
**Transsexual Prisoners and the Eighth Amendment:
A Reconsideration of *Kosilek v. Spencer* and Why
Prison Officials May Not Be Constitutionally Required
To Provide Sex-Reassignment Surgery**

*“Requiring the state to fund a medical procedure for a first-degree murderer that many private citizens cannot afford and that those receiving medical coverage from the state do not have the option to receive undermines the public’s confidence in government and our institutions of corrections and justice.”*¹

I. INTRODUCTION

For many Americans, the thought of providing any form of medical care to a convicted murderer is incomprehensible, a sentiment embodying the tenuous interplay between principles of morality and the rule of law.² The reality is that prisoners throughout the United States frequently undergo various medical procedures to treat their health care needs, but for transsexual prisoners, the uphill battle to receive treatment, including hormone therapy and sex-reassignment surgery (SRS), has been plagued by the courts’ general resistance to recognize the severity of gender dysphoria.³ The Eighth Amendment has long been interpreted to afford a prisoner the right to receive adequate medical care and treatment for his or her serious medical needs.⁴ The Supreme Court has further explained that the Eighth Amendment’s protections must conform

1. Bruce Tarr, *Statement on DOC Appeal of Kosilek Ruling*, TARR TALK (Sept. 26, 2012, 6:18 PM), <http://www.tarrtalk.com/2012/09/statement-on-doc-appeal-of-kosilek.html>.

2. See *Kosilek v. Maloney (Kosilek I)*, 221 F. Supp. 2d 156, 160 (D. Mass. 2002) (“[T]he idea that an imprisoned male murderer may ever have a right to receive female hormones and sex reassignment surgery may understandably strike some people as bizarre.”). The court curtailed the temptation to view gender identity disorder treatment, including sex-reassignment surgery, from a purely moral, social perspective. See *id.* Instead, the court mandated that cases that often strike a nerve with society, like this one, require a neutral application of the Eighth Amendment. See *id.*

3. See Darren Rosenblum, “Trapped” in *Sing Sing: Transgendered Prisoners Caught in the Gender Binarism*, 6 MICH. J. GENDER & L. 499, 516-19 (2000) (overviewing difficult struggles facing transgendered prisoners to receive adequate treatment); Christine Peek, Comment, *Breaking Out of the Prison Hierarchy: Transgender Prisoners, Rape, and the Eighth Amendment*, 44 SANTA CLARA L. REV. 1211, 1213-18 (2004) (discussing inability of transgendered individuals to seek appropriate forms of medical care).

4. See U.S. CONST. amend. VIII; *Estelle v. Gamble*, 429 U.S. 97, 103-06 (1976) (asserting Eighth Amendment mandates providing medical care to prisoners).

to shifting and maturing notions of decency and social justice.⁵

Gender Identity Disorder (GID) has been recognized as a mental illness; individuals currently incarcerated and suffering from GID—or gender dysphoria as it has been recently renamed—assert that SRS is a “medically necessary” treatment for this condition under the Eighth Amendment.⁶ In 2012, the United States District Court for the District of Massachusetts became the first American court to grant an injunction mandating a prison to provide SRS to a transsexual prisoner in the case of *Kosilek v. Spencer (Kosilek II)*.⁷ Michelle Kosilek, a male-to-female transsexual currently serving a life sentence for the murder of her wife, sought to have the Massachusetts Department of Corrections (DOC) provide her with the controversial procedure.⁸ The DOC doctors determined that the only adequate treatment for Kosilek’s condition was to undergo the procedure but nonetheless denied treatment out of the purported rising fears for prison security.⁹ Holding that the security concerns were merely a pretext for denying treatment, the court found that prison officials were deliberately indifferent to Kosilek’s serious medical needs and ordered the treatment.¹⁰

In response to the district court’s order, a vigorous debate ensued at the state and national levels regarding the constitutionality of providing or denying SRS based on security concerns and costs to the American taxpayer.¹¹ Transsexual

5. See *Estelle*, 429 U.S. at 102 (“The Amendment embodies ‘broad and idealistic concepts of dignity, civilized standards, humanity, and decency’” (quoting *Jackson v. Bishop*, 404 F.2d 571, 579 (8th Cir. 1968))); *Trop v. Dulles*, 356 U.S. 86, 101 (1958) (“The Amendment must draw its meaning from the evolving standards of decency that mark the progress of a maturing society.”).

6. See Anita C. Barnes, Note, *The Sexual Continuum: Transsexual Prisoners*, 24 NEW ENG. J. ON CRIM. & CIV. CONFINEMENT 599, 610-13 (1998) (explaining needs of transsexual prisoners include seeking SRS historically unavailable within prisons). See generally E. Coleman et al., *Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People, Version 7*, 13 INT’L J. TRANSGENDERISM 165 (2011). Since the court’s ruling in *Kosilek v. Spencer (Kosilek II)*, 889 F. Supp. 2d 190 (D. Mass. 2012), the term “gender dysphoria” has replaced the diagnostic name of “gender identity disorder.” *Gender Dysphoria*, AM. PSYCHIATRIC ASS’N (last visited Apr. 26, 2014), <http://www.dsm5.org/documents/gender%20dysphoria%20fact%20sheet.pdf>.

7. See *Kosilek II*, 889 F. Supp. 2d at 196. In this Note, the term “transsexual” is used to refer to individuals who identify or who are named as such in various court opinions. In several opinions and an assortment of literature on the subject, transsexuals, transgendered, and gender nonconforming individuals are misnamed and improperly identified. This Note will use pronouns that refer to the individual’s preferred gender identity. See Sydney Tarzwell, Note, *The Gender Lines Are Marked with Razor Wire: Addressing State Prison Policies and Practices for the Management of Transgender Prisoners*, 38 COLUM. HUM. RTS. L. REV. 167, 167 n.1 (2006), for a discussion of the importance of proper classification.

8. See *Kosilek II*, 889 F. Supp. 2d at 196-97.

9. *Id.* at 197-98.

10. *Id.* at 198-99; see *infra* Part II.D.2 (discussing findings on testimony before court in *Kosilek II*).

11. See Travis Andersen, *State Appealing Federal Ruling Granting Sex Change for Inmate Michelle Kosilek*, BOSTON.COM (Sept. 26, 2012, 8:00 PM), <http://www.boston.com/metrodesk/2012/09/26/state-appealing-federal-ruling-granting-sex-change-for-inmate-michelle-kosilek/EjcKFdJ4liXYjc5aUHIr1K/story.html>. Historically, private insurance companies have refused to provide coverage for SRS. See Rebecca Mann, Note, *The Treatment of Transgender Prisoners, Not Just an American Problem—A Comparative Analysis of American, Australian, and Canadian Prison Policies Concerning the Treatment of Transgender Prisoners and*

and transgendered individuals suffering from GID or gender dysphoria possess “a strong and persistent cross-gender identification,” which is “manifested by symptoms such as preoccupation with getting rid of primary and secondary sex characteristics . . . or [a] belief that he or she was born the wrong sex.”¹² As suggested by the Standards of Care (SOC), established by the World Professional Association for Transgender Health (WPATH) governing the commonly used course of treatment for GID, treatment may require hormone therapy, real-life experience living as a member of the opposite sex, and SRS.¹³ In cases where medical professionals deem SRS to be the only option, courts across the country will be faced with the question of whether denying the surgery constitutes cruel or unusual punishment in violation of a prisoner’s Eighth Amendment rights.¹⁴

Part II of this Note will explore the evolution of the case law surrounding a transsexual prisoner’s right to adequate medical treatment under the Eighth Amendment, as well as the growth of GID or gender dysphoria as a recognized psychological disease or mental illness. Part III of this Note will address two important elements ignored in the federal district court’s decision and important for any future analysis of whether a court should grant SRS to a prisoner: the dramatic effect of security interests after the procedure on the Eighth Amendment landscape and the important distinction between providing “curative” and “adequate” treatment for gender dysphoria or GID.

II. HISTORY

In early 2011, the Federal Bureau of Prisons (BOP) issued a memorandum setting forth its policy for the evaluation and treatment of prisoners with GID by BOP personnel.¹⁵ The policy provided that prisoners with GID would be

a “Universal” Recommendation To Improve Treatment, 15 LAW & SEXUALITY 91, 102-04 (2006) (discussing American insurance policies concerning transsexual treatments); Bradley A. Sultan, Note, *Transsexual Prisoners: How Much Treatment Is Enough?* 37 NEW ENG. L. REV. 1195, 1205 n.73 (2003) (noting Massachusetts insurance plan’s excluding “services and supplies that are related to sex change surgery”).

12. AM. PSYCHIATRIC ASS’N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 27 (4th ed. 2000) [hereinafter DSM-IV-TR]; see *Sonyeea v. Spencer*, 851 F. Supp. 2d 228, 231-32 (D. Mass. 2012) (discussing Gender Identity Disorder under DSM-IV-TR).

13. *Coleman et al.*, *supra* note 6, at 170-71 (overviewing treatment options for GID); see *Alexander v. Weiner*, 841 F. Supp. 2d 486, 488-89 (D. Mass. 2012) (finding plaintiff entitled to laser hair removal pursuant to SOC treatment options).

14. See *Kosilek II*, 889 F. Supp. 2d 190, 196 (D. Mass. 2012) (noting uniqueness of unprecedented order allowing SRS).

15. See Memorandum from Newton E. Kendig, Assistant Dir., Health Servs. Div., Fed. Bureau of Prisons, and Charles E. Samuels Jr., Assistant Dir., Corr. Programs Div., Fed. Bureau of Prisons, to Chief Exec. Officers (May 31, 2011) [hereinafter BOP Memo], available at <http://www.glad.org/uploads/docs/cases/adams-v-bureau-of-prisons/2011-gid-memo-final-bop-policy.pdf>; see also Press Release, Gay & Lesbian Advocates & Defenders, Federal Bureau of Prisons Makes Major Change in Transgender Media Policy (Sept. 30, 2011), <http://www.glad.org/current/pr-detail/federal-bureau-of-prisons-makes-major-change-in-transgender-medical-policy> (discussing treatment change to BOP policy for GID inmates). The memorandum published by the BOP

afforded individualized treatment options based on the accepted “standards of care,” as opposed to the past procedure of keeping prisoners at the same level of treatment they were receiving prior to incarceration.¹⁶ The federal district court’s treatment mandate raises the issue of whether denying transsexual prisoners SRS is indeed a violation of a prisoner’s Eighth Amendment right.¹⁷

A. *The Eighth Amendment Right to Medical Care While in Custody*

A long history of cases before the Supreme Court has routinely interpreted the constitutional prohibition against “cruel and unusual punishment” under the Eighth Amendment.¹⁸ Expanding from the early interpretation of the Amendment, which focused on the bar against torture and other barbarous methods of punishment for prisoners, the Court has since noted that the words of the clause are “not precise, and their scope is not static.”¹⁹ The Amendment’s reach today is far more flexible and is largely influenced by society’s growing notions of what it believes defines humane and just treatment.²⁰

1. *Establishment of the Deliberate Indifference Standard*

Inherent in the understanding of the Eighth Amendment is that the treatment and conditions to which an inmate is subjected while in custody and the punishment for a particular crime must be both in accord with the dignity of man and not “excessive.”²¹ The inquiry into “excessiveness” has two aspects:

establishes that when inmates receive a possible GID diagnosis, they will be subjected to medical and mental health evaluations from medical professionals competent to handle sexual disorders. See BOP Memorandum, *supra*.

16. See BOP Memorandum, *supra* note 15 (overviewing changes to BOP policy).

17. See *Kosilek II*, 889 F. Supp. 2d at 239-40 (holding Kosilek’s serious medical need outweighed pretextual security concerns and requiring DOC provide surgery).

18. See U.S. CONST. amend. VIII (“Excessive bail shall not be required, nor excessive fines imposed, nor cruel and unusual punishments inflicted.”); *Gregg v. Georgia*, 428 U.S. 153, 169-73 (1976) (reviewing Court decisions preventing cruel and unusual punishments); *In re Kemmler*, 136 U.S. 436, 447 (1890) (“Punishments are cruel when they involve torture or a lingering death”); *Wilkerson v. Utah*, 99 U.S. 130, 135-36 (1878) (holding punishment of torture and like cruelty barred by amendment).

19. *Trop v. Dulles*, 356 U.S. 86, 100-01 (1958) (“The Amendment must draw its meaning from the evolving standards of decency that mark the progress of a maturing society.”); see *Gregg*, 428 U.S. at 172-73 (“It is clear from the . . . precedents that the Eighth Amendment has not been regarded as . . . static”); *Furman v. Georgia*, 408 U.S. 238, 316-22 (1972) (Marshall, J., concurring) (recounting derivation of language from English law as influencing American prohibition of barbaric, tortuous punishments); *Weems v. United States*, 217 U.S. 349, 371-73 (1910) (explaining underlying English influences on intent to prevent cruelty other than “bodily pain or mutilation”). See generally Anthony F. Granucci, “*Nor Cruel and Unusual Punishments Inflicted:*” *The Original Meaning*, 57 CALIF. L. REV. 839 (1969) (discussing English law development of the clause).

20. See *Estelle v. Gamble*, 429 U.S. 97, 102-03 (1976) (stating Amendment embodies changing standards of humanity and decency); *Weems*, 217 U.S. at 378 (explaining Federal Constitution holds new meaning as society progresses).

21. *Gregg*, 428 U.S. at 173.

“the punishment must not involve the unnecessary and wanton infliction of pain;” and the “punishment must not be grossly out of proportion to the severity of the crime.”²² The Supreme Court has outlined the general standards necessary to challenge physical punishments under the Eighth Amendment, and the landmark case of *Estelle v. Gamble*²³ established the current test for challenging the denial of medical treatment to prisoners.²⁴

In *Estelle*, the Court took up the issue of the evolving interpretations of the Eighth Amendment’s Cruel and Unusual Punishment Clause.²⁵ Although the Court denied the prisoner’s claim, it reasoned that a denial or delay of medical care, or an interference with prescribed treatment to a prisoner, would result in pain and suffering that does not serve any penological purpose.²⁶ Identifying that prisoners deserve medical care that they cannot provide themselves, the Court established that “deliberate indifference to serious medical needs of prisoners constitutes the ‘unnecessary and wanton infliction of pain.’”²⁷

The deliberate indifference test formulated by the *Estelle* Court works to provide later courts with a definitive legal framework for analyzing Eighth Amendment prisoner claims.²⁸ After *Estelle*, the Court expanded the test to contain both objective and subjective components.²⁹ A prisoner must allege not

22. *Id.*; see *Johnson v. Glick*, 481 F.2d 1028, 1033 (2d Cir. 1973) (“Not every push or shove, even if it may later seem unnecessary in the peace of a judge’s chambers, violates a prisoner’s constitutional rights.”).

23. 429 U.S. 97 (1976).

24. See *id.* at 104 (indicating deliberate indifference to prisoners’ serious medical needs violates Eighth Amendment).

25. See *id.* at 107-08 (holding respondent’s seventeen examinations in three months failed to amount to deliberate indifference).

26. See *id.* at 103-05. The Court noted that “[a]n inmate must rely on prison authorities to treat his medical needs; if the authorities fail to do so, those needs will not be met.” *Id.* at 103. Preventing a prisoner from receiving medical care becomes the equivalent of “torture or a lingering death,” which the Court expressly prohibited. *Id.*; see *Brown v. Plata*, 131 S. Ct. 1910, 1928 (2011) (“A prison that deprives prisoners of basic sustenance, including adequate medical care, is incompatible with the concept of human dignity and has no place in civilized society.”). Prisoners may challenge cruel and unusual punishments by filing *Bivens* actions against the individual federal officials, as established under 42 U.S.C. § 1983. See *Bivens v. Six Unknown Named Agents*, 403 U.S. 388, 397 (1971) (establishing federal officials eligible for suit for constitutional violations).

27. See *Estelle v. Gamble*, 429 U.S. 97, 104 (1976) (quoting *Gregg v. Georgia*, 428 U.S. 153, 173 (1976)). In setting the current cause of action of “deliberate indifference” to challenge denials of medical care under § 1983, the Court effectively incorporated the “excessiveness” test developed by the *Gregg* Court. *Id.* The Court further noted that the indifference can be manifested several ways by either prison doctors or prison guards denying or delaying such care. See *id.*

28. *Estelle*, 429 U.S. at 104-05 (establishing requisites for claiming Eighth Amendment violation); see *Kosilek II*, 889 F. Supp. 2d 190, 198-99 (D. Mass. 2012) (analyzing prisoner’s deliberate indifference claim based on established Eighth Amendment jurisprudence); Nikolas Andreopoulos, Note, *Kosilek v. Maloney: In Prison While Imprisoned in the Body of the Opposite Sex: Examining the Issue of “Cruel and Unusual Punishment” Presented by an Incarcerated Transsexual*, 27 W. NEW ENG. L. REV. 219, 223-26 (2005) (discussing Court’s attempt in *Estelle* to provide specific legal analysis).

29. See *Wilson v. Seiter*, 501 U.S. 294, 298-99, 303 (1991) (finding cruel and unusual punishment analysis does not stop after objective inquiry satisfied). In *Wilson*, the Court explained the history of the formulation of the objective and subjective components of the test. See *id.* at 298.

only that “a substantial risk of serious harm” objectively exists, but also that the prison official possessed a culpable state of mind by not acting appropriately.³⁰ Deliberate indifference requires a state of mind more intentional than negligence and less than acting with specific purpose to cause harm, and is recognized as equivalent to recklessness under a criminal law standard by the Supreme Court.³¹ Furthermore, the Court in *Farmer v. Brennan*³² determined that “[t]he Eighth Amendment does not outlaw cruel and unusual conditions; it outlaws cruel and unusual punishments. . . . [A]n official’s failure to alleviate a significant risk that he should have perceived but did not, while no cause for commendation, cannot under our cases be condemned as the infliction of punishment.”³³ Additionally, a prison official’s conduct may not violate the Eighth Amendment if the countervailing concerns, such as prison security, are found to outweigh any finding of deliberate indifference.³⁴

2. Requirement of Finding a Serious Medical Need

In the medical care context, an inmate is entitled to receive adequate medical treatment in order to prevent a substantial risk of serious injury.³⁵ For a claim to constitute a violation of the Eighth Amendment, “a prisoner must allege acts

30. See *Farmer v. Brennan*, 511 U.S. 825, 837-39 (1994) (surveying Court’s establishment of subjective component). As explained in *Wilson v. Seiter*, the inquiry does not end with the objective standard, but continues with the subjective inquiry into the prison official’s state of mind. See *id.* at 834; *Wilson*, 501 U.S. at 302-03.

31. See *Farmer*, 511 U.S. at 835; *Whitley v. Albers*, 475 U.S. 312, 325-26 (1986) (determining no Eighth Amendment violation to prisoner shot during riot because guard lacked required wantonness); *Rhodes v. Chapman*, 452 U.S. 337, 347-48 (1981) (holding “double ceiling” not cruel and unusual punishment for lack of unnecessary or wanton pain). In *Farmer*, the Supreme Court held that “subjective recklessness as used in the criminal law is a familiar and workable standard that is consistent with the Cruel and Unusual Punishments Clause as interpreted in our cases, and we adopt it as the test for ‘deliberate indifference’ under the Eighth Amendment.” 511 U.S. at 839-40.

32. 511 U.S. 825 (1994).

33. *Id.* at 837-38 (internal quotation marks omitted). Several cases after *Estelle* confirmed that a prison official’s state of mind must be analyzed and the conduct must amount to “obduracy and wantonness, not inadvertence or error in good faith.” *Whitley*, 475 U.S. at 319; see *Wilson*, 501 U.S. at 299 (quoting language from *Whitley*). For example, an inmate would be unable to claim an Eighth Amendment violation “if a prison boiler malfunctions accidentally during a cold winter”—an act sure to inflict pain upon the prisoner. *Wilson*, 501 U.S. at 300.

34. See *Battista v. Clarke*, 645 F.3d 449, 454 (1st Cir. 2011) (recognizing security concerns play important role in balancing analysis); *Kosilek I*, 221 F. Supp. 2d 156, 162 (D. Mass. 2002) (declaring “security is a legitimate consideration for Eighth Amendment purposes”); see also *Farmer*, 511 U.S. at 844-45 (1994) (explaining maintaining reasonable prison safety requires incorporating dangerous nature of prisoners and other security concerns); *Helling v. McKinney*, 509 U.S. 25, 37 (1993) (suggesting deliberate indifference consideration also “appropriate vehicle to consider arguments regarding the realities of prison administration”).

35. See *Estelle v. Gamble*, 429 U.S. 97, 103-05 (1976) (establishing claim of deliberate indifference for inmate’s medical need in denying or delaying care); see also *West v. Atkins*, 487 U.S. 42, 54 (1988) (“[T]he State has a constitutional obligation, under the Eighth Amendment, to provide adequate medical care to those whom it has incarcerated.”); Andrew Brunsten, Comment, *Hepatitis C in Prisons: Evolving Toward Decency Through Adequate Medical Care and Public Health Reform*, 54 UCLA L. REV. 465, 483-84 (2006) (outlining Eighth Amendment requirement for prisons to provide adequate medical care).

or omissions sufficiently harmful to evidence deliberate indifference to serious medical needs.”³⁶ According to the United States Court of Appeals for the Fifth Circuit, in order for a prisoner to establish deliberate indifference, he must show evidence that prison officials “refused to treat him, ignored his complaints, intentionally treated him incorrectly, or engaged in any similar conduct that would clearly evince a wanton disregard for any serious medical needs.”³⁷

As defined by the court in *Kosilek II*, a serious medical need is one where a substantial risk of serious harm will develop if the inmate is not adequately treated.³⁸ Several federal circuit courts of appeals employ their own factors for defining a “serious medical need,” each with its own distinctions; however, the First Circuit, where *Kosilek*’s case continues to be heard, defines a serious medical need as 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.”³⁹ Additionally, a serious medical need may be manifested either physically or mentally; thus, a deliberate indifference to a prisoner’s psychological condition will also constitute a violation of the Eighth Amendment.⁴⁰ While the *Estelle* Court

36. *Estelle*, 429 U.S. at 106. Multiple cases since the landmark decision of *Estelle* have assessed whether a prisoner’s claim in fact constituted deliberate indifference. See, e.g., *Battista*, 645 F.3d at 455 (finding deliberate indifference towards prisoner with GID by denying hormone therapy); *Jett v. Penner*, 439 F.3d 1091, 1097-98 (9th Cir. 2006) (finding deliberate indifference by failing to ensure plaintiff saw orthopedist for timely care of fracture); *Soneeya v. Spencer*, 851 F. Supp. 2d 228, 248-50 (D. Mass. 2012) (finding DOC officials deliberately indifferent to prisoner’s serious medical needs by failing to evaluate GID). But see, e.g., *Mata v. Saiz*, 427 F.3d 745, 759-60 (10th Cir. 2005) (dismissing claim of deliberate indifference against nurse knowing prisoner suffering from severe chest pain); *Smith v. Carpenter*, 316 F.3d 178, 188-89 (2d Cir. 2003) (holding no deliberate indifference for deprivation of HIV medication); *Gibson v. Cnty. of Washoe*, 290 F.3d 1175, 1196-97 (9th Cir. 2002) (reasoning sheriff deputies not deliberately indifferent to inmate’s mental health condition).

37. *Domino v. Tex. Dep’t of Criminal Justice*, 239 F.3d 752, 756 (5th Cir. 2001) (quoting *Johnson v. Treen*, 759 F.2d 1236, 1238 (5th Cir. 1985)) (internal quotation marks omitted); see *Feeney v. Corr. Med. Servs., Inc.*, 464 F.3d 158, 162 (1st Cir. 2006) (“The care provided must have been so inadequate as to shock the conscience.” (quoting *Torraco v. Maloney*, 923 F.2d 231, 234 (1st Cir. 1991)) (internal quotation marks omitted)).

38. See *Kosilek II*, 889 F. Supp. 2d 190, 229 (D. Mass. 2012).

39. *Gaudreault v. Municipality of Salem*, 923 F.2d 203, 208 (1st Cir. 1990) (holding no serious medical need for prisoner suffering assault by arresting police officers); see, e.g., *Farrow v. West*, 320 F.3d 1235, 1243 (11th Cir. 2003) (“In our circuit, a serious medical need is considered 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.’” (quoting *Hill v. Dekalb Reg’l Youth Det. Ctr.*, 40 F.3d 1176, 1187 (11th Cir. 1994))); *Chance v. Armstrong*, 143 F.3d 698, 702 (2d Cir. 1998) (“Factors that have been considered include the existence of an injury that a reasonable doctor or patient would find important and worthy of comment or treatment; the presence of a medical condition that significantly affects an individual’s daily activities; or the existence of chronic and substantial pain.” (quoting *McGuckin v. Smith*, 974 F.2d 1050, 1059-60 (9th Cir. 1992))); *Monmouth Cnty. Corr. Institutional Inmates v. Lanzaro*, 834 F.2d 326, 347 (3d Cir. 1987) (adopting same standard as Eleventh Circuit).

40. See *Torraco v. Maloney*, 923 F.2d 231, 234 (1st Cir. 1991); *Partridge v. Two Unknown Police Officers*, 791 F.2d 1182, 1187 (5th Cir. 1986) (“A serious medical need may exist for psychological or

analyzed serious physical medical needs, the eventual application to mental health needs is warranted because there is “no underlying distinction between the right to medical care for physical ills and its psychological or psychiatric counterpart.”⁴¹

While prisoners with serious medical needs are entitled to receive medical care, courts have routinely established that the standard for the level of care must be “adequate.”⁴² Whether an Eighth Amendment violation occurs largely depends on the type of treatment that the prisoner receives in relation to the accepted medical standards.⁴³ If the physician chooses an “easier but less efficacious” treatment plan, the prison official or physician may be found to be deliberately indifferent.⁴⁴ The treatment provided to the inmate, however, does not have to be the most ideal treatment available, or even the accepted opinion of other medical professionals; the treatment need only be “adequate.”⁴⁵ Physicians should tailor a prisoner’s treatment to his or her individual needs, but the mere fact that “a prisoner might prefer a different treatment does not give rise to an Eighth Amendment violation.”⁴⁶

psychiatric treatment, just as it may exist for physical ills.”).

41. *Bowring v. Godwin*, 551 F.2d 44, 47 (4th Cir. 1977); *cf.* *Coleman v. Wilson*, 912 F. Supp. 1282, 1298 & n.10 (E.D. Cal. 1995) (listing six factors in consideration for establishing minimally adequate prison mental health care delivery system).

42. *See Kosilek II*, 889 F. Supp. 2d at 197-99 (overviewing prisoner’s right to adequate medical care); *see also* *Estelle v. Gamble*, 429 U.S. 97, 105 (1976) (holding wanton failure to provide adequate medical care violates Eighth Amendment). Adequate care is most often the product of “sound medical judgment,” which is based on the individual patient’s needs. *Kosilek II*, 889 F. Supp. 2d at 207 (quoting *Chance*, 143 F.3d at 703). Further, the First Circuit has defined adequate care as the “services at a level reasonably commensurate with modern medical science and of a quality acceptable within prudent professional standards.” *United States v. DeCologero*, 821 F.2d 39, 43 (1st Cir. 1987).

43. *See Stevens v. Goord*, 535 F. Supp. 2d 373, 384-85 (S.D.N.Y. 2008) (finding medical decisions contrary to accepted medical standards may constitute deliberate indifference).

44. *Waldrop v. Evans*, 871 F.2d 1030, 1035 (11th Cir. 1989) (“[G]rossly incompetent medical care or choice of an easier but less efficacious course of treatment can constitute deliberate indifference.”); *see also* *Williams v. Vincent*, 508 F.2d 541, 544 (2d Cir. 1974) (holding prison officials likely deliberately indifferent for failing to reattach severed portion of ear).

45. *See Sanchez v. Vild*, 891 F.2d 240, 242 (9th Cir. 1989) (“A difference of [medical] opinion does not amount to a deliberate indifference to [appellant’s] serious medical needs.”); *Dean v. Coughlin*, 804 F.2d 207, 215 (2d Cir. 1986) (reasoning prisons not required to provide model system of medical care). The *Dean* court asserted that only the minimum level of care is required by the Federal Constitution to constitute adequate treatment. *Dean*, 804 F.2d at 215. Specifically, the court held that a

correctional facility is not a health spa, but a prison in which convicted felons are incarcerated. . . . We are governed by the principle that the objective is not to impose upon a state prison a model system of dental care beyond average needs but to “provide the minimum level of [dental] care required by the Constitution.”

Id. (quoting *Ruiz v. Estelle*, 679 F.2d 1115, 1150 (5th Cir. 1982)).

46. *Chance v. Armstrong*, 143 F.3d 698, 703 (2d Cir. 1998); *see* *Watson v. Caton*, 984 F.2d 537, 540 (1st Cir. 1993) (indicating courts refuse to allow constitutional claims for disagreements between doctors and prisoners regarding treatment); Kate Douglas, Comment, *Prison Inmates Are Constitutionally Entitled to Organ Transplants—So Now What?*, 49 ST. LOUIS U. L.J. 539, 550-51 (2005) (overviewing notion of deliberate

Furthermore, negligence or medical malpractice on behalf of the treating physician does not automatically rise to the level of deliberate indifference to serious medical needs.⁴⁷ Under the deliberate indifference recklessness standard, a physician does not violate the Eighth Amendment if he or she should have known about a risk, but in fact did not.⁴⁸ Alternatively, a person who is aware of a substantial risk of serious harm, but chooses to continue in spite of that risk, may be liable for their indifference upon the wanton infliction of pain.⁴⁹ Whether a course of treatment for a prisoner is based on professional judgment, medical malpractice, or deliberate indifference is a determination to be made by the factfinder.⁵⁰

3. *Denials of Adequate Care and Legitimate Penological Concerns*

The subjective views of prison officials may justify the denial of care, if based on “legitimate, penological considerations.”⁵¹ Consequently, the denial of adequate care in certain instances will be subject to a balancing test of those interests against the inmate’s medical needs.⁵² If an official is found to have acted in good faith, the denial of adequate care may not constitute the unnecessary or wanton infliction of pain.⁵³ Moreover, as discussed in the

indifference does not include disagreements with doctor’s choice of treatment).

47. See *Estelle*, 429 U.S. at 105-06 (holding negligent misdiagnoses does not constitute valid claim under Eighth Amendment); *Hathaway v. Coughlin*, 99 F.3d 550, 553 (2d Cir. 1996) (noting mere allegations of negligent malpractice do not state claim of deliberate indifference). In *Hathaway*, the court explicitly stated that a finding of medical malpractice could be used as merely evidence for a finding of a failure to provide adequate treatment or disregard of a substantial risk of serious harm. *Hathaway*, 99 F.3d at 553.

48. See *Gibson v. Cnty. of Washoe*, 290 F.3d 1175, 1188 (9th Cir. 2002) (holding Eighth Amendment violation requires drawing inference of harm, not merely awareness of risk); see also *supra* note 31 and accompanying text (outlining equating of deliberate indifference to standard of recklessness in formulating subjective state-of-mind prong of analysis).

49. See *Farmer v. Brennan*, 511 U.S. 825, 837 (1994) (rejecting purely objective test for deliberate indifference); *Gibson*, 290 F.3d at 1188.

50. See *Campbell v. Sikes*, 169 F.3d 1353, 1368-71 (11th Cir. 1999) (examining role of expert testimony in jury finding of subjective intent in deliberate indifference inquiry); *Rogers v. Evans*, 792 F.2d 1052, 1062 (11th Cir. 1986) (clarifying finding of fact before jury necessary for determining deliberate indifference to mental health needs).

51. See *Kosilek II*, 889 F. Supp. 2d 190, 206, 209-11 (D. Mass. 2012) (overviewing whether security, treatment cost, and political controversy form legitimate penological justifications for consideration); see also *White v. Farrier*, 849 F.2d 322, 325 (8th Cir. 1988) (“Actions without a penological justification may constitute an unnecessary infliction of pain.”); cf. *Turner v. Safley*, 482 U.S. 78, 89 (1987) (resolving issue of violations of constitutional rights warranted if reasonably related to legitimate penological interests).

52. See *Kosilek II*, 889 F. Supp. 2d at 199-200, 206 (outlining use of balancing penological justifications against providing treatment to determine finding of deliberate indifference); see also *Kosilek I*, 221 F. Supp. 2d 156, 183 (D. Mass. 2002) (noting choice to deny treatment constitutes deliberate indifference if not based on penological purposes).

53. See *Soneeya v. Spencer*, 851 F. Supp. 2d 228, 250-51 (D. Mass. 2012) (noting DOC must act in good faith or acknowledge security concerns regarding serious medical needs); see also *Whitley v. Albers*, 475 U.S. 312, 319 (1986) (“It is obduracy and wantonness, not inadvertence or error in good faith, that characterize the conduct prohibited by the Cruel and Unusual Punishments Clause, whether that conduct occurs in connection with . . . supplying medical needs”); see also *Kosilek I*, 221 F. Supp. 2d at 161 (stating prison official

recent First Circuit decision of *Battista v. Clarke*,⁵⁴ “[m]edical ‘need’ in real life is an elastic term: security considerations also matter at prisons or civil counterparts, and administrators have to balance conflicting demands . . . so long as the balancing judgments are within the realm of reason and made in good faith, the officials’ actions are not ‘deliberate indifference.’”⁵⁵

The *Battista* court thoroughly examined the issue of security concerns within the prison setting and determined that if the case had been adequately argued, the case might have been decided differently.⁵⁶ The First Circuit acknowledged that security concerns and the realities of prison administration require considerations beyond the professional medical judgment that a treatment should be provided to a prisoner.⁵⁷ The security concerns at issue consisted of fears that female garb and the development of breasts would increase the number of sexual assaults by male detainees.⁵⁸ The First Circuit noted that the circumstances surrounding *Battista* presented different considerations from what had appeared in other transsexual prisoner cases that allowed hormone therapy.⁵⁹ Ultimately, however, the appellant’s claim failed due to the inadequacy of the formulation of her arguments, not the dismissal of security concerns as a legitimate factor for consideration.⁶⁰

acting in good faith may justify denial of adequate medical care).

54. 645 F.3d 449 (1st Cir. 2011).

55. *Id.* at 454 (quoting *Farmer v. Brennan*, 511 U.S. 825, 844-45 (1994)). In *Battista*, the First Circuit considered whether a civilly committed inmate suffering from GID should be given hormone therapy and female garb despite DOC officials asserting that security concerns preclude the treatment options. *See id.* at 450-52. The court reasoned that while constraints on an official often arise due to the nature of the institutional setting, the officials here exhibited a lack of professional judgment amounting to deliberate indifference. *See id.* at 453, 455.

56. *Id.* at 454-55. The court stated that “this would be a much harder case if defendants had proffered a persuasive and untainted professional judgment that—while hormone therapy would help Battista—the dangers, security costs and other impediments made it infeasible.” *Id.* at 454. The court implied that if the treatment center engaged in a timely inquiry of whether the treatment could be effective, then the administrator’s denials of care might have been justified. *See id.* at 454-55. The argument by the DOC was not that they disagreed with the medical judgment that hormone therapy might be proper in this instance, but rather that security concerns overrode such an allowance. *See id.* at 452.

57. *Battista*, 645 F.3d at 455 (citing *Cameron v. Tomes*, 990 F.2d 14, 20 (1st Cir. 1993)). In *Cameron*, the court explained, “[a]ny professional judgment that *decides* an issue involving conditions of confinement must embrace security and administration, and not merely medical judgments. . . . The administrators are responsible to the state and to the public for making professional judgments of their own, encompassing institutional concerns as well as individual welfare.” *Cameron*, 990 F.2d at 20.

58. *Battista*, 645 F.3d at 451. The specific security concerns mentioned in a 2009 report included the fact that the treatment center housed sexual offenders and consisted of an open floor plan. *Id.* There was also no possibility of moving Battista to another facility. *Id.*

59. *Id.* at 453-54. The court noted that the large number of male sex offenders at the treatment center significantly increased the threat to security presented by Battista’s proposed therapy. *Id.* at 454. Furthermore, the court noted that she had a record of infractions, “sexual contacts” and “risk-taking,” which may have led to “greater risk from invited or uninvited sexual contact.” *Id.* Because of the risk to security, the allowance of hormone therapy—which was allowed in other GID cases—could be conditioned on a balancing of medical treatment and institutional concerns. *See id.*

60. *See id.* at 455. The court determined that the district court properly found deliberate indifference

Security is not the only concern or factor that courts have considered in the analysis of deliberate indifference.⁶¹ The cost of providing medical care normally does not justify a prison official's denial of treatment in response to a claim of deliberate indifference.⁶² Some courts have theorized, however, that prison officials may consider cost as a factor in determining appropriate medical care.⁶³ Cost considerations are warranted so long as the care provided does not fall below the minimal requirements of adequate care.⁶⁴ The standard of adequate medical care does not mandate that prison officials provide the most expensive treatment option so long as the officials do not act with deliberate indifference.⁶⁵

While scholars and judges alike have argued that cost has no role in denying medical treatment, the United States Court of Appeals for the Seventh Circuit in *Maggert v. Hanks*⁶⁶ ruled that cost of treatment may be grounds for denial of care with regard to GID cases.⁶⁷ Importantly, the court explained that the

based on the defendant's "delays, poor explanations, missteps, changes in position and rigidities." *Id.* Nothing in the court's reasoning held that the security positions listed were inadequate to justify a denial of treatment. *See id.*

61. *See Kosilek I*, 221 F. Supp. 2d 156, 162 (D. Mass. 2002) (theorizing multiple factors influence balancing test of interests to determine whether treatment warranted); *supra* note 51 and accompanying text (introducing balancing test based on legitimate penological considerations); *see also* *Woodall v. Foti*, 648 F.2d 268, 272 (5th Cir. 1981) (reasoning whether refusal of medical care constitutes deliberate indifference requires consideration of competing factors). In *Woodall*, the court examined the relevant factors to be considered in assessing claims of deliberate indifference and noted "that the essential test is one of medical necessity and not one simply of desirability." *Woodall*, 648 F.2d at 272.

62. *See Ancata v. Prison Health Servs., Inc.*, 769 F.2d 700, 705 (11th Cir. 1985) ("Lack of funds for facilities cannot justify an unconstitutional lack of competent medical care and treatment for inmates."); *Gates v. Collier*, 501 F.2d 1291, 1320 (5th Cir. 1974) ("Shortage of funds is not a justification for continuing to deny citizens their constitutional rights.").

63. *See* Douglas, *supra* note 46, at 552-53 (explaining cost considerations relevant for determining level of medical care rather than denying treatment); *see also* *Hamm v. DeKalb Cnty.*, 774 F.2d 1567, 1573-74 (11th Cir. 1985) (holding government interest in limiting costs of detention facility just if providing reasonable medical care); *Bowring v. Godwin*, 551 F.2d 44, 47-48 (4th Cir. 1977) (holding right to treatment limited by reasonable cost not merely desired treatment); *Taylor v. Barnett*, 105 F. Supp. 2d 483, 489 & n.2 (E.D. Va. 2000) ("[T]he Eighth Amendment does not forbid prison officials from considering cost in determining the appropriate course of treatment so long as the treatment does not put the prisoner at risk of serious injury."). *But see Kosilek I*, 221 F. Supp. 2d at 162 (noting security concerns may justify withholding medical treatment but controversy or cost do not). In a decision written ten years before *Kosilek II*, the district court definitively argued that concerns about spending taxpayer money on a controversial treatment is never a penological consideration. *See id.* at 161, 182, 192.

64. Douglas, *supra* note 46, at 552-53 (citing *Hamm* for proposition that cost considerations permissible unless violating deliberate indifference standard); *see Taylor*, 105 F. Supp. 2d at 489 n.2 (finding health care decisions based solely on cost considerations unconstitutional).

65. *See supra* note 45 and accompanying text (discussing adequate care not equivalent to most ideal treatment); *see also* Marc J. Posner, *The Estelle Medical Professional Judgment Standard: The Right of Those in State Custody To Receive High-Cost Medical Treatments*, 18 AM. J.L. & MED. 347, 365 (asserting *Estelle* standard gives doctors ability to choose between treatment options regardless of expense); Douglas, *supra* note 46, at 552-53 (contending adequate care does not require most expensive treatment).

66. 131 F.3d 670 (7th Cir. 1997).

67. *See id.* at 672 (holding denial of treatment costing beyond average wealth does not constitute cruel and unusual punishment). The court explained, "[i]t is not the cost per se that drives this conclusion," noting

Eighth Amendment does not require “curative treatment” of gender dysphoria; that is, an official will not be deemed deliberately indifferent if a curative measure is denied.⁶⁸ Although the court noted that SRS is a recognized cure for gender dysphoria, it nonetheless concluded that “it does not follow that the prisons have a duty to authorize the hormonal and surgical procedures that in most cases at least would be necessary to ‘cure’ a prisoner’s gender dysphoria.”⁶⁹ The Seventh Circuit has yet to affirmatively grant SRS for a transsexual prisoner.⁷⁰

B. Recognition of GID/Gender Dysphoria as a Mental Illness

1. Definition of GID

GID is defined as “a conflict between a person’s physical gender and the gender he or she identifies as.”⁷¹ In May 2013, the American Psychiatric Association removed GID from the latest version of its *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV) and reclassified it as “gender dysphoria.”⁷² According to the revised DSM-IV (known as DSM-IV-TR),

that GID is not considered a “severe enough condition to warrant expensive treatment at the expense of others than the person suffering from it.” *Id.* It is important to note that the Seventh Circuit decided *Maggert* in 1997, prior to the new research on GID, and the Circuit later distinguished this decision in *Fields v. Smith*. See 653 F.3d 550, 555-56 (7th Cir. 2011) (noting any refusal of effective treatment without justification of alternate treatment serves no penological purpose); *infra* notes 93-94 and accompanying text (discussing *Fields* decision). The court concluded that the *Maggert* court based its decision on “empirical assumptions” that the cost of treatment was too high and alternatives existed, but reasoned that hormone therapy and SRS may be appropriate treatments if a need is actually demonstrated as the only effective treatment. *Id.* at 555-57. The *Fields* court also drew an analogy between GID treatment and the treatment of other illnesses: if a prison cannot justify a denial of chemotherapy to an inmate with cancer, the court reasoned that it seemingly follows that a prison cannot deny SRS to a qualifying transsexual. See *id.* at 557 (“Just as the legislature cannot outlaw all effective cancer treatments for prison inmates, it cannot outlaw the only effective treatment for a serious condition like GID.”); cf. *O’Donnabhain v. Comm’r*, 134 T.C. 34, 70 (2010) (ruling SRS effective treatment for GID, not merely cosmetic for tax purposes).

68. See *Maggert*, 131 F.3d at 672 (holding Eighth Amendment does not guarantee inmate curative treatment for gender dysphoria).

69. *Id.* at 671.

70. See *Fields*, 653 F.3d at 558-59 (upholding enjoinder of Act 105 that prohibited hormone therapy and SRS to prisoners). The court specifically held that SRS could not be prohibited, but acknowledged that the effective treatment for plaintiff was hormone therapy; the court did not reach the issue of SRS. See *id.* at 556-58.

71. *Gender Identity Disorder*, PUBMED HEALTH, <http://www.ncbi.nlm.nih.gov/pubmedhealth/PMH0002495> (last visited Apr. 26, 2014). “Gender” is not synonymous with “sex,” which refers to the biological difference between a male and female encompassing internal and external sex organs. See ANN-MAREE NOBELIUS & JO WAINER, MONASH UNIV., GENDER AND MEDICINE: A CONCEPTUAL GUIDE FOR MEDICAL EDUCATORS 5-8 (Feb. 2004), available at <http://www.med.monash.edu.au/gendermed/docs/A4TutorManual120504screen.pdf> (describing social differences between “sex” and “gender” and highlighting common misuses). “Gender” describes the characteristics that are most commonly associated with masculinity or femininity, which are predominantly influenced by cultural and societal norms. See *id.* at 5.

72. See Eric Cameron, *APA To Remove “Gender Identity Disorder” from DSM-5*, HUMAN RIGHTS CAMPAIGN (Dec. 4, 2012), <http://www.hrc.org/blog/entry/apa-to-remove-gender-identity-disorder-from-dsm-5>.

“*gender identity* refers to an individual’s self-perception as male or female . . . gender dysphoria denotes strong and persistent feelings of discomfort with one’s assigned sex, the desire to possess the body of the other sex, and the desire to be regarded by others as a member of the other sex.”⁷³ The Supreme Court has defined a “transsexual” as “one who has ‘[a] rare psychiatric disorder in which [the] person feels persistently uncomfortable about his or her anatomical sex,’ and who typically seeks medical treatment, including hormonal therapy and surgery, to bring about a permanent sex change.”⁷⁴

Individuals suffering from GID may exhibit a desire to become a member of the opposite sex as well as possess feelings and reactions characteristic of the other sex.⁷⁵ Common to GID diagnoses is a “[p]reoccupation with getting rid of primary and secondary sex characteristics (e.g., request for hormones, surgery, or other procedures to physically alter sexual characteristics and simulate the other sex) or belief in having been born with the wrong sex.”⁷⁶ In diagnosing a person with GID, there must not only be cross-gender identification, but also an expressed discomfort about the inappropriateness and difficulty of assuming the person’s assigned sex and gender, respectively.⁷⁷ Adults with GID may be unable to function in their societal roles.⁷⁸ Many

For purposes of this Note, and in order to properly analyze the Kosilek II decision, citations and references will be to GID as defined under the DSM-IV-TR.

73. DSM-IV-TR, *supra* note 12. In *Phillips v. Michigan Department of Corrections*, the court noted that the plaintiff was a transsexual, but that transsexualism was part of the broad classification of gender dysphoria. See 731 F. Supp. 792, 793 n.2 (W.D. Mich. 1990), *aff’d*, 932 F.2d 969 (6th Cir. 1991). Gender dysphoria is a “fairly broad psychiatric term describing discomfort and rejection of one’s gender based on physical characteristics and sex assigned at birth.” *Id.*

74. Farmer v. Brennan, 511 U.S. 825, 829 (1994); see also Louis J. Gooren, *Care of Transsexual Persons*, 364 NEW ENG. J. MED. 1251, 1251 (2011) (summarizing treatment options for care of transsexual patients). “For most transsexuals (about 66%), the disorder has an early onset, in childhood; for the remainder, it develops much later in life. For this older group of patients, usually men, the transition to a new sex from one they have lived in for many years is particularly difficult.” Gooren, *supra*, at 1251.

75. See Gooren, *supra* note 74, at 1252 tbl.2. The term “transgender” is often used synonymously with “transsexual.” See Franklin H. Romeo, Note, *Beyond a Medical Model: Advocating for a New Conception of Gender Identity in the Law*, 36 COLUM. HUM. RTS. L. REV. 713, 713 n.1 (2005) (defining transgender, transsexual, and other terms individuals use to self-identify).

76. Gooren, *supra* note 74, at 1252 tbl.2. GID, gender dysphoria, and transsexualism are all clinical terms used throughout court opinions and prison policies. See Tarzwell, *supra* note 7, at 168 n.1 (discussing use of terms transgender and transsexual). The terms are used to describe transgender individuals, each with very specific gender attitudes and histories. *Id.*

77. DSM-IV-TR, *supra* note 12, at 27. In boys, there is a strong prevalence of a wish to partake in stereotypical activities of girls and a preference for dressing in girls’ or women’s clothing. *Id.* In girls, there is a preference for clothing and activities usually associated with boys’ preferences and at times an aversion to urinate in a sitting position. *Id.* Occasionally, girls with GID may wish to not grow breasts or menstruate, but may desire to grow up as a man. *Id.*

78. *Id.* at 27-28. As DSM-IV-TR notes, “[s]ome males with Gender Identity Disorder resort to self-treatment with hormones and may very rarely perform their own castration or penectomy.” *Id.* at 28. According to Doctor Simona Giordano, violence becomes an “extreme manifestation of psychological and social rejection” of GID. SIMONA GIORDANO, CHILDREN WITH GENDER IDENTITY DISORDER: A CLINICAL, ETHICAL, AND LEGAL ANALYSIS 59 (2013).

individuals with GID resort only to those activities that enable them to “lessen gender distress.”⁷⁹ In rarer cases, people with GID may attempt suicide or engage in substance abuse.⁸⁰

2. Prevalence of GID

The SOC acknowledge the difficulty in accurately estimating the prevalence of transsexualism and transgenderism due to the lack of thorough epidemiologic studies; however, the SOC depict that the trend of people seeking clinical care is rising.⁸¹ The prevalence of transsexualism in North America in 2011 was estimated to be at a three to one ratio in males to females; comparatively, the higher number of male patients corresponded with late-onset GID.⁸² According to data collected on the prevalence of SRS, it is estimated that from the 1970s to the year 2000, 10,000 successful surgeries were performed worldwide.⁸³ Within American prisons, it is estimated that transgendered prisoners number in the low thousands, although this number is merely a rough estimate.⁸⁴ The number of individuals with GID seeking SRS—as collected from population statistical data from European countries—is estimated to be 1 per 30,000 males and 1 per 100,000 females.⁸⁵

3. Potential Treatments for GID/Gender Dysphoria

Potential treatment options for GID—as proposed by the SOC—include, among others: changes in gender expression and role; hormone therapy; surgery to change primary and/or secondary sex characteristics; and psychotherapy.⁸⁶ Specifically, SRS is deemed the last step in the treatment

79. DSM-IV-TR, *supra* note 12, at 28. The manifestations of GID also vary based on age and gender; females may suffer less from social isolation because of the general peer acceptance of cross-gender activities. *Id.* at 29.

80. *Id.* at 28; see GIORDANO, *supra* note 78, at 59 (finding children and adolescents with gender dysphoria at high risk for suicide).

81. See Coleman et al., *supra* note 6, at 169-70 (discussing epidemiologic considerations for ascertaining incidence and prevalence of transsexualism, transgenderism, and gender-nonconforming identities); see also DSM-IV-TR, *supra* note 12, at 29 (noting lack of epidemiological data on prevalence of GID). The SOC suggest that the studies reported are derived from clinics with patients that met the criteria for gender dysphoria, yet overlooked individuals seeking treatment that did not meet acceptable criteria. See Coleman et al., *supra* note 6, at 170.

82. Gooren, *supra* note 74, at 1251-52.

83. See Laura Dean et al., *Lesbian, Gay, Bisexual, and Transgender Health: Findings and Concerns*, 4 J. GAY & LESBIAN MED. ASS'N 101, 131-32 (2000). Dean states that the same collection of statistical data found that approximately 4,500 to 6,000 U.S. residents underwent SRS. *Id.* at 132.

84. See Rosenblum, *supra* note 3, at 517. In the State of New York in the year 2000, for example, there were seventy prisoners receiving hormone treatments, seventeen of whom were housed in New York City prisons. *Id.* Additionally, it is difficult to ascertain a definitive number of transgendered prisoners because the claims of transsexuality lack specificity. See *id.* at 517 & n.82.

85. See DSM-IV-TR, *supra* note 12, at 29.

86. Coleman et al., *supra* note 6, at 166. Successful treatment options to alleviate gender dysphoria vary according to the individual. *Id.* at 170. Some individuals are able to integrate their transgender feelings into

process, if medically necessary.⁸⁷ For some individuals with gender dysphoria, “relief . . . cannot be achieved without modification of their primary and/or secondary sex characteristics to establish greater congruence with their gender identity.”⁸⁸ SRS for male-to-female transsexuals “involves the removal of the external male sexual organs and the construction of an artificial vagina by plastic surgery. [The surgical procedure] is supplemented by hormone treatments that facilitate the change in secondary sex characteristics.”⁸⁹ Prior to the procedure, the individual should live for twelve consecutive months in the gender role of the desired gender to give him or her the opportunity to explore the gender role prior to undergoing the irreversible surgery.⁹⁰

All of the proposed treatment options in the SOC are flexible clinical guidelines for people with gender dysphoria, and suggestions of hormone therapy and surgery may be modified based on individual health care determinations.⁹¹ The SOC do not give credence to any legitimate penological concerns that may affect treatment, mandating that institutional settings should not impact treatment determinations.⁹²

their assigned sex at birth, while for others, the only treatment option may be hormone treatment or SRS. *Id.* at 170-71.

87. *Id.* at 199. The SOC advocate for surgical treatment of gender dysphoria due to the potential for harm if treatment is denied. *Id.* Moreover, the SOC assert that genital and breast surgical procedures are not elective, but medically necessary if a showing for the need is made by a qualified mental health professional. *Id.*; cf. *Pinneke v. Preisser*, 623 F.2d 546, 549-50 (8th Cir. 1980) (holding state Medicaid program could not deny SRS if only available treatment and medically necessary); *G.B. v. Lackner*, 145 Cal. Rptr. 555, 559 (Ct. App. 1978) (determining SRS not “cosmetic” surgery).

88. Coleman et al., *supra* note 6, at 199. The SOC assert that “[f]ollow-up studies have shown an undeniable beneficial effect of sex reassignment surgery on postoperative outcomes such as subjective well-being, cosmesis, and sexual function.” *Id.*; see JUDITH V. BECKER & BRADLEY R. JOHNSON, *THE AMERICAN PSYCHIATRIC PUBLISHING TEXTBOOK OF PSYCHIATRY* 734-35 (5th ed. 2008) (overviewing data suggesting extremely positive results for SRS for changes in social functioning).

89. Douglas K. Smith, Comment, *Transsexualism, Sex Reassignment Surgery, and the Law*, 56 CORNELL L. REV. 963, 970 n. 37 (1971).

90. *Id.*; see Juliet Bourke, *Transsexualism—The Legal, Psychological and Medical Consequences of Sex Reassignment Surgery*, 6 CURRENT ISSUES CRIM. JUST. 275, 282 (1994) (finding eligibility for surgery requires transsexual prepare physically and mentally for surgery). Bourke asserts that in preparation for the procedure, the transsexual must not only prepare for the physical consequences, but must also be aware that gender dysphoria will continue post-surgery. *Id.* at 282. “[T]he transsexual must prove that s/he can live and be accepted in their gender for one or two years.” *Id.*

91. See Coleman et al., *supra* note 6, at 166 (expressing flexible nature of clinical guidelines). The SOC assert that the guidelines put forth should apply to all transsexual, transgender, and gender-nonconforming people regardless of an institutional housing environment. *Id.* at 206. Specifically, the SOC state that persons with GID should be afforded the same health care that individuals not in an institutional setting would receive. See *id.* (“Health care for transsexual, transgender, and gender-nonconforming people living in an institutional environment should mirror that which would be available to them if they were living in a noninstitutional setting within the same community.”). See William Byne et al., *Report of the APA Task Force on Treatment of Gender Identity Disorder*, 41 ARCHIVES SEXUAL BEHAV. 759 (2012), for a discussion and evaluation of various treatment options for GID.

92. See Coleman et al., *supra* note 6, at 206-07. In stark opposition to the conclusions expressed in the SOC regarding institutional environments, courts recognize that security concerns must be factored into medical treatment determinations. See *Battista v. Clarke*, 645 F.3d 449, 454 (1st Cir. 2011) (noting medical

Moreover, while the cost of SRS varies depending on the individual and a culmination of different factors, the average cost for male-to-female surgeries can easily exceed \$100,000.⁹³ The court in *Fields* analogized GID treatment to the treatment of other illnesses: if a prison cannot justify a denial of chemotherapy to an inmate with cancer, it seemingly follows that a prison cannot deny SRS to a qualifying transsexual.⁹⁴

*C. Recognition of GID as a “Serious Medical Need” and
the Development of Transsexual Prisoner Case Law*

One of the first reported federal cases involving a transsexual prisoner arose in the case of *Supre v. Rickets*.⁹⁵ The district court noted that in response to the plaintiff’s requests for treatment for her gender dysphoria, the defendants asserted that treatment, including SRS, could not be completed in the prison environment.⁹⁶ In grappling with the prison’s failure to understand the “bizarre actions of the plaintiff,” the district court expounded that the plaintiff was “afflicted with pathology recognized by the established medical community as a serious one with a recognized treatment that was denied the plaintiff by the institution charged with her incarceration and care.”⁹⁷ Other courts have not

need encompasses security concerns); *see also* *Farmer v. Carlson*, 685 F. Supp. 1335, 1342 (M.D. Penn. 1988) (“Clearly, placing plaintiff, a twenty-one year old transsexual, into the general population at [a high-security] institution, could pose a significant threat to internal security . . .”).

93. *See* Travis Cox, Comment, *Medically Necessary Treatments for Transgender Prisoners and the Misguided Law in Wisconsin*, 24 WIS. J.L. GENDER & SOC’Y 341, 361 (2009) (overviewing costs associated with SRS); *see also* *Maggert v. Hanks*, 131 F.3d 670, 672 (7th Cir. 1997) (“[T]he total cost [of SRS] . . . can easily reach \$100,000, [which] puts the treatment beyond the reach of a person of average wealth. Withholding from a prisoner an esoteric medical treatment that only the wealthy can afford does not strike us as a form of cruel and unusual punishment.”). In *Fields*, the district court noted that the genital SRS for a male-to-female transsexual would cost approximately \$20,000. *See* *Fields v. Smith*, 712 F. Supp. 2d 830, 837 (E.D. Wis. 2010), *aff’d*, 653 F.3d 550 (7th Cir. 2011).

94. *See* *Fields*, 653 F.3d at 557. Further, the court theorized that if the Wisconsin statute mandated cancer patients only be treated with pain killers, then the court would undoubtedly find that unconstitutional. *See id.* at 556.

95. 596 F. Supp. 1532, 1533 (D. Colo. 1984), *rev’d*, 792 F.2d 958 (10th Cir. 1986). The plaintiff argued that the prison authorities were withholding treatment for gender dysphoria. *Id.* Spending twenty-three hours a day in protective custody, the plaintiff sought hormone therapy and sex reassignment therapy. *Id.* Throughout her life, the plaintiff made six attempts to remove her own testicles and at least one attempt at committing suicide. *Id.* According to the other findings by the district court, the plaintiff’s testicles had been surgically removed and the prison doctors recommended that plaintiff receive treatment such as estrogen therapy and permitted to “live as a female.” *Id.* at 1534.

96. *Id.* at 1534. The district court granted a continuance of the trial, conditioned on the defendant providing low levels of hormones to the plaintiff in addition to the defendant forming a committee to overview treatment of transsexuals while incarcerated. *Id.*

97. *Id.* at 1535. The district court discussed the severity of the plaintiff’s illness and the high probability that her life was in danger; however, the judge disregarded any possibility of providing any expensive treatment options to the plaintiff, such as SRS. *See id.* (“Although it would not be reasonable to expect the prison system to finance an expensive sex change operation, minimal treatment was not being administered to the plaintiff . . .”). On appeal, the Tenth Circuit reversed the decision of the district court, determining that the plaintiff did not make a successful demonstration of deliberate indifference because some treatment had been provided to

been so favorable toward gender dysphoric prisoners when it comes to their reluctance to recognize transsexualism as a mental illness.⁹⁸

Another early decision involving questions of medical treatment for transsexuals, *Lamb v. Maschner*,⁹⁹ evidenced the uncertainty of a court to consider whether the plaintiff was even a transsexual.¹⁰⁰ The plaintiff primarily requested hormone therapy in preparation for SRS, yet additionally sought to be transferred to a women's prison facility, with access to female cosmetics and clothing.¹⁰¹ The court briefly mentioned the difficulties facing prison administrators in responding to the plaintiff's requests for relief.¹⁰² Moreover, the court stated that not only did the defendant believe allowing SRS was "inappropriate," but that providing the surgery would be "inadvisable in a prison environment."¹⁰³ The court reasoned that prison authorities must be afforded great deference in decisions about what behavior will be allowed within the institution, and determined that the plaintiff's arguments for treatment were insufficient to find a constitutional violation.¹⁰⁴

The decisions of *Supre* and *Lamb* demonstrate an early resistance and opposition by the courts to grant prison medical personnel blanket authority to prescribe whatever medical treatment was available to assist a prisoner.¹⁰⁵

the plaintiff. See *Supre v. Ricketts*, 792 F.2d 958, 962-63 (10th Cir. 1986) (determining unclear whether requested treatment beyond testosterone therapy medically necessary).

98. See Andreopoulos, *supra* note 28, at 236-40 (discussing reluctance and difficulty of courts to understand GID as treating serious medical illness).

99. 633 F. Supp. 351 (D. Kan. 1986).

100. See *id.* at 353-54 (claiming medical records do not evidence need for treatment). The district court judge commented that there was a question of whether the plaintiff was a transsexual by explaining, "[p]laintiff's medical history indicates that he is a nonconformist and receives an 'apparent delight in defying conventions, rules and regulations, [and] his motivation for the sex reassignment surgery is certainly in question.'" *Id.* at 354.

101. *Id.* at 352-53.

102. See *id.* at 353 (denying plaintiff's requests for prison transfer and women's clothing due to realities of prison administration). The district court explained that allowing a male prisoner into a women's prison would violate women's rights, despite any therapeutic effect it would have on the plaintiff. See *id.* The court further stated that prison officials had been justified in not providing female clothing because they must have the ability to make determinations on what prisoners wear within the prison's walls. See *id.*; see also *Hill v. Estelle*, 537 F.2d 214, 215 (5th Cir. 1976) ("[L]awful incarceration results in the necessary limitation of many privileges and rights of the ordinary citizen."). Prison authorities have broad discretion when it pertains to cleanliness and personal identification. See *Brooks v. Wainwright*, 428 F.2d 652, 653 (5th Cir. 1970) (explaining court's reluctance to interfere with administrative functions of prisons).

103. See *Lamb*, 633 F. Supp. at 353-54 (noting no recommendations made for access to hormone treatment or necessity of SRS). But see *Coleman et al.*, *supra* note 6, at 206-07 (explaining SRS not properly denied on basis of housing in institutional or prison setting).

104. See *Lamb*, 633 F. Supp. at 353. The court determined that the defendant prison should properly determine whether segregation of the sexes was possible in the prison environment and the court should give appropriate deference to that decision. See *id.* at 353; see also *Bell v. Wolfish*, 441 U.S. 520, 547 (1979) ("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.").

105. See Debra Sherman Tedeschi, *The Predicament of the Transsexual Prisoner*, 5 TEMP. POL. & CIV.

Courts continued to resist providing hormone therapy and other advanced treatment options, but in the pivotal decision of *Meriwether v. Faulkner*,¹⁰⁶ the Seventh Circuit acknowledged that a transsexual prisoner indeed has the right to some form of treatment if none is currently provided.¹⁰⁷ The court recognized that transsexualism is a “serious psychiatric disorder” and “a very complex medical and psychological problem.”¹⁰⁸ In addressing the recognition of transsexualism as a disorder, the court noted that SRS is routinely established as medically necessary for the treatment of the disorder and cannot be characterized as cosmetic surgery.¹⁰⁹

Similarly, in a recent matter of first impression, the United States Tax Court addressed whether SRS constituted “medical care” not compensated for by insurance and thus a deductible expense for the taxpayer, or whether the surgery was merely a cosmetic alteration.¹¹⁰ In determining that SRS had become a recognized and accepted treatment for GID, the Tax Court held that the costs associated with the surgery were deductible expenses as a form of medical care, as opposed to nondeductible expenses for cosmetic surgery.¹¹¹ Alternatively, in an opinion that concurred in part and dissented in part, one judge argued that SRS does not “treat” GID at all, but rather “mitigates” the

RTS. L. REV. 27, 35-39 (1995) (discussing courts’ handling of transsexual plaintiffs in *Supre* and *Lamb*). The district judge in *Supre* initially granted low-level treatment only to be eventually overturned by the Tenth Circuit, and the court in *Lamb* went so far as to question the merits of the plaintiff’s alleged condition. *See id.* at 39.

106. 821 F.2d 408 (7th Cir. 1987).

107. *See id.* at 413. The court qualified its holding—that the plaintiff was entitled to some form of treatment as required under the Eighth Amendment—by emphasizing that the plaintiff did not have the right to any form of treatment; unless an informed judgment was made to support the proposed treatment option, it was properly left within the prison official’s authority to deny the “highly controversial nature of some of [the treatment] options.” *Id.* at 414.

108. *Id.* at 411-12. The plaintiff in *Meriwether*, a preoperative transsexual serving a thirty-five year sentence, filed a § 1983 action against the state’s DOC challenging her conditions of confinement. *Id.* at 409-10. Despite her nine years of estrogen therapy and surgical augmentation of her face, breasts, and hips, the DOC denied plaintiff all forms of medical treatment, including psychiatric therapy, after her incarceration in the facility. *Id.* at 410. Because the prison did not provide any medical care, the decision of the court fell into the recognized scenario theorized in the *Supre* and *Lamb* decisions. *See id.* at 414.

109. *Id.* at 412-13; *see G.B. v. Lackner*, 145 Cal. Rptr. 555, 559 (Ct. App. 1978) (“It is clearly impossible to conclude that transsexual surgery is cosmetic surgery”); *Doe v. Lackner*, 145 Cal. Rptr. 570, 572 (Ct. App. 1978) (“We do not believe, by the wildest stretch of the imagination, that such surgery can reasonably and logically be characterized as cosmetic.”). The court in *G.B. v. Lackner* defined cosmetic surgery as “[s]urgery to alter the texture or configuration of the skin and its relationship with contiguous structures of any feature of the human body” and noted that castration and penectomy cannot be termed as procedures that only alter the texture and configuration of the skin. *Id.* at 558.

110. *O’Donnabhain v. Comm’r*, 134 T.C. 34, 54 (2010). The taxpayer (a male-to-female transsexual) deducted costs associated with her SRS under I.R.C. § 213. *Id.* at 42, 49; *see I.R.C. § 213(a)* (2012) (allowing deduction for expenses “not compensated for by insurance or otherwise, for medical care of the taxpayer, his spouse, or a dependent”).

111. *O’Donnabhain*, 134 T.C. at 77. Determining that GID constituted a “disease” and that sex reassignment surgery “treated” the condition, the Tax Court allowed the deduction as “medical care” under the statute. *Id.*

disorder.¹¹² Subsequently, the judge argued that the surgery was “cosmetic,” explaining:

A procedure that changes the patient’s healthy male body (in fact, that disables his healthy male body) and leaves his mind unchanged (i.e., with the continuing misperception that he is female) has not treated his mental disease. On the contrary, that procedure has given up on the mental disease, has capitulated to the mental disease, has arguably even changed sides and joined forces with the mental disease.”¹¹³

In *Meriwether*, after the court analyzed the plaintiff’s claims and found at least some level of medical treatment should be provided, the court engaged in an important inquiry into whether a transsexual prisoner could be kept in administrative segregation as a protective measure.¹¹⁴ Administrative segregation may provide sufficient relief for transsexuals from repeat sexual assaults in the general population.¹¹⁵ The Seventh Circuit nonetheless outlined that prolonged confinement in administrative segregation may constitute either a violation of due process or cruel and unusual punishment under the Eighth Amendment.¹¹⁶

According to the Human Rights Campaign—an organization advocating for placement in facilities that is in line with one’s identified gender rather than one’s sex at birth—individual prison officials are responsible for the initial determination of where a transgender inmate is placed, but the decision is usually based on sex at birth or external genitalia.¹¹⁷ The court also recognized

112. See *id.* at 115-18 (Gustafson, J., concurring in part and dissenting in part) (comparing and analyzing congressional intent behind terms “treat” and “mitigate”).

113. *Id.* at 122 (Gustafson, J., dissenting in part). Judge Gustafson—dissenting on the issue of “treatment”—ultimately concluded even if the surgery was the most appropriate medical option for the GID patient, the procedure still did not “treat” the underlying medical illness, and thus was “cosmetic.” See *id.* (Gustafson, J., dissenting in part)

114. See *Meriwether v. Faulkner*, 821 F.2d 408, 415-17 (7th Cir. 1987) (inquiring into whether prison possessed any feasible alternatives to invalidate administrative segregation); *cf.* *Hewitt v. Helms*, 459 U.S. 460, 477 n.9 (1983) (finding administrative segregation requires periodic review of whether security risks mandate confinement).

115. See *Meriwether*, 821 F.2d at 417-18. Due to the very nature of the prisoner’s status as a transsexual in a male prison, the court explained that “the risk of assault would appear to be sufficiently serious to require the defendants to take some minimal measures to protect her from assault.” *Id.* at 417. The court avoided a definitive determination on the issue of how best to protect the plaintiff; instead, it simply noted that failing to protect the prisoner would, nonetheless, constitute deliberate indifference. See *id.* at 418.

116. *Id.* at 414-15.

117. See *Sex-Segregated Placement of Transgender Inmates in Federal Prison Facilities*, HUMAN RIGHTS CAMPAIGN, <https://www.callitout.org/files/images/blog/2009/06/Sex-Segregated-Placement-of-Transgender-In-mates-in-federal-prison-facilities.pdf> (last visited Apr. 26, 2014); *cf.* MASS. GEN. LAWS ANN. ch. 46, § 13(e) (West 2014) (“If a person has completed sex reassignment surgery, so-called, and has had his name legally changed by a court . . . the birth record of said person shall be amended to reflect the newly acquired sex and name . . .”).

the inherent impasse facing institutions in attempting to protect the prisoner against sexual assaults while respecting the prisoner's desire to not be placed indefinitely in administrative segregation.¹¹⁸ Prison administrators attempting to accommodate transsexuals in the institutional setting are faced with choosing between the lesser of two evils: violating an inmate's Eighth Amendment right not to be subjected to unnecessarily prolonged isolation or risking the inmate's physical well-being in the general population.¹¹⁹

D. Kosilek I & II and the Granting of SRS

I. Kosilek I

The DOC and its respective Commissioners first encountered the legal struggles surrounding Michele Kosilek's desire to seek treatment for her GID in the federal district court decision of *Kosilek I*.¹²⁰ In 2000, Michael Maloney, then Commissioner of the DOC, adopted a "freeze-frame" policy requiring prisoners to only receive hormones for which they had been prescribed prior to incarceration, and further, prohibited the option for the prisoner to receive SRS.¹²¹ After reviewing the applicable Eighth Amendment standards, the court acknowledged that if DOC doctors recommended hormones or SRS, security concerns might have made it impossible to provide adequate medical care.¹²² During a meeting to discuss the proposed enactment of the policy, Maloney expressed concerns about security regarding hormones and SRS, in part because about twenty-five percent of the inmates were sex offenders, and

118. *Meriwether*, 821 F.2d at 417. It appeared to the *Meriwether* court that a transsexual prisoner created an inherent security threat, noting a male-to-female transsexual housed in the male general population would "undoubtedly create . . . a volatile and explosive situation." *Id.* at 417 (internal quotation marks omitted). See Travis Wright Colopy, Note, *Setting Gender Identity Free: Expanding Treatment for Transsexual Inmates*, 22 HEALTH MATRIX 227, 267 (2012), for a discussion of providing secure housing accommodations for transsexuals.

119. See *Meriwether*, 821 F.2d at 417 (explaining prison officials can only use best judgment and should receive deference in security matters); see also *Sandin v. Conner*, 515 U.S. 472, 482 (1995) ("[I]nvolvement of federal courts in the day-to-day management of prisons . . . has run counter to the view expressed in several of our cases that federal courts ought to afford appropriate deference and flexibility to state officials trying to manage a volatile environment.").

120. See *Kosilek I*, 221 F. Supp. 2d 156, 159 (D. Mass. 2002). After originally being incarcerated in 1990, Kosilek filed a pro se suit under § 1983 seeking an injunction for treatment of her GID, namely to be provided with SRS. *Id.* Kosilek's requested injunction sought to require the DOC to provide her with a doctor specializing in the treatment of GID and for that doctor to prescribe whatever treatment he or she deemed appropriate. *Id.*

121. *Id.* at 159-60; see Andreopoulos, *supra* note 28, at 242-44 (outlining Maloney's policy regarding treatment of prisoners with GID).

122. *Kosilek I*, 221 F. Supp. 2d at 162. In contrast, under the policy, the court noted that there was no security concern with housing Kosilek who was "living largely as a woman in a medium security male prison." *Id.* The court explained that keeping inmates in general population who receive hormone therapy did not present a safety issue, as it has been done safely in both the United States and Canada. *Id.*

having a female in a male prison presented a significant threat to safety.¹²³ The policy adopted by the DOC stated that the “Department of Corrections has determined that [opportunities for the Real Life Experience that is recommended prior to sex reassignment surgery] cannot be afforded inmates since security and operational concerns do not allow inmates to dress and function as members of the opposite sex.”¹²⁴

In reviewing the policy adopted by the DOC, the court ruled that while Kosilek suffered from a severe case of GID, Maloney’s refusal to provide treatment did not constitute deliberate indifference.¹²⁵ The court invoked the two-prong analysis under the deliberate indifference standard and determined that Kosilek satisfied the objective component, elaborating that “absent adequate treatment, there is a significant risk that Kosilek will again attempt suicide and may, like some other inmates, succeed.”¹²⁶ On the other hand, the court found the substantive prong not met, noting that the decision by Maloney to deny treatment was not the result of an intent to harm Kosilek, but rather the belief that no such harm would result through that denial.¹²⁷ The court’s decision effectively placed Maloney on notice that Kosilek had a serious medical need that required medical treatment, and the court believed Maloney would fulfill his duty to provide proper treatment in the future if medical personnel deemed such treatment necessary.¹²⁸

123. *Id.* at 170. The district court also noted that Maloney did not have the option or authority to place Kosilek in a women’s facility when a court initially sentenced her as a male. *Id.*

124. *Id.* at 171 (alteration in original). *But see* Battista v. Clarke, 645 F.3d 449, 455-56 (1st Cir. 2011) (determining despite security concerns, plaintiff entitled to hormone therapy). Kosilek lived safely in the Massachusetts Correctional Institute at Norfolk (MCI-Norfolk); however, the court noted that she had been abused at other facilities. *Kosilek I*, 221 F. Supp. 2d at 176.

125. *Kosilek I*, 221 F. Supp. 2d at 195; *see* Linda Chin, Note, *A Prisoner’s Right to Transsexual Therapies: A Look at Brooks v. Berg*, 11 CARDOZO WOMEN’S L.J. 151, 169-71 (2004) (explaining district court’s reasoning in *Kosilek I*). Maloney did not view Kosilek’s condition as requiring treatment and believed that the policy put forth would adequately protect Kosilek. *Kosilek I*, 221 F. Supp. 2d at 190-91. The court explained that the issue in the case was that Maloney did not believe the law required him to provide hormones or SRS to Kosilek because of security and cost concerns. *Id.* at 191.

126. *See Kosilek I*, 221 F. Supp. 2d 156, 165, 193 (D. Mass. 2002) (holding Kosilek entitled to medical evaluation regarding severity of GID as serious medical need); *see also* Andreopoulos, *supra* note 28, at 244-45 (discussing Kosilek’s meeting objective component in deliberate indifference analysis).

127. *See id.* at 161-62 (reasoning Maloney prevented medical determinations regarding care because believed law so required). As the court concluded, “Maloney knew many facts from which it could have been inferred that Kosilek was at substantial risk of serious harm if he did not receive adequate treatment. Maloney did not, however, actually draw that inference.” *Id.* at 161. The court further reasoned that the fact that Maloney was not a medical professional and his attorneys’ influence over him precluded his finding that a serious medical need existed. *See id.* at 191. *But see* Chin, *supra* note 125, at 170 (“Maloney’s actions may seem ignorant, if not malicious . . .”).

128. *See Kosilek I*, 221 F. Supp. 2d at 193-94; *see also Kosilek II*, 889 F. Supp. 2d 190, 217 (D. Mass. 2012) (discussing court’s reasoning behind *Kosilek I*’s finding of no deliberate indifference). The court believed that Maloney was “genuinely concerned about the welfare of the inmates for whom he is ultimately responsible for,” and anticipated that the DOC would subsequently provide a medical professional to assess Kosilek’s condition in order to execute its constitutional duties. *Kosilek I*, 221 F. Supp. 2d at 193-94. The court limited its findings, however, by noting that

2. *Kosilek II and Security Determinations*

In the aftermath of *Kosilek I*, the DOC provided a GID specialist to evaluate Kosilek, as directed by the court, and that specialist recommended treatment options, including SRS, if necessary.¹²⁹ After receiving hormone treatment for over a year, doctors recommended Kosilek for SRS because “it [was] quite likely that Michelle [would] attempt suicide again if she [was] not able to change her anatomy.”¹³⁰ A subsequent security review recommended to the Commissioner of the DOC that the surgery be denied because the DOC would be unable to protect Kosilek’s safety after the procedure.¹³¹

At the trial in *Kosilek II*, several witnesses testified to the fact that, in accordance with the SOC, SRS may be the only adequate treatment for GID.¹³² While some doctors consistently suggested that the surgery was medically necessary, DOC personnel testified that “the safety and security concerns presented by the prospect of undertaking sex reassignment surgery for Michelle Kosilek [were] insurmountable,” and thus DOC officials denied Kosilek the

the court does not intend to denigrate the significance of Maloney’s security concerns.

. . . [If] sex reassignment surgery might be deemed medically necessary. . . . Maloney may consider whether security requirements make it truly necessary to deny Kosilek adequate care for his serious medical need. If and when he makes such a decision, a court may have to determine again whether the Eighth Amendment has been violated.

Id. at 194-95.

129. *See Kosilek II*, 889 F. Supp. 2d at 201. The evaluation by Doctor David Seil recommended that SRS may be a possible option once Kosilek completed the required one-year test period living as a female in prison. *Id.* at 218. With regard to security concerns, Luis Spencer, the superintendent of MCI-Norfolk, which housed Kosilek, addressed Maloney’s fears in *Kosilek I* by explaining that although no security threat was currently present, “as these treatments continue and Inmate Kosilek begins to develop physical changes, our security concerns may have to be re-evaluated.” *Id.* at 219.

130. *See id.* at 221. The court noted that the DOC retained several doctors known to oppose SRS as a means of achieving its goal of denying the treatment to Kosilek. *See id.* at 202, 220-21. Despite the repeated suggestions by the DOC’s doctors that the surgery was the only adequate treatment, the commissioner repeatedly denied the treatment because “she remained determined not to be the first corrections official to authorize such treatment, which she believed would be unpopular with elected officials, the media and the public.” *Id.* at 222.

131. *See id.* at 219 (describing DOC’s course of conduct regarding formulation of reports expressing fears of security). The court was quick to note that, while the DOC expressly stated that the surgery would present a “security nightmare,” the “real reason” was actually “to avoid public and political criticism that providing the prescribed treatment would foreseeably provoke.” *Id.* at 223-24.

132. *Kosilek II*, 889 F. Supp. 2d at 226. According to a report written by doctors examining Kosilek, “[g]iven her continued psychological distress, despite the treatment she has already had for GID in making a social and hormonal transition, sex reassignment surgery is the only treatment at this point that would ameliorate Kosilek’s continued gender dysphoria.” *Id.* According to other physicians (including one that does not follow the SOC), however, the resulting depression resulting from a denial of the surgery can be treated with drug therapy. *See id.* at 227. Further, these doctors argued that the surgery was not medically necessary because having the “real life experience” as a female (as prescribed under the SOC) is impossible within the prison environment. *See id.* The court also noted that one of these physicians did not follow “prudent professional standards.” *Id.* at 227.

procedure.¹³³ After a lengthy factual discussion detailing Kosilek's medical history and the evidence presented at trial, the court thoroughly analyzed her claim under the Eighth Amendment.¹³⁴

After concluding Kosilek had a serious medical need and SRS was the only adequate treatment, the court focused primarily on whether security concerns might outweigh providing the procedure.¹³⁵ The court acknowledged that if the decision was made in good faith based on "reasonable security concerns" then judgment would defer to DOC officials; however, the court found the DOC's justification pretextual and not based on good faith.¹³⁶ The court concluded that the DOC denied Kosilek the surgery not because of legitimate penological concerns stemming from good-faith beliefs in security, but rather to avoid criticism from and controversy among the public.¹³⁷

In reviewing the trial testimony of the DOC officials and doctors, the court concluded that the motivation behind denying the surgery was based on personal objections and fears of spending taxpayer money on a controversial procedure.¹³⁸ The court qualified its holding twice by a clarification of the narrow issue presented in the case, i.e., "whether the defendant reasonably and in good faith determined that security concerns required denying Kosilek the only adequate treatment for his serious medical need;" the court did not determine where Kosilek would be incarcerated or how best to protect her after the surgery was completed.¹³⁹ The court reasoned that the inability of prison

133. *See id.* at 228. At trial, on the issue of security, the defendants provided two expert witnesses that affirmatively testified regarding the risk of violence facing transsexuals in prison. *See id.*

134. *See Kosilek II*, 889 F. Supp. 2d 190, 229 (D. Mass. 2012) (discussing requirements for Kosilek to prevail under Eighth Amendment standard). The court outlined five requisite factors for Kosilek to prevail on her claim for injunctive relief: she had a serious medical need; the only adequate treatment for the medical need was SRS; serious harm would befall Kosilek if she did not receive this treatment; legitimate penological concerns, such as security, did not preclude providing the treatment; and denial of treatment would likely continue in the future. *Id.* at 229.

135. *See id.* at 229-30, 237-38 (determining Kosilek's GID constituted serious medical need and treatment abstention rose to deliberate indifference).

136. *Kosilek II*, 889 F. Supp. 2d at 239-40; *see also supra* notes 51-57 and accompanying text (examining role of penological considerations in determinations of deliberate indifference). While it is reasonable for an official to consider issues of prison security, the Eighth Amendment is violated when the official's conduct is "wanton." *See Wilson v. Seiter*, 501 U.S. 294, 303 (1991) (defining "wantonness" as requirement for official's malicious state of mind). Furthermore, the court in *Kosilek II* noted that the pretext arose from the defendant's denial of "the only adequate treatment for Kosilek's serious medical need in order to avoid public and political criticism." *Kosilek II*, 889 F. Supp. 2d at 240.

137. *Kosilek II*, 889 F. Supp. 2d at 240.

138. *See id.* at 246-47. "[T]he court finds that the purported security considerations that Dennehy and Clarke claim motivated their decisions to deny Kosilek sex reassignment surgery are largely false and any possible genuine concerns have been greatly exaggerated to provide a pretext for denying the prescribed treatment." *Id.* at 241.

139. *See id.* at 245, 250. The court stated clearly that their holding was "narrowly drawn":

If the DOC decides that Kosilek must be segregated and locked up 23 hours a day to reasonably assure his safety, it is foreseeable that the court may be asked to decide whether that decision is

officials to objectively determine institutional security concerns led to a constitutional violation, and thus allowed the injunction Kosilek was seeking.¹⁴⁰

III. ANALYSIS

A. Prison Security Concerns Likely Outweigh Providing SRS

A firestorm of debate ensued following the ruling of *Kosilek II*, which pitted constitutional idealism against pure pragmatism in the form of a “Sophie’s choice”: Should the Commonwealth fund SRS for a convicted murder with taxpayer’s money and thereby threaten prison security, or should the Commonwealth deny the procedure, thereby relegating Kosilek to a life of dealing with a debilitating mental condition with no potential recourse?¹⁴¹ It is indisputable that under the Eighth Amendment, a prison is constitutionally required to provide adequate treatment to a prisoner with a serious medical need.¹⁴² This precedent notwithstanding, if the security concerns surrounding a given procedure deemed medically necessary make it infeasible for officials to provide that treatment and thereafter ensure the safety of the prisoner, the Supreme Court has mandated that a court should defer to the official’s judgment.¹⁴³ The good-faith belief of a prison administrator should not be substituted for the opinions of the evaluating physicians who believe the proposed treatment must be provided if doing so would jeopardize the prisoner’s well-being.¹⁴⁴ Accordingly, the decision of *Kosilek II* presented the

reasonable and made in good faith. . . . That issue, however, is not now ripe for resolution.

Id. at 250. The court cautioned, however, that long term segregation may constitute an Eighth Amendment violation of its own. *See id.* at 245.

140. *See id.* at 250-51. The court emphasized that the scope of its injunction was narrow; the court was utilizing the “least intrusive means necessary to correct the violation of that right.” *Id.* Following the district court’s decision in *Kosilek II* ordering the DOC to provide SRS for Kosilek, the DOC appealed. *Kosilek v. Spencer*, 740 F.3d 733, 736 (1st Cir. 2014). On February 12, 2014 the First Circuit affirmed the district court’s decision in *Kosilek II*, but went on to withdraw its opinions and grant a rehearing en banc. *See id.* Oral arguments were held before the First Circuit panel on May 8, 2014. *See Order of Court*, U.S. COURT OF APPEALS FOR THE FIRST CIRCUIT, <http://www.ca1.uscourts.gov/sites/ca1/files/calendar.pdf> (last visited May 21, 2014).

141. *See supra* note 11 and accompanying text.

142. *See supra* notes 35-37 and accompanying text (discussing application of Eighth Amendment protection to medical care context in prisons).

143. *See supra* notes 104, 118-19 and accompanying text (explaining deference accorded to prison officials in addressing matters of institutional security); *see also* *Battista v. Clarke*, 645 F.3d 449, 454-55 (1st Cir. 2011) (emphasizing treatment deniable not based on inept medical care but competing institutional considerations).

144. *See supra* note 42 (referencing factors for consideration in deciding issue of adequate medical care). The First Circuit found that prison administrators are not required to follow what the doctors recommend as the best course of treatment. *See Cameron v. Tomes*, 990 F.2d 14, 20 (1st Cir. 1993). Rather, the professional judgment of the doctors must be supplemented with the professional judgments of prison officials. *See id.* As courts ultimately have the final say on issues of constitutionality, the First Circuit made clear that decisions of

quintessential example of how difficult a court's application of this balancing test can be—the court grappled with the fundamental issue of whether providing medically necessary SRS jeopardized security to the point that it would become impossible for the prison to protect both Kosilek's security and mental health.¹⁴⁵

Comprehensively analyzing security concerns requires more than evaluating whether a prison merely denied treatment because of an official's pretext.¹⁴⁶ A court, in determining whether to grant an injunction for SRS, should not omit a discussion of what repercussions granting the procedure would have.¹⁴⁷ In other words, a court must consider the possibility of voluntarily subjecting the prisoner to “onerous” treatment which may constitute “a form of extrajudicial punishment.”¹⁴⁸ If Kosilek was to indeed receive the surgery and become, for all intents and purposes, a genetically-female individual, how would prison officials protect her from attacks by fellow male prisoners?¹⁴⁹

While recognizing that no prisoner had undergone SRS before while incarcerated, the court declined to discuss the practical aspects of how the prison system would accommodate this novel security issue.¹⁵⁰ When the only option for prisoner safety may be indefinite segregation (which may itself become a constitutional violation, a possible result mentioned in the decision), then this possibility should be incorporated into the decision-making process as to whether the officials were truly acting with pretext when articulating their security concerns.¹⁵¹ Instead, the *Kosilek II* court equated the new and unchartered security concerns presented with a postoperative transsexual with

care encompass more than simply a medical judgment. *See id.*

145. *See supra* notes 135-37 and accompanying text (overviewing issue presented in allowing or denying Kosilek's injunction).

146. *See supra* notes 135-39 and accompanying text (describing reasoning behind court's finding of pretext).

147. *See supra* note 139 and accompanying text (explaining *Kosilek II* declined to indulge in housing discussion postsurgery).

148. *See supra* notes 115-16 (evaluating Eighth Amendment prohibitions to long-term segregation applied to transsexual prisoners). The court in *Kosilek II* theorized that, under a model similar to what the court allowed in *Battista*, prison administrators could provide a “modified protective custody.” *See Kosilek II*, 889 F. Supp. 2d 190, 245 (D. Mass. 2012).

149. *See Kosilek II*, 889 F. Supp. 2d at 243-45, 250. The court's conclusions regarding the concerns of security ultimately did not encompass any consideration about where Kosilek should be housed after the surgery and how officials would safeguard Kosilek's well-being if SRS was successfully performed. *See id.* At 243-45. That is, if Kosilek returned to an all-male facility, the question remains whether the prison could reasonably be expected to protect her from attacks or, if Kosilek moved to an all-female facility, if her notoriety would result in an instability in the prison community. *See id.*

150. *See id.* at 244-45 (noting uncertainty regarding security procedures for prisoner requesting and receiving SRS).

151. *See id.* at 245 (excluding discussion of postsurgery housing from discussion of whether good-faith security concerns justified denial). The court refused to give any merit to a discussion of whether granting the procedure for Kosilek would itself result in a form of “extrajudicial punishment.” *See id.* Instead, the court essentially believed the security concerns would be no different from those presented with other forms of treatment, such as hormone therapy. *See id.*

those that arise when a gender-dysphoric prisoner receives hormone therapy; however, the reality is that there is an inherent difference between an individual who becomes biologically female after SRS is completed and a biologically male individual undergoing hormone therapy in an all-male facility.¹⁵² The court effectively disregarded these eventual issues, choosing to overlook them because it had already determined the officials were not entitled to their due deference.¹⁵³ Whether or not a court agrees with the decisions of the DOC officials who are denying medical care, the court still must engage in an analysis of the practical and actual security ramifications of housing a postoperative transsexual, and not leave such determinations hanging in the balance.¹⁵⁴

*B. The Eighth Amendment Does Not Require Curative Treatment
for Gender Dysphoria*

According to the DOC officials testifying in *Kosilek II*, failing to provide Kosilek with surgery was “quite likely” to result in further suicide attempts or other self-harming actions.¹⁵⁵ Yet, an important distinction arises from what medical professionals recommended and what is constitutionally required: long-standing precedent dictates that prison officials need not “cure” a prisoner’s illness and are only required to ensure that needless suffering is avoided by providing adequate care.¹⁵⁶ As such, there is an inherent difference between an official who ignores all of a prisoner’s medical problems and an

152. *See id.* at 245. In support of the court’s dismissal of addressing whether keeping Kosilek in indefinite segregation postsurgery, the court contemplated that the problems of housing Kosilek would be similar to those presented in *Battista*, where a “modified protective custody” program was successful. *Id.* There are wholly different security concerns that present themselves with SRS: not only will Kosilek likely be subjected to increased sexual assaults if left in a general prison population, but her body will now be capable of engaging in sexual intercourse. *See Bourke, supra* note 90, at 282 (listing physical consequences of SRS including possibility for sexual intercourse after procedure).

153. *See supra* notes 135-37 (stating conclusions made by court in justifying withholding of deference). The court could not hold that the officials acted with deliberate indifference simply because the court gave no deference their decision; the real and valid security concerns still must be considered in determining whether to grant SRS. *See Kosilek II*, 889 F. Supp. 2d at 202-03 (overviewing court’s findings of “pretext” and dismissal of security concerns).

154. *See Kosilek II*, 889 F. Supp. 2d 190, 244 n.21, 245 n.22 (D. Mass. 2012) (introducing arguments during trial regarding detention after surgery). During trial, the court noted that the DOC Commissioner did not believe it was “truly impossible” to provide safe conditions for a postoperative transsexual, but suggested a “23 hour lock down” as one of the acceptable solutions. *See id.* at 244 n.21. Defendants discussed the possibility of a special unit for transsexual prisoners during trial but this played no significant role in the court’s reasoning. *See id.* at 244-45 & n.22.

155. *See supra* notes 129-34 (describing medical testimony presented in *Kosilek II* regarding necessity of surgery). In a letter submitted to the DOC Commissioner, two treating physicians stated, “further delay in providing the recommended treatment likely will result in continued or increased levels of distress for each afflicted individual, with the possibility of self-inflicted injury.” *Kosilek II*, 889 F. Supp. 2d at 238.

156. *See Sultan, supra* note 11, at 1219-20 (theorizing prison not required to cure transsexuals of GID through surgery); *see also Phillips v. Mich. Dep’t of Corrs.*, 731 F. Supp. 792, 800 (W.D. Mich. 1990), *aff’d*, 932 F.2d 969 (6th Cir. 1991) (finding denial of curative treatment not unconstitutional).

official who provides some medical treatment options, short of any curative measures.¹⁵⁷ One commentator suggested the importance of focusing on the difference between, for example, constitutionally required treatment for a prisoner with cancer (where the condition itself is potentially fatal) and a transsexual prisoner with gender dysphoria (where the condition is absolutely not fatal).¹⁵⁸ As discussed previously, GID by itself is not a life-threatening condition, and while it is the duty of the prison to prevent the wanton infliction of pain upon a prisoner, it is also the prison's duty to protect the prisoner from harming himself.¹⁵⁹

Mandating SRS effectively increases the level of treatment from what is merely adequate (the constitutionally required treatment) to treatment that is deemed by the SOC as the "last resort curative option."¹⁶⁰ As one commentator importantly distinguishes, it should not be implied that SRS is necessarily outside of health insurance coverage or forever considered "cosmetic" surgery, but nonetheless, there is a meaningful difference between transsexuals who are incarcerated and transsexuals who are not.¹⁶¹ Expanding on the reasoning proffered by the Court in *Estelle* and Judge Posner in *Maggert*, treatment should not be provided to prisoners when the treatment is largely unavailable to unincarcerated individuals.¹⁶² As another commentator notes, refusing SRS to inmates can be distinguished from the tax court decision of *O'Donnabhain* because under I.R.C. § 213 there is no limit to the treatment provided, whereas

157. See *supra* note 37 and accompanying text (noting deliberate indifference requires finding intentional refusal to treat or wanton disregard of medical condition). Utilizing the court's reasoning in *Torraco v. Maloney*, which required that inferring an official's state of mind for a finding of deliberate indifference requires evidence of treatment "so inadequate as to shock the conscience," the fact that Kosilek has received various treatments just short of SRS cannot be deemed to be truly deliberately indifferent. See *Torraco v. Maloney*, 923 F.2d 231, 234 (1st Cir. 1991) (explaining deliberate indifference standard).

158. See Sultan, *supra* note 11, at 1219 & n.178 (stating refusal to provide surgery not equivalent to treating cancer because not life-threatening condition). According to Sultan, the severity of GID cannot be disputed, but there are stark differences between treating leukemia or heart disease—conditions where if no treatment is provided, the patient will certainly die. *Id.* at 1219 n.178, 1226.

159. See *id.* at 1226-27 (describing GID as serious medical need but surgery beyond necessary level of treatment); see also Dean, *supra* note 83, at 129 (stating transgendered individuals face risk of self-harm such as suicide and castration). It is interesting to note that while the court in *Kosilek II* relied on testimony regarding the risk of suicide if Kosilek did not receive treatment, there was no evidence that the court heard testimony regarding the possibility of suicide in patients after receiving SRS. See Byne, *supra* note 91, at 782 (summarizing case report data suggesting increased risk in suicide among patients who received surgery).

160. See *supra* notes 45-46 and accompanying text (noting prisoners not entitled to model system of medical care but only adequate treatment); see also Chin, *supra* note 125, at 175 (noting SRS above basic medical necessity). Sultan further noted that if a prison provides SRS merely on the basis that the individual is suicidal, any other inmate could threaten suicide to receive their desired form of treatment. See Sultan, *supra* note 11, at 1202 n.45 (noting suicidal feelings constitute primary concern when courts petitioned for treatment).

161. See Chin, *supra* note 125, at 175 n.220.

162. See Colopy, *supra* note 118, at 265 (arguing surgery mostly unavailable and unnecessary for many unincarcerated transsexuals); see also *Maggert v. Hanks*, 131 F.3d 670, 671 (7th Cir. 1997) ("A prison is not required by the Eighth Amendment to give a prisoner medical care that is as good as he would receive if he were a free person, let alone an affluent free person.").

under the Eighth Amendment, a prison need only provide treatment that is medically necessary.¹⁶³

Moreover, the dissenting judge in *O'Donnabhain* alluded to the importance of distinguishing between treatment of the underlying mental disorder and treatment of the disorder's symptoms.¹⁶⁴ During the trial of *Kosilek II*, the court noted that Doctor Schmidt—a physician deemed by the court not to be a “prudent professional”—recommended that the depression resulting from the denial of SRS could be treated with antidepressants and psychotherapy to alleviate her risk of serious harm.¹⁶⁵ Interestingly, the court noted that Doctor Stephen Levine (an expert witness found to be a prudent professional) would not provide antidepressants as treatment for GID and would not provide a transsexual in the community with drugs over SRS.¹⁶⁶ Doctor Schmidt testified that because Kosilek could not successfully complete the real-life experience requirement, the surgery should not be performed.¹⁶⁷ The court explained that the physician's approach regarding treatment with antidepressants could not be aimed at curing the mental illness that caused Kosilek's suffering, but rather at managing the symptoms of that illness to reduce the intensity of her suffering and her risk of suicide.¹⁶⁸

An important argument arises in the context of the dissenting judge's opinion in *O'Donnabhain*, however, in which the judge noted SRS does not

163. See Colopy, *supra* note 118, at 266 (comparing § 213 requirement with Eighth Amendment standards); see also *supra* notes 110-13 and accompanying text (discussing holding and reasoning of *O'Donnabhain*).

164. See *O'Donnabhain v. Comm'r*, 134 T.C. 34, 121-22 (2010) (Gustafson, J., concurring in part, dissenting in part) (arguing surgery only “mitigates” effects of mental disease). The tax judge argued that the procedure does not change the patient's mental state, but, importantly, leaves it unchanged. *Id.* at 122. “[SRS] has given up on the mental disease, has capitulated to the mental disease, has arguably even changed sides and joined forces with the mental disease.” *Id.*

165. See *Kosilek II*, 889 F. Supp. 2d 190, 227 (D. Mass. 2012) (describing testimony provided by Doctor Schmidt regarding recommendation for withholding surgery). The court further noted in the testimony that Doctor Schmidt testified both in the decision of *Kosilek II* and *O'Donnabhain* regarding the SOC as “merely guidelines” as opposed to a true “community standard.” See *id.* at 236. It was Dr. Schmidt's refusal to follow the SOC that contributed to the court's finding that he was not a prudent professional. See *id.* at 235.

166. See *id.* at 235. As Chin noted, however, there is a stark difference between providing treatment for transsexuals with GID and gender dysphoria in prison and treating unincarcerated transsexuals in the general community. See Chin, *supra* note 125, at 175 n.220.

167. See *Kosilek II*, 889 F. Supp. 2d at 233-34; see also *supra* note 90 (discussing requirement for living in desired gender role for one to two years). While the guidelines are indeed flexible suggestions for proper treatment, the SOC note that it is an expert clinical consensus that a patient seeking the surgery should have the opportunity to live in their new desired gender role for an extended period. See Coleman et al., *supra* note 6, at 202-03. If prison officials determine that a course of treatment, such as SRS, is not feasible based on legitimate countervailing concerns, however, then there will be no violation under the Eighth Amendment. See Battista v. Clarke, 645 F.3d 449, 454-55 (1st Cir. 2011) (finding deliberate indifference while acknowledging potential merits of argument security could justify denial of treatment).

168. See *Kosilek II*, 889 F. Supp. 2d at 233-34 (“In [Dr. Schmidt's] opinion, this approach would be sufficient to diminish Kosilek's mental anguish to a point at which he no longer suffers serious harm from his gender identity disorder and, therefore, no longer has a serious medical need.”).

effectively cure an individual of gender dysphoria, but only helps to treat the symptoms because the underlying mental illness is still present.¹⁶⁹ If SRS is in fact viewed only as a procedure treating the symptoms of GID and not curing the mental disorder, then it stands to reason that following Doctor Schmidt's recommendations or other alternatives to SRS indeed constitute the minimal necessary treatment under the Eighth Amendment.¹⁷⁰ There are two anticipated results of this argument: either a transsexual is provided treatment for the *symptoms* of GID under the *O'Donnabhain* dissent approach (and thus SRS is no longer medically necessary to ensure the prisoner does not continue to suffer), or SRS is a treatment used to *cure* the disease (and thus the treatment is beyond the requirements of the Eighth Amendment as the amendment does not require prison officials to provide curative treatment).¹⁷¹ By providing a transsexual with continued hormone therapy, antidepressant regimes, female clothing and cosmetics, and other similarly less invasive treatment options, a prison has effectively met its Eighth Amendment requirement.¹⁷²

The fundamental principle stemming from *Estelle* holds that a prisoner is not entitled to the same type of treatment as an unincarcerated person.¹⁷³ Denying prisoners the opportunity to receive a "state-of-the-art" procedure, such as SRS, cannot be deemed to amount to what the framers of the Eighth Amendment envisioned to constitute "physical torture or a lingering death."¹⁷⁴ It is well established that for unincarcerated transsexuals, the possibility of obtaining the procedure is dim.¹⁷⁵ It can be argued that insurance companies and healthcare providers would be automatically inclined to provide coverage and prescribe the surgery if the medical community generally accepted the treatment as

169. See *O'Donnabhain*, 134 T.C. at 121-22 (Gustafson, J., concurring in part, dissenting in part) (arguing SRS constitutes cosmetic surgery because treatment only mitigates symptoms). The judge explained that even if the procedure is the best treatment that medicine can provide, the mental disease itself is not treated, only its symptoms, and so the procedure is "cosmetic surgery" under § 213. See *id.* at 122.

170. See Colopy, *supra* note 118, at 264-65 (determining SRS beyond minimum effective treatment required under Eighth Amendment). But cf. *Kosilek II*, 889 F. Supp. 2d at 233-34 (rejecting Dr. Schmidt's approach to treat Kosilek's symptoms rather than "cure" mental illness).

171. Compare *O'Donnabhain v. Comm'r*, 134 T.C. 34, 121-22 (2010) (Gustafson, J., concurring in part, dissenting in part) (arguing SRS only mitigates symptoms of GID), and Bourke, *supra* note 90, with *Kosilek II*, 889 F. Supp. 2d 190, 233-34 (D. Mass. 2012) (reasoning Doctor Schmidt's approach inappropriate because aimed at managing symptoms rather than cure).

172. See Colopy, *supra* note 118, at 264 n.270 (noting medically necessary treatment equals treatments to prevent pain, suffering, and further deterioration). Under the basic level of treatment approach as Dr. Schmidt recommended, Kosilek's resulting symptoms from being denied the surgery could be treated effectively. See *Kosilek II*, 889 F. Supp. 2d at 233-34.

173. See Colopy, *supra* note 118, at 264 (reasoning minimum effective treatment under Eighth Amendment does not require curing long-term condition); see also *supra* notes 35-37 (overviewing applicable standards for asserting claim of deliberate indifference).

174. See Sultan, *supra* note 11, at 1226-27; see also *supra* text accompanying notes 86-88 (referencing SRS as last step in treatment process).

175. See Mann, *supra* note 11, at 102-04 (explaining difficulty in receiving insurance coverage for treatments relating to SRS or postoperative treatments); see also GIORDANO, *supra* note 78, at 97 (describing employment discrimination precludes many transsexuals from affording expensive procedures).

medically necessary for unincarcerated transsexuals.¹⁷⁶

A potential repercussion of providing SRS to incarcerated transsexuals, while many unincarcerated transsexuals rarely can even afford the procedure, is the potential for individuals to commit crimes with the hope that the state will be forced to provide them with treatment.¹⁷⁷ The court in *Kosilek I* responded to the argument that nontranssexuals may seek the procedure to be transferred to a women's facility, but was silent in response to the court's legitimate argument in *Maggert* that the current disparity between available treatment for incarcerated and unincarcerated transsexuals would drive those desperately seeking treatment to consider prison.¹⁷⁸ Certainly if an individual is willing to commit suicide or perform self-castration, an individual with severe GID may be willing to risk his or her freedom if it meant that the opportunity to have SRS would come to fruition.¹⁷⁹

IV. CONCLUSION

It is undisputed that prisoners suffering from GID or gender dysphoria have the inherent right to treatment for their symptoms under the Eighth Amendment. However, Providing SRS presents a wholly different circumstance: if the procedure indeed acts as a curative measure for gender dysphoria, then the procedure is beyond what is required for basic medical necessity, and if the treatment is focused on the symptoms of gender dysphoria, then other alternatives exist to ensure the prisoner does not suffer from any "wanton infliction of pain."

Security within prisons is a legitimate penological concern that must be taken into consideration when deciding what procedure to provide to an inmate. Proper consideration of where postoperative transsexuals will be housed, whether they must be held in administrative segregation (which in itself could

176. See Mann, *supra* note 11, at 104 (stating reluctance of insurance companies to provide coverage for reconstructive surgery except when medically necessary); see also *Maggert v. Hanks*, 131 F.3d 670, 672 (7th Cir. 1997) ("Gender dysphoria is not, at least not yet, generally considered a severe enough condition to warrant expensive treatment at the expense of others than the person suffering from it."); Dean et al., *supra* note 83, at 128 (describing transsexuals excluded from coverage despite diagnosis of GID because treatment viewed as experimental).

177. See Sultan, *supra* note 11, at 1206-07 (theorizing providing treatment to incarcerated transsexuals while unincarcerated transsexuals cannot afford treatment creates risks). Sultan notes the irony in providing legal remedies to incarcerated transsexuals while their unincarcerated counterparts are denied any protection in obtaining treatment. See *id.* at 1206 n.81.

178. See *Maggert*, 131 F.3d at 672 ("[W]e cannot see what is cruel about refusing a benefit to a person who could not have obtained the benefit if he had refrained from committing crimes. We do not want transsexuals committing crimes because it is the only route to obtaining a cure."). No mention was made in *Kosilek II* regarding the argument of unincarcerated transsexuals attempting to use prison mandated treatment to provide them with SRS when it would be otherwise impossible for them to receive the procedure. See Sultan, *supra* note 11, at 1206-07.

179. See Sultan, *supra* note 11, at 1207 n.83 (referencing "Dog Day Afternoon" where protagonist attempted to rob bank to finance transsexual partner's surgery).

amount to extrajudicial punishment), and how to ensure their safety and that of others must be included in determining whether the procedure is feasible in prisons and whether an official truly acted with deliberate indifference to the prisoner's condition. On balance, SRS is most likely not an appropriate treatment option for incarcerated transsexuals under the Eighth Amendment. With many unincarcerated transsexuals left without the possibility of ever receiving the procedure, a court should accordingly defer to the security considerations presented with the procedure, or alternatively, accept the conclusion that the procedure constitutes a curative treatment outside the scope of the Eighth Amendment's protections.

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