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Now You See Me: Problems and Strategies for Introducing Gender Self-Determination into the Eighth Amendment for Gender Nonconforming Prisoners

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COMMENTS

NOW YOU SEE ME: PROBLEMS AND STRATEGIES FOR INTRODUCING GENDER SELF-DETERMINATION INTO THE EIGHTH AMENDMENT FOR GENDER NONCONFORMING PRISONERS

LIZZIE BRIGHT*

As the fight for transgender rights becomes more visible in the United States, the plight of incarcerated transgender individuals seeking medical care behind bars is likewise gaining attention—and some trans prisoners are gaining access to gender-affirming care. However, progress for incarcerated members of the trans community has been slow, piecemeal, and not without problems. As federal court opinions in Eighth Amendment access-to-care cases brought by trans prisoners show, how a court interprets the subjective intent requirements of the Eighth Amendment and how the imprisoned plaintiff pleads his/her/their case can make or break the claim. Further, courts and plaintiffs rely on medical diagnoses often couched in fixed binary transition to make a cognizable constitutional claim for medical care. For incarcerated gender nonconforming (“GNC”) individuals, the established binary-based medical diagnoses increasingly accepted by courts and prison officials may not reflect GNC individuals’ gender identities or medical needs. However, utilizing updated medical standards that enable patient gender self-determination in Eighth Amendment claims may extend Eighth Amendment protection to GNC people in American prisons. Deploying medical standards that are not aimed at binary transition in Eighth Amendment litigation can provide an avenue for incarcerated GNC individuals both to regain some power of gender self-determination and to

* A.B., University of Chicago, 2011; J.D. candidate, Northwestern University Pritzker School of Law, 2018. Thanks to Laura for her unconditional love and support throughout this process. Thanks to Steph and Annie for showing me there is a way to be gender nonconforming and butch while rejecting toxic masculinity.

ensure GNC prisoners have access to the gender-affirming medical care to which they are entitled.

TABLE OF CONTENTS

INTRODUCTION.....	138
I. BACKGROUND.....	140
II. STANDARDS OF CARE: CONVENTIONAL AND EMERGING	
MODELS	145
A. GNC-Inclusive Models of Care	146
B. Fixed Binary Models of Care	146
C. Models of Care and the Eighth Amendment	148
III. THE EIGHTH AMENDMENT: LOOKING AT EVERYONE EXCEPT THE	
PRISONER	150
A. The Basic Framework: Serious Medical Need and	
Deliberate Indifference	150
B. Deference to Medical Knowledge	152
IV. CASE LAW: CHALLENGES AND OPPORTUNITIES FOR GNC	
PLAINTIFFS	156
A. Challenges: When Courts Let Prisons Use Their Own	
Problematic Experts and Policies to (Mis)Treat Inmates	156
B. Opportunities: Shifting Subjectivity and Refocusing on the	
Prisoner	160
C. A Case that Could Win?	166
CONCLUSION.....	169

INTRODUCTION

Americans have become more aware of issues facing the transgender community in the past several years—Caitlyn Jenner’s “coming out,” Laverne Cox’s role on *Orange is the New Black*, and Gavin Grimm’s case challenging a school’s bathroom policy have all garnered national attention.¹ Laverne Cox has spoken publicly about the plight of transwomen in prison,²

¹ See, e.g., Moriah Balingit, *Gavin Grimm just wanted to use the bathroom. He didn’t think the nation would debate it.*, WASH. POST (Aug. 30, 2016), https://www.washingtonpost.com/local/education/gavin-grimm-just-wanted-to-use-the-bathroom-he-didnt-think-the-nation-would-debate-it/2016/08/30/23fc9892-6a26-11e6-ba32-5a4bf5aad4fa_story.html?utm_term=.ec2767706b40; Kathleen Parker, *Opinion: Caitlyn Jenner’s Coming Out*, WASH. POST (June 2, 2015) https://www.washingtonpost.com/opinions/caitlyn-jenners-coming-out/2015/06/02/da17bb80-095f-11e5-95fd-d580f1c5d44e_story.html?utm_term=.5f5b0cdbaef3; Jazz Jennings, *The 100 Most Influential People: Laverne Cox*, TIME (Apr. 16, 2015), <http://time.com/collection-post/3822970/laverne-cox-2015-time-100/>.

² See, e.g., Shannon Vestal Robson, *Laverne Cox Gives a Hint About Sophia’s Season 4 Storyline on OITNB*, POP SUGAR (Jan 19, 2016), <http://www.popsugar.com/entertainment/>

and “[t]he issue of whether a transsexual³ person is entitled to hormone therapy or sex-reassignment surgery while in prison has been litigated extensively.”⁴ Yet, virtually no cases have been brought by prisoners seeking gender-affirming⁵ care that is not aimed at fixed binary “male to female” or “female to male” transition. Most problematically, even correctional⁶ facilities that do have protocols in place providing for medical care for transgender inmates⁷ tend to use standards of care that cover only fixed binary transition.⁸

In her article *Feminism and the (Trans)gender Entrapment of Gender Nonconforming Prisoners*, Julia Oparah details the experiences of a gender nonconforming (GNC) former prisoner, Bakari.⁹ Bakari, who identifies as genderqueer,¹⁰ which to them means neither wholly male nor female, was

Laverne-Cox-Quote-About-Trans-Women-Prison-2016-39833058 (discussing harsh conditions transwomen face in prison, including solitary confinement).

³ Some courts and sources use the outdated term “transsexual” to mean transgender. Where sources have used this word, I have left it in. I have also left in where sources use the term “transgendered” rather than transgender.

⁴ Karen Moulding & National Lawyers Guild, Lesbian, Gay, Bisexual and Transgender Committee, *Access to Medical Treatment in Prison*, in *SEXUAL ORIENTATION AND THE LAW* § 10:26 (2016).

⁵ See Jae Puckett, *Research Blog—Barriers to Gender-Affirming Care for Transgender and Gender Non-conforming Individuals*, IMPACT: THE LGBT HEALTH DEV. PROGRAM (Dec. 10, 2015), <http://www.impactprogram.org/research-blog/research-blog-barriers-gender-affirming-care-transgender-gender-non-conforming-individuals/#sthash.GkJdfxmS.dpbs>. Gender-affirming care refers to a variety of medical treatments, including hormones and surgery. *Id.*

⁶ I used this term as another word for “prison”—I do not believe prisons serve any legitimate corrective or rehabilitative function.

⁷ I will periodically use the terms “prisoner” and “inmate” to describe people who are incarcerated. This is meant only as shorthand, not as language intended to dehumanize the overwhelming number of people incarcerated in the United States.

⁸ See, e.g., FED. BUREAU OF PRISONS, *MEDICAL MANAGEMENT OF TRANSGENDER INMATES* 11 (Dec. 2016), available at https://www.bop.gov/resources/pdfs/trans_guide_dec_2016.pdf (“Feminizing treatment is generally the more complex of the two gender-affirming regimens” compared to masculinizing treatment) (emphasis added). The Federal Bureau of Prisons’ guide provides care guidelines only for male-to-female and female-to-male inmates—that is, only for inmates seeking fixed binary transition. *Id.* at 11–19.

⁹ Julia C. Oparah, *Feminism and the (Trans)gender Entrapment of Gender Nonconforming Prisoners*, 18 *UCLA WOMEN’S L.J.* 239, 239–40 (2012). “They/their” is sometimes used as a singular pronoun by gender nonconforming and genderqueer individuals. *Id.*

¹⁰ Genderqueer is often synonymous with gender nonconforming. See *CTR. OF EXCELLENCE FOR TRANSGENDER HEALTH, GUIDELINES FOR THE PRIMARY AND GENDER-AFFIRMING CARE OF TRANSGENDER AND GENDER NONBINARY PEOPLE* 15 (Madeline B. Deutsch ed., 2d ed. 2016) (“Genderqueer is another term used by some with [the gender nonconforming] range of identities”) [hereinafter “UCSF”]. For a discussion of specifically

housed in a California prison according to their perceived biological sex.¹¹ While “penal systems are premised on the existence of a rigid gender binary,” Bakari asserted their “right to gender self-determination, including the right to embrace a shifting and fluid gender identity.”¹² People like Bakari exist in this country’s many prisons, and they face high hurdles to receive the gender-affirming medical care they deserve as human beings.

Showing courts, which defer to medical expertise in their Eighth Amendment jurisprudence, that there are medical protocols inclusive of GNC identities is a viable first step in this process of restoring gender self-determination to GNC prisoners. This Note will examine strategies and barriers to getting GNC-competent medical protocols in front of courts, with the goal of challenging the prevailing prison medical regime of fixed binary-based care and ultimately moving the law toward a self-determinative model of gender identity.¹³

I. BACKGROUND

While locked up, Bakari observed higher levels of victimization of gender nonconforming prisoners by staff, such as punishing individuals within the “women’s” prison who grew facial hair.¹⁴ Prison abolition group Black and Pink’s 2015 report likewise found that nearly 80% of trans and gender nonconforming (“TGNC”) prisoners experienced emotional suffering as a result of having to conceal their gender while locked up.¹⁵ The report also found that over a third of TGNC individuals surveyed had used hormones prior to being incarcerated, and 44% reported being denied hormones once incarcerated.¹⁶ While the overall prevalence of TGNC individuals in the U.S. may be low, this community is disproportionately represented in America’s correctional system: almost one in six transgender people in the U.S. has been locked up in a state or federal prison, and nearly

genderqueer identity, see *LGBTQ+ Definitions*, TRANS STUDENT EDUC. RES., <http://www.transstudent.org/definitions> (last visited June 9, 2017).

¹¹ See Oparah, *supra* note 9, at 240.

¹² *Id.*

¹³ For a brief examination of gender self-determination and the granting of discrete legal rights to marginalized groups, see Eric A. Stanley, *Gender Self-Determination*, 1 TSQ: TRANSGENDER STUD. Q. 19, 89 (2014).

¹⁴ See Oparah, *supra* note 9, at 241.

¹⁵ JASON LYDON ET AL., COMING OUT OF CONCRETE CLOSETS, BLACK & PINK 1, 4 (Oct. 21, 2015), <http://www.blackandpink.org/wp-content/uploads/Coming-Out-of-Concrete-Closets.-Black-and-Pink.-October-21-2015.-Executive-Summary-and-Recommendations.pdf> (using the terms “transgender, nonbinary gender, and Two-Spirit” to describe TGNC individuals).

¹⁶ See *id.*

half of all black transgender Americans have been incarcerated.¹⁷ Forty-three percent of the TGNC-identified individuals surveyed by Black and Pink had a diagnosis of Gender Identity Disorder or Gender Dysphoria (“GID” or “GD”), and nearly one-third of TGNC prisoners were denied a GID/GD diagnosis when they sought one.¹⁸ One of these two diagnoses is typically required before accessing gender-affirming care in prison.¹⁹ While it is becoming more common for prisons to provide hormone therapy for some transgender inmates and, for example, for prisons to allow transwomen to wear feminine clothing in prison, access to surgery and care for all TGNC people behind bars is far from the norm.²⁰

It is vital to note that many of the transgender inmates seeking gender-affirming care in American prisons likely do identify within the binary—meaning as men or women, and not as a non-binary gender(s).²¹ Their claims and the courts’ binary-based responses might therefore accurately reflect plaintiffs’ self-identification (though even after a hard-fought gender-validating win in court, transgender inmates face heightened levels of

¹⁷ See Esinam Agbemenu, *Medical Transgressions in America’s Prisons: Defending Transgender Prisoners’ Access to Transition-Related Care*, 30 COLUM. J. GENDER & L. 1, 1–2 (2015). There is a high likelihood GNC prisoners are lumped into the “transgender” category for prison statistics. “The broad category of transgender encompasses both pre and post-operative transgender individuals, genderqueer individuals, cross-dressers, the androgynous, and other gender non-conforming people.” *Id.* at 9.

¹⁸ LYDON ET AL., *supra* note 15, at 4. GD has become the more accepted term, but because some cases cited also use the term GID, I will use both terms in tandem. See Camille Beredjick, *DSM-V to Rename Gender Identity Disorder ‘Gender Dysphoria,’* THE ADVOCATE (July 23, 2012, 7:00 PM), <http://www.advocate.com/politics/transgender/2012/07/23/dsm-replaces-gender-identity-disorder-gender-dysphoria>.

¹⁹ See Agbemenu, *supra* note 17, at 2–3.

²⁰ See *Soneeya v. Spencer*, 851 F. Supp. 2d 228, 246 (D. Mass. 2012) (holding prison officials violated the Eighth Amendment in denying care, including providing feminine clothing that the plaintiff prisoner’s “medical providers indicated were necessary for her treatment”); see also *Moulding & National Lawyers Guild*, *supra* note 4 (explaining that hormone access is more available as a result of litigation but that access to surgery remains inconsistent).

²¹ See Oparah, *supra* note 9, at 246–47 (“Although transgender and transsexual are not synonyms, case law generally focuses on the experiences of male-to-female transsexuals” with courts relying on binary-based GID diagnosis “[r]ather than challenging the gender binary.”). All of this is not to say that transgender plaintiffs in any type of suit share a universal goal of “passing” for a cisgender person—many are proud to be transgender. This Note also does not seek to demean transgender individuals as lesser than GNC individuals, or even to artificially divide the TGNC community into those who are transgender and those who are GNC, when individuals may identify as both. Rather, this Note seeks to examine how courts and resulting law may treat incarcerated individuals who seek gender-affirming care that is not necessarily aimed at binary transition, and what challenges to binary care models are available.

violence back in prison).²² In healthcare access just as in what has come to be whitewashed as the “gay rights movement,” transgender individuals, especially transwomen of color, are trailblazers.²³ It is their claims of a right to gender-affirming care that will continue to pave the way, now and in the future, for care that is not couched in binary transition.

The case law surrounding transgender prisoners has focused mostly on the experiences of transwomen.²⁴ The reliance of courts on medical diagnosis pathologizes transgender persons, granting them rights only when they are defined as abnormal or sick.²⁵ Excluded from legal protections are those who do not seek diagnosis or medical care in relation to their gender identity.²⁶ Also excluded are those who do seek care but not with a goal of permanent transition from one end of the binary to the other.²⁷ For example, a GNC person who seeks temporary hormone therapy to achieve certain secondary sex characteristics but not others²⁸ may be denied treatment under the current diagnostic regime and may not have the sort of binary-based evidence of medical need (for example, a constant lifelong desire to live as “the opposite sex”²⁹) currently relied on by courts in Eighth Amendment

²² LYDON ET AL., *supra* note 15, at 5 (e.g., LGBTQ survey respondents were six times more likely to be sexually assaulted in prison than other inmates, and TGNC individuals are targeted more severely than lesbian, gay, and bisexual inmates).

²³ See Kamms, *Never Forget #024: Transwomen of Color Kickstarted the Gay Rights Movement (Stonewall)*, THE VISIBILITY PROJECT (May 26, 2016), <http://www.thevisibilityproject.com/2016/05/26/never-forget-transwomen-of-color-kickstarted-the-gay-rights-movement-stonewall-uprising/> (last visited Nov. 1, 2016).

²⁴ Oparah, *supra* note 9, at 246 (citing Darren Rosenblum, “Trapped” in *Sing Sing: Transgendered Prisoners Caught in the Gender Binarism*, 6 MICH. J. GENDER & L. 499, 522 (2000)). The Eighth Amendment’s prohibition of cruel and unusual punishment enables prisoners to sue for denial of medical care in prison. See generally *Estelle v. Gamble*, 429 U.S. 97 (1976).

²⁵ See Oparah, *supra* note 9, at 246–47; see generally Silpa Maruri, *Hormone Therapy for Inmates: A Metonym for Transgender Rights*, 20 CORNELL J.L. & PUB. POL’Y 807 (2011).

²⁶ See Oparah, *supra* note 9, at 247. For example, an inmate may seek non-medical interventions such as chest binding to express gender.

²⁷ See Hannah Mogul-Adlin, *Unanticipated: Healthcare Experiences of Gender Nonbinary Patients and Suggestions for Inclusive Care*, 5–7 (2015) (master’s thesis, Yale School of Public Health), available at <http://elischolar.library.yale.edu/ysphtdl/1197> (describing the medical profession’s conception of “transgenderedness” as based on permanent binary transition from one sex to the “opposite sex”).

²⁸ See *FTM Testosterone Therapy Basics*, HUDSON’S FTM RES. GUIDE, <http://www.ftmguide.org/ttherapybasics.html> (last visited May 23, 2017). Only some effects of testosterone—voice change and hair growth, for example—are permanent after a period of “t” (testosterone) usage, while other effects, such as fat placement on the body, may revert to pre-t placement once hormone therapy is stopped. *Id.*

²⁹ See, e.g., *Rowe v. Corr. Med. Servs., Inc.*, No. 1:08-CV-827, 2010 WL 3779561, at *4 (W.D. Mich. Aug. 18, 2010), *report and recommendation adopted*, No. 1:08CV827, 2010 WL

litigation.

Numerous authors have tackled the issues arising from transgender prisoners' Eighth Amendment access to medical care claims from the lens of pathology.³⁰ Medical diagnosis reinforced by legal standards defines TGNC individuals on terms set by doctors and courts—rather than allowing TGNC individuals to define themselves.³¹ The end result is the perpetuation of “simplistic binaries, which squeeze out anything or anyone that doesn't fit” but that are legible to mainstream society.³² What remains less discussed than the pathologizing of transgender persons via binary-based medical diagnosis is the elimination of gender fluidity and non-binary identities under the current legal-medical regime. In particular, the current structure of Eighth Amendment jurisprudence does not allow room for gender self-determination and instead emphasizes the subjective view of prison officials and institutional medical opinion.³³ GNC prisoners may be forced to bring their Eighth Amendment denial of care claims in the mold of binary-transition-care claims instead of as GNC individuals. But newer GNC-inclusive medical standards that enable patients to self-define their identities already exist, and these standards are one way to undo the erasure of GNC prisoners under the current Eighth Amendment denial-of-care regime. Although the integration of these newer guidelines into the case law is a real challenge for prisoners, a handful of cases demonstrate possible pitfalls and paths to getting non-binary conceptions of gender in front of the courts.

The issue addressed in this Note—how to achieve gender self-

3779437 (W.D. Mich. Sept. 22, 2010) (finding no Eighth Amendment violation from prison policy defining “gender identity disorders” as binary-based: “A person with a gender identity disorder is unhappy with his/her biological sex, and desires to be considered a member of the opposite sex.”).

³⁰ See, e.g., Tara Dunnavant, *Bye-Bye Binary: Transgender Prisoners and the Regulation of Gender in the Law*, 9 FED. CTS. L. REV. 15, 21 (2016) (discussing medical models of gender that “pathologize gender transgression”); see also 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, 718 (2005) (describing the “medical model, in which gender nonconformity is explained as a psychological condition most appropriately treated through medical services”).

³¹ See Dunnavant, *supra* note 30 at 21–22. I use GNC to mean people within the greater TGNC umbrella who do not necessarily define themselves as transgender but who identify as gender nonconforming.

³² *Id.* at 22.

³³ Farmer v. Brennan, 511 U.S. 825, 826 (1994) (reiterating that the Eighth Amendment has a subjective prong requiring officials to be “aware” of risks to inmates); Fields v. Smith, 653 F.3d 550, 555 (7th Cir. 2011) (affirming district court finding of Eighth Amendment violation where defendant prison officials, including medical staff, “knew of the serious medical need but refused to provide hormone therapy” to transgender inmates) (emphasis added).

determination for TGNC prisoners by litigating standards of care not based on a fixed gender binary—is but a tiny piece of the TGNC-equality puzzle. Other authors have already noted that equal protection claims are often a “losing strategy” for transgender plaintiffs because the Supreme Court appears unwilling to expand those classifications receiving heightened scrutiny under the Fourteenth Amendment.³⁴ Equal Protection arguments may not leave room for true gender self-determination beyond the binary if Equal Protection is based on fixed “immutable” traits—though immutability itself may not be sacrosanct in determining suspect classifications.³⁵ The criminalization of TGNC people—particularly of gender nonconforming individuals³⁶ and transwomen of color³⁷—has far-reaching consequences that necessitate multiple approaches. As with other intersecting marginalized and surveilled communities, the effects of criminalization of TGNC individuals impacts their access to housing, education, and employment.³⁸ The very fact that a body of case law exists dealing with access to gender-affirming care for TGNC individuals behind bars is a symptom of the greater penalization of the TGNC community.³⁹ In order to dismantle the systemic oppression of TGNC individuals, litigants and activists must deploy multiple strategies inside and outside the courtroom—and always under the leadership of the TGNC community. This Note is intended only to outline one possible—and imperfect—route for moving toward self-determination for a subset of the

³⁴ See Sarah Halbach, Comment, *Framing A Narrative of Discrimination Under the Eighth Amendment in the Context of Transgender Prisoner Health Care*, 105 J. CRIM. L. & CRIMINOLOGY 463, 471–72 (2015). Halbach notes that, in the employment context, courts are becoming more willing to extend equal protection and Title VII protections to transgender individuals. *Id.* at 473; see also Glenn v. Brumby, 663 F.3d 1312, 1319 (11th Cir. 2011) (holding discrimination against transgender individuals is “sex-based discrimination that is subject to heightened scrutiny under the Equal Protection Clause”).

³⁵ See *Frontiero v. Richardson*, 411 U.S. 677, 686 (1973) (finding the immutability of a trait is a factor in the Equal Protection analysis); see also Chinyere Ezie, *Deconstructing the Body: Transgender and Intersex Identities and Sex Discrimination—the Need for Strict Scrutiny*, 20 COLUM. J. GENDER & L. 141, 180 (2011) (discussing the history and current place of immutability in the Equal Protection framework).

³⁶ *Quick Guide to the Criminalization of Transgender and Gender Non-Conforming People*, TRANSFORMATIVE JUST. L. PROJECT OF ILL., <https://www.prisonlegalnews.org/media/publications/Guide%20to%20Criminalization%20of%20Trans%20%26%20Gender%20Non-Conforming%20People%20Transformative%20Justice%20Law%20Proj.%20of%20IL.pdf> (last visited Feb. 12, 2017).

³⁷ Dina Kopansky, *Locked Out: How the Disproportionate Criminalization of Trans People Thwarts Equal Access to Federally Subsidized Housing*, 87 TEMP. L. REV. 125, 137 (2014).

³⁸ See *id.* at 126, 128.

³⁹ See *id.* at 142 (explaining that the incarceration rate for transgender individuals is “far higher than the incarceration rate for non-trans people”).

TGNC community in the United States

II. STANDARDS OF CARE: CONVENTIONAL AND EMERGING MODELS

The medical model of gender, which utilizes psychiatric diagnosis of Gender Identity Disorder/Gender Dysphoria (“GID”/“GD”) to legitimize transgender status in the eyes of the law, can secure rights for transgender individuals.⁴⁰ But the currently dominant iteration of the medical model “assumes that two genders exist and enforces the norms typically associated with these genders.”⁴¹ The medical model has enabled access to rights and protections, but at a cost: the binary gets reinforced, permanent transition within two options is required, and GNC plaintiffs remain out in the cold.⁴² The medical model also “sets up the medical establishment as a gatekeeping institution that regulates gender nonconformity and predicates legal rights on access to health care,”⁴³ all of which plays out in Eighth Amendment claims. As will be explored in depth below, the Eighth Amendment’s prohibition against cruel and unusual punishment⁴⁴ applies when prisoners are denied adequate medical care.⁴⁵ To make a successful Section 1983⁴⁶ claim for a violation of the Eighth Amendment based on, for example, the right to adequate medical treatment, a prisoner must successfully allege both that the need for medical care was serious⁴⁷ and that the prison officials subjectively knew of the need for care.⁴⁸ Eighth Amendment cases involving deprivation of medical care often turn on the medical opinions and expertise of prison doctors.⁴⁹ Like the Eighth Amendment requirement of subjective knowledge and accompanying deference to medical opinion, officials and doctors are the ones with the power to diagnose and define the imprisoned plaintiff’s gender

⁴⁰ See Romeo, *supra* note 30, at 725.

⁴¹ *Id.* at 724–25.

⁴² *Id.* at 726–27.

⁴³ *Id.* at 730.

⁴⁴ U.S. CONST. amend. VIII.

⁴⁵ See *Estelle v. Gamble*, 429 U.S. 97 (1976).

⁴⁶ See 42 U.S.C. § 1983 (2012). Section 1983 allows individuals to sue when the government has violated a constitutional right. It is the statutory vehicle for prisoners to sue prisons when prisons fail to meet Eighth Amendment standards of medical care and is independent of the Eighth Amendment’s jurisprudential framework.

⁴⁷ *Estelle*, 429 U.S. at 104.

⁴⁸ *Farmer v. Brennan*, 511 U.S. 825, 837 (1994); see also *De’Lonta v. Angelone (De’Lonta I)*, 330 F.3d 630, 634 (4th Cir. 2003) (“[the Eighth Amendment] requires that a prison official actually know of and disregard an objectively serious condition, medical need, or risk of harm.”).

⁴⁹ See, e.g., *Kosilek v. Spencer*, 774 F.3d 63, 88–89 (1st Cir. 2014), *cert. denied sub nom. Kosilek v. O’Brien*, 135 S. Ct. 2059 (2015) (holding that the district court erred in part by improperly “substituting its own beliefs for those of multiple medical experts”).

under the traditional medical model.

A. GNC-INCLUSIVE MODELS OF CARE

The binary medical model is no longer the only model of care for TGNC individuals. Professional literature that includes fluid and non-binary genders exists. The American Psychological Association (“APA”) published its Guidelines for Psychological Practice with Transgender and Gender Nonconforming People in 2015.⁵⁰ The APA Guidelines affirm that gender identity may be non-binary and fluid.⁵¹ Likewise, the Center of Excellence for Transgender Health at the University of California, San Francisco’s Guidelines for the Primary and Gender-Affirming Care of Transgender and Gender Nonbinary People (“UCSF Guidelines”) provide a model of treatment for GNC individuals that accommodate fluid and non-binary identities,⁵² such as providing lower doses of hormones for limited periods of time rather than requiring permanent use of treatments that aim to transition someone from one end of the binary to the other.⁵³ The UCSF Guidelines stress that the GNC patient’s identity should guide his/her/their own care and that a GNC individual’s “authentic [gender] expression” may include characteristics and treatments that others see as mismatched or not identifiable as purely masculine or feminine.⁵⁴ UCSF’s Guidelines take the approach that individuals seeking gender-affirming care have “differing desires for gender-affirming treatments.”⁵⁵ Finally, the UCSF Guidelines contrast their approach with the approach still holding sway in transgender prisoner cases: “In contrast to past practices in which a set pathway involved a requirement of psychological assessment → hormones → genital surgery, the current standard of care is to allow each transgender person to seek only those interventions which they desire to affirm their own gender identity.”⁵⁶

B. FIXED BINARY MODELS OF CARE

Many prison systems in the U.S. now provide gender-affirming care for at least some transgender inmates.⁵⁷ The most recent edition of the

⁵⁰ Am. Psychological Ass’n, *Guidelines for Psychological Practice with Transgender and Gender Nonconforming People*, 70:9 AM. PSYCHOL. 832, 836, 862 (2015).

⁵¹ *Id.* at 836, 862.

⁵² See CTR. OF EXCELLENCE FOR TRANSGENDER HEALTH, *supra* note 10, at 15 (use of GNC-inclusive terminology).

⁵³ See *id.* at 70.

⁵⁴ See *id.* at 70–71.

⁵⁵ *Id.* at 17.

⁵⁶ *Id.* at 23.

⁵⁷ See Moulding & National Lawyers Guild, *supra* note 4.

Diagnostic and Statistical Manual of Mental Disorders (“DSM-V”), meanwhile, pays mere lip service to GNC individuals.⁵⁸ The DSM-V, also called the “psychiatrist’s bible,”⁵⁹ is used in multiple correctional systems in the United States⁶⁰ and appears frequently in the case law dealing with TGNC inmates.⁶¹ The DSM-V’s diagnostic scheme for gender dysphoria, which is in widespread use in prisons, requires six months of feeling “marked incongruence between one’s experienced/expressed gender and assigned gender” and at least two of a menu of symptoms:

1. A marked incongruence between one’s experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics).
2. A strong desire to be rid of one’s primary and/or secondary sex characteristics because of a marked incongruence with one’s experienced/expressed gender (or in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics).
3. A strong desire for the primary and/or secondary sex characteristics of the other gender.
4. A strong desire to be of the other gender (or some alternative gender different from one’s assigned gender).
5. A strong desire to be treated as the other gender (or some alternative gender different from one’s assigned gender).
6. A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one’s assigned gender).⁶²

The DSM-V’s first two diagnostic options assume one has to feel a

⁵⁸ AM. PSYCHIATRIC ASS’N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS § 302.85 (2013).

⁵⁹ Lila Leonard, *Gender Reassignment Surgery in Prisons: How the Eighth Amendment Guarantees Medical Treatments Not Covered by Private Insurance or Medicare for Law-Abiding Citizens*, 11 RUTGERS J.L. & PUB. POL’Y 626, 629–30 (2014) (citing Dana Beyer, *The End of Transgender as a Mental Illness*, HUFFINGTON POST (Dec. 5, 2012, 9:34 PM), http://www.huffingtonpost.com/dana-beyer/theendof-transgender-as-a-mental-illness_b_2238147.html).

⁶⁰ See Thomas A. Fulks & Sonya Khilnani, *Diagnosing Mental Illness: What Does the DSM-5 Mean for Corrections?*, CORRECTIONS (Oct. 13, 2014), <http://www.corrections.com/news/article/37711-diagnosing-mental-illness-what-does-the-dsm-5-mean-for-corrections->; Ashley Hughes, *Transgender Prisoners and the Law*, 23 PRO SE 1, 1 (2013), <https://nebula.wsimg.com/36240e9309608e53e6b242b12d0201e1?AccessKeyId=58077DB5116E2803DCE5&disposition=0&alloworigin=1> (describing the DSM-V in the transgender prisoner context as “the manual medical professionals use to classify mental health conditions”).

⁶¹ See, e.g., *Fields v. Smith*, 653 F.3d 550, 550 (7th Cir. 2011).

⁶² AM. PSYCHIATRIC ASS’N, *supra* note 58, at § 302.85.

mismatch between, for example, one's breasts and one's gender identity to get the benefits of a gender dysphoria diagnosis, when, as the UCSF report points out, one can have both "breasts and facial hair as part of authentic expression."⁶³ Item Three assumes there is some defined static "other gender," while items Four and Five presuppose a defined, implicitly opposite "other gender" with "alternative gender"⁶⁴ tacked on. Item Six presupposes that there are "typical feelings and reactions"⁶⁵ of one's desired gender identity, which flies in the face of gender as a fluid and self-determined—rather than a cookie cutter two-sizes-fit-all—identity. In 2012, the DSM-V did change its terminology from GID to GD in an effort to better capture GNC individuals, with one member of the American Psychiatric Association admitting "there is a whole community of people out there who . . . live between the two binary categories."⁶⁶ Though the DSM-V moved further "away from the gender binary, making the condition more inclusive for those people who do not fit neatly into one gender category,"⁶⁷ serious issues with its diagnostic criteria remain—particularly in terms of gender fluidity and acknowledging that some people identify with what could be called "mixed sex characteristics."⁶⁸ Even the World Professional Association of Transgender Health's ("WPATH") newest standards of care (also used by prisons and thus by courts) have a hierarchy of identity: "[a]ccording to WPATH, although nonconformity to gender roles is common, it does not always rise to the level of gender dysphoria."⁶⁹ Many GNC individuals just do not meet the requirements of GID/GD as set out by the widely-used DSM-V or WPATH.⁷⁰

C. MODELS OF CARE AND THE EIGHTH AMENDMENT

The Eighth Amendment and, thus, "the Constitution require individualized assessment by medical providers, rather than decision-making

⁶³ UCSF, *supra* note 10, at 71.

⁶⁴ AM. PSYCHIATRIC ASS'N, *supra* note 58, at § 302.85.

⁶⁵ *Id.*

⁶⁶ Beredjick, *supra* note 18.

⁶⁷ Halbach, *supra* note 34, at 481.

⁶⁸ *Id.*

⁶⁹ Dunnivant, *supra* note 30, at 25. WPATH also acknowledges that care should be "individualized," but courts may use this as a means to deny the need for surgery, as the *Kosilek* en banc court did. WPATH's Standards of Care are not widely accessible to the public, though downloads are available for a fee of \$45.00. See *Standards of Care – Historical Compilation of Versions 1–6*, WPATH, http://www.wpath.org/site_store_product.cfm?store_product=38&display_category=0 (last visited Oct. 25, 2017).

⁷⁰ See Romeo, *supra* note 30, at 731.

by administrators to bar entire classes of treatment.”⁷¹ Medical providers and the medical protocols they rely on decide who has a valid Eighth Amendment claim in front of the court.⁷² Indeed, “[w]ithout a clear diagnosis of gender dysphoria, it may be challenging to convince a court of the urgency of the individual’s medical need,” and thus, an Eighth Amendment claim will always fail.⁷³ The medical and psychological literature, even the DSM-V with its parenthetical attempts to include GNC individuals, is moving toward recognizing gender as non-binary and fluid.⁷⁴ Yet courts, through the binary-based medical literature still in common use, remain dependent on static and binary notions of gender to assess the claims of transgender prisoners seeking care, using fixed binary language and evidence to validate gender identity in a way that excludes GNC persons while establishing rights to care for some transgender persons seeking fixed binary transition. Court reliance on such increasingly outdated conceptions of gender⁷⁵ plays into both the Eighth Amendment’s requirement of subjective knowledge on the part of officials tasked with providing care to inmates and the diagnoses meeting the objective requirement. Depending on how courts construct the subjective prong of the Eighth Amendment—the requirement that prison officials or medical staff know what the inmate’s medical need is—there is more or less room for newer GNC-inclusive medical opinions to influence courts. For example, the more a court evaluates the subjective intent of an official sued under the Eighth Amendment through a reasonableness lens, the more room there is for a new medical opinion. The more a court abdicates its inferential

⁷¹ Moulding & National Lawyers Guild, *supra* note 4, at § 10:26.

⁷² See, e.g., *Fields v. Smith*, 712 F. Supp. 2d 830, 855–56 (E.D. Wis. 2010), *supplemented* (July 9, 2010), *aff’d*, 653 F.3d 550 (7th Cir. 2011) (citing *Estate of Cole by Pardue v. Fromm*, 94 F.3d 254, 261–62 (7th Cir. 1996)) (explaining that the Eighth Amendment requires “medical treatment” to be far outside of conventional standards for a claim to succeed). What care medical staff provides and how that care measures up to the medical profession’s own standards makes or breaks an Eighth Amendment argument: “deliberate indifference may be inferred based upon a medical professional’s erroneous treatment decision only when the medical professional’s decision is such a substantial departure from accepted professional judgment, practice, or standards as to demonstrate that the person responsible did not base the decision on such a judgment.” *Id.*

⁷³ Moulding & National Lawyers Guild, *supra* note 4, at § 10:26.

⁷⁴ See Halbach, *supra* note 34 at 481.

⁷⁵ See, e.g., *Kosilek v. Spencer*, 774 F.3d 63, 73, 78, 88–89 (1st Cir. 2014) (emphasizing the need for GID patients to have “real-life experience” in a “cross gender role”). The prison officials’ language is taken up by the court, and “real-life experience” based on “family” and “social relationships” suggests living as a widely discernible, binary gender, while the language of “cross-gender” roles sounds like transition from one end of the binary to another, rather than allowing for a fluid gender identity. *Id.* Ultimately, the *Kosilek* court decided there is “no support for the district court’s conclusion that no reasonable medical expert could opine that [Michelle] Kosilek lacked real-life experience.” *Id.* at 88.

power to objectively evaluate subjective knowledge of care options, the less room there is for new medical opinions. UCSF-type standards of care may enter the picture depending on how educated on TGNC inmates an official must be in order to claim that his response to an inmate's needs was reasonable. The differing approaches courts take to evaluate official knowledge and granting deference to prison medical staff can determine how willing a court is to let standards other than the DSM-V, WPATH, or a prison's own guidelines into their opinions.

Medical theories of gender are not perfect—they pathologize and disempower individuals who are forced to seek medicine to validate their humanity in the eyes of the law—but there are more inclusive standards of care available that can make room for gender self-determination behind prison walls. Such inclusive medical standards will get litigated under the Eighth Amendment.⁷⁶

III. THE EIGHTH AMENDMENT: LOOKING AT EVERYONE EXCEPT THE PRISONER

A. THE BASIC FRAMEWORK: SERIOUS MEDICAL NEED AND DELIBERATE INDIFFERENCE

Trans and gender nonconforming people are overrepresented in prison populations,⁷⁷ and their attempts to get adequate care are governed by the Eighth Amendment.⁷⁸ In *Estelle v. Gamble*, the Supreme Court decided that, in denial of medical care cases, “deliberate indifference to serious medical needs of prisoners constitutes the ‘unnecessary and wanton infliction of pain’ . . . proscribed by the Eighth Amendment.”⁷⁹ This standard applies to doctors providing the care and other officials denying or delaying access to medical services—though it does not apply to accidents.⁸⁰ Some level of intent is required of the bad actors.⁸¹ In *Farmer v. Brennan*, a case that

⁷⁶ See Dan Manville, *Federal Legal Standards for Prison Medical Care*, PRISON LEGAL NEWS (May 15, 2003) <https://www.prisonlegalnews.org/news/2003/may/15/federal-legal-standards-for-prison-medical-care/> (giving an overview of Eighth Amendment prison medical care litigation).

⁷⁷ See Romeo, *supra* note 30, at 714–15.

⁷⁸ See Leonard, *supra* note 59, at 642 (“[T]he [*Fields*] court held that ‘[p]rison officials violate the Eighth Amendment’s proscription against cruel and unusual punishment when they display deliberate indifference to serious medical needs of prisoners.’”) (citing *Fields v. Smith*, 653 F.3d 550, 554 (7th Cir. 2011) (internal quotations omitted)).

⁷⁹ 429 U.S. 97, 104 (1976) (internal citation omitted).

⁸⁰ *Id.* at 104–06.

⁸¹ See *id.* at 116 (Stevens, J., dissenting) (“[B]y its repeated references to ‘deliberate indifference’ and the ‘intentional’ denial of adequate medical care, I believe the Court

notably dealt with violence against a transwoman that her jailers failed to prevent, the Supreme Court readdressed the issue of denial of care and built upon the reasoning of *Estelle*.⁸² In *Farmer*, the Court declined to adopt an objective test for deliberate indifference, instead requiring the plaintiff prisoner to show that the prison official had actual knowledge of the risk at hand:

... [A] prison official cannot be found liable under the Eighth Amendment for denying an inmate humane conditions of confinement unless the official knows of and disregards an excessive risk to inmate health or safety; the official must both be aware of facts from which the inference could be drawn that a substantial risk of serious harm exists, and he must also draw the inference.⁸³

Estelle and *Farmer* set out a daunting task for prisoners seeking to make Eighth Amendment denial of care claims: 1) the medical need must be serious (objective), 2) the actions of the prison officials in denying care must be intentional (subjective), 3) those officials must know the facts giving rise to the risk (subjective), 4) the officials must then connect those facts to the risk (subjective), and 5) the officials must not have taken reasonable action to lessen the risk of harm (subjective, in that reasonableness is judged in light of official knowledge of the risk).⁸⁴

Medical diagnoses serve two functions under this Eighth Amendment framework. First, they meet the objective prong to show that the medical need of the prisoner was serious.⁸⁵ Second, an official's knowledge of such

improperly attaches significance to the subjective motivation of the defendant as a criterion for determining whether cruel and unusual punishment has been inflicted.”). The *Estelle* majority is careful to skirt an intent requirement, stating that the Eighth Amendment is violated when “the indifference is manifested by prison doctors in their response to the prisoner’s needs or by prison guards in intentionally denying or delaying access to medical care” *Id.* at 104–05. The exclusion of “accidents” and “inadvertent” denials of care by prison staff makes intent a practical necessity for Eighth Amendment claims. *See id.* at 105–06. The intent requirement became more robust in *Wilson v. Seiter*, a conditions of confinement case: “The source of the intent requirement is not the predilections of this Court, but the Eighth Amendment itself, which bans only cruel and unusual punishment. If the pain inflicted is not formally meted out as punishment by the statute or the sentencing judge, some mental element must be attributed to the inflicting officer before it can qualify.” 501 U.S. 294, 300 (1991).

⁸² 511 U.S. 825, 828–29, 835 (1994) (“This case requires us to define the term ‘deliberate indifference [first set out in *Estelle v. Gamble*],’ as we do by requiring a showing that the official was subjectively aware of the risk.”).

⁸³ *Id.* at 837.

⁸⁴ *Farmer*, 511 U.S. at 837; *Estelle*, 429 U.S. at 104–06. For a concise delineation of the Eighth Amendment’s subjective and objective framework in the caselaw, see *De’Lonta v. Angelone (De’Lonta I)*, 330 F.3d 630, 633–34 (4th Cir. 2003).

⁸⁵ *See* Dunnivant, *supra* note 30, at 29. At least in the First Circuit, plaintiffs can also show a serious medical need when it is “so obvious that even a lay person would easily recognize the necessity for a doctor’s attention.” *Mahan v. Plymouth Cty. House of Corr.*, 64

a diagnosis can meet the subjective prong by showing an official was aware of and then deliberately indifferent to the prisoner's need for care.⁸⁶ Important to the possibilities for the proposed solution of introducing GNC-inclusive care standards, the “responded reasonably to the risk”⁸⁷ defense for officials may give them room to choose what care is adequate to meet a GID/GD diagnosis—or not.

The Eighth Amendment has a particular relationship to medicine, and TGNC prisoners bringing claims under it rely on medical definitions of gender identity to meet the Eighth Amendment's intricate obstacle course of requirements for liability.⁸⁸ Not surprisingly, courts defer to medical expertise in determining what counts as a serious medical need and what constitutes deliberate indifference to the need.

B. DEFERENCE TO MEDICAL KNOWLEDGE

The Eighth Amendment's two prong test relies heavily on medical expertise—objectively by looking for institutional medical opinion of when gender identity deserves treatment through diagnosis, and subjectively through prison officials' knowledge of the prisoners' identities and care options. While prison officials and medical staff have latitude⁸⁹ in diagnosing and treating GID/GD, state legislatures setting limits on gender-affirming care for transgender inmates may not be treated so kindly by courts. In the landmark trans rights case *Fields v. Smith*, the Seventh Circuit struck down Wisconsin's ban on providing hormone therapy for transgender

F.3d 14, 18 (1st Cir. 1995). Whether a lay person will identify the need of a transgender person, never mind a potentially even more foreign-seeming GNC person, as in need of gender affirming care is debatable and worthy of much more research.

⁸⁶ See *Farmer*, 511 U.S. at 842 (“Whether a prison official had the *requisite knowledge* of a substantial risk is a question of fact subject to demonstration in the usual ways, including inference from circumstantial evidence.”) (emphasis added). *Farmer* adds that if “the circumstances suggest that the defendant-official being sued had been exposed to information concerning the risk and thus ‘must have known’ about it, then such evidence could be sufficient to permit a trier of fact to find that the defendant-official had actual knowledge of the risk.”) *Id.* at 842–43. But this is not the same as a lower should-have-known standard; such a should-have-known “inference cannot be conclusive, for we know that people are not always conscious of what reasonable people would be conscious of.” *Id.* at 842 (internal quotations omitted). Ultimately, *Farmer* makes clear “prison officials who lacked knowledge of a risk cannot be said to have inflicted punishment.” *Id.* at 844.

⁸⁷ *Id.* at 844.

⁸⁸ See Halbach, *supra* note 34, at 479. Halbach's article also provides a useful discussion of the various critiques of the medical model's ways of defining gender identity.

⁸⁹ See, e.g., *Rowe v. Corr. Med. Servs., Inc.*, No. 1:08-CV-827, 2010 WL 3779561, at *7 (W.D. Mich. Aug. 18, 2010), *report and recommendation adopted*, No. 1:08CV827, 2010 WL 3779437 (W.D. Mich. Sept. 22, 2010). The leeway prison officials have to make care decisions for inmates is discussed in depth below.

prisoners as a violation of the Eighth Amendment.⁹⁰ The Seventh Circuit found that because the defendants failed to proffer evidence that alternative treatments for GID/GD were effective, the blanket ban on hormone therapy did not “constitutionally limit the discretion of physicians,”⁹¹ but instead eliminated the discretion of these physicians and thus constituted cruel and unusual punishment⁹²—reiterating the primacy of medical standards to which prison officials are held. The *Fields* court distinguished Wisconsin’s ban on hormone therapy for prisoners from the so-called partial birth abortion ban upheld by the Supreme Court in *Gonzalez v. Carhart*, which prevents doctors from performing certain abortion procedures: “*Carhart* is not helpful to defendants in this case because they did not present any medical evidence that alternative treatments for GID are effective.”⁹³ Importantly, the Supreme Court upheld the ban in *Carhart* in part because the “Court has given state and federal legislatures wide discretion to pass legislation in areas where there is medical and scientific uncertainty.”⁹⁴ The implication is that medical expertise has the power to restore legislative authority to outlaw certain treatments, even in the face of constitutional challenges like those posed by prisoners seeking adequate medical care. It is not surprising then that multiple transgender prisoner cases turn on the medical expertise of prison officials.

The First Circuit’s decision in *Kosilek v. Spencer*, which overturned a district court order requiring the Massachusetts Department of Corrections (“DOC”) to provide gender-affirming surgery to a transwoman, lambasts the district court for “substituting its own beliefs for those of multiple medical experts” in its order to the DOC.⁹⁵ In the First Circuit, adequate medical care for Eighth Amendment purposes is defined as care “measured against ‘prudent professional standards.’”⁹⁶ The District Court for the Eastern District of Wisconsin, affirmed by the Seventh Circuit in *Fields*, likewise held “deliberate indifference may be inferred ‘when the medical professional’s decision is such a substantial departure from accepted professional judgment, practice, or standards as to demonstrate that the

⁹⁰ *Fields v. Smith*, 653 F.3d 550, 559 (7th Cir. 2011).

⁹¹ *Id.* at 556–57.

⁹² *Id.*

⁹³ *Id.* at 557.

⁹⁴ *Gonzales v. Carhart*, 550 U.S. 124, 163 (2007).

⁹⁵ 774 F.3d 63, 88–89 (1st Cir. 2014), *cert. denied sub nom.* *Kosilek v. O’Brien*, 135 S. Ct. 2059 (2015).

⁹⁶ *Nunes v. Mass. Dep’t of Correction*, 766 F.3d 136, 142 (1st Cir. 2014) (citing *United States v. DeCologero*, 821 F.2d 39, 43 (1st Cir. 1987)). *DeCologero* defined care within medical standards as “services at a level reasonably commensurate with modern medical science.” 821 F.2d at 43. Care approaching the medical norm is adequate.

person responsible did not base the decision on such a judgment.”⁹⁷ Violation of the Eighth Amendment is in large part determined based on the care standards used by doctors treating prisoners.⁹⁸ In *Rowe v. Correctional Medical Services Inc.*, where a transwoman’s attempt to get an injunction enabling her access to hormones, a bra, and outside medical opinion was denied, the court reiterated judicial deference to medical expertise in Eighth Amendment denial of care cases: “where the prisoner is receiving treatment with the dosage levels based on the considered professional judgment of a physician, this court is reluctant to second-guess that judgment.”⁹⁹ In *Rowe*, the court further stated: “[t]he Sixth Circuit has never required the trial court to substitute its judgment for that of the medical providers who treat the transsexuals on a day-to-day basis.”¹⁰⁰

This deference to medical expertise presents obstacles to the prisoner seeking to base his/her/their claim on a less binary-focused medical standard: treatment based on medical standards, no matter how backward and binary, may negate an Eighth Amendment deliberate indifference claim.¹⁰¹ In *Kothmann v. Rosario*, however, the Eleventh Circuit denied a motion to dismiss brought by the Chief Health Officer (“CHO”) of the Florida Department of Corrections when transman Sebastian Kothmann was denied gender-affirming care (testosterone) and sued.¹⁰² The *Kothmann* court found that the CHO’s awareness that Kothmann had GID, that Kothmann was seeking hormone treatment for GID, and that “in the medical community, hormone therapy is the medically recognized, accepted and appropriate treatment for GID” were enough to meet the subjective test of the Eighth

⁹⁷ *Fields v. Smith*, 712 F. Supp. 2d 830, 855–56 (E.D. Wis. 2010), *supplemented* (July 9, 2010), *aff’d*, 653 F.3d 550 (7th Cir. 2011) (citing *Estate of Cole* by *Pardue v. Fromm*, 94 F.3d 254, 261–62 (7th Cir. 1996)). *Pardue* noted, “deliberate indifference may be inferred based upon a medical professional’s erroneous treatment decision only when the medical professional’s decision is such a substantial departure from accepted professional judgment, practice, or standards as to demonstrate that the person responsible did not base the decision on such a judgment.” *Pardue*, 94 F.3d at 261–62.

⁹⁸ *Rowe v. Corr. Med. Servs., Inc.*, No. 1:08-CV-827, 2010 WL 3779561, at *6 (W.D. Mich. Aug. 18, 2010), report and recommendation adopted, No. 1:08CV827, 2010 WL 3779437 (W.D. Mich. Sept. 22, 2010) (“[W]here the prisoner is receiving treatment, the dosage levels of which are based on the considered professional judgment of a physician, courts are reluctant to second-guess the physician’s judgment.”).

⁹⁹ *Id.* at *7.

¹⁰⁰ *Id.* at *8.

¹⁰¹ See *Kosilek v. Spencer*, 774 F.3d 63, 108 (1st Cir. 2014), *cert. denied sub nom. Kosilek v. O’Brien*, 135 S. Ct. 2059 (2015) (Thompson, J., dissenting) (discussing the *Kosilek* majority’s allowance for the Massachusetts Department of Corrections to cherry pick medical opinions on which to base care for trans prisoners).

¹⁰² 558 F. App’x 907 (11th Cir. 2014).

Amendment.¹⁰³ Likewise, in *De'Lonta v. Angelone*, the Fourth Circuit reversed a district court's dismissal of a transgender prisoner's Eighth Amendment claim at summary judgment.¹⁰⁴ The Fourth Circuit held that "[i]n dismissing De'lonta's suit, the district court incorrectly determined, based on the limited record before it, that the suit was nothing more than a challenge to the medical judgment of [Virginia Department of Corrections] doctors."¹⁰⁵ Rather than assuming doctors base their decisions in medical protocol and deferring accordingly, the Fourth Circuit questioned whether the decision to deny De'Lonta care was based on medical opinion at all.¹⁰⁶ Thus, deference to medical expertise does not necessarily give carte blanche to prison medical staff to determine what constitutes appropriate treatment.

Deference to medical expertise is a double-edged sword under the Eighth Amendment: medical expertise can strip prisoners of their power to self-determine their gender, reinforce the binary, and preclude court examination of treatment regimens, but it also provides an avenue whereby new conceptions of gender identity can be recognized under the law and old binary standards may be challenged.¹⁰⁷ Current medical provider competency in caring for transgender and GNC patients—in and outside the penitentiary—is not perfect even for endocrinologists who prescribe hormones.¹⁰⁸ However, with more medical professionals seeking and accessing training in caring for TGNC patients,¹⁰⁹ the Eighth Amendment's deference to medical knowledge could prove a powerful tool for GNC inmates seeking non-binary care while locked up. Of course, medical education must continue expanding the training all providers receive regarding care for the TGNC community.¹¹⁰ Getting more prisoner-

¹⁰³ *Kothmann v. Rosario*, 558 F. App'x 907, 911 (11th Cir. 2014).

¹⁰⁴ 330 F.3d 630, 631 (4th Cir. 2003). Note that the courts involved in Ophelia De'Lonta's multiple suits against Virginia prison officials alternatively spell her name De'lonta and De'Lonta.

¹⁰⁵ *Id.* at 634.

¹⁰⁶ *Id.* at 635.

¹⁰⁷ Diagnosis also may depoliticize GID/GD cases, easing pressure on prison officials to deny treatments that members of the public may not want their tax money paying for. *See* Halbach, *supra* note 34, at 487. "The [District of Massachusetts in Michelle Kosilek's 2002 case regarding hormones] warned, however, that if the [D]OC Commissioner were to base his decision on concerns about cost or political controversy, he would violate the Eighth Amendment." *Id.*

¹⁰⁸ *See* Anna Almendrala, *Doctors Want to Learn More About Treating Transgender Patients, Survey Shows*, HUFFINGTON POST (Jan. 11, 2017, 8:18 PM), http://www.huffingtonpost.com/entry/promising-doctors-survey-reveal-positive-attitude-toward-transgender-patients_us_5876a220e4b05b7a465d9fa4.

¹⁰⁹ *See id.*

¹¹⁰ *See generally* Jordan Aiken, *Promoting an Integrated Approach to Ensuring Access to*

empowering standards of care in front of courts that will accept such expertise is the key to a litigation-based solution that utilizes the growing TGNC-competence of medicine.

IV. CASE LAW: CHALLENGES AND OPPORTUNITIES FOR GNC PLAINTIFFS

Eighth Amendment claims regarding gender-affirming care have thus far been brought by transgender-identified prisoners.¹¹¹ It is those cases that illustrate the interplay between the Eighth Amendment's subjective and objective standards and courts' reliance on a binary medical-legal conception of gender. Some cases provide openings for GNC-inclusive standards of care, whereas others do not.¹¹²

A. CHALLENGES: WHEN COURTS LET PRISONS USE THEIR OWN PROBLEMATIC EXPERTS AND POLICIES TO (MIS)TREAT INMATES

While the First Circuit in *Kosilek* noted that "GID is a serious medical need, and one which mandates treatment, [and that issue] is not in dispute in this case," it nonetheless found that the Eighth Amendment does not mandate surgery with a diagnosis of GID.¹¹³ *Kosilek* held, "[t]he choice of a medical option that, although disfavored by some in the field, is presented by competent professionals does not exhibit a level of inattention or callousness to a prisoner's needs rising to a constitutional violation."¹¹⁴ At first, the court's reasoning here seems to give weight to alternative medical views of gender, perhaps alternatives to the binary of the DSM-V as laid out by courts that favor newer medical guidelines that take account of GNC identities. However, differing interpretations of one standard of care (which had a fixed

Gender Incongruent Health Care, 31 BERKELEY J. GENDER L. & JUST. 1 (2016).

¹¹¹ See Oparah, *supra* note 9, at 246 (citing Darren Rosenblum, "Trapped" in *Sing Sing: Transgendered Prisoners Caught in the Gender Binarism*, 6 MICH. J. GENDER & L. 499, 512 (2000)).

¹¹² See, e.g., *Kosilek v. Spencer*, 774 F.3d 63, 92 (1st Cir. 2014), *cert. denied sub nom. Kosilek v. O'Brien*, 135 S. Ct. 2059 (2015) (holding courts "do not sit to substitute [their] own judgment for that of prison administrators" when prison administrators make decisions regarding health care regimens and security measures). *But see* *Kothmann v. Rosario*, 558 F. App'x 907, 910 (11th Cir. 2014) (holding that a prison official would not be liable for an Eighth Amendment violation if she could "establish that Kothmann 'received adequate mental health treatment for his GID'" rather than just for the symptoms the prison treated him for) (citing *Kothmann v. Rosario*, No. 5:13-CV-28-OC-22PRL, 2013 WL 12096653, at *5 (M.D. Fla. June 6, 2013), *aff'd*, 558 F. App'x 907 (11th Cir. 2014)) (emphasis in circuit and district court opinions).

¹¹³ *Kosilek*, 774 F.3d at 86. The *Kosilek* court acknowledged that the DSM-V terminology changed from GID to gender dysphoria but kept using GID because it was the term used throughout most of the case's lengthy litigation history. *Id.* at 68 n.1.

¹¹⁴ *Id.* at 91–92.

binary “real life experience” requirement) is one of the grounds on which the First Circuit reversed the district court:

We find no support for the district court’s conclusion that no reasonable medical expert could opine that Kosilek lacked real-life experience, particularly in light of the contrary testimony from medical experts concerning the range of social, environmental, and professional considerations that are necessary to constitute a real-life experience under the Standards of Care.¹¹⁵

The First Circuit also found fault with what it characterized as the district court “ignor[ing] significant contrary evidence regarding the breadth and variety of acceptable treatments for GID within the medical community.”¹¹⁶ In *Kosilek*, multiple possible methods of caring for TNGC prisoners allows for denial of care.¹¹⁷ Under the *Kosilek* framework there is not subjective deliberate indifference if the denial is based on *some* medical opinion, even the most restrictive among other options. This is the Eighth Amendment’s reasonable risk prevention liability shield at its most extreme, with no evaluation of what is reasonable beyond that the prison officials sought some form of medical expertise to justify the lack of care provided to Michelle Kosilek.¹¹⁸

The First Circuit refuses to read objective reasonableness into the subjective prong: “[m]oreover, a later court decision—ruling that the prison administrators were wrong in their estimation of the treatment’s reasonableness—does not somehow convert that choice into one exhibiting the sort of obstinacy and disregard required to find deliberate indifference.”¹¹⁹ In *Kosilek*, a strong subjective Eighth Amendment prong requires a higher showing of official state of mind from the plaintiff. Combined with a low threshold for what counts as medical expertise, this approach resulted in the denial of care to an incarcerated transwoman.

Rowe v. Correctional Medical Services, like *Kosilek*, held that a prisoner’s treatment regime is up to prison medical staff to decide—not for the prisoner to have a say in beyond requesting medical care.¹²⁰ *Rowe* relied

¹¹⁵ *Id.* at 88.

¹¹⁶ *Id.* at 89.

¹¹⁷ *See id.* at 82–83 (citing *Ferranti v. Moran*, 618 F.2d 888, 891 (1st Cir. 1980) (The subjective prong of the Eighth Amendment “does not impose upon prison administrators a duty to provide care that is ideal, or of the prisoner’s choosing” and Eighth Amendment claims that “simply reflect a disagreement on the appropriate course of treatment . . . fall[] short of alleging a constitutional violation.”)).

¹¹⁸ *See id.* at 91–92 (citing precedent indicating deliberate indifference is not met when the dispute centers not on the absence of treatment but the choice of a course of treatment).

¹¹⁹ *Id.* at 92.

¹²⁰ *See* No. 1:08-CV-827, 2010 WL 3779561, at *8, *9 (W.D. Mich. Aug. 18, 2010), *report and recommendation adopted*, No. 1:08CV827, 2010 WL 3779437 (W.D. Mich. Sept.

on Michigan Department of Corrections (“MDOC”) policies that were explicitly binary.¹²¹ The MDOC policies stated, “[a] person with a gender identity disorder is unhappy with his/her biological sex, and desires to be considered a member of the opposite sex” and “has a longstanding desire to replace his or her own physical sexual characteristics . . . with those of the opposite sex.”¹²² *Rowe* is adamant in its deference to internal prison policies regarding GID treatment over external and established medical expertise, even under a standard of review that is meant to be deferential to the plaintiff trying to fight the defendant officials’ motion for summary judgment.¹²³ The *Rowe* court adds, “the court is not bound to blindly adopt a non-moving party’s version of the facts.”¹²⁴ Note that this is a departure from the approach taken toward summary judgment in *De’Lonta I* discussed above and below.¹²⁵ The court assumes the MDOC policy is “sound medical judgment”: “the [15-month] delay in authorizing hormone therapy treatment was based on the sound exercise of medical judgment, as set forth in the Policy Directive.”¹²⁶ In denying the prisoner’s request to have an outside medical evaluation done regarding her GID, the court notes, “plaintiff disagrees with the prescribed course of treatment as a transsexual” and gives the plaintiff’s view no weight.¹²⁷ The *Rowe* opinion ultimately held that the “plaintiff has no cause of action under the Eighth Amendment to require a specific treatment, such as the requested hormone therapy or a bra.”¹²⁸ *Rowe* refused to examine the adequacy of care—one means of questioning the standards of care prisons are using—under the Eighth Amendment, essentially finding

22, 2010) (citing *Westlake v. Lucas*, 537 F.2d 857, 860 n.5 (6th Cir.1976)) (noting federal courts “are generally reluctant to second guess medical judgments” made by prison staff and that the “plaintiff has no cause of action under the Eighth Amendment to require a specific treatment, such as the requested hormone therapy . . .”).

¹²¹ *Id.* at *4.

¹²² *Id.*

¹²³ *Id.* at *3 (citing *McLean v. 988011 Ontario Ltd.*, 224 F.3d 797, 800 (6th Cir. 2000)) (“In deciding a motion for summary judgment, the court views the factual evidence and draws all reasonable inferences in favor of the nonmoving party.”).

¹²⁴ *Id.*

¹²⁵ See *De’Lonta v. Angelone (De’Lonta I)*, 330 F.3d 630, 633 (4th Cir. 2003) (citing *Veney v. Wyche*, 293 F.3d 726, 730 (4th Cir. 2002)) (“A complaint should not be dismissed . . . unless after accepting all well-pleaded allegations in the plaintiff’s complaint as true and drawing all reasonable factual inferences from those facts in the plaintiff’s favor, it appears certain that the plaintiff cannot prove any set of facts in support of his claim entitling him to relief.”) (emphasis added). The difference in each court’s acceptance level of the plaintiff’s version of the facts in *Rowe* and *De’Lonta I* pushes toward opposite results in each case.

¹²⁶ *Rowe*, 2010 WL 3779561, at *6.

¹²⁷ *Id.* at *9.

¹²⁸ *Id.*

that some level of treatment is automatically enough to bar deliberate indifference: “[a]s a general rule, ‘[w]here a prisoner has received some medical attention and the dispute is over the adequacy of the treatment, federal courts are generally reluctant to second guess medical judgments and to constitutionalize claims which sound in state tort law.’”¹²⁹ Attacking prison policies directly is not a winning strategy under *Rowe*: because “MDOC physicians undertook testing and examinations before authorizing the hormone therapy consistent with the requirements of Policy Directive,” they are not liable for deliberate indifference during the over one-year period when the plaintiff did not receive hormones.¹³⁰ The *Rowe* court emphasizes the prison’s policy rather than the harm caused to the plaintiff or the adequacy of the knowledge of the defendant officials.

As Judge Thompson’s dissent concludes, the *Kolisek* majority “enables correctional systems to further postpone their adjustment to the crumbling gender binary.”¹³¹ When courts enable wide prison discretion over choice of care for inmates, a prison doctor can select a treatment plan that does not fit an inmate’s needs as long as long as it is based on some “competent” medical opinion, no matter how much other experts disagree with that opinion.¹³² *Kosilek*’s and *Rowe*’s use of established binary-based conceptions of gender in GID diagnoses foreclose treatment of GNC inmates as the inmates themselves conceive of it and as emerging medical experts acknowledge.

Thompson’s scathing dissent spells out the implications: the majority “gives correctional departments serious leeway with the Eighth Amendment. If they do not want to provide a prisoner with care recommended by one or more than one medical provider, they need only find a doctor with a differing mind set (typically not a difficult task).”¹³³ But there are bright spots—other courts’ Eighth Amendment jurisprudence pokes holes in prison officials’ power to deny care for TGNC inmates.

¹²⁹ *Id.* at *8 (internal citations omitted). The “some” treatment standard of *Rowe* also seems to conflict with the individualized care requirement of the Eighth Amendment. *See, e.g., Kosilek v. Spencer*, 774 F.3d 63, 91 (1st Cir. 2014), *cert. denied sub nom. Kosilek v. O’Brien*, 135 S. Ct. 2059 (2015) (mentioning “the requirement that medical care be individualized based on a particular prisoner’s serious medical needs”).

¹³⁰ *Rowe*, 2010 WL 3779561, at *7.

¹³¹ *Kosilek*, 774 F.3d at 113 (Thompson, J., dissenting).

¹³² *See Kosilek*, 774 F.3d at 91–92 (“The choice of a medical option that, although disfavored by some in the field, is presented by competent professionals does not exhibit a level of inattention or callousness to a prisoner’s needs rising to a constitutional violation.”).

¹³³ *Id.* at 108.

B. OPPORTUNITIES: SHIFTING SUBJECTIVITY AND REFOCUSING ON THE PRISONER

In *Kothmann v. Rosario*, the court softened the Eighth Amendment's subjective prong where *Kosilek* hardened it. *Kothmann's* attribution of subjective knowledge to the Chief Health Officer (Rosario) based on the existence of a recommended GID treatment pushes the limits of Farmer's clarification that circumstantial evidence can be used to "suggest that the defendant-official being sued had been exposed to information concerning the risk and thus 'must have known' about it," enabling the trier of fact to infer actual subjective knowledge.¹³⁴ Reviewing the district court ruling de novo but assuming the facts in Kothmann's complaint to be true, the Eleventh Circuit went the extra mile and stuck with the inference that it was possible Rosario had actual knowledge certain treatment protocols were the required (reasonable) way to treat Sebastian Kothmann, thereby slipping an objective evaluation into their assessment of Rosario's actions.¹³⁵ *Kothmann* also rejected Rosario's argument that the treatment she provided—counseling—was enough since "inmates are entitled to some form of treatment, but not necessarily their preferred method."¹³⁶ The Eleventh Circuit found that because the hormone treatment Kothmann sought was medically necessary, Rosario had to provide it.¹³⁷

The court's assumption that Rosario was aware of what the care guidelines for transgender inmates are softens the subjective prong of the Eighth Amendment into something more akin to the objective approach favored by Justice Stevens's concurrence in *Farmer*: "a state official may inflict cruel and unusual punishment without any improper subjective

¹³⁴ *Farmer v. Brennan*, 511 U.S. 825, 842–43 (1994).

¹³⁵ *Kothmann v. Rosario*, 558 F. App'x 907, 911 (11th Cir. 2014) ("[W]e hold that Kothmann has alleged facts sufficient to show that Rosario knew that hormone treatment was the recognized, accepted, and medically necessary treatment for Kothmann's GID, yet knowingly refused Kothmann's repeated requests for such treatment . . ."). *Kothmann* seems to turn a defense available in *Farmer* on its head: while "prison officials who actually knew of a substantial risk to inmate health or safety may be found free from liability if they responded reasonably to the risk," by providing counseling for example, *Kothmann* says an unreasonable response, such as providing only counseling, counts against an official. Harm to the inmate is not the emphasis of *Farmer's* reasonableness of response analysis, and thus *Farmer* implicitly sets a lower bar for officials to meet than *Kothmann*: "In addition, prison officials who actually knew of a substantial risk to inmate health or safety may be found free from liability if they responded reasonably to the risk, even if the harm ultimately was not averted." See *Farmer*, 511 U.S. at 844.

¹³⁶ *Kothmann*, 558 F. App'x at 911–12. In *Kothmann*, the treatment was "hormone treatment . . . the accepted, medically necessary treatment for Kothmann's GID." *Id.* at 912.

¹³⁷ See *id.*

motivation.”¹³⁸ The *Kothmann* court did not care if Rosario had an improper subjective motive here; the court saw her departure from the standard GID treatment as objectively unreasonable and her knowledge that the protocols existed as enough subjective intent to meet the Eighth Amendment standard of deliberate indifference.¹³⁹

The bright spot in *Kothmann*, despite its reliance on binary diagnosis,¹⁴⁰ is the framework it provides: the existence of a medical opinion that a course of treatment is “medically necessary,” or even reasonable in the court’s eyes, can work to override the subjective prong of the Eighth Amendment, at least to get past a 12(b)(6) motion.¹⁴¹ Established-by-the-prison standards of care and the subjective intent of the official (however backward)¹⁴² who plays gatekeeper to care can be overcome by an objective reasonableness analysis, which sneaks in under the *Farmer* allowance for courts to make an inference of subjective knowledge based on surrounding facts.¹⁴³

Like *Kothmann*, *De’Lonta v. Angelone*—the Fourth Circuit case that reversed a district court’s grant of summary judgment against a transwoman seeking hormones in prison—examines the decisions of medical personnel with a grain of skepticism,¹⁴⁴ leaving the door open for plaintiffs to challenge the actual standards of care used by prisons. The Fourth Circuit rejected the district court’s characterization of the case as “nothing more than a challenge to the medical judgment of [prison] doctors” and thus outside the bounds of the Eighth Amendment.¹⁴⁵ Based upon memos between prison doctors and the prison’s policy not to provide gender-affirming care to inmates, the

¹³⁸ *Farmer*, 511 U.S. at 858 (Stevens, J., concurring on stare decisis grounds).

¹³⁹ *Kothmann*, 558 F. App’x at 911 (“Rosario knew that hormone treatment was the recognized, accepted, and medically necessary treatment for Kothmann’s GID, yet knowingly refused Kothmann’s repeated requests for such treatment and thus was deliberately indifferent to a serious medical need.”). Knowledge, not intent, drove the court’s analysis.

¹⁴⁰ *See id.* at 909. The court looked at fixed identity to evaluate Kothmann’s diagnosis: “[Kothmann] was diagnosed with GID in 2005 and, since that time, he has been under a doctor’s care and has ‘regularly taken prescribed testosterone, except when [he] was prevented from doing so by [his] incarceration.’” *Id.*

¹⁴¹ *Id.*

¹⁴² *Id.* at 908. According to Kothmann, Rosario “‘vetoed’ a prison doctor’s referral of Kothmann to the endocrinology staff, who could prescribe hormone treatment, because [Rosario believed] ‘endocrinology is not for cosmetic issues.’” *Id.*

¹⁴³ *Farmer*, 511 U.S. at 842 (“Whether a prison official had the requisite knowledge of a substantial risk is a question of fact subject to demonstration in the usual ways, including inference from circumstantial evidence.”).

¹⁴⁴ *See, e.g.*, 330 F.3d 630, 635 (4th Cir. 2003) (finding that one prison doctor’s denial of care to De’Lonta “was based solely on the Policy rather than on a medical judgment concerning De’Lonta’s specific circumstances”).

¹⁴⁵ *Id.* at 634.

De'lonta I court inferred that the prison officials' decision to deny care was "based solely on the Policy rather than on a medical judgment concerning De'lonta's specific circumstances."¹⁴⁶ Such grounds for a medical decision are inadequate because they are not medical opinion at all—medical standards must be standards, not mere decisions that happen to be made by medical staff.¹⁴⁷ The court points out that "nothing in the record suggests that [the defendant-official's] opinion was a basis for the denial of De'lonta's requested treatment."¹⁴⁸ Rather than readily defer to the prison's medical staff, the *De'lonta I* court scrutinized the care the prison provided by making clear what was not in the record: "nothing in the record refutes the allegation that Appellees know that De'lonta's compulsive self-mutilation began after the discontinuation of her hormone therapy."¹⁴⁹ The court continued: "Moreover, Dr. Marsh's memo is at most only a comment on the appropriateness of one possible treatment and does not refute De'lonta's claim that she has not received any treatment to suppress her compulsion to mutilate herself."¹⁵⁰ The Fourth Circuit was not willing to sustain the dismissal of a trans prisoner's claim by filling in the medical blanks, instead requiring the defendant doctors to make clear the medical basis of their decisions and defend their expertise via the record.¹⁵¹ The *De'lonta I* court even required the defendants to "demonstrate" for the limited treatment De'Lonta received to purportedly alleviate her "compulsion" to self-harm "that the treatment was provided for that purpose or that it was deemed to be a reasonable method of preventing further mutilation."¹⁵² The court demanded that defendants show that their treatment plan was "reasonable" rather than show that they subjectively thought it to be acceptable care¹⁵³—leaving room for a challenge based on newer, more GNC-friendly standards of care. The court added that it "make[s] no comment on the type of treatment, if any, to which D'lonta is entitled,"¹⁵⁴ indicating that medical

¹⁴⁶ *Id.* at 635.

¹⁴⁷ *See id.* (emphasizing that medical opinion and not mere prison policy must be the basis for care decisions).

¹⁴⁸ *Id.* (emphasis added).

¹⁴⁹ *Id.* at 634.

¹⁵⁰ *Id.* at 635.

¹⁵¹ *See id.* (pointing out that "nothing in the record suggests that [prison physician] Dr. Marsh's *opinion* was a basis for the denial of De'lonta's requested treatment" and that "policy" took the place of "medical judgment" in treating De'Lonta) (emphasis added).

¹⁵² *Id.* (emphasis added).

¹⁵³ *Id.* at 634–35 (agreeing with De'Lonta that her care "was abruptly terminated for no legitimate reason" even though the prison provided evidence that doctors were involved in De'Lonta's case).

¹⁵⁴ *Id.* at 636.

opinion retains power to turn the case. But the Fourth Circuit decision punched out an opening for better medical opinion to get in front of the court and set at least a higher bar prison that medical opinion must meet in showing the reasonableness of the basis of the care prisons provide (or deny) to defeat an Eighth Amendment suit. Because the Fourth Circuit demanded the prison doctors show the medical support for their denial of care and the doctors failed to do so, Ophelia De'Lonta's Eighth Amendment claim survived summary judgement.¹⁵⁵ For Eighth Amendment plaintiffs appealing dismissal at summary judgement, *De'Lonta I* provides a template for closer court scrutiny of prison medical staff decisions to deny care.¹⁵⁶

In *Wolfe v. Horn*, where a transwoman who had already been prescribed hormones before she was incarcerated and was subsequently denied hormones in prison, the Eastern District of Pennsylvania held that “abrupt termination of prescribed hormonal treatments by a prison official with no understanding of Wolfe’s condition, and failure to treat her severe withdrawal symptoms or after-effects, could constitute ‘deliberate indifference.’”¹⁵⁷ Jessica Wolfe’s case suggests that medical knowledge of a condition is necessary when care is denied or the denying official faces an Eighth Amendment claim.¹⁵⁸ More importantly, *Wolfe*, like *Kothmann* and *De'Lonta I*, takes a step toward evaluating prison officials via objective criteria, holding that “deliberate indifference” is “essentially a subjective standard” but that “objective factors may inform the viability of a ‘deliberate indifference’ claim.”¹⁵⁹ Here, one of those factors was the fact that officials without adequate knowledge of gender-affirming care were involved in decision-making.¹⁶⁰ This puts the onus on prison officials to allow only those educated about the needs of transgender inmates to make decisions regarding their care and gives prisons some motive to stay current on standards of care that are more GNC-inclusive.

Norsworthy v. Beard provides a useful model for courts and litigants to shrink the subjective shield the Eighth Amendment hands to defendants that rely on their own binary-based medical standards in treating TGNC

¹⁵⁵ *Id.* at 635–36.

¹⁵⁶ *See generally* *De'Lonta v. Angelone (De'Lonta I)*, 330 F.3d 630 (4th Cir. 2003).

¹⁵⁷ 130 F. Supp. 2d 648, 653 (E.D. Pa. 2001).

¹⁵⁸ *Id.* *Wolfe* uses the *Farmer v. Brennan* allowance for an inference of knowledge, pushing toward objective reasonableness and away from subjective intent prong of the Eighth Amendment: “‘deliberate indifference’ is [a] fact question which may be demonstrated through circumstantial evidence that risks were obvious.” *Id.* (citing *Farmer v. Brennan*, 511 U.S. 825, 842 (1994)).

¹⁵⁹ *Id.* at 652 n.6.

¹⁶⁰ *Id.* at 653.

inmates.¹⁶¹ In *Norsworthy*, the court found that the plaintiff prisoner, Michelle-Lael Bryanna Norsworthy, had stated an Eighth Amendment claim for injunctive relief to receive gender-affirming surgery.¹⁶² The court allowed her claim to move forward and let her question the extent of the prison officials' expertise in trans care: "The Court agrees with Norsworthy's contention that she should have the opportunity to explore the Defendants' motives and the extent and nature of their knowledge through discovery."¹⁶³ It is key to the *Norsworthy* court's Eighth Amendment analysis that the plaintiff be able to question the standard of care used by officials: "[d]efendant's argument that Norsworthy's medical indifference claim must fail because she received some treatment for her gender dysphoria is also unconvincing, as a prisoner need not prove that she was completely denied medical care in order to prevail."¹⁶⁴ *Norsworthy* gets at the adequacy of the care the prison provided in alleviating the prisoner's medical problem, rather than shrugging off the question of adequacy when the prisoner gets some treatment, no matter how limited.¹⁶⁵ This gives her an opportunity to attack the prison's treatment regimen itself and provides the opening to propose better guidelines.¹⁶⁶

Prison treatment plans are not invincible to Eighth Amendment attacks, and *Diamond v. Owens* illustrates that a prisoner can challenge prison policies that define and limit what counts as GID/GD worthy of medical

¹⁶¹ 87 F. Supp. 3d 1104, 1117 (N.D. Cal. 2015).

¹⁶² *Id.*

¹⁶³ *Id.*

¹⁶⁴ *Id.*

¹⁶⁵ *See id.* at 1118 (holding that "[b]ecause there is no recommendation by a treating physician or other medical provider against sex reassignment surgery, this is not a case in which prison staff have simply reviewed and affirmed medical decisions made by others" and thus that defense is unavailable to the defendant prison officials.). In other words, *Norsworthy* does not let officials who denied care escape all liability based on the fact that no doctor *actively ordered* care but instead places a burden on prison staff to justify what they did based on medical opinion. *See also* Wolfe v. Horn, 130 F. Supp. 2d 648, 653 (E.D. Pa. 2001) (noting that "while Wolfe may have received some medical attention in prison, there is a fact question as to whether Wolfe received any treatment for *transsexualism*" rather than just for depression, lending credence to Wolfe's deliberate indifference claim) (emphasis added).

¹⁶⁶ *See Norsworthy*, 87 F. Supp. 3d at 1117–18 (viewing skeptically "that after Norsworthy's treating psychologist explicitly recommended sex reassignment surgery, Norsworthy was removed from his care and [a prison doctor with no experience treating trans patients] was assigned to prepare a pretextual report recommending that sex reassignment surgery be denied"). The court then allowed Michelle Norsworthy's claim to proceed to discovery, enabling further exploration of the defendant doctors' and officials' motives for denying her care in the face of another doctor's recommendation she receive surgery. *Id.* at 1118.

treatment.¹⁶⁷ Ashley Diamond, a transwoman incarcerated in Georgia, challenged the Georgia Department of Corrections’ (“GDOC”) “freeze frame” policy, which mandated care only for inmates identified as transgender at intake or who had a “history” of receiving gender-affirming care in the past.¹⁶⁸ The GDOC rules are steeped in a conception of fixed gender,¹⁶⁹ but more importantly, the court was willing to question the GDOC’s policies based on the prison’s outright denial of care.¹⁷⁰ The policy conflicted with elements of established care standards used by prison psychologists which prescribed hormones as the necessary treatment for Diamond’s diagnosis.¹⁷¹ Like Ophelia De’Lonta in Virginia, Ashley Diamond got her claim past dismissal.¹⁷² Diamond succeeded by alleging facts sufficient to show that

the Defendants knew the medically accepted and recognized gender dysphoria treatment pursuant to the [WPATH] Standards of Care; knew about Diamond’s diagnosis . . . and communicated with her directly about her gender dysphoria. But they knowingly and repeatedly refused her requested treatment, refused to refer her for treatment, and, at most, prescribed or authorized treatment—psychotropic drugs and counseling—they knew was medically inadequate.¹⁷³

In *Diamond*, medical staff could not skate by on court deference to their own views of gender-affirming care or prison policies when facts are presented that they were aware of external standards, at least at the pleading stage.¹⁷⁴ The potential result is that prison care guidelines do not always

¹⁶⁷ 131 F. Supp. 3d 1346, 1353 (M.D. Ga. 2015).

¹⁶⁸ *Id.* at 1354. Diamond also alleged that the prison guards failed to protect her from sexual assault while she was incarcerated, in violation of the Eighth Amendment. *Id.* at 1353. Because medical care, and not the additional serious problem of violence against transwomen in prison, is the subject of this Note, I will not be focusing on the assault element of Ashley Diamond’s case. It is worth noting that the court did not dismiss Diamond’s failure to protect claim, nor did it grant qualified immunity to prison guards who failed to protect her from assault behind bars. *Id.* at 1368–69, 1379–80.

¹⁶⁹ *See id.* at 1353, 1354 (noting the prison’s policy assumed gender affirming care was an on/off switch that was flipped at intake, and even if a person who had a previous diagnosis and prescription for hormone therapy was locked up, that individual only received “maintenance” level hormone therapy—not the level his/her/their condition medically required).

¹⁷⁰ *Id.* at 1354, 1372–73 (describing Diamond’s allegation that the GDOC’s “freeze-frame policy[]” prevented medical professionals from initiating treatment for gender dysphoria” and taking as true that she was given care that was “medically inadequate pursuant to the Standards of Care” instead of the GDOC policy).

¹⁷¹ *See id.* at 1356–57.

¹⁷² *Id.* at 1353.

¹⁷³ *Id.* at 1373.

¹⁷⁴ *Id.* at 1372–73 (holding that Ashley Diamond’s “allegations, taken as true, sufficiently show the Defendants were subjectively aware of a substantial risk of serious harm” when such allegations included “(1) all Defendants were aware of the medically

override external medical standards. Plaintiffs who can show prison officials have some awareness of external care standards may be able to attack the standards used by the prison and force a shift toward more GNC-inclusive care models.

C. A CASE THAT COULD WIN?

To get a court to let in medical opinion that restores some gender self-determination to GNC inmates, the incarcerated plaintiff must plead in such a way that invites courts to adopt the closer scrutiny of official knowledge of appropriate care deployed by the *Kothmann*, *Norsworthy*, *Diamond*, *De'Lonta*, and *Wolfe* courts, instead of the reasonable prevention of risk option to avoid liability championed in *Kosilek* and *Rowe*. A complaint emphasizing the continued suffering of the plaintiff and presenting enough facts to enable a court to infer that there are standards of care that would alleviate such suffering may do the job of flipping emphasis from subjective knowledge to something closer to objective reasonableness. Objective reasonableness and a shift in focus to the real human prisoner provide a path to challenge the subjective view of prison officials that their version of treatment is good enough to dodge Eighth Amendment liability. For claims facing summary judgment, emphasizing the holes the defendants left in the record regarding the medical basis of their decisions a la *De'Lonta I*¹⁷⁵ or presenting facts enough to show officials were aware of multiple standards of care as in *Diamond*¹⁷⁶ are viable strategies to extend litigation into a stage where Eighth Amendment subjectivity can further be eroded in favor of the TGNC prisoners being denied care.

Norsworthy provides the best model. Michelle-Lael Norsworthy made her successful claim by emphasizing not “that Defendants ‘should have known’ that sex reassignment surgery was medically necessary . . . [but] [r]ather . . . that Defendants were fully aware that Norsworthy faces a serious medical need for sex reassignment surgery and failed to address her ongoing

accepted and recognized treatment for gender dysphoria pursuant to the Standards of Care, which includes hormone therapy and gender expression; (2) all Defendants knew psychotropic drugs and counseling alone were medically inadequate pursuant to the Standards of Care . . .”).

¹⁷⁵ See *De'Lonta v. Angelone (De'Lonta I)*, 330 F.3d 630, 635 (4th Cir. 2003) (finding, for example, that “nothing in the record suggests that [a prison doctor’s] opinion was a basis for the denial of De'lonta’s requested treatment” based on the record presented by the defendant officials).

¹⁷⁶ See *Diamond v. Owens*, 131 F. Supp. 3d 1346, 1372–73 (M.D. Ga. 2015) (finding that Diamond’s allegations, taken as true, did show from facts including her repeated suicide attempts and medical history with a GD diagnosis that the “[d]efendants were aware of the medically accepted and recognized treatment for gender dysphoria pursuant to the Standards of Care” and yet denied Diamond such care).

anguish.”¹⁷⁷ This switch from what prison officials decide is a medical necessity to their awareness of the prisoner’s suffering enabled Norsworthy to get past the defense that there was merely a “disagreement between her various caregivers” and thus no deliberate indifference since a course of treatment that did not allow for gender-affirming surgery was chosen by officials with multiple “legitimate” options.¹⁷⁸ It may be troubling to goad courts into action by requiring gruesome prisoner suffering before the Eighth Amendment is met,¹⁷⁹ but it returns the focus to the actual prisoner and gives space to question standards of care and whether or not the standards prisons use are actually working to prevent harm to inmates. Norsworthy then had room to utilize the opinion of one caregiver who prescribed her the desired treatment over the objections of prison officials¹⁸⁰—officials who often receive deference, as they did in *Kosilek* and *Rowe*. *Norsworthy* points to officials’ subjective awareness that their preferred bare-bones treatment plans were not reducing harm to the plaintiff as possibly being enough to make an Eighth Amendment claim.¹⁸¹ A claim structured this way enables outside medical opinion that disagrees with prison policy to become part of the case.

De’Lonta v. Angelone provides a useful template for Eighth Amendment claims facing summary judgement.¹⁸² Ophelia De’Lonta’s eight-year quest

¹⁷⁷ *Norsworthy v. Beard*, 87 F. Supp. 3d 1104, 1117–18 (N.D. Cal. 2015).

¹⁷⁸ *Id.* at 1118.

¹⁷⁹ *Farmer v. Brennan* specifically aimed to foreclose such a requirement that the risk of harm from denial of care became real harm under the Eighth Amendment: “Consistently with this principle, a subjective approach to deliberate indifference does not require a prisoner seeking ‘a remedy for unsafe conditions to await a tragic event such as an actual assault before obtaining relief.’” 511 U.S. 825, 845 (1994) (internal citations omitted). For a discussion of how requiring suffering from inmates before care will be mandated is problematic, see Danielle Matricardi, *Binary Imprisonment: Transgender Inmates Ensnared Within the System and Confined to Assigned Gender*, 67 MERCER L. REV. 707, 724 (2016) (“Thus, jurisdictions that focus on gender dysphoria’s physical manifestations severely limit redress for inmates with gender dysphoria who do not display drastic symptoms of suicide or self-harm.”). The path this Note advocates does not require a catastrophic event like a suicide attempt to occur before the claim can be litigated but moves to reemphasize the perspective of the prisoner in shaping his/her/their own care. *Id.*

¹⁸⁰ See *Norsworthy*, 87 F. Supp. 3d at 1118 (finding that Norsworthy stated a claim for deliberate indifference in part because she was pretextually removed by prison officials from the care of a psychologist who recommended gender affirming surgery).

¹⁸¹ See *id.* at 1117–18 (holding Norsworthy’s complaint made a cognizable Eighth Amendment claim because it “does not allege that Defendants ‘should have known’ that sex reassignment surgery was medically necessary[, but r]ather, it alleges that Defendants were fully aware that Norsworthy faces a serious medical need for sex reassignment surgery and failed to address her ongoing anguish”).

¹⁸² See 330 F.3d 630, 631 (4th Cir. 2003) (“Because we conclude that it does not appear beyond doubt that De’lonta cannot prove facts to support her claim, we reverse and remand for further proceedings.”).

to obtain hormones behind bars,¹⁸³ which included “an injunction requiring [the prison] to arrange for her to be treated by a doctor with expertise in transsexualism,”¹⁸⁴ inched forward—eventually to a settlement between De’Lonta and the Virginia Department of Corrections (“VDOC”) whereby De’Lonta would receive hormone therapy.¹⁸⁵ In Ophelia De’Lonta’s case, VDOC even consulted with a “an outside Gender Identity Specialist” to provide De’Lonta the care she sought.¹⁸⁶ VDOC’s officials let in new medical standards following De’Lonta’s first victory in the Fourth Circuit¹⁸⁷—showing judicial deference to prison medical staff under the Eighth Amendment framework is not above challenge. While procedurally winning reversal of a summary judgement motion is not a win on the merits,¹⁸⁸ such a victory at the appellate level can be a powerful bargaining chip for settlement as *De’Lonta I* shows. By emphasizing the lack of medical expertise presented by prison officials in the record, the *De’Lonta I* court enabled the plaintiff to fill the gaps left by the prison doctors, reassert her identity, and eventually access a medical expert who actually met her needs.

While it is true that “[t]he medical model of the Eighth Amendment will

¹⁸³ *Id.* at 632.

¹⁸⁴ *Id.*

¹⁸⁵ *See De’lonta v. Johnson*, 708 F.3d 520, 522 (4th Cir. 2013) (“The parties [in *De’Lonta I*] subsequently reached a settlement in which VDOC acknowledged De’lonta’s serious medical need and agreed to provide continuing treatment.”). In 2011, Ophelia De’Lonta again sued VDOC officials for denying her gender-affirming surgery, and defeated VDOC’s 12(b)(6) motion in the Fourth Circuit, in part because prison officials ignored the WPATH Standards of Care’s recommendation that those suffering from GID have access to surgery. *See id.* at 522–24. The Fourth Circuit also held that the district court erred because VDOC providing some level of treatment did not mean VDOC officials met the burden of the Eighth Amendment. *See id.* at 526. *De’lonta v. Johnson* reinforces the reasoning of its predecessor *De’Lonta v. Angelone*, reapplying the same skepticism of VDOC officials’ medical decisions to again enable De’Lonta’s claim to move forward. The Ninth Circuit also cited *De’lonta v. Johnson* in its reversal of a district court’s Rule 12(b)(6) dismissal of a transwoman’s Eighth Amendment claim. *Rosati v. Igbinoso*, 791 F.3d 1037, 1040 (9th Cir. 2015) (citing *De’lonta v. Johnson*, 708 F.3d 520, 526 n.4 (4th Cir. 2013) (plaintiff not required to point to medical opinion in her favor for her denial of care claim to be plausible)). *Rosati* points to the viability of the *De’Lonta I* approach to more thoroughly questioning prison medical expertise in Eighth Amendment cases across circuits. *See* 791 F.3d at 1040 (“*Rosati* plausibly alleges her symptoms . . . are so severe that prison officials recklessly disregarded an excessive risk to her health by denying SRS [“sex reassignment surgery”] solely on the recommendation of a physician’s assistant with no experience in transgender medicine.”).

¹⁸⁶ *De’lonta*, 708 F.3d at 522.

¹⁸⁷ *Id.* at 526 (“Appellees [VDOC] have provided De’lonta with *some* treatment consistent with the GID Standards of Care . . .”).

¹⁸⁸ *See De’lonta I*, 330 F.3d at 636 (explaining that in reversing summary judgment the court “make[s] no comment on the merits of any issues not yet addressed by the district court”).

always be somewhat in conflict with a conception of gender identity based only on self-identification,¹⁸⁹ the current regime of prisoner/patient being fit into a fixed binary checklist like that of the DSM-V¹⁹⁰ can be shifted into a model more like the UCSF's, where the patient sets the checklist for the doctor to fulfill.¹⁹¹ Getting those standards into the courtroom may be possible where a court makes the inferential leap of *Kothmann*, uses a more objective focus on official knowledge of gender-affirming care as in *Wolfe*, or uses the suffering of the inmate as the litmus test for treatment as in *Norsworthy*. It may also be possible when courts question the basis of medical decisions in the record as in *De'Lonta I*, or when facts show that officials knew what other care models are available as in *Diamond*. These cases show that new care guidelines can make it behind bars when courts do not let officials hide behind the Eighth Amendment's subjective prong. These cases present palatable ways to incorporate self-determination into Eighth Amendment cases, with the hope that such care models erode fixed binary conceptions of gender in the law generally, perhaps as a first push away from legitimizing gender via medicine across the board. The other hope is that prisoner-defined care will return the incarcerated individual's definition of self into the Eighth Amendment equation, thereby diluting the current emphasis on expert and official viewpoints.¹⁹²

CONCLUSION

In response to the pathologizing of TGNC persons via medical diagnosis, “transgender activists and progressive psychiatrists have argued that the diagnosis should be eliminated altogether and that transgender individuals should be considered to be engaging in an act of self-determination, an exercise of autonomy.”¹⁹³ An approach based on self-determination rather than external medical definition may also solve some of the roadblocks put in front of GNC prisoners by expanding rights to care beyond only cases where a prisoner seeks permanent transition. As Silpa Maruri points out in the context of pathologizing trans status, “GID and its relationship to the Eighth Amendment remains a complicated problem, implicating the tension between the desire of transgender people to access

¹⁸⁹ Halbach, *supra* note 34, at 482.

¹⁹⁰ See AM. PSYCHIATRIC ASS'N, *supra* note 58 at § 302.85 (listing factors for GD diagnosis).

¹⁹¹ See UCSF, *supra* note 10, at 70 (“The approach to hormone therapy should be guided by the person’s desired configuration of secondary sex characteristics.”).

¹⁹² See, e.g., *Kosilek v. Spencer*, 774 F.3d 63, 88–89 (1st Cir. 2014), *cert. denied sub nom.* *Kosilek v. O’Brien*, 135 S. Ct. 2059, (2015) (finding error in the district court second-guessing prison medical expertise).

¹⁹³ See Maruri, *supra* note 25, at 811.

the means to achieve self-definition through transitioning and the compromise of self-definition that transgender people must make by accepting a GID di[a]gnosis [sic].¹⁹⁴ The same is true of GNC inmates who may seek care by filing claims in courtrooms where a medical diagnosis impliedly based in the binary is the only proven ticket to gender-affirming care.¹⁹⁵ GNC prisoners have to fit the GID/GD model of having a “gender problem” to satisfy court notions of medical need and the many demands of the Eighth Amendment. Plaintiffs must show that prison officials know of (subjective intent and knowledge)¹⁹⁶ and are thus “able” to treat the gender “condition” (objective serious medical need)¹⁹⁷ before that Section 1983 claim will hit its target. The kind of treatment officials can provide is partially up for grabs depending on how a court deploys the Eighth Amendment’s mean subjective barb.¹⁹⁸ Once a court is willing to question the treatment prisons provide (or deny), newer GNC-inclusive standards of care can enter the scene.

As a step toward establishing a right to define one’s own gender, medical diagnosis can be used as a tool to legitimize self-determined identity even under the Eighth Amendment. Diagnoses pathologize TGNC individuals, but litigated carefully, they are one way of chipping away at the Eighth Amendment’s relentless emphasis on the subjectivity of prison officials and erasure of those injured—the prisoners.

¹⁹⁴ *Id.* at 821–22.

¹⁹⁵ See Oparah, *supra* note 9, at 247 (“[B]y producing a class of individuals who have been diagnosed with GID, and are undergoing or have completed SRS, the medical model creates a hierarchy of transgendered people.” Because “the courts rely on evidence provided by medical experts regarding the legitimacy of a transgender individual’s claim, those who are not under a doctor’s care are excluded from legal protections.”).

¹⁹⁶ *Farmer v. Brennan*, 511 U.S. 825, 837 (1994).

¹⁹⁷ See *Soneeya v. Spencer*, 851 F. Supp. 2d 228, 244 (D. Mass. 2012) (“[I]t is well established that GID may constitute a serious medical need.”).

¹⁹⁸ For example, a plaintiff can beat the subjective requirement by relying on the circumstantial evidence option of *Farmer*, which is an easier hurdle for plaintiffs to leap since they do not have to delve into the defendants’ minds. See *Farmer v. Brennan*, 511 U.S. 825, 842–43 (1994) (holding that circumstantial evidence of knowledge of harm or risk may meet the subjective deliberate indifference requirement of the Eighth Amendment). The *Norsworthy* court’s crediting of circumstantial evidence from Michelle Norsworthy’s complaint is a prime example of the slippage of subjective intent into more easily proven objective reasonableness based on surrounding facts: “The [complaint] does not allege that there was a genuine difference of medical opinion; rather, it alleges that Defendants’ purported reliance on the opinions of non-specialized, inexperienced health care providers was clearly unreasonable and pretextual and thus evidence of deliberate indifference.” *Norsworthy v. Beard*, 87 F. Supp. 3d 1104, 1116 (N.D. Cal. 2015).