

NOTES

CIRCUIT COURT DYSPHORIA: THE STATUS OF GENDER CONFIRMATION SURGERY REQUESTS BY INCARCERATED TRANSGENDER INDIVIDUALS

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Incarcerated transgender individuals with gender dysphoria have increasingly turned to the courts to seek medical relief in the form of gender confirmation surgery (GCS). These claims generally allege that prison officials’ denials of GCS amount to deliberate indifference, which is forbidden under the cruel and unusual punishment provision of the Eighth Amendment. To date, the First, Fifth, and Ninth Circuits have been the primary federal appellate courts to address whether to grant requests for GCS under the Eighth Amendment. The Fifth Circuit’s legal reasoning enables prisons to institute categorical bans on GCS without considering an incarcerated individual’s factual circumstances and the evolution of medical knowledge on gender dysphoria. This Note suggests that instead, courts should adopt the legal approach of the First Circuit and Ninth Circuit, or the “Kosilek–Edmo framework,” to better vindicate the constitutional right to medical care of incarcerated transgender individuals and adhere to Eighth Amendment precedent. The framework urges courts to examine the subjective prong of deliberate indifference on a case-by-case basis of medical need, rely on experts familiar with the World Professional Association for Transgender Health Standards of Care, and apply increased scrutiny when considering the security concerns prison officials may have in granting GCS requests or other accommodation requests by incarcerated transgender individuals.

INTRODUCTION	2236
I. HISTORY OF GENDER DYSPHORIA IN THE CONTEXT OF PRISONS	2239
A. Medical Consensus on Gender Dysphoria and Prison Health Care.....	2239
1. Gender Dysphoria in the DSM-5 and the WPATH.....	2239

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2. Incarceration and Gender Dysphoria	2243
B. Development of Eighth Amendment Claims by Incarcerated Transgender Individuals	2248
1. Serious Medical Need	2249
2. Subjective Deliberate Indifference.....	2251
II. RECONCILING DELIBERATE INDIFFERENCE UNDER <i>KOSILEK–EDMO</i> AND <i>GIBSON</i>	2253
A. The First Circuit’s Approach to Deliberate Indifference	2254
B. The Fifth Circuit’s Approach to Deliberate Indifference	2257
C. Questioning the Circuit Split: The Ninth Circuit’s Approach to Deliberate Indifference	2263
III. TOWARD AN EQUITABLE APPLICATION OF DELIBERATE INDIFFERENCE.....	2267
A. Recommending the <i>Kosilek–Edmo</i> Framework.....	2268
B. Standardizing and Applying the <i>Kosilek–Edmo</i> Framework	2269
CONCLUSION	2272

INTRODUCTION

Vanessa Lynn is a pre-operational male-to-female transgender individual residing in a correctional facility in Texas.¹ Lynn, who has gender dysphoria, has lived openly as female for several decades.² Officials, however, have provided Lynn with only limited treatment, such as hormone therapy, to aid her suffering from gender dysphoria while in prison.³ A lack of fuller medical treatment, which would entail gender confirmation surgery (GCS) through modification of one’s primary and/or secondary sex characteristics,⁴ has caused Lynn to experience immense anguish. In an attempt to accommodate her own medical needs, Lynn has inflicted severe harm upon herself, including tying a tight string around her testicles,

1. This Note refers to Vanessa Lynn by her preferred name and pronouns, although the Fifth Circuit refers to her by her assigned name, Scott Gibson, and by male pronouns. See *Gibson v. Collier*, 920 F.3d 212, 216 (5th Cir. 2019), cert. denied, 140 S. Ct. 653 (2019) (mem.).

2. *Id.* at 217–18.

3. *Id.*

4. See *infra* section I.A.1. This Note refers to “sex reassignment surgery” by its newer classification and identification, “gender confirmation surgery (GCS).” See Loren S. Schechter, ‘Gender Confirmation Surgery’: What’s in a Name?, *Huffington Post* (Apr. 20, 2012), https://www.huffpost.com/entry/gender-confirmation-surgery_b_1442262 [<https://perma.cc/28PG-JJ8G>] (last updated Feb. 2, 2016) (explaining how “gender confirmation surgery” is the most accurate label for the plastic surgery that takes place); see also Gender Confirmation Surgeries, Am. Soc’y of Plastic Surgeons, <https://www.plasticsurgery.org/reconstructive-procedures/gender-confirmation-surgeries> [<https://perma.cc/3LMM-WWXQ>] (last visited Sept. 1, 2020) (describing the surgical options available for transgender patients).

repeatedly cutting herself, and attempting suicide three times while incarcerated.⁵ Lynn swears that without GCS, she will castrate herself or commit suicide.⁶ Despite her self-harm and continued mental pain, the Texas Department of Criminal Justice (TDCJ) has categorically refused to evaluate Lynn for GCS.⁷ Believing this denial violated her Eighth Amendment right to be free from cruel and unusual punishment, Lynn filed a pro se complaint in 2016 in the U.S. District Court for the Western District of Texas, alleging violations of her rights under 42 U.S.C. § 1983.⁸ She argued that TDCJ's system-wide ban on GCS constituted deliberate indifference to her gender dysphoria.⁹ The district court granted TDCJ's motion for summary judgment.¹⁰

Much scholarship has been written in the past about the difficulties of obtaining relief for incarcerated transgender individuals with gender dysphoria under the Eighth Amendment's cruel and unusual punishment framework.¹¹ In particular, scholars have focused great attention¹² on the first federal circuit court case to have decided this issue, *Kosilek v. Spencer (Kosilek IV)*.¹³ In *Kosilek IV*, the First Circuit ruled that the incarcerated individual's particular factual circumstances did not support a finding of deliberate indifference for a prison's failure to provide GCS.¹⁴ No other circuit court tested or contested this outcome for years.

5. Petition for Writ of Certiorari at 4, *Gibson*, 140 S. Ct. 653 (No. 18-1586), 2019 WL 2711440.

6. *Gibson*, 920 F.3d at 217.

7. *Id.* at 217–18.

8. *Gibson v. Livingston*, No. W-15-CA-190, 2016 U.S. Dist. LEXIS 195724, at *19–20 (W.D. Tex. Aug. 31, 2016).

9. *Id.* at *22–23.

10. *Id.* at *34.

11. See, e.g., Susan S. Bendlin, *Gender Dysphoria in the Jailhouse: A Constitutional Right to Hormone Therapy?*, 61 *Clev. St. L. Rev.* 957, 974 (2013) (describing how “bias against transgender individuals and misunderstandings about [g]ender [d]ysphoria may influence the outcome”); Lindsey V. Gilbert, *Comment, Crossing the Line: Examining Sex Reassignment Surgery for Transsexual Prisoners in the Wake of Kosilek v. Spencer*, 23 *S. Cal. Rev. L. & Soc. Just.* 29, 55–56 (2013) (explaining how some are opposed to GCS as a treatment option because they view it as medically controversial, costly, and unnecessary for individuals who are supposed to face punishment for committing crime); Lindsey Ruff, *Note, Trans-Cending the Medicalization of Gender: Improving Legal Protections for People Who Are Transgender and Incarcerated*, 28 *Cornell J.L. & Pub. Pol’y* 127, 144–45 (2018) (“For many plaintiffs, satisfying both parts of the ‘deliberate indifference’ inquiry proves to be an insurmountable hurdle.”).

12. See, e.g., Bethany L. Edmondson, *Note, Trans-lating the Eighth Amendment Standard: The First Circuit’s Denial of a Transgender Prisoner’s Constitutional Right to Medical Treatment*, 51 *Ga. L. Rev.* 585, 594–96 (2017).

13. This final decision, *Kosilek v. Spencer (Kosilek IV)*, 774 F.3d 63 (1st Cir. 2014), was composed of an en banc court that ultimately reversed the initial appellate decision. See *Kosilek v. Spencer (Kosilek III)*, 740 F.3d 733, 736 (1st Cir. 2014).

14. 774 F.3d at 96.

In March 2019, the Fifth Circuit ruled on a similar Eighth Amendment claim by an incarcerated transgender individual.¹⁵ In *Gibson v. Collier*, the Fifth Circuit agreed with the First Circuit in its holding, affirming the district court's decision that the denial of GCS to Lynn did not violate the Eighth Amendment's deliberate-indifference standard.¹⁶ Mere months after *Gibson*, the Ninth Circuit disagreed with the Fifth Circuit's ruling and the First Circuit's outcome, holding in *Edmo v. Corizon* that when officials deny medically necessary GCS to an incarcerated transgender individual, the responsible officials are indeed deliberately indifferent.¹⁷ In coming to their decisions, the First and Ninth Circuits relied on a fact-specific approach to determine the plaintiff's medical need for GCS, in contrast to the Fifth Circuit's categorical ban on GCS.¹⁸ The proper standard for determining what amounts to deliberate indifference by prison officials now remains in question for incarcerated transgender individuals seeking surgical relief for gender dysphoria.

This Note argues that despite the outcome-determinative split between the First and Fifth Circuits in opposition to that of the Ninth Circuit, the real circuit split exists between the First and Ninth Circuits' similar interpretations of deliberate indifference in *Kosilek IV* and *Edmo* and the Fifth Circuit's unprecedented interpretation of deliberate indifference in *Gibson*. Of these approaches, the Note ultimately proposes that courts should follow the *Kosilek-Edmo* framework, which aligns most soundly with how other courts have interpreted deliberate indifference in the past for incarcerated individuals (transgender and others alike) and best upholds their constitutional right to medical care under the Eighth Amendment.¹⁹ Part I of this Note provides medical background information on gender dysphoria and an overview of Eighth Amendment jurisprudence on claims by incarcerated transgender individuals. Part II considers the competing legal applications of deliberate indifference among the *Kosilek IV*, *Gibson*, and *Edmo* courts and describes how the *Kosilek-Edmo* framework lies in contrast to the *Gibson* court's approach. Part III recommends that courts adopt the *Kosilek-Edmo* framework and offers jurisprudential recommendations for how courts can standardize

15. *Gibson v. Collier*, 920 F.3d 212, 218 (5th Cir. 2019), cert. denied, 140 S. Ct. 653 (2019) (mem.).

16. *Id.* at 228.

17. 935 F.3d 757, 797 (9th Cir. 2019). "Medically necessary" under the Eighth Amendment generally means a medical need so obvious that an ordinary person would recognize that it warrants treatment by a doctor. See *Gaudreault v. Municipality of Salem*, 923 F.2d 203, 208 (1st Cir. 1990); *Laaman v. Helgemoe*, 437 F. Supp. 269, 311 (D.N.H. 1977); *infra* section I.B.1 (discussing how courts determine what treatment is medically necessary).

18. See *infra* section II.C.

19. See *infra* Part III.

their deliberate-indifference analyses on these types of claims in the future.

I. HISTORY OF GENDER DYSPHORIA IN THE CONTEXT OF PRISONS

Many of the incarcerated transgender individuals who file Eighth Amendment claims do so because they seek injunctive relief for gender-dysphoria treatment, whether that relief constitutes access to psychiatric treatment, hormone therapy, or GCS. This Part provides a medical and legal overview of how deliberate-indifference claims for GCS have developed. Section I.A first provides medical background on gender dysphoria, including how medical practitioners have defined gender dysphoria and the appropriate standards of diagnosis. Section I.B examines the two prongs an incarcerated individual must satisfy to succeed on an Eighth Amendment claim of deliberate indifference, setting out what these prongs look like in practice for transgender individuals.

A. *Medical Consensus on Gender Dysphoria and Prison Health Care*

This section explains what the appropriate medical standards are for how medical professionals currently diagnose gender dysphoria and contextualizes gender dysphoria in the context of prisons. Section I.A.1 provides an overview of how medical communities define gender dysphoria, as many courts use professional standards of care to aid in determinations of whether the treatment provided to an incarcerated individual is constitutionally adequate.²⁰ Section I.A.2 provides background on the realities of gender dysphoria for incarcerated individuals. Because determinations of deliberate indifference often involve significant factual findings on medical issues and the subjective knowledge of these issues by prison officials, an understanding of the medical and legal framework of Eighth Amendment claims by transgender individuals is crucial to analyzing the decisionmaking process of courts in this context.²¹

1. *Gender Dysphoria in the DSM-5 and the WPATH.* — According to the American Psychological Association (APA), transgender and gender-nonconforming people are individuals who possess a gender identity that does not fully align with their assigned sex at birth.²² Around 1.4 million adults

20. See, e.g., *Allard v. Baldwin*, 779 F.3d 768, 772 (8th Cir. 2015).

21. See, e.g., *Lopez v. Swaney*, 741 F. App'x 486, 487–88 (9th Cir. 2018) (discussing questions of fact to determine if the defendant knew of the plaintiff's serious medical needs and whether the defendant responded to those needs with deliberate indifference).

22. Am. Psych. Ass'n, *Guidelines for Psychological Practice with Transgender and Gender Nonconforming People*, 70 *Am. Psych.* 832, 832 (2015), <https://www.apa.org/practice/guidelines/transgender.pdf> [<https://perma.cc/3Q7N-7WS2>]. For background information on terminology surrounding trans issues, see generally *Fact Sheet: Transgender & Gender Nonconforming Youth in School*, Sylvia Rivera L. Project, <https://srp.org/resources/fact-sheet-transgender-gender-nonconforming-youth-school> [<https://perma.cc/DK8V-HG4N>] (last visited Sept. 1, 2020).

in the United States identify as transgender.²³ The number of individuals identifying as transgender may actually be much greater, as population estimates tend to underreport the number of transgender individuals.²⁴ Research on transgender issues has progressed greatly in recent years, spearheaded by organizations such as the APA. The APA originally diagnosed certain transgender individuals with a condition known as “gender identity disorder (GID).”²⁵ In the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), however, the APA has referred to the condition as “gender dysphoria.”²⁶ This terminology change came partly in recognition that it is *dysphoria* itself that is the problem—rather than one’s identity.²⁷ The DSM-5 identifies gender dysphoria in adolescents and adults as “a marked incongruence between one’s experienced/expressed gender and assigned gender, of at least 6 months’ duration,” which is manifested by at least two of the following criteria:

1. A marked incongruence between one’s experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics).
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 (or in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics).
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 (or some alternative gender different from one’s assigned gender).
5. A strong desire to be treated as the other gender (or some alternative gender different from one’s assigned gender).
6. A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one’s assigned gender).²⁸

These feelings must be accompanied by “clinically significant distress or impairment in social, occupational, or other important areas of functioning.”²⁹ Medical studies have increasingly documented how transgender individuals experience higher levels of self-harm, anxiety,

23. Andrew R. Flores, Jody L. Herman, Gary J. Gates & Taylor N. T. Brown, *The Williams Inst., How Many Adults Identify as Transgender in the United States?* 2 (2016), <https://williamsinstitute.law.ucla.edu/wp-content/uploads/Trans-Adults-US-Aug-2016.pdf> [<https://perma.cc/B4P5-5WHL>].

24. Am. Psych. Ass’n, *supra* note 22, at 832.

25. Am. Psychiatric Ass’n, *Diagnostic and Statistical Manual for Mental Disorders* 451 (5th ed. 2013).

26. *Id.*

27. *Id.*

28. *Id.* at 452.

29. *Id.*

depression, suicidal ideations, and other mental health concerns compared to others.³⁰ Appropriate treatment for gender dysphoria, including GCS, can help save lives.³¹ For transgender individuals with gender dysphoria, surgery has been found to reduce levels of suicidality from twenty to thirty percent to less than one to two percent after treatment.³² Subsequently, standards of care have emerged to address the health care needs of transgender and gender-nonconforming individuals with gender dysphoria.

The World Professional Association for Transgender Health (WPATH) is an international professional association with the mission of advancing transgender health.³³ Although WPATH does not explicitly

30. See Tracy A. Becerra-Culqui, Yuan Liu, Rebecca Nash, Lee Cromwell, W. Dana Flanders, Darios Getahun, Shawn V. Giammattei, Enid M. Hunkeler, Timothy L. Lash, Andrea Millman, Virginia P. Quinn, Brandi Robinson, Douglas Roblin, David E. Sandberg, Michael J. Silverberg, Vin Tangpricha & Michael Goodman, *Mental Health of Transgender and Gender Nonconforming Youth Compared with Their Peers*, *Pediatrics*, May 2018, at 1, 7–9 (finding that transgender and gender-nonconforming youth have a higher prevalence of anxiety, attention disorders, mental health diagnoses, suicidal ideation, and self-inflicted injuries compared to their cisgender counterparts); Larry Nuttbrock, Sel Hwahng, Walter Bockting, Andrew Rosenblum, Mona Mason, Monica Macri & Jeffrey Becker, *Psychiatric Impact of Gender-Related Abuse Across the Life Course of Male-to-Female Transgender Persons*, 47 *J. Sex Rsch.* 12, 12–23 (2010) (finding that lifetime major depression of male-to-females was almost three times higher, lifetime suicide ideation was more than three times higher, and lifetime suicide plans and attempts were seven to ten times higher than the corresponding estimates in the general population).

31. See Position Statement on Medical Necessity of Treatment, Sex Reassignment, and Insurance Coverage in the U.S.A., World Pro. Ass'n for Transgender Health (Dec. 21, 2016), <https://www.wpath.org/media/cms/Documents/Web%20Transfer/Policies/WPATH-Position-on-Medical-Necessity-12-21-2016.pdf> [<https://perma.cc/8Y9H-D26U>] [hereinafter WPATH 2016 Position Statement] (“In some cases, [GCS] is the only effective treatment for the condition, and for some people genital surgery is essential and life-saving.”); see also Chastity Blankenship & Lisa M. Carter, *The Incarceration of Gender: Assessing, Managing, and Treating the Needs of Transgender Inmates*, in *The Politics of Gender* 93, 102 (Adrienne M. Trier-Bieniek ed., 2018) (“Based on a doctor’s recommendation the importance of [GCS] is life altering for [incarcerated] transgender [individuals] and their families.”).

32. D. Morgan Bassichis, “It’s War in Here”: A Report on the Treatment of Transgender and Intersex People in New York State Men’s Prisons 28 (Dean Spade ed., 2007), <https://srp.org/files/warinhere.pdf> [<https://perma.cc/JF6D-2KRX>] (citing Interview with Nicholas R. Gorton, transgender health expert (July 14, 2005)); Tammi S. Etheridge, *Safety v. Surgery: Sex Reassignment Surgery and the Housing of Transgender Inmates*, 15 *Geo. J. Gender & L.* 585, 608 (2014) (quoting Bassichis, *supra*, at 28).

33. Eli Coleman, Walter Bockting, Marsha Botzer, Peggy Cohen-Kettenis, Griet DeCuyper, Jamie Feldman, Lin Fraser, Jamison Green, Gail Knudson, Walter J. Meyer, Stan Monstrey, Richard K. Adler, George R. Brown, Aaron H. Devor, Randall Ehrbar, Randi Ettner, Evan Eyler, Rob Garofalo, Dan H. Karasic, Arlene Istar Lev, Gal Mayer, Heino Meyer-Bahlburg, Blaine Paxton Hall, Friedmann Pfäfflin, Katherine Rachlin, Bean Robinson, Loren S. Schechter, Vin Tangpricha, Mick van Trotsenburg, Anne Vitale, Sam Winter, Stephen Whittle, Kevan R. Wylie & Ken Zucker, *Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People* 1 (7th ed. 2012), <https://>

define gender dysphoria in its own language, the organization recognizes the definitions promulgated in the DSM-5 as “descriptive criteria for gender dysphoria [that] were developed to aid in diagnosis and treatment to alleviate the clinically significant distress and impairment that is frequently, though not universally, associated with transsexual and transgender conditions.”³⁴ WPATH is responsible for publishing standards of care (“Standards of Care”) to guide health professionals in providing medical and psychological support to transgender individuals. The guidelines themselves are deliberately flexible in order to meet the various needs of transgender, transsexual, and gender-nonconforming people.³⁵ Numerous international and professional organizations rely upon these developed Standards of Care to treat individuals with gender dysphoria.³⁶ Among others, the APA and the American Medical Association recognize the Standards of Care as the authoritative best practices for treatment.³⁷ In addition, the National Commission on Correctional Health Care, a leading professional organization on the health care needs of individuals in prison, supports the WPATH Standards of Care as the accepted standards for gender-dysphoria treatment in correctional facilities.³⁸

WPATH articulates several options for treating individuals with gender dysphoria: (1) changes in gender expression and role (such as living in a gender role consistent with one’s gender identity); (2) hormone therapy; (3) surgery to change primary and/or secondary sex characteristics; and (4) psychotherapy.³⁹ Importantly, WPATH advocates for an individualized approach by medical professionals to determine which treatment option is best for an individual with gender dysphoria.⁴⁰ WPATH recognizes that for some individuals, sex reassignment surgery (SRS), contemporarily referred to as GCS, is medically necessary to alleviate gender dys-

www.wpath.org/media/cms/Documents/SOC%20v7/Standards%20of%20Care_V7%20Full%20Book_English.pdf [<https://perma.cc/W3C6-XU9V>].

34. WPATH 2016 Position Statement, *supra* note 31.

35. *Edmo v. Idaho Dep’t of Corr.*, 358 F. Supp. 3d 1103, 1111 (D. Idaho 2018).

36. *Id.* (“The World Professional Association of Transgender Health (‘WPATH’) Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People were first promulgated in 1979 and are the internationally recognized guidelines for the treatment of individuals with gender dysphoria.”).

37. *Diamond v. Owens*, 131 F. Supp. 3d 1346, 1354 n.3 (M.D. Ga. 2015). The American Medical Student Association, the American Psychological Association, the American Family Practice Association, the Endocrine Society, the National Association of Social Workers, the American Academy of Plastic Surgeons, the American College of Surgeons, Health Professionals Advancing LGBTQ Equality, the HIV Medicine Association, the Lesbian, Bisexual, Gay and Transgender Physician Assistant Caucus, and Mental Health America also all endorse the WPATH Standards of Care as representative of the consensus of the medical and mental health communities on gender-dysphoria treatment. *Edmo v. Corizon, Inc.*, 935 F.3d 757, 769 (9th Cir. 2019).

38. *Edmo*, 935 F.3d at 771.

39. *Coleman et al.*, *supra* note 33, at 9–10.

40. *Id.* at 58.

phoria by establishing greater congruence with one's identity through modification of one's primary and/or secondary sex characteristics.⁴¹ Before an individual receives genital reconstruction surgery, which is usually the last step in treatment, WPATH recommends that an individual meets the following criteria:

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 (unless hormones are not clinically indicated for the individual);
6. 12 continuous months of living in a gender role that is congruent with their gender identity.⁴²

Significantly, WPATH articulates that the Standards of Care apply to all individuals irrespective of imprisonment; this articulation is based on the principle that “[p]eople should not be discriminated against in their access to appropriate health care based on where they live, including institutional environments such as prisons.”⁴³ Indeed, WPATH now explicitly advocates that appropriate gender recognition of one's identity should extend to those who are incarcerated.⁴⁴ WPATH states that for the purposes of mental and physical health, people must be able to freely express their gender identity. Free expression requires opposing medical requirements that act as barriers to recognition of one's gender, such as the requirement that individuals receive puberty blockers or hormones before they are allowed to change their legal sex.⁴⁵ These statements become especially important when examining the medical needs and claims of transgender individuals in prisons.

2. *Incarceration and Gender Dysphoria.* — People who are incarcerated have a constitutional right to health care under the Eighth Amendment.⁴⁶

41. *Id.* at 54–58.

42. *Id.* at 60.

43. *Id.* at 67.

44. WPATH Identity Recognition Statement, World Pro. Ass'n for Transgender Health (Nov. 15, 2017), <https://www.wpath.org/media/cms/Documents/Web%20Transfer/Policies/WPATH%20Identity%20Recognition%20Statement%2011.15.17.pdf> [<https://perma.cc/8CXA-F9J4>].

45. *Id.*

46. See *Estelle v. Gamble*, 429 U.S. 97, 103–04 (1976) (noting that deliberate indifference to the serious medical needs of incarcerated individuals violates the Eighth Amendment); *infra* section I.B. Some individuals may wonder why people in prison should have access to adequate health care at all. Professor Sharon Dolovich previews this argument: “Offenders are sent to prison because they have committed a crime, perhaps a very serious one. And if while in prison they experience serious physical or psychological pain, it is not because the state is cruel but because the prisoners deserve it.” Sharon

Still, services do not usually come free of charge, despite the fact that around eighty percent of people in prison are poor.⁴⁷ In most states, people who are incarcerated must pay copayments for medical care.⁴⁸ The cost of a copayment is typically between three to five dollars, but in general, certain conditions, such as chronic conditions, are exempted from these costs and fees.⁴⁹ Incarcerated individuals, however, typically earn fourteen to sixty-three cents per hour, so having to pay even a few dollars can make care cost prohibitive.⁵⁰ Shrinking prison budgets, a prison population that is the world's highest, and the prevalence of for-profit health care contracts have contributed to an epidemic of poor health care in U.S. prisons.⁵¹ Many prisons do not provide basic treatment or mechanisms, apart from litigation, to implement mental health services.⁵² Issues like underscreening, poor tracking of individuals with mental health issues, lack of timely access to mental health staff, and other factors all adversely affect access to mental health treatment for incarcerated individuals.⁵³ Transgender individuals must operate within this neglected and deficient mental health system when they seek treatment for gender dysphoria. Although there is insufficient publicly available data to determine the exact number of transgender individuals in prison, transgender individuals are

Dolovich, *Cruelty, Prison Conditions, and the Eighth Amendment*, 84 *N.Y.U. L. Rev.* 881, 918 (2009). For an explanation of the problems with this objection, see *id.* at 918–21.

47. Michelle Andrews, *Even in Prison, Health Care Often Comes with a Copay*, NPR (Sept. 30, 2015), <https://www.npr.org/sections/health-shots/2015/09/30/444451967/even-in-prison-health-care-often-comes-with-a-copay> [<https://perma.cc/XP7V-BKEF>].

48. *Id.*

49. State and Federal Prison Co-Pay Policies and Sourcing Information, Prison Pol'y Initiative (Apr. 19, 2017), https://www.prisonpolicy.org/reports/copay_policies.html [<https://perma.cc/ALK4-ULMP>].

50. Wendy Sawyer, *The Steep Cost of Medical Co-Pays in Prison Puts Health at Risk*, Prison Pol'y Initiative (Apr. 19, 2017), <https://www.prisonpolicy.org/blog/2017/04/19/copays> [<https://perma.cc/7UMW-DPHN>].

51. Ashley Hurst, Brenda Castañeda & Erica Ramsdale, *Deliberate Indifference: Inadequate Health Care in U.S. Prisons*, 170 *Annals Internal Med.* 563, 563 (2019).

52. Hum. Rts. Watch, *Ill-Equipped: U.S. Prisons and Offenders with Mental Illness* 94 (2003), <https://www.hrw.org/reports/2003/usa1003/usa1003.pdf> [<https://perma.cc/DUQ9-QKWR>] (discussing how incarcerated individuals turn to the courts to enforce mental health care provisions within prisons because alongside the National Commission on Correctional Health Care, court decisions and settlement agreements have produced guidelines on necessary aspects of mental health care inside prisons).

53. See *id.* (explaining that no prison system provides procedures for screening the mentally ill, a range of mental health treatment services, a sufficient number of mental health professionals, adequate and confidential records, or protocols for identifying and treating suicidal people).

more likely than cisgendered⁵⁴ individuals to be incarcerated.⁵⁵ This reality stems, in part, from the harsh life experiences many transgender individuals face, such as diminished economic and educational opportunities as well as childhood abuse or homelessness.⁵⁶

The provision of medical treatment for incarcerated transgender individuals is unlikely to gain much public support given the argument that adequate health care does not exist for many incarcerated populations, the financial costs of treatment, and the discrimination and stigma transgender individuals face in particular.⁵⁷ Even outside of prison, many transgender individuals struggle to secure appropriate care: Although numerous insurers—including Medicare and numerous Medicaid programs—cover both surgical and nonsurgical care, thirty states allow health insurance plans to exclude care for transgender individuals from coverage.⁵⁸ In general, transgender patients are less likely to be insured than the general U.S. population and often find appropriate medical care to be lacking.⁵⁹ Both the high financial burden of treatment and discrimination from providers have resulted in transgender patients reporting that they

54. “Cisgender is a term describing individuals whose gender corresponds with the legal sex that they were assigned at birth.” Olga Tomchin, Comment, Bodies and Bureaucracy: Legal Sex Classification and Marriage-Based Immigration for Trans* People, 101 Calif. L. Rev. 813, 816 n.12 (2013).

55. Morgan S. Mason, Note, Breaking the Binary: How Shifts in Eighth Amendment Jurisprudence Can Help Ensure Safe Housing and Proper Medical Care for Inmates with Gender Dysphoria, 71 Vand. L. Rev. En Banc 157, 162 (2018).

56. *Id.*

57. Blankenship & Carter, *supra* note 31, at 102.

58. Keren Landman, Fresh Challenges to State Exclusions on Transgender Health Coverage, NPR (Mar. 12, 2019), <https://www.npr.org/sections/health-shots/2019/03/12/701510605/fresh-challenges-to-state-exclusions-on-transgender-health-coverage> [<https://perma.cc/QY66-7QBJ>]. Such exclusionary policies by states have resulted in litigation for injunctive relief to remedy irreparable harm, and transgender plaintiffs have been successful in recent years. See, e.g., *Flack v. Wis. Dep’t of Health Servs.*, 328 F. Supp. 3d 931, 954 (W.D. Wis. 2018) (granting injunctive relief to two Medicaid enrollees who were denied surgical procedures for gender dysphoria by the State of Wisconsin). Indeed, this litigation is likely to grow given the Supreme Court’s recent Title VII ruling, which recognizes that Title VII’s protections against discrimination on the basis of sex in the workplace include protections for homosexual or transgender individuals. See *Bostock v. Clayton County*, 140 S. Ct. 1731, 1737 (2020). As Justice Samuel Alito noted in dissent: “Healthcare benefits may emerge as an intense battleground under the Court’s holding. Transgender employees have brought suit under Title VII to challenge employer-provided health insurance plans that do not cover costly sex reassignment surgery. Similar claims have been brought under the Affordable Care Act (ACA)” *Id.* at 1781 (Alito, J., dissenting); see also *Walker v. Azar*, No. 20-CV-2834, 2020 WL 4749859, at *1–3 (E.D.N.Y. Aug. 17, 2020) (issuing a stay and preliminary injunction to prevent the Department of Health and Human Services from enacting rules that would exclude gender identity from the ACA’s prohibitions on discrimination in light of *Bostock*).

59. Megan Lane, Graham C. Ives, Emily C. Sluiter, Jennifer F. Waljee, Tsung-Hung Yao, Hsou Mei Hu & William M. Kuzon, Trends in Gender-Affirming Surgery in Insured Patients in the United States, 6 *Plastic Reconstruction Surgery Glob. Open* 1, 1 (2018).

have delayed seeking health care to meet their urgent needs and to secure preventative care.⁶⁰ In the 2015 U.S. Transgender Survey, fifty-five percent of patients who sought coverage for transition-related surgery reported that they had been denied within the past year.⁶¹

Moreover, “transgender and gender non-conforming communities have been disproportionately subject” to residing in ill-equipped correctional facilities and are thus in disproportionate need of medical services in prison—especially compared to other incarcerated populations.⁶² For example, many facilities continue to house transgender people strictly according to their assigned gender or genital anatomy at birth, which increases their susceptibility to abuse.⁶³ A 2009 National Prison Rape Elimination Commission Report following the 2003 passage of the Prison Rape Elimination Act⁶⁴ found that in particular, male-to-female transgender individuals are at special risk of horrific treatment, such as sexual abuse and rape, because most of these individuals are placed in men’s prisons that tend to reinforce and reward extreme masculinity and aggression.⁶⁵ In general, incarcerated transgender individuals are more likely to be sexually assaulted compared to the general prison population: According to federal data from 2011–2012, around forty percent of transgender individuals reported experiencing sexual victimization in state and federal prisons within the past year⁶⁶ compared to the national rate of around four percent in state and federal prisons.⁶⁷ Testimony before the National Prison Rape Elimination Commission details that

60. *Id.*

61. Sandy E. James, Jody L. Herman, Susan Rankin, Mara Keisling, Lisa Mottet & Ma’ayan Anafi, Nat’l Ctr. for Transgender Equal., *The Report of the 2015 U.S. Transgender Survey* 8 (Dec. 2016), <https://www.transequality.org/sites/default/files/docs/usts/USTS%20Full%20Report%20-%20FINAL%201.6.17.pdf> [<https://perma.cc/4VGQ-WFVB>].

62. Bassichis, *supra* note 32, at 13–14.

63. Nat’l Ctr. for Transgender Equal., *LGBTQ People Behind Bars: A Guide to Understanding the Issues Facing Transgender Prisoners and Their Legal Rights* 6 (2018), <https://transequality.org/sites/default/files/docs/resources/TransgenderPeopleBehindBars.pdf> [<https://perma.cc/7DK9-GY3K>] [hereinafter *LGBTQ People Behind Bars*].

64. 34 U.S.C. §§ 30301–30309 (2018) (codifying a federal law to deter prison rape and sexual assault).

65. Nat’l Prison Rape Elimination Comm’n, *National Prison Rape Elimination Commission Report* 73–74 (June 2009), <https://www.ncjrs.gov/pdffiles1/226680.pdf> [<https://perma.cc/PG5L-64ZF>].

66. Allen J. Beck, DOJ, Bureau of Just. Stat., *Sexual Victimization in Prisons and Jails Reported by Inmates, 2011–12: Supplemental Tables: Prevalence of Sexual Victimization Among Transgender Adult Inmates tbl.1* (2014), https://www.bjs.gov/content/pub/pdf/svpjri1112_st.pdf [<https://perma.cc/844J-583J>].

67. Allen J. Beck, Marcus Berzofsky, Rachel Caspar & Christopher Krebs, DOJ, Bureau of Just. Stat., *Sexual Victimization in Prisons and Jails Reported by Inmates, 2011–12*, at 6 (2013), <https://www.bjs.gov/content/pub/pdf/svpjri1112.pdf> [<https://perma.cc/QRB3-X6YU>].

every single transgender survey respondent who has gone to jail or prison has reported discrimination there, likely because they are transgender.⁶⁸

It also becomes more difficult for transgender individuals to receive medical attention for the high rates of HIV/AIDS, sexually transmitted infections, depression, mental illness, and other urgent health concerns they may experience while in prison.⁶⁹ Although receiving any kind of health care in prison can be difficult, regardless of the population, access to mental health professionals capable of issuing a diagnosis of gender dysphoria can be a particular challenge, and medical doctors' lack of knowledge on transgender lives makes it especially difficult for individuals to obtain an accurate diagnosis.⁷⁰ For example, the New York State Department of Corrections and Community Supervision has contracted with only one doctor over a five-year period capable of supplying the necessary diagnosis of gender dysphoria.⁷¹ The average wait time to see this doctor is six months, which results in delays before treatments, such as hormone shots, that further exacerbate suffering.⁷² Certain facilities have prison administrators, rather than health care providers, make decisions on the medical needs of transgender individuals.⁷³

Because many facilities lack an official policy for the care of incarcerated transgender individuals, "what constitutes adequate medical attention is not well established and can mean a variety of outcomes for [incarcerated individuals]," such as therapy, hormones, and access to health products for one's preferred gender.⁷⁴ Some prison systems refuse to provide GCS as an option for treatment for gender dysphoria at all, even when such treatment could be life-saving.⁷⁵ Indeed, nineteen states do not have policies addressing treatment for incarcerated transgender individuals.⁷⁶ Instead, certain states continue to operate "freeze frame" policies that freeze treatment options for incarcerated transgender individuals at the level of treatment they received prior to their incarceration.⁷⁷

68. Letter from Christopher Daley, Dir., Transgender L. Ctr., to Nat'l Prison Rape Elimination Comm'n 2 (Aug. 15, 2005) (on file with the *Columbia Law Review*).

69. Bassichis, *supra* note 32, at 13–14.

70. Mik Kinkead & Juana Paola Peralta, Testimony from the Sylvia Rivera Law Project: Public Hearing on Healthcare in New York Correctional Facilities 3 (Oct. 30, 2017), <https://srlp.org/wp-content/uploads/2018/12/Testimony-from-SRLP-10.30.17.pdf> [<https://perma.cc/R5HJ-GH4D>].

71. *Id.*

72. *Id.*

73. LGBTQ People Behind Bars, *supra* note 63, at 6.

74. Blankenship & Carter, *supra* note 31, at 101.

75. LGBTQ People Behind Bars, *supra* note 63, at 15.

76. Mason, *supra* note 55, at 172.

77. Pierre Bienaimé, How Trans Inmates Are Getting Each Other Access to Treatment Inside, *Vice* (July 1, 2019), https://www.vice.com/en_us/article/8xz3m3/trans-prisoners-treatment-hormone-therapy [<https://perma.cc/XHS7-XQR5>] (providing testimony that Maine and Nevada appear to still operate freeze-frame policies).

Although the Federal Bureau of Prisons rejected such policies on a national level in 2011, most incarcerated people are held in state prisons,⁷⁸ forcing a “state by state battle” to compel prisons to allow treatment for those diagnosed with gender dysphoria while in prison.⁷⁹ Currently, local jails have to pay for the care of incarcerated people, so officials face heavy pressure to avoid treatment due to cost.⁸⁰ Court records are thus replete with stories of individuals attempting self-castration or suicide due to mental anguish without proper treatment.⁸¹ For example, officials provided transgender plaintiff Ophelia De'lonta with both psychological counseling and hormone therapy for her gender dysphoria and allowed her to dress as a woman while in prison.⁸² However, she continued to note her “extreme distress” and “imminent” urges to self-castrate for several years.⁸³ De'lonta eventually carried out a self-castration attempt in July 2010.⁸⁴ Still, prison officials denied her an evaluation for surgical treatment.⁸⁵ Medical treatment that does not alleviate the suicidal ideations and self-harm associated with gender dysphoria should not be considered adequate.⁸⁶ For years, incarcerated transgender individuals like De'lonta have turned to the courts to seek hormone therapy and/or GCS, claiming that denial of this treatment amounts to cruel and unusual punishment.

B. *Development of Eighth Amendment Claims by Incarcerated Transgender Individuals*

This section lays out the legal standard that allows incarcerated transgender individuals to seek redress for their medical needs. The Eighth Amendment to the United States Constitution states, “Excessive bail shall not be required, nor excessive fines imposed, *nor cruel and unusual punishments inflicted.*”⁸⁷ In 1976, the U.S. Supreme Court ruled in *Estelle v. Gamble* that deliberate indifference to the serious medical problems of

78. Compare the 1,134,700 people held in state facilities to the 154,200 people held in federal facilities in 2016. Danielle Kaebler & Mary Cowhig, DOJ, Bureau of Just. Stat., Correctional Populations in the United States, 2016, at 13 tbl.3 (2018), <https://www.bjs.gov/content/pub/pdf/cpus16.pdf> [<https://perma.cc/3YS7-3J2D>].

79. Bienaimé, *supra* note 77.

80. Homer Venters, *Life and Death in Rikers Island* 148 (2019).

81. See, e.g., *Diamond v. Owens*, 131 F. Supp. 3d 1346, 1353 (M.D. Ga. 2015); *supra* text accompanying notes 2–6.

82. *De'lonta v. Johnson*, 708 F.3d 520, 525 (4th Cir. 2013).

83. *Id.* at 522.

84. *Id.*

85. *Id.* at 523.

86. Medical professionals should determine adequacy of treatment depending on individual need in accordance with the WPATH standards. See *supra* section I.A.1 (describing the suicide rates of transgender people and the WPATH standards).

87. U.S. Const. amend. VIII (emphasis added).

incarcerated individuals constitutes cruel and unusual punishment.⁸⁸ Such deliberate indifference amounts to the “unnecessary and wanton infliction of pain” proscribed by the Eighth Amendment.⁸⁹ Deliberate indifference applies to both prison doctors and prison guards and allows incarcerated individuals to state a cause of action under 42 U.S.C. § 1983.⁹⁰ To satisfy a showing of deliberate indifference, courts have generally recognized that an incarcerated individual must prove (1) that their medical need is serious and (2) that the prison officials possess the subjective intent to refuse or deny care.⁹¹ Section I.B.1 examines how courts have interpreted the first prong of medical need over time and in relation to claims by incarcerated individuals seeking relief for gender dysphoria. Section I.B.2 addresses the hurdle that is often more difficult for transgender plaintiffs, which is proving that an official has subjectively acted with deliberate indifference toward one’s medical need.

1. *Serious Medical Need.* — To prevail on a deliberate-indifference claim, transgender plaintiffs must first show that their gender dysphoria constitutes an objectively serious medical need.⁹² In *Estelle*, the Court recognized that medical needs requiring medical attention under the Eighth Amendment range from “physical torture or a lingering death”⁹³ to “less serious cases,” resulting from the “denial of medical care,” which could cause “pain and suffering which no one suggests would serve any penological purpose.”⁹⁴ After *Estelle*, several circuit courts relied on the standard 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.”⁹⁵ In 1996, however, Congress enacted the Prison Litigation Reform Act (PLRA), which changed the way courts considered medical need by requiring an incarcerated individual to demonstrate physical injury before pursuing a

88. 429 U.S. 97, 104 (1976).

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

90. *Id.* at 104–05.

91. See, e.g., *Kosilek IV*, 774 F.3d 63, 82–83 (1st Cir. 2014); *Hill v. Dekalb Reg’l Youth Det. Ctr.*, 40 F.3d 1176, 1186 (11th Cir. 1994); *Monmouth Cnty. Corr. Institutional Inmates v. Lanzaro*, 834 F.2d 326, 346–47 (3d Cir. 1987).

92. See generally *Kosilek IV*, 774 F.3d at 82–83; *Hill*, 40 F.3d at 1186; *Monmouth Cnty. Corr. Institutional Inmates*, 834 F.2d at 346–47 (outlining the burden of proof for transgender plaintiffs to prevail on deliberate-indifference claims).

93. *Estelle*, 429 U.S. at 103 (internal quotation marks omitted) (quoting *In re Kemmler*, 136 U.S. 436, 447 (1890)).

94. *Id.* at 103 (citing *Gregg*, 428 U.S. at 170–74).

95. *Gaudreault v. Municipality of Salem*, 923 F.2d 203, 208 (1st Cir. 1990) (citing *Monmouth Cnty. Corr. Institutional Inmates*, 834 F.2d at 347; *Hendrix v. Faulkner*, 525 F. Supp. 435, 454 (N.D. Ind. 1981)); *Laaman v. Helgemoe*, 437 F. Supp. 269, 311 (D.N.H. 1977) (citations omitted).

civil action for mental or emotional injury suffered as well.⁹⁶ In general, the passage of the PLRA made civil rights cases harder for incarcerated individuals to both bring and win.⁹⁷ Courts continue to differ on how to approach the serious-medical-need standard as well as the physical-injury requirement.⁹⁸ Indeed, correctional facilities themselves have created categories of medical conditions to determine access to treatment, with “medically necessary” issues warranting care in contrast to other conditions that may, appropriately or not, be considered “cosmetic.”⁹⁹ The debate over what constitutes medical necessity informs the question of which treatments prison officials are obligated to provide under the Eighth Amendment.

The questions of physical injury and medical necessity, however, are often less relevant to the claims brought by transgender plaintiffs seeking injunctive relief in the form of GCS for several reasons. First, the PLRA’s requirement of physical injury applies to money damages rather than injunctive relief, such as a court order for hormone therapy or surgery.¹⁰⁰ Second, federal appellate courts, including the First, Fifth, and Ninth Circuits, have held, in accordance with the DSM-5, that gender dysphoria can constitute a serious medical need, thus fulfilling this first prong of deliberate indifference.¹⁰¹ Although there has not yet been a per se finding

96. Omnibus Consolidated Rescissions and Appropriations Act of 1996, Pub. L. No. 104-134, 110 Stat. 1321 (codified at 42 U.S.C. § 1997e(e) (2018)) (“No Federal civil action may be brought by a prisoner confined in a jail, prison, or other correctional facility, for mental or emotional injury suffered while in custody without a prior showing of physical injury . . .”).

97. Margo Schlanger, Trends in Prisoner Litigation, as the PLRA Enters Adulthood, 5 U.C. Irvine L. Rev. 153, 162 (2015) [hereinafter Schlanger, Trends]. For more information on the history of the PLRA and its effect on the federal judiciary, see generally Rachel Poser, Why It’s Nearly Impossible for Prisoners to Sue Prisons, *New Yorker* (May 30, 2016), <https://www.newyorker.com/news/news-desk/why-its-nearly-impossible-for-prisoners-to-sue-prisons> (on file with the *Columbia Law Review*). The PLRA was partly designed to limit frivolous lawsuits by incarcerated individuals; for a brief history on these lawsuits and how some cases dismissed as frivolous actually contained serious issues, see generally Jon O. Newman, Foreword: Pro Se Prisoner Litigation: Looking for Needles in Haystacks, 62 *Brook. L. Rev.* 519, 521–22 (1996) (discussing, for example, how a case mischaracterized as being about an individual’s request for a certain kind of peanut butter concealed the more substantive issue of a prison account being incorrectly debited).

98. See Laura D. Smolowe, Comment, Rejecting the Cosmetic Label to Revive the Eighth Amendment, 23 *Yale L. & Pol’y Rev.* 357, 364 (2005); Know Your Rights: The Prison Litigation Reform Act (PLRA), ACLU, https://www.aclu.org/sites/default/files/images/asset_upload_file79_25805.pdf [<https://perma.cc/X8CC-KNRX>] (last visited Sept. 1, 2020).

99. Smolowe, *supra* note 98, at 358.

100. ACLU, *supra* note 98.

101. See *Edmo v. Corizon, Inc.*, 935 F.3d 757, 785 (9th Cir. 2019); *Gibson v. Collier*, 920 F.3d 212, 219 (5th Cir. 2019), cert. denied, 140 S. Ct. 653 (2019) (mem.); *Kosilek IV*, 774 F.3d 63, 86 (1st Cir. 2014); see also *Fields v. Smith*, 653 F.3d 550, 555 (7th Cir. 2011) (affirming the district court holding that gender dysphoria is a serious medical need); *Mason*, *supra* note 55, at 183 (describing how the Fourth, Eighth, and Tenth Circuits have suggested that gender dysphoria can be a serious medical need depending on the case).

by the Supreme Court that gender dysphoria is a serious medical need,¹⁰² evidence such as psychological distress, suicidal ideation, and threats of self-harm by transgender plaintiffs has often led state actors challenging the Eighth Amendment claims of incarcerated individuals to concede this prong.¹⁰³ This was the case in *Gibson*: “Here, the State of Texas does not appear to contest that [Lynn] has a serious medical need, in light of [her] record Instead, the State disputes that it acted with deliberate indifference to [her] medical needs.”¹⁰⁴ In the majority of cases where courts find that gender dysphoria constitutes a serious medical need, the plaintiff has already resorted to self-harm while awaiting treatment, thus rendering the court’s analysis on this prong retrospective.¹⁰⁵ While such self-harm is a problem for the health and safety of plaintiffs in and of itself, this general acknowledgement of gender dysphoria as a serious medical need makes the second prong, the subjective inquiry into deliberate indifference, the real locus of dispute for claims by transgender plaintiffs seeking relief in court. Unsurprisingly, circuit courts have differed on how to determine whether a prison official possesses the subjective intent to be deliberately indifferent to an incarcerated individual’s need, as this inquiry depends on the extent to which courts deem the treatment provided to the plaintiff to be constitutionally adequate.¹⁰⁶

2. *Subjective Deliberate Indifference*. — In addition to demonstrating serious medical need, transgender plaintiffs must be able to show that prison officials meet the subjective-intent requirement of deliberate indifference in order to obtain relief under the Eighth Amendment.¹⁰⁷ In *Farmer v. Brennan*, the Supreme Court adopted the standard of “subjective recklessness” as the test for deliberate indifference.¹⁰⁸ The plaintiff in *Farmer* was a transgender woman who was placed with men in prison and suffered harm, including rape, as a result.¹⁰⁹ Dee Farmer argued that the prison officials’ failure to protect her safety by housing her in a penitentiary with a violent environment and history of assault amounted to deliberate indifference.¹¹⁰ In deciding that the prison officials had a responsibility to prevent incarcerated individuals from inflicting harm on one another, the Court set out a standard for the subjective element of delib-

102. Esinam Agbemenu, Note, Medical Transgressions in America’s Prisons: Defending Transgender Prisoners’ Access to Transition-Related Care, 30 Colum. J. Gender & L. 1, 2–3 (2015).

103. See, e.g., *De’lonta v. Johnson*, 708 F.3d 520, 524 (4th Cir. 2013) (“[Appellees] conceded[e] that De’lonta’s need for protection from self-mutilation is a serious medical need . . .”).

104. *Gibson*, 920 F.3d at 219; see also *infra* section II.B.

105. Agbemenu, *supra* note 102, at 3.

106. See *infra* Part II.

107. See *supra* note 91 and accompanying text.

108. 511 U.S. 825, 839–40 (1994).

109. *Id.* at 829–30.

110. *Id.* at 830–31.

erate indifference that requires more than mere negligence. Under this test, a prison official cannot be found liable “unless the official *knows of and disregards* an excessive risk to inmate health or safety; *the official must both be aware of facts* from which the inference could be drawn that a substantial risk of serious harm exists, and *he must also draw the inference.*”¹¹¹ The Court clarified that “an Eighth Amendment claimant need not show that a prison official acted or failed to act believing that harm actually would befall an inmate; *it is enough that the official acted or failed to act* despite his knowledge of a substantial risk of serious harm.”¹¹² The Court further held that an Eighth Amendment claim is still viable if the harm to be suffered by the incarcerated individual is to occur at some point in the future.¹¹³

The challenge for transgender claimants with severe gender dysphoria comes from proving that prison officials who deny GCS do so with an awareness that substantial risk of harm could result from such denial.¹¹⁴ Courts have held that a prison official can be deliberately indifferent to the increased risk of self-harm faced by incarcerated individuals, such as those suffering from mental illnesses like depression.¹¹⁵ However, prison officials may be less familiar with the particular circumstances and potential harm certain transgender individuals face without treatment for gen-

111. *Id.* at 837 (emphasis added). Courts accordingly instruct juries to adhere to this subjective culpability requirement when examining deliberate indifference cases with issues of proof: “It is not enough merely to find that a reasonable person would have known, or that the defendant should have known, and juries should be instructed accordingly.” *Id.* at 843 n.8.

112. *Id.* at 842 (emphasis added) (citations omitted).

113. *Id.* at 845. (“[O]ne does not have to await the consummation of threatened injury to obtain preventive relief.” (internal quotation marks omitted) (quoting *Pennsylvania v. West Virginia*, 262 U.S. 553, 593 (1923))). See also *Helling v. McKinney*, 509 U.S. 25, 33 (1993) (“It would be odd to deny an injunction to inmates who plainly proved an unsafe, life-threatening condition in their prison on the ground that nothing yet had happened to them.”).

114. While such harm can be psychological, there is not a clear consensus on the appropriate level of mental harm required to sustain an Eighth Amendment claim. See *Hum. Rts. Watch*, *supra* note 52, at 212 (“There is no clear definition of, or consensus about, what constitutes a sufficiently serious mental health condition to implicate the Eighth Amendment.”). However, a diagnosis “with a mental [health issue] that includes being actively suicidal” fits into a federally recognized definition of mental harm warranting treatment. *Id.*

115. See, e.g., *Gates v. Cook*, 376 F.3d 323, 332 (5th Cir. 2004) (“Prison officials must provide humane conditions of confinement . . . Further, mental health needs are no less serious than physical needs.”); *Braggs v. Dunn*, 367 F. Supp. 3d 1340, 1345–50, 1359 (M.D. Ala. 2019) (holding that officials from the Alabama Department of Corrections were deliberately indifferent for failing to provide adequate periodic mental health evaluations to incarcerated individuals in segregation who were at risk of self-harm from depression, anxiety, and other psychological harms).

der dysphoria, such as the potential for self-castration.¹¹⁶ In addition, prison officials often have to balance competing considerations regarding the effects of their efforts to assist an individual, such as the security concerns that could arise by transferring a transgender individual to a facility aligned with their gender identity where the individual may incite unrest among other incarcerated individuals.¹¹⁷ Acknowledging these realities, courts afford prison officials deference when analyzing whether they have acted with deliberate indifference in limiting or retracting the rights of incarcerated individuals and pretrial detainees:

Since problems that arise in the day-to-day operation of a corrections facility are not susceptible of easy solutions, prison 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.¹¹⁸

Thus, courts must consider security concerns arising from the provision of GCS when adjudicating the subjective prong of a deliberate-indifference claim. Given that the Supreme Court has not yet ruled on whether a prison official's denial of GCS to an incarcerated transgender individual can constitute deliberate indifference to one's medical need, circuit courts have set the standard on the appropriate level of care required to reject such a claim.

II. RECONCILING DELIBERATE INDIFFERENCE UNDER *KOSILEK-EDMO* AND *GIBSON*

This Part analyzes how circuit courts have recently approached the question of whether denial of GCS to an incarcerated transgender individual violates the Eighth Amendment. The First and Ninth Circuits have reached different outcomes for the transgender plaintiffs in their jurisdic-

116. See, e.g., *Edmo v. Idaho Dep't of Corr.*, 358 F. Supp. 3d 1103, 1126–28 (D. Idaho 2018) (describing how the plaintiff, an incarcerated individual, was at risk of irreparable harm without GCS as evidenced by the plaintiff's two prior attempts at self-castration).

117. See *infra* text accompanying notes 139–141 (explaining the security concerns that could arise by providing GCS to an incarcerated individual). This balancing act is required for numerous constitutional claims that arise within prisons. See, e.g., *Bell v. Wolfish*, 441 U.S. 520, 559 (1979) (explaining how prison officials must balance their need to search an individual for contraband with the Fourth Amendment protection against an invasion of the individual's personal rights).

118. *Bell*, 441 U.S. at 521. See also *Campbell v. Kallas*, 936 F.3d 536, 545 (7th Cir. 2019) (describing how medical professionals are entitled to deference unless no minimally competent professional would have acted in that way); *Battista v. Clarke*, 645 F.3d 449, 454 (1st Cir. 2011) (describing how security judgments at prisons are entitled to deference as long as they are “within the realm of reason and made in good faith”). But see *Hunt v. Dental Dep't*, 865 F.2d 198, 200 (9th Cir. 1989) (“In deciding whether there has been deliberate indifference to an inmate's serious medical needs, we need not defer to the judgment of prison doctors or administrators.”).

tions on whether denial of GCS constitutes deliberate indifference.¹¹⁹ This Part argues, however, that the existence of the “circuit split” between the courts is questionable when solely examining the First and Ninth Circuits’ application of law to fact. Instead, this Part argues that the Fifth Circuit’s determination of deliberate indifference represents a real split in deliberate-indifference doctrine, despite its holding matching that of the First Circuit. Section II.A analyzes the First Circuit’s approach in *Kosilek IV*. Section II.B critiques the approach of the Fifth Circuit, which similarly ruled on these types of claims when it decided *Gibson*.¹²⁰ This section contrasts the *Gibson* approach to that of *Kosilek IV* as well as to deliberate-indifference precedent more broadly. Finally, section II.C examines the Ninth Circuit’s decision in *Edmo*, the most recent circuit court decision on this issue. This last section draws comparisons to the First Circuit’s reasoning in *Kosilek IV*, terming the concomitant legal analysis the “*Kosilek–Edmo* framework,” and challenges the idea of the extant circuit split.

A. *The First Circuit’s Approach to Deliberate Indifference*

In 2014, the First Circuit became the first circuit court to evaluate whether the denial of GCS to an incarcerated transgender individual violates the Eighth Amendment, and it found that such a denial did not in *Kosilek IV*.¹²¹ In *Kosilek IV*, plaintiff Michelle Kosilek was an anatomically male individual with gender dysphoria who self-identified as female.¹²² She was convicted of first-degree murder for the strangulation of her wife in 1992 and was sentenced to life imprisonment without parole, eventually serving her first twenty years of incarceration at a medium security male prison.¹²³ During this period of incarceration, Kosilek did not attempt to harm herself in relation to her gender dysphoria.¹²⁴ Kosilek had, however, attempted self-castration in the past and had also twice attempted suicide

119. *Edmo v. Corizon, Inc.*, 935 F.3d 757, 803 (9th Cir. 2019) (holding that the denial of GCS to an incarcerated individual constituted deliberate indifference); *Kosilek IV*, 774 F.3d 63, 96 (1st Cir. 2014) (holding that the refusal to provide GCS did not constitute deliberate indifference).

120. *Gibson v. Collier*, 920 F.3d 212, 218 (5th Cir. 2019), cert. denied, 140 S. Ct. 653 (2019) (mem.).

121. 774 F.3d at 96. Kosilek’s case spanned more than twenty years and produced two lengthy district court decisions as well as two appellate decisions. See *Kosilek III*, 740 F.3d 733, 736 (1st Cir. 2014) (affirming the district court’s decision, which ordered the Massachusetts Department of Corrections to provide Kosilek with GCS); *Kosilek v. Spencer (Kosilek II)*, 889 F. Supp. 2d 190, 250–51 (D. Mass. 2012) (issuing an injunction to correct the violation of Kosilek’s Eighth Amendment right to adequate medical care in the form of GCS); *Kosilek v. Maloney (Kosilek I)*, 221 F. Supp. 2d 156, 195 (D. Mass. 2002) (finding that Kosilek lacked adequate care for her serious medical need but could not prove that this result was a product of deliberate indifference or that the defendant would be deliberately indifferent in the future).

122. *Kosilek IV*, 774 F.3d at 68.

123. *Id.* at 68–69.

124. *Id.* at 69.

while awaiting trial for the murder of her wife in 1990.¹²⁵ She initiated multiple lawsuits beginning in 1992, alleging that the provision of “supportive therapy” to cope with her gender dysphoria, as opposed to direct, fuller treatment through GCS, amounted to an Eighth Amendment violation.¹²⁶ *Kosilek IV*, the final en banc decision by the First Circuit, reversed a panel decision by the First Circuit that was initially favorable to the plaintiff.¹²⁷ This last decision relied on an extensively developed factual record¹²⁸ and recognized the plaintiff’s objectively serious medical need.¹²⁹ The court disputed that the care provided to the plaintiff was inadequate and that the Department of Corrections (DOC) subjectively knew or should have known that the provided treatment was inadequate.¹³⁰

In coming to this conclusion, the First Circuit primarily relied on medical judgment that had questioned the medical consensus around the effects of GCS.¹³¹ Although the WPATH Standards of Care existed at the time of the decision, the First Circuit relied almost exclusively on one doctor’s determination that WPATH did not represent consensus and that there was still a “lack of rigorous research in the field.”¹³² Further, doctors expressed concern that “an incarcerative environment might well be insufficient to expose Kosilek to the variety of societal, familial, and vocational pressures foreseen by a real-life experience.”¹³³ The court took this concern seriously given that a transgender individual’s ability to have a “real-life experience” in the community before undergoing GCS is related to a criterion of the WPATH Standards of Care.¹³⁴ Thus, reliance on medical testimony that gender-dysphoria treatment was still evolving and not

125. *Id.*

126. *Id.* Kosilek initially filed a pro se complaint in 1992 but was then able to obtain pro bono counsel for future complaints. *Kosilek I*, 221 F. Supp. 2d at 159.

127. *Kosilek IV*, 774 F.3d at 96; *Kosilek III*, 740 F.3d 733, 736 (1st Cir. 2014). Note that both dissenters in *Kosilek IV* served on the original panel decision in *Kosilek III*, and both took issue with the majority’s lack of proper deference to the factual findings of the trial court. *Kosilek IV*, 774 F.3d at 99 (Thompson, J., dissenting); *id.* at 114 (Kayatta, J., dissenting).

128. The fully developed factual records included expert testimony from medical professionals on the medical necessity of GCS for Kosilek, similar testimony from a court-appointed expert, a report on medical necessity by the health-services provider that was contracted by the DOC, a security report by the DOC, and further testimony by witnesses and other DOC officials on both the severity of medical need and safety and security concerns. *Kosilek IV*, 774 F.3d at 70–82.

129. *Id.* at 89.

130. *Id.* at 89, 91.

131. *Id.* at 78.

132. *Id.*

133. *Id.* at 88.

134. See *supra* text accompanying note 42 (explaining that “[twelve] continuous months of living in a gender role that is congruent with their gender identity” is part of the Standards of Care).

appropriate for incarcerated individuals played a significant role in the First Circuit's outcome.¹³⁵

The First Circuit also paid special attention to the specific factual circumstances Kosilek faced, ultimately finding that Kosilek's treatment regimen of hormones, facial hair removal, feminine clothing, and access to regular mental health treatment did not wantonly disregard the plaintiff's needs but, rather, accounted for them.¹³⁶ Importantly, the First Circuit noted that "significant time" had passed since Kosilek first exhibited symptoms of suicidal ideation or attempted self-castration because her current treatment regimen had helped alleviate the negative effects of gender dysphoria.¹³⁷ Furthermore, the court found that the DOC employed a plan to minimize Kosilek's risk of future harm.¹³⁸ The reliance on these factual findings undercut the plaintiff's efforts to demonstrate that the denial of surgery constituted deliberate indifference.

Evaluating this subjective prong of deliberate indifference further, the court provided deference to the DOC in the fact-specific debate over the security concerns that could arise if Kosilek received GCS.¹³⁹ The First Circuit noted the DOC's security concerns that were "particularly relevant in Kosilek's case," such as the fear that Kosilek, who had a history of violence against a female domestic partner, would cause trouble if housed in a female prison population with a high number of domestic violence survivors.¹⁴⁰ In addition, the DOC worried that other incarcerated individuals would "use threats of suicide to extract concessions from the prison administration" or that Kosilek would be a victim of assault after receiving GCS.¹⁴¹ The deference to these security concerns in Kosilek's case, coupled with the prison officials' reliance on medical testimony questioning the necessity of GCS as the best course of treatment, caused the court to ultimately conclude that Kosilek could not fulfill the subjective-intent requirement of deliberate indifference.¹⁴²

Though the First Circuit's analysis of the subjective prong of deliberate indifference was riddled with factual disputes,¹⁴³ the First Circuit's

135. *Kosilek IV*, 774 F.3d at 78.

136. *Id.* at 90.

137. *Id.* Kosilek admitted to the significant stabilization in her mental state. *Id.*

138. *Id.* The district court, however, had reached a contrary conclusion. Despite being aware of the DOC's plan to provide more comprehensive treatment, the court found that *all* treatment apart from GCS was inadequate for Kosilek, who continued to experience great anguish and the high likelihood of another suicide attempt. *Id.* at 105 (Thompson, J., dissenting).

139. See *id.* at 93–96 (majority opinion); see also *supra* section I.B.2 (describing the subjective deliberate-indifference requirement).

140. *Kosilek IV*, 774 F.3d at 93.

141. *Id.* at 92–93.

142. *Id.* at 91–92.

143. For example, the district court did not credit the security concerns that could arise if Kosilek received GCS, finding them to be both "pretextual and unreasonable" because

actual legal analysis on this prong—one that requires an individualized inquiry and testimony based on the circumstances of a specific plaintiff—was not in question. As one of the dissenting judges acknowledged, “All the parties and all the judges in this case, including the trial judge, agree on the controlling principles of law, long ago established by the Supreme Court.”¹⁴⁴ Nevertheless, both the medical consensus around the WPATH Standards of Care and the case law surrounding the issue of GCS have developed since the 2014 decision. Five years later, the Fifth and Ninth Circuits would respectively uphold and challenge the outcome of the First Circuit’s decision.¹⁴⁵

B. *The Fifth Circuit’s Approach to Deliberate Indifference*

The Fifth Circuit’s 2019 ruling in *Gibson* represents an unprecedented split away from the First Circuit’s application of deliberate indifference to the Eighth Amendment claim in *Kosilek IV*, despite the Fifth Circuit’s claims to the contrary. *Gibson* centered on plaintiff Lynn, an anatomically male transgender individual diagnosed with gender dysphoria who experienced severe physical and psychological suffering.¹⁴⁶ Despite her requests for GCS once in prison, the Texas Department of Criminal Justice denied her consideration for the surgery, as it was not part of TDCJ’s treatment policy.¹⁴⁷ Lynn filed suit.¹⁴⁸ As was the case in *Kosilek IV*,¹⁴⁹ the defendants recognized Lynn’s objectively serious medical need but claimed they were not subjectively and deliberately indifferent in refusing to evaluate her for surgery.¹⁵⁰ The Fifth Circuit ultimately agreed, affirming the district court’s summary judgment ruling that dismissed Lynn’s Eighth

DOC officials did not consult with experts when making security deliberations. *Kosilek II*, 889 F. Supp. 2d 190, 240–41 (D. Mass. 2012). In addition, Judge Ojetta Rogerie Thompson, dissenting from *Kosilek IV*, suggested that a medical consensus was actually in place in 2014 but that the DOC deliberately brought in an opponent to GCS. *Kosilek IV*, 774 F.3d at 107 (Thompson, J., dissenting). Predicting a case like *Gibson*, Judge Thompson presciently warned, “It is no stretch to imagine another department of corrections stealing a page from this play book, i.e., just bring in someone akin to Osborne.” *Id.* In a similar dissent, Judge William Kayatta predicted that “no prison may be required to provide [GCS] to a prisoner who suffers from gender dysphoria as long as a prison official calls up Ms. Osborne or Dr. Schmidt.” *Id.* at 115 (Kayatta, J., dissenting).

144. *Kosilek IV*, 774 F.3d at 114 (Kayatta, J., dissenting).

145. See *infra* sections II.B–C.

146. *Gibson v. Collier*, 920 F.3d 212, 217 (5th Cir. 2019), cert. denied, 140 S. Ct. 653 (2019) (mem.); see also *supra* text accompanying notes 1–10.

147. *Gibson*, 920 F.3d at 216–18.

148. *Id.* at 218.

149. See *Kosilek IV*, 774 F.3d at 86 (“That [gender dysphoria] is a serious medical need, and one which mandates treatment, is not in dispute in this case.”).

150. *Gibson*, 920 F.3d at 219.

Amendment claim.¹⁵¹ This decision was flawed on both procedural and substantive grounds.

Procedurally, Lynn originally filed a pro se complaint against the Director of the TDCJ, who moved for summary judgment on the bases of qualified immunity and sovereign immunity.¹⁵² Lynn responded to this motion on the merits of her Eighth Amendment claim.¹⁵³ The district court rejected the Director's two immunity defenses yet granted summary judgment on the basis of the Eighth Amendment claim, which resulted in Lynn's pro se appeal.¹⁵⁴ As the dissenting judge in the Fifth Circuit case, Judge Rhesa Hawkins Barksdale, pointed out, however, the district court erred in numerous procedural capacities. For example, the district court failed to provide Lynn with proper notice that it was considering summary judgment on a basis not advanced by the Director.¹⁵⁵ The court decided to proceed on the summary judgment motion even though there had been no discovery, meaning that Lynn lacked access to material facts that would help prove her medical need for GCS.¹⁵⁶ This procedural posture lies in stark contrast to the extensively developed factual record in *Kosilek IV*. As Judge Barksdale noted, "[T]his case is a far cry from *Kosilek*, which spanned over 20 years, had a very 'expansive' record, and was not decided by summary judgment."¹⁵⁷ The Fifth Circuit appointed counsel on Lynn's behalf, but Lynn continued to seek appeal solely on the merits of the Eighth Amendment claim rather than on procedural defects.¹⁵⁸

Apart from these procedural anomalies, the Fifth Circuit's deliberate-indifference analysis on the subjective prong represents a substantive split from the legal standard of *Kosilek IV* by mounting a categorical ban on GCS. Indeed, the Fifth Circuit majority stated that their disagreement with the dissent "concerns not the record evidence in *Kosilek* or *Edmo* . . . but the governing constitutional standard."¹⁵⁹ To start, the court refused to consider Lynn's specific factual circumstances and, instead, relied almost exclusively on the outdated medical testimony of doctors summarized by the First Circuit in *Kosilek IV* to construct its own summary judgment record.¹⁶⁰ The court, supposedly following *Kosilek IV* precedent, stated, "We

151. Id. at 216.

152. Id. at 218.

153. Id.

154. Id.

155. Id. at 230 (Barksdale, J., dissenting).

156. Id. (explaining that Lynn filed discovery requests for admission, which were never answered by the Director, who instead filed a motion for a protective order due to the Director's qualified-immunity defense).

157. Id. at 233 (citing *Kosilek IV*, 774 F.3d 63, 68 (1st Cir. 2014)).

158. Id. at 218 (majority opinion).

159. Id. at 226.

160. See id. at 222–24 (recounting testimony from *Kosilek IV* and concluding that "[a]ny evidence of [Lynn]'s personal medical need would not alter the fact that sex reassignment surgery is fiercely debated within the medical community"). The Fifth Circuit's use of the

see no reason to depart from the First Circuit. To the contrary, we agree with the First Circuit that the WPATH Standards of Care do not reflect medical consensus, and that in fact there is no medical consensus at this time.”¹⁶¹ The Fifth Circuit’s reasoning here actually contradicts the fact-specific approach to deliberate indifference set out in *Kosilek IV*.¹⁶² Recall that the First Circuit evaluated Kosilek’s individual and serious medical circumstances, such as attempted self-castration and suicidal thoughts, when determining whether the DOC had the subjective intent to be deliberately indifferent for refusing GCS.¹⁶³ By contrast, the *Gibson* court rejected Lynn’s request for a medical evaluation, despite the fact that Lynn’s symptoms of gender dysphoria matched those of Kosilek.¹⁶⁴ Unlike Kosilek, Lynn was not even afforded the opportunity to *prove* the medical-necessity aspect of her deliberate-indifference claim because she never received the medical evaluation for GCS that she requested in the first place.¹⁶⁵ In discarding the plaintiff’s request for surgery in light of new medical testimony, the Fifth Circuit ignored the advance of medical research that has led the medical community to hold the WPATH Standards of Care as the governing standard for transgender health, as the U.S. District Court for the District of Idaho had recognized the previous year¹⁶⁶ and the Ninth Circuit recognized a few months later.¹⁶⁷ Because GCS is “fiercely

First Circuit’s testimony comes despite the fact that TDCJ did not cite *Kosilek IV* in its briefing, much less rely on the evidence as dispositive. *Id.* at 232, 240 (Barksdale, J., dissenting). In dissent, Judge Barksdale noted that the majority is not only “improperly taking evidence from another case” but also “refusing to evaluate those facts in the requisite light most favorable to [Lynn],” as summary judgment, and Supreme Court precedent, require. *Id.* at 232.

161. *Id.* at 223 (majority opinion). However, evidence suggests that some of the doctors at the Johns Hopkins School of Medicine who were cited by the *Kosilek IV* court for the proposition that GCS is medically controversial may have changed their minds—the Johns Hopkins School of Medicine has now resumed providing GCS to transgender individuals. *Id.* at 235 (Barksdale, J., dissenting). For example, Dr. Cynthia Osborne, who testified against GCS in *Kosilek IV*, now agrees that GCS can be medically necessary for some individuals with gender dysphoria, making the *Gibson* majority’s use of her older testimony even more questionable. See *Edmo v. Corizon, Inc.*, 935 F.3d 757, 796 (9th Cir. 2019).

162. *Gibson*, 920 F.3d at 238 (Barksdale, J., dissenting) (“This blanket ban on even an evaluation for [GCS] is clearly contrary to *Kosilek*’s holding.”).

163. *Kosilek IV*, 774 F.3d 63, 90 (1st Cir. 2014).

164. See *id.* at 69 (describing Kosilek’s suicidal ideations and self-castration attempts); Petition for Writ of Certiorari at 4, *Gibson v. Collier*, 140 S. Ct. 653 (2019) (No. 18-1586), 2019 WL 2711440 (describing how Lynn abused her testicles in order to express anguish related to her gender dysphoria).

165. *Gibson*, 920 F.3d at 230 (Barksdale, J., dissenting).

166. See *Edmo v. Idaho Dep’t of Corr.*, 358 F. Supp. 3d 1103, 1120–21, 1124 (D. Idaho 2018) (“WPATH Standards of Care are the accepted standards of care for treatment of transgender patients.”).

167. See *Edmo v. Corizon, Inc.*, 935 F.3d 757, 789 (9th Cir. 2019). In fact, the Fifth Circuit acknowledged the divergent outcome in the *Edmo* district decision, but ultimately rejected its relevance, saying that because the district court “took sides in an ongoing

debated,” the Fifth Circuit reasoned that evidence of Lynn’s individual need was irrelevant, and, tautologically, the court could not find TDCJ to be deliberately indifferent to such need despite its categorical policy against the provision of this surgery.¹⁶⁸

In addition to affirming summary judgment on the supposed lack of medical consensus, the court declared that Lynn could not state a plausible claim for cruel and unusual punishment “under the plain text and original meaning of the Eighth Amendment, *regardless of any facts* [she] might have presented.”¹⁶⁹ The Fifth Circuit’s originalist understanding is that a prison policy, such as one that bans GCS, cannot be “unusual” if most prisons follow that policy.¹⁷⁰ The court hypothesized that if the FDA prohibits a particular drug, the Eighth Amendment would not require an individualized assessment for an incarcerated individual requesting that drug.¹⁷¹ In effect, the court rejected the idea that the Eighth Amendment requires individualized assessments of requested remedies for medical need. Instead, a categorical ban on a medical treatment is appropriate as long as that ban aligns with other prison policies that question the value of a certain treatment.¹⁷²

Circuit courts have repeatedly upheld deference to administrators in creating prison policy,¹⁷³ yet the Fifth Circuit’s ruling goes beyond mere deference to administrators in its deliberate-indifference analysis by drastically redefining the cruel and unusual punishment provision of the Eighth Amendment. The Fifth Circuit essentially raises the burden of transgender claimants, who must now demonstrate “universal” acceptance of GCS in order to satisfy at least the subjective prong of deliberate indifference.¹⁷⁴ Such a standard is unworkable, especially considering the amount of societal controversy and stigma surrounding the transgender community that could be improperly imputed to medical considerations. The decision makes it plausible for the majority of prison policies to continuously offer outdated medical treatment plans for transgender individuals, such as policies that only provide psychological counseling for gender dysphoria, without these plans being struck down under the Eighth

medical debate . . . the judgment of the district court in *Edmo* should not survive appeal.” *Gibson*, 920 F.3d at 225.

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

169. *Id.* at 228 (emphasis added).

170. *Id.* at 226. As the dissent notes, this “text-and-original-understanding analysis” overlooks decades of both Supreme Court and circuit precedent. *Id.* at 242 (Barksdale, J., dissenting).

171. *Id.* at 216 (majority opinion).

172. See *id.* at 222–23. “There is no intentional or wanton deprivation of care if a genuine debate exists within the medical community about the necessity or efficacy of that care.” *Id.* at 220.

173. See *supra* note 118 and accompanying text.

174. *Gibson*, 920 F.3d at 220.

Amendment.¹⁷⁵ Likewise, this decision will likely rework Eighth Amendment analysis for *any* claimant seeking preventative care or treatment with a hint of medical controversy and could lead to dire consequences.¹⁷⁶ If most prisons begin instituting policies against the provision of COVID-19 vaccinations or stating that individuals suffering from infections should receive “natural” remedies rather than antibiotics, it is unclear whether these categorical bans could be considered *unusual* punishment under the Fifth Circuit’s analysis. This line of thinking does not conform to established medical recommendations, which favor case-by-case determinations of medical need,¹⁷⁷ or to deliberate-indifference precedent.¹⁷⁸

Although the First, Fifth, and Ninth Circuits are the primary federal circuit courts to have analyzed and ruled on the merits of deliberate-indifference claims for GCS to date, other district and appellate courts seem to reject a categorical approach similar to *Gibson’s* when examining the needs of transgender claimants with gender dysphoria in recent years.¹⁷⁹ The U.S. District Court for the Northern District of California maintained a deliberate-indifference claim by an incarcerated plaintiff with gender dysphoria who asserted that a prison’s policy to categorically deny GCS violated her constitutional rights.¹⁸⁰ Similarly, in a Fourth Circuit

175. See, e.g., *Keohane v. Fla. Dep’t of Corr. Sec’y*, 952 F.3d 1257, 1275–79 (11th Cir. 2020) (finding that the defendant Florida Department of Corrections (FDC) could not be held liable for its policy of initially providing mental health counseling, rather than hormone treatment, to treat the plaintiff’s gender dysphoria, and the FDC’s denial of the plaintiff’s social-transitioning-related requests did not constitute deliberate indifference).

176. See Petition for Writ of Certiorari at 18, *Gibson v. Collier*, 140 S. Ct. 653 (2019) (No. 18-1586), 2019 WL 2711440 (proposing that under the Fifth Circuit’s standard, the debate around vaccinations would theoretically allow states to not have to provide such care to incarcerated individuals).

177. See, e.g., Tamara Syrek Jensen, Joseph Chin, James Rollins, Elizabeth Koller, Linda Gousis & Katherine Szarama, Final Decision Memorandum on Gender Reassignment Surgery for Medicare Beneficiaries with Gender Dysphoria, Ctrs. for Medicare & Medicaid Servs. (Aug. 30, 2016), <https://www.cms.gov/medicare-coverage-database/details/nca-decision-memo.aspx?NCAId=282> [<https://perma.cc/PE9Y-4CGN>] (explaining how the Centers for Medicare and Medicaid Services recommend local Medicare Administrative Contractors use a case-by-case approach to determine coverage of GCS). Recall that the WPATH Standards of Care also favor case-by-case determinations of medical need according to established criteria. See *supra* section I.A.1.

178. The Ninth Circuit also effectively summarizes pertinent deliberate-indifference precedent. See *Edmo v. Corizon, Inc.*, 935 F.3d 757, 794–96 (9th Cir. 2019); *infra* section II.C (explaining how the *Edmo* decision critiques *Gibson’s* unprecedented nature).

179. But see *Lamb v. Norwood*, 899 F.3d 1159, 1163 (10th Cir. 2018) (affirming summary judgment on the basis that existing treatment and the sparse summary judgment record precluded a finding of deliberate indifference when a prison denied an incarcerated individual surgery and further hormones to treat her gender dysphoria).

180. *Norsworthy v. Beard*, 87 F. Supp. 3d 1104, 1113–14 (N.D. Cal. 2015) (“The Court finds that Norsworthy has adequately alleged that a policy or custom played a part in the constitutional violations she alleges.”); see also *Denegal v. Farrell*, No. 1:15-cv-01251, 2017 WL 2363699, at *4–6 (E.D. Cal. May 31, 2017) (denying summary judgment where a

case, the court held that appellees were deliberately indifferent for refusing to evaluate a transgender plaintiff for GCS, although the court did not analyze whether the surgery itself was appropriate for the plaintiff in that case.¹⁸¹ It is true that the provision of an individualized medical evaluation in the face of a prison's categorical treatment policy can impede a finding of deliberate indifference by showing that officials have facially paid adequate attention to medical need.¹⁸² Whatever the ultimate finding, however, these rulings suggest that individual assessments do and should indeed matter to Eighth Amendment analysis—even when a prison institutes a categorical denial of a treatment for a medical need, like gender dysphoria, that is less well-known and, perhaps, carries a hint of medical and social controversy.

Apart from the realm of deliberate-indifference claims by transgender individuals, federal appellate courts have conducted fact-specific inquiries and individual assessments of incarcerated individuals' general needs when determining whether an official has subjectively exhibited deliberate indifference. In *Rachel v. Troutt*, the Tenth Circuit, when evaluating a claim alleging officials' deliberate indifference, stated that “[e]ach step of this [deliberate-indifference] inquiry is fact-intensive.”¹⁸³ Similarly, the Third Circuit has asserted that such claims are “fact-intensive” and “require further development of the record.”¹⁸⁴ Courts have also rejected categorical denials of medical evaluations in the past for other treatments. As the Ninth Circuit put it in regard to another deliberate-indifference claim, the “blanket, categorical denial of medically indicated surgery solely on the basis of an administrative policy that ‘one eye is good enough for [incar-

transgender woman alleged that GCS, which she was refused, was medically necessary to treat gender dysphoria when certain similar procedures, including vaginoplasty, were available to treat the medical needs of cisgender women); *Shadle v. Frakes*, No. 8:16CV546, 2017 U.S. Dist. LEXIS 53731, at *3 (D. Neb. Apr. 7, 2017) (rejecting summary judgment due to an alleged denial of hormone therapy and GCS); *Tate v. Wexford Health Source Inc.*, No. 3:16-cv-00092, 2016 WL 687618, at *1–3 (S.D. Ill. Feb. 19, 2016) (holding that the plaintiff could proceed in her complaint when a prison's policy prevented evaluation for GCS and failed to train staff members to treat individuals with gender dysphoria).

181. *De'lonta v. Johnson*, 708 F.3d 520, 525 (4th Cir. 2013); see also *Rosati v. Igbinoso*, 791 F.3d 1037, 1039–40 (9th Cir. 2015) (holding that a blanket policy against GCS is sufficient to sustain a complaint of deliberate indifference); *Fields v. Smith*, 653 F.3d 550, 559 (7th Cir. 2011) (holding that a plaintiff could state a valid Eighth Amendment claim when a prison refuses to consider an incarcerated individual for GCS).

182. See, e.g., *Praylor v. Tex. Dep't of Crim. Just.*, 430 F.3d 1208, 1209 (5th Cir. 2005) (rejecting a finding of deliberate indifference where the claimant had been evaluated on two occasions and was subject to mental health screening but was denied eligibility for hormone treatment).

183. *Rachel v. Troutt*, 820 F.3d 390, 394 (10th Cir. 2016) (internal quotation marks omitted) (quoting *Hartsfield v. Colburn*, 491 F.3d 394, 397 (8th Cir. 2007)); see also *Patel v. Kent Sch. Dist.*, 648 F.3d 965, 975 (9th Cir. 2011) (“Deliberate-indifference cases are by their nature highly fact-specific . . .”).

184. *Leamer v. Fauver*, 288 F.3d 532, 547 (3d Cir. 2002).

cerated individuals]’ is the paradigm of deliberate indifference.”¹⁸⁵ With its originalist interpretation of the Eighth Amendment, the *Gibson* court set itself in opposition to not only *Kosilek IV* (and, as will next be explored, *Edmo*) but also to the application of the subjective prong of deliberate indifference used by federal courts at large. In doing so it created a new split among the courts as to the appropriate legal standard required by the Constitution.

C. *Questioning the Circuit Split: The Ninth Circuit’s Approach to Deliberate Indifference*

Edmo v. Corizon, which the Ninth Circuit decided just months after *Gibson*, marks the first occasion where a federal appellate court has ordered a state’s Department of Corrections to provide GCS to an incarcerated transgender individual based on a deliberate-indifference claim. *Edmo* centers on the plaintiff Adree Edmo, a male-to-female transgender individual with gender dysphoria in the custody of the Idaho Department of Corrections for sexual abuse of a minor.¹⁸⁶ Like *Kosilek* and *Lynn*, *Edmo* had twice attempted self-castration to remove her male genitalia, causing the state to agree that she objectively experienced distress from gender dysphoria.¹⁸⁷ Despite this agreement and *Edmo*’s medical history, the state continued to only provide *Edmo* with hormone therapy, rather than the more comprehensive treatment of GCS she had requested as medically necessary.¹⁸⁸ The Ninth Circuit ultimately relied on expert testimony about the plaintiff’s medical needs and the WPATH Standards of Care to find the state deliberately indifferent for its provision of insufficient medical treatment.¹⁸⁹

As with the *Kosilek IV* court, the *Edmo* court began its analysis of the subjective prong of deliberate indifference by examining the prison officials’ knowledge of and attention to the plaintiff’s medical needs in light of the existing medical consensus. In its analysis of this prong, the court stated that “it is enough” that the state’s doctor “knew of and disregarded an excessive risk” to the plaintiff’s health by rejecting her request for GCS and refusing to reevaluate or recommend any changes to her treatment plan.¹⁹⁰ One of the state’s doctors knew about *Edmo*’s attempts to castrate herself, yet continued the same course of insufficient treatment.¹⁹¹ This

185. *Colwell v. Bannister*, 763 F.3d 1060, 1063 (9th Cir. 2014); see also *Roe v. Elyea*, 631 F.3d 843, 862–63 (7th Cir. 2011) (holding that a failure to consider an individual’s condition by categorically denying certain treatment for hepatitis C infection departs from professional norms).

186. *Edmo v. Corizon, Inc.*, 935 F.3d 757, 772 (9th Cir. 2019).

187. *Id.* at 773–74, 785.

188. *Id.* at 773–74.

189. *Id.* at 803.

190. *Id.* at 793.

191. *Id.*

knowledge then made it difficult for the state to feign ignorance of the extent of Edmo's suffering from gender dysphoria and her continued risk of future harm.

The Ninth Circuit's analysis on this prong mirrored that of the First Circuit's, as both compared the specific plaintiff's symptoms of gender dysphoria to the adequacy of defendants' actions. The key difference was simply the appropriateness of the surgery for the specific claimant, rather than a dispute over the proper legal analysis. Whereas the Ninth Circuit found that the withholding of GCS constituted deliberate indifference due to Edmo's particular factual circumstances of significant distress,¹⁹² the First Circuit found the DOC's plan of action, which was specifically tailored to the needs of Kosilek, to be sufficient.¹⁹³ Indeed, in all their deliberations, the First Circuit made clear that their determination on the appropriateness of GCS was only relevant to Kosilek's particular situation. The court stated, "[W]e are simply unconvinced that our decision on the record before us today will foreclose all litigants from successfully seeking [GCS] in the future. Certain facts in this particular record . . . including the medical providers' non-uniform opinions regarding the necessity of [GCS] . . . were important factors impacting the decision."¹⁹⁴ In the view of both the First and Ninth Circuits, then, the determination of deliberate indifference requires taking a fact-specific approach to the subjective prong of Eighth Amendment claims by transgender individuals.

Another difference that helps explain the divergence between the First and Ninth Circuits' outcomes was the supposed degree of medical consensus surrounding GCS at the time of decision.¹⁹⁵ Unlike the Massachusetts Department of Corrections in *Kosilek IV* (and subsequently, the *Gibson* court),¹⁹⁶ the Idaho Department of Corrections in *Edmo* agreed with the plaintiff that the WPATH Standards of Care represent the governing standard of treatment for gender dysphoria.¹⁹⁷ This recognition highlights how the intervening years between the First Circuit's decision and the Ninth Circuit's decision have helped medical consensus around gender dysphoria develop alongside new research. The Ninth Circuit explicitly acknowledged as much when affirming injunctive relief for Edmo.¹⁹⁸

192. *Id.*

193. See *supra* text accompanying notes 136–138 (explaining the First Circuit's acknowledgement of Kosilek's medical improvement and the DOC's actions to minimize future harm).

194. *Kosilek IV*, 774 F.3d 63, 91 (1st Cir. 2014).

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

196. See *Kosilek IV*, 774 F.3d at 86 ("In contrast, the DOC argues that full progression through the Standards of Care's triadic sequence is not the only adequate treatment option . . ."); *supra* notes 160–161 and accompanying text.

197. *Edmo*, 935 F.3d at 769, 788 n.16.

198. *Id.* at 803 (describing how courts have been discussing claims of incarcerated transgender individuals for a long time, during which "the medical community's understanding of what treatments are safe and medically necessary to treat gender dysphoria has

Perhaps the starkest example of the shift in medical consensus relates to the previous concern, seen in *Kosilek IV*, that transgender individuals in prison could not meet the WPATH criterion that an individual seeking GCS should spend one year living in a gender role congruent with their gender identity.¹⁹⁹ Although both doctors hired by the state asserted this argument in *Edmo*, the Ninth Circuit did not shy away from its critique of this testimony: “These opinions run head-on into the WPATH Standards of Care”²⁰⁰ In rejecting treatment that failed to provide GCS to the plaintiff, the Ninth Circuit found that the state’s treatment of Edmo’s gender dysphoria was objectively indifferent as a matter of professional judgment.²⁰¹

A final factual difference between the First and Ninth Circuit cases centers on the issue of security concerns. As previously mentioned, the First Circuit relied on a factual record that gave deference to administrators based on the security concerns for other incarcerated individuals and for the plaintiff invoked by the plaintiff’s history of domestic violence. Relying on this record made providing Kosilek with GCS seem less appropriate.²⁰² Meanwhile, the Ninth Circuit noted the absence of these security concerns in its own analysis of the record.²⁰³ While it is clear that there are factual differences that help explain the split between the First and Ninth Circuit’s outcomes, a split between the courts on the requisite legal analysis to ascertain deliberate indifference for less routine medical procedures is not apparent.

After the *Edmo* decision, the media began to run stories of the circuit split between the *Edmo* and *Kosilek IV* courts and the consequences for future transgender plaintiffs seeking similar relief.²⁰⁴ It is true that the First and Ninth Circuits disagreed in their holdings on whether the denial of GCS violated the Eighth Amendment. However, the Ninth Circuit’s approach to determining deliberate indifference mirrored that of the First Circuit in important ways, which calls into question the actual existence of

changed as more information becomes available, research is undertaken, and experience is gained”).

199. *Kosilek IV*, 774 F.3d at 78.

200. *Edmo*, 935 F.3d at 789 (“Dr. Garvey and Dr. Andrade’s view—that GCS cannot be medically indicated for transgender inmates who did not present in a gender-congruent manner before incarceration—contradicts these accepted standards.”).

201. *Id.* at 792.

202. *Kosilek IV*, 774 F.3d at 93–94.

203. *Edmo*, 935 F.3d at 794.

204. See, e.g., Amanda Peacher & James Dawson, Court Says Idaho Must Provide Gender Confirmation Surgery to Transgender Inmate, NPR (Aug. 23, 2019), <https://www.npr.org/2019/08/23/753788697/court-says-idaho-must-provide-gender-confirmation-surgery-to-transgender-inmate> [<https://perma.cc/97E2-728C>]; Helen Santoro, Transgender Prisoners in the West Now Have Tools for Self-Advocacy, High Country News (Oct. 2, 2019), <https://www.hcn.org/articles/gender-transgender-prisoners-in-the-west-now-have-tools-for-self-advocacy> [<https://perma.cc/M2HS-U5XT>].

such a split. Both courts employed an individualized, case-by-case approach, reliant on the prevailing WPATH standards to evaluate an incarcerated individual's claims. Such an approach can be categorized as the "*Kosilek-Edmo* framework."

Although many scholars have criticized the *Kosilek IV* opinion, these criticisms have largely centered on the decision's reliance on medical testimony that did not represent the scholars' views of medical consensus at the time, or on the court's specific application of the law to facts; the First Circuit's case-by-case approach to deliberate indifference for transgender individuals' claims itself has not been a main point of concern.²⁰⁵ As Judge Ojetta Rogeriee Thompson stated in dissent, "While the relief ordered by the district court, and affirmed by a majority of the original panel, was unprecedented, *Kosilek's* case is not a legally complicated one. Rather it is a fact-intensive dispute . . ." ²⁰⁶ The Ninth Circuit agreed with this description of the *Kosilek IV* legal standard.²⁰⁷ Thus, it is unsurprising that the *Edmo* court followed the First Circuit's legal approach, noting, "Our approach mirrors the First Circuit's, but the important factual differences between cases yield different outcomes."²⁰⁸

At the other end of the spectrum, the Ninth Circuit acknowledged its opposition to *Gibson's* uncompromising approach, including the Fifth Circuit's failure to consider new medical knowledge on the state of GCS according to the WPATH Standards of Care.²⁰⁹ The Ninth Circuit stated, per curiam, "We respectfully disagree with the categorical nature of our sister circuit's holding."²¹⁰ In this remark, the Ninth Circuit specifically took aim at the Fifth Circuit's refusal to order an individualized assessment of the plaintiff's medical need and reliance, instead, on the *Kosilek IV* court's testimony.²¹¹ The Ninth Circuit believed this refusal countered Eighth Amendment precedent, which demanded a fact-based analysis like

205. See, e.g., Hana Church, Comment, Prisoner Denied Sex Reassignment Surgery: The First Circuit Ignores Medical Consensus in *Kosilek v. Spencer*, 57 B.C. L. Rev. Elec. Supplement 17, 18 (2016) (arguing that the First Circuit erroneously failed to defer to medical consensus when determining an incarcerated individual's Eighth Amendment right); Edmondson, *supra* note 12, at 595 (arguing that the First Circuit misapplied the applicable law and ignored modern medical science in its analysis); Ruff, *supra* note 11, at 148 (arguing for alternate legal grounds that would permit transgender people to assert a right to gender expression independent of the right to medical care).

206. *Kosilek IV*, 774 F.3d at 97 (Thompson, J., dissenting).

207. *Edmo*, 935 F.3d at 794 ("Several years ago, the First Circuit, sitting en banc, employed that fact-based approach to evaluate a gender dysphoric prisoner's Eighth Amendment claim seeking GCS.").

208. *Id.*

209. *Id.* at 795 ("Most fundamentally, *Gibson* relies on an incorrect, or at best outdated, premise: that '[t]here is no medical consensus that [GCS] is a necessary or even effective treatment for gender dysphoria.'" (quoting *Gibson v. Collier*, 920 F.3d 212, 222–23 (5th Cir. 2019), cert. denied, 140 S. Ct. 653 (2019) (mem.))).

210. *Id.*

211. See *id.*

its own analysis and that of *Kosilek IV*.²¹² The Fifth Circuit's dearth of factual analysis is not surprising: *Gibson* had almost no factual record, in stark contrast to that of *Kosilek IV* and *Edmo*, in which factual records included information on the claimants' course of treatment, medical records, and expert testimony.²¹³ Still, the Ninth Circuit's blatant critique highlights the unsoundness of the Fifth Circuit's deliberate-indifference interpretation. When compared to the *Kosilek–Edmo* framework, the Fifth Circuit essentially requires plaintiffs to meet a higher burden of proof for subjective deliberate indifference—universal acceptance of the denied medical treatment—without a case-by-case determination of individual need or concern for how medical standards can change faster than the prison policies (or contracted health care services) that determine treatment options.²¹⁴

III. TOWARD AN EQUITABLE APPLICATION OF DELIBERATE INDIFFERENCE

The issue of providing medically necessary health care to incarcerated transgender individuals as required by the Eighth Amendment is wrought with challenges. Policy solutions to increase access to health care for *any* population within prison are unlikely to gain public support—let alone for a population as discriminated against as transgender individuals.²¹⁵ The high cost of surgical procedures and the struggles of transgender individuals to gain access to GCS outside the prison context make the transgender prison population all the more susceptible to scrutiny and continuously likely to seek redress from the legal system.²¹⁶ Recognizing this dynamic and the split between circuit courts on how to approach the subjective prong of deliberate indifference for GCS claims, this Part instead suggests ways for courts to more consistently approach requests by transgender plaintiffs for injunctions going forward. Section III.A recommends that future courts adjudicating GCS claims follow the *Kosilek–Edmo* framework, which allows for medical need to be examined on an individual basis in light of nationally recognized and evolving standards, best adhering to the demands of the Eighth Amendment. Section III.B establishes recommendations for courts to standardize their analyses within this framework as well as possible applications of the framework to similar contexts.

212. See *id.* at 766, 794 (“Our decision cleaves to settled Eighth Amendment jurisprudence, which requires a fact-specific analysis of the record (as construed by the district court) in each case.”); *supra* section II.B (explaining how the *Gibson* court rejects deliberate-indifference precedent).

213. See *Edmo*, 935 F.3d at 775–81 (describing testimony from relevant witnesses, including four expert witnesses in the field of gender dysphoria, alongside other aspects of the factual record); *Gibson*, 920 F.3d at 230 (Barksdale, J., dissenting) (describing how no discovery had been taken for the proceeding); *Kosilek IV*, 774 F.3d 63, 74–82 (1st Cir. 2014) (describing the three rounds of testimony on both medical necessity and security concerns).

214. See *supra* section II.B.

215. See *supra* note 57 and accompanying text.

216. See *supra* section I.A.2.

A. *Recommending the Kosilek–Edmo Framework*

The circuit splits among the First, Fifth, and Ninth Circuits call for greater guidance on how to approach deliberate-indifference claims for GCS or for gender dysphoria care more generally. The Fifth Circuit’s approach sets the benchmark for fulfilling the subjective prong of deliberate indifference too high for transgender individuals seeking treatment. In the court’s view, a prison official cannot be deliberately indifferent for failure to provide treatment that lacks medical consensus—ignoring that GCS is now actually well-established within the medical community and that the stigma surrounding trans issues can lead to a false veneer of controversy.²¹⁷ The court essentially allows prisons to institute a categorical ban on GCS and, presumably, other kinds of care if most other prisons do not provide that treatment, claiming that denying treatment would then not be *unusual*.²¹⁸ On the other hand, the *Kosilek–Edmo* framework assesses an official’s liability by examining an individual plaintiff’s factual circumstances against the official’s awareness and conformity to nationally recognized medical standards, like the WPATH Standards of Care.²¹⁹

Circuit courts should adopt the *Kosilek–Edmo* framework going forward. By examining medical need on an individual basis in comparison to medical consensus, the *Kosilek–Edmo* framework enables courts to continuously consider the progression of medical knowledge surrounding gender dysphoria when determining deliberate indifference, without giving undue weight—like the *Gibson* court would—to the potentially archaic treatment policies that prisons may be instituting on this front.²²⁰ In this way, the *Kosilek–Edmo* framework better vindicates the constitutional right to medical care for incarcerated transgender individuals while still ensuring that frivolous claims are dismissed. For example, a court using the framework may still easily dismiss an Eighth Amendment claim on the type of one’s *preferred* treatment for gender dysphoria, such as surgical treatment, when alternative treatments, like hormone therapy, would suffice as an adequate alternative for that plaintiff according to expert testimony on the appropriate WPATH Standards of Care.²²¹ In addition, the fact-specific aspects of the *Kosilek–Edmo* framework have ample jurisprudential support already, which should guide lower courts to follow the *Kosilek–Edmo* framework for transgender plaintiffs seeking GCS going forward.²²²

217. See *supra* section II.B.

218. See *supra* section II.B.

219. See *supra* section II.C.

220. See *supra* sections II.B–C.

221. See *Lamb v. Norwood*, 899 F.3d 1159, 1162 (10th Cir. 2018) (holding that prison officials do not act with deliberate indifference merely when they provide medical treatment that is subpar or varies from the incarcerated individual’s preference).

222. See *supra* notes 179–185 and accompanying text.

B. *Standardizing and Applying the Kosilek–Edmo Framework*

There are several ways to standardize the *Kosilek–Edmo* approach that will meet the constitutional rights of incarcerated individuals while adhering to precedent. First, at the most basic level, implementation of the approach requires a fact-specific analysis of the subjective prong of deliberate indifference, so courts should reject prison policies that threaten individualized medical assessments. In practice, assessing whether a prison’s medical policy effectively serves as a categorical ban—and thus, should be struck down—may be more difficult than it appears at first glance. It is quite possible that a prison’s official policy does not categorically forbid GCS, but that other factors essentially render the prison policy as a ban on GCS regardless of medical need. Such factors could include the lack of access to medical professionals capable of issuing an initial diagnosis of gender dysphoria, precluding evaluation,²²³ or the exclusion of GCS as a treatment option by the health care service contracted by the prison. The latter was the case in *Gibson*. The Texas Department of Criminal Justice refused to provide a medical evaluation of Lynn for GCS, as it was not formally part of their health care plan for gender dysphoria.²²⁴ However, their official policy actually required an individualized medical examination—the policy stated that individuals with gender dysphoria must be “evaluated by appropriate medical and mental health professionals and treatment determined *on a case by case basis* as clinically indicated.”²²⁵ Thus, judges should be circumspect when analyzing how a prison’s official policy is manifested in practice. Courts could follow the approach of the Northern District of California, which, in finding that a prison policy served as a categorical ban on GCS, deferred to testimony by doctors stating that there was an “understanding” among prison medical providers that prison policy excluded GCS as a treatment option.²²⁶

223. Kinkead & Peralta, *supra* note 70, at 3 (explaining how the New York State Department of Corrections and Community Supervision has contracted with only one doctor capable of diagnosing gender dysphoria, which is necessary for incarcerated transgender individuals to receive treatment).

224. See *supra* section II.B.

225. *Gibson v. Collier*, 920 F.3d 212, 238 (5th Cir. 2019) (Barksdale, J., dissenting) (emphasis added) (citation omitted), cert. denied, 140 S. Ct. 653 (2019) (mem.).

226. *Norsworthy v. Beard*, 87 F. Supp. 3d 1164, 1177 (N.D. Cal. 2015) (“Kohler . . . testified that it is still her understanding that hormone therapy and mental health treatment are the only currently available treatments for incarcerated patients. Norsworthy testified that her providers had indicated . . . that [California Department of Corrections and Rehabilitation] had a policy of not providing [GCS] to transgender inmates.”); see also *Bayse v. Dozier*, No. 5:18-cv-00049-TES-CHW, 2019 WL 3365854, at *7 (M.D. Ga. May 21, 2019) (“Even if the policy is somewhat ambiguous as to the availability of [GCS], courts that have reviewed similar prison policies have turned to physicians’ interpretations and implementation of those policies to determine whether the policy, in practice, serves as a ban on [GCS].”).

Second, courts should rely extensively on expert testimony, individualized to the incarcerated individual, to assess the adequacy of prison officials' responses to meet the objectively serious medical needs related to that individual's gender dysphoria. Both inside and outside the Eighth Amendment context, courts regularly rely on the testimony of experts to assess medical and scientific evidence in light of established consensus.²²⁷ It is true that there is no universal understanding of what constitutes "adequacy" of treatment for gender dysphoria.²²⁸ Recall, however, that numerous professional organizations agree that the WPATH Standards of Care, which recommend GCS in some instances for individuals experiencing significant dysphoric distress, represent the established standards of care for trans health care within the medical community.²²⁹ WPATH recognizes that their standards should apply to incarcerated individuals,²³⁰ and the WPATH Standards of Care are deliberately flexible and thus, able to be used and adapted according to fact-specific inquiries, as called for by the *Kosilek-Edmo* framework. At a baseline, lower courts would do well to agree with the *Edmo* court that individuals who fail to ascribe to the WPATH Standards of Care depart from widely established medical norms and should not be accorded much testimonial weight as experts.²³¹ Therefore, testimony of a medical evaluation performed by an individual unfamiliar with gender dysphoria and the WPATH Standards of Care should not proscribe a finding of deliberate indifference.²³² Instead, only medical professionals familiar with the diverse needs of individuals with gender dysphoria should be considered "experts" capable of providing an individualized medical evaluation of the plaintiff in question, and subsequently, evaluating the adequacy of the prison officials' medical responses to the plaintiff's gender dysphoria.

227. See, e.g., *Atkins v. Virginia*, 536 U.S. 304, 316 n.21 (2002) (discussing how a national consensus by professional organizations "with germane expertise" had developed against using the death penalty to execute mentally ill individuals); *Daubert v. Merrell Dow Pharms., Inc.*, 509 U.S. 579, 588 (1993) (explaining how Rule 702 of the Federal Rules of Evidence requires the trial judge to ensure an expert's testimony is reliable and relevant to the task at hand).

228. See *supra* section I.A.2.

229. See *supra* section I.A.1.

230. See *supra* section I.A.1.

231. "In the final analysis under the Eighth Amendment, we must determine, considering the record, the judgments of prison medical officials, and the views of prudent professionals in the field, whether the treatment decision of responsible prison authorities was medically acceptable." *Edmo v. Corizon, Inc.*, 935 F.3d 757, 786 (9th Cir. 2019). The Ninth Circuit found that the WPATH Standards of Care represent the views of prudent professionals; the individuals in this case departed from these medical norms and "lacked expertise." *Id.* at 787.

232. See *Etheridge*, *supra* note 32, at 605 ("Despite the call for judgment to be exercised by a qualified professional in the case of individuals with mental disabilities, courts continuously allow untrained prison officials to make important decisions regarding transgender prisoners.").

Finally, courts should proceed with caution when evaluating the validity of prison officials' security concerns over the provision of GCS, which are typically afforded deference as part of the subjective analysis of deliberate indifference.²³³ In general, plaintiffs rarely have direct evidence sufficient to adjudicate an officer's state of mind as required by this subjective analysis.²³⁴ Further, the subjective deliberate-indifference standard may invite defendants to misconstrue their knowledge of the harm an incarcerated individual faces, incentivizing prison officials to offer ex post facto security concerns to justify medical inaction.²³⁵ Societal stigma against transgender individuals and general lack of knowledge surrounding gender dysphoria can make deference to security concerns all the more questionable, as transgender individuals already face increased challenges maintaining their deliberate-indifference claims, even when valid.²³⁶ The district court decision in the *Kosilek* series initially found that "the purported security considerations that [Massachusetts DOC Commissioners] Dennehy and Clarke claim motivated their decisions to deny Kosilek [GCS] are largely false and any possible genuine concerns have been greatly exaggerated to provide a pretext for denying the prescribed treatment."²³⁷ Thus, as other scholars have advanced, it is imperative that judges be wary of according too much deference to prison officials, especially regarding matters as sensitive as the constitutional question of deliberate indifference.²³⁸ Such scrutiny is appropriate considering that courts have previously used a "good faith" test to determine how much weight to ascribe to security considerations that could arise by providing treatment to transgender individuals.²³⁹ A successful employment of the *Kosilek-Edmo* framework—one that recognizes the constitutional right of incarcerated transgender individuals to be free of cruel and unusual punishment—would require courts to be particularly critical of the reasonableness of security concerns surrounding claims for GCS. To do this, lower courts should rely on outside experts capable of making a case-by-case determi-

233. See supra note 118 and accompanying text.

234. Margo Schlanger, Am. Const. Soc'y for L. & Pol'y, Restoring Objectivity to the Constitutional Law of Incarceration 14 (2018), <https://www.acslaw.org/wp-content/uploads/2018/09/Schlanger-Sept-2018-IB-Restoring-Objectivity.pdf> (on file with the *Columbia Law Review*) [hereinafter Schlanger, Restoring Objectivity]. The majority of incarcerated individuals are pro se plaintiffs in civil rights cases, making it even more difficult to gather the requisite evidence to prove the subjective prong of deliberate indifference. Schlanger, Trends, supra note 97, at 167 tbl.6.

235. Schlanger, Restoring Objectivity, supra note 234, at 14.

236. See supra note 11 and accompanying text.

237. *Kosilek II*, 889 F. Supp. 2d 190, 241 (D. Mass. 2012).

238. See, e.g., Mason, supra note 55, at 186 (calling for judges "to treat more skeptically the spurious arguments that prison officials commonly advance").

239. See, e.g., *Battista v. Clarke*, 645 F.3d 449, 455 (1st Cir. 2011) (finding that the denial of a hormone therapy request based on security concerns was not made in good faith considering that defendants did not take the request seriously, took several years to produce a security justification, and based this security justification on inaccurate data).

nation of the security risks posed by an individual, rather than relying solely on experts retained by the DOC. In addition, courts should, to the extent possible, balance deference to administrators with objective indicia of an individual's security risk, like the DOC's Classification Manual (which states, for example, how an individual's tendency to be a flight risk influences their security classification).²⁴⁰

Courts can and should employ this framework in similar contexts apart from requests for GCS as well, such as requests for safe housing accommodations and other provisions of gender-dysphoria treatment (like hormone therapy²⁴¹) by transgender individuals. For example, it is entirely feasible for a court to conduct a fact-specific inquiry—based on expert testimony about the security concerns and the individual's medical needs—into how prison officials should respond to an individual's desire to live in housing that aligns with their gender identity, if constitutionally appropriate. In fact, the Supreme Court conducted a similar factual inquiry for the subjective prong of deliberate indifference in *Farmer v. Brennan* when determining whether the respondent federal prison officials were deliberately indifferent to the transgender petitioner's safety by housing the petitioner in a facility where she was eventually assaulted.²⁴² Some aspects of the *Kosilek–Edmo* framework will not be relevant in the housing context, such as reliance on the WPATH Standards of Care. However, other aspects, including courts' ability to more deliberately scrutinize proffered security concerns, will remain relevant to requests for gender-dysphoria accommodations besides GCS as well. By adopting the *Kosilek–Edmo* framework, courts may be better equipped to provide incarcerated transgender individuals with the protection mandated to them by the U.S. Constitution.

CONCLUSION

When compared to *Kosilek* and *Edmo*, the Fifth Circuit's decision in *Gibson* represents a major split in deliberate-indifference doctrine pertaining to requests for gender confirmation surgery by incarcerated transgender individuals. It raises the burden of proof for the subjective prong of deliberate indifference to an untenable degree, redefining the cruel and unusual punishment provision of the Eighth Amendment in the process. In doing so, the Fifth Circuit allows prisons to evade abiding by new medical knowledge on gender dysphoria and, potentially, other

240. *Kosilek II*, 889 F. Supp. 2d at 242 (explaining the DOC's Male Classification Manual, which is used to determine the level of security risk posed by an incarcerated individual).

241. See, e.g., *Battista*, 645 F.3d at 455 (finding deliberate indifference of medical needs against prison officials and upholding an injunction for hormone therapy and access to female clothing).

242. 511 U.S. 825, 826 (1994) (“Whether an official had the requisite knowledge is a question of fact subject to demonstration in the usual ways, and a factfinder may conclude that the official knew of a substantial risk from the very fact that it was obvious.”).

medical needs as well. When future courts do inevitably adjudicate claims for gender confirmation surgery, this Note suggests that they instead follow the *Kosilek–Edmo* framework by assessing the subjective prong on a case-by-case basis of medical need irrespective of other prisons' policies writ large. Courts should reject categorical prison policies on medical treatments, rely on experts familiar with the WPATH Standards of Care for medical assessments, and apply increased caution when considering the security concerns prison officials may proffer in regard to providing certain accommodations to incarcerated transgender individuals. The adoption of these changes could go a long way toward ensuring that the constitutional promise of the Eighth Amendment is met.

