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## ARTICLE

# A STATE'S OBLIGATION TO FUND HORMONAL THERAPY AND SEX-REASSIGNMENT SURGERY FOR PRISONERS DIAGNOSED WITH GENDER IDENTITY DISORDER

*Rena Lindevaldsen*<sup>†</sup>

### I. INTRODUCTION

For the first time in United States history, on September 4, 2012, a federal judge ordered a state to provide male-to-female sex-reassignment surgery to a prison inmate with gender identity disorder (“GID”). Patients with GID suffer psychological distress, including depression, thoughts of suicide, and the desire to amputate sex organs, because their perception of reality is different than actual reality—namely, they believe their gender is different than their biological sex. For many GID patients, they are certain that their psychological distress will be alleviated if they can become the sex they believe they should be through the use of cross-gender hormones, cross-dressing, and, for some, sex-reassignment surgery. In the situation of prisoners with GID, the question becomes whether the state must provide the desired hormones or sex-reassignment surgery.

Although the United States Supreme Court has concluded that a state has an obligation to provide prisoners with medical care that meets minimal standards of adequacy, a prisoner establishes an Eighth Amendment violation only when state officials are deliberately indifferent to serious medical needs. This article explores whether a state law imposing a flat ban on the use of funds to provide cross-gender hormones or sex-reassignment surgery for prisoners diagnosed with GID satisfies the Eighth Amendment standard of deliberately indifferent to serious medical needs. In other words, the issue is whether it constitutes cruel and unusual punishment for a state to refuse to provide hormones or sex-reassignment surgery to GID prisoners. The district court in *Kosilek v. Spencer*<sup>1</sup> held that it does: the state

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1. *Kosilek v. Spencer*, No. 00-12455-MLW, 2012 WL 3799660 (D. Mass. Sept. 4, 2012).

violated the Eighth Amendment in providing feminizing hormones to Kosilek but refusing to provide him sex-reassignment surgery.<sup>2</sup>

Part I of this article lays out a state's obligation to provide medical treatment to its prisoners consistent with the Supreme Court's current Eighth Amendment precedent.<sup>3</sup> Part II discusses issues unique to a state's determination of proper treatment for GID prisoners. Those issues primarily focus on the conflicting views in the medical community on the proper treatment of GID patients. Part III highlights several recent court decisions that exemplify the conflicts discussed in Part II, including whether a state's obligation differs with respect to GID prisoners who commenced hormonal treatment before entering the prison system and those who were diagnosed with GID while in prison. Part IV asserts that a state acts consistently with its Eighth Amendment obligations when it prohibits the use of any funds for hormonal therapy or sex-reassignment surgery of GID prisoners. The proper course of treatment for GID should be to treat the underlying causes of the psychological distress, not to alter the prisoner's physical characteristics to match the gender the prisoner believes he should be.

## II. THE EIGHTH AMENDMENT PROHIBITION AGAINST CRUEL AND UNUSUAL PUNISHMENT

### A. *The Supreme Court Has Decided That the Eighth Amendment Prohibits More Conduct Than That Prohibited by Our Founders.*

The text of the Eighth Amendment provides that "cruel and unusual punishments" shall not be "inflicted."<sup>4</sup> Since early in the twentieth century, the Supreme Court has expressly rejected the notion that the Eighth Amendment is to be interpreted according to the standards that prevailed when the Eighth Amendment was adopted in 1791 . . .<sup>5</sup> Instead, the Supreme Court has tested the constitutionality of criminal punishments—primarily the death penalty—by asking whether the imposed punishment

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2. *Id.* at \*53.

3. For purposes of this article, the author is analyzing the Eighth Amendment claim as if the Supreme Court has properly determined that the prohibition of cruel and unusual punishment has evolved, and will continue to do so, from the meaning given to the Amendment by the founders. This author, however, shares the views of Justices Thomas and Scalia as more fully discussed *infra* Part II.A.

4. U.S. CONST. amend. VIII.

5. *Weems v. United States*, 217 U.S. 349, 367 (1910).

comports with “evolving standards of decency that mark the progress of a maturing society.”<sup>6</sup> To determine what comports with the evolving standards of decency, the Court considers “objective indicia of society’s standards, as expressed in legislative enactments and state practice.”<sup>7</sup> As a result, what constitutes cruel and unusual punishment “necessarily embodies a moral judgment” that “change[s] as the basic mores of society change.”<sup>8</sup> In fact, the Court has also expressly stated that its “own independent judgment” plays a part in the determination of whether certain punishment violates the Eighth Amendment.<sup>9</sup>

The evolving standards of decency test has led the Court to prohibit excessive sanctions,<sup>10</sup> prohibit the death penalty for certain classes of crimes<sup>11</sup> or for crimes committed by certain individuals,<sup>12</sup> require punishments to be proportional to the crime,<sup>13</sup> require individualized

6. *Trop v. Dulles*, 356 U.S. 86, 101 (1958); *see also Kennedy v. Louisiana*, 554 U.S. 407, 419–20 (2008) (repeating the evolving standards of decency as the prevailing standard).

7. *Kennedy*, 554 U.S. at 421 (quoting *Roper v. Simmons*, 543 U.S. 551, 563 (2005)).

8. *Id.* at 419 (quoting *Furman v. Georgia*, 408 U.S. 238, 382 (1972) (Burger, C.J., dissenting)).

9. *Id.* at 421. The fact that the Court admittedly interprets the Eighth Amendment according to its own value judgments about the validity of the punishment raises separation of powers concerns. When any court substitutes its own policy judgment for that of the legislature, it improperly usurps legislative powers. The Utah Supreme Court has explained that

“As a general rule, making social policy is a job for the Legislature, not the courts. This is especially true when the determination or resolution requires placing a premium on one societal interest at the expense of another: The responsibility for drawing lines in a society as complex as ours—of identifying priorities, weighing the relevant considerations and choosing between competing alternatives—is the Legislature’s, not the judiciary’s.”

*Jones v. Barlow*, 154 P.3d 808, 817 (Utah 2007) (quoting *Van v. Zahorik*, 597 N.W.2d 15, 18 (Mich. 1999)).

10. *See, e.g., Gregg v. Georgia*, 428 U.S. 153, 173 (1976).

11. *Coker v. Georgia*, 433 U.S. 584, 600 (1977) (declaring it unconstitutional to execute a man who had raped an adult woman).

12. The Supreme Court has declared unconstitutional statutes that permitted execution of juveniles, *Roper*, 543 U.S. at 570–73, and those deemed “mentally retarded,” *Atkins v. Virginia*, 536 U.S. 304, 318, 320 (2002).

13. *Weems v. United States*, 217 U.S. 349, 367 (1910).

sentencing determinations,<sup>14</sup> and prohibit a mandatory sentence of life without parole for juvenile homicide offenders.<sup>15</sup>

Justices Scalia and Thomas have criticized the evolving standards of decency standard as inconsistent with the original understanding of the Eighth Amendment. In particular, they reject the notion that the Eighth Amendment prohibits certain punishment for specified classes of offenders or that it requires individualized sentencing in capital punishment.<sup>16</sup> Rather, the Eighth Amendment prohibition was originally intended to “prohibit[] torturous *methods* of punishment—specifically methods akin to those that had been considered cruel and unusual at the time the Bill of Rights was adopted.”<sup>17</sup>

In short, it does not authorize courts to invalidate any punishment they deem disproportionate to the severity of the crime or to a particular class of offenders. Instead, the clause “leaves the unavoidably moral question of who “deserves” a particular nonprohibited method of punishment to the judgment of the legislatures that authorize the penalty.”<sup>18</sup>

In fact, Justices Thomas and Scalia have explained that courts did not even begin applying the Eighth Amendment to claims concerning prison conditions until the 1960s, and it was not until 1976 that the Supreme Court first did so.<sup>19</sup> From the founding era until the mid-1900s, “punishment” in the Eighth Amendment was assigned the generally understood meaning of “the penalty imposed for the commission of a crime.”<sup>20</sup> In 1976, however, the United States Supreme Court took a different approach to the meaning of cruel and unusual punishments.

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14. *Zant v. Stephens*, 462 U.S. 862, 879 (1983) (declaring that in death penalty cases, the Eighth Amendment requires an “*individualized* determination on the basis of the character of the individual and the circumstances of the crime”) (emphasis added).

15. *Miller v. Alabama*, 132 S. Ct. 2455, 2475 (2012).

16. *Id.* at 2482 (Thomas, J., dissenting).

17. *Id.* at 2483 (Thomas, J., dissenting) (quoting *Graham v. Florida*, 130 S. Ct. 2011, 2044 (2010) (Thomas, J., dissenting)).

18. *Id.* at 2483 (Thomas, J., dissenting) (quoting *Graham*, 130 S. Ct. at 2045 (Thomas, J., dissenting)).

19. See *Helling v. McKinney*, 509 U.S. 25, 40 (1993).

20. *Id.* at 38.

*B. The Eighth Amendment As Applied to Medical Treatment of Prisoners.*

In 1976, the United States Supreme Court held for the first time that “deliberate indifference to serious medical needs of prisoners constitutes the ‘unnecessary and wanton infliction of pain’” prohibited by the Eighth Amendment.<sup>21</sup> Prison officials, therefore, must provide “humane conditions of confinement;” “ensure that inmates receive adequate food, clothing, shelter, and medical care[;]” and “must ‘take reasonable measures to guarantee the safety of the inmates.’”<sup>22</sup> Failure to provide this basic care is “incompatible with the concept of human dignity and has no place in civilized society.”<sup>23</sup>

Although prison officials must provide adequate medical care, not every failure to provide such care constitutes an Eighth Amendment violation. For example, an accident or even basic negligence is not sufficient.<sup>24</sup> Rather, to state a claim, “a prisoner must allege acts or omissions sufficiently harmful to evidence deliberate indifference to serious medical needs. It is only such indifference that can offend “evolving standards of decency” in violation of the Eighth Amendment.”<sup>25</sup> The prisoner must also show that the prison official acted with deliberate indifference to “a substantial risk of serious harm.”<sup>26</sup>

The deliberate indifference to a substantial risk of serious harm includes both an objective and subjective component.<sup>27</sup> The inmate demonstrates the objective component by showing that “he is incarcerated under conditions posing a substantial risk of serious harm.”<sup>28</sup> If the inmate’s claim is based on a denial of medical care, the inmate must also demonstrate that he has a serious medical need for which he has not received adequate medical care.<sup>29</sup>

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

22. *Farmer v. Brennan*, 511 U.S. 825, 832 (1994) (quoting *Hudson v. Palmer*, 468 U.S. 517, 526–27 (1984)).

23. *Brown v. Plata*, 131 S. Ct. 1910, 1928 (2011) (concluding that the Eighth Amendment had been violated by the lack of medical attention afforded mentally ill prison inmates as a result of extensive overcrowding in California prisons).

24. *Farmer*, 511 U.S. at 835.

25. *Kosilek v. Spencer*, No. 00-12455-MLW, 2012 WL 3799660, at \*10 (D. Mass. Sept. 4, 2012) (quoting *Estelle*, 429 U.S. at 102–04).

26. *Farmer*, 511 U.S. at 842.

27. *Id.* at 846.

28. *Id.* at 834.

29. *Id.* at 837.

A serious medical need is one that has been diagnosed by a physician as requiring treatment or “one that is so obvious that even a lay person would easily recognize the necessity for a doctor’s attention.”<sup>30</sup> The First Circuit has explained that adequate services provided to treat a serious medical need are those “reasonably commensurate with modern medical science and of a quality acceptable within prudent professional standards.”<sup>31</sup> It also must be based on “sound medical judgment” that is determined by the individual prisoner’s needs.<sup>32</sup> In analyzing the objective component of an Eighth Amendment medical care claim, courts point out that a prisoner need not receive “ideal care” or “the care of his choice.”<sup>33</sup> Rather, prison officials are entitled to exercise discretion in deciding among different adequate treatments.

The subjective component of the claim focuses on the prison official’s knowledge of the need for medical care and his deliberate indifference toward the serious medical need.<sup>34</sup> “[T]he 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.”<sup>35</sup> A court is permitted to infer an official’s state of mind from his behavior. Thus, deliberate indifference to the serious medical needs of an inmate can be demonstrated by evidence of “denial, delay, or interference with prescribed health care.”<sup>36</sup> Nevertheless, even if a prison official knows of the substantial risk of serious harm that a prisoner faces, the Eighth Amendment is not violated if the denial of the particular medical care is “based on reasonable,

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30. *Mahan v. Plymouth Cnty. House of Corr.*, 64 F.3d 14, 18 (1st Cir. 1995) (quoting *Gaudreault v. Mun. of Salem*, 923 F.2d 203, 208 (1st Cir. 1990)).

31. *United States v. Derbes*, 369 F.3d 579, 583 (1st Cir. 2004) (quoting *United States v. DeCologero*, 821 F.2d 39, 43 (1st Cir. 1987)).

32. See *Iseley v. Beard*, 200 Fed. Appx. 137, 141–42 (3d Cir. 2006); *Bates v. Witt*, 215 F.3d 1329 (7th Cir. 2000) (unpublished table decision). The sound medical judgment component does not, however, mean that prisoners state an Eighth Amendment claim simply by alleging facts giving rise to the suggestion of medical malpractice. See *Estelle v. Gamble*, 429 U.S. 97, 106 (1976). Rather, the sound medical judgment component focuses on whether the medical determination made by the prison officials was based on an individualized assessment of how to appropriately treat the prisoner.

33. See, e.g., *Kosilek v. Spencer*, No. 00-12455-MLW, 2012 WL 3799660, at \*3 (D. Mass. Sept. 4, 2012).

34. *Id.* at \*13.

35. *Id.* (quoting *Farmer v. Brennan*, 511 U.S. 825, 837 (1994)).

36. *Battista v. Clarke*, 645 F.3d 449, 453 (1st Cir. 2011) (quoting *DesRosiers v. Moran*, 949 F.2d 15, 19 (1st Cir. 1991)).

good faith judgments balancing the inmate's medical needs with other legitimate, penological considerations."<sup>37</sup>

For example, in *Perkins v. Kansas Department of Corrections*,<sup>38</sup> the Tenth Circuit Court of Appeals dismissed a prisoner's Eighth Amendment claim based on the state's failure to provide a specific prescription drug for the prisoner's HIV.<sup>39</sup> The prisoner conceded that the state provided two drugs to treat his HIV.<sup>40</sup> He claimed, however, that unless he was given a third drug, his HIV would become immune to the first two drugs.<sup>41</sup> The court found that the prisoner "simply disagrees with medical staff about the course of his treatment. This disagreement does not give rise to a claim for deliberate indifference to serious medical needs."<sup>42</sup>

In contrast, in *Chance v. Armstrong*,<sup>43</sup> the Second Circuit Court of Appeals denied the motion by prison officials to dismiss an Eighth Amendment claim that raised the question of whether the prison's refusal to provide a certain course of treatment preferred by the inmate was based on sound medical judgment.<sup>44</sup> In response to Mr. Chance's ongoing dental concerns, a dentist and oral surgeon recommended that Mr. Chance have three teeth pulled.<sup>45</sup> Mr. Chance asserted that less invasive and painful procedures would remedy his dental problems.<sup>46</sup> Another dentist advised Mr. Chance that his dental problems could be resolved by pulling one tooth and filling another.<sup>47</sup> In fact, yet another dentist eventually filled one of the teeth, resolving the problems with that tooth.<sup>48</sup>

For purposes of the motion to dismiss, the court assumed that the dental problems constituted a serious medical condition sufficient to state an Eighth Amendment claim<sup>49</sup> and that he had received inadequate treatment

37. *Kosilek*, 2012 WL 3799660, at \*11.

38. *Perkins v. Kansas Dep't of Corr.*, 165 F.3d 803 (10th Cir. 1999).

39. *Id.* at 811.

40. *Id.*

41. *Id.*

42. *Id.*

43. *Chance v. Armstrong*, 143 F.3d 698 (2d Cir. 1998).

44. *Id.* at 704.

45. *Id.* at 700.

46. *Id.* at 700–701.

47. *Id.* at 701.

48. *Id.*

49. *Id.* at 702.



for that condition.<sup>50</sup> As to deliberate indifference, the court explained that “mere disagreement over the proper treatment does not create a constitutional claim.”<sup>51</sup> In *Chance*, however, the question was whether the decision to pull three teeth was based on sound medical judgment (and thus the prisoner simply disagreed with the course of treatment chosen) or based on a monetary incentive—namely, that the oral surgeon would be paid more money to pull three teeth rather than one.<sup>52</sup> The court explained that if the decision was not made on sound medical judgment, it would constitute deliberate indifference to the prisoner’s medical needs.<sup>53</sup>

In the context of GID prisoners asserting Eighth Amendment claims, the key question is whether a prison’s decision to categorically, or on a case-by-case basis, provide psychotherapy rather than cross-gender hormones or sex-reassignment surgery is one that constitutes deliberate indifference to a serious medical need.

## II. UNDERSTANDING AND TREATING GENDER IDENTITY DISORDER

### A. *How the Medical Profession Defines Gender Identity Disorder*

Gender identity disorder is listed as a psychiatric disorder in the DSM-IV-TR.<sup>54</sup> The DSM is a manual published by the American Psychiatric Association and is used by mental health professionals as an assessment and diagnostic tool. It identifies mental health conditions and describes symptoms and other statistics concerning the mental health condition. A task force report of the American Psychological Association<sup>55</sup> on Gender Identity and Gender Variance explained that “the diagnostic criteria for GID include (a) a strong or a persistent cross-gender identification, (b) persistent discomfort with one’s sex or a sense of inappropriateness in the

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50. *Id.* at 703.

51. *Id.*

52. *Id.* at 703–04.

53. *Id.* at 704.

54. The DSM refers to the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders. It expected that the DSM-V, to be published in 2013, will no longer include GID as a disorder. Rather, it will be identified as gender dysphoria. American Psychiatric Association, *Recent Updates to Proposed Revisions for DSM-5*, DSM-5 DEVELOPMENT (last visited Mar. 2, 2013), <http://www.dsm5.org/Pages/RecentUpdates.aspx>.

55. The American Psychological Association and American Psychiatric Association are two separate entities.

gender role associated with one's sex, and (c) clinically significant distress or impairment in functioning."<sup>56</sup>

The feelings of dysphoria can vary in intensity. Some patients are able to manage the discomfort, while others become unable to function without taking steps to correct the disorder. A person with GID often experiences severe anxiety, depression, and other psychological disorders. Those with GID may attempt to commit suicide or to mutilate their own genitals.<sup>57</sup>

One court has described GID as believing that a person is "cruelly imprisoned within a body incompatible with their real gender identity."<sup>58</sup> In recent years, some have referred to GID as gender dysphoria in an effort to destigmatize GID.<sup>59</sup> Regardless of the label, there are differences of opinion concerning the proper course of treatment for those with GID or gender dysphoria.<sup>60</sup>

#### *B. There Are Conflicting Views on the Proper Course of Treatment of GID.*

While there seems to be some variation in the appropriate treatment regimen of a GID-diagnosed patient based on their age, treatment approaches can be generally divided into two categories. One approach is to provide GID patients with hormones and, for some, sex-reassignment surgery, based on certain protocols established by the Harry Benjamin International Gender Dysphoria Association's *Standards of Care for Gender*

56. AM. PSYCHOLOGICAL ASS'N, REPORT OF THE APA TASK FORCE ON GENDER IDENTITY AND GENDER VARIANCE 31 (2009) [hereinafter 2008 GENDER IDENTITY TASK FORCE REPORT], available at <http://www.apa.org/pi/lgbt/resources/policy/gender-identity-report.pdf>.

57. *Fields v. Smith*, 653 F.3d 550, 553 (7th Cir. 2011).

58. *Farmer v. Moritsugu*, 163 F.3d 610, 611 (D.C. Ct. App. 1998) (quoting THE MERCK MANUAL OF MEDICAL INFORMATION 418 (1997)).

59. James Phillips, *Gender Identity Disorder in Prison: Depending on a Diagnosis That is Soon to Disappear*, PSYCHIATRIC TIMES (Sept. 23, 2012), available at <http://www.psychiatristimes.com/gender-disorders/content/article/10168/2105073>; cf. 2008 GENDER IDENTITY TASK FORCE REPORT, *supra* note 56, at 11, 22, 26.

60. See 2008 GENDER IDENTITY TASK FORCE REPORT, *supra* note 56, at 45. GID is distinct from the incredibly small number of people who have an intersex condition. Individuals with GID have normal genitalia. By contrast, a person with an intersex condition has genitalia that cannot be classified as male or female or has sex chromosomes that are inconsistent with the person's physical characteristics. See Teresa Zakaria, Note, *By Any Other Name: Defining Male and Female in Marriage Statutes*, 3 AVE MARIA L. REV. 349, 358 (2005) (citing Leonard Sax, *How Common is Intersex? A Response to Anne Fausto-Sterling*, 39 J. SEX. RES. 174, 175 (2002)). The intersex conditions have a prevalence of approximately 0.018%. *Id.*

*Identity Disorder*.<sup>61</sup> This approach seeks to align the patient's biological sex with his beliefs about his gender. Another approach is to treat the underlying causes of GID through psychological counseling or psychotherapy.<sup>62</sup> This second approach seeks to align the patient's beliefs about his gender with his biological sex. The different treatment approaches are driven in large part by ideological differences regarding "the origins, meanings, and fixity/malleability of gender identity."<sup>63</sup>

In 1980, the American Psychiatric Association first classified GID as a mental disorder.<sup>64</sup> Since the late 1970s, shortly after the American Psychiatric Association declassified homosexuality as a mental disorder, there has been a growing number of practitioners and advocacy groups who believe that identifying patients as having GID and treating them with the goal of aligning gender identity with the genetic sex is to "pathologize differences in gender identity or expression."<sup>65</sup> These practitioners maintain

61. Now in its seventh version, the Harry Benjamin standards have been adopted by the World Professional Association for Transgender Health (WPATH) as the appropriate treatment protocols. The Harry Benjamin standards are available at <http://www.wpath.org/documents2/socv6.pdf>. That the medical profession is relying on the work of Harry Benjamin as established protocols in this area is itself problematic. Dr. Harry Benjamin, an international sexologist, was a colleague of Alfred Kinsey. Among other things that should call into question the validity of his work, Dr. Kinsey admittedly performed sexual experiments on hundreds of infants and children. See JUDITH A. REISMAN, *CRIMES AND CONSEQUENCES: THE RED QUEEN AND THE GRAND SCHEME* 132–65 (2d ed. 1998). Dr. Benjamin wrote the introduction to a book of another Kinsey colleague, Rene Guyon. Mr. Guyon was a French lawyer who coined the phrase "sex by age eight or else it's too late." Ronald D. Ray, *Kinsey's Legal Legacy*, *THE NEW AMERICAN*, Jan. 19, 1998, at 31. In the introduction to Mr. Guyon's book, entitled *Sexual Ethics*, Dr. Benjamin wrote that, based on Kinsey's work, we needed to completely revise our legal and moral codes. "It probably comes as a jolt to many, even open-minded people, when they realize that chastity cannot be a virtue because it is not a natural state." *Id.*

62. Paul McHugh, *Surgical Sex*, *FIRST THINGS*, Nov. 2004, at 34–38, available at <http://www.firstthings.com/article/2009/02/surgical-sex--35>.

63. William Byne et al., *Report of the American Psychiatric Association Task Force on Treatment of Gender Identity Disorder*, 41 *ARCHIVES OF SEXUAL BEHAVIOR* 759, 769 (2012), available at <http://www.springerlink.com/content/65145105t4000220/?MUD=MP>.

64. Heino F. L. Meyer-Bahlburg, *From Mental Disorder to Iatrogenic Hypogonadism: Dilemmas in Conceptualizing Gender Identity Variants As Psychiatric Conditions*, 39 *ARCHIVES OF SEXUAL BEHAVIOR* 461, 462 (2010), available at <http://www.springerlink.com/content/p64152610v67k476/>.

65. WORLD PROFESSIONAL ASSOCIATION FOR TRANSGENDER HEALTH, *STANDARDS OF CARE FOR THE HEALTH OF TRANSEXUAL, TRANSGENDER, AND GENDER NONCONFORMING PEOPLE 3* (7th ver. 2012) [hereinafter *WPATH Standards of Care*], available at [http://www.wpath.org/documents/SOC\\_V7\\_03-17-12.pdf](http://www.wpath.org/documents/SOC_V7_03-17-12.pdf).

that the proper approach of treatment is to “provide care . . . that affirms patients’ gender identities and reduces the distress of gender dysphoria.”<sup>66</sup>

“Affirmation,” in this context, often translates into doing whatever is necessary to bring external gender characteristics in line with internal belief of gender.<sup>67</sup> For those who seek to affirm the patient’s gender identity when it conflicts with his biological sex, GID is *not* considered a disorder. Thus, patients who identify as the opposite gender of their genetic sex are to be encouraged to accept and embrace their inner belief. This can be accomplished by encouraging patients to live as the opposite gender role, undertaking a hormone regimen to either delay puberty or change their physical appearance to reflect their expressed gender identity, or undergoing sex-reassignment surgery to remove and replace sexual organs with those of the person’s desired gender.<sup>68</sup>

The greater a patient’s distress over the incongruence between his biological sex and desired gender, the more prone the professional is to recommend changing that patient’s biological characteristics through hormones and surgery.<sup>69</sup> The World Professional Association for Transgender Health (“WPATH”) is among the organizations that support a person’s ability to choose to undergo hormone therapy and sex-reassignment surgery. WPATH describes itself as an international, professional association with a mission to promote “evidence-based care, education, research, advocacy, public policy, and respect for transgender health.”<sup>70</sup> WPATH believes that pathologizing differences in gender identity expression—including even diagnosing someone with GID—demonstrates a lack of respect for patients.<sup>71</sup> Instead, treatment should affirm a person’s choice of gender identity.<sup>72</sup>

The WPATH *Standards of Care* set forth protocols for treatment.<sup>73</sup> The treatment options for patients with GID include living consistent with one’s gender identity (which may involve cross-dressing), hormone therapy to

66. *Id.*

67. *Id.* at 1, 3, 5.

68. *Id.* at 9–10.

69. For example, the WPATH takes the position that “[t]reatment is available to assist people with such distress to explore their gender identity and find a gender role that is comfortable for them.” *Id.* at 5.

70. *Id.* at 1.

71. *Id.* at 3.

72. *Id.*

73. *Id.* at 9–10.

feminize or masculinize the body, puberty-delaying hormones in children or adolescents, surgery to change sex characteristics, and psychotherapy.<sup>74</sup> The treatment protocols indicate that prior to surgery to change sex characteristics, a person should engage in a twelve-month period of taking hormones and living in a gender role that is consistent with his perceived gender identity.<sup>75</sup> For children, the treatment protocols also provide that delaying hormones should be used to prevent onset of puberty and that children as young as sixteen could be given cross-gender hormones.<sup>76</sup> Dr. Norman Spack at the Gender Management Clinic in Boston, Massachusetts, reports that he has worked with a local plastic surgeon to have breast removal surgery performed on a female who desired to transition to being a male.<sup>77</sup> Since the Clinic opened in 2007, Dr. Spack and others have worked with an average of nineteen children per year to assist them in changing their biological sex characteristics to reflect their gender identity.<sup>78</sup>

GID stands alone, however, in treating patients in a manner that fosters the patient's belief about himself when that belief does not align with reality.<sup>79</sup> For example, those with a Compulsive Overeating Disorder are encouraged to reduce their mental dependency on food consumption,<sup>80</sup> while patients with Anorexia or Bulimia are encouraged to increase their food intake or retain their food, despite mental impulses to the contrary.<sup>81</sup> In other words, an anorexic is not encouraged to believe she is overweight and in need of losing weight; she is encouraged to attain a proper understanding of the role of food in her life and a healthy self-perception.

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74. *Id.* at 9–14.

75. *Id.* at 60.

76. *Id.* at 18–20.

77. The Associated Press, *Sex-Change Treatment for Kids on the Rise* (Feb. 2012), available at [http://www.cbsnews.com/8301-204\\_162-57381241/sex-change-treatment-for-kids-on-the-rise/](http://www.cbsnews.com/8301-204_162-57381241/sex-change-treatment-for-kids-on-the-rise/).

78. *Id.*

79. See, e.g., Zakaria, *supra* note 60, at 349, 359 & n.47 (“GID is the only pathology for which ‘the patient makes the diagnosis and prescribes the treatment’”).

80. Denise E. Wilfley et al., *A Randomized Comparison of Group Cognitive-Behavioral Therapy and Group Interpersonal Psychotherapy for the Treatment of Overweight Individuals with Binge-Eating Disorder*, 59 ARCHIVES GENERAL PSYCHIATRY 713, 717–18 (Aug. 2002), available at <http://archpsyc.jamanetwork.com/article.aspx?articleid=206650>.

81. Cynthia M. Bulik et al., *Anorexia Nervosa*, in 1 HANDBOOK OF EVIDENCE-BASED PRACTICE IN CLINICAL PSYCHOLOGY 575, 580 (Peter Sturmey & Michel Hersen eds., 2012); see also Zakaria, *supra* note 60, at 362.

No one would suggest that liposuction is the proper treatment protocol for the malnourished anorexic because she believes she is overweight.

Body Integrity Identity Disorder ("BIID") is probably the most analogous disorder to GID, and yet the course of treatments for each differs drastically. BIID causes a physically whole person to desire to become an amputee.<sup>82</sup> As with GID, the belief is so persistent that some patients have attempted self-amputation of a limb.<sup>83</sup> If the American Psychological Association were to approach BIID in the same way it approaches the treatment of GID, then it and other mental health professionals would encourage their patients to schedule appointments with surgeons to remove healthy limbs. Yet, given the very few instances where BIID amputations have been performed,<sup>84</sup> it seems that the medical establishment does not believe it constitutes sound medical judgment to perform an amputation on a physically whole person, even if the patient desires to be an amputee.

It seems inconsistent with other treatment modalities to foster a client's version of reality that is inconsistent with actual reality, the actual reality being the biological facts; additionally, an effort to help the patient is also inconsistent when it fosters that belief with a hormone regimen or major surgery that fails to treat the root issues of the mental distress. Thus, there are other professionals who take the position that GID patients should be treated with psychotherapy rather than hormones and surgery.<sup>85</sup> Significantly, even those professionals who advocate the use of hormones or surgery believe that psychotherapy is an important part of treatment.<sup>86</sup>

This other approach is justified for several reasons. First, and perhaps most obvious, is the perspective that gender is an immutable trait, is binary

82. Michael B. First, *Desire for Amputation of a Limb: Paraphilia, Psychosis, or a New Type of Identity Disorder*, 35 *PSYCHOL. MED.* 919, 926–27 (2005), available at <http://www.biid-info.org/images/d/d8/Desire-for-amputation-of-a-limb.pdf>.

83. *Id.* at 926.

84. *Id.* at 919 (observing that seventeen percent of subjects had an arm or leg amputated with one-third obtaining the amputation through a doctor); see also Mo Costandi, *The Science and Ethics of Voluntary Amputation*, *NEUROPHILOSOPHY* (May 30, 2012), <http://www.guardian.co.uk/science/neurophilosophy/2012/may/30/1> (describing how a doctor's decision to perform voluntary amputations was deemed an "inappropriate" medical procedure).

85. McHugh, *supra* note 62.

86. WPATH Standards of Care, *supra* note 65, at 61 ("[I]t is recommended that these patients also have regular visits with a mental health or other medical professional.").

in nature, and coincides from birth with an individual's sex.<sup>87</sup> The Supreme Court has long held that sex is an immutable characteristic.<sup>88</sup> At birth, the sex of the child is determined by genes contained in two of the forty-six chromosomes in human cells, referred to as the "sex chromosomes."<sup>89</sup> Once a child is born, the child's family then develops and fosters a child's identity, including gender identity, by teaching the child gender-appropriate behavior. GID, therefore, is properly viewed as the result of one or more physiological problems, or a result of environmental factors influencing a person's perception of a particular gender.<sup>90</sup> Biologically, however, nothing is wrong with the person.

Second, the psychotherapy approach that seeks to align one's gender identity with biological sex avoids the medical risks associated with hormone use and sex-reassignment surgery, as well as the ethical risk of not being able to obtain informed consent from a patient with a mental disorder. Prolonged use of hormones to chemically change the body to appear more like the targeted gender have serious health risks.<sup>91</sup> These risks can include, among others, an increased likelihood of cardiovascular disease, stroke, deep vein thrombosis, pulmonary embolism, diabetes, elevated liver enzymes, sleep apnea, hypertension, and the destabilization of psychiatric disorders in patients who are bipolar or schizoaffective.<sup>92</sup> Hormone treatment also can negatively impact a patient's future ability to have children. As with any surgery, sex-reassignment surgery carries its own risks, including post-operative bleeding, hematoma, infection, hypertrophic scarring, and other risks associated with the attempt to alter

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87. Scripture also affirms the binary nature of sex. See *Genesis* 1:27 ("So God created mankind in his own image, in the image of God he created them; male and female he created them."); *Genesis* 5:2 ("He created them male and female, and blessed them. . . ."); *Mark* 10:6 ("But from the beginning of the creation, God 'made them male and female.'").

88. See, e.g., *Caban v. Mohammed*, 441 U.S. 380, 398 (1979); *Regents of Univ. of Cal. v. Bakke*, 438 U.S. 265, 360 (1978); *Craig v. Boren*, 429 U.S. 190, 212 n.2 (1976) (Stevens, J., concurring).

89. See *Zakaria*, *supra* note 60, at 352 (citing D. PETER SNUSTAD & MICHAEL J. SIMMONS, *PRINCIPLES OF GENETICS* 126, 137 (3d ed. 2003)).

90. K. J. Zucker, *Children with Gender Identity Disorder: Is There a Best Practice?*, 56 *NEUROPSYCHIATRIE DE L'ENFANCE ET DE L'ADOLESCENCE* 358, 363 (2008).

91. GENDER IDENTITY RESEARCH AND EDUCATION SOCIETY, *A GUIDE TO HORMONE THERAPY FOR TRANS PEOPLE* 10–12 (2007), available at <http://www.gires.org.uk/assets/DOH-Assets/pdf/doh-hormone-therapy.pdf>.

92. *Id.*; see also *WPATH Standards of Care*, *supra* note 65, at 40.

genitalia.<sup>93</sup> Both hormone treatment and sex-reassignment surgery may irrevocably transform the body, which has serious implications for GID patients who later report regret for having chosen this treatment approach.<sup>94</sup> In addition, while informed consent is recognized as professionally necessary in order to expose a GID patient to the serious risks associated with hormones or surgery,<sup>95</sup> questions arise about the ability to obtain informed consent for surgery to alter one's physical characteristics from a person who is suffering from a mental disorder concerning his gender identity.

Third, statistics demonstrate that most children, and a small number of adults, diagnosed with GID eventually become "comfortable with their natal gender."<sup>96</sup> While there is little research into whether successful therapy is the cause for the patient eventually accepting a gender identity that is consistent with his biological sex,<sup>97</sup> the phenomenon itself implies that GID is a mental disorder in need of psychotherapy rather than hormones and surgery to alter one's physical characteristics.

The fourth rationale for the therapy-only approach is that in the absence of solid medical evidence concerning the causes of and effective treatment modalities for GID, medical professionals should take the approach that is consistent with their ethical obligation to do no harm. Psychotherapy is the only alternative that does not *harm* an individual who *may actually be* mentally impaired. If GID is a disorder, the only professional way to deal with it is to attempt to *fix* the problem. Barring clear evidence that GID is *not* a mental disorder, discretion would advise that a conservative approach that does not increase the health risks of a patient is the responsible choice.<sup>98</sup>

When the GID patient is a prisoner, the treatment options are more complicated. Given the debate surrounding the proper treatment of GID, a key question in the litigation by prisoners who have alleged deliberate indifference to serious medical needs has been whether the prison's chosen

93. CAMERON BOWMAN & JOSHUA GOLDBERG, CARE OF THE PATIENT UNDERGOING SEX REASSIGNMENT SURGERY (SRS) 11–14, 23–26 (2006), available at <http://transhealth.vch.ca/resources/library/tcpdocs/guidelines-surgery.pdf>.

94. See Stig-Eric Olsson & Anders Möller, *Regret After Sex Reassignment Surgery in a Male-to-Female Transsexual: A Long-Term Follow-Up*, 35 ARCHIVES OF SEXUAL BEHAVIOR 501, 501 (2006).

95. WPATH Standards of Care, *supra* note 65, at 24.

96. Byne et al., *supra* note 63, at 763.

97. *Id.* at 771–72.

98. Cf. McHugh, *supra* note 62.



method of treatment constituted deliberate indifference. In Wisconsin, the Seventh Circuit Court of Appeals directed the prison officials to provide hormones or sex-reassignment surgery to prisoners.<sup>99</sup> In Massachusetts, a federal district court held that the Eighth Amendment required the state to pay for a prisoner's sex-reassignment surgery.<sup>100</sup>

### III. EXPLORING WHETHER THE EIGHTH AMENDMENT REQUIRES PRISON OFFICIALS TO PROVIDE HORMONES OR SEX-REASSIGNMENT SURGERY TO PRISONERS WITH GID

#### A. *The Seventh Circuit Court of Appeals Concluded That a Complete Ban on Providing Hormones to Prisoners with GID Violated the Eighth Amendment.*

In an effort to prevent taxpayer funding of hormone therapy or sex-reassignment surgery for prison inmates, Wisconsin passed the Inmate Sex Change Prevention Act in 2005.<sup>101</sup> Prior to the Act, the Department of Corrections ("DOC") permitted prison officials to provide hormones to GID prisoners but would not provide sex-reassignment surgery.<sup>102</sup> All three plaintiffs had been receiving hormones prior to the Act's passage.<sup>103</sup> After the passage of the Act, but prior to its effective date, the DOC began tapering plaintiffs off their hormones in order to be in compliance with the Act on its effective date of January 24, 2006.<sup>104</sup> Alleging violations of the Eighth and Fourteenth Amendments to the U.S. Constitution, the plaintiffs filed suit, requesting a preliminary injunction.<sup>105</sup> The Eighth Amendment claim was premised on refusal to provide hormones and the failure to provide an individualized assessment of whether hormones are appropriate

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

100. *Kosilek v. Spencer*, No. 00-12455-MLW, 2012 WL 3799660 (D. Mass. Sept. 4, 2012).

101. *Id.* at 552–53.

102. *Fields v. Smith*, 712 F. Supp. 2d 830, 850 n.5. (E.D. Wis. 2010).

103. *Id.* at 863.

104. Second Amended Complaint for Declaratory and Injunctive Relief at 1, 8, *Fields v. Smith*, 712 F. Supp. 2d 830 (E.D. Wis. 2010) (No. 06-C-112); *Sundstrom v. Frank*, 630 F. Supp. 2d 974, 977 (E.D. Wis. 2007).

105. *Id.*

for each prisoner.<sup>106</sup> The court granted a preliminary injunction prohibiting the withdrawal of hormone therapy.<sup>107</sup>

Plaintiffs Andrea Fields, Matthew Davison, and Vankemah Moaton are all male-to-female transsexuals who were prisoners in a Wisconsin correctional facility at the time of the lawsuit.<sup>108</sup> All of the plaintiffs were diagnosed with GID and were provided hormones prior to passage of the Act.<sup>109</sup> After the DOC began tapering plaintiffs off the hormones, the plaintiffs alleged that they experienced various symptoms, including nausea, muscle weakness, increased facial and chest hair, breast reduction, mood swings, and depression.<sup>110</sup> After the district court granted a preliminary injunction, and when the plaintiffs began receiving cross-gender hormones again, their symptoms subsided.<sup>111</sup>

Although the plaintiffs may have experienced short-term side effects as the state reduced and then eliminated the hormones, medical professionals actually disagree as to the long-term consequences of taking someone off hormones. For example, in *Barnhill v. Cheery*,<sup>112</sup> the GID prisoner alleged that he suffered a variety of negative side effects following the prison's refusal to continue his hormones.<sup>113</sup> Dr. Do, a medical doctor with twenty-six years of experience, testified that in that case "[i]t is unreasonable to believe that [the plaintiff] is currently suffering any physical withdrawal symptoms as a result of his not being prescribed female hormones' because '[t]he physical effects of exogenous estrogen or other female hormones do not reside in the system for years.'"<sup>114</sup>

According to the district and circuit court decisions in *Fields*, the state did not defend the law on the grounds that hormones and sex-reassignment surgery were improper treatment options for GID. Rather, the state argued that (1) the state did not violate the Eighth Amendment when it refused to

106. *Fields*, 712 F. Supp. 2d at 834.

107. *Id.* at 835; *see also Sundstrom*, 630 F. Supp. 2d at 977. The initial lawsuit included Kari Sundstrom and Lindsey Blackwell. They were dismissed from the lawsuit in October of 2007 because they were released from prison. *Fields*, 712 F. Supp. 2d at 834 n.1.

108. *Id.* at 835.

109. *Id.*

110. *Id.*

111. *Id.*

112. *Barnhill v. Cheery*, No. 8:06-CV-922-T-23TGW, 2008 WL 759322 (M.D. Fla. March 20, 2008).

113. *Id.* at \*2.

114. *Id.* at \*3.

provide a specific form of treatment desired by the prisoner,<sup>115</sup> and (2) it has legitimate safety and security concerns for passing the Act.<sup>116</sup> Because the state “did not produce any evidence that another treatment could be an adequate replacement for hormone therapy,”<sup>117</sup> the state doomed its argument that the court should defer to the state’s decision not to provide hormones or sex-reassignment surgery.

With respect to the alleged security concern, the plaintiffs in *Fields* argued that the Act did not advance the state’s interests in prison safety.<sup>118</sup> Generally, prison administrators are given “wide-ranging deference in the adoption and execution of policies and practices that in their judgment are needed to preserve internal order and discipline and to maintain institutional security.”<sup>119</sup> That deference is afforded unless the actions are “taken in bad faith and for no legitimate purpose.”<sup>120</sup> The primary security concern that relates to GID prisoners is the problems caused as a result of sexual activity among inmates, which can result in volatile and dangerous conditions.<sup>121</sup>

In *Fields*, the state’s security expert testified that the more feminine a male prisoner becomes the more likely it becomes that he will be a victim of sexual assault by fellow prisoners.<sup>122</sup> The same expert, however, also testified that a prison he worked for in another state was able to manage security concerns raised by men who were receiving feminizing hormones.<sup>123</sup> In concluding that the state’s security concerns were insufficient to overcome the plaintiffs’ claims, the district court found that,

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115. *Fields v. Smith*, 653 F.3d 550, 554–55 (7th Cir. 2011).

116. *Id.*

117. *Id.* at 556.

118. *Id.* at 557.

119. *Id.* at 557–58 (quoting *Whitley v. Albers*, 475 U.S. 312, 321–22 (1986)).

120. *Id.* at 558 (quoting *Whitley*, 475 U.S. at 322).

121. *Fields v. Smith*, 712 F. Supp. 2d 830, 868 (E.D. Wis. 2010).

122. *Fields*, 653 F.3d at 557. The National Center for Lesbian Rights understands the increased safety risk, stating that housing inmates who have not had sex-reassignment surgery, based on their birth sex regardless of how they have lived or how much treatment they have undergone puts male to female transsexuals at great risk of sexual violence. *Rights of Transgendered Prisoners*, NATIONAL CENTER FOR LESBIAN RIGHTS 1 (June 2006), available at <http://www.nclrights.org/site/DocServer/RightsOfTransgenderPrisoners.pdf?docID=6381>. Some propose that prisons should place men who are taking feminizing hormones in the female prison population. E.g., Darren Rosenblum, “Trapped” in *Sing Sing: Transgendered Prisoners Caught in the Gender Binarism*, 6 MICH. J. GENDER & L. 499, 531 (2000).

123. *Fields*, 712 F. Supp. 2d at 868.

although one of the plaintiffs had been sexually assaulted while receiving hormones in prison, there was nothing in the record to indicate he would not have otherwise been the victim of sexual assault.<sup>124</sup> The Seventh Circuit affirmed the district court's conclusion as to the security concern.<sup>125</sup> By order dated August 5, 2011, the Seventh Circuit affirmed the district court's grant of a permanent injunction preventing implementation of the Act.<sup>126</sup> Specifically, the district court restrained the state and prison officials from enforcing or attempting to enforce the provisions of the Act that place a complete ban on the provision of cross-gender hormones.<sup>127</sup>

*B. A Federal Judge in Massachusetts Is the First to Order a State to Pay for a Prisoner with GID to Receive a Sex-Reassignment Surgery.*<sup>128</sup>

Robert Kosilek, who prefers to be called Michelle, is a male-to-female transsexual prisoner housed in a state prison in Massachusetts.<sup>129</sup> He brought suit, asking that the state be required to pay for his transition from male to female.<sup>130</sup> After more than a decade of litigation and at least five publicly available opinions by the district and circuit court of appeals, on September 4, 2012, a federal district judge in Massachusetts became the first judge in the nation to order a prison to provide a sex-reassignment surgery for one of its prisoners.<sup>131</sup>

Kosilek was convicted in 1992 of murdering his wife and sentenced to life in prison without parole.<sup>132</sup> Prior to meeting his wife, Kosilek had taken female hormones, which had made him feel "normal" for the first time in

124. *Id.*

125. *Fields*, 653 F.3d at 558. Plaintiffs separately claimed in *Fields* that the state's categorical ban on providing hormones or sex-reassignment surgery violated the Equal Protection Clause of the Fourteenth Amendment. *Fields*, 712 F. Supp. 2d at 867. Although the district court held that the Act violated the Fourteenth Amendment, the Seventh Circuit declined to reach the issue. *Fields*, 653 F.3d at 559.

126. *Id.*

127. *Fields*, 712 F. Supp. 2d at 869.

128. *Kosilek v. Spencer*, No. 00-12455-MLW, 2012 WL 3799660 (D. Mass. Sept. 4, 2012).

129. *Id.* at \*1.

130. *Id.*

131. *Id.* at \*53; see also Pauline Kim, *Massachusetts Judge Rules for Inmate's Sex-Change Surgery*, CNN HEALTH (Sep. 6, 2012), <http://www.cnn.com/2012/09/04/health/massachusetts-sex-change-surgery-inmate/index.html>.

132. *Kosilek*, 2012 WL 3799660, at \*1.

his life.<sup>133</sup> The trial testimony revealed that Kosilek regularly was abused by his grandfather and, when Kosilek announced his desire to live as a girl, was stabbed by his stepfather.<sup>134</sup> Kosilek eventually obtained female hormones from a doctor in exchange for sex.<sup>135</sup>

While in a drug rehabilitation facility, Kosilek met his wife, Cheryl McCaul, who was a volunteer at the facility.<sup>136</sup> McCaul convinced Kosilek that his transsexualism “would be cured by ‘a good woman.’”<sup>137</sup> Unfortunately, during his marriage his distress over gender identity continued.<sup>138</sup> In 1990, after McCaul became angry when she discovered Kosilek wearing McCaul’s clothing, Kosilek murdered her.<sup>139</sup> While awaiting trial for murder, he began taking female hormones in the form of birth control pills that a guard illegally provided to Kosilek.<sup>140</sup> Prior to his trial, the county sheriff denied Kosilek any treatment for his gender identity disorder.<sup>141</sup> Kosilek then twice attempted suicide and once attempted to castrate himself.<sup>142</sup> After his conviction, Kosilek began “living like a woman,” and changed his name to Michelle.<sup>143</sup>

While Kosilek was in prison, doctors under contract with the DOC diagnosed Kosilek with GID and prescribed hormones and, possibly, sex-reassignment surgery.<sup>144</sup> At that time, the DOC’s policy presumptively permitted prisoners to obtain hormones if the prisoner had been prescribed hormones prior to entering the prison facility, but it only allowed an increase or decrease in treatment if it was determined to be medically necessary and approved by both the Director of the Department of Health Services Division and the Commissioner.<sup>145</sup> GID was the only medical condition that required DOC doctors to obtain the Commissioner’s

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133. *Kosilek v. Malone*, 221 F. Supp. 2d 156, 163–64 (D. Mass. 2002).

134. *Id.* at 163.

135. *Id.*

136. *Id.* at 164.

137. *Id.*

138. *Kosilek v. Spencer*, No. 00-12455-MLW, 2012 WL 3799660, at \*17 (D. Mass. Sept. 4, 2012).

139. *Id.*

140. *Id.* at \*18.

141. *Id.*

142. *Id.*

143. *Id.*

144. *Id.* at \*19.

145. *Id.* at \*22.

approval to provide treatment that doctors found to be medically necessary.<sup>146</sup> After the DOC failed to provide Kosilek with the prescribed hormones, because he had not been receiving them prior to incarceration, he filed suit asserting an Eighth Amendment claim.<sup>147</sup>

In 2002, the federal district court concluded that Kosilek had a serious medical need and had been denied adequate medical care.<sup>148</sup> The court, however, did not order the DOC to provide hormones.<sup>149</sup> Instead, the court issued an opinion explaining that Kosilek must be provided hormones unless the DOC concludes, in good faith, that it could not discharge its duty to protect the safety of its inmates.<sup>150</sup> The court specifically cautioned the DOC that it would constitute an Eighth Amendment violation if the hormones, and possibly sex-reassignment surgery, were denied as a result of costs or potential public controversy.<sup>151</sup> After the decision, doctors engaged a GID specialist to evaluate Kosilek.<sup>152</sup>

Pursuant to the Harry Benjamin *Standards of Care*, the doctor recommended that Kosilek be provided estrogen therapy, electrolysis to remove facial hair, and access to female clothing and makeup.<sup>153</sup> The doctor specifically mentioned that after a year of treatment with hormones and living as a female, Kosilek should be assessed for the possibility of sex-reassignment surgery.<sup>154</sup>

The DOC asked the superintendent of the prison where Kosilek was housed to prepare a written report as to whether it would create any security risks to provide hormones to Kosilek.<sup>155</sup> Specifically, the DOC was concerned that a security risk existed in light of the large population of sex offenders in the prison system.<sup>156</sup> The superintendent's report concluded that providing hormones would not present a security risk but that the risk

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146. *Id.*

147. *Id.* at \*2, \*21.

148. *Id.* at \*5.

149. *Id.*

150. *Id.*

151. *Id.*

152. *Id.* at \*6.

153. *Id.* at \*22.

154. *Id.* at \*23.

155. *Id.*

156. *Id.*

would need to be reevaluated once Kosilek began to experience physical changes from the hormone treatment.<sup>157</sup>

In August 2003, Kosilek began taking estrogen hormones and, in October 2003, he began wearing female undergarments.<sup>158</sup> In December 2003, a new Commissioner, Ms. Dennehy, took office.<sup>159</sup> Dennehy had played an integral role as part of the DOC's prior efforts to prevent Kosilek from receiving hormones for his GID.<sup>160</sup> Before she would consider approving laser hair removal or any additional steps toward sex-reassignment surgery, Dennehy ordered a reevaluation of Kosilek.<sup>161</sup>

In September 2004, Kosilek had been taking hormones for a year and was due for an evaluation for possible sex-reassignment surgery.<sup>162</sup> Rather than use doctors identified by the University of Massachusetts Correctional Health Program, which was under contract with the DOC to provide medical services to prison inmates, Dennehy commissioned another expert to evaluate Kosilek.<sup>163</sup> Dennehy selected an individual who was working with two other states that also did not believe sex-reassignment surgery should be provided to prisoners with GID.<sup>164</sup>

In the meantime, the doctors retained from University of Massachusetts issued their report.<sup>165</sup> The doctors concluded that Kosilek had demonstrated an ability to live as a female in a male prison while taking the prescribed hormones.<sup>166</sup> Nevertheless, Kosilek "continued to be 'quite distressed' about his male anatomy."<sup>167</sup> They opined that "given her previous suicide attempts, her ongoing distress, and the lack of other goals in her life, it is quite likely that [Kosilek] will attempt suicide again if she is not able to change her anatomy."<sup>168</sup> The doctors recommended that Kosilek have sex-reassignment surgery.<sup>169</sup> The court opinion makes clear that DOC officials

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157. *Id.*

158. *Id.*

159. *Id.* at \*6.

160. *Id.*

161. *Id.* at \*24.

162. *Id.*

163. *Id.*

164. *Id.*

165. *Id.*

166. *Id.*

167. *Id.*

168. *Id.*

169. *Id.*

did not believe that the Department should be required to pay for an inmate's sex-reassignment surgery and that they did not want to be the first in the nation to pay for sex-reassignment surgery for a prisoner.<sup>170</sup>

The key legal question in *Kosilek* was whether the failure to provide sex-reassignment surgery violated the Eighth Amendment prohibition against cruel and unusual punishment.<sup>171</sup> The district court heard conflicting testimony about the proper course of treatment for GID.<sup>172</sup> The position in support of treating GID with hormones and sex-reassignment surgery was based primarily on the *Standards of Care* established by Harry Benjamin and adopted by WPATH.<sup>173</sup> As discussed previously, those standards establish a triadic sequence of hormones, real-life experience living as a member of the opposite-sex, and sex-reassignment surgery.<sup>174</sup> The *Standards of Care* are based on the premise that sex-reassignment surgery "is not 'experimental, investigational, elective, cosmetic,' or optional in any meaningful sense."<sup>175</sup>

The state offered expert testimony from Dr. Schmidt, who believed that the proper course of treatment for GID is psychotherapy and antidepressants.<sup>176</sup> Describing Dr. Schmidt as an imprudent professional, the court rejected his testimony, concluding that Dr. Schmidt's approach is not "aimed at curing the mental illness," but rather is designed to simply "manag[e] the symptoms of that illness to reduce the intensity of the suffering and the risk of suicide."<sup>177</sup> In other words, the court accepted the viewpoint that providing hormones and sex-reassignment surgery to align one's biological sex with one's perception of reality is aimed at "curing" the patient, whereas providing psychotherapy in an attempt to discover root causes to the intense desire to live inconsistently with one's biological sex is unprofessional conduct. The district court ordered the DOC to provide sex-reassignment surgery.<sup>178</sup>

170. *Id.* at \*23.

171. *Id.* at \*2.

172. *Id.* at \*35 n.12.

173. *Id.* at \*35–37.

174. *See id.* at \*36; *see also supra* notes 65–69 and accompanying text.

175. *Id.* at \*36.

176. *Id.* at \*38.

177. *Id.*

178. *Id.* at \*53. The court did not order DOC to transfer *Kosilek* to a female facility after the surgery. Instead, the court explained that the DOC "has the discretion to make good



C. *A Federal District Court Upholds a Policy That Prohibits Hormones Except in a Limited Set of Circumstances.*<sup>179</sup>

Texas adopted yet another approach to treatment of GID prisoners. A health care policy for the correctional system in Texas prohibits prison officials from providing hormones to transsexual patients unless the prisoner meets specific, limited criteria. The prisoner must (1) have a confirmed parole or discharge date of no more than 180 days from the date that the prisoner requests hormones, (2) demonstrate that he will receive sex-reassignment surgery immediately upon discharge, and (3) provide letters from a “free world physician and psychiatrist/psychologist” stating that the prisoner has been on hormone therapy and intends to have sex-reassignment surgery.<sup>180</sup> Those who do not satisfy the conditions, however, are still eligible to receive mental health treatment.<sup>181</sup>

After the prison refused to provide plaintiff, Allen Young, with feminizing hormones, he brought suit alleging an Eighth Amendment violation. The medical professionals in the prison concluded that Mr. Young suffered from GID but that he did not satisfy the criteria to receive hormones. In particular, the plaintiff did not have a confirmed release date within 180 days and did not provide a physician’s letter stating that he had been taking hormones and planned to have sex-reassignment surgery immediately upon discharge.<sup>182</sup> In lieu of hormones, Mr. Young was referred for mental health counseling.<sup>183</sup>

The court reviewed prior case law from the circuit courts, finding that “[n]ot a single decision, however, mandates hormone therapy. The manner of treatment is within the discretion of the prison.”<sup>184</sup> Because *Kosilek* had not yet been decided, the court did not factor that case into its decision. The court concluded that the defendants had not been deliberately indifferent to Mr. Young’s medical needs and that the policy was reasonable and supported by legitimate penological interests.<sup>185</sup> Thus, the court upheld a

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faith, reasonable decisions concerning security if the surgery genuinely creates or increases any risk to Kosilek or others.” *Id.* at \*54.

179. *Young v. Univ. of Tex. Med. Branch Corr. Health Care*, No. 6:11CV363, 2012 WL 262983 (E.D. Tex. Jan. 11, 2012), *aff’d*, 2012 WL 262617 (E.D. Tex. Jan. 30, 2012).

180. *Id.* at \*9.

181. *Id.* at \*15.

182. *Id.* at \*9.

183. *Id.* at \*15.

184. *Id.* at \*14.

185. *Id.* at \*15.

policy that prohibited prison officials from providing cross-gender hormones except in a very limited set of circumstances.

*D. A Federal District Court in Virginia Upholds a Decision Not to Provide Sex-Reassignment Surgery.*<sup>186</sup>

A federal district court in Virginia upheld Virginia's decision not to provide sex-reassignment surgery. In *De'Lonta*, Michael Stokes brought an Eighth Amendment claim against the Virginia Department of Corrections ("VDOC") for its refusal to provide Stokes with sex-reassignment surgery.<sup>187</sup> Stokes was diagnosed with GID and identified as a pre-operative transsexual female.<sup>188</sup> VDOC had provided him with hormones for four years before this current lawsuit was filed.<sup>189</sup> While he was in prison, the VDOC implemented a policy prohibiting prison officials from providing hormones or sex-reassignment surgery to its prisoners.<sup>190</sup> Stokes challenged that policy in court, which resulted in a settlement between the parties to provide Stokes cross-gender hormones.

Prior to Stokes's second lawsuit, Stokes had lived as a female in the male correctional facility for more than a year by dressing and living as a woman.<sup>191</sup> Stokes, however, alleged that because VDOC would not provide sex-reassignment surgery, the distress from the GID made him want to castrate himself.<sup>192</sup> He claimed that Virginia's refusal to provide sex-reassignment surgery constituted a denial of adequate medical care and placed him at a substantial risk of serious medical harm.<sup>193</sup>

The district court dismissed the Eighth Amendment claim because Mr. Stokes had received medical care, albeit not the sex-reassignment surgery he desired. Citing a Seventh Circuit decision, the court explained that "[a]

186. *De'Lonta v. Johnson*, No. 7:11-CV-00257, 2011 WL 5157262 (W.D. Va. Oct. 28, 2011), *rev'd*, 2013 WL 310350 (4th Cir. Jan. 28, 2013) (concluding that *De'Lonta* had stated a claim for relief but refusing to suggest whether he would succeed on the merits or be entitled to any particular remedy).

187. *De'Lonta*, 2011 WL 5157262, at \*1. He separately alleged that it constituted a Fourteenth Amendment equal protection violation to deny his request to be housed in the female facility. *Id.* at \*3.

188. *Id.*

189. *Id.* at \*2.

190. *Id.* at \*3.

191. *Id.*

192. *Id.*

193. *Id.*

prison is not required by the Eighth Amendment to give a prisoner medical care that is as good as he would receive if he were a free person, let alone an affluent free person. He is entitled only to minimum care. . . . Withholding from a prisoner an esoteric medical treatment that only the wealthy can afford does not strike us as a form of cruel and unusual punishment.”<sup>194</sup> The court held that VDOC was not deliberately indifferent to Mr. Stokes’ medical needs. Rather, he had received treatment and his “dissatisfaction with the progress or choice of treatment” did not state an Eighth Amendment claim.<sup>195</sup>

As the various court decisions highlight, there is no consensus as to the proper course of treatment for GID or, more particularly, whether a state’s decision to pursue one course of treatment over another constitutes an Eighth Amendment violation.

#### IV. HAVING TAKEN SIDES IN AN ONGOING POLICY, IDEOLOGICAL, AND MEDICAL CONTROVERSY, THE COURTS HAVE IMPROPERLY INTERFERED WITH THE DISCRETION OF PRISON OFFICIALS TO CHOOSE AMONG TREATMENT ALTERNATIVES FOR GID PRISONERS.

The courts that have ordered states to provide hormone or sex-reassignment surgery have taken sides in an ongoing cultural controversy and, as a result, have crossed the line from neutral arbiter of the law to policy maker.<sup>196</sup> In a 1992 article, Dr. Paul McHugh explained that he

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194. *Id.* at \*5 (quoting *Maggert v. Hanks*, 131 F.3d 670, 671 (7th Cir. 1997)). The Seventh Circuit in *Fields* disagreed with its prior decision in *Maggert*, stating that the cost of hormones and sex-reassignment surgery had declined since the late 1990s when *Maggert* was decided. *Fields v. Smith*, 653 F.3d 550, 555–56 (7th Cir. 2011). The court in *Fields* explained that hormones cost between \$300–\$1,000 per inmate, per year, and that sex-reassignment surgery could be performed for approximately \$20,000. *Id.* at 555. The court pointed out that surgeries for coronary bypass or kidney transplant were more expensive, and yet, the department of corrections had paid for those surgeries. *Id.* at 555–56. Comparing the cost of cross-gender hormones and sex-reassignment surgery to that of a heart bypass begs the underlying question of the proper course of treatment for GID. If it is considered a mental disorder that can be effectively treated through psychotherapy, then it is not comparable to heart bypass or kidney transplant.

195. *De'Lonta*, 2011 WL 5157262, at \*6.

196. *Cf. Lawrence v. Texas*, 539 U.S. 558, 602 (2003) (Scalia, J., dissenting). In *Lawrence*, Justice Scalia states that the Court’s opinion to overrule prior precedent and declare unconstitutional Texas’s anti-sodomy law “is the product of a Court, which is the product of a law-profession culture, that has largely signed on to the so-called homosexual agenda, by

cautions his psychiatry students at The Johns Hopkins University School of Medicine about “the power of cultural fashion to lead psychiatric thought and practice off in false, eve[n] disastrous, directions.”<sup>197</sup> He maintains that one of those missteps concerns the medical profession’s response to the demand by GID patients for sex-reassignment surgery.

Dr. McHugh’s statements are particularly relevant given that Johns Hopkins was one of the first hospitals to perform sex-reassignment surgery.<sup>198</sup> When Dr. McHugh became director at Johns Hopkins School of Medicine in 1975, he made it a priority to no longer perform the surgeries.<sup>199</sup> After studying patients with GID who had sought or received sex-reassignment surgery, the decision was made to no longer perform these surgeries.<sup>200</sup> Through his research, Dr. McHugh found that sex-reassignment surgery had not cured the patients because it had not treated

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which I mean the agenda promoted by some homosexual activists directed at eliminating the moral opprobrium that has traditionally attached to homosexual conduct.” *Id.*

197. Paul R. McHugh, *Psychiatric Misadventures*, THE AMERICAN SCHOLAR 497–510, at Part III (Autumn 1992), available at <http://www.lhup.edu/~dsimanek/mchugh.htm>. Although Dr. McHugh does not address it as another psychiatric misstep, the declassification of homosexuality as a mental disorder in order to appease various social and advocacy groups, has led to alarming consequences. For example, in September 2012, California passed a law that prohibits licensed mental health professionals from providing any counseling to a minor for the purpose of discouraging a person’s chosen sexual orientation. Pursuant to the California law, the counseling has been deemed harmful and, therefore, parents have been stripped of the right to consent to medical treatment on behalf of their children. See S.B. 1172, 2012 Leg., 2011–2012 Sess. (Cal. 2012) (to be codified at CAL. BUS. & PROF. CODE § 865).

198. See McHugh, *supra* note 62.

199. *Id.*

200. *Id.* He concluded his article by stating that the medical profession had “wasted scientific and technical resources and damaged our professional credibility by collaborating with madness [of changing one’s sex through surgery in order to discover one’s true identity] rather than trying to study, cure, and ultimately prevent it.” *Id.*

the underlying causes that had manifested themselves as GID.<sup>201</sup> Similarly, many other hospitals stopped performing the surgeries.<sup>202</sup>

The American Psychological Association has admitted that the American Psychiatric Association declassified homosexuality as a mental disorder based on emerging, not established, science and the public pressure to help alleviate discrimination based on sexual orientation; Dr. McHugh points out that those who advocated for sex-reassignment surgery were similarly swept away by prevailing cultural fashion.<sup>203</sup>

The zeal for this sex-change surgery—perhaps, with the exception of frontal lobotomy, the most radical therapy ever encouraged by twentieth century psychiatrists—did not derive from critical reasoning or thoughtful assessments. These were so faulty that no one holds them up anymore as standards for launching any therapeutic exercise, let alone one so ir retrievable as a sex-change operation. The energy came from the fashions of the seventies that invaded the clinic—if you can do it and he wants it, why not do it? It was all tied up with the spirit of doing your thing, following your bliss, an aesthetic that sees diversity as everything and can accept any idea, including that of permanent sex change, as interesting and that views resistance to such ideas as uptight if not oppressive.<sup>204</sup>

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201. *Id.* Even the APA Task Force on Gender Identity and Gender Variance pointed out that “[c]oexisting psychiatric conditions occur frequently among children referred for clinical evaluation.” 2008 GENDER IDENTITY TASK FORCE REPORT, *supra* note 56, at 47. In other words, there are underlying problems manifesting themselves in a variety of ways, including as GID. The APA, however, did not acknowledge that GID is the manifestation of issues that need resolving. Rather, the APA takes the position that GID itself can be cured by changing one’s sex characteristics. *Id.* at 32.

202. See McHugh, *supra* note 62. Dr. McHugh’s conclusions are bolstered by a study published in 2011 that followed postoperative transsexuals in Sweden and found many had continued health and psychological issues even after surgery, including higher rates of suicide. See Travis Wright Colopy, *Setting Gender Identity Free: Expanding Treatment for Transsexual Inmates*, 22 HEALTH MATRIX 227, 266 (2012) (discussing study by Cecilia Dhejne et al., *Long-Term Follow-Up of Transsexual Persons Undergoing Sex Reassignment Surgery: Cohort Study in Sweden*, PLOS ONE (Feb. 2011), <http://www.plosone.org/article/info:doi/10.1371/journal.pone.0016885>); see also Travis Cox, *Medically Necessary Treatments for Transgender Prisoners and the Misguided Law in Wisconsin*, 24 WISC. J.L. GENDER & SOC’Y 341, 365 (2009) (discussing dissatisfaction of post-operative patients).

203. McHugh, *supra* note 197, at Part III.

204. *Id.*

Rather than performing surgery to remove or alter body parts, Dr. McHugh believes that the licensed mental health professionals must “learn how to manage this condition as a mental disorder when we fail to prevent it.”<sup>205</sup> For those physicians who recommend sex-reassignment surgery, he stated that they have “abandon[ed] the role of protecting patients from their symptoms and become little more than technicians working on behalf of a cultural force.”<sup>206</sup>

Outside the context of Eighth Amendment prisoner cases, the courts are also divided on whether a person’s sex is determined at birth or whether it can be changed by surgery. A 1976 decision by a New Jersey intermediate appellate court concluded that a man who had undergone a male-to-female sex-reassignment surgery should be treated as a woman for purposes of a marriage license.<sup>207</sup> As a result of the court decision, M.T., who had been born a male, was deemed a female and, therefore, permitted to marry a man.

Conversely, a Texas Court of Appeals in 1999 rejected the *M.T.* reasoning, concluding that biology determined one’s sex.<sup>208</sup> After pointing out its belief that the legislature could determine whether someone who undergoes a sex change surgery should be legally treated as having changed his sex, the court held that because “male chromosomes do not change with either hormonal treatment or sex reassignment surgery. . . . [A] post-operative female transsexual is still a male.”<sup>209</sup> In reaching its decision, the *Littleton* court pointed out that an Ohio court had reached a similar decision in 1987 in determining for probate purposes that a male who became a post-operative female was not validly married to another male.<sup>210</sup>

Adopting the reasoning of *Littleton*, in 2004, a Florida Court of Appeals declared a marriage void that had been entered into between a biological female and a biological female who had undergone a female-to-male sex reassignment.<sup>211</sup> In the context of a custody dispute, the wife and birth mother claimed the marriage was void. The court of appeals agreed with

205. *Id.*

206. *Id.*

207. *M.T. v. J.T.*, 355 A.2d 204, 210–11 (N.J. Super. Ct. App. Div. 1976)

208. *Littleton v. Prange*, 9 S.W.3d 223 (Tex. App. 1999).

209. *Id.* at 230.

210. *Id.* at 228 (citing *In re Ladrach*, 513 N.E.2d 828, 832 (Ohio Prob. Ct. 1987) (“[A] person’s sex is determined at birth by an anatomical examination by the birth attendant.”)).

211. *Kantaras v. Kantaras*, 884 So. 2d 155, 161 (Fla. Dist. Ct. App. 2004).

her, concluding that sex is determined at birth and, therefore, the marriage between two women was void.<sup>212</sup>

The idea that people can change their sex has led to some strange circumstances, including the headline *Thomas Beatie, The 'Pregnant Man,' Wants A Fourth Child*.<sup>213</sup> Thomas Beatie was born female, underwent partial sex-reassignment surgery, married a woman, and eventually became pregnant. While Beatie was pregnant with her fourth child, she was attempting to divorce her wife.<sup>214</sup> The Arizona court hearing the divorce matter questioned whether Arizona could divorce the couple—Arizona prohibits same-sex marriage.<sup>215</sup>

The lack of clarity in the psychiatric and legal community about the immutability of gender, whether GID should be classified as a mental disorder, and, more importantly, what is the appropriate course of treatment for GID, prompted the *Psychiatric Times* to publish an article immediately after the *Kosilek* decision was issued. The article criticized the *Kosilek* decision as “foolishness” based on “psychiatric experts, who may again have led psychiatry down the slippery slope of diagnostic overreaching.”<sup>216</sup> Dr. Phillips highlighted the fact that there is ongoing controversy surrounding the proper diagnosis, label, and treatment of GID.<sup>217</sup> He explained that the DSM-5 workgroups, who have been working on changes to the DSM-IV, have been criticized for their decision to change Gender Identity Disorder to Gender Dysphoria in an alleged effort to remove social stigma attached to those with GID.<sup>218</sup> He characterized the current understanding about GID as one of “bewilderment over how to treat” it, highlighting that “as with other value-laden diagnoses, there is no

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212. *Id.*

213. Thomas Beatie, *The 'Pregnant Man,' Wants Fourth Child*, HUFFINGTON POST (Sept. 4, 2012, 5:19 PM), available at [http://www.huffingtonpost.com/2012/09/04/thomas-beatie-pregnant-man-fourth-child\\_n\\_1855318.html](http://www.huffingtonpost.com/2012/09/04/thomas-beatie-pregnant-man-fourth-child_n_1855318.html).

214. *Id.*

215. *Id.*; ARIZ. CONST. art. XXX.

216. James Phillips, *Gender Identity Disorder in Prison: Depending on a Diagnosis that is Soon to Disappear?*, PSYCHIATRIC TIMES (Sept. 28, 2012), <http://www.psychiatrictimes.com/genderdisorders/content/article/10168/2105073>. Dr. Phillips is an associate clinical professor of psychiatry at the Yale School of Medicine.

217. *Id.*

218. *Id.*

scientific way to decide whether GID or Gender Dysphoria is or is not a psychiatric illness."<sup>219</sup>

It is precisely the lack of clarity about GID, including its proper course of treatment, that should lead courts to affirm a state's decision not to provide hormone therapy or sex-reassignment surgery. Given that a prisoner does not state an Eighth Amendment claim by alleging that the prison failed to provide the treatment the prisoner prefers,<sup>220</sup> prisoners should not be able to demand injunctive relief requiring states to provide hormones or sex-reassignment surgery. A state's decision to treat GID prisoners with psychotherapy does not constitute a failure to treat with adequate medical care. As Dr. Phillips pointed out, the decision not to provide hormones or sex-reassignment surgery may be a failure to treat in a manner that is consistent with current politically driven agendas, but it is not failure to adhere to sound, professional medical judgment.

#### V. CONCLUSION

As with the American Psychiatric Association's 1973 decision to declassify homosexuality as a mental disorder, the recent push to declassify GID as a mental disorder has its roots in an ideologically driven agenda. In a 2009 task force report on Appropriate Therapeutic Responses to Sexual Orientation, the American Psychological Association reported that the decision to declassify homosexuality as a mental disorder in the DSM was based on "emerging scientific evidence and encouraged by the social movement for ending sexual orientation discrimination . . ."<sup>221</sup> In other words, the science did not then (or now) support the notion that

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<sup>219</sup>219. *Id.* Dr. Phillips also questioned the expert testimony offered in favor of Mr. Kosilek. "We can wonder, after psychiatry's disastrous experiences with homosexuality and the violent sexual predator statutes, why the plaintiff psychiatrists [Dr. Appelbaum and his colleagues] would allow themselves to be sucked into this morass of another dubious, value-driven, sex-related diagnosis? Does psychiatry need to look foolish one more time for its diagnostic overreaching?" *Id.*

<sup>220</sup>220. See *Chance v. Armstrong*, 143 F.3d 698, 703 (2d Cir. 1998); *Sanchez v. Vild*, 891 F.2d 240, 242 (9th Cir. 1989); *Lane v. Vinzant*, 657 F.2d 468, 473 (1st Cir. 1981); *Randall v. Wyrick*, 642 F.2d 304, 308 (8th Cir. 1981). Judge Posner, in *Maggert v. Hanks*, has also pointed out that "[w]ithholding from a prisoner an esoteric medical treatment that only the wealthy can afford does not strike us as a form of cruel and unusual punishment." *Maggert v. Hanks*, 131 F.3d 670, 672 (7th Cir. 1997).

<sup>221</sup>221. AM. PSYCHOLOGICAL ASS'N, REPORT OF THE AMERICAN PSYCHOLOGICAL ASSOCIATION TASK FORCE ON APPROPRIATE THERAPEUTIC RESPONSES TO SEXUAL ORIENTATION 11 (2009), available at <http://www.apa.org/pi/lgbt/resources/therapeutic-response.pdf>.



“homosexuality per se is not a mental disorder,”<sup>222</sup> but political ideologies drove the medical determination.

Similarly, the American Psychological Association’s report on gender identity and gender variance admits that there is not “sufficient research concerning many transgender issues to develop empirically based guidelines related to all important areas of practice . . . .”<sup>223</sup> Nevertheless, the APA adopts the view that one’s gender identity should be affirmed, even if it is not congruent with one’s biological sex, because of discrimination and stereotyping that is alleged to exist.<sup>224</sup> The ideologically driven agenda is demonstrated by the resolutions contained in the APA’s report on gender identity, where the organization states that mental health professionals “take a leadership role in working against discrimination toward transgender and gender-variant individuals,” including support for “civil marriage and all its attendant benefits, rights, privileges and responsibilities, regardless of gender identity or expression.”<sup>225</sup> Encouraging a particular course of treatment to assist the movement for civil marriage between any two persons, regardless of gender, is what Dr. McHugh refers to as “technicians working on behalf of a cultural force.”<sup>226</sup>

Hijacked by the same ideologically driven agenda, courts have expanded the Eighth Amendment beyond its intended scope to require states to provide hormones and even sex-reassignment surgery to prisoners who suffer such distress from the realities of their physical characteristics that they self-mutilate and attempt suicide. Common sense dictates that the proper course of treatment is to identify the underlying causes of the mental distress and treat those issues—not to humor the patient’s false sense of gender identity. Doctors do not humor the deathly malnourished anorexic who believes her mental distress will improve if she could simply lose more weight or the healthy individual whose strong desire to be an amputee leads to self-amputation; why, then, do treatment protocols exist that call for mental health professionals to alter an otherwise healthy body in order to align the existing characteristics with one’s perception of gender?

Playing God, courts are acting on the presumption that we are not all created male and female, but that we are created male, female, male who should be female, and female who should be male. As a result, courts have

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222. *Id.*

223. 2008 GENDER IDENTITY TASK FORCE REPORT, *supra* note 56, at 4.

224. *Id.* at 4, 65–66.

225. *Id.* at 66.

226. McHugh, *supra* note 197, at Part III.

begun to mandate that states pay for hormones and surgeries that indulge a prisoner's improper self-image. In the process, courts are taking sides in a public policy debate over the immutability of sex, gender, and gender identity. Not only are courts exceeding their authority in making such policy decisions, but they are complicit in requiring doctors to violate their obligation to "do no harm" when they order prisons to provide cross-gender hormones or sex-reassignment surgery.