SUFFERING UNCOMPOUNDED: CIVILIZING HEALTHCARE STANDARDS FOR GENDER DYSPHORIC PRISONERS

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INTRODUCTION

In the recently decided case of *Edmo v. Corizon, Inc.*, the United States Court of Appeals for the Ninth Circuit issued a decision highly relevant to the still-developing field of transgender rights in the United States.[1] As a transgender prisoner of the Idaho Department of Corrections (IDOC) suffering from the debilitating psychological effects of severe gender dysphoria (GD), Edmo was denied the opportunity to pursue gender confirmation surgery (GCS) in an effort to alleviate her symptoms.[2] Although Adree Edmo started her life as Mason Dean Edmo, she began to view herself as a woman as early as five or six years old.[3] Throughout her childhood and teenage years, as she wrestled with issues related to the incongruities inherent to her psychological condition, later diagnosed as GD, Edmo alternatingly presented herself as both a man and a woman.[4] At the time, her behavior led many to label her as homosexual; however, she felt that such a label did not accurately portray her self-image.[5] Likely as a result of these life-long internal and, at times, external struggles, Edmo suffered from an array of other psychological issues. Prior to her incarceration in 2012 for sexual abuse of a fifteen-year-old male, Edmo suffered from major depressive disorder, anxiety, and alcohol and drug addiction.[6] Additionally, she had attempted suicide twice in 2010 and 2011.[7]

It was not until Edmo was sent to prison at twenty-one years old and, subsequently, met with Corizon[8] psychologist Dr. Scott Eliason that she was formally diagnosed with GD, then known as gender identity disorder.[9] It was around this time that Edmo fully embraced her gender identity and began to live as a woman full-time.[10] She legally changed her name from Mason to Adree Edmo, altered her birth certificate from "male" to "female" in recognition of her newly-embraced identity, and, for all intents and purposes, began to live as a woman to the best of her ability—complicated as it was by prison

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

2 *Id.* at 772–73.

3 *Id.* at 772.

4 *Id.*

5 Edmo v. Idaho Dep't of Corr., 358 F. Supp. 3d 1103, 1116 (D. Idaho 2018).

6 *Edmo*, 935 F.3d at 772.

7 *Edmo*, 358 F. Supp. 3d at 1116.

8 Corizon, Inc. is a private corporation that provides healthcare services for inmates in the custody of the Idaho Department of Corrections. *Edmo*, 935 F.3d at 767 n.1.

9 *Id.* at 772.

10 *Id.*

regulations barring such behavior—by wearing makeup, female undergarments, and her hair in "feminine hairstyles."[11]

In addition to these non-medical methods of self-treatment, prison medical officials pursued a course of traditional clinical GD treatment. Upon entering the IDOC as an inmate, Edmo was, as all prisoners are, entitled to adequate state-provided healthcare.[12] Accordingly, Edmo almost immediately began a continuing course of hormone therapy that resulted in her breasts growing, her body fat being redistributed, her skin changing, and her mental state improving.[13] Clinically speaking, hormone therapy had a positive effect on alleviating her GD by beginning to bring the incongruency between how she felt and how she looked into alignment.[14] The prison also provided Edmo with prescription medications to treat her depression and anxiety; psychiatric counseling to help work through her underlying mental health issues, as well as her history of trauma, abuse, and suicide attempts; and group counseling sessions.[15]

Regardless of the positive effects these combined treatments may have had on Edmo, the basic underlying self-perceptions that caused her GD remained unchanged.[16] Edmo continued to suffer from depression, anxiety, embarrassment, and disgust with her external appearance, and, in what was surely a desperate attempt to resolve her internal strife, twice attempted to remove her own male genitalia herself with a razor blade.[17] Additionally, in an effort to avoid further, seriously life-threatening self-injury and ease her mental and emotional anguish, Edmo relied on self-medication through physical pain by cutting her arms instead; however, she continued to give self-castration serious consideration.[18]

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[11] *Id.* at 772–77.

[12] Estelle v. Gamble, 429 U.S. 97 (1976).

[13] *Edmo*, 935 F.3d at 772.

[14] *Id.*

[15] *Id.* at 772–73.

[16] The court noted that despite Edmo "gain[ing] the maximum physical changes associated with hormone treatment":

> Edmo continues to experience significant distress related to gender incongruence. Much of that distress is caused by her male genitalia. Edmo testified that she feels "depressed, embarrassed, [and] disgusted" by her male genitalia and that this is an "everyday reoccurring thought." Her medical records confirm her disgust, noting repeated efforts by Edmo to purchase underwear to keep, in Edmo's words, her "disgusting penis" out of sight.

Id. at 772 (second alteration in original).

[17] *Id.* at 772–74.

[18] *Id.* at 774.

In the period between her self-castration attempts, Dr. Eliason, consulting with other IDOC medical and administrative officials, evaluated Edmo for the possibility of pursuing GCS as the next treatment option.[19] Confusingly, Dr. Eliason simultaneously observed that while treatment had effectively begun to alleviate Edmo's condition, noting that she appeared to be doing well and in a good mood, she clearly remained frustrated by her enduring male anatomy, and, as evidenced by her first attempt at self-castration, that her GD was actually worsening.[20] Even so, working under IDOC medical procedures that required a determination of medical necessity before considering GCS,[21] Dr. Eliason evaluated Edmo's medical necessity under a seemingly self-created, novel framework[22] and, supported by other IDOC officials, concluded that the current treatment plan, combined with further monitoring, was sufficient.[23] Although Edmo's second attempt at self-castration was even more gruesome and desperate than the first, the prison never evaluated her for the medical necessity of GCS again.[24]

After considering the state of current medical science in the area of transgender health, the requirements imposed upon states by the Eighth Amendment, and the particular circumstances of the case, the Ninth Circuit found that Edmo's constitutional rights had been violated and affirmed an injunction issued by the district court ordering that the procedure be provided.[25]

Although the court issued a strong vindication of the respondent's rights using language that connoted a clear confidence in its convictions, this in no way lessens the judicial power and legal import of a conflicting opinion issued by the United States Court of Appeals for the Fifth Circuit several months prior to *Edmo*.[26] It is already settled that prison inmates are entitled to provision of adequate medical care during their incarceration.[27] In *Edmo*, however, the adequacy of the

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19 *Id.* at 773.

20 *Id.*

21 *Id.*

22 Edmo's expert witness later testified that Dr. Eliason's evaluating criteria were not "germane to transgender people," incongruent with the WPATH Standards of Care (discussed below), and "bizarre." *Id.* at 778.

23 *Id.* at 773.

24 *Id.* at 774.

25 *Id.* at 803.

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

27 *See, e.g.*, Brown v. Plata, 563 U.S. 493, 511 (2011) ("A prison that deprives prisoners of basic sustenance, including adequate medical care, is incompatible with the concept of human dignity and has no place in civilized society."); West v. Atkins, 487 U.S. 42, 56 (1988) ("[T]he

appellee's medical care was demonstrated to be lacking, as the treatments she was undergoing had failed to provide her with adequate relief from the symptoms she was experiencing.[28] The prison and her physician's "deliberate indifference" to this suffering, established by their denial of GCS, also known as sex reassignment surgery—"an accepted, effective, medically indicated treatment for [GD]"[29]—was, under the circumstances, seen to implicate the Eighth Amendment's prohibition on cruel and unusual punishments.[30]

As already alluded to, the current split between the Ninth and Fifth Circuit Courts is centered on this very determination: the question of whether individualized assessment of prison inmates suffering from the psychological effects associated with GD, the disorder determined to be the source of the prisoners' issues, and, if determined to be medically necessary, the right to a procedure that can alleviate those effects, is required under the Eighth Amendment. The conflict in opinion between the circuits has its basis in the question of whether medical science has yet reached consensus on the efficacy, necessity, and appropriateness of GCS.[31]

The particular facts of *Edmo* provide an intriguing look into a variety of legal questions within the wider context of transgender rights. The opinion, issued by the Ninth Circuit per curiam, developed over a course of discussion that included questions of the breadth of the Eighth Amendment's Cruel and Unusual Punishments Clause, prisoners' rights to medical care, state penal procedures, the nature and specificity of injunctive relief, and waiver of procedural rights, as well as extralegal questions of the relative weights of professional medical opinion and authority, the current state of medical science, and social awareness of transgender health issues.

As of today, questions of transgender rights, identity, psychology, and social acceptance are at the forefront of numerous discussions

State [has a] constitutional duty to provide adequate medical treatment to those in its custody . . . ."); Estelle v. Gamble, 429 U.S. 97, 103 (1976) ("These elementary principles establish the government's obligation to provide medical care for those whom it is punishing by incarceration.").

28 *Edmo*, 935 F.3d at 787.

29 *Id.* at 770 (quoting De'lonta v. Johnson, 708 F.3d 520, 523 (4th Cir. 2013)).

30 *Id.* at 803; *see also* U.S. CONST. amend. VIII ("Excessive bail shall not be required, nor excessive fines imposed, nor cruel and unusual punishments inflicted.").

31 *Compare Edmo*, 935 F.3d at 770–71, *with* Gibson v. Collier, 920 F.3d 212, 221–25 (5th Cir. 2019) ("[T]here is no consensus in the medical community about the necessity and efficacy of sex reassignment surgery as a treatment for gender dysphoria.") (citing Kosilek v. Spencer, 774 F.3d 63, 73 (1st Cir. 2014)).

throughout the United States.[32] The controversy surrounding these questions may possibly be a compellingly illustrative microcosm of the wider social issues facing the United States in 2020, as the political, social, and moralistic differences between Americans appear to be widening. As evidenced by the existence of a circuit split related to these questions, especially one as geographically convenient to those who might default to focusing on perceived or actual differences in regional normative decision-making, one thing is clear at the very least: disagreements over individual rights breed controversy. Circuit splits show that perhaps some legal questions are not as simple and clear-cut as advocates of one position or the other may assert them to be. They are clear and convincing evidence that controversial topics generate controversy because there are fundamental disagreements that go to the core of the legal questions that allow them to be adjudicated.

This Note explores the Ninth Circuit's holding in *Edmo* within the context of its split with the Fifth Circuit decision in *Gibson v. Collier*,[33] as well as transgender prisoner rights to effective and appropriate medical treatment under the Eighth Amendment. Contrary to the blanket prescription proffered by the Fifth Circuit, this Note argues that a uniform standard for the treatment of prisoner medical issues is inherently unreasonable and unjust, and that the Ninth Circuit's prescribed method of individualized assessment for the medical necessity of GCS is the correct legal standard to implement. Essentially, if the Supreme Court grants certiorari for an appropriate case, the Ninth Circuit's holding should be considered highly relevant and persuasive authority in shaping the future of transgender prisoners' constitutional rights.

This Note proceeds in three Parts. Part I reviews the relevant scientific, medical, and legal background surrounding GD treatment for transgender prisoners. Part II analyzes the circuit split between the Fifth and Ninth Circuit Courts, as well as related holdings offered by other Circuit Courts and the current state of relevant Eighth Amendment jurisprudence. Part III argues that, given the current state of medical consensus and Eighth Amendment definitions, the court's decision in *Edmo* was correct in its substance, appropriate in its scope, and a reasonable metric by which future Supreme Court cases should be measured.

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32 *See Issues*, NAT'L CTR. FOR TRANSGENDER EQUAL., https://transequality.org/issues [https://perma.cc/74NN-CZFT] (listing and summarizing some of the various issues currently facing the transgender community); *see also* Bostock v. Clayton Cty., 140 S. Ct. 1731 (2020).

33 920 F.3d 212 (5th Cir. 2019).

I. BACKGROUND

A. *Transgender Health Issues and the DSM-5*

Any serious discussion of transgender health must begin with an understanding of the actual terminology applied in the Fifth Edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) definition of GD.[34] As both the Ninth and Fifth Circuits,[35] as well as the healthcare providers in their respective prison systems, relied on this definition as the proper standard for evaluating and diagnosing GD, an extensive understanding of it is appropriate here.

The use of "gender," as opposed to "sex," was, by many accounts, first pushed into the legal world in the 1970s by then-ACLU litigator Ruth Bader Ginsburg.[36] At the time, "gender" was used more as a simple grammatical term denoting the differences between masculine, feminine, or neutral nouns and pronouns present in many languages.[37] Although Ginsburg may have intended her arguably novel use of gender to be equivalent to sex,[38] the DSM-5 distinguishes between the two, with "sex" or "sexual" referring to male and female biological indicators—sex chromosomes, hormones, and genitalia—and "gender" in reference to the sociological construct of what it means to actually live as "man" or "woman" in society.[39] In framing it this way, then, the DSM-5's definition of GD focuses on the distress that accompanies the incongruities between a patient's expressed or experienced gender and their gender assigned at birth; their "natal gender."[40]

In essence, transgender people—the spectrum of people who transiently or persistently identify with a gender different from their assigned natal gender—may experience this distress, labeled as GD, as a result of the differences between how sexual characteristics should

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34 AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 451–59 (5th ed. 2013) [hereinafter DSM-5].

35 *See generally Edmo*, 935 F.3d 757; *Gibson*, 920 F.3d 212.

36 As a lawyer writing briefs for the U.S. Supreme Court, Ruth Bader Ginsburg began to use "gender" when a secretary advised her, "I'm typing all these briefs and articles for you and the word sex, sex, sex, is on every page. Don't you know those nine men [on the Supreme Court], they hear that word and their first association is not the word you want them to be thinking? Why don't you use the word 'gender'? It is a grammatical term and it will ward off distracting associations."

JUDITH M. BENNETT, HISTORY MATTERS: PATRIARCHY AND THE CHALLENGE OF FEMINISM 16 (U. Pa. Press 2010) (alteration in original).

37 *Id.*

38 *Id.*

39 DSM-5, *supra* note 34, at 451.

40 *Id.*

translate into preconceived, societal expectations of gender roles and how particular transgender people view themselves, especially when the means for bringing this incongruity into alignment, such as hormone therapy or surgery, are unavailable.[41] As not all transgender people actually experience GD as a result of their gender identity issues, the DSM-5 focuses on the associated dysphoria[42] as the clinical problem to be treated.[43] Furthermore, in keeping with formal definitions of sex and gender, the DSM-5 distinguishes between trans*gender*, as explained previously, and trans*sexual*—individuals seeking or undergoing varying degrees of transition methods from male-to-female or female-to-male via physical treatments, including hormone therapy and surgery,[44] and/or less invasive, socially inclined treatments, such as dressing and behaving as another gender or using alternate gender pronouns and names.[45]

Differences between patients are common, as GD presents along a varied spectrum. As alluded to in the formal definition below, some patients suffer from genital fixation, in that they exhibit a strong desire to be rid of their own sex characteristics and/or to have the sex characteristics of another gender.[46] Others may focus only on the emotional and psychological aspects of gender differences as their goal, without any desire to actually transition physically, and may find more novel ways to assuage their dysphoria by assuming a role not typically seen as conventionally male or female.[47]

The DSM-5 clarifies GD diagnosis criteria for adolescents and adults thusly:

> A. A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months' duration, as manifested by at least two of the following:
>
> 1. A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics . . . .

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41 *Id.*

42 "A condition in which a person experiences intense feelings of depression, discontent, and in some cases indifference to the world around them." *Id.* at 821 (definition of dysphoria).

43 *Id.* at 451.

44 *Id.*

45 *What Is Gender Dysphoria?*, AM. PSYCHIATRIC ASS'N, https://www.psychiatry.org/patients-families/gender-dysphoria/what-is-gender-dysphoria [https://perma.cc/7DXA-E9U6].

46 DSM-5, *supra* note 34, at 454.

47 *Id.*

2. A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender . . . .
3. A strong desire for the primary and/or secondary sex characteristics of the other gender.
4. A strong desire to be of the other gender . . . .
5. A strong desire to be treated as the other gender . . . .
6. A strong conviction that one has the typical feelings and reactions of the other gender . . . .

B. The condition is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning.[48]

Clarifying the DSM-5 definition, which alludes to "impairment," early-onset childhood GD may result in stunted social and emotional growth, as it contributes to a failure to develop typical peer relationships and skills, resulting in isolationism and distress.[49] In younger individuals, harassment for being "different" can result in an aversion to attending school or participating in age-typical activities with peers.[50] Adult preoccupation with gender identity issues may have detrimental effects on work productivity and relationships; is often associated with increased rates of varying degrees of stigmatization, discrimination, and victimization; and can result in detrimental negative self-conception, as well as increased rates of additional mental disorders—most commonly anxiety and depressive disorders—school dropout, and unemployment.[51]

B. *WPATH Standards of Care*

The World Professional Association for Transgender Health Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People (WPATH Standards) applies the

[48] *Id.* at 452–53. As these criteria are age-dependent, the DSM-5 has a separate set applying to gender dysphoric children, which focuses on more concrete behaviors typically characteristic of prepubescent and adolescent children such as playmate and recreation preferences, clothing choices, and fantasy-play. *Id.* at 452–54.

[49] *Id.* at 457. *See generally* Annelou L. C. de Vries et al., *Poor Peer Relations Predict Parent- and Self-Reported Behavioral and Emotional Problems of Adolescents with Gender Dysphoria: A Cross-National, Cross-Clinic Comparative Analysis*, 25 EUR. CHILD & ADOLESCENT PSYCHIATRY 579 (2016).

[50] DSM-5, *supra* note 34, at 457–58.

[51] *Id.* at 458–59.

DSM-5 definition and provides an extensive study on the medical issues surrounding the treatment of GD for all age groups.[52] These standards, while admittedly asserted by WPATH themselves, represent the best available science and professional consensus on transgender health issues and treatment options, and provide clinicians with standards and procedures in their treatment of transgender patients suffering from GD.[53] It is important to note that the WPATH Standards are merely guidelines—a set of professionally accumulated standards that accommodate deviation by individual medical practitioners resulting from unique patient circumstances, experiential-based strategies, research protocols, or other reasons.[54] Additionally, the WPATH Standards affirm that GD falls along a varied spectrum necessitating individualized treatment plans, and that while hormone therapy or surgery are, in many cases, medically necessary, others may forgo invasive medical intervention by relying on psychotherapy[55] to help them integrate their unique psychological makeup into their natal gender, assume their desired gender role, or some other combination of available treatment options.[56] The WPATH Standards also accommodate for attempts at non-clinical treatment through self-help and social support.[57]

Unsurprisingly, the WPATH Standards stress the importance of the professional competency of clinicians working with GD patients at the various levels of treatment. Mental health professionals should meet all the normal expectations of individuals in that field including appropriate credentials from accredited institutions and competent understanding of the DSM-5, as well as knowledge and understanding of GD diagnosis and treatment; the ability to distinguish GD from

52 *See generally* WORLD PRO. ASS'N FOR TRANSGENDER HEALTH, STANDARDS OF CARE FOR THE HEALTH OF TRANSSEXUAL, TRANSGENDER, AND GENDER-NONCONFORMING PEOPLE (7th Version 2012) [hereinafter WPATH Standards]. Part XIV of the WPATH Standards, addressing their applicability to those living in institutional environments, is particularly applicable to the current discussion. This Part generally asserts that, regardless of individual housing situations, the WPATH Standards should be applied, and that incarceration is generally an unacceptable basis for denying medically necessary treatment. *Id.* at 67. Although Part XIV allows prisons room for reasonable accommodations to deviate from the WPATH Standards in light of the particular difficulties inherent to the environment, it does not countenance abject denial of treatment. *Id.* at 68.

53 *Id.* at 1.

54 *Id.* at 2.

55 While mental health screening and assessment is a required prerequisite for GD patients seeking hormone therapy and surgical intervention, formal psychotherapy, while recommended for its ability to help patients explore self-help options and work through their issues, is not required. *Id.* at 28–30.

56 *Id.* at 8–9.

57 *Id.* at 10.

other, coexisting mental health issues; cultural[58] and medical understanding of transgender health concerns; and continuing education on GD assessment and treatment protocols.[59] Additionally, the WPATH Standards highly recommend that neophytes to the field of transgender health closely consult with, or refer patients to, established, competent professionals with experience in the field.[60]

1. Individualized Assessment

As the individual health concerns different patients present, as well as the appropriate treatment options applicable to various cases, vary considerably, the WPATH Standards stress that patients must be evaluated on an individualized basis at every level of GD diagnosis and treatment. Healthcare providers must determine whether an individual's GD is the primary diagnosis or secondary to other mental health issues; incorporate treatment plans for various coexisting conditions that might complicate GD resolution, such as depression, anxiety, self-harm, and substance abuse; establish individual ability to give informed consent for treatment; and assess individual eligibility for, and medical necessity of, hormone therapy and surgery.[61]

Since access to hormone therapy and other treatment options was not a primary issue in the relevant cases, the following discussion of individualized assessment focuses on GCS. The WPATH Standards assert first and foremost that, regardless of the ethical questions involved with permanent surgical alteration of functional anatomical structures, GCS[62] is both an effective and, under the right, individual

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[58] Cultural competency encompasses not only an understanding of transgender people as a community in general, but also an understanding of the cultural background of individual patients. The WPATH Standards admit their findings and understanding of GD have their basis in Western cultural ethos, and that this may limit their exact applicability to patients with different cultural upbringings and conceptions of gender. *Id.* at 22, 32.

[59] *Id.* at 22.

[60] *Id.* at 23, 33.

[61] *Id.* at 23–27.

[62] As is the case with most things connected to gender identity issues, the terms applied to surgical options for GD treatment have cultivated controversy and disagreement in their own right. Relying on the previously explained DSM-5 definitions of "sex" and "gender," however, may serve to at least partially simplify the differences between the terms, complicated as they are by questions of temporal and regional differences in sociocultural understanding of GD. *See* DSM-5, *supra* note 34, at 451. The term used by the Ninth Circuit, as well as this Note, "gender confirmation surgery," applies to a wide variety of surgical procedures aimed at feminizing (or masculinizing) patients not necessarily involving genital reconstruction. *See generally* Edmo v. Corizon, Inc., 935 F.3d 757 (9th Cir. 2019). These include facial feminization surgeries, such as

circumstances, medically necessary treatment option.[63] Formalization of individualized assessment for surgical eligibility under the WPATH Standards has its basis in two sets of preoperative requirements. First, candidates must submit two referral letters from qualified mental health professionals indicating their independent patient assessments and their recommendations for the necessity of GCS as treatment for their GD.[64] Second, the patient must satisfy the following criteria proving their individual eligibility:

> 1. Persistent, well-documented gender dysphoria;
>
> 2. Capacity to make a fully informed decision and to consent for treatment;
>
> 3. Age of majority in a given country;
>
> 4. If significant medical or mental health concerns are present, they must be well controlled;
>
> 5. 12 continuous months of hormone therapy as appropriate to the patient's gender goals . . . .
>
> 6. 12 continuous months of living in a gender role that is congruent with their gender identity.[65]

Again, while not all gender dysphoric individuals want or need surgical intervention, the WPATH Standards firmly assert that, given the requisite severity and symptoms of individual cases of GD, the desires of individual patients, and the recommendations of qualified healthcare providers working under the WPATH Standards' informed, consensus-based criteria, GCS is, in fact, a medically necessary component of an effective treatment plan.[66]

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rhinoplasty, hair transplants, and lip feminization; breast augmentation; as well as genital surgeries like orchiectomy and vaginoplasty. Jens U. Berli et al., *What Surgeons Need to Know About Gender Confirmation Surgery When Providing Care for Transgender Individuals: A Review*, 152 JAMA SURGERY 394, 398 (2017). Alternately, as used by the Fifth Circuit and the WPATH Standards, "sex reassignment surgery" may, considering the DSM-5 definitions, arguably refer specifically to procedures changing the legal "sex" of the patient by altering their genitals. *See generally* Gibson v. Collier, 920 F.3d 212 (5th Cir. 2019). *See also* WPATH Standards, *supra* note 52, at 54. Furthermore, others prefer the term "gender affirming surgery," and denounce the use of the previous terms as inaccurate and outdated, respectively. *Glossary of Terms Related to Transgender Communities*, STAN. UNIV. VADEN HEALTH CTR., https://vaden.stanford.edu/health-resources/lgbtqia-health/transgender-health/glossary-terms-related-transgender-communities [https://perma.cc/G8TS-235L]. While many seem to use these and a multiplicity of other terms interchangeably, the lack of universally agreed-upon terminology likely contributes to continuing widespread confusion and controversy.

63 WPATH Standards, *supra* note 52, at 54–55.

64 *Id.* at 27–28.

65 *Id.* at 60.

66 *See generally id.* at 54–64.

C. *Medical Consensus*

The push for a formalized process of consensus development in the medical field began in the 1950s with the need to synthesize expert opinions on clinical practices.[67] By 1990, the American Institute of Medicine (AIM) had finalized such desired standards into a set of formalized methods for the formation of consensus-based clinical practice guidelines (CPG), resulting in a substantial increase in the proliferation of both formal and informal CPGs.[68] Furthermore, consensus-based medical opinion has become one of the primary tools used by both patients and doctors in their assessment of the appropriateness of a given clinical decision for a course of treatment, and, as has been demonstrated on countless occasions, a useful standard

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[67] Bory Kea & Benjamin Chih-An Sun, *Consensus Development for Healthcare Professionals*, 10 INTERNAL & EMERGENCY MED. 373, 373 (2015).

[68] *Id.* at 374.

by which judges[69] analyze medical questions in the context of litigation.[70]

The guidelines established by the AIM involve five components that can be applied in a variety of consensus building methods. The initial tasks are to define the goal, recruit appropriately qualified participants, and review and synthesize the current literature available on the subject.[71] Next, participants must establish the particular method, by implicit or explicit approaches, by which they will aggregate their judgements and form a consensus.[72] The more informal implicit approach involves a more subjective judgement by participants, as conclusions are organized into a consensus qualitatively or by majority-

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69 The district court's acceptance of Edmo's expert witness testimony over that of the State's naturally raises questions of the ability of non-expert judges to appropriately and adequately weigh conflicting professional opinions on medical consensus and necessity. Mark A. Hall & Gerard F. Anderson, *Health Insurers' Assessment of Medical Necessity*, 140 U. PA. L. REV. 1637, 1681 n.167 (1992); *see also* Sandeep K. Narang & Stephan R. Paul, *Expert Witness Participation in Civil and Criminal Proceedings*, 139 PEDIATRICS e1, e3 (2017), https://pediatrics.aappublications.org/content/pediatrics/139/3/e20164122.full.pdf [https://perma.cc/JP26-PFLJ] ("Critics have voiced concern over judicial discretionary power in admitting experts, because some judges lack the requisite scientific or medical background to interpret potentially complex medical issues.") (citing Bert Black, *The Supreme Court's View of Science: Has Daubert Exorcised the Certainty Demon?*, 15 CARDOZO L. REV. 2129 (1994)). As the court demonstrated, such decisions made in the presence of contradictory testimony may rest on determinations about the relative credibility of witnesses. *See* Edmo v. Corizon, Inc., 935 F.3d 757, 780 (9th Cir. 2019); *see also* FED. R. EVID. 702 advisory committee's notes to 2000 amendment (discussing reliability assessment of expert testimony). The current circuit split between the Fifth and Ninth Circuits, fundamentally based on the prescribed credibility of largely similar and equally conflicting sets of expert testimonies, however, raises further questions about the ability of the judicial system to render truly objective justice when judges can look at essentially the same information and issue conflicting holdings. *Compare Edmo*, 935 F.3d at 780 ("medically necessary"), *with* Gibson v. Collier, 920 F.3d 212, 223 (5th Cir. 2019) ("no medical consensus that sex reassignment surgery is a necessary or even effective treatment for gender dysphoria"). In light of the perceived or actual differences in regional normative decision-making across the United States and between the various circuits, proponents of either side of the GCS debate will likely view these conflicting opinions as symptomatic of regional sociopolitical biases, which might possibly contribute to decreased confidence in the ability of these courts to function objectively. However, triers of fact, whether juries or judges, are empowered with this great responsibility, and require discretion to make determinations based on their perceptions of the relative value of evidence presented. Narang & Paul, *supra*, at e3.

70 Kea & Sun, *supra* note 67, at 374; *see, e.g.*, *Edmo*, 935 F.3d at 795 ("[M]edical consensus is that GCS is effective and medically necessary in appropriate circumstances."); Campbell v. Kallas, 936 F.3d 536, 539 (7th Cir. 2019) ("[WPATH] justifies this requirement by citing an 'expert clinical consensus'"); *Gibson*, 920 F.3d at 223 ("no medical consensus that sex reassignment surgery is a necessary or even effective treatment for gender dysphoria"); Kosilek v. Spencer, 774 F.3d 63, 106 (1st Cir. 2014) (Thompson, J., dissenting) ("[T]he consensus was that the only way to adequately treat that problem was with sex reassignment surgery.").

71 Kea & Sun, *supra* note 67, at 374.

72 *Id.*

wins voting.[73] In contrast, the explicit method involves a far more statistical-based analysis and is defined by its use of meta-analyses, statistical modeling, anonymized rounds of voting, explicit rules defining what constitutes a final "consensus" for the group, and, when appropriate, the weighting of individual judgements.[74] Once a consensus has been reached, a new CPG is published and disseminated; however, it is prudent to release drafts of the consensus document for peer review and public consultation in order to foster public support through consideration of alternative viewpoints, thereby decreasing the risk of groupthink bias and increasing the validity of the new CPG.[75]

D. *Eighth Amendment Standards: Cruel and Unusual Punishment*

Considering the painstaking process that defined the Constitutional Convention, which produced the United States Constitution and the Bill of Rights, it may come as a surprise that debate surrounding the Eighth Amendment was fairly brief,[76] and, despite illuminating objections, the amendment passed without alteration.[77] However, the insight offered by the two objecting representatives cut to the core of both future Eighth Amendment jurisprudence and the self-conflicting nature of the amendment itself: crucial humanitarian protections and problematic ambiguity. In the roughly 230 years since these debates, courts at every level have attempted to resolve such ambiguities to better serve the humanitarian goals inherent to the Constitution's prohibition on cruel and unusual punishments, resulting

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73 *Id.* at 377–78.

74 *Id.* at 378.

75 *Id.* at 378–79.

76 The short debate proceeded thusly:

> Mr. Smith, of South Carolina, objected to the words "nor cruel and unusual punishments;" the import of them being too indefinite.
>
> Mr. Livermore.—The clause seems to express a great deal of humanity, on which account I have no objection to it; but as it seems to have no meaning in it, I do not think it necessary. What is meant by the terms excessive bail? Who are to be the judges? What is understood by excessive fines? It lies with the court to determine. No cruel and unusual punishment is to be inflicted; it is sometimes necessary to hang a man, villains often deserve whipping, and perhaps having their ears cut off; but are we in future to be prevented from inflicting these punishments because they are cruel? If a more lenient mode of correcting vice and deterring others from the commission of it could be invented, it would be very prudent in the Legislature to adopt it; but until we have some security that this will be done, we ought not to be restrained from making necessary laws by any declaration of this kind.

1 ANNALS OF CONG. 782–83 (1789) (Joseph Gales ed., 1834).

77 *Id.* at 783.

in a deluge of judicial standards regulating the treatment of those allegedly breaching society's legal boundaries.[78]

1. Adequate Care, Serious Medical Need, and Deliberate Indifference

The adequacy of healthcare services provided by prison medical staff is a central aspect of prison healthcare standards under the Eighth Amendment, and the particular inadequacies and ineffectiveness of specific courses of treatment provided to prisoners have helped to inform courts in their analyses of the "deliberate indifference" standard.[79] In simple terms, the definition of "adequate care" within this context is not a particularly complicated one, and generally seems to follow a common-sense approach to prison medical services. According to a memorandum issued by the American Civil Liberties Union (ACLU), adequate prison healthcare systems are defined by, among other things, readily available access to care; competent and qualified medical staff, including necessary specialists, that take actions pursuant to legitimate medical judgement; intake procedures that screen for serious medical issues requiring prompt attention; access to internal or external facilities, staff, and procedures for emergency care; hygienic equipment and facilities; an accurate system of medical records; and access to prescription medications and medically necessary diets.[80] These standards represent an amalgamation of numerous court decisions[81] that have sought to clarify the meaning of the general Eighth Amendment guarantee of prisoners' rights to adequate medical care while incarcerated.[82]

Beyond establishing basic inadequacy of prison healthcare as identified above, modern Eighth Amendment conceptions require

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78 *See generally* JOHNNY H. KILLIAN ET AL., THE CONSTITUTION OF THE UNITED STATES OF AMERICA: ANALYSIS AND INTERPRETATION, S. DOC. NO. 108-17, at 1563–1603 (2d Sess. 2002) (history and application of the Eighth Amendment).

79 *See infra* note 81.

80 NATIONAL PRISON PROJECT, ACLU, KNOW YOUR RIGHTS: MEDICAL, DENTAL, AND MENTAL HEALTH CARE 5–7 (2012), https://www.aclu.org/other/know-your-rights-medical-dental-and-mental-health-care-0 [https://perma.cc/L75W-CDK9].

81 *See generally id.* at 5–7 nn.25–36 (citations to court cases establishing adequate care standards and definitions); Hayes v. Snyder, 546 F.3d 516, 524–26 (7th Cir. 2008) (failing to refer prisoner to necessary specialist); Norfleet v. Webster, 439 F.3d 392, 396 (7th Cir. 2006) (may infer deliberate indifference when treatment decisions are "so far afield of accepted professional standards as to raise the inference that it was not actually based on a medical judgment"); Newman v. Alabama, 503 F.2d 1320, 1331–33 (5th Cir. 1974) (unhygienic state of medical facilities).

82 *See supra* note 27.

prisoners asserting claims against their penal institutions to establish that prison officials, which includes healthcare providers, provided inadequate care "sufficiently harmful to evidence deliberate indifference to serious medical needs,"[83] as such treatment "constitutes the 'unnecessary and wanton infliction of pain' proscribed by the Eighth Amendment."[84] Successful application of this standard in court necessitates satisfying a two-part test incorporating both an objective arm, the existence of serious medical need, and a subjective one, demonstrating deliberate indifference by prison officials to that need.[85]

On the objective side, the Supreme Court has yet to identify the traits of medical needs that facilitate designation as "serious"; however, circuit courts confronted with this issue have thus far acted on their own, and, in some cases, have reached some consensus definitions. It can therefore be said that "[a] 'serious' medical need is one that has been diagnosed by a physician as mandating treatment or one that is so obvious that even a lay person would easily recognize the necessity for a doctor's attention."[86] Beyond this more rudimentary conception, circuit courts have also agreed that "[t]he existence of an injury that a reasonable doctor or patient would find important and worthy of comment or treatment; the presence of a medical condition that significantly affects an individual's daily activities; or the existence of chronic and substantial pain" all constitute serious medical needs.[87] Courts also consider the adverse effects of and potential for harm from delaying or denying treatment,[88] as well as whether "a condition of urgency" regarding the health of the prisoner exists.[89]

83 Estelle v. Gamble, 429 U.S. 97, 106 (1976).

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

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

86 Gutierrez v. Peters, 111 F.3d 1364, 1373 (7th Cir. 1997) (citation omitted); *see, e.g.*, Riddle v. Mondragon, 83 F.3d 1197, 1202 (10th Cir. 1996); Mahan v. Plymouth Cnty. House of Corr., 64 F.3d 14, 18 (1st Cir. 1995); Sheldon v. Pezley, 49 F.3d 1312, 1316 (8th Cir. 1995); Hill v. Dekalb Reg'l Youth Det. Ctr., 40 F.3d 1176, 1187 (11th Cir. 1994); Monmouth Cnty. Corr. Institutional Inmates v. Lanzaro, 834 F.2d 326, 347 (3d Cir. 1987).

87 Chance v. Armstrong, 143 F.3d 698, 702 (2d Cir. 1998) (quoting McGuckin v. Smith, 974 F.2d 1050, 1059–60 (9th Cir. 1992)); *see, e.g.*, Sarah v. Thompson, No. 03–2633, 2004 WL 2203585, at *1 (6th Cir. Sept. 15, 2004); Gutierrez v. Peters, 111 F.3d 1364, 1373 (7th Cir. 1997); Riddle v. Mondragon, 83 F.3d 1197, 1202 (10th Cir. 1996).

88 Smith v. Carpenter, 316 F.3d 178, 185–89 (2d Cir. 2003); *see also* Gutierrez v. Peters, 111 F.3d 1364, 1370 (7th Cir. 1997); Leavitt v. Corr. Med. Servs., Inc., 645 F.3d 484, 501–03 (1st Cir. 2011).

89 Charles v. Orange Cnty., 925 F.3d 73, 86 (2d Cir. 2019) ("such as one that may produce death, degeneration, or extreme pain"); *cf.* Brock v. Wright, 315 F.3d 158, 163–64 (2d Cir. 2003) ("We do not, therefore, require an inmate to demonstrate that he or she experiences pain that is at the limit of human ability to bear, nor do we require a showing that his or her condition will degenerate into a life-threatening one. . . . to establish [] seriousness . . . .").

In addition to these defined judicial standards for evaluating medical seriousness, there is also statutory authority that requires consideration. Commonly known as the Prison Litigation Reform Act (PLRA), 42 U.S.C. § 1997e states in relevant part that "[n]o Federal civil action may be brought by a prisoner . . . for mental or emotional injury suffered while in custody without a prior showing of physical injury."[90] Despite the PLRA's particularly definitive wording, which might be read to strictly limit the legal definition of "serious" to medical needs arising from injuries of a purely physical nature, courts have interpreted the statute to apply much less stringently than might be implied. Most notably, numerous circuit courts agree that the physical injury limitation does not bar suits for mental or emotional injury seeking injunctive or declaratory relief.[91] It is clear then that mental and emotional injuries, their actual or potential effects, and conditions falling within the judicial standards identified above may, under appropriate circumstances, constitute "serious medical needs" mandating treatment and satisfy the objective arm of the Eighth Amendment test.

Contrary to the objective arm of the test, the exact boundaries of which are drawn from circuit court decisions, the subjective arm is centered on Supreme Court jurisprudence.[92] It is clear from the words "deliberate indifference" that the standard is grounded in a personal, internal level of culpability similar to that employed in criminal law mens rea requirements. A prisoner must establish that prison officials actually *knew* about "a substantial risk of serious harm" but disregarded such a risk anyway "by failing to take reasonable measures to abate it."[93] Accordingly, in order to determine this culpability, "official[s] must both be aware of facts from which the inference could be drawn that a substantial risk of serious harm exists, and [they] must also draw the inference."[94]

In forming this standard, the Supreme Court first reasoned that inadvertent negligence, characteristic of normal medical malpractice claims, was insufficiently serious to implicate Eighth Amendment

90 42 U.S.C. § 1997e(e) (2013).

91 *See, e.g.*, Hutchins v. McDaniels, 512 F.3d 193, 197 (5th Cir. 2007) ("[T]he physical injury requirement does not bar declaratory or injunctive relief for violations of a prisoner's Constitutional rights."); Thompson v. Carter, 284 F.3d 411, 418 (2d Cir. 2002) ("[W]e agree with all the circuits to have addressed the issue . . . 1997e(e) does not prevent a prisoner from obtaining injunctive or declaratory relief."); Perkins v. Kan. Dep't of Corr., 165 F.3d 803, 808 (10th Cir. 1999); Davis v. D.C., 158 F.3d 1342, 1347 (D.C. Cir. 1998).

92 Farmer v. Brennan, 511 U.S. 825, 835–40 (1994).

93 *Id.* at 847.

94 *Id.* at 837.

protections.[95] Furthermore, the Court has made it clear that, beyond cases of officers using excessive force, acting or failing to act "for the very purpose of causing harm or with knowledge that harm will result"[96] is an inappropriately high standard to require in cases involving prison conditions.[97] Instead falling between these extremes, the Court has clarified that subjective recklessness, relying on the Model Penal Code definition, is the appropriate level of culpability sufficient to establish deliberate indifference.[98] While establishing subjective recklessness on the part of prison medical officials can be difficult, as in many instances courts will defer to their judgements,[99] there are several circumstances under which courts have found deliberate indifference. These include, but are not limited to, persisting in treatments known to be ineffective,[100] ignoring obvious medical needs,[101] making medical decisions contrary to professional judgement,[102] and delaying treatments absent legitimate justifications.[103]

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95 [I]n the medical context, an inadvertent failure to provide adequate medical care cannot be said to constitute "an unnecessary and wanton infliction of pain" or to be "repugnant to the conscience of mankind." Thus, a complaint that a physician has been negligent in diagnosing or treating a medical condition does not state a valid claim of medical mistreatment under the Eighth Amendment. Medical malpractice does not become a constitutional violation merely because the victim is a prisoner.

Estelle v. Gamble, 429 U.S. 97, 105–06 (1976).

96 *Farmer*, 511 U.S. at 835–36.

97 *Id.* (citing Wilson v. Seiter, 501 U.S. 294, 302–03 (1991)).

98 *Id.* at 836–37; *see* Model Penal Code § 2.02(2)(c) (requiring a *conscious* disregard of substantial and unjustifiable risk).

99 *See* Edmo v. Corizon, Inc., 935 F.3d 757, 786 (9th Cir. 2019) ("Typically, '[a] difference of opinion between a physician and the prisoner—or between medical professionals—concerning what medical care is appropriate does not amount to deliberate indifference.'") (internal citation omitted); Norton v. Dimazana, 122 F.3d 286, 292 (5th Cir. 1997); Vaughan v. Lacey, 49 F.3d 1344, 1346 (8th Cir. 1995).

100 Greeno v. Daley, 414 F.3d 645, 654–55 (7th Cir. 2005); Rouse v. Plantier, 182 F.3d 192, 197 (3d Cir. 1999).

101 Phillips v. Roane Cnty., 534 F.3d 531, 539–41 (6th Cir. 2008). *But see* Reeves v. Collins, 27 F.3d 174, 176–77 (5th Cir. 1994).

102 Estate of Cole by Pardue v. Fromm, 94 F.3d 254, 262 (7th Cir. 1996) ("[The] decision is such a substantial departure from accepted professional judgment, practice, or standards as to demonstrate that the person responsible did not base the decision on such a judgment.").

103 *See* Cordero v. Ahsan, 452 F. App'x 150, 153–54 (3d Cir. 2011); Tyler v. Smith, 458 F. App'x 597, 598 (9th Cir. 2011). Legitimate justifications for delaying prisoner treatment may include, for example, safety and security concerns, Kosilek v. Spencer, 774 F.3d 63, 83 (1st Cir. 2014), or the lack of qualified prison officials on duty to properly address "non-emergency medical needs," COLUM. HUM. RTS. L. REV., A JAILHOUSE LAWYER'S MANUAL 714 (11th ed. 2017).

II. ANALYSIS

A. *Related Decisions*

Both *Edmo* and *Gibson* are part of a larger set of inter-circuit cases dealing with the same basic question: what treatments are owed to transgender prison inmates? To begin with, while GCS continues to be a source of disagreement, hormone therapy does not seem to garner such controversy. Indeed, federal courts have been reviewing cases involving medical treatment for transgender prison inmates for decades, and have, since the 1980s, supported the constitutional right to medical treatment for GD like any other legitimate medical condition.[104] With advances in medical and social understanding of GD over time,[105] courts and prison systems now largely support provision of hormone therapy without much controversy.[106] Support for surgical intervention, however, has proven to be less definitive. Unlike *Edmo*, which delivered a clear affirmation of Edmo's right to surgery,[107] the lack of definitive statements of the constitutional right to GCS for prisoners is a common issue among cases preceding it.[108]

When Andrea Fields and a group of other gender dysphoric prisoners sued the Wisconsin Department of Corrections (WDOC) seeking a permanent injunction against enforcement of Wisconsin's Inmate Sex Change Prevention Act, which prohibited the use of state resources for providing or facilitating hormone therapy or GCS, the Seventh Circuit agreed that the law was facially invalid under the Eighth

104 *See* White v. Farrier, 849 F.2d 322, 325 (8th Cir. 1988) ("[T]ranssexualism is a serious medical need."); Meriwether v. Faulkner, 821 F.2d 408, 411–14 (7th Cir. 1987). *But see* Supre v. Ricketts, 792 F.2d 958, 963 (10th Cir. 1986) (holding that transgender inmate was entitled to GD treatment, but not necessarily with female hormones).

105 *See* WPATH Standards, *supra* note 52, at 33–40 (discussion of hormone therapy).

106 *See* Kothmann v. Rosario, 558 F. App'x 907, 911 (11th Cir. 2014) (denying hormone treatment for gender dysphoric prisoner, "the recognized, accepted, and medically necessary treatment" under the circumstances, held unconstitutional under the Eighth Amendment); *see also* Edmo v. Corizon, Inc., 935 F.3d 757, 772 (9th Cir. 2019); Gibson v. Collier, 920 F.3d 212, 224 (5th Cir. 2019); Fields v. Smith, 653 F.3d 550 (7th Cir. 2011); Battista v. Clarke, 645 F.3d 449 (1st Cir. 2011).

107 *Edmo*, 935 F.3d at 803.

108 History certainly shows that constitutional jurisprudence is often slow to develop, and, in light of traditional judicial restraint and justiciability requirements, individual cases and controversies are generally decided on the merits of the particular facts inherent to the particular situation. Rather than issuing sweeping declarations of law that might more easily settle the wider context of legal issues and preemptively define the rights of potential future litigants, judicial opinions, like that of *Edmo*, limit their effect to legal questions present for adjudication. Kermit Roosevelt, *Judicial Restraint*, ENCYC. BRITANNICA, https://www.britannica.com/topic/judicial-restraint (last visited Aug. 28, 2021).

Amendment.[109] Although the plaintiffs did not seek surgery,[110] the court reasoned that complete removal of even the possible consideration of GCS justified invalidating the entire law as necessary to preventing ongoing and future constitutional violations.[111] While the plaintiffs were granted relief and the law was invalidated, thereby allowing them access to medically necessary hormone therapy, the court failed to issue the kind of hardline, conclusive holding seen in *Edmo*, instead limiting its opinion to the invalidation.[112] The court determined that lack of consideration for *possible* provision of GCS constituted deliberate indifference, but stopped short of ordering the prison to actually provide treatment.[113]

About a year and a half later, the Fourth Circuit reviewed the dismissal of Ophelia De'lonta's (born Michael Stokes) case against the Virginia Department of Corrections for continued denial of consideration for GCS.[114] Even though the prisoner suffered from severe GD and was undergoing hormone therapy and other common GD treatments, prison medical personnel refused to evaluate her for GCS despite repeated attempts at self-castration.[115] When her suit was dismissed for failure to state a claim, the Fourth Circuit argued that although the prison had provided some treatment, the Constitution required them to provide treatment that actually addressed the prisoner's serious medical needs adequately.[116] The court asserted that

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109 *Fields*, 653 F.3d at 559.

110 This holding seems strange considering the requirement of another PLRA provision, 18 U.S.C. § 3626, that prisoner relief be narrowly tailored to correcting violations of the plaintiff's rights by the least intrusive means, the so-called "need-narrowness-intrusiveness" standard. *See* Blake P. Sercye, Comment, *"Need-Narrowness-Intrusiveness" Under the Prison Litigation Reform Act of 1995*, 2010 U. CHI. LEGAL F. 471, 472 (2010). Here, however, the court asserted that any applications of the invalidated law would be unconstitutional deliberate indifference to the serious medical needs inherent to GD. *Fields*, 653 F.3d at 554–59.

111 *Fields*, 653 F.3d at 559.

112 *Compare id.*, *with Edmo*, 935 F.3d at 803.

113 *Fields*, 653 F.3d at 559.

114 De'lonta v. Johnson, 708 F.3d 520 (4th Cir. 2013).

115 *Id.* at 522–23.

116 The Fourth Circuit argued:

> By analogy, imagine that prison officials prescribe a painkiller to an inmate who has suffered a serious injury from a fall, but that the inmate's symptoms, despite the medication, persist to the point that he now, by all objective measure, requires evaluation for surgery. Would prison officials then be free to deny him consideration for surgery, immunized from constitutional suit by the fact they were giving him a painkiller? We think not. Accordingly, although Appellees and the district court are correct that a prisoner does not enjoy a constitutional right to the treatment of his or

persisting in clearly ineffective treatments and refusing to consider alternatives in the face of an ongoing risk of self-mutilation stated a sufficiently plausible claim for deliberate indifference to her serious medical need appropriate for adjudication.[117] However, they declined to judge the merits of the claim or suggest remedies, again falling short of *Edmo*.[118]

In the context of the current circuit split, perhaps the most important case in this chronology came to the First Circuit in 2014. Michelle Kosilek, a prisoner at the Massachusetts Department of Correction (MDOC), suffered from a legitimate case of GD, albeit less severe than others, and was undergoing a standard treatment plan when she sued for failure to provide GCS.[119] Following a series of intensive and conflicting reports issued by the various doctors and organizations the prison employed to evaluate Kosilek's case, MDOC determined that, while GCS would likely relieve her dysphoria, and denying it could result in deterioration of her mental state, Kosilek's improving prognosis under her treatment plan showed GCS was not medically necessary under the circumstances.[120] More specifically, denial of GCS was not sufficiently harmful to Kosilek to implicate the Eighth Amendment.[121] Additionally, unlike the cases in the current split, the MDOC raised safety and security concerns related to Kosilek's post-surgery housing that contributed to the court's decision.[122] Considering the elevated risk for sexual assault against Kosilek due to the high percentage of sex-offenders in all-male Massachusetts prisons, the

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> her choice, the treatment a prison facility does provide must nevertheless be adequate to address the prisoner's serious medical need.

Id. at 523–26.

117 *Id.* at 526–27.

118 *Id.* at 526.

119 Kosilek v. Spencer, 774 F.3d 63 (1st Cir. 2014). Despite previous attempts at self-harm, Kosilek had not tried again for the twenty years previous to this case, and, according to testimony offered at trial, her treatment plan had produced highly positive results on the severity of her symptoms negating the absolute medical necessity of GCS. *Compare id.* at 69–79, *with* Edmo v. Corizon, Inc., 935 F.3d 757, 773–74 (9th Cir. 2019) (multiple attempts at self-castration throughout her course of pre-operative GD treatment).

120 *Kosilek*, 774 F.3d at 69–79. Furthermore, it was asserted at trial that any risk of reemergence of Kosilek's suicidal ideation could be sufficiently handled by MDOC medical staff. *Id.* at 77.

121 *Id.* at 89–91.

122 *Id.* at 92–96. "As long as prison administrators make judgments balancing security and health concerns that are 'within the realm of reason and made in good faith,' their decisions do not amount to a violation of the Eighth Amendment." *Id.* at 92 (citing Battista v. Clarke, 645 F.3d 449, 454 (1st Cir. 2011)). Additionally, "[t]he subjective prong [of the Eighth Amendment] also recognizes that, in issues of security, '[p]rison administrators . . . should be accorded wide-ranging deference in the adoption and execution of policies and practices that in their judgment are needed to preserve internal order and discipline and to maintain institutional security.'" *Id.* at 92 (citing Bell v. Wolfish, 441 U.S. 520, 547 (1979)).

likelihood of causing severe mental distress for the significant portion of prisoners with histories of sexual abuse by male partners in all-female prisons—given Kosilek's history as a man—and the deleterious effect segregated, isolated housing would likely have on Kosilek's mental state, the security report concluded that, as long as surgery was not determined to be absolutely medically necessary for Kosilek, GCS was inappropriate.[123]

In another decision issued by the Ninth Circuit, which they later referenced in *Edmo*,[124] the court reversed a dismissal of a transgender inmate's complaint alleging that she was denied medically necessary GCS due to California's blanket policy against providing inmates with the procedure.[125] Like Edmo, Mia Rosati suffered from severe GD, and, despite ongoing treatment, had attempted self-castration several times, a clear indication, as already seen, that her treatment plan was ineffective.[126] Just as other reviews of these kinds of cases did before, the court refused to judge the case on its merits, and, instead, limited its holding to asserting that Rosati had stated a sufficiently plausible claim for deliberate indifference to her serious medical need appropriate for adjudication.[127]

In the last case included in this chronology, the Seventh Circuit interestingly almost seems to have prompted the holding in *Edmo*. Notwithstanding the resounding invalidation of the Inmate Sex Change Prevention Act just a few years prior, the court, in reviewing a denial of GCS for a gender dysphoric prisoner, ruled in favor of the prison.[128] Campbell, also an inmate at the WDOC, had been diagnosed with GD and was undergoing hormone therapy.[129] In following their expert's interpretation of the WPATH Standards criteria for GCS eligibility, however, WDOC determined that the sixth criterion could likely not be met in a prison setting, and denied Campbell's request for surgery.[130] In the ensuing litigation, the Seventh Circuit presented a detailed discussion of Supreme Court and intra-circuit precedent weighing in on prison medical care, deliberate indifference, qualified immunity,

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123 *Id.* at 73–74.

124 *Edmo*, 935 F.3d at 785, 796.

125 Rosati v. Igbinoso, 791 F.3d 1037 (9th Cir. 2015).

126 *Id.* at 1038–40.

127 *Id.*

128 Campbell v. Kallas, 936 F.3d 536, 549 (7th Cir. 2019). In explaining its decision, the court noted that "*Fields* [*v. Smith*] doesn't place 'beyond debate' the proposition that medical professionals violate the Eighth Amendment when they provide hormone therapy but decide—after extensive deliberation and consultation with an outside expert—to deny sex-reassignment surgery." *Id.* at 547.

129 *Id.* at 540–41.

130 *Id.* at 540–42; *see supra* note 65 and accompanying text.

and, most importantly, notice.[131] Essentially, the court reasoned that, in light of the fact that Campbell was already undergoing treatment, and that the decision to deny GCS was made as a result of consultation with an outside expert, the absence of any case law clearly establishing a right to GD treatment beyond hormone therapy meant that WDOC officials did not have notice that such a denial could constitute an unconstitutional deprivation of rights under the Eighth Amendment, and therefore had not acted with deliberate indifference to Campbell's serious medical needs.[132]

B. *Split Circuits:* Edmo *and* Gibson

In March of 2019, the Fifth Circuit issued a blanket opinion holding that "[a] state does not inflict cruel and unusual punishment by declining to provide sex reassignment surgery to a transgender inmate."[133] As demonstrated repeatedly in the previous Section, these cases generally seem to present a fairly consistent picture of what GD can look like within the penal system, and *Gibson* is no different. Although Vanessa Lynn Gibson began her life as Scott Lynn Gibson, she started living as a woman around fifteen years old.[134] Like Edmo, Gibson was already incarcerated by the time she was diagnosed with GD, and while Gibson's history of treatment and self-harm is less clear than the record seen in *Edmo*,[135] it is clear that she began hormone therapy and counseling following her diagnosis.[136]

As seen in numerous other cases of severe GD, these treatments helped, but did not fully ameliorate, Gibson's dysphoria, leading her to submit several requests for GCS, all of which were denied.[137] Regardless of Gibson's reasons for pursuing surgical intervention, Texas Department of Criminal Justice (TDCJ) policy required that

131 *Campbell*, 936 F.3d at 543–49.

132 *Id.* at 545–49 ("Because no case clearly establishes that denying treatment beyond hormone therapy is unconstitutional . . . . it's enough to note that a factfinder may infer deliberate indifference only where a prison medical professional makes 'a medical decision that has no support in the medical community' and provides 'a suspect rationale . . . for making it.'") (quoting Petties v. Carter, 836 F.3d 722, 729 n.2 (7th Cir. 2016)).

133 Gibson v. Collier, 920 F.3d 212, 215 (5th Cir. 2019).

134 *Id.* at 216–17.

135 *Compare* Edmo v. Corizon, Inc., 935 F.3d 757, 771–75 (9th Cir. 2019), *with Gibson*, 920 F.3d at 216–17, Gibson v. Livingston, No. W-15-CA-190, 2016 U.S. Dist. LEXIS 195724, at *2–15 (W.D. Tex. Aug. 31, 2016), *and* Complaint at 21–23, Gibson v. Livingston, No. W-15-CA-190 (W.D. Tex. Aug. 31, 2016) [hereinafter Complaint].

136 *Gibson*, 920 F.3d at 216–17.

137 *Id.*

appropriate professionals evaluate transgender inmates to determine individualized treatment plans according to accepted standards of care.[138] While it is unclear whether this policy actually prohibited GCS, TDCJ medical personnel pointed to the lack of its designation as part of GD treatment protocol under the policy to justify their denials.[139] The ensuing litigation challenged the constitutionality of the policy, as Gibson claimed that it essentially institutionalized a system of deliberate indifference to her serious medical need by preventing even consideration of whether GCS was medically necessary for her under the circumstances.[140]

As the Fifth Circuit later recounted, there are several reasons beyond TDCJ policy considerations why denial of GCS was justifiable and constitutionally sound. Conveniently, the *Edmo* court took the time to discuss and rebut each of these justifications, thereby providing a useful rubric by which to gauge the sources and nature of what caused the circuit split.

1. Medical Consensus

The primary differentiating factor between the *Edmo* and *Gibson* courts that led to their divergent holdings was how the courts viewed the WPATH Standards and the credence they give to the efficacy and medical necessity of GCS.[141] Unlike *Edmo*, wherein the dispute existed within the bounds of a mutual acceptance of the consensus around the WPATH Standards,[142] *Gibson* provided almost no discussion of the standards themselves, and instead focused on the alleged lack of consensus in the medical community about the validity of the WPATH Standards' recommendations, thereby sidestepping individualized assessment requirements that even the TDCJ policy mandated.[143] Analyzing the WPATH Standards within the context of consensus-

138 *Id.* at 217–18.

139 *Id.*

140 *Id.* at 218.

141 *Compare id.* at 223 ("There is no medical consensus that [GCS] is a necessary or even effective treatment for gender dysphoria. . . . WPATH Standards of Care do not reflect medical consensus . . . ."), *and id.* at 221 ("This on-going medical debate dooms Gibson's claim."), *with* Edmo v. Corizon, Inc., 935 F.3d 757, 796 (9th Cir. 2019) ("The consensus is that GCS is effective and medically necessary in appropriate circumstances.").

142 *Edmo*, 935 F.3d at 769 ("Each expert in this case relied on the WPATH Standards of Care in rendering an opinion.").

143 *See generally Gibson*, 920 F.3d 212. *See supra* note 138 and accompanying text.

formation as outlined in Part I,[144] however, seems to show that *Gibson* misunderstood the term.

Since the WPATH Standards' initial publication in the late 1970s, they have undergone several iterations, reflecting numerous revisions to their recommendations over time.[145] The substantial departures from previous versions emphasize the importance of the current, seventh version, as they represent cultural changes, advances in medical knowledge, and increased appreciation of the numerous healthcare issues present in the transgender community beyond hormone therapy and GCS.[146] Alterations were effected through a rigorous consensus development process that followed AIM guidelines closely. The established goal of the revision committee was to identify areas of the previous version that needed further research and development, review current medical literature, and recommend possible changes in conformity with new evidence.[147] The participants recruited to contribute to this consensus conference represented an impressive group of highly qualified individuals drawn from largely American and European circles, including Dr. Walter Bockting, a clinical psychologist and co-director of the Initiative for LGBT Health at the New York State Psychiatric Institute;[148] Dr. Heino Meyer-Bahlburg, professor of clinical psychology specializing in GD and intersexuality;[149] Mick van Trotsenburg, OBGYN and transgender health researcher at the University Hospital St. Pölten-Lilienfeld in Austria;[150] and numerous other healthcare professionals and researchers.[151] The extensive group of expert participants was then directed to review the current version of the WPATH Standards, as well as new research on appropriate topics, and submit recommendation papers for publication, debate, and peer review in the International Journal of Transgenderism.[152]

Experts involved in this stage of the process focused on numerous domestic and international clinical studies utilizing statistical analyses

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144 *See generally* Kea & Sun, *supra* note 67.

145 WPATH Standards, *supra* note 52, at 107.

146 *Id.* at 1 n.2.

147 *Id.* at 109.

148 *See generally* Profile of *Walter Bockting, PhD*, COLUM. UNIV. SCH. OF NURSING, http://www.nursing.columbia.edu/profile/wbockting [https://perma.cc/ZY26-XUFB].

149 *See generally* Profile of *Heino F. Meyer-Bahlburg, PhD*, COLUM. UNIV. DEP'T OF PSYCHIATRY, https://www.columbiapsychiatry.org/profile/heino-f-meyer-bahlburg-phd [https://perma.cc/C8MS-A3Y5].

150 *See generally* Profile of *Mick van Trotsenburg*, RESEARCHGATE, https://www.researchgate.net/profile/Mick_Van_Trotsenburg [https://perma.cc/5SUA-5ZFZ].

151 *See* WPATH Standards, *supra* note 52, at 111–12 (list of contributing researchers and authors).

152 *Id.* at 109–10.

to ascertain the degree to which GCS had produced positive results, including quality of life, changes in patient GD scores, the prevalence of post-surgical regret, suicide and mortality rates, and general satisfaction with treatment results.[153] While the WPATH Standards caution that many of these studies suffer from certain drawbacks, statistical analysis tends to show steady increases in patient satisfaction with GCS results over time as the WPATH Standards have improved.[154]

The aggregation process involved both implicit and explicit methods for synthesizing the participants' findings. Following the initial recommendation papers submitted by participants, the WPATH Board of Directors established a revision committee to review and debate their findings; a writing group charged with compiling and further reviewing the new findings into the new WPATH Standards; an international advisory group of transsexual, transgender, and gender non-conforming people to give their input; and hired a technical writer to re-review the recommendation papers and revision committee debates, create surveys to determine in which areas the experts stood in agreement and which needed further discussion, and to compile a draft of the new CPG for the writing group to work with.[155] These various groups worked together for over a year, compiling three separate drafts of the new WPATH Standards that were each circulated among the various groups for discussion, debate, and revision until a final draft was approved in late 2011 for publication in 2012.[156]

Although the WPATH Standards appear to have been formed according to established norms of medical consensus formation, such consensus means little if not respected and accepted by the medical community, as well as the public. Such was the case when the U.S. Preventative Services Task Force issued a new CPG asserting that annual mammograms for women under fifty years old were no longer

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153 *See generally id.* at 107–09 (discussing clinical outcomes of various gender dysphoria treatments).

154 *Id.* Although statistics tend to show that the effectiveness of GCS for treating GD has improved as the WPATH Standards have more effectively defined appropriate candidacy for the procedure, more studies are needed. This is eminently true for studies focusing on the outcomes of current assessment and treatment protocols, the long-term effects of hormone therapy without surgery, treatments not aimed at maximizing feminization and masculinization, and studies comparing the relative effectiveness of different treatments. *See generally id.* However, the differences in the severity and nature of individual cases means that not all gender dysphoric patients are appropriate for surgical alteration, which serves to further complicate this area of transgender health research. *See generally* DSM-5, *supra* note 34, 452–53 (diagnosis of gender dysphoria is established if the patient exhibits at least two of six symptoms, each of which is qualitative).

155 WPATH Standards, *supra* note 52, at 110.

156 *Id.*

necessary in the absence of particular risk factors.[157] Despite their reliance on current research literature, there was a large public backlash against the CPG, led by patient advocacy groups, professional societies, and women fearing it as a threat to their lives and insurance coverage, which led to revisions of the new standard.[158] The same kind of negative reaction has not been associated with the WPATH Standards. On the contrary, there is a large body of professional, public, and judicial acceptance of the WPATH Standards, as well as of its particular treatment recommendations.[159] Although universal acceptance of this socially controversial treatment has not yet been reached,[160] it is safe to

157 Kea & Sun, *supra* note 67, at 378–79.

158 *Id.* at 379.

159 *See, e.g.*, Edmo v. Corizon, Inc., 935 F.3d 757, 770 (9th Cir. 2019) ("The weight of opinion in the medical and mental health communities agrees that GCS is safe, effective, and medically necessary in appropriate circumstances."); Kosilek v. Spencer, 774 F.3d 63, 76–79 (1st Cir. 2014) (expert testimony established that surgery was not medically necessary under the circumstances, but did not rule it out as a "prudent course of treatment"); Fields v. Smith, 653 F.3d 550, 554 (7th Cir. 2011) ("In the most severe cases, sexual reassignment surgery may be appropriate."); Anne A. Lawrence, *Gender Identity Disorders in Adults: Diagnosis and Treatment*, *in* HANDBOOK OF SEXUAL AND GENDER IDENTITY DISORDERS 423, 442–49 (David L. Rowland & Luca Incrocci eds., 2008) (beginning her discussion of treatments for gender dysphoria by favorably citing to the WPATH Standards as "an important resource for professionals who treat clients with gender identity concerns," and concluding that expert medical consensus views GCS as having a high degree of success); Daphna Stroumsa, *The State of Transgender Health Care: Policy, Law, and Medical Frameworks*, 104 AM. J. PUB. HEALTH e31, e33 (2014) (noting professional societies that have endorsed the WPATH Standards, and asserting that surgery is "neither controversial nor experimental"); William Byne et al., *Gender Dysphoria in Adults: An Overview and Primer for Psychiatrists*, 3 TRANSGENDER HEALTH 57, 59 (2018) ("In the absence of other comprehensive English language guidelines, U.S. providers and their professional associations came to rely heavily on the [WPATH Standards]. . . . in evaluating the medical necessity of transition treatments . . . ."); William M. Kuzon, Jr. et al., *Exclusion of Medically Necessary Gender-Affirming Surgery for America's Armed Services Veterans*, 20 AMA J. ETHICS 403, 404–08 (2018) (arguing that the VA health benefits package should be amended to provide for all "medically necessary surgical services," including sex reassignment, due to "consensus of the scientific medical community [] that gender-affirming surgery is medically necessary for appropriate candidates," established, in part, by the WPATH Standards); Amy Ellis Nutt, *Transgender Surgeries Are on the Rise, Says First Study of its Kind*, WASH. POST (Feb. 28, 2018, 11:00 AM), https://www.washingtonpost.com/news/to-your-health/wp/2018/02/28/transgender-surgeries-are-on-the-rise-says-first-study-of-its-kind [https://perma.cc/YG36-5JEM] (asserting wide consensus on the medical necessity and efficacy of surgery "for both the physical and mental health of transgender people").

160 Gibson v. Collier, 920 F.3d 212, 221 (5th Cir. 2019) ("[T]here is no consensus in the medical community about the necessity and efficacy of sex reassignment surgery as a treatment for gender dysphoria."); *see also* Stroumsa, *supra* note 159, at e33 (arguing that potential reasons for the lack of universal acceptance of medical necessity include individual biases, lack of cultural understanding, and a lack of adequate education about transgender health issues within "medical, physician assistant, and nursing schools"). *But see* Johanna J. Go, *Should Gender Reassignment Surgery Be Publicly Funded?*, 15 J. BIOETHICAL INQUIRY 527, 533 (2018) (there is no "cogent rebuttal of the clinical consensus" in favor of the "clinical necessity" of surgery).

say consensus of the medical community actually engaged in the treatment of gender dysphoric patients is firmly established.

While consensus in favor of the WPATH Standards is strong, the *Gibson* court appears to have distorted the nature of consensus-formation by reframing the Eighth Amendment standard to require universal acceptance.[161] Although the court clarified that "universal" does not connote unanimity, they asserted that the substantial, good-faith conflict among experts precludes GCS from acceptance as a medically necessary procedure prisons would be constitutionally compelled to provide its inmates.[162] As *Edmo* and numerous other authorities have pointed out, however, an overwhelming body of qualified professionals support the WPATH Standards' clinical recommendations for the medical necessity of GCS as a treatment for GD, and that, in reality, despite large numbers of individual objectors, there are no competing standards nor organized groups of equally qualified experts supporting their objections with equally researched, organized, peer-reviewed, and accepted scientific proof.[163]

2. Individualized Assessment and the Eighth Amendment

As previously stated, the crucial factor differentiating *Edmo* and *Gibson* was the question of medical consensus around GCS and the WPATH Standards.[164] Once rejected, the case became much easier for the *Gibson* court, as standard Eighth Amendment arguments were nullified by the simple premise that GCS was about as effective and medically necessary as treating cancer with candy. This divergence explains why the court was able to reject Gibson's request to remand the case to trial for presentment of evidence of individual need for the procedure, as such a presentation would accomplish nothing.[165] The court reasoned that while Gibson satisfied the objective arm of the

161 *Gibson*, 920 F.3d at 220 ("[T]o state an Eighth Amendment claim, he must demonstrate 'universal acceptance by the medical community . . . .'").

162 *Id.*

163 *Edmo*, 935 F.3d at 769 ("As the State acknowledged to the district court, the WPATH Standards of Care 'provide the best guidance,' and 'are the best standards out there.' 'There are no other competing, evidence-based standards that are accepted by any nationally or internationally recognized medical professional groups.'"); *see also supra* note 159; Go, *supra* note 160.

164 *See supra* notes 141–43 and accompanying text.

165 *Gibson*, 920 F.3d 223–24.

Eighth Amendment test by demonstrating serious medical need,[166] she failed to established that the TDCJ was deliberately indifferent by refusing to provide her with an individualized assessment of her personal need for GCS, as the Constitution does not require provision of frivolous, ineffective medical procedures just because the prisoner requests them.[167]

Again, the Fifth Circuit seems to have misunderstood the appropriate terminology and standards at play. As discussed in Part I, the Eighth Amendment offers robust protections for prison inmates against cruel and unusual punishment, and, in this context, it does so by requiring the provision of adequate medical care.[168] The Ninth Circuit recognized that the IDOC's decision to persist with Edmo's treatment plan despite its ineffectiveness, which likely only prolonged and possibly even worsened her GD, was, constitutionally speaking, grossly inadequate under the circumstances.[169] The inadequacy in *Edmo*, however, was not that the prison had failed to assess Edmo's need based on her individual circumstances, but, rather, that the prison had unjustifiably departed from accepted standards for how one should conduct that assessment.[170]

On the other hand, the Fifth Circuit discounted individualized assessment altogether on the mistaken premise that GCS was not widely supported by the medical community.[171]

When taking the vast jurisprudence behind the Eighth Amendment into consideration, simple logic clarifies that individualized assessment of the particular medical needs of inmates is part of the constitutional standard. First, the question of serious medical need is necessarily based on an objective assessment of the particular inmate's circumstances.[172] It would be quite impossible to assess the severity of harm suffered by an inmate without close consideration of their individual health status. Second, deliberate indifference is a subjective standard in that it questions whether prison officials were actually aware of, and ignored, those particular circumstances.[173] Again,

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166 *Id.* at 219 ("Here, the State of Texas does not appear to contest that Gibson has a serious medical need, in light of his record of psychological distress, suicidal ideation, and threats of self-harm.").

167 *Id.* at 219–20.

168 Estelle v. Gamble, 429 U.S. 97, 102–06 (1976).

169 Edmo v. Corizon, Inc., 935 F.3d 757, 793 (9th Cir. 2019).

170 *Id.* at 792.

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

172 *See, e.g.*, Farmer v. Brennan, 511 U.S. 825, 834 (1994); Hudson v. McMillian, 503 U.S. 1, 8 (1992); Leavitt v. Corr. Med. Servs., Inc., 645 F.3d 484, 500 (1st Cir. 2011); Smith v. Carpenter, 316 F.3d 178, 185 (2d Cir. 2003).

173 *Farmer*, 511 U.S at 847.

actual awareness of the risk of harm is only possible if officials individually assess the inmate. Although the two arms of this test are independent questions,[174] they are both necessarily based on an understanding of the individual inmate. Furthermore, circuit courts have attacked other prison policies limiting consideration of treatment options, as such limitations do not allow for full individualized assessment.[175] The constitutional requirement is provision of *adequate* medical care, and despite a certain amount of treatment standardization in medicine, healthcare professionals widely agree that proper care requires consideration of the biological, psychological, and sociocultural differences between individuals to build effective treatment plans.[176] Simply put, effective treatment requires understanding. The TDCJ never understood Gibson's need for GCS because they never tried.[177]

Beyond these Eighth Amendment standards, *Gibson* also analyzed the language of the amendment itself. Notwithstanding concerns about the ambiguity inherent to "nor cruel and unusual punishments inflicted" expressed by some framers of the amendment,[178] the Fifth Circuit relied on a textualist-originalist argument to assert its point.[179] Unsurprisingly, the court relied heavily on the writings of former Supreme Court Justice Antonin Scalia,[180] a well-known advocate for originalism.[181] The court referenced a book Justice Scalia co-authored in which he asserted that the "and" in "cruel *and* unusual" reflected a single categorial distinction that necessarily limited application of the Eighth Amendment to punishments exhibiting both cruelty and unusualness.[182] With this argument established, the court contended that even if denying GCS was *cruel*, the fact that only one prisoner had

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174 *Hudson*, 503 U.S. at 8.

175 Colwell v. Bannister, 763 F.3d 1060, 1063 (9th Cir. 2014); Roe v. Elyea, 631 F.3d 843, 859–60 (7th Cir. 2011); Fields v. Smith, 653 F.3d 550, 559 (7th Cir. 2011); Monmouth Cnty. Corr. Institutional Inmates v. Lanzaro, 834 F.2d 326, 347 (3d Cir. 1987).

176 Lena Ansmann & Holger Pfaff, *Providers and Patients Caught Between Standardization and Individualization: Individualized Standardization as a Solution*, 7 INT'L J. HEALTH POL'Y & MGMT. 349, 349–50 (2018).

177 Gibson v. Collier, 920 F.3d 212, 232 (5th Cir. 2019) (Barksdale, J., dissenting).

178 *See supra* note 76.

179 *Gibson*, 920 F.3d at 226.

180 *Id.* at 226–27.

181 *See, e.g.*, Georgia v. Randolph, 547 U.S. 103, 142–45 (2006) (Scalia, J., dissenting); Lawrence Rosenthal, *An Empirical Inquiry into the Use of Originalism: Fourth Amendment Jurisprudence During the Career of Justice Scalia*, 70 HASTINGS L.J. 75, 77–92 (2018).

182 "The punishment must meet both standards to fall within the constitutional prohibition." *Gibson*, 920 F.3d at 226 (citing ANTONIN SCALIA & BRYAN A. GARNER, READING LAW: THE INTERPRETATION OF LEGAL TEXTS 116 (2012)).

ever been granted GCS in the United States meant that denial was not *unusual*, and therefore could not be said to be unconstitutional.[183]

As the *Edmo* court recognized, this too was a misstep by the Fifth Circuit.[184] Although it may have presented a valid analysis of the amendment's text, the argument was inappropriate considering the controlling deliberate indifference standard.[185] Furthermore, framing the denial of possibly necessary treatment as a legitimate punishment is unconvincing at best. Even a cursory review of the record shows that Gibson suffered a great deal as a result of her GD,[186] the kind of suffering prisons would unlikely be able to justify as penologically pertinent.[187] Even if they could justify it, it seems clear that allowing prisoners to suffer due to a lack of medical treatment as punishment is a prime example of cruelty, unusualness, and deliberate indifference. The issue was not that refusing to provide GCS was usual. Rather, the issue was that denying necessary medical treatment without legitimate justifications,[188] regardless of the treatment, was *un*usual.

3. Disagreement over *Kosilek*

Likely due to an extremely sparse record[189] and lack of in-circuit precedent, the *Gibson* court relied heavily on *Kosilek* in formulating its opinion.[190] Most importantly, the court concluded that *Kosilek* had determined that the WPATH Standards and GCS were not supported by medical consensus, and that their decision authorized blanket bans

183 *Id.* at 216, 226–28 ("[I]t cannot be cruel *and unusual* to deny treatment that no other prison has ever provided—to the contrary, it would only be unusual if a prison decided *not* to deny such treatment."); *see also id.* at 228 n.11.

184 *See* Edmo v. Corizon, Inc., 935 F.3d 757, 797 n.21 (9th Cir. 2019).

185 *Id.*; *see also* Estelle v. Gamble, 429 U.S. 97 (1976).

186 *See Gibson*, 920 F.3d at 217; Gibson v. Livingston, No. W-15-CA-190, 2016 U.S. Dist. LEXIS 195724, at *2–15 (W.D. Tex. Aug. 31, 2016), *aff'd sub nom* Gibson v. Collier, 920 F.3d 212 (5th Cir. 2019); Complaint, *supra* note 135; Amended Affidavit, Gibson v. Livingston, No. W-15-CA-190 (W.D. Tex. Aug. 31, 2016).

187 *See Estelle*, 429 U.S. at 103–05 ("[D]enial of medical care may result in pain and suffering which no one suggests would serve any penological purpose. . . . deliberate indifference to serious medical needs of prisoners constitutes the 'unnecessary and wanton infliction of pain' proscribed by the Eighth Amendment.") (citation omitted).

188 *See* Kosilek v. Spencer, 774 F.3d 63, 92–96 (1st Cir. 2014) (legitimate safety and security concerns).

189 Filing pro se, Gibson only submitted the WPATH Standards to support her case, and failed to use expert witness testimony that could have demonstrated wide acceptance of the WPATH Standards. *Gibson*, 920 F.3d at 220–21.

190 *See generally id.* (extensively referencing *Kosilek*'s facts, expert testimony, and holding).

against provision of GCS.[191] However, the *Edmo* court contested these conclusions, and devoted several pages of analysis as to why and how the Fifth Circuit's reading was incorrect.[192]

As this Note has already discussed the extensive nature of the consensus supporting the WPATH Standards and GCS,[193] restating that which has already been established is unnecessary. It is therefore sufficient to say that the Ninth Circuit presented an equally, if not more, compelling list of authorities supporting the same in general, allowing it to conclude that the Fifth Circuit's conclusion was unique, incorrect, and outdated.[194] As far as *Gibson*'s understanding of *Kosilek*'s conclusions specifically, the Fifth Circuit appears to have completely misstated the record.[195] Additionally, the Ninth Circuit pointed out that while *Gibson* might have had a reasonable basis to believe that one of the witnesses testifying in *Kosilek* suggested that GCS is never medically necessary, she has since reversed herself and completely supports the efficacy and necessity of GCS under the appropriate circumstances.[196]

In regards to *Gibson*'s consideration of *Kosilek*'s alleged authorization of blanket bans against GCS, the Fifth Circuit again completely misread the record. Notwithstanding the dissenting opinion in *Kosilek*, arguing that the majority opinion effectively opened the door to blanket bans,[197] as well as Gibson's imprudent acknowledgement of the *Kosilek* dissent's veracity,[198] the majority opinion strongly disclaimed any intention to authorize such a policy, as it would conflict with individualized assessment requirements under the Eighth Amendment.[199] Furthermore, the record clearly shows that despite *Kosilek*'s holding that denying GCS was admissible under the

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191 *Id.* at 216, 223–25.

192 Edmo v. Corizon, Inc., 935 F.3d 757, 794–97 (9th Cir. 2019).

193 *See supra* Section II.B.1.

194 *Edmo*, 935 F.3d at 795 (particularly note the paragraph beginning "[a]s the record here demonstrates").

195 *See id.* at 795–96. *Compare* Kosilek v. Spencer, 774 F.3d 63, 79 (1st Cir. 2014) ("prudent professionals would generally not deny surgery to a fully eligible individual"), *and id.* at 89–91 ("unique circumstances" here justify denying GCS), *with Gibson*, 920 F.3d at 222–23 (citing *Kosilek*, 774 F.3d at 74–79) ("[T]he unmistakable conclusion that emerges . . . There is no medical consensus that [GCS] is a necessary or even effective treatment for gender dysphoria.").

196 *Edmo*, 935 F.3d at 795–96 (discussing Dr. Cynthia Osborne).

197 *Kosilek*, 774 F.3d at 106–07 (Thompson, J., dissenting).

198 Besides the material deficiencies in the Fifth Circuit's analysis, the procedural issues are astounding. Gibson filed her complaint pro se without professional counsel that might have prevented her from acknowledging such a fatal piece of evidence. Once counsel was appointed, the record shows consistent failure to dispute important facts, as well as generally inept handling of the case. Additionally, even though counsel attempted to retract Gibson's acceptance of the *Kosilek* dissent, the court appears to have ignored the effort. *Gibson*, 920 F.3d at 218–25.

199 *Kosilek*, 774 F.3d at 91.

circumstances, the court arrived at that decision through a standard deliberate indifference analysis that considered Kosilek's individual circumstances, as well as the other unique circumstances of the case.[200] Although the Fifth Circuit relied almost exclusively on *Kosilek* in formulating its categorically inclusive holding,[201] they appear to have done so without ever having actually read the substance of the opinion.

III. PROPOSAL

Considering the complicated sociopolitical climate of the United States in 2020,[202] as well as the peculiar cultural and legal history of this country, it is perhaps not all that surprising that members of a relatively misunderstood and, undoubtedly in certain circles, socially unacceptable group like the transgender community continue to have to fight for basic acknowledgement of the particular issues inherent to their reality. For better or worse, skepticism and distrust seem to pervade reactions to questions with unfamiliar answers and misunderstood implications. However, it is important to remember that the United States is a nation of laws. Despite the growing pains that have caused innumerable deviations from the laudable ideals espoused in the Declaration of Independence and the Constitution since the nation's founding, inclusion, understanding, and tolerance have increased significantly over time thanks, in part, to the American legal system.

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200 *See id.* at 89–91; *accord Edmo*, 935 F.3d at 797.

201 "A state does not inflict cruel and unusual punishment by declining to provide sex reassignment surgery to a transgender inmate." *Gibson*, 920 F.3d at 215.

202 Consider nationwide protests and riots against systemic racism, a Supreme Court decision expanding federal protections against sexual orientation and gender identity discrimination in employment, an attempt to deport non-citizen international students, a worldwide pandemic, and an upcoming divisive election. *See, e.g.*, Bostock v. Clayton Cnty., 140 S. Ct. 1731 (2020); *Black Lives Matter: A Movement in Photos*, ABC NEWS (July 10, 2020, 4:18 PM), https://abcnews.go.com/US/photos/black-lives-matter-movement-photos-44402442/image-71721116 [https://perma.cc/56MD-ZJNY]; Colin Dwyer, *Protestors Fell Confederate Monument in D.C., Provoking Trump's Fury*, NPR (June 20, 2020, 10:29 AM), https://www.npr.org/sections/live-updates-protests-for-racial-justice/2020/06/20/881199628/protesters-fell-confederate-monument-in-d-c-provoking-trumps-fury [https://perma.cc/GVN7-JHPQ]; Priscilla Alvarez & Catherine E. Shoichet, *International Students May Need to Leave US if Their Universities Transition to Online-Only Learning*, CNN (July 7, 2020, 1:00 PM), https://www.cnn.com/2020/07/06/politics/international-college-students-ice-online-learning/index.html [https://perma.cc/8SV6-FX39]; Rachel Treisman, *Global Coronavirus Deaths Surpass 600,000, With U.S. Accounting for Nearly a Quarter*, NPR (July 19, 2020, 3:55 PM), https://www.npr.org/sections/coronavirus-live-updates/2020/07/19/892817304/global-coronavirus-deaths-surpass-600-000-with-u-s-accounting-for-nearly-a-quart [https://perma.cc/6GBT-ZCB8]; *Our Guide to the 2020 Election*, N.Y. TIMES, https://www.nytimes.com/news-event/2020-election [https://perma.cc/QV4H-9JVL].

Regardless of the amount of time social equality will take to reach uniformity throughout the country, the current state of medical science and Eighth Amendment definitions dictate that the Ninth Circuit's holdings in *Edmo* should be considered a final judgement on the merits of the questions this Note contemplates: should transgender prisoners suffering from GD be accorded individualized assessments to determine their need and eligibility for GCS, and, if determined to be medically necessary under the circumstances, should surgery be provided? Despite the definitively conflicting opinion of the Fifth Circuit, the answer is a resounding yes. Substantively, the Ninth Circuit's affirmation of the district court's grant of injunctive relief, an order to provide Edmo with GCS,[203] was firmly based on the widely accepted WPATH Standards for evaluating surgical candidacy, as well as the established legal standards dictating the proper treatment of prisoners that flow from the Eighth Amendment.[204] Indeed, given these constitutional standards, contemplating any scenario in which individualized assessment of any prisoner's medical condition should be bypassed is difficult.

Moreover, in reversing the individual improper applications of liability under the district court's grant of injunctive relief, thereby more properly narrowing its scope, the Ninth Circuit exercised responsible application of injunctive relief standards.[205] The Ninth Circuit appears to have done its job well in considering and applying these standards when formulating their opinion. As a result of this excellent work, the relevant opinions issued by other circuit courts,[206] and the exceedingly weak showing by the Fifth Circuit in *Gibson*, this Note humbly proposes that if the Supreme Court grants certiorari for an appropriate case, *Edmo* should be taken into consideration as highly relevant and persuasive precedential authority that can be used to settle the current circuit split in favor of enhanced, guaranteed civil rights for the

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203 *Edmo*, 935 F.3d at 803.

204 *See supra* Part II.

205 The Ninth Circuit held that while "[a]n official-capacity suit for injunctive relief is properly brought against any persons who 'would be responsible for implementing any injunctive relief,'" which included the director and deputy director of the IDOC, the prison's warden, and the IDOC itself, as well as those that "personally participated in the deprivation of Edmo's constitutional rights"—Edmo's prison psychiatrist—Edmo had failed to demonstrate the liability of the other defendants, and reversed the district court's injunctions against them. *See Edmo*, 935 F.3d at 799–800. In doing so, the court properly fulfilled the PLRA's need-narrowness-intrusiveness requirement by appropriately limiting the scope of injunctive relief to what is "certain to benefit members of the plaintiff class." *See* Sercye, *supra* note 110, at 489.

206 *See supra* Section II.A.

transgender prison population suffering from the severe psychological effects of gender dysphoria.[207]

There is, of course, the argument that the particular security concerns inherent to running a prison system can and, on occasion, should stand as an effective bar against facilitating a procedure that serves to complicate an already precariously ordered system.[208] One could also argue that the high cost of GCS is too high to justify the expenditure.[209] While these issues are anything but trivial, focusing on them tends to obscure the fact that the Eighth Amendment exists to ensure the rights of prisoners who, like anyone else, require medical care.[210] While Michelle Kosilek may have been denied GCS partially due to security concerns, the decision was also based on the concerted opinion that it was not medically necessary and, therefore, legitimately did not outweigh those concerns.[211] Claiming security concerns cannot always bring the conversation to a full stop. Likewise, while costs are important to consider, the Eighth Amendment standards are clear,[212] and perhaps the real issue lies in other deep-set problems and inefficiencies that cause prison healthcare costs to be as high as they are.[213] There are better ways to deal with high-cost procedures than just ignoring abject human suffering.

CONCLUSION

Given the defective analysis that resulted in the Fifth Circuit's holding in *Gibson*, it almost seems counterintuitive to modern

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207 The Supreme Court has already denied Gibson's petition for certiorari, so it is difficult to know when and if an appropriate case will actually reach the Supreme Court for final resolution. Gibson v. Collier, 920 F.3d 212 (5th Cir. 2019), *cert. denied*, 2019 WL 6689657 (U.S. Dec. 9, 2019) (No. 18-1586).

208 *See supra* notes 122–23 and accompanying text.

209 The estimated cost of GCS and related treatments could run as high as $50,000. *Sex Reassignment Surgery Cost*, COST HELPER HEALTH, https://health.costhelper.com/sex-reassignment-surgery.html#:~:text=For%20patients%20not%20covered%20by,facial%20features%20more%20masculine%20or [https://perma.cc/TUP2-2VV2]. For comparison, the average healthcare cost for American prisoners in 2015 was just under $6,000. Shivpriya Sridhar et al., *The Costs of Healthcare in Prison and Custody: Systematic Review of Current Estimates and Proposed Guidelines for Future Reporting*, 9 FRONTIERS IN PSYCHIATRY 1, 1, 5 (2018).

210 The Constitution even guarantees prisoners that right! Estelle v. Gamble, 429 U.S. 97 (1976).

211 *See supra* notes 119–23 and accompanying text.

212 *See supra* Section I.D.

213 Some reasons for the high cost of prison healthcare include an aging prison population that requires more care, substance abuse issues, and logistical costs of bringing healthcare to prisoners when it is not readily available. PEW CHARITABLE TR. STATE HEALTH CARE SPENDING PROJECT, MANAGING PRISON HEALTH CARE SPENDING 2–11 (2013).

conceptions of judicial professionalism that such an opinion should be given any weight in either federal or state courts. GD is a recognized mental health condition that, like many other psychological issues, presents a varying scale of severity that necessitates individualized medical assessments to determine the proper course of treatment. As it is both counterproductive and practically impossible to determine whether the Fifth Circuit's decision stemmed from malicious biases against transgender people, no effort at exploring that possibility will be made here.

The important thing to contemplate, however, is the question of what kind of prison system Americans want. Of course, the frequency of these cases would be significantly diminished if the United States had fewer prisoners, but, again, no effort at exploring options for prison and criminal law reform will be made here. Instead, the question is far simpler. Do Americans want their prison system to exercise fundamentally unreasonable, unfair, and unjust practices by ignoring the unnecessary and unjustifiable additional suffering of those designated for institutionalization? Or would a system that takes responsibility for the people it punishes by not allowing them to degenerate to the point of reliance on life-threatening self-harm be better? Only time will tell.