate pronouns as among those “basic sensitivity protocols” that specialists working with transgender patients *must* be familiar with. Coleman et al., *supra* note 2, at 52.

126. Compare *White v. Farrier*, 849 F.2d 322, 325 (8th Cir. 1988) (reversing district court’s grant of summary judgment in favor of a transgender inmate who claimed deliberate indifference to his medical needs), and *Maggert v. Hanks*, 131 F.3d 670, 671–72 (7th Cir. 1997) (upholding district court dismissal of transgender prisoner Eighth Amendment claim, and holding that prisons do not “have a duty to authorize the hormonal and surgical procedures that . . . would be necessary” to treat gender dysphoria), with *Fields v. Smith*, 653 F.3d 550 (7th Cir. 2011) (striking down state ban on prisoner HRT and SRS as unconstitutional), and *Rosati*, 791 F.3d at 1040 (transgender prisoner’s claim that SRS denied by prison officials was medically necessary sufficient to state an Eighth Amendment claim).

127. *Nondiscrimination in Health Programs and Activities Proposed Rule*, DEP’T OF HEALTH & HUMAN SERVS., <http://www.hhs.gov/civil-rights/for-individuals/section-1557/nondiscrimination-health-programs-and-activities-proposed-rule/index.html> [https://perma.cc/RLT2-83AD]; Kimberly Leonard, *Obama Defends Health Rights for Transgender Americans*, U.S. NEWS & WORLD REP. (Sept. 3, 2015, 3:14 PM), <http://www.usnews.com/news/articles/2015/09/03/obamacare-expands-rights-for-transgender-patients> [https://perma.cc/ZSY6-K7JX].

128. Ellie Krug, *We Hear You Knocking: An Essay on Welcoming “Trans” Lawyers*, 41 WM. MITCHELL L. REV. 181, 198 (2015).

129. See, e.g., Ellie Krug, *About Me*, <http://elliekrug.com/about/> [https://perma.cc/TS9G-VY4M] (last visited Jan. 20, 2016); Mitch Kellaway, *Meet Obama’s Newest Trans Appointee: Attorney Shannon Minter*, ADVOCATE (June 9, 2015, 2:28 PM), <http://www.advocate.com/politics/transgender/2015/06/09/meet-obamas-newest-trans-appointee-attorney-shannon-minter> [https://perma.cc/QG5D-WJ8F]. Minter practiced law in a number of states prior to his appointment by President

integrated into all levels of the legal profession, it is unthinkable that the badges of shame attendant to the transgender experience (including limits on access to necessary medical care) would not wither on the vine, precisely as has happened for women, African Americans, gays, lesbians, and other minority groups throughout our nation's history.¹³⁰

Finally, the public—particularly Millennials and the generation following them—has shown an increasing willingness to accept the transgender community as a part of the fabric of public life.¹³¹ Surveys of American attitudes towards transgender people have begun to find support for vesting transgender citizens with the same rights and protections as all other groups.¹³² This has regularly, although not universally, played out in real life, as states and localities have begun to face backlash when they deny transgender people equal or fair treatment under the law.¹³³ This backlash has extended to the denial of

Obama; the article also mentions several other transgender legal appointees within the Obama Administration. *Id.*

130. Leti Volpp, *Talking "Culture": Gender, Race, Nation, and the Politics of Multiculturalism*, 96 COLUM. L. REV. 1573, 1614 (1996). It is not difficult to find shining examples of this process. *See e.g.*, U.S. CONST. amends. XIII, XIV, XV, XIX; *Obergefell v. Hodges*, 135 S. Ct. 2584, 2596 (2015); *Brown v. Bd. of Educ.*, 347 U.S. 384, 493 (1954); Lily Ledbetter Fair Pay Act of 2009, Pub. L. No. 111-2, 123 Stat. 5 (codified as 42 U.S.C. § 2000e-5 (2012)).

131. *See, e.g.*, Robert P. Jones & Daniel Cox, *How Race and Religion Shape Millennial Attitudes on Sexuality and Reproductive Health: Findings from the 2015 Millennials, Sexuality, and Reproductive Health Survey*, PUB. RELIGION RES. INST. 5 (2015), <http://publicreligion.org/site/wp-content/uploads/2015/03/PRRI-Millennials-Web-FINAL.pdf> [<https://perma.cc/BG8T-VE3J>]; Sarah McBride & Zenen Jaimes Pérez, *Millennials Overwhelmingly Support Comprehensive LGBT Nondiscrimination Protections*, CTR. FOR AM. PROGRESS (Apr. 7, 2015), <https://www.americanprogress.org/issues/lgbt/news/2015/04/07/110523/millennials-overwhelmingly-support-comprehensive-lgbt-nondiscrimination-protections/> [<https://perma.cc/CV6Q-YDR6>]; Jorge Rivas, *Half of young people believe gender isn't limited to male and female*, FUSION (Feb. 3, 2015, 8:20 AM), <http://fusion.net/story/42216/half-of-young-people-believe-gender-isnt-limited-to-male-and-female/> [<https://perma.cc/2C2Y-WAYK>].

132. *See, e.g.*, *Where the Public Stands on Religious Liberty v. Nondiscrimination*, PEW RES. CTR. (Sept. 28, 2016), <http://www.pewforum.org/2016/09/28/where-the-public-stands-on-religious-liberty-vs-nondiscrimination/> [<https://perma.cc/G5K9-MFGE>]; Daniel Trotta, *Exclusive: Women, Young more open on Transgender Issue in U.S.*, REUTERS (Apr. 21, 2016), <http://www.reuters.com/article/us-usa-lgbt-poll-idUSKCN0XI11M> [<https://perma.cc/BXM9-EHNF>]; Daniel Cox & Robert P. Jones, *Strong Majorities of Americans Favor Rights and Legal Protections for Transgender People*, PUB. RELIGION RES. INST. (Nov. 3, 2011), <http://publicreligion.org/newsroom/2011/11/news-release-strong-majorities-favor-rights-and-legal-protections-for-transgender-people/> [<https://perma.cc/ZA4S-2QA9>]; McBride & Pérez, *supra* note 131.

133. *See, e.g.*, Nicholas Wells, *Transgender Bathroom Law is Costing North Carolina Millions in Lost Sports Tourism*, FISCAL TIMES (Sept. 17, 2016), <http://www.thefiscaltimes.com/2016/09/17/Transgender-Bathroom-Law-Costing-North-Carolina-Millions-Lost-Sports-Tourism> [<https://perma.cc/4YY7-GE2Z>]; Andrew Cain,

health care for transgender prisoners, and was strong enough in at least one recent case to spur intervention by the Department of Justice.¹³⁴

The inference to be drawn by these developments is indisputable. Much in the way that same-sex couples' increasingly public presence—combined with “substantial cultural and political developments” in the late 20th century—heralded a change in public attitudes about homosexuality leading up to *Obergefell*, the events of the past decade have shown an increasing public acceptance of transgenderism in general and within prisons.¹³⁵ Where the people's elected representatives once ignored the plight of transgender people, they now intervene on their behalf.¹³⁶ Where the public once recoiled at the notion of providing transgender prisoners access to appropriate health care, they now express public outrage on social media and in our major newspapers when it is denied.¹³⁷

Virginia Defeated Own Transgender Bathroom Bill in February, ROANOKE TIMES (March 29, 2016, 7:02 PM), http://www.roanoke.com/news/politics/virginia-defeated-own-transgender-bathroom-bill-in-february/article_4d76dce4-dca8-527c-9704-7e0127cd9853.html [https://perma.cc/T38E-S4Q4]; Henry Molski, *'Leelah's Law' Petition: 200K Signatures in 2 Days*, CIN. ENQUIRER (Jan. 2, 2015), <http://www.usatoday.com/story/news/2015/01/02/leelahs-law-petition-reaches-goal/21181323/> [https://perma.cc/4SWL-9LMY]; Statement of Interest of the United States, *supra* note 5.

134. See Statement of Interest of the United States, *supra* note 5.

135. *Obergefell*, 135 S. Ct. at 2596. There is an argument to be made that the American public as a whole has not yet reached this inflection point in its support for transgender rights. The reoccurring fights over transgender bathroom access, for instance, suggest that there are still places in the United States that have not embraced—and even resisted—the concept of a transgender identity. See, e.g., Holly Yan, *South Dakota Could be First State to Ban Transgender Students in Some Restrooms*, CNN (Feb. 17, 2016, 6:56 PM), <http://www.cnn.com/2016/02/17/politics/south-dakota-school-restrooms-transgender-bill/> [https://perma.cc/89L6-7TEU]; Alexa Ura, *Bathroom Fears Flush Houston Discrimination Ordinance*, TEX. TRIB. (Nov. 3, 2015), <https://www.texastribune.org/2015/11/03/houston-anti-discrimination-ordinance-early-voting/> [https://perma.cc/8ELM-WPCM]. Then again, there are still plenty of places in the United States that oppose the concept of same-sex marriage in spite of (and perhaps in opposition to) *Obergefell*. See, e.g., *Changing Attitudes on Gay Marriage*, PEW RES. CTR. (May 12, 2016), <http://www.pewforum.org/2016/05/12/changing-attitudes-on-gay-marriage/> [https://perma.cc/L3HZ-MU6H] (finding that thirty-seven percent of Americans continue to oppose gay marriage, nearly a year after *Obergefell*); Jay Michaelson, *Map: The States Still Fighting Gay Marriage*, DAILY BEAST (July 9, 2015), <http://www.thedailybeast.com/articles/2015/07/09/marriage-backlash-bring-it-on.html> [https://perma.cc/5VRG-UMJW] (documenting continued opposition to gay marriage in the wake of *Obergefell*).

136. See Statement of Interest of the United States, *supra* note 5; Juliet Eilperin, *Obama's Quiet Transgender Revolution*, WASH. POST (Dec. 1, 2015), https://www.washingtonpost.com/politics/obamas-quiet-transgender-revolution/2015/11/30/6879527e-95e4-11e5-b5e4-279b4501e8a6_story.html [https://perma.cc/4W7X-DYJG].

137. See, e.g., Editorial Board, *Question Prison Spending, Not Treatments*, NEWS J. (May 27, 2016),

B. Failure to Provide Transitional Care Constitutes “Deliberate Indifference”

As the Eighth Amendment evolves to meet our standards of basic decency, so must its offspring. In the context of transgender prisoners’ quest to access adequate medical care, this means that we are not beholden to the judiciary’s prior view of what constitutes “deliberate indifference to a serious medical need.”¹³⁸ Nor are we limited by our own past prejudices and misconceptions.¹³⁹ With that in mind, this Comment proposes that the Eighth Amendment should be interpreted to protect a transgender inmate’s ability to access medical care related to gender dysphoria while incarcerated, up to and including HRT and SRS.

The *Estelle-Farmer* standard for assessing a prisoner’s claim of being provided inadequate medical care rests on the idea that inmates rely on prison officials to treat them when they get sick, and that failing to do so causes unnecessary suffering.¹⁴⁰ The standard has two prongs.¹⁴¹ First, an inmate must show that they have a serious medical need requiring treatment.¹⁴² Second, that inmate must show that prison administrators knew of an excessive risk to inmate health or safety but acted with “deliberate indifference” to that medical need.¹⁴³ Additionally, prison administrators may offer penological justifications for their failure to provide medical care.¹⁴⁴

<http://www.delawareonline.com/story/opinion/editorials/2016/05/27/editorial-question-prison-spending-not-hormone-treatments/85057284/> [https://perma.cc/ZHM2-TPEZ]; Editorial Board, *Prisons and Jails Put Transgender Inmates at Risk*, N.Y. TIMES (Nov. 9, 2015), <http://www.nytimes.com/2015/11/09/opinion/prisons-and-jails-put-transgender-inmates-at-risk.html> [https://perma.cc/3BX6-GGSK]; *California Prisons Take Lead on Transgender Rights*, FRESNO BEE (Nov. 9, 2015), <http://www.fresnobee.com/opinion/editorials/article43817829.html> [https://perma.cc/V9XN-9XZM].

138. See *supra* note 64.

139. See, e.g., *Transgendered inmates push for state-funded sex-change surgery*, *supra* note 4.

140. *Estelle v. Gamble*, 429 U.S. 97, 103 (1976) (“[I]f the authorities fail to do so, those needs will not be met. In the worst cases, such a failure may actually produce physical ‘torture or a lingering death,’ the evils of most immediate concern to the drafters of the Amendment.”) (quoting *In re Kemmler*, 136 U.S. 436, 447 (1890)); *Fields v. Smith*, 653 F.3d 550, 556 (7th Cir. 2011); *Spicer v. Williamson*, 132 S.E. 291, 293 (N.C. 1926); cf. *Norington v. Mitcheff*, No. 3:11-CV-282 RM, 2012 WL 6600101, at *2 (N.D. Ind. Dec. 18, 2012) (a state cannot “outlaw” an effective medical treatment altogether, because doing so serves “no legitimate penological purpose”).

141. See *supra* notes 61–63 and accompanying text.

142. *Supra* note 63 and accompanying text.

143. *Supra* note 63 and accompanying text.

144. A point which is addressed in *infra* Section II.C.

The first prong of this test—having a serious medical need that requires treatment—is an objective standard.¹⁴⁵ To be considered “serious,” a prisoner’s condition needs to be diagnosed by a physician as one requiring treatment, or one that is so obvious that “even a lay person would perceive the need” for treatment.¹⁴⁶ But this does not mean that a person’s foot has to be falling off to qualify. On the contrary, any condition that could lead to significant injury (or the “unnecessary and wanton infliction of pain”) absent treatment is enough to make a medical condition serious.¹⁴⁷ To date, federal circuit courts have held that asthma, Hepatitis C, a dislocated finger, preliminary symptoms of a heart attack, heartburn and vomiting, and minor burns satisfy this prong.¹⁴⁸ Even dental care has cleared the ‘seriousness’ bar in multiple federal circuit courts.¹⁴⁹

In the realm of transgender prisoner health, the first prong of this standard has already been accepted by most courts for years.¹⁵⁰ Even federal courts that found a reason to deny an inmate access to HRT or SRS have explicitly or tacitly accepted this fact.¹⁵¹ Although the potential negative effects of gender dysphoria sit, like many diseases,

145. *Farmer v. Brennan*, 511 U.S. 825, 834 (1994); *Estelle*, 429 U.S. at 106.

146. *Kosilek v. Spencer*, 774 F.3d 63, 82 (1st Cir. 2014); *Roe v. Elyea*, 631 F.3d 843, 857 (7th Cir. 2011) (quoting *Greeno v. Daley*, 414 F.3d 645, 653 (7th Cir. 2005)).

147. *Whitley v. Albers*, 475 U.S. 312, 319 (internal quotation omitted); *Estelle*, 429 U.S. at 105–06; *see also Roe*, 631 F.3d at 857.

148. *See generally Roe*, 631 F.3d at 861–62; *Estate of Carter v. City of Detroit*, 408 F.3d 305 (6th Cir. 2005); *Adams v. Poag*, 61 F.3d 1537, 1543 (11th Cir. 1995).

149. *Hartsfield v. Colburn*, 491 F.3d 394, 397 (8th Cir. 2007); *Wynn v. Southward*, 251 F.3d 588, 593 (7th Cir. 2001); *Hunt v. Dental Dep’t*, 865 F.2d 198, 200 (9th Cir. 1989).

150. *See Kosilek*, 774 F.3d at 86; *Cuoco v. Moritsugu*, 222 F.3d 99, 106 (2d Cir. 2000); *White v. Farrier*, 849 F.2d 322, 325 (8th Cir. 1988); *Meriwether v. Faulkner*, 821 F.2d 408, 413 (7th Cir. 1987). For evidence of the medical community’s broad acceptance of gender dysphoria as a serious condition, one need only look to its inclusion in the DSM-I through V. *See DSM-V*, *supra* note 18. *See also* H-185.950, *Removing Financial Barriers to Care for Transgender Patients*, AM. MED. ASS’N (July 2013), <http://www.ama-assn.org/ama/pub/about-ama/our-people/member-groups-sections/glbtt-advisory-committee/ama-policy-regarding-sexual-orientation.page?https://perma.cc/3955-SPEC>.

151. *See, e.g., Kosilek*, 774 F.3d at 86 (“That [gender dysphoria] is a serious medical need, and one which mandates treatment, is not in dispute in this case.”); *compare Praylor v. Tex. Dep’t of Crim. Justice*, 430 F.3d 1208, 1209 (5th Cir. 2005) (per curiam) (assuming that “transsexualism does present a serious medical need” but holding that failure to provide hormone therapy was not deliberate indifference), *with Supre v. Ricketts*, 792 F.2d 958, 963 (10th Cir. 1986) (denying hormone therapy to a transgender inmate, but acknowledging the existence of plaintiff’s “medical conditions” requiring treatment), *and White v. Farrier*, 849 F.2d 322, 325 (8th Cir. 1998) (concluding that “transsexualism is a serious medical need” but reversing district court’s grant of summary judgment in inmate’s favor).

on a spectrum of intensity,¹⁵² there is an overwhelming consensus in the legal and medical communities that gender dysphoria is a genuine medical condition that can cause a person serious harm if left untreated.¹⁵³

The second prong, “deliberate indifference,” is a subjective standard with a murky definition.¹⁵⁴ It is said to invoke something more than mere negligence but less than intentionality, requiring at minimum that an official knows of and disregards an excessive risk to an inmate’s health or safety.¹⁵⁵ This knowledge and disregard can be established by showing that an official either acted or failed to act, including by inference from prison officials’ attitudes and conduct, their failure to follow administrative policies, as well as circumstantial evidence that the risk itself was obvious.¹⁵⁶ The fact that a prisoner was not literally ignored after demanding treatment—or even received *some* form of treatment—does not, on its own, defeat a claim that she was denied the “minimal” amount of care required to satisfy the Eighth Amendment.¹⁵⁷

Herein lies a question at the heart of the *Estelle-Farmer* framework: assuming that gender dysphoria is a serious medical condition, once it is diagnosed what is the minimum ‘floor’ for medical care necessary to treat it?¹⁵⁸ The Supreme Court has been clear that the Constitution does not require prisons to be comfortable places (they are, after all, meant to serve as a form of punishment).¹⁵⁹ Only those conditions that deny an inmate access to the “minimum civilized

152. See Coleman et al., *supra* note 2, at 5; see *supra* notes 19–21 and accompanying text.

153. Coleman et al., *supra* note 2, at 2; see also *Fields v. Smith*, 712 F. Supp. 2d 830, 842–43 (E.D. Wis. 2010); *supra* notes 116–19 and accompanying text.

154. *Farmer v. Brennan*, 511 U.S. 825, 838 (1994); cf. *Wilson v. Seiter*, 501 U.S. 294, 300 (1991) (holding that if an officer’s actions inflict pain upon an inmate, a mental element must be present for the actions to be considered punishment).

155. *Farmer*, 511 U.S. at 837; *Estelle v. Gamble*, 429 U.S. 97, 105–06 (1976). In *Farmer*, the Court elaborated that the “deliberate” part of “deliberate indifference” is comparable to the criminal law standard for “subjective recklessness,” while conceding the term’s inherent ambiguity. 511 U.S. at 838.

156. *Farmer*, 511 U.S. at 842–43, 845–47 (“[A] factfinder may conclude that a prison official knew of a substantial risk from the very fact that [it] was obvious.”); see *Raynor v. Pugh*, 817 F.3d 123, 126 (4th Cir. 2016); *Bonner-Turner v. City of Ecorse*, 627 Fed. Appx. 400, 407 (6th Cir. 2015) (“[F]ailure to follow administrative policies . . . may be considered as evidence of an officer’s knowledge.”).

157. *Roe v. Elvea*, 631 F.3d 843, 857–58 (7th Cir. 2011); see also *Hudson v. McMillian*, 503 U.S. 1, 9 (1992); *Estelle*, 429 U.S. at 104–05; *White v. Napoleon*, 897 F.2d 103, 109, 114–15 (3d Cir. 1990) (reversing dismissal of deliberate indifference claims where a doctor actually provided medical care that was objectively unreasonable).

158. See *Hudson*, 503 U.S. at 9.

159. *Hudson*, 503 U.S. at 8–9, 22; *Rhodes v. Chapman*, 452 U.S. 337, 348–49 (1981).

measure” of medical care can rise to the level of a constitutional violation.¹⁶⁰

On the other hand, prisons cannot inflict wanton and unnecessary pain on prisoners, and must abide by *Estelle*’s admonition that the government has an ongoing duty under the Eighth Amendment to provide prisoners with medical care.¹⁶¹ And what constitutes civilized society’s measure of adequate medical care is a necessarily subjective judgment, one that applies the evolving standards of contemporary decency discussed *supra* in Section II.A.¹⁶² Thus, answering this question requires turning to objective indicia of what those standards might be.¹⁶³

Fortunately, the medical community has provided us with a major piece of the puzzle: the ‘gold standard’ Standards of Care.¹⁶⁴ Having long recognized the seriousness of gender dysphoria, WPATH has set out a comprehensive guide for treating its negative effects based on the best available science and expert professional consensus, a guide that is recognized as authoritative by the American Medical Association, the American Psychiatric Association, and the American Psychological Association.¹⁶⁵ The Standards of Care is designed for flexible application, recognizing vast deviations in the effects of gender dysphoria.¹⁶⁶ However, they are *inflexible* in their universality. Irrespective of a person’s housing situation, the Standards of Care is to apply in their entirety, and “health care for [transgender] people living in an institutional environment should mirror that which would be available to them if they were living in a non-institutional setting.”¹⁶⁷

Collectively, the Standards of Care, the change of public opinion in favor of transgender rights over the past decade,¹⁶⁸ and common sense dictate that the ‘floor’ for providing treatment for gender dysphoria is the amount necessary to alleviate its negative effects. If a person is experiencing suicidal ideation, and being given access to

160. *Rhodes*, 452 U.S. at 347; *Estelle*, 429 U.S. at 116 n.13 (Stevens, J., dissenting) (“Of course, not every instance of improper health care violates the Eighth Amendment.”).

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

162. *Gregg v. Georgia*, 428 U.S. 153, 171 (1976); *Trop v. Dulles*, 356 U.S. 86, 100–01 (1958); *Weems v. United States*, 217 U.S. 349, 373 (1910).

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

164. *See supra* notes 24–27 and accompanying text.

165. *Norsworthy v. Beard*, 87 F. Supp. 3d 1164, 1170 (N.D. Cal. 2015); Coleman et al., *supra* note 2, at 166; Agbemenu, *supra* note 14, at 8.

166. *Kosilek v. Spencer*, 774 F.3d 63, 70 & n.3, 86, 88 (7th Cir. 2011).

167. Coleman et al., *supra* note 2, at 206. This also implies that doctors who fail to abide by the Standards of Care (or are cherry-picked by corrections officials to deny treatment) should be disregarded altogether. *See Norsworthy*, 87 F. Supp. 3d at 1192; *Kosilek*, 774 F.3d at 90 n.12.

168. *See supra* Section II.A.

gender-appropriate clothing does not alleviate her symptoms—after a sufficient period of observation,¹⁶⁹ of course—it follows that she should be allowed to progress along the Standards of Care’s sequence of treatment as her doctor reasonably believes to be necessary. If access to a certain type of treatment causes a person’s condition to improve, then she has reached the “minimum” level of care needed to treat her.¹⁷⁰ Crucial to this assessment is that the doctor and patient, rather than untrained corrections officials, are guiding the treatment process.¹⁷¹

As such, a prisoner who is diagnosed by a doctor with gender dysphoria but forbidden from engaging in Standards of Care-prescribed treatment by prison officials can claim that he or she has been treated with deliberate indifference *if* that failure has caused the negative effects of gender dysphoria to continue or progress. This result is demanded by modern psychiatric medicine and the public’s “evolving standards of decency,”¹⁷² which have grown to recognize the seriousness of gender dysphoria as a condition and which would undoubtedly see pain caused by the denial of treatment as “unnecessary and wanton,” given its seriousness.¹⁷³ Because of this, such a result is also demanded by the terms and meaning of the Eighth Amendment.¹⁷⁴

Under the framework described *supra*, a transgender prisoner would have grounds to sue to obtain medical care by meeting the following conditions.¹⁷⁵ First, the inmate must identify himself or herself as a transgender person to prison authorities and request to see a doctor. If that request is granted, a doctor capable of accurately diagnosing gender dysphoria¹⁷⁶ would then have to determine that the inmate is suffering from any of the negative side effects associated with

169. Coleman et al., *supra* note 2, at 207.

170. See generally *Rhodes v. Chapman*, 452 U.S. 337, 348–49 (1981); see also *Hudson v. McMillian*, 503 U.S. 1 8–9, 22 (1992) (Thomas, J., dissenting).

171. *Fields v. Smith*, 712 F. Supp. 2d 830, 866 (E.D. Wis. 2010).

172. See *supra* Section II.A; *Trop v. Dulles*, 356 U.S. 86, 100–01 (1958).

173. *Estelle v. Gamble*, 429 U.S. 97, 104 (1976) (quoting *Gregg v. Georgia*, 428 U.S. 153, 173 (1976)).

174. U.S. CONST. amend. VIII.

175. Most likely using the federal civil rights statute. 42 U.S.C. § 1983 (2012).

176. I address the risk of prison officials circumventing this process by “doc shopping” for a physician unable or unwilling to diagnose or prescribe treatment for gender dysphoria in *infra* Section III.D. See *Rosati v. Ighinosa*, 791 F.3d 1037, 1040 (9th Cir. 2015) (per curiam); *Pyles v. Fahim*, 771 F.3d 403, 412 (7th Cir. 2014) (where the need for one was obvious, failure to provide a doctor with “specialized expertise” for the purposes of diagnosing an inmate permits an inference of deliberate indifference); *De’lonta v. Johnson*, 708 F.3d 520, 526 n.4 (4th Cir. 2013); *Hoptowitz v. Ray*, 682 F.2d 1237, 1252–53 (9th Cir. 1982), *abrogated on other grounds by Sandin v. Conner*, 515 U.S. 472 (1995).

the condition.¹⁷⁷ Once that determination is made, the doctor and patient would then have to create a treatment plan consistent with the Standards of Care that is designed to alleviate the prisoner's suffering. This treatment plan would be tailored to the prisoner's specific needs, and designed to provide them with the minimum treatment needed to ameliorate the effects of gender dysphoria—no more, no less. What form that treatment takes will differ on a case-by-case basis. Some inmates may only need access to clothing that allows them to accurately display a gender identity; others may require therapy sessions with a licensed psychiatrist; and some may require more advanced treatments, up to and including HRT and SRS.¹⁷⁸ A failure to provide that treatment, barring extraordinary circumstances, would be grounds for an injunction.¹⁷⁹

Under this framework, there is no requirement that any prisoner claiming to experience gender dysphoria will automatically have to receive any treatment that they want.¹⁸⁰ Just as it is true that prison officials cannot substitute their judgments for a doctor's, neither can a prisoner.¹⁸¹ For the same reasons that a healthy prisoner who requests invasive surgery could be fairly denied without running afoul of the Eighth Amendment, so would a prisoner who demands immediate SRS without any proof that they experience gender dysphoria.¹⁸² This allows the doctor to retain her discretion to administer treatment to a prisoner, while simultaneously protecting the inmate's access to health care.¹⁸³

177. These effects could be as mild as discomfort or as severe as suicidal ideation or self-mutilation.

178. See *supra* notes 27–28 and accompanying text.

179. *Monsanto Co. v. Geertson Seed Farms*, 561 U.S. 139, 156–57 (2010).

180. *Long v. Nix*, 86 F.3d 761, 765 (8th Cir. 1996); *Meriwether v. Faulkner*, 821 F.2d 408, 413 (7th Cir. 1987); cf. *Gerber v. Hickman*, 291 F.3d 617, 621 (9th Cir. 2002) (incarceration inherently infringes upon fundamental rights).

181. *Zentmeyer v. Kendall Cry., Ill.*, 220 F.3d 805, 810–12 (7th Cir. 2000).

182. See, e.g., *Norrington v. Mitcheff*, No. 3:11-CV-282 RM, 2012 WL 6600101, at *12 (N.D. Ind. Dec. 18, 2012) (doctor's method-driven conclusion that inmate who “was uncooperative . . . provided inconsistent information about her personal history; occasionally refused to speak or declined to discuss gender issues” did not suffer from gender dysphoria was not deliberate indifference).

183. It is true that transgender identities are not limited to the pathological confines of the DSM or Standards of Care, and that painting transgender people as psychologically “ill” raises a number of complicated moral questions about the nature of gender and social identity. See *supra* notes 13–15 and accompanying text. It is also beyond question that the Eighth Amendment is ill-equipped to answer these questions, or provide a prisoner with access to treatment on any ground *but* the need to treat a serious medical condition. Unfortunately, under the paradigm proposed here, prison doctors will have the discretion to deny a prisoner HRT or SRS, but *only* if the Standards of Care would allow for that conclusion. Indeed, the primary check on prisons ‘doc shopping’ for a physician unwilling to diagnose or prescribe treatment for gender dysphoria would be the Standards of Care.

C. Addressing Corrections Officials' Concerns

In addition to disputing the constitutional basis for prisoners' claims,¹⁸⁴ those seeking to deny transgender prisoners access to medical care have consistently offered three reasons why doing so would be unduly burdensome. First, corrections officials argue that allowing a person to transition while incarcerated creates an untenable security risk, putting the inmate in danger of assault or worse.¹⁸⁵ Second, officials claim that they cannot accommodate a transgender person who wants to be moved into housing that aligns with their gender identity, with no alternative but to put them in solitary confinement.¹⁸⁶ Last, both corrections officials and politicians have claimed that the cost of providing treatments like HRT and SRS is too high to be reasonable.¹⁸⁷

These concerns must be addressed in order to advance the primary Eighth Amendment argument, because actions supported by a reasonable penological justification are likely to be given strong weight by courts as a matter of prison administration.¹⁸⁸ The points made *supra* in Sections III.A and III.B address the primary barriers to constitutional scrutiny of prison policies. And as Justice Kennedy has written, “[c]ourts may not allow constitutional violations to continue simply because a remedy would involve intrusion into the realm of prison administration.”¹⁸⁹ But the Supreme Court has stated time and time again that prison administrators are to be given wide-ranging deference in deciding how to best maintain internal security within an institution.¹⁹⁰ Even with the law on the side of the prisoners and the Standards of Care stating that the same treatments should be given to

184. See *supra* Section II.B.

185. *Kosilek v. Spencer*, 774 F.3d 63, 74 (1st Cir. 2014); *Fields v. Smith*, 653 F.3d 550, 557 (7th Cir. 2011); *Soneeya v. Spencer*, 851 F. Supp. 2d 228, 238–40 (D. Mass. March 29, 2012); cf. *Konitzer v. Wall*, No. 12-cv-874-bbc, 2013 WL 2297059, at *2 (W.D. Wis. May 24, 2013) (transgender inmate was denied access to a hair loss medication on “security” grounds). This is one of the more ironic arguments made by corrections officials: ‘We’re trying to help you by denying you access to health care.’

186. See *supra* note 44 and accompanying text.

187. *Fields*, 653 F.3d at 555–56; *Maggert v. Hanks*, 131 F.3d 670, 671–72 (7th Cir. 1997); *Young v. Univ. of Tex. Med. Branch Corr. Health Care*, No. 6:11 cv 363, 2012 WL 262983, at *14 (E.D. Tex. Jan. 11, 2012); *Smith*, *supra* note 3; *Transgendered inmates push for state-funded sex-change surgery*, *supra* note 4.

188. *Turner v. Safley*, 482 U.S. 78, 89 (1987); *Estelle v. Gamble*, 429 U.S. 97, 103 (1976); *Fields*, 653 F.3d at 556.

189. *Brown v. Plata*, 563 U.S. 493, 511 (2011).

190. See e.g., *Overton v. Bazzetta*, 539 U.S. 126, 133 (2003); *Whitley v. Albers*, 475 U.S. 312, 321–22 (1986).

the free and incarcerated alike, prison officials' concerns will always be given due consideration under the *Estelle-Farmer* analysis.¹⁹¹

There is no empirical evidence to support a claim that allowing inmates to receive treatment for gender dysphoria destabilizes the internal security of a prison. In the inverse, there is no evidence that *preventing* them from receiving such treatment *improves* the internal security of prisons. Both the district and circuit courts in *Fields v. Smith* rejected these arguments against providing HRT, noting that the State of Wisconsin's own security expert believed the connection between HRT and increased risk of sexual assaults to be an "incredible stretch."¹⁹²

The evidence that does exist suggests only that transgender people are already at a greater risk of sexual assault than the general prison population, whether or not they have been treated for gender dysphoria.¹⁹³ Corrections departments are well within their authority—and indeed, are required¹⁹⁴ by law—to work to reduce occurrences and the risk of sexual assault within prisons.¹⁹⁵ But absent a showing that treatments for a serious medical condition like gender dysphoria actually, demonstrably increase such violence, there is no basis on which to argue that prison security is threatened by providing those treatments.

Tied into this argument linking transgender medical care to assault is a debate about how transgender prisoners should be housed. Placement in solitary confinement (or "segregation") is a common response to a prisoner's attempts to be removed to gender-accurate housing, either out of a lack of a better alternative or fear for that inmate's safety.¹⁹⁶ Corrections officials have been loath to put biologically male prisoners in female housing and vice versa, particularly in cases like Michele Kosilek's, where the inmate was convicted of a violent crime against a woman.¹⁹⁷

Making individualized housing determinations based on gender identity—rather than sex organs—does not, however, threaten a penological interest in maintaining security within a prison. The

191. *Fields*, 653 F.3d at 556 (quoting *Estelle*, 429 U.S. at 103–04); *Whitley*, 475 U.S. at 321–22; *Coleman et al.*, *supra* note 2, at 206.

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

193. *See generally* BECK, *supra* note 35.

194. *See infra* notes 191–194 and accompanying text.

195. *Giraldo v. Cal. Corr. & Rehab*, 168 Cal. App. 4th 231, 250 (2008).

196. *See, e.g., Farmer v. Brennan*, 511 U.S. 825, 830–31 (1994); Bolcer, *supra* note 51.

197. *Kosilek v. Spencer*, 774 F.3d 63, 93 (1st Cir. 2014); *Fields*, 712 F. Supp. 2d at 853; *but see Meriwether v. Faulkner*, 821 F.2d 408, 417 (7th Cir. 1987).

complex issues surrounding the housing of transgender prisoners¹⁹⁸ is beyond the scope of this Comment, but it suffices to reiterate that transgender prisoners are much less safe than the general prison population under the current system and merit protection from those dangers.¹⁹⁹ The sharply increased risk of sexual assault accompanying their transgender status comes with the risk that prisons lacking more nuanced policies will inadvertently subject those prisoners to sexual assault.²⁰⁰ The decision to leave a prisoner among those who do not share their gender identity not only fails to decrease their risk of assault—and thus improve prison security—but actually keeps them at a *higher* risk than if they were allowed to transition and moved to alternate or gender-identified housing.²⁰¹ This risk ought to be high in the mind of prison administrators, who were admonished by Justice Souter in *Farmer* to remember that “allowing the beating or rape of one prisoner by another serves no legitimate penal objective any more than it squares with evolving standards of decency.”²⁰² Whether an inmate is male, female, or transgender, “being violently assaulted in prison is simply not ‘part of the penalty that criminal offenders pay for their offenses against society.’”²⁰³

Furthermore, a universal policy that places transgender prisoners in segregated housing for extended periods of time instead of allowing them to move into housing that aligns with their gender identity (following a diagnosis of gender dysphoria) may violate the Prison

198. I will note one suggestion worth considering, made in a 2002 proposal by two California attorneys seeking to improve conditions for transgender inmates in San Francisco County Jail. See generally MURRAY D. SCHEEL & CLAIRE EUSTACE, NAT’L LAWYERS GUILD & CITY & CTY. OF S.F. HUMAN RIGHTS COMM’N, MODEL PROTOCOLS ON THE TREATMENT OF TRANSGENDER PERSONS BY SAN FRANCISCO COUNTY JAIL 4–6 (2002). The thrust of the proposal involves an “individualized assessment for appropriate housing” that focuses on gender identity, rather than a person’s biological sex organs, and a screen for inmates that are at-risk of victimizing others. *Id.*

199. BECK, *supra* note 35; see also VALERIE JENNESS ET AL., CTR. FOR EVIDENCE-BASED CORRS., VIOLENCE IN CALIFORNIA CORRECTIONAL FACILITIES: AN EMPIRICAL EXAMINATION OF SEXUAL ASSAULT 2 (May 16, 2007), <http://ucicorrections.seweb.uci.edu/files/2013/06/BulletinVol2Issue2.pdf> [<https://perma.cc/B5B8-WMKQ>].

200. See *Lojan v. Crumbsie*, No. 12 CV 0320(LAP), 2013 WL 411356, at *4 (S.D.N.Y. Feb. 1, 2013) (citing *Powell v. Schriver*, 175 F.3d 107, 115 (2d Cir. 1999) (“In our view, it was as obvious in 1991 as it is now that under certain circumstances the disclosure of . . . transsexualism could place that inmate in harm’s way.”)); see *Giraldo*, 168 Cal. App. 4th at 237; *supra* notes 48–51 and accompanying text.

201. *Norsworthy v. Beard*, 87 F. Supp. 3d 1164, 1180, 1194 (N.D. Cal 2015). This sort of indifference to a heightened risk of sexual assault evokes the facts central to *Farmer*, 511 U.S. at 829–30.

202. *Farmer*, 511 U.S. at 833 (internal citations omitted).

203. *Id.* at 834 (citing *Rhodes v. Chapman*, 452 U.S. 337, 347 (1981)).

Rape Elimination Act (PREA).²⁰⁴ The PREA mandates that prisons and jails across the country assess each inmate’s risk of sexual abuse (taking into account the prisoner’s LGBT status) and make individual housing placements in accordance with that risk.²⁰⁵ Unless there is no other possible way to protect an inmate from sexual assault, inmates are not generally allowed to be placed in “involuntary segregated housing” for more than thirty days, or until “an alternative means of separation from likely abusers can be arranged.”²⁰⁶ As a result, any prison that declines to provide a transgender inmate with the opportunity to live in housing that would likely put them at a lower risk of sexual assault—in this case, an MtF transgender person—and instead puts them in segregation could risk a lawsuit on PREA grounds.²⁰⁷

Finally, legislators and corrections officials have argued that the cost of providing treatments like HRT and SRS is far too high to be considered the “minimal” care required under *Estelle-Farmer*. For decades this position was considered reasonable, finding support both from public figures willing to use transgender inmates as a political punching bag and even some members of the judiciary, unquestioningly accepting the proposition that HRT and SRS were too unusual and expensive to reasonably be provided to inmates.²⁰⁸ As Judge Posner wrote in a 1997 opinion, “[w]ithholding from a prisoner an esoteric medical treatment that only the wealthy can afford does not strike us as a form of cruel and unusual punishment . . . We do not want

204. ACLU, *End the Abuse: Protecting LGBTI Prisoners from Sexual Assault*, 5 (2014) (“Under PREA prisoners cannot be placed in [segregation] unless (1) an assessment of all available alternatives is made and (2) a determination has been made that no alternative means of separation is available The regulations also prohibit agencies from ‘plac[ing] . . . transgender . . . inmates in dedicated facilities, units, or wings solely on the basis of such identification or status.’”).

205. 28 C.F.R. §§ 115.341(a), .41(b), .41(c)(7), .42(c) (2015).

206. 28 C.F.R. §§ 115.43(a), .43(c).

207. A lawsuit on Fourteenth Amendment grounds may also be possible under these circumstances. See, e.g., *Medina-Tejada v. Sacramento Cty.*, No. Civ.S-04-138FCD/DAD, 2006 WL 483158 (E.D. Cal. Feb. 27, 2006). However, inmate sexual assault lawsuits have traditionally faced serious institutional hurdles. See Amy Laderburg, *The “Dirty Little Secret:” Why Class Actions Have Emerged as the Only Viable Option for Women Inmates Attempting to Satisfy the Subjective Prong of the Eighth Amendment in Suits for Custodial Sexual Abuse*, 40 WM & MARY L. REV. 323, 324 & n.4 (1998).

208. See, e.g., *Kosilek v. Spencer*, 740 F.3d 733, 754, 767 (1st Cir. 2014); *Kosilek v. Spencer*, 774 F.3d 63, 80–81, 95 (1st Cir. 2014); *Maggert v. Hanks*, 131 F.3d 670, 671–72 (7th Cir. 1997); *Young v. Univ. of Tex. Med. Branch Corr. Health Care*, No. 6:11 cv 363, 2012 WL 262983, at *14 (E.D. Tex. Jan. 11, 2012); *Transgendered Inmates Push for State-Funded Sex-Change Surgery, Transgendered inmates push for state-funded sex-change surgery*, *supra* note 4.; Smith, *supra* note 3.

transsexuals committing crimes because it is the only route to obtaining a cure.”²⁰⁹

This argument is spurious and irrelevant. The district court’s factual findings in *Fields*—containing a highly detailed analysis of the costs of treatments for gender dysphoria—discredit the idea that the costs of HRT and SRS are outrageous.²¹⁰ It is true that (1) the cost of HRT can be up to \$1,000 per inmate per year, (2) the cost of genital SRS is approximately \$20,000, and (3) neither of these are trifling sums of money for a prison to spend. Yet prisons across the country regularly pay for all types of medically necessary treatments for inmates, from organ transplants to bypass surgery.²¹¹ These treatments can sometimes cost thousands or tens of thousands of dollars, even without the cost of post-operative treatment.²¹² Notwithstanding the fact that not all of those suffering from gender dysphoria will not even require HRT or SRS, prisons cannot talk out of both sides of their mouth by guaranteeing treatment for one type of serious condition, then claim that treating another serious condition would be too expensive.²¹³

Yet more important than the cost of the treatment is the *need* for the treatment. Since *Estelle*, the common law notion that “the public be required to care for the prisoner, who cannot by reason of the deprivation of his liberty, care for himself” has been a cornerstone of Eighth Amendment jurisprudence.²¹⁴ Cost may factor into a prison’s decision about which types of treatment to provide, but it cannot foreclose on doctor-prescribed, medically necessary treatment on the basis of cost alone.²¹⁵ The parade of horrors envisioned by Judge

209. *Maggert*, 131 F.3d at 672.

210. *Fields v. Smith*, 712 F. Supp. 2d 830, 836–37, 863 (2010).

211. *Id.* at 837.

212. Estimates provided by two doctors to the *Washington Post* placed the cost of a full surgical transition from female to male at “\$75,000 or more;” for male to female, up to \$50,000. Lenny Bernstein, *Here’s How Sex Reassignment Surgery Works*, WASH. POST (Feb. 9, 2015), <https://www.washingtonpost.com/news/to-your-health/wp/2015/02/09/heres-how-sex-reassignment-surgery-works/> [<https://perma.cc/25ZU-D37P>]. As with any surgical procedure, the overall costs of HRT and SRS will vary widely based on where it is performed, the extent of treatments performed, and the person’s coverage under Medicare or private insurance.

213. *Roe v. Elyea*, 631 F.3d 843, 863 (7th Cir. 2011); *Ancata v. Prison Health Servs. Inc.*, 769 F.2d 700, 705 (11th Cir. 1985).

214. *Estelle v. Gamble*, 429 U.S. 97, 103–04 (1976) (citing *Spicer v. Williamson*, 132 S.E. 291, 293 (N.C. 1926)).

215. *Roe*, 631 F.3d at 863; *Ancata*, 769 F.2d at 705. One could even argue that as long as the treatment is medically necessary, cost should not be a factor at all. See *Harris v. Thigpen*, 941 F.2d 1495, 1509 (11th Cir. 1991) (“We are aware that systemic deficiencies in medical care may be related to a lack of funds allocated to prisons by the state legislature. Such a lack, however, will not excuse the failure of correctional systems to maintain a certain minimum level of medical service necessary to avoid the imposition of cruel and unusual punishment.”); see also *Wellman v.*

Posner²¹⁶ and others²¹⁷ is thus not only unsupported by any evidence in statistics or science, but is more or less irrelevant in the face of a prisoner's legitimate case of gender dysphoria.

D. Differentiating Between Gender Dysphoria and Other Ailments

A final point on the unique nature of gender dysphoria is worth making here, if only to address the critique—made by those like the Wisconsin politician mentioned in the Introduction²¹⁸—that providing HRT or SRS to prisoners could open the door to providing *any* medical care that would improve a prisoner's psychological health. Debates about gender dysphoria often circle back to this issue: What's to stop any prisoner from simply threatening suicide in order to procure breast enhancement surgery, liposuction, or lip collagen injections? The constitutional necessity for prisons to treat conditions other than gender dysphoria is an issue outside of this Comment's scope, but bears enough on its central thesis to merit a brief response.

It is important to keep in mind that gender dysphoria is a well-established, medically-recognized condition for which there are several widely-accepted treatments, depending on the circumstances.²¹⁹ In many cases, the treatments a doctor prescribes for gender dysphoria will eventually include HRT. In some cases, a doctor will find that a transgender person is eligible under the Standards of Care undergo SRS.²²⁰ What matters is that, under the formulation for making an Eighth Amendment claim outlined above, only a medical condition recognized as “serious” can ever qualify an inmate to demand treatment of any kind.²²¹

Faulkner, 715 F.2d 269, 274 (7th Cir. 1983); *Newman v. Alabama*, 559 F.2d 283, 286 (5th Cir. 1977). This would explain the State of Wisconsin's choice, during oral arguments in the Seventh Circuit, to disclaim any argument that its blanket ban on SRS and HRT was justified by cost savings. See Oral Argument at 15:18, *Fields v. Smith*, 653 F.3d 550, 556 (7th Cir. 2011) (Nos. 10-2339 and 10-2466).

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

217. *Supra* note 208 and accompanying text.

218. *Transgendered inmates push for state-funded sex-change surgery*, *supra* note 4.

219. See *supra* notes 18–29 and accompanying text; see also *supra* note 84 and accompanying text.

220. See *supra* notes 28–29 and accompanying text.

221. *Supra* notes 139–41 and accompanying text.

It is unclear what medically-recognized condition opponents of providing treatment for gender dysphoria invoke in attempting to connect HRT and SRS to procedures like liposuction, but such issues about body image could possibly be classified under the wide umbrella of body dysmorphic disorder (BDD). BDD is classified under the DSM-V as a type of obsessive-compulsive disorder in which the patient “experience[s] extreme anxiety over a real or imagined physical flaw.”²²² This flaw could be an obsession with having small breasts, a large stomach, or thin lips, depending on the person. If left untreated, BDD can lead to anxiety, depression, self-mutilation, and in rare cases suicide.²²³ Thus, opponents argue, the same logic that is applied to gender dysphoria could readily be used to provide a person who is merely sad with bigger breasts, a flatter stomach, or fuller lips. If both SRS and collagen injections can alleviate a person’s psychological suffering, what is the difference between them?

The answer to this is simple: modern medicine. Neither the DSM-V nor any other source in medical literature identifies a specific set of allowed treatments for BDD, unlike with gender dysphoria.²²⁴ One group, the International Obsessive Compulsive Disorder Foundation, recommends cognitive behavioral therapy and medication as two forms of treatments that appear to be approved by existing medical literature.²²⁵ However, exactly *zero* sources recommend surgery as a treatment for BDD. In fact, countless studies of those with BDD who chose to undergo elective cosmetic surgery like liposuction or breast enhancement have found that the symptoms of BDD remained unchanged following surgery, making it at best an ineffective treatment for BDD.²²⁶ Nothing indicates that a reasonable medical professional

222. DSM-V, *supra* note 18.

223. D. Veale, *Body Dysmorphic Disorder*, 80 POSTGRADUATE MED. J. 67, 68 (2004), <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1742928/pdf/v080p00067.pdf> [<https://perma.cc/Q857-N2AW>].

224. *See generally* Coleman et al., *supra* note 2.

225. *See* Katherine A. Phillips & Eric Hollander, *Treating Body Dysmorphic Disorder with Medication: Evidence, Misconceptions, and a Suggested Approach*, 5 BODY IMAGE 13 (2008); *How Is BDD Treated?*, INT’L OBSESSIVE COMPULSIVE DISORDER FOUND., <https://bdd.iocdf.org/about-bdd/how-is-bdd-treated/> [<https://perma.cc/A4QT-WP77>] (last visited Jan. 20, 2016).

226. *See, e.g.*, Andri S. Bjornsson et al., *Body Dysmorphic Disorder*, 12 DIALOGUES IN CLINICAL NEUROSCIENCE 221, 225–27 (2010); Canice E. Crerand et al., *Surgical and Minimally Invasive Cosmetic Procedures Among Persons with Body Dysmorphic Disorder*, 65 ANNALS OF PLASTIC SURGERY 11, 11–16 (2010); Canice E. Crerand et al., *Nonpsychiatric Medical Treatment of Body Dysmorphic Disorder*, 46 PSYCHOSOMATICS 549, 549–55 (2005); Katherine A. Phillips et al., *Surgical and Nonpsychiatric Medical Treatment of Patients with Body Dysmorphic Disorder*, 42 PSYCHOSOMATICS 504, 504–10 (2001).

would ever prescribe a rhinoplasty to even the most psychologically troubled patient.

On the other hand, SRS has been found to be an effective treatment for gender dysphoria's negative symptoms with "undeniable" beneficial outcomes if prescribed effectively.²²⁷ If SRS were shown to be ineffective or harmful to those experiencing the negative effects of gender dysphoria, the *Estelle-Farmer* framework would end any Eighth Amendment inquiry about a prisoner's entitlement to it. But this is not the case. The key point ignored by this 'liposuction for all' line of counterargument—and all of its variants²²⁸—is that the Eighth Amendment only protects a prisoner's right to have a serious medical condition (which BDD is) addressed with *reasonable* minimum care under current medical practices (which liposuction, breast enhancement, and collagen injections are not).²²⁹ SRS and HRT can clear both hurdles of the *Estelle-Farmer* analysis; surgical treatments of BDD would necessarily trip over the second.

CONCLUSION

Dostoyevsky's contention that "the degree of civilization in a society is revealed by entering its prisons" speaks to a core challenge that transgender prisoners' face in advancing this cause.²³⁰ For many Americans, the likelihood that they are close with a person who is or has been incarcerated is not high; the chances that they are close to a transgender person are even lower.²³¹ As a result, even among

227. Coleman et al., *supra* note 2, at 55.

228. The specific malady used in this failed counterargument may differ, from BDD to anxiety to some other type of minor malady. Addressing every potential form of this argument is unnecessary here, but the response to each one should be approximately the same under *Estelle-Farmer*. Appropriate prison responses to inmate medical issues must be objectively reasonable under prevailing professional and scientific norms. Put otherwise: broken arms are fixed with splints, not robotic replacements; headaches are fixed with Advil, not lobotomies; and so on. See *Estelle v. Gamble*, 429 U.S. 97 (1976).

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

230. Erwin James, *Prisons must be a priority for Brown*, *GUARDIAN* (June 25, 2007), <http://www.theguardian.com/society/2007/jun/25/1> [<https://perma.cc/BF5S-VQXK>]. This quote is sometimes misattributed to Winston Churchill.

231. Given the fact that both prisoners and transgender people represent relatively small minority populations within the United States, that is. BUREAU OF JUSTICE STAT., PRISONERS IN 2014 (Sept. 2015), http://www.bjs.gov/content/pub/pdf/p14_Summary.pdf [<https://perma.cc/C7MY-NWB8>]; Claire Cain Miller, *The Search for the Best Estimate of the Transgender Population*, *N.Y. TIMES* (June 8, 2015), <http://www.nytimes.com/2015/06/09/upshot/the-search-for-the-best-estimate-of-the-transgender-population.html> [<https://perma.cc/KYY9-YM3L>]; see also *supra* notes 31–32 and accompanying text.

proponents of criminal justice reform and civil rights for transgender Americans, the transgender prisoners' fight to access appropriate medical care may appear to be so niche as to marginalize its urgency to some. The fact that prisoners have traditionally been among the groups with the least access to political mechanisms for change²³² further complicates the chance for systemic reform on this issue in any legislature, state or federal. So while Dostoyevsky's measure of civility may be correct, it relies on someone being willing to measure it in the first place; that is, someone willing to challenge the patterns and practices of an institution isolated from outside assessment by design.

Still, it is hard to deny that the twin tides of transgender acceptance and prisoner empathy have begun to turn. The mainstream of American political discourse has begun to tackle questions about gender identity and prisoner treatment with a newfound open-mindedness,²³³ embodied in part by the Obama administration's direct intervention in a transgender prisoner's lawsuit and epitomized in popular culture by television shows like *Orange Is the New Black*.²³⁴ Efforts to address abysmal prison conditions across the country also permeate into this discussion, mixing together with those aforementioned factors to create a powerful argument against the American prison system's institutional inertia. There can be only one end to this argument: Much like the scourges of excessive overcrowding,²³⁵ unlimited placement in disgusting isolation cells,²³⁶ and limits on an inmate's access to food,²³⁷ deprivation of transgender prisoners' medical care cannot stand forever.

The proposal made in this comment is intended to be simple in its logic, and rooted in our society's undeniably evolved "standards of decency that mark the progress of a maturing society."²³⁸ The Eighth Amendment protects all prisoners' access to treatment for serious medical conditions; gender dysphoria is a serious medical condition; thus, failing to provide a prisoner with an adequate opportunity for diagnosis and treatment of gender dysphoria constitutes "deliberate indifference" by prison authorities. This should be the beginning and end of any discussion about whether or not to provide transgender prisoners with access to adequate medical care—yet the triad of social anxiety, legislative inertia, and jurisprudential ambivalence that often

232. Sharon Dolovich, *Cruelty, Prison Conditions, and the Eighth Amendment*, 84 N.Y.U. L. REV. 881, 974–76 (2009).

233. See *supra* notes 114–34 and accompanying text.

234. *Orange is the New Black* (Netflix 2013).

235. See generally *Brown v. Plata*, 563 U.S. 493, 511 (2011).

236. See generally *Hutto v. Finney*, 437 U.S. 678 (1978).

237. See generally *Foster v. Runnels*, 554 F.3d 80 (8th Cir. 2009).

238. *Trop v. Dulles*, 356 U.S. 86, 101 (1958); see also *supra* notes 114–34 and accompanying text.

stupefies the American political system has turned a simple discussion into a convoluted debate at the intersection of law, medicine, and penal policy. Whether the courts will ultimately end the debate and grant this minority-within-a-minority their due dignity and medical care is an open question. Unless courts themselves have become “deliberately indifferent” to the pleas of the imprisoned, there should be little reason to deny it to them.