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Transcending the Corporeal Prison: Eighth Amendment Jurisprudence, the Evolving Standard of Decency, and Sex Reassignment Surgery After *Kosilek v.* *Spencer*

Yini Zhang[†]

Introduction

On August 21, 2013, Judge Denise Lind sentenced Army intelligence analyst Bradley Manning to thirty-five years in prison,¹ thus ending the federal government's three-year prosecution of the individual behind one of the largest classified information leaks in U.S. history.² The next day, Manning made headlines again—not for the conviction, but for a statement read by Manning's lawyer on *The Today Show*.³ In that short statement, Manning announced: “I want everyone to know the

†. J.D. Candidate, University of Minnesota Law School, 2016. Many thanks to the editors and staff of *Law and Inequality: A Journal of Theory and Practice* for all the time and work put into reviewing and editing this Comment. Special thanks to Professor June Carbone for her guidance and suggestions throughout this process. Finally, thank you to my parents for teaching me the power of the written word.

1. Julie Tate, *Bradley Manning Sentenced to 35 Years in WikiLeaks Case*, WASH. POST (Aug. 21, 2013), http://www.washingtonpost.com/world/national-security/judge-to-sentence-bradley-manning-today/2013/08/20/85bee184-09d0-11e3-b87c-476db8ac34cd_story.html.

2. *Id.* Manning was arrested in May 2010 in Iraq. See Kevin Poulsen & Kim Zetter, *U.S. Intelligence Analyst Arrested in Wikileaks Video Probe*, WIRED (June 6, 2010, 9:31 PM), <http://www.wired.com/2010/06/leak/>.

3. Scott Stump, *Bradley Manning: I Want To Live as a Woman*, TODAY (Aug. 22, 2013, 6:35 AM), <http://www.today.com/news/bradley-manning-i-want-live-woman-6C10974915>; see also Adam Gabbatt, *'I Am Chelsea Manning,' Says Jailed Soldier Formerly Known as Bradley*, GUARDIAN (Aug. 22, 2013, 12:35 PM), <http://www.theguardian.com/world/2013/aug/22/bradley-manning-woman-chelsea-gender-reassignment>; Emmarie Huettelman, *'I Am a Female,' Manning Announces, Asking Army for Hormone Therapy*, N.Y. TIMES, Aug. 22, 2013, at A17. Although Manning is still biologically male, see Kristin Hulaas Sunde, *Whistleblower Chelsea Manning Thanks Amnesty Activists for Their Support*, AMNESTY INT'L (Apr. 8, 2015), <https://www.amnesty.org/en/latest/campaigns/2015/04/whistleblower-chelsea-manning-thanks-amnesty-activists-for-their-support/>, this Comment will refer to Manning and all transgender individuals by how each person self-identifies.

real me. I am Chelsea Manning. I am a female.”⁴ Since that announcement, Manning’s pursuit of medical treatment for her gender dysphoria (GD) has increased the public’s awareness of that “condition”⁵ and of the uphill battle fought by inmates to receive relevant medical care.⁶

4. *I Am Chelsea: Read Manning’s Full Statement*, TODAY (Aug. 22, 2013, 6:35 AM), <http://www.today.com/news/i-am-chelsea-read-mannings-full-statement-6C10974052> [hereinafter *I Am Chelsea*].

5. Both the American Psychiatric Association’s (APA) DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (5th ed. 2013) [hereinafter DSM-5], and the World Health Organization’s INTERNATIONAL STATISTICAL CLASSIFICATION OF DISEASES AND RELATED HEALTH PROBLEMS (10th ed. 1992) [hereinafter ICD-10], classify gender dysphoria (GD) as a medical condition or illness. However, the use of such terminology is debated in transgender, gender activist, and clinical communities. See Alice Dreger, *Why Gender Dysphoria Should No Longer Be Considered a Medical Disorder*, PAC. STANDARD (Oct. 18, 2013), <http://www.psmag.com/health-and-behavior/take-gender-identity-disorder-dsm-68308>. But if GD is not classified as a medical condition, the Eighth Amendment likely does not apply—at least in terms of providing individuals access to medical treatment, under which hormone therapy and psychotherapy fall. See U.S. CONST. amend. VIII. Notably, the APA, in a fact sheet about GD, states: “It is important to note that gender nonconformity is not in itself a mental disorder. The critical element of gender dysphoria is the presence of clinically significant distress associated with the condition.” AM. PSYCHIATRIC ASS’N, GENDER DYSPHORIA FACTSHEET 1 (2013), <http://www.dsm5.org/documents/gender%20dysphoria%20fact%20sheet.pdf>.

6. In the statement released on August 22, 2013, Manning wrote: “I want to begin hormone therapy as soon as possible.” *I Am Chelsea*, *supra* note 4. In April 2014, a Kansas judge granted Manning’s petition to change her name to Chelsea Elizabeth Manning. Ernesto Londoño, *Convicted Leaker Bradley Manning Changes Legal Name to Chelsea Elizabeth Manning*, WASH. POST (Apr. 23, 2014), http://www.washingtonpost.com/world/national-security/convicted-leaker-bradley-manning-changes-legal-name-to-chelsea-elizabeth-manning/2014/04/23/e2a96546-cb1c-11e3-a75e-463587891b57_story.html [hereinafter *Convicted Leaker Bradley Manning*]. An Army spokesperson stated that Manning’s records will be altered to reflect the name change but that the order would have no effect on Manning’s recognized sex. *Id.* In July 2014, the Bureau of Prisons denied the Army’s request to transfer Manning to a civilian facility for better GD treatment; in response, the military began preparations to provide Manning with initial treatments. *Manning’s Gender Treatments To Be Begun by the Military*, ASSOCIATED PRESS, July 17, 2014, <http://www.nytimes.com/2014/07/18/us/politics/mannings-gender-treatments-to-be-begun-by-the-military.html>. However, in a statement released on August 22, 2014, Manning claimed that the U.S. Department of Defense had failed to provide the promised treatment. Jessica Glenza, *Chelsea Manning Says She Is Being Denied Gender-Reassignment Treatment*, GUARDIAN (Aug. 22, 2014, 11:09 AM), <http://www.theguardian.com/world/2014/aug/22/chelsea-manning-denied-gender-reassignment-treatment>. Manning filed suit in the U.S. District Court for the District of Columbia on September 23, 2014, alleging that the military’s denial of medical treatment for her GD violated her constitutional rights under the Eighth Amendment. *Manning v. Hagel*, No. 1:14-CV-01609, 2014 WL 4721671, at *2 (D.D.C. Sept. 23, 2014); see Bill Mears, *Chelsea Manning Sues To Get Transgender Medical Treatment*, CNN (Sept. 24, 2014), <http://www.cnn.com/2014/09/23/justice/chelsea-manning-lawsuit>. In February 2015, the Army approved hormone therapy for Manning. *Chelsea Manning’s Hormone Therapy Approved by US Army*, BBC, (Feb. 13, 2015), <http://www.bbc.com/news/world-us-canada-31459921>.

When the television show *Orange Is the New Black* premiered weeks before Manning's statement, Laverne Cox's portrayal of Sophia Burset captured the public's attention.⁷ In the show's first season, Burset, a male-to-female (MTF) transgender inmate, is denied hormone treatment due to the prison's budget cutbacks and frequently struggles with inadequate medical care.⁸ Cox, a transgender woman, has been credited with shining a spotlight on transgender issues and catalyzing the public conversation about the "T in LGBT."⁹ Cox's advocacy for transgender rights and her portrayal of Burset led to her being the first transgender person to appear on the cover of *Time Magazine* and the first transgender person to receive an Emmy nomination.¹⁰

Cox and Manning did not only increase the public's awareness of transgender issues, but they also highlighted the struggles faced by transgender inmates. According to one study, 16% of transgender individuals have been incarcerated at some point in their lives, compared to only 2.7% of the general population.¹¹ The disparity in incarceration rates is even greater for African American (47%) and American Indian (30%) transgender individuals.¹² In addition, 7% of survey respondents alleged that they were incarcerated solely because of police officer bias against transgender and gender-nonconforming (TGNC) individuals.¹³

7. Dylan Matthews, 'Orange Is the New Black' Is the Best Show About Prison Ever Made, WASH. POST (July 17, 2013), <http://www.washingtonpost.com/blogs/wonkblog/wp/2013/07/17/orange-is-the-new-black-is-the-best-tv-show-about-prison-ever-made/>; Alyssa Rosenberg, Why Laverne Cox of "Orange Is the New Black" Is a Star, WASH. POST (June 6, 2014), <http://www.washingtonpost.com/news/act-four/wp/2014/06/06/why-laverne-cox-of-orange-is-the-new-black-is-a-star>.

8. Arin Andrews, *Why Laverne Cox's Emmy Nomination Matters*, VOGUE (Aug. 23, 2014, 11:00 AM), <http://www.vogue.com/988955/laverne-cox-emmy-nomination>.

9. Jonathan Capehart, *Time To Talk About the T in LGBT*, WASH. POST (June 2, 2014), <http://www.washingtonpost.com/blogs/post-partisan/wp/2014/06/02/time-to-talk-about-the-t-in-lgbt/> (noting that most people are unfamiliar with transgender issues but that more people are learning about them).

10. Andrews, *supra* note 8.

11. JAIME M. GRANT ET AL., NAT'L TRANSGENDER DISCRIMINATION SURVEY, INJUSTICE AT EVERY TURN: A REPORT OF THE NATIONAL TRANSGENDER DISCRIMINATION SURVEY 163 (2001), http://www.endtransdiscrimination.org/PDFs/NTDS_Report.pdf.

12. *Id.*

13. *Id.* It is important to note that "transgender" and "gender-nonconforming" are not synonymous terms. GLAAD *Media Reference Guide—Transgender Issues*, GLAAD, <http://www.glaad.org/reference/transgender> (last visited Jan. 10, 2015). To wit:

Gender nonconformity refers to the extent to which a person's gender identity, role, or expression differs from the cultural norms prescribed for people of a particular sex. *Gender dysphoria* refers to discomfort or

In addition, while incarcerated, 35% of respondents reported harassment by other inmates, and 37% reported harassment by correctional officers and/or staff.¹⁴ Sixteen percent of the respondents who had been incarcerated reported that they were the victims of physical assaults, and 15% experienced sexual assault perpetrated by other inmates and/or staff.¹⁵ The survey also found that MTF persons were more likely than female-to-male (FTM) transgender individuals to be victims of both physical and sexual assaults.¹⁶

distress that is caused by a discrepancy between a person's gender identity and that person's sex assigned at birth (and the associated gender role and/or primary and secondary sex characteristics). Only *some* gender-nonconforming people experience gender dysphoria at *some* point in their lives.

Eli Coleman et al., *Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People, Version 7*, 13 INT'L J. TRANSGENDERISM 165, 168 (2011) (citations omitted). The treatment of gender nonconforming inmates is beyond the scope of this Comment.

14. GRANT ET AL., *supra* note 11, at 166.

15. *Id.* at 167. One study that surveyed inmates at twelve (adult) men's prisons found that nearly 32% of inmates had reported at least one physical assault, and approximately 3% had reported at least one sexual assault. Nancy Wolff & Jing Shi, *Contextualization of Physical and Sexual Assault in Male Prisons: Incidents and Their Aftermath*, 15 J. CORRECTIONAL HEALTH CARE 58, 64 (2009). The Department of Justice (DOJ) recently released the results of a two-year study on the rates of sexual victimization of inmates at various correctional facilities nationwide. ALLEN J. BECK ET AL., BUREAU OF JUSTICE STATISTICS, SEXUAL VICTIMIZATION IN PRISONS AND JAILS REPORTED BY INMATES 2011–12 (2013), <http://www.bjs.gov/content/pub/pdf/svpjri1112.pdf>. The report estimated that 4% of state and federal prison inmates, and 3.2% of jail inmates, experienced at least one incident of sexual victimization by another inmate or by facility staff. *Id.* at 7. Further, the DOJ report found that 34.6% transgender inmates in state and federal prisons and 34% of transgender inmates in jails were victims of at least one such incident. ALLEN J. BECK, BUREAU OF JUSTICE STATISTICS, SUPPLEMENTAL TABLES: PREVALENCE OF SEXUAL VICTIMIZATION AMONG TRANSGENDER ADULT INMATES 9 tbl.1 (2014), http://www.bjs.gov/content/pub/pdf/svpjri1112_st.pdf. It is clear from the DOJ report that transgender inmates are more susceptible to sexual victimization. *See id.*

16. GRANT ET AL., *supra* note 11, at 167. Twenty-one percent of MTF survey participants reported being physically assaulted, whereas only 11% of FTM individuals experienced such assaults. *Id.* at 163. Twenty percent of MTF individuals and 6% of FTM individuals reported sexual assaults. *Id.* at 167. A number of factors may account for this difference. First, federal authorities generally incarcerate preoperative transgender inmates according to biological sex. *See Farmer v. Brennan*, 511 U.S. 825, 829 (1994). Therefore, MTF inmates, regardless of their physical characteristics, are often placed in male facilities. LAMBDA LEGAL, TRANSGENDER INCARCERATED PEOPLE IN CRISIS 1 (2015), http://www.lambdalegal.org/sites/default/files/publications/downloads/2015_transgender-incarcerated-people-in-crisis-fs-v5-singlepages.pdf. Other studies have discovered trends in the physical characteristics of male inmates targeted for sexual assault. For example, such victims are more likely to be smaller in stature or have more feminine features than their attackers. Wolff & Shi, *supra* note 15, at 60. For a summary of several of these studies, see *id.* at 59.

The survey further showed that correctional facilities fail to provide proper medical care to many TGNC inmates.¹⁷ Twelve percent of respondents reported that they were denied routine medical treatment because of biases against TGNC individuals,¹⁸ and 17% reported that they were refused hormone treatments.¹⁹ As the survey results demonstrate, correctional facilities have denied—and continue to deny—transgender inmates the medical care their physicians and other medical professionals deem necessary to their well-being.²⁰

But courts have only recently started to take an active role in recognizing and protecting the rights of transgender inmates.²¹ While Cox and Manning catapulted transgender issues onto the national stage, the United States District Court for the District of Massachusetts quietly expanded the access of transgender inmates to medically necessary treatment.²² In *Kosilek v. Spencer* (*Kosilek II*), the district court and a three-judge panel of the First Circuit laid the groundwork for the country's first state-funded inmate sex reassignment surgery (SRS).²³ But the First Circuit, after rehearing the case en banc, reversed the decision.²⁴ Michelle Kosilek's battle, which spanned two decades, exemplifies the process many transgender inmates must contend with to receive adequate medical treatment for gender dysphoria.²⁵

Part I of this Comment briefly reviews the history of medical treatment for inmates, of GD treatment in general, and of GD treatment for transgender inmates. Part II provides background information on Michelle Kosilek and her conviction and outlines the procedural history of *Kosilek I*²⁶ and *Kosilek II*.²⁷ Part III

17. See GRANT ET AL., *supra* note 11, at 169.

18. *Id.*

19. *Id.*

20. See LAMBDA LEGAL, *supra* note 16.

21. Federal courts of appeal have consistently recognized GD as a serious medical condition. See *id.* at 2. For a discussion of the judiciary's role in shaping transgender inmates' access to medical care for GD, see *infra* Part I.

22. *Kosilek v. Spencer* (*Kosilek II District Court*), 889 F. Supp. 2d 190 (D. Mass. 2012), *aff'd*, 740 F.3d 733 (1st Cir. 2014), *rev'd en banc*, 774 F.3d 63 (1st Cir. 2014), *cert. denied*, 135 S. Ct. 2059 (2015) (mem.).

23. *Kosilek v. Spencer* (*Kosilek II First Circuit*), 740 F.3d 733, 773 (1st Cir. 2014), *rev'd en banc*, 774 F.3d 63 (1st Cir. 2014), *cert. denied*, 135 S. Ct. 2059 (2015) (mem.).

24. *Kosilek v. Spencer* (*Kosilek II En Banc*), 774 F.3d 63, 96 (1st Cir. 2014) (en banc), *cert. denied*, 135 S. Ct. 2059 (2015) (mem.).

25. *Id.* For a discussion of the lawsuits Kosilek filed, see *infra* Part II.

26. *Kosilek v. Maloney* (*Kosilek I*), 221 F. Supp. 2d 156 (D. Mass. 2002). Kosilek filed two lawsuits in 1992: *Kosilek I*, 221 F. Supp. 2d 156, and *Kosilek v. Nelson*,

discusses both First Circuit decisions in *Kosilek II*. Part IV examines how the Eighth Amendment applies to medical treatment provided to inmates with GD, specifically within the context of the evolving jurisprudence on what constitutes “cruel and unusual punishment.”²⁸ Finally, the Conclusion emphasizes the importance of *Kosilek II* in light of the mistreatment suffered by inmates with GD and the continued callousness towards transgender inmates’ serious medical needs by the corrections system.

Ultimately, this Comment will argue that depriving transgender inmates of medically necessary treatments is nothing short of cruel and unusual punishment and fits into the developing concept of what constitutes prohibited treatment of inmates under the Eighth Amendment.

I. The Rights of Inmates to Medical Treatment, Medical Treatment for Gender Dysphoria, and Access to Medical Treatment for Transgender Inmates

A. Medical Treatment for Incarcerated Individuals

In *Pennsylvania Department of Corrections v. Yeskey*, the Supreme Court held that the Americans with Disabilities Act (ADA) applies to correctional facilities.²⁹ However, 42 U.S.C. § 12211(b) states: “Under this chapter, the term ‘disability’ shall not include . . . transvestism, transsexualism, pedophilia, exhibitionism, voyeurism, gender identity disorders not resulting from physical impairments, or other sexual behavior disorders”³⁰ As a result, the Eighth Amendment has been crucial to securing adequate medical care for inmates with gender dysphoria.³¹

No. C.A.92-12820-MLW, 2000 WL 1346898 (D. Mass. Sept. 12, 2000). Because the latter was dismissed, in this Comment, *Kosilek I* refers only to the former lawsuit.

27. *Kosilek II First Circuit*, 740 F.3d 733.

28. U.S. CONST. amend. VIII.

29. Pa. Dep’t of Corr. v. Yeskey, 524 U.S. 206, 213 (1998) (citing Americans with Disabilities Act (ADA), 42 U.S.C. § 12141).

30. 42 U.S.C. § 12211(b) (2015). While the ADA Amendments Act of 2008 expanded the definition of “disability,” Congress retained the GD exclusion from the original statute. Pub. L. No. 110-325, § 4, 122 Stat. 3553, 3555 (2008). The language and structure of the ADA categorize transgender persons with pedophiles and other “sexual behavior disorders.” 42 U.S.C. § 12211(b). For a discussion of Congress’s continuous denial of ADA protection for transgender individuals, see Kevin M. Barry, *Disabilityqueer: Federal Disability Rights Protection for Transgender People*, 16 YALE HUM. RTS. & DEV. L.J. 1 (2014).

31. LAMBDA LEGAL, *supra* note 16, at 2.

In the 1976 landmark case *Estelle v. Gamble*, the Supreme Court held that the Eighth Amendment's prohibition against cruel and unusual punishment requires the government to provide medical care for inmates.³² In so holding, the Court stated:

An inmate must rely on prison authorities to treat his medical needs; if the authorities fail to do so, those needs will not be met. In the worst cases, such a failure may actually produce physical "torture or a lingering death" In less serious cases, denial of medical care may result in pain and suffering which no one suggests would serve any penological purpose.³³

Furthermore, the inmate's resultant suffering may have significant consequences: "Deliberate indifference to serious medical needs of prisoners constitutes the 'unnecessary and wanton infliction of pain' proscribed by the Eighth Amendment."³⁴ In *Brown v. Plata*, the Court continued to expand on the importance of inmates' medical care and stated that "[a] prison that deprives prisoners of basic sustenance, including adequate medical care, is incompatible with the concept of human dignity and has no place in civilized society."³⁵

In order to prevail on an Eighth Amendment claim, an inmate must show more than that he or she received inadequate medical care.³⁶ Rather, to state a cause of action, the inmate must demonstrate "deliberate indifference" on the part of prison officials.³⁷ This deliberate indifference test has two prongs: one objective and one subjective.³⁸ Therefore, to satisfy the objective prong, the inmate must show that the harm suffered was objectively sufficient to comprise a constitutional violation.³⁹ The subjective prong requires the inmate to prove that the prison officials acted "with a sufficiently culpable state of mind."⁴⁰ To satisfy the two-prong test in cases alleging failure to provide medical treatment, the inmate must show (1) that he or she had a

32. *Estelle v. Gamble*, 429 U.S. 97, 107–08 (1976).

33. *Id.* at 103 (citations omitted).

34. *Id.* at 104 (citation omitted).

35. *Brown v. Plata*, 131 S. Ct. 1910, 1928 (2011).

36. *Estelle*, 429 U.S. at 104.

37. *Id.*

38. *Hudson v. McMillian*, 503 U.S. 1, 8 (1992) (citing *Wilson v. Seiter*, 501 U.S. 294, 298 (1991)).

39. *Id.*

40. *Id.* at 21.

medical need that, if left untreated, would cause serious harm, and (2) that prison officials knew that the prisoner had a high risk of harm if untreated.⁴¹

B. Medical Treatment for Gender Dysphoria

The medical profession has been historically slow to recognize and accept GD,⁴² but various medical professional associations, and both the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)*⁴³ and the tenth edition of the *International Statistical Classification of Diseases and Related Health Problems (ICD-10)*, recognize it as a medical condition.⁴⁴ In 2013, the *DSM-5* changed its official diagnosis from “gender

41. *Farmer v. Brennan*, 511 U.S. 825, 834 (1994). In *Farmer*, a MTF transgender inmate who had undergone some treatments for gender dysphoria prior to incarceration was placed in the general male population of a federal prison. *Id.* The inmate alleged that, within two weeks, a fellow prisoner physically and sexually assaulted her. *Id.* In discussing the elements of an Eighth Amendment claim, Justice Souter, writing for a unanimous Court, stated:

Our cases have held that a prison official violates the Eighth Amendment only when two requirements are met. First, the deprivation alleged must be, objectively, “sufficiently serious,” a prison official’s act or omission must result in the denial of “the minimal civilized measure of life’s necessities.” . . . The second requirement follows from the principle that “only the unnecessary and wanton infliction of pain implicates the Eighth Amendment.” To violate the Cruel and Unusual Punishments Clause, a prison official must have a “sufficiently culpable state of mind.” In prison-conditions cases that state of mind is one of “deliberate indifference” to inmate health or safety

Id. (citations omitted). See also *Kosilek II District Court*, 889 F. Supp. 2d 190, 206–07 (D. Mass. 2012), *aff’d*, 740 F.3d 733 (1st Cir. 2014), *rev’d en banc*, 774 F.3d 63 (1st Cir. 2014), *cert. denied*, 135 S. Ct. 2059 (2015) (mem.).

42. John M. Ohle, *Constructing the Trannie: Transgender People and the Law*, 8 J. GENDER RACE & JUST. 237, 252 (2004). Ohle discusses what he terms the “medicalization of the transgender individual” and the benefits and disadvantages of classifying GD as a medical disorder. *Id.* at 271. While classifying GD as a medical condition permits transgender individuals to seek medical care, it also designates them as sick or diseased. *Id.* A discussion of whether GD should be categorized as a medical condition or illness, and the legal consequences of doing so, is beyond the scope of this Comment. The transgender inmates discussed in this Comment have generally been diagnosed with GD and have sought medical treatments such as hormone therapy or SRS. Because the jurisprudence has evolved to view GD as a medical condition for which inmates can receive treatment—perhaps the only way to secure treatment—this Comment refers to GD as a medical condition.

43. *DSM-5*, *supra* note 5, at 451–59 (recognizing GD for the first time).

44. *ICD-10*, *supra* note 5, at 311–87. While many countries quickly adopted the *ICD-10*, the United States delayed the transition from the *ICD-9* until October 1, 2015. See Protecting Access to Medicare Act of 2014, Pub. L. No. 113-93, § 212, 128 Stat. 1040, 1047 (2014).

identity disorder” to “gender dysphoria.”⁴⁵ Along with the change in labeling came an important shift in the focus of the diagnosis.⁴⁶ The previous edition of the book, the *DSM-IV-TR*,⁴⁷ emphasized the *dissonance* in gender identity that individuals with GD experience as a result of the incongruity between his or her birth gender and how he or she identifies.⁴⁸ The *DSM-5*, on the other hand, emphasizes the *distress* experienced by individuals because of that incongruity.⁴⁹ The new diagnostic class of “gender dysphoria” eliminates the previous emphasis on cross-gender identification, and, further, it acknowledges that GD is “a unique condition in that it is a diagnosis made by mental health care providers, although a large proportion of the treatment is endocrinological and surgical . . .”⁵⁰ The *ICD-10* refers to the condition as “gender identity disorder” (GID),⁵¹ a term that encompasses the diagnoses of “transsexualism”,⁵² “dual-role transvestism”,⁵³ “gender identity disorder of childhood”,⁵⁴ “other gender identity disorders”,⁵⁵ and “gender identity disorder, unspecified.”⁵⁶

45. Compare *DSM-5*, *supra* note 43, at 451–59 (stating that people whose gender at birth is the opposite of the one with which they identify are diagnosed with “gender dysphoria”), with AM. PSYCHIATRIC ASS’N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 576 (4th ed. text rev. 2000) [hereinafter *DSM-IV-TR*] (identifying “gender identity disorder” as the diagnostic name associated with individuals who desire to be a different gender from their assigned gender).

46. AM. PSYCHIATRIC ASS’N, HIGHLIGHTS OF CHANGES FROM *DSM-IV-TR* TO *DSM-5*, at 14–15, <http://www.dsm5.org/Documents/changes%20from%20dsm-iv-tr%20to%20dsm-5.pdf> [hereinafter APA, HIGHLIGHTS OF CHANGES FROM *DSM-IV-TR* TO *DSM-5*]; see also Wynne Parry, *Gender Dysphoria: DSM-5 Reflects Shift in Perspective on Gender Identity*, HUFFINGTON POST (updated Aug. 4, 2013, 5:12 AM), http://www.huffingtonpost.com/2013/06/04/gender-dysphoria-dsm-5_n_3385287.html (discussing the *DSM-5* changes).

47. *DSM-IV-TR*, *supra* note 45.

48. APA, HIGHLIGHTS OF CHANGES FROM *DSM-IV-TR* TO *DSM-5*, *supra* note 46, at 14–15.

49. Parry, *supra* note 46.

50. APA, HIGHLIGHTS OF CHANGES FROM *DSM-IV-TR* TO *DSM-5*, *supra* note 46, at 14.

51. *ICD-10*, *supra* note 44, § F64. This Comment will refer to the condition as both gender dysphoria and gender identity disorder since both are medically recognized diagnoses.

52. *Id.* § F64.0.

53. *Id.* § F64.1.

54. *Id.* § F64.2.

55. *Id.* § F64.8.

56. *Id.* § F64.9.

While treatment plans are tailored to each individual, most of the medical community in the United States has adopted accepted standards of care (SOC).⁵⁷ The SOC are flexible and can be modified to meet each individual patient's diverse needs.⁵⁸ First and foremost, the goal of any treatment for GD is to support the individual's decisions about physical modifications to his or her body.⁵⁹ Psychological and medical treatments for GD include psychotherapy, hormone treatment, and SRS.⁶⁰ In addition, the SOC advocate for social support, such as through peer-support groups, and for changes in gender expression, including name changes and hair removal through electrolysis.⁶¹

For some transgender individuals, SRS is a medically necessary treatment.⁶² Healthcare professionals and the SOC recognize that, for some, "relief from gender dysphoria cannot be achieved without modification of their primary and/or secondary sex characteristics to establish greater congruence with their gender identity."⁶³ SRS can therefore provide some of these individuals with comfort and a greater sense of ease.⁶⁴ The SOC outline a number of requirements that an individual must meet before SRS can be considered⁶⁵—for example, for genital surgery, the SOC recommend twelve months of continuous hormone therapy and twelve months of living as the gender congruent with the individual's identity.⁶⁶

C. *A History of Medical Treatments for GD Available to Transgender Inmates*

Historically, transgender inmates have been denied medical treatment for GD.⁶⁷ For example, in 2010, the Wisconsin state legislature banned hormone therapy and SRS for inmates.⁶⁸ State

57. Coleman et al., *supra* note 13, at 166.

58. *Id.*

59. *Id.* at 199.

60. *Id.* at 171.

61. *Id.* at 171–72.

62. *Id.* at 199.

63. *Id.*

64. Studies have demonstrated the positive effects (e.g., increased subjective well-being) of SRS in post-operative outcomes. *Id.*

65. *Id.* at 201–03.

66. *Id.* at 202.

67. LAMBDA LEGAL, *supra* note 31.

68. Inmate Sex Change Prevention Act, WIS. STAT. § 302.386(5m) (2010).

legislatures are not alone in denying transgender inmates medical care for GD: Federal and state courts have also consistently denied such care under the Eighth Amendment.⁶⁹

In *Heard v. Franzen*, the United States District Court for the Northern District of Illinois rejected an inmate's request for SRS and entered judgment for the director of the Illinois Department of Corrections ("IDOC").⁷⁰ The court held that an inmate's desire for SRS was not a serious disease or injury under the Eighth Amendment.⁷¹ Furthermore, the court found that the plaintiff failed to demonstrate that serious medical harm would result from the refusal, and, therefore, that the inmate failed to meet the objective prong of the deliberate indifference test.⁷² Because the court determined that a vaginectomy was not medically necessary, the IDOC's discretion to determine an inmate's medical treatment trumped the desires of the inmate.⁷³ In any case, it was IDOC policy to prohibit SRS for inmates.⁷⁴

Heard is just one of many cases that have denied transgender individuals adequate medical care for their gender dysphoria. The Seventh Circuit held in *Maggert v. Hanks* that, when a prison psychiatrist did not diagnose an inmate with GD, the prison's refusal to provide hormone therapy did not violate the Eighth Amendment.⁷⁵ Although the court stated that GD was a serious psychiatric disorder, it concluded: "[I]t does not follow that the prisons have a duty to authorize the hormonal and surgical procedures that in most cases at least would be necessary to 'cure' a prisoner's gender dysphoria."⁷⁶ Likewise, in *Long v. Nix*, the U.S. District Court for the Southern District of Iowa held that, although the plaintiff inmate was diagnosed with GID, the disorder did not constitute a serious medical need, and the prison's denial of hormone therapy and feminine clothing did not violate

69. See, e.g., *B.C. v. Estes*, No. 5:13-cv-00344-KOB-JHE, 2014 WL 4415975 (N.D. Ala. July 23, 2014); *Smith v. N.J. Dep't of Corr.*, 2010 WL 4008172 (N.J. Super. Ct. App. Div. Aug. 27, 2010).

70. *Heard v. Franzen*, No. 80 C 467, 1980 U.S. Dist. LEXIS 11909, at *6 (N.D. Ill. June 12, 1980). The inmate, scheduled to undergo a medically necessary hysterectomy, requested a vaginectomy based on a longstanding desire for SRS. *Id.* at *1-*2. The inmate's physician stated that it would be safer to perform both procedures at the same time, but the Illinois Department of Corrections rejected the request. *Id.* at *1.

71. *Id.* at *1-*3.

72. *Id.* at *4.

73. *Id.*

74. *Id.*

75. *Maggert v. Hanks*, 131 F.3d 670, 672 (7th Cir. 1997).

76. *Id.* at 671.

Long's Eighth Amendment rights.⁷⁷ Other courts have also held that inmates do not have a constitutional right to hormone therapy where it is not medically necessary.⁷⁸

However, courts have increasingly acknowledged that GD is a serious medical or psychiatric condition.⁷⁹ Some courts have held that medical treatment for GD is necessary and that the denial of treatment can constitute an Eighth Amendment violation.⁸⁰ Courts have found this to be especially true in cases where the inmate engaged in self-mutilation and attempted suicide because of his or her lack of medical treatment for GD.⁸¹ In addition, in *Fields v. Smith*, the Seventh Circuit held that Wisconsin's state law prohibiting hormone therapy and SRS violated the Eighth Amendment's prohibition against cruel and unusual punishment.⁸² After establishing that GD is a serious medical condition, the court in *Fields* stated: "Surely, had the Wisconsin legislature passed a

77. *Long v. Nix*, 877 F. Supp. 1358, 1365–66 (S.D. Iowa 1995), *aff'd*, 86 F.3d 761 (8th Cir. 1996); *see also* *White v. Farrier*, 849 F.2d 322, 324, 327–28 (8th Cir. 1988) (holding that a transgender inmate has no right to wear cosmetics or "cross-dress").

78. *E.g.*, *Meriwether v. Faulkner*, 821 F.2d 408, 413 (7th Cir. 1987); *Supre v. Ricketts*, 792 F.2d 958, 963 (10th Cir. 1986); *Lamb v. Maschner*, 633 F. Supp. 351, 353–54 (D. Kan. 1986).

79. *See Maggert*, 131 F.3d at 671 (classifying gender dysphoria as a "serious psychiatric disorder"); *Meriwether*, 821 F.2d at 413 (holding that "transsexualism" is a serious medical need); *Supre*, 792 F.2d at 963 (holding that, while the plaintiff did not have a right to hormone treatment, some form of treatment should be provided); *Lamb*, 633 F. Supp. at 354 (stating that the inmate's psychological treatment for GD was sufficient); *see also* GAY & LESBIAN ADVOCATES & DEFS., TRANSGENDER LEGAL ISSUES IN NEW ENGLAND 25–26 (2005), http://www.masstpc.org/pubs/Transgender_Legal_Issues.pdf.

80. *See, e.g.*, *Soneeya v. Spencer*, 851 F. Supp. 2d 228, 252 (D. Mass. 2012) (holding that the Department of Corrections violated an inmate's Eighth Amendment rights where the inmate was diagnosed with GID by a medical professional, the disorder was likely to lead to serious harm if untreated, and treatment was delayed and inconsistent); *Phillips v. Mich. Dep't of Corr.*, 731 F. Supp. 792, 800 (W.D. Mich. 1990), *aff'd*, 932 F.2d 969 (6th Cir. 1991) (holding that the inmate satisfied both the objective and subjective prongs of the deliberate indifference test and that denial of treatment for the inmate's gender dysphoria deprived the inmate of a constitutional right); *see also* *De'Lonta v. Angelone*, 330 F.3d 630, 634 (4th Cir. 2003) (holding that GD constitutes a serious medical need where the individual engages in self-mutilation, triggering Eighth Amendment rights).

81. *De'Lonta*, 330 F.3d at 634; *Adams v. Fed. Bureau of Prisons*, 716 F. Supp. 2d 107, 111 (D. Mass. 2010) (holding that prison officials may not be deliberately indifferent to GD where the inmate attempted suicide and self-castration multiple times during a four-year period and requested evaluation and treatment for GD multiple times); *Konitzer v. Frank*, 711 F. Supp. 2d 874, 907 (E.D. Wis. 2010) (holding that a reasonable jury could find that real-life experience, as recommended by the SOC, was appropriate for the inmate because a physician believed that refusing the treatment would put the inmate at risk for self-harm and self-castration).

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

law that DOC inmates with cancer must be treated only with therapy and pain killers, this court would have no trouble concluding that the law was unconstitutional.”⁸³ Keeping in line with the existing case law, the district court’s decision in *Kosilek II* represented the next logical step in providing adequate treatment for inmates with GD.

II. The Factual Background and Procedural History of *Kosilek v. Spencer*

Michelle Kosilek, who was born Robert Kosilek, suffers from GD.⁸⁴ Since the age of three, Kosilek has believed that she is a woman trapped inside a male body.⁸⁵ When she was three, Kosilek’s mother left her in an orphanage, where she was abused for her attempts to dress as a girl.⁸⁶ After she returned to her mother’s custody at the age of ten, her grandfather repeatedly raped her, and her stepfather stabbed her because of her expressed desire to live as a girl.⁸⁷ She ran away from home as a teenager and engaged in drug use and prostitution.⁸⁸ She frequently dressed as a woman and received female hormones from various sources.⁸⁹ After she was assaulted several times, Kosilek ceased using hormones.⁹⁰ Despite her history of substance abuse, incarceration, prostitution, and physical altercations, Kosilek earned a college degree and held various jobs.⁹¹ While receiving treatment for drug abuse, Kosilek met Cheryl McCaul, a volunteer counselor at a drug rehabilitation center.⁹² McCaul believed that she could “cure” Kosilek’s GD because Kosilek just needed “a good woman,” and the two married.⁹³

83. *Id.* at 556.

84. *Kosilek v. Maloney (Kosilek I)*, 221 F. Supp. 2d 156, 158 (D. Mass. 2002).

85. *Id.*

86. *Id.* at 163.

87. *Id.*

88. *Id.*

89. *Id.*

90. *Id.* Kosilek developed breasts while on female hormones and was gang raped as a result while incarcerated in Chicago. *Id.* She was later assaulted by two men outside a gay bar. *Id.*

91. *Id.* at 163–64.

92. *Id.* at 164.

93. *Id.*

In 1990, Kosilek murdered McCaul.⁹⁴ Kosilek was convicted in 1992⁹⁵ and was sentenced to life in prison without the possibility of parole.⁹⁶ While she awaited trial, Kosilek illegally obtained female hormones from a guard.⁹⁷ She also repeatedly self-harmed: She attempted suicide twice,⁹⁸ and she tried to castrate herself.⁹⁹ Upon her conviction, Kosilek was placed under the responsibility of the Massachusetts Department of Corrections (“MDOC”) in a medium-security men’s prison.¹⁰⁰ While incarcerated, Kosilek changed her name to Michelle.¹⁰¹ She now lives her life as a woman to the greatest extent possible.¹⁰²

A. Kosilek I: *The Fight Begins*

In 1992, Kosilek filed a complaint against MDOC alleging that it had violated her Eighth Amendment rights by denying her adequate medical care to evaluate her GD.¹⁰³ A MDOC-retained specialist examined Kosilek for her severe GD¹⁰⁴ and recommended five action items: (1) that she should receive psychotherapy from a qualified therapist; (2) that she should receive female hormones; (3) that she should consult with a surgeon about SRS; (4) that she should be subject to psychiatric monitoring; and (5) that she should be given access to female personal care products, such as makeup.¹⁰⁵

94. *Kosilek II First Circuit*, 740 F.3d 733, 738 (1st Cir. 2014), *rev’d en banc*, 774 F.3d 63 (1st Cir. 2014), *cert. denied*, 135 S. Ct. 2059 (2015) (mem.).

95. *Id.*

96. *Kosilek I*, 221 F. Supp. 2d at 158.

97. *Kosilek II First Circuit*, 740 F.3d at 738.

98. *Id.* One attempt occurred while Kosilek was taking antidepressants. *Id.*

99. *Id.*

100. *Id.*

101. *Id.*

102. *Id.*

103. *Kosilek I*, 221 F. Supp. 2d 156, 159 (D. Mass. 2002).

104. *Id.* at 168. The specialist, Dr. Marshall Forstein, was employed because of the litigation, and his recommendations were not the focus of MDOC’s considerations in treating Kosilek. *Id.*

105. *Id.* The recommendations were consistent with the SOC. *Id.* at 158–59. The SOC referenced by the court in both *Kosilek I* and *Kosilek II* are found in Walter Meyer III et al., Harry Benjamin Int’l Gender Dysphoria Ass’n, *Standards of Care for Gender Identity Disorders, Sixth Version*, 13 J. PSYCHOL. & HUM. SEXUALITY 1 (2001). The Harry Benjamin International Gender Dysphoria Association later became the World Professional Association for Transgender Health. *Kosilek II First Circuit*, 740 F.3d at 739 n.6. The SOC set forth by Coleman et al., *see supra* note 13, are a revision of the SOC used by the *Kosilek* courts. *See Kosilek II First Circuit*, 740 F.3d at 739 n.6.

Subsequently,¹⁰⁶ MDOC retained another consultant, Dr. Richard Dickey, who did not adhere to the SOC and who imposed stricter requirements before he would prescribe hormones or recommend SRS.¹⁰⁷ Dr. Dickey did not consider Kosilek a candidate for SRS because she was incarcerated, and he recommended that Kosilek not receive hormone therapy unless she became depressed and unable to function.¹⁰⁸ Based on a number of considerations, including Dr. Dickey's work, MDOC Commissioner Michael Maloney adopted a "freeze-frame" policy for inmates with GID.¹⁰⁹

In 2002, ten years after Kosilek initially filed her complaint, the U.S. District Court for the District of Massachusetts held that she had failed to meet the subjective prong of the deliberate indifference test and thus did not establish an Eighth Amendment

106. *Kosilek I*, 221 F. Supp. 2d at 173. MDOC asked Dr. Forstein whether Kosilek's status as an inmate and not as a member of the general population altered his recommendations. *Id.* When he replied in the negative, he was terminated. *Id.*

107. *Id.* Dr. Dickey required the individual to have one year or more of real life experience living in the community, which is impossible for inmates. *Id.* Such a requirement is expressly rejected by the SOC: "The SOC in their entirety apply to all transsexual, transgender, and gender-nonconforming people, *irrespective of their housing situation*. People should not be discriminated against in their access to appropriate health care based on where they live, including institutional environments such as *prisons* or long-/intermediate-term facilities." Coleman et al., *supra* note 13, at 206 (emphases added) (citation omitted).

108. *Kosilek I*, 221 F. Supp. 2d at 174. Even then, Dr. Dickey prescribed MDOC-provided hormones on a trial basis in order to determine whether the therapy would improve Kosilek's condition. *Id.* After the adoption of the freeze-frame policy, *see infra* note 109, MDOC implemented the Revised Treatment Plan for Kosilek which stated that (1) a licensed mental health professional would provide treatment and consult with Dr. Dickey if necessary, and (2) psychopharmacological drugs would be prescribed to treat Kosilek's depression. *Kosilek I*, 221 F. Supp. 2d at 174.

109. *Kosilek I*, 221 F. Supp. 2d at 170–71. The freeze-frame policy stated that an inmate with GD would be managed according to how he or she entered the correctional system and did not permit deviations for individualized care. *Id.* at 169, 171. Maloney made the decision based on several factors: (1) a memorandum that summarized Dr. Dickey's research, which surveyed sixty-four correctional programs worldwide and found that the majority would not consider SRS for an inmate, *id.* at 169–70; (2) the fact that Maloney was told that Dr. Dickey advocated the freeze-frame policy, *id.* at 169; (3) the fact that Maloney did not know about the SOC; (4) the fact that MDOC's attorneys found no cases holding that the Constitution required the provision of hormones if the inmate was not taking hormones before incarceration, *id.* at 170; and (5) the fact that the freeze-frame policy is employed by other prison facilities. *See, e.g., Farmer v. Moritsugu*, 163 F.3d 610 (D.C. Cir. 1998). Maloney's decision was in part based on his misunderstanding of the U.S. Bureau of Prison's policy, which was a freeze-frame policy that permitted treatment alterations if the inmate's medical needs changed. *Kosilek I*, 221 F. Supp. 2d at 186–87.

violation.¹¹⁰ However, the court found that Kosilek suffered from a serious medical need and that she had been denied adequate medical care.¹¹¹ It also concluded that the freeze-frame policy¹¹² prohibited medical professionals from adequately treating Kosilek and other transgender inmates because it did not permit deviations for individualized care.¹¹³ But, according to the court, Kosilek failed to show (1) that Maloney was deliberately indifferent to Kosilek's serious medical need, and (2) that Maloney would be deliberately indifferent to her serious medical need in the future.¹¹⁴ Furthermore, the court concluded that while Maloney's recommendations were motivated by the public's criticism of providing these treatments using public funds, he was also motivated by sincere security concerns.¹¹⁵

B. Kosilek II: *The Fight Continues*

In 2000, while awaiting the court's judgment in *Kosilek I*, Kosilek sued MDOC and a number of its medical professionals on the grounds that the denial of SRS violated the Eighth Amendment.¹¹⁶ After the court issued its decision in *Kosilek I* in 2002, Maloney made a number of changes to MDOC policy regarding inmates with GD.¹¹⁷ First, the freeze-frame policy was

110. *Kosilek I*, 221 F. Supp. 2d at 195.

111. *Id.* at 189.

112. At least one other court has held that, while the policy is permissible, decisions regarding an inmate's treatment must be made on an individual basis. *Allard v. Gomez*, 9 F. App'x 793, 795 (9th Cir. 2001). Dr. Dickey testified at trial, but the court found him unpersuasive because he did not subscribe to the SOC, which prudent medical professionals followed. *Kosilek II District Court*, 889 F. Supp. 2d 190, 216 (D. Mass. 2012), *aff'd*, 740 F.3d 733, 738 (1st Cir. 2014), *rev'd en banc*, 774 F.3d 63 (1st Cir. 2014), *cert. denied*, 135 S. Ct. 2059 (2015) (mem.).

113. *Kosilek I*, 221 F. Supp. 2d at 193.

114. *Id.* at 195. The court stated: "This court's decision puts Maloney on notice that Kosilek has a serious medical need which is not being properly treated. Therefore, he has a duty to respond reasonably to it. This court expects that he will." *Id.* at 162.

115. *Id.* at 191. Regarding security concerns, Maloney estimated that 25% of the inmates under MDOC custody were sex offenders. *Id.* at 194. As a result, he was concerned that permitting an inmate with breasts to live as a woman in a men's facility would lead to violence and injuries to both correctional personnel and inmates. *Id.* at 170. Maloney also believed that permitting Kosilek to have makeup would lead to its use by Kosilek or other inmates to escape custody. *Id.*

116. *Kosilek II First Circuit*, 740 F.3d 733, 738 (1st Cir. 2014), *rev'd en banc*, 774 F.3d 63 (1st Cir. 2014), *cert. denied*, 135 S. Ct. 2059 (2015) (mem.).

117. *Id.* at 740. The district court opined that "[i]f Maloney had remained the Commissioner of the [M]DOC, he might have heeded the court's warning that an injunction would issue if he denied Kosilek adequate medical care because of a fear of controversy or criticism." *Kosilek II District Court*, 889 F. Supp. 2d at 201. However, Deputy Commissioner Kathleen Dennehy became the Commissioner in

replaced with a presumptive policy: Inmates received hormone therapy if they were prescribed the treatment at the time of incarceration, and treatment plans could be altered as deemed necessary by medical professionals.¹¹⁸ Dr. David Seil, a gender-identity-disorder specialist retained by MDOC, evaluated Kosilek and recommended a course of treatment including estrogen therapy, electrolysis hair removal, and access to female personal items.¹¹⁹ Dr. Seil also noted that SRS might be a final step in treating Kosilek.¹²⁰ Kosilek followed Dr. Seil's plan from 2003 to 2006, and the prison reported no resultant security issues.¹²¹ By September 2004, Kosilek had been receiving hormone treatments and living as a woman for more than one year; therefore, under the SOC and Dr. Seil's recommendations, she was eligible to be evaluated for SRS.¹²²

The consultants MDOC hired to evaluate Kosilek disagreed over the best course of treatment.¹²³ One organization recommended SRS,¹²⁴ but another consultant disagreed.¹²⁵ Dr.

December 2003 and immediately stated that "she wanted to 'regroup on this GID stuff.'" *Kosilek II First Circuit*, 740 F.2d at 741. Dennehy testified at trial that she would rather retire than obey an order from the U.S. Supreme Court to authorize SRS for an inmate. *Id.* at 750. Three more Commissioners would join the fray before the First Circuit issued its first opinion in January 2014: James Bender in May 2007; Bender's successor, Harold Clarke, in November 2007, *Kosilek II First Circuit*, 740 F.3d at 755; and Luis Spencer, who was appointed in May 2011, *Kosilek II District Court*, 889 F. Supp. 2d at 229.

118. *Kosilek II District Court*, 889 F. Supp. 2d at 218.

119. *Kosilek II First Circuit*, 740 F.3d at 740–41.

120. *Id.* at 741.

121. *Kosilek II District Court*, 889 F. Supp. 2d at 219.

122. *Kosilek II First Circuit*, 740 F.3d at 741. MDOC contracted the University of Massachusetts Correctional Health Program ("UMass") to provide medical and mental health services for all inmates. *Id.* at 740.

123. *Kosilek II First Circuit*, 740 F.3d at 742–44. Dr. Kenneth Appelbaum, UMass's Mental Health Program Director, recommended retaining the Fenway Community Health Center ("Fenway Center"), a facility focused on serving the LGBT community. *Id.* at 742. Gregory Hughes, MDOC Director of Mental Health and Substance Abuse Services, expressed concerns that the Fenway Center might be too sympathetic to Kosilek and too readily recommend SRS. *Id.* at 742. Hughes recommended Cynthia Osborne, a gender-identity specialist with experience working with correctional facilities. *Id.* Hughes believed that Osborne would be more objective and sympathetic to MDOC. *Id.* However, MDOC retained the Fenway Center first, and Dr. Kevin Kapila and Dr. Randi Kaufman evaluated Kosilek. *Id.*

124. *Id.* The Fenway Center reported that Kosilek had surpassed the requisite one-year period of hormone treatment necessary to receive SRS, and that she adapted well to the treatments provided, but that she still suffered from substantial distress. *Id.*

125. *Id.* at 743. MDOC, dissatisfied with the Fenway Center report, hired Osborne to conduct a peer review of the report. *Id.* Osborne criticized the Fenway Center for failing to consider whether Kosilek suffered from any personality

Kenneth Appelbaum recommended SRS based on a report drafted by the doctors at the Fenway Community Health Center of Massachusetts evaluating Kosilek ("Fenway Center Report").¹²⁶

The case attracted significant public and media attention.¹²⁷ At the trial, which began in 2006, medical professionals for both Kosilek and MDOC testified that Kosilek had GD.¹²⁸ Several of the medical professionals testified that the SOC were generally accepted and widely used in treating GD,¹²⁹ and some stated that SRS was medically necessary to adequately treat Kosilek's GD.¹³⁰ Commissioners Kathleen Dennehy and Harold Clarke continuously claimed that the security concerns posed by SRS were "insurmountable."¹³¹

disorders and opined that the SOC were not suitable in a prison environment. *Id.* at 743–44. As the district court notes, Osborne was a faculty member of Johns Hopkins University School of Medicine, whose head of psychiatry was known for his belief that SRS is "religiously abhorrent." *Kosilek II District Court*, 889 F. Supp. 2d at 221. Furthermore, Osborne was involved in *De'Lonta v. Angelone*, 330 F.3d 630, 634 (4th Cir. 2003). In *De'Lonta*, Osborne recommended the termination of an inmate's hormone therapy, and the inmate then mutilated her genitals. *Id.* at 635. Osborne was also one of several medical professionals retained by the Wisconsin Department of Corrections to assess an inmate with GD. *Konitzer v. Frank*, 711 F. Supp. 2d 874, 883, 887 (E.D. Wis. 2010). Osborne concluded that "focusing on Konitzer's treatment on adjustment rather than cross gender transition [was] a clinically sound and ethically wise stance." *Id.* at 889. Notably, that inmate attempted to castrate herself several times (and was ultimately successful) and attempted suicide at least twice. *Id.* at 905.

126. *Kosilek II District Court*, 889 F. Supp. 2d at 221–22.

127. *Id.* at 225. Kosilek's suits were widely covered by the local media and garnered significant opposition from both the general public and politicians. *E.g.*, Brian McGrory, *A Test Case for a Change*, BOS. GLOBE (June 13, 2000), <http://www.bostonglobe.com/metro/2000/06/13/test-case-for-change/s9jYsy33HXfJ3aJRNYpMO/story.html>; Eileen McNamara, *When Gender Isn't Relevant*, BOS. GLOBE (June 11, 2006), http://www.boston.com/news/local/articles/2006/06/11/when_gender_isnt_relevant/. Clarke received one letter signed by seventeen state senators and another signed by twenty-five state representatives opposing the use of public funds for SRS for an inmate. *Kosilek II District Court*, 889 F. Supp. 2d at 246. As the court noted, Dennehy participated in a local news broadcast in which she noted that she was opposed to providing Kosilek with surgery. *Id.* at 223. The same news segment interviewed a state senator, who stated that he was sponsoring a bill that would prohibit the use of tax revenues to provide SRS to inmates. *Id.* at 215.

128. *Kosilek II District Court*, 889 F. Supp. 2d at 225–27.

129. *Id.* at 226.

130. *Id.*

131. *Id.* at 228. Dennehy claimed that the SRS would have to be performed out of state due to a lack of qualified physicians in Massachusetts and that this would provide Kosilek with an opportunity to escape custody. *Kosilek II First Circuit*, 740 F.3d at 745. The question of where to house Kosilek after SRS also posed concerns. MDOC was unable to create a special ward for prisoners with GD. *Kosilek II En Banc*, 774 F.3d 63, 74 (1st Cir. 2014) (en banc), *cert. denied*, 135 S. Ct. 2059 (2015) (mem.). According to MDOC, transferring Kosilek to an out-of-state facility would be difficult because it was unlikely that any state would be willing to take her. *Id.*

In 2012, the U.S. District Court for the District of Massachusetts decided *Kosilek II*, holding that MDOC needed to provide Kosilek with SRS “as promptly as possible.”¹³² The district court made five findings. First, Kosilek successfully established that she suffered from severe gender identity disorder, which would result in serious harm if not properly treated.¹³³ Second, as seen from testimony of various medical professionals, SRS was the only adequate method to treat Kosilek’s GID; therefore, Kosilek satisfied the objective prong of the deliberate indifference test.¹³⁴ Third, Kosilek also satisfied the subjective prong of the deliberate indifference test because officials at the University of Massachusetts Correctional Health Program and Dennehy all knew that Kosilek’s severe GID, if left untreated by the recommended means, posed a serious risk of harm.¹³⁵ Fourth, MDOC did not assert its security concerns in good faith; instead, the court concluded that MDOC’s primary objective was to avoid

at 80. And, if Kosilek remained in the men’s facility, she would be at risk for physical and sexual assault. *Id.* at 79. Spencer, then-superintendent of MCI-Norfolk, stated that the only alternative would be to place Kosilek in the high-security Special Management Unit, where Kosilek would be confined to her cell for twenty-three hours a day. *Kosilek II First Circuit*, 740 F.3d at 749.

Similarly, Dennehy and others argued that transferring Kosilek to a women’s facility was problematic. *Id.* at 745. According to Lynne Bissonnette, superintendent of MCI-Framingham, where Kosilek would likely be housed, the majority of female inmates at the facility were victims of domestic abuse or sexual assault. *Id.* at 751. Bissonnette was concerned that Kosilek, who had strangled her wife, might become a predator or the victim of violence. *Id.* Bissonnette further noted that, unlike male inmates, female inmates requiring mental health services beyond those provided by prison staff were not sent to a secured facility, but to a public state hospital. *Id.* This, combined with MCI-Framingham’s weak security perimeter, presented the risk that Kosilek would try to escape custody. *Id.* For a thorough discussion of MDOC’s testimony regarding safety concerns, see *Kosilek II En Banc*, 774 F.3d at 79–82.

While the post-operative incarceration of an inmate is a significant issue, it is beyond the scope of this Comment. However, it is interesting to note that Clarke’s former employer, the Washington Department of Corrections, housed a post-operative MTF inmate in a female facility without any issues, despite the fact that she was incarcerated for murdering a female family member. *Kosilek II District Court*, 889 F. Supp. 2d at 244.

132. *Kosilek II District Court*, 889 F. Supp. 2d at 251.

133. *Id.* at 230.

134. *Id.* at 236. The court concluded that MDOC’s expert, Dr. Chester Schmidt, was not a prudent professional based on his rejection of the SOC and the testimony of the other medical professionals. *Id.* at 235–36. His proposed treatment of continuing hormones and providing psychotherapy and medication to manage Kosilek’s GD and depression would only treat the *symptoms* of Kosilek’s GD. *Id.* at 236. However, treatment of the underlying cause required SRS. *Id.* Dr. Schmidt’s treatment plan would not reduce Kosilek’s suffering to the point where it no longer constituted a serious medical need. *Id.*

135. *Id.* at 238.

criticism and controversy.¹³⁶ Lastly, MDOC's deliberate indifference would continue without judicial intervention.¹³⁷ With the words "[d]efendant shall take forthwith all of the actions reasonably necessary to provide Kosilek sex reassignment surgery as promptly as possible,"¹³⁸ the court ordered the first state-funded sex reassignment surgery for a transgender inmate in the country's history.¹³⁹

III. The First Circuit Weighs in

A. Round One: Direct Appeal

MDOC appealed on two grounds,¹⁴⁰ alleging that the district court erred in finding that (1) MDOC violated the Eighth Amendment right to adequate medical treatment by denying Kosilek's SRS treatment,¹⁴¹ and (2) MDOC was deliberately indifferent to Kosilek's serious medical needs.¹⁴²

In January 2014, a three-judge panel for the First Circuit Court of Appeals affirmed the lower court's decision.¹⁴³ It found that MDOC had no legitimate penological reasons for denying Kosilek SRS, and thus violated her Eighth Amendment rights.¹⁴⁴ According to the panel, there was sufficient evidence to support the district court's conclusion that SRS would be the only medically adequate treatment for Kosilek's GD.¹⁴⁵ MDOC alleged that the district court's holding effectively required a medical treatment to be curative to comport with the Eighth Amendment.¹⁴⁶ The First-Circuit panel disagreed and found that the district court's conclusion was limited to the facts of Kosilek's

136. *Id.* at 247.

137. *Id.* at 250–51.

138. *Id.* at 251.

139. *See id.* The court declined to decide who should perform the surgery, where it should be performed, and where Kosilek should be incarcerated afterwards. *Id.*

140. *Kosilek II First Circuit*, 740 F.3d 733, 759 (1st Cir. 2014), *rev'd en banc*, 774 F.3d 63 (1st Cir. 2014), *cert. denied*, 135 S. Ct. 2059 (2015) (mem.).

141. *Id.*

142. *Id.*

143. *Id.*

144. *Id.* at 772–73.

145. *Id.* at 766. While MDOC provided numerous forms of treatment for Kosilek, including hormone therapy, psychotherapy, and feminine items, SRS was medically required and in-line with the SOC. *See supra* notes 65, 66. Several physicians testified that Kosilek had been on hormones for a significant amount of time and met the minimum real-life-experience living requirement necessitated by the SOC. *Kosilek II First Circuit*, 740 F.3d at 765–66. Thus, the next logical treatment was SRS. *Id.* at 766.

146. *Kosilek II First Circuit*, 740 F.3d at 765.

case—it did not require curative treatment in order to be constitutionally adequate.¹⁴⁷ Drawing on the Fourth Circuit’s opinion in *De’Lonta v. Johnson*, the panel reiterated that a violation of the Eighth Amendment did not require a total denial of treatment and that “some” treatment was not the same as “adequate” treatment.¹⁴⁸ Thus, the district court did not err when it concluded, based on credible physician testimony, that Kosilek suffered from a life-threatening disorder for which surgery was the only adequate treatment.¹⁴⁹ Thus, the objective prong of the deliberate indifference test was satisfied.¹⁵⁰

Second, the three-judge panel concluded that the district court did not err in finding that MDOC falsified and embellished its security risk rationales for denying Kosilek SRS.¹⁵¹ While MDOC’s decisions regarding medical care for inmates are entitled to substantial deference, that deference is not limitless.¹⁵² The district court had found evidence of unnecessary delay tactics¹⁵³ in MDOC’s inadequate security reviews,¹⁵⁴ exaggerated security concerns,¹⁵⁵ and overt deference to public criticism.¹⁵⁶ Additionally, MDOC’s concerns about capitulating to inmate threats of suicide did not convince the First Circuit panel that deference was appropriate.¹⁵⁷ Therefore, the subjective prong of the deliberate indifference test was also satisfied.¹⁵⁸

147. *Id.*

148. *Id.* (citing *De’Lonta v. Johnson*, 708 F.3d 520, 520–26 (4th Cir. 2013)).

149. *Id.* at 765–66.

150. *Id.* at 766.

151. *Id.* at 769–71.

152. *Id.* at 767–68. The court cites *Battista v. Clarke*, 645 F.3d 449 (1st Cir. 2011), which affirmed the district court’s order to MDOC to provide hormone therapy for an inmate with GD.

153. *Kosilek II First Circuit*, 740 F.3d at 768.

154. *Id.* at 769.

155. *Id.* at 769–71. The First Circuit reviewed the district court’s findings regarding security, namely: (1) MDOC’s experience in transporting prisoners ensures that it is “near certain” (in the words of *Clarke*) that Kosilek would be securely transported to and from surgery; and (2) there was evidence of feasible housing options for Kosilek post-SRS both at MCI-Norfolk and MCI-Framingham. *Id.* at 769.

156. *Id.* at 771. While there was not overwhelming evidence that public criticism played a strong role in MDOC’s decision, the court deferred to the judgment of the district court regarding questions of credibility. *Id.*

157. *Id.* at 772. While the court agreed that MDOC should not yield to inmate threats of self-harm, it concluded that self-harm for inmates with GD was not uncommon, MDOC was well-equipped to assess whether threats were legitimate or manufactured, and the penological objective was not sufficient to deny medical treatment deemed necessary by medical professionals. *Id.*

158. *Id.*

Judge Torruella dissented on the grounds that the majority's decision extended beyond the limits of established Eighth Amendment jurisprudence.¹⁵⁹ According to Judge Torruella, the district court's division of the issues into five distinct topics wrongly precluded the court from considering the areas where the objective and subjective prongs of the test overlap.¹⁶⁰ Judge Torruella argued that the denial of SRS, while "uncompassionate" or "unpopular," was not "imprudent," especially in light of Kosilek's incarceration and status as an inmate.¹⁶¹ As to the "serious risk" of Kosilek experiencing emotional distress, Judge Torruella noted that "if an alternative short of surgery is still sufficient to address, with minimal adequacy, Kosilek's medical need, no constitutional claim can arise."¹⁶² MDOC had taken steps to treat Kosilek's GD, and Kosilek had admitted that the care was tailored to—and adequately treated—her severe emotional distress.¹⁶³ The dissent found that MDOC articulated genuine security concerns.¹⁶⁴ The district court's finding that MDOC was influenced by public criticism was insufficient because the evidence showed only that public opposition existed—not that public criticism was what motivated MDOC.¹⁶⁵ Therefore, the dissent would have held that Kosilek's Eighth Amendment claim failed because the MDOC's

159. *Id.* at 773 (Torruella, J., dissenting).

160. *Id.* at 777.

161. *Id.* at 777–80. Judge Torruella also took issue with the district court's recasting of the testimony of its own independent expert witness, Dr. Stephen Levine. *Id.* at 778–79. Dr. Levine stated that MDOC's expert witness, Dr. Schmidt, and the treatment plan he advocated complied with prudent professional standards. *Id.* at 779. The district court, however, dismissed this finding and required Dr. Levine to presume that Kosilek met all the SOC requirements and faced no other obstacles to surgery. *Id.* at 778. The dissent found no evidence that Dr. Levine believed Dr. Schmidt's treatment proposal was unreasonable. *Id.* at 780.

162. *Id.* at 780.

163. *Id.* at 781.

164. *Id.* at 781. The dissent cites *Farmer v. Brennan*, where the Supreme Court held that the prison officials' decision to permit the inmate to remain in the general male population, despite her pre-operation feminine form, could amount to subjective indifference. *Id.* at 782 (citing *Farmer v. Brennan*, 511 U.S. 825, 834 (1994)). The dissent disagreed with the district court's conclusions about security in two ways: (1) the rapid speed with which MDOC performed a security review did not mean that the review was inadequate, and (2) MDOC's unfamiliarity with Kosilek's personal characteristics, and with her record of good behavior, did not preclude them from testifying to general security concerns created by housing a post-operation Kosilek in the general male population. *Id.* The dissent also argued that a lack of security incidents at the prison did not "render inappropriate or unreasonable [M]DOC's concerns that issues might present themselves in Kosilek's post-operative future." *Id.* at 782–83.

165. *Id.* at 783.

denial of SRS was not medically imprudent: It had provided Kosilek with treatment that decreased her mental anguish, and it was prepared to offer additional treatment.¹⁶⁶

B. Round Two: Rehearing *En Banc*

On February 12, 2014, the First Circuit reheard the case en banc.¹⁶⁷ On December 16, 2014, it reversed the January 2014 opinion and remanded the case to the trial court for dismissal.¹⁶⁸ Unlike the January 2014 decision that had concluded that the correct standard of review was “clear error,”¹⁶⁹ the First Circuit on rehearing stated that “[t]he ultimate legal conclusion of whether prison administrators have violated the Eighth Amendment is reviewed *de novo*.”¹⁷⁰

This time, the First Circuit held that Kosilek failed to satisfy both prongs of the test.¹⁷¹ Regarding the objective prong, the court of appeals disagreed with the district court’s finding that Dr. Schmidt’s views were medically imprudent.¹⁷² Based on the record, the en banc First Circuit concluded that the SOC are flexible.¹⁷³ As part of its imprudence finding, the district court had emphasized the fact that Dr. Schmidt did not write letters of recommendation, but this court found that Dr. Schmidt’s letters confirming Kosilek’s readiness for SRS were equivalent to letters of recommendation.¹⁷⁴ The majority opinion also stated that the district court had misinterpreted Dr. Schmidt’s testimony to mean that he believed

166. *Id.* at 784.

167. *Kosilek II En Banc*, 774 F.3d 63, 68 (1st Cir. 2014) (en banc), *cert. denied*, 135 S. Ct. 2059 (2015) (mem.).

168. *Id.* at 96.

169. *Kosilek II First Circuit*, 740 F.3d at 763.

170. *Kosilek II En Banc*, 774 F.3d at 84. Both Judges Kayatta and Thompson, who were members of the original panel, disagreed with the standard of review. *Id.* at 97–102 (Thompson, J., dissenting); *id.* at 115 (Kayatta, J., dissenting). Judge Kayatta argued in his dissent: “Until today, there was absolutely no precedent (and the majority cites none) for reviewing such quintessentially factual findings under anything other than the clear error test.” *Id.* at 115 (Kayatta, J., dissenting). While Judge Kayatta did not agree with the district court’s findings, he reminded the majority: “I am not the trial judge in this case. Nor are my colleagues. And that is the rub.” *Id.* at 114. Judge Thompson was less forgiving in her dissent, providing a detailed analysis of the appropriate standard of review and asserting that the majority “maneuver[ed] the standard of review into its most favorable form.” *Id.* at 98 (Thompson, J., dissenting). Judge Torruella, author of the majority opinion, had argued for *de novo* review in his dissent on the three-judge panel. *Kosilek II First Circuit*, 740 F.3d at 763 (Torruella, J., dissenting).

171. *Kosilek II En Banc*, 774 F.3d at 96.

172. *Id.* at 87.

173. *Id.* at 87.

174. *Id.* at 88.

antidepressants and psychotherapy alone were sufficient to treat GD.¹⁷⁵ To the contrary, the court found that MDOC's expert testified that he believed the MDOC treatment plan continued Kosilek's ameliorative GD treatments (hormone therapy and electrolysis) and provided antidepressants and psychotherapy if she developed suicidal ideation.¹⁷⁶ Lastly, although the trial court found Dr. Schmidt imprudent because he believed that real-life experience was impossible in prison,¹⁷⁷ the First Circuit found that prudent medical professionals disagreed over what constitutes real-life experience.¹⁷⁸ For example, Dr. Levine expressed doubts that an inmate could be exposed to the types of societal, familial, and vocational pressures that make up real-life experience.¹⁷⁹ Therefore, since Dr. Schmidt was not an imprudent professional, the Fenway Center's recommendations were not the only medically prudent plan.¹⁸⁰

The en banc court of appeals believed that the district court had mischaracterized MDOC's treatment plan, which was to continue Kosilek's existing GD treatments.¹⁸¹ The question before the court, therefore, was not whether antidepressants and psychotherapy adequately treated Kosilek's GD, but whether the denial of SRS was sufficiently harmful to violate the Eighth Amendment in light of the treatment MDOC did provide.¹⁸² MDOC had a plan to treat Kosilek if she developed depression or suicidal ideation.¹⁸³ Therefore, in the eyes of the en banc First Circuit, MDOC could choose one of two treatment plans recommended by prudent medical professionals—one that involved SRS and one that did not—and MDOC's choice of one over the other did not violate the Eighth Amendment.¹⁸⁴

As for the subjective prong, the court held that Kosilek failed to show that MDOC was deliberately indifferent to her serious risk of harm.¹⁸⁵ Judge Torruella reiterated his earlier dissent: "The choice of a medical option that, although disfavored by some in the

175. *Id.*

176. *Id.*

177. *Id.*

178. *Id.*

179. *Id.* Again, the SOC arguably contradict the type of argument made by Dr. Schmidt. See *supra* note 107.

180. *Kosilek II En Banc*, 774 F.3d at 89.

181. *Id.*

182. *Id.*

183. *Id.* at 90.

184. *Id.*

185. *Id.* at 91.

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."¹⁸⁶ Even if the district court determined that the prison officials erred in evaluating the treatment's reasonableness, it did not mean that MDOC was deliberately indifferent.¹⁸⁷ In addition, the court concluded that MDOC's safety concerns were reasonable.¹⁸⁸ The district court had focused on the fact that there had been no security issues for Kosilek, but that fact did not negate MDOC's concerns for *future* safety issues that might arise if Kosilek received SRS.¹⁸⁹ The court found that the district court disregarded MDOC's decades of experience operating correctional facilities, and that the post-operative housing concerns were "within the realm of reason."¹⁹⁰

Further, according to the en banc court, the trial judge's findings—that MDOC security concerns were pretextual and that the officials' decisions were motivated by public criticism—were erroneous for two reasons.¹⁹¹ First, even if MDOC were motivated by public and political criticism, that fact did not negate the relevance of the reasonable safety concerns articulated by MDOC officials.¹⁹² MDOC was consistent in its expressed concerns, and Kosilek did not produce evidence that the concerns lacked merit.¹⁹³ Second, a court must examine the current attitudes and conduct of the prison officials to determine injunctive relief.¹⁹⁴ The district court based its pretext conclusion on the actions of Commissioner Dennehy, whose attitude did not necessarily reflect those of her successors.¹⁹⁵ There was no evidence that public criticism influenced Commissioner Clarke—who actually made the decision to deny Kosilek SRS—or Commissioner Spencer.¹⁹⁶

The dissent penned by Judge Thompson first criticized the grant of the rehearing en banc.¹⁹⁷ She argued: "This case does not satisfy the well-settled requirements for a grant of en banc."¹⁹⁸

186. *Id.* at 91–92.

187. *Id.* at 92.

188. *Id.* at 94.

189. *Id.* at 93.

190. *Id.* at 94 (quoting *Battista v. Clarke*, 645 F.3d 449, 454 (1st Cir. 2011)).

191. *Id.* at 94–95.

192. *Id.* at 94.

193. *Id.* at 95.

194. *Id.* (citing *Farmer v. Brennan*, 511 U.S. 825, 845 (1994)).

195. *Id.*

196. *Id.* at 96.

197. *Id.* at 97 (Thompson, J., dissenting).

198. *Id.* En banc relief is typically granted if "en banc consideration is necessary to secure or maintain uniformity of the court's decisions . . . or [if] the proceeding

More importantly, Judge Thompson disagreed with the majority's conclusion that the appropriate standard of review is *de novo*.¹⁹⁹ Judge Thompson argued that, if the majority had reviewed the district court's decision under the appropriate standard—clear error review—the trial court's conclusion that Kosilek satisfied both prongs was well supported for several reasons.²⁰⁰ First, the district court's finding that Dr. Schmidt was not a prudent medical professional was not clearly erroneous in light of Dr. Schmidt's fundamental disagreement with the widely accepted SOC²⁰¹ and his rejection of the belief that real-life experience is possible in prison.²⁰² Additionally, while Dr. Schmidt testified that Kosilek progressed well on her treatment, the majority of other testifying medical professionals believed the suggested treatment plan was unreasonable.²⁰³ Finally, both the testimony and evidence presented to the district court show that only SRS was adequate to treat Kosilek's GID.²⁰⁴ The evidence supported the lower court's conclusion that Kosilek was still in danger of life-threatening risk of harm, and that she continued to suffer substantial mental anguish.²⁰⁵ The district court did not disregard the rest of Kosilek's treatment plan, as the majority asserted, but simply concluded as the fact finder that "treating the underlying disorder and its symptoms are two very different things."²⁰⁶

Judge Thompson also argued that the evidence supported the district court's finding as to the subjective prong.²⁰⁷ First, the majority's argument that prison officials are insulated from Eighth Amendment claims when they choose between contradictory medical opinions is highly problematic²⁰⁸ because, under that logic, prison officials could ignore the recommendations of medical professionals by simply finding a physician with a different

involves a question of exceptional importance." *Id.* Judge Thompson argued that this case matched neither criteria. *Id.*

199. *Id.* at 97–98. See *supra* note 170.

200. *Kosilek II En Banc*, 774 F.3d at 102, 113 (Thompson, J., dissenting).

201. *Id.* at 102.

202. *Id.* at 103. The majority claimed that the district court reached this conclusion on its own. *Id.* at 88 (majority opinion). However, Judge Thompson pointed to the district court's findings in *Kosilek I*, which were based on testimony from medical professionals, and its incorporation of the conclusion into *Kosilek II District Court*. *Id.* at 103 (Thompson, J., dissenting).

203. *Id.* at 104.

204. *Id.* at 105–06.

205. *Id.*

206. *Id.* at 106.

207. *Id.* at 107.

208. *Id.*

opinion.²⁰⁹ In addition, the district court's conclusion that MDOC was deliberately indifferent was supported by a finding of "denial, delay, or interference with prescribed health care."²¹⁰ Third, evidence supported the finding that the security concerns cited by MDOC were pretextual: The district court noted that MDOC's security reports were rushed and results-driven.²¹¹ The district court also believed that the security concerns were greatly exaggerated because of the "throw-it-up-and-see-what-sticks approach" taken by MDOC.²¹² Many of the concerns cited by MDOC—such as transportation and housing—were either embellished or within MDOC's power to adequately resolve.²¹³ Lastly, Judge Thompson argued that the district court had sufficient basis to find that Commissioner Dennehy's successors were not credible.²¹⁴ Because the evidence supported the district court's finding of deliberate indifference, the district court did not clearly err.²¹⁵ The majority's decision, Judge Thompson believed, "pave[d] the way for unprincipled grants of en banc relief, decimate[d] the deference paid to a trial judge following a bench trial, aggrieve[d] an already marginalized community, and enable[d] correctional systems to further postpone their adjustment to the crumbling gender binary."²¹⁶

IV. *Kosilek II* and Eighth Amendment Jurisprudence

A. *The Eighth Amendment and Medical Treatment*

The Eighth Amendment states: "Excessive bail shall not be required, nor excessive fines imposed, nor cruel and unusual punishments inflicted."²¹⁷ At the heart of the amendment is the fear of "the imposition of torture and other cruel punishments . . . by judges acting beyond their lawful

209. *Id.* at 108.

210. *Id.* at 109 (quoting *Battista v. Clarke*, 645 F.3d 449, 453 (1st Cir. 2011)).

211. *Id.* at 110.

212. *Id.*

213. *Id.* at 110–11.

214. *Id.* at 112–13. The district court found that several of Clarke's claims were not credible and criticized his hasty security review (suggesting improper motivation), the fact that he did not consult Spencer (then-superintendent of MCI-Norfolk), and his lack of familiarity with the trial record before denying the surgery once he took office. *Id.*

215. *Id.* at 113.

216. *Id.*

217. U.S. CONST. amend. VIII.

authority.”²¹⁸ In adopting the Eighth Amendment, the drafters of the Constitution “were primarily concerned, however, with proscribing ‘tortures’ and other ‘barbarous’ methods of punishment.”²¹⁹ Early in Eighth Amendment jurisprudence, the courts utilized the prohibition against cruel and unusual punishment to assess whether specific methods of execution were sufficiently cruel to amount to a constitutional violation.²²⁰ Notably, the Supreme Court declined to restrict the definition of “barbarous” and “torture” to the eighteenth-century understanding of the terms.²²¹ Recognizing that for “a principle to be vital, [it] must be capable of wider application than the mischief which gave it birth,” the Court has applied the Eighth Amendment flexibly.²²² Expanding further on the adaptability of the Eighth Amendment, the Court has acknowledged that the judgment of what constitutes cruel and unusual punishment cannot be “fastened to the obsolete, but may acquire meaning as public opinion becomes enlightened by a humane justice.”²²³ In short, the Supreme Court’s interpretation of the Eighth Amendment is not static or fixed to a single point in time.²²⁴

Importantly, the Supreme Court noted:

The Amendment embodies “broad and idealistic concepts of dignity, civilized standards, humanity, and decency . . .” against which we must evaluate penal measures. Thus, we have held repugnant to the Eighth Amendment punishments which are incompatible with “the evolving standards of decency that mark the progress of a maturing society,” or which “involve the unnecessary and wanton infliction of pain.”²²⁵

An assessment of the allegedly unconstitutional treatment requires an assessment of contemporary views regarding the punishment.²²⁶ In the past two decades, the Supreme Court has

218. *Ingraham v. Wright*, 430 U.S. 651, 665 (1977) (citing *Weems v. United States*, 217 U.S. 349, 371–73 (1910)).

219. *Gregg v. Georgia*, 428 U.S. 153, 170 (1976) (citing Anthony F. Granucci, “*Nor Cruel and Unusual Punishments Inflicted*”: *The Original Meaning*, 57 CAL. L. REV. 839, 842 (1969)).

220. *Id.* at 170.

221. *Id.* at 171.

222. *Id.* (citing *Weems*, 217 U.S. at 373).

223. *Id.* (citing *Weems*, 217 U.S. at 378).

224. *Id.* at 172–73.

225. *Estelle v. Gamble*, 429 U.S. 97, 102–03 (1976) (citations omitted).

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

held that executions of the intellectually disabled²²⁷ and offenders under the age of eighteen at the time of the crime's commission²²⁸ constitute cruel and unusual punishment.

Furthermore, the prohibition against cruel and unusual punishment has not been limited to physical punishments.²²⁹ The Eighth Amendment thus establishes the right of inmates to humane treatment.²³⁰ The Supreme Court has held that the denial of medical treatment for inmates by prison officials may rise to the level of a constitutional violation.²³¹ In the landmark case of *Estelle v. Gamble*, the Supreme Court articulated the obligation of prison officials to provide adequate medical services as follows:

An inmate must rely on prison authorities to treat his medical needs; if the authorities fail to do so, those needs will not be met. In the worst cases, such a failure may actually produce physical "torture or a lingering death," the evils of most immediate concern to the drafters of the Amendment. In less serious cases, denial of medical care may result in pain and suffering which no one suggests would serve any penological purpose. The infliction of such unnecessary suffering is inconsistent with contemporary standards of decency as manifested in modern legislation codifying the common law view that "it is but just that the public be required to care for the prisoner, who cannot by reason of the deprivation of his liberty, care for himself."

We therefore conclude that deliberate indifference to serious medical needs of prisoners constitutes the "unnecessary and wanton infliction of pain," proscribed by the Eighth Amendment.²³²

The idea that convicted criminals are guaranteed adequate medical care by the Constitution, but average citizens living productively in the community are not granted such a right, is bizarre.²³³ This may be why courts have defined adequate medical

227. *Atkins v. Virginia*, 536 U.S. 304, 304 (2002).

228. *Roper v. Simmons*, 543 U.S. 551, 551 (2005); see Jordon Calvert Greenlee, *Victims of Youth: Equitable Sentencing Reform for Juvenile Offenders in the Wake of Miller v. Alabama and Jackson v. Hobbs*, 33 LAW & INEQ. 263 (2015); Lindsey E. Krause, *One Size Does Not Fit All: The Need for a Complete Abolition of Mandatory Minimum Sentences for Juveniles in Response to Roper, Graham, and Miller*, 33 LAW & INEQ. 481 (2015).

229. *Estelle*, 429 U.S. at 102.

230. *Kosilek I*, 221 F. Supp. 2d 156, 160 (D. Mass. 2002).

231. *Estelle*, 429 U.S. at 104.

232. *Id.* at 103–05 (citations omitted).

233. *Kosilek II District Court*, 889 F. Supp. 2d 190, 198 (D. Mass. 2012), *aff'd*, 740 F.3d 733, 763 (1st Cir. 2014), *rev'd en banc*, 774 F.3d 63 (1st Cir. 2014), *cert. denied*, 135 S. Ct. 2059 (2015) (mem.). Some might argue that if *Kosilek* is provided SRS, other transgender individuals who cannot afford SRS may commit minor crimes to become eligible for the procedure while incarcerated. However,

care as the minimum required treatment for the inmate's condition.²³⁴ But, as the Supreme Court has held, incarcerated individuals are unique because they cannot procure medical services for themselves and must rely on prison officials to supply them with the basic necessities of life, such as medical treatment.²³⁵ Although some view inmates like Kosilek as "hated criminal[s], deserving of punishment,"²³⁶ the district court in *Kosilek I* counseled:

Kosilek is a special case precisely because of her crime. Because of the heinousness of her crime, Kosilek is serving a life sentence without the possibility of parole. *Kosilek I*, 221 F. Supp. 2d at 158. Kosilek will never have a chance to live in the community and receive SRS unless it is provided by MDOC. Real-life experience for Kosilek is different from real-life experience for other transgender individuals because prison is Kosilek's permanent environment. Therefore, real-life experience for Kosilek necessarily means living as a woman within the confines of a prison. As several medical professionals testified, and the district court found, SRS is "medically necessary" to treat Kosilek's GD and alleviate her substantial mental distress. *Kosilek II District Court*, 889 F. Supp. 2d at 226. To eliminate the problem of individuals committing minor crimes to access SRS while incarcerated, MDOC could institute a policy that SRS would only be available to inmates serving life sentences and for whom SRS is medically necessary.

234. *Kosilek II First Circuit*, 740 F.3d 733, 774 (1st Cir. 2014) (Torruella, J., dissenting), *rev'd en banc*, 774 F.3d 63 (1st Cir. 2014), *cert. denied*, 135 S. Ct. 2059 (2015) (mem.). The dissent stated:

[T]his worthy pledge of protection is made practicable through the creation of a floor below which the standard of care must not fall. Prison officials commit no violation so long as the medical care is minimally adequate. . . . "[T]his obligation is met in full measure by the provision of . . . services at a level reasonably commensurate with modern medical science and of a quality acceptable within prudent professional standards." This limit on the scope of the Eighth Amendment's protection is clear: care need not be ideal, so long as it is both diligent and within the bounds of prudence. Neither do all instances of inadequate care constitute constitutional violations.

Id. at 774–75 (citations omitted); *see also Estelle*, 429 U.S. at 105 ("[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."); *Maggert v. Hanks*, 131 F.3d 670, 672 (7th Cir. 1997) (stating that a prisoner is only entitled to minimum medical care); *Jackson v. Faire*, 846 F.2d 811, 817 (1st Cir. 1988) ("[T]he Constitution does require that prisoners be provided with a certain minimum level of medical treatment.").

235. *Estelle*, 429 U.S. at 103. In *Brown v. Plata*, the Supreme Court declared:

To incarcerate, society takes from prisoners the means to provide for their own needs. Prisoners are dependent on the State for food, clothing, and necessary medical care. A prison's failure to provide sustenance for inmates "may actually produce 'physical torture or a lingering death.'" Just as a prisoner may starve if not fed, he or she may suffer or die if not provided adequate medical care.

131 S. Ct. 1910, 1928 (2011) (citations omitted).

236. Rachel Rezabek, (*D*)evolving Standards of Decency: The Unworkability of Current Eighth Amendment Jurisprudence as Illustrated by *Kosilek v. Spencer*, 87 S. CAL. L. REV. 389, 418 (2014).

The Constitution does not protect this right [to medical treatment] because we are a nation that coddles criminals. Rather, we recognize and respect this right because we are, fundamentally, a decent people, and decent people do not allow other human beings in their custody to suffer needlessly from serious illness or injury.²³⁷

The evolution and expansion of Eighth Amendment jurisprudence does not arise from a misguided attempt by the Court to “coddle criminals.” Criminals—especially murderers like Kosilek—are unpopular candidates for compassionate, humane treatment because, arguably, they denied their victims any semblance of compassion. However, at the heart of the Eighth Amendment is “the concept of human dignity,”²³⁸ which prohibits not only the deprivation of basic necessities for survival, but guarantees an inmate a life without “unnecessary and wanton infliction of pain.”²³⁹ Under the Eighth Amendment, an inmate’s lack of compassion for his or her victim does not and cannot justify the government’s lack of compassion for the inmate. After all, “an eye for an eye only ends up making the whole world blind.”²⁴⁰

B. Adequate Treatment for Gender Dysphoria

An inmate diagnosed with gender dysphoria is no different from an inmate with a broken leg, schizophrenia, kidney failure, or any other medical condition. As the Seventh Circuit stated: “Surely, had the Wisconsin legislature passed a law that DOC inmates with cancer must be treated only with therapy and pain killers, this court would have no trouble concluding that the law was unconstitutional.”²⁴¹ Many courts have recognized that GD can be a severe medical condition²⁴²—one that is recognized by

237. *Kosilek I*, 221 F. Supp. 2d 156, 160 (D. Mass. 2002).

238. *Brown*, 131 S. Ct. at 1928.

239. *Gregg v. Georgia*, 428 U.S. 153, 173 (1976).

240. GANDHI (Columbia Pictures 1982). While this quote is frequently attributed to Mohandas Karamchand Gandhi, there is no record of Gandhi ever using the phrase. For a brief history of the saying, see Garson O’Toole, *An Eye for an Eye Will Make the Whole World Blind*, QUOTE INVESTIGATOR (Dec. 27, 2010), <http://quoteinvestigator.com/2010/12/27/eye-for-eye-blind> (last visited Oct. 18, 2015).

241. *Fields v. Smith*, 653 F.3d 552, 556 (7th Cir. 2011).

242. Seven circuits have held that gender dysphoria is a serious medical condition. See *Battista v. Clarke*, 645 F.3d 449, 454–55 (1st Cir. 2011); *Fields*, 653 F.3d at 554; *DeLonta v. Angelone*, 330 F.3d 630, 634 (4th Cir. 2003); *Cuoco v. Moritsugu*, 222 F.3d 99, 106 (2d Cir. 2000); *Brown v. Zavaras*, 63 F.3d 967, 970 (10th Cir. 1995); *Phillips v. Mich. Dep’t of Corr.*, 932 F.2d 969 (6th Cir. 1991); *White v. Farrier*, 849 F.2d 322, 325 (8th Cir. 1988); *Kosilek I*, 221 F. Supp. 2d at 184.

various medical associations.²⁴³ Just like any other medical condition, there are generally recognized standards of care for GD, and it is the duty of the prison officials to provide care that comports with these standards. While prison officials are entitled to deference regarding the safety and security of correctional facilities and inmates, they do not have the specialized knowledge necessary to diagnose and treat medical conditions.²⁴⁴ Just as courts must defer to the judgment of prison officials, prison officials must defer to the judgment of medical professionals. To do otherwise permits prison officials to abdicate their duty to provide adequate medical care for the inmates for whom they are responsible.

The SOC for gender dysphoria includes hormone therapy, electrolysis, and sex reassignment surgery.²⁴⁵ Under the SOC, SRS may be necessary for some individuals with severe GD.²⁴⁶ Several medical professionals deemed Kosilek as one such individual.²⁴⁷ It is true that physicians do not always agree on the best course of treatment for every patient. As evidenced by Kosilek, professional opinions can—and often do—span the spectrum. But as Judge Thompson warned in her dissent, allowing prison officials to deny an inmate treatment because contrasting medical opinions exist is a slippery slope.²⁴⁸ Assessing the proper course of treatment for a patient is a difficult task; every patient is unique, and considerations include the patient's symptoms and responses to different treatments, as well as the available treatment options. Physicians assess the patient's medical needs and history to design a treatment plan—rarely is there only one possible course of action.

Given the complexity of designing treatment plans, permitting prison officials to capitalize on disagreements between medical professionals is both unfair and unreasonable. The Supreme Court has held that the humane treatment of inmates and the provision of adequate medical care is *required* by the Eighth Amendment.²⁴⁹ Guidelines such as the SOC and

243. See *supra* notes 45, 51.

244. *Kosilek II First Circuit*, 740 F.3d 733, 767 (1st Cir. 2014), *rev'd en banc*, 774 F.3d 63 (1st Cir. 2014), *cert. denied*, 135 S. Ct. 2059 (2015) (mem.).

245. See *supra* text accompanying notes 57, 58, 59, 60, 61, 62, 63, 64.

246. See *supra* text accompanying notes 63, 64.

247. See *Kosilek II En Banc*, 774 F.3d 63, 75–76 (1st Cir. 2014) (en banc), *cert. denied*, 135 S. Ct. 2059 (2015) (mem.); *Kosilek II District Court*, 889 F. Supp. 2d at 226.

248. *Kosilek II En Banc*, 774 F.3d at 107–08 (Thompson, J., dissenting).

249. See *supra* text accompanying notes 229, 230, 231, 232.

individualized plans that receive the support of multiple physicians must be given significant weight in determining the best treatment for an inmate's condition. Otherwise, the result is a case like *Kosilek II*. There, both the SOC and the majority of testifying medical professionals recommended SRS. However, when MDOC was displeased by the Fenway Center's SRS recommendation, it merely hired another consultant.²⁵⁰ Osborne, this new consultant, attacked the Fenway Report and concluded that Kosilek was not eligible for SRS, much to MDOC's advantage.²⁵¹ The First Circuit's en banc opinion essentially sanctioned MDOC's attempt to game the system and to provide Kosilek with the treatment it *wanted* to be adequate, rather than the treatment *deemed* adequate by a majority of the medical professionals it consulted.

By insulating prison officials from a deliberate indifference finding whenever there are contrasting medical opinions,²⁵² the First Circuit permits prison officials to overrule physicians. But medical treatments have long-lasting and serious consequences for patients. For example, Kosilek attempted self-castration and suicide because of her gender dysphoria.²⁵³ Several physicians and Kosilek testified that she would be likely to attempt suicide again if she were denied SRS.²⁵⁴ In one of the cases discussed by the majority, *De'Lonta v. Johnson*, the inmate mutilated her genitals multiple times.²⁵⁵ In that case, the Fourth Circuit concluded that, even though the Virginia Department of Corrections provided the petitioner with psychological care and hormone treatment in line with the SOC, "it does not follow that they have necessarily provided her with *constitutionally adequate* treatment."²⁵⁶ So, even if MDOC's preferred plan effectively treats any suicidal ideation that may arise,²⁵⁷ allowing MDOC to treat the symptoms of Kosilek's disorder—and not the cause of the symptoms—should

250. *Kosilek II First Circuit*, 740 F.3d 733, 742 (1st Cir. 2014), *rev'd en banc*, 774 F.3d 63 (1st Cir. 2014), *cert. denied*, 135 S. Ct. 2059 (2015) (mem.); *see supra* text accompanying notes 123, 124, 125.

251. *Kosilek II First Circuit*, 740 F.3d at 743.

252. *Kosilek II En Banc*, 774 F.3d at 107 (Thompson, J., dissenting).

253. *Kosilek II First Circuit*, 740 F.3d at 738.

254. *Kosilek II En Banc*, 774 F.3d at 75–76.

255. *De'Lonta v. Johnson*, 708 F.3d 520, 522 (4th Cir. 2013). The petitioner, De'Lonta, is the same inmate in *De'Lonta v. Angelone*, 330 F.3d 630, 634 (4th Cir. 2003). *Id.* at 522. Like Kosilek, De'Lonta's fight has spanned over a decade and multiple court decisions. *See id.*; *De'Lonta*, 330 F.3d at 634.

256. *De'Lonta*, 708 F.3d at 526.

257. *Kosilek II En Banc*, 774 F.3d at 86.

not qualify as adequate treatment.²⁵⁸ Kosilek testified about the mental anguish and continued distress caused by her male genitalia;²⁵⁹ combined with doctors' testimony regarding Kosilek's likely future suicidal ideation, MDOC's and the First Circuit's denial of SRS amounts to the type "unnecessary and wanton infliction of pain"²⁶⁰ that the Eighth Amendment prohibits.

C. *The Stigma of Being Transgender*

Unfortunately, inmates with gender dysphoria suffer from the additional stigma of being transgender. As discussed in the Introduction, transgender individuals are disproportionately incarcerated as compared to the general public, and transgender inmates are more likely to be victims of physical and sexual assaults.²⁶¹ However, the discrimination that transgender individuals face neither starts nor ends within the fenced premises of correctional facilities. TGNC individuals are four-times more likely to live in extreme poverty.²⁶² TGNC survey respondents also experienced twice the rate of unemployment; 90% experienced discrimination or harassment at work; 47% stated they experienced adverse employment actions, such as termination; 16% felt compelled to work in illegal professions like drug dealing or prostitution; and 26% reported losing a job due to being TGNC.²⁶³ Unfortunately, the discrimination is no less intense in K-12 education: 78% of TGNC individuals reported being harassed; 35% reported being physically assaulted; 12% reported being the victim of sexual violence; and 15% felt so severely harassed that they discontinued their education.²⁶⁴ TGNC individuals also reported alarmingly high rates of housing

258. See *id.* at 106 (Thompson, J. dissenting). The district court found a clear difference between treating the symptoms and treating the underlying disorder, echoing the Seventh Circuit decision in *Fields v. Smith*. *Kosilek II District Court*, 89 F. Supp. 2d 190, 208 (D. Mass. 2012) (citing *Fields v. Smith*, 653 F.3d 550, 556 (7th Cir. 2011)), *aff'd*, 740 F.3d 733, 763 (1st Cir. 2014), *rev'd en banc*, 774 F.3d 63 (1st Cir. 2014), *cert. denied*, 135 S. Ct. 2059 (2015) (mem.). Additionally, physicians from the Fenway Center testified that the preferred treatment plan should address Kosilek's underlying disorder, GD, and not just her symptoms. *Kosilek II En Banc*, 774 F.3d at 106. Treating the underlying disorder is not, as MDOC argued on appeal, the same as requiring treatment that cures the underlying disorder. *Kosilek II First Circuit*, 740 F.3d at 765.

259. *Kosilek II District Court*, 889 F. Supp. 2d at 226.

260. *Gregg v. Georgia*, 428 U.S. 153, 173 (1976).

261. See *supra* text accompanying notes 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21.

262. GRANT ET AL., *supra* note 11, at 2 (defining extreme poverty as a household income of less than \$10,000 per year).

263. *Id.* at 3.

264. *Id.*

discrimination: 19% were refused housing and 55% were harassed by staff or residents of homeless shelters.²⁶⁵ Respondents also reported discrimination and harassment in public accommodations²⁶⁶ and health care.²⁶⁷

Given the high rates of discrimination and harassment suffered by TGNC individuals both inside and outside of prison, it is clear that even with the recent spotlight on transgender individuals,²⁶⁸ public opinion has a long way to go. The current attitude towards transgender individuals does not comport with the “broad and idealistic concepts of dignity, civilized standards, humanity, and decency” embodied by the Eighth Amendment.²⁶⁹ But change is coming, and it reflects “the evolving standards of decency that mark the progress of a maturing society.”²⁷⁰ Judge Kayatta in his dissent stated:

[The district court’s decision in *Kosilek II*] happens to produce a result in this case that some of us find surprising, and much of the public likely finds shocking. Scientific knowledge advances quickly and without regard to settled norms and arrangements. It sometimes draws in its wake a reluctant community, unnerved by notions that challenge our views of who we are and how we fit into the universe.²⁷¹

Sometimes, law must be transformative and courts must be a catalyst of change to our society’s standards of decency. From *Brown v. Board of Education*²⁷² to *United States v. Windsor*,²⁷³ courts have advanced standards of human dignity where Congress and the American public have faltered. Had the holding of the three-judge First Circuit panel remained, the courts would have again served as the protector of “dignity, civilized standards, humanity, and decency.”²⁷⁴ The First Circuit abdicated its duty to protect the rights of all individuals in this nation by ignoring the

265. *Id.* at 4.

266. *Id.* at 5. Distressingly, 53% of respondents reported being disrespected at a business or government agency. *Id.*

267. *Id.* at 6. Nineteen percent of TGNC individuals reported that they were denied health care. *Id.* at 6.

268. See *supra* text accompanying notes 1, 2, 3, 4, 5, 6, 7, 8, 9, 10.

269. *Estelle v. Gamble*, 429 U.S. 97, 102 (1976).

270. *Trop v. Dulles*, 356 U.S. 86, 101 (1958).

271. *Kosilek II En Banc*, 774 F.3d 63, 115 (1st Cir. 2014) (Kayatta, J., dissenting).

272. *Brown v. Bd. of Educ. of Topeka*, 349 U.S. 294 (1955).

273. 133 S. Ct. 2675 (2013).

274. *Estelle*, 429 U.S. at 102 (quoting *Jackson v. Bishop*, 404 F.2d 571, 579 (8th Cir. 1968)).

serious medical need of Kosilek and other inmates like her who suffer from GD. However, as Judge Thompson stated in her dissent:

I am confident that this decision will not stand the test of time, ultimately being shelved with the likes of *Plessy v. Ferguson*, deeming constitutional state laws requiring racial segregation, and *Korematsu v. United States*, finding constitutional the internment of Japanese-Americans in camps during World War II. I only hope that day is not far in the future, for the precedent the majority creates is damaging.²⁷⁵

Conclusion

Chelsea Manning and Laverne Cox are shining a national spotlight on transgender issues. Although transgender individuals are traditionally an underprivileged group, targeted for discrimination in all spheres of life, this heightened visibility should lead to increased understanding of transgender issues and to wider public acceptance. Out of sight, transgender inmates continue to fight for adequate medical care and the treatments necessary to treat their gender dysphoria. We have already seen the result of treatment denials: attempted or successful self-castration, and attempted suicide.²⁷⁶ Michelle Kosilek has attempted both.²⁷⁷

Michelle Kosilek's fight for SRS highlights the underlying issues with defining adequate medical treatment. In the First Circuit, the medical services provided need only be "at a level reasonably commensurate with modern medical science and of a quality acceptable within prudent professional standards,"²⁷⁸ and only treatment "so inadequate as to shock the conscience" violates the Eighth Amendment.²⁷⁹ But this standard permits a wide range of treatments—a range further increased by *Kosilek II*. A controversial underlying medical condition and a stigmatized inmate further complicates the question of what constitutes adequate treatment. Judges, like prison officials, are not medical professionals. The First Circuit's decision in *Kosilek II* ignores the wide spectrum of opinions inherent in medical diagnosis. While the court noted that its decision "in no way suggests that

275. *Kosilek II En Banc*, 774 F.3d at 113 (Thompson, J., dissenting).

276. See *supra* text accompanying note 81.

277. See *supra* text accompanying note 99.

278. *United States v. DeCologero*, 821 F.2d 39, 43 (1st Cir. 1987).

279. *Torraco v. Maloney*, 923 F.2d 231, 235 (1st Cir. 1991) (quoting *Sires v. Berman*, 834 F.2d 9, 13 (1st Cir. 1987)).

correctional administrators wishing to avoid treatment need simply find a single practitioner willing to attest that some well-accepted treatment is not necessary,” it does appear to demand a high level of consensus.²⁸⁰ The majority of testifying physicians asserted that SRS was medically necessary for Kosilek, but the voice of the minority carried the day. At the very least, the First Circuit Court of Appeals set a high bar for inmate petitioners to establish that the medical care they received was inadequate.

Innovations constantly change what is possible in the field of medicine. The First Circuit must clarify how it defines “adequate” treatment and how judges can navigate the ever-changing tides of medical science and professional standards. Here, the First Circuit gave little weight to the SOC, which are widely accepted and used in treating GD. Instead, the majority focused on the ability of physicians to craft individualized treatment plans under the SOC. In doing so, it turned this flexibility into a gauge for bare minimum treatment.

The First Circuit acknowledged but did not decide whether adequate medical treatment must address the underlying medical condition or must merely control the inmate’s symptoms. *Kosilek II* suggests that the latter is sufficient; such a rule is consistent with the circuit’s “shock the conscience” test.²⁸¹ However, one must ask whether this approach is in line with “the evolving standards of decency that mark the progress of a maturing society.”²⁸² Unfortunately, this is likely the end of Kosilek’s legal battle for adequate treatment; the Supreme Court denied her petition for writ of certiorari on May 4, 2015.²⁸³ But the fight

280. *Kosilek II En Banc*, 774 F.3d at 90 n.12.

281. *Torraco*, 923 F.2d at 235 (quoting *Sires v. Berman*, 834 F.2d 9, 13 (1st Cir. 1987)).

282. *Trop v. Dulles*, 356 U.S. 86, 101 (1958); see *supra* text accompanying notes 221, 222, 223, 224, 225, 226, 227, 228.

283. *Kosilek v. O’Brien*, 135 S. Ct. 2059 (2015) (mem.).

continues for other transgender inmates.²⁸⁴ As our standards of decency evolve, we must reassess both how we treat prisoners and how we determine how to treat prisoners. “When it comes to human dignity, we cannot make compromises.”²⁸⁵

284. See, e.g., *Rosati v. Igbinoso*, 791 F.3d 1037, 1040 (9th Cir. 2015) (holding that an inmate’s complaint was sufficient to state a claim where prison officials allegedly violated the Eighth Amendment by denying her request for SRS); *Norsworthy v. Beard*, 87 F. Supp. 3d 1164, 1195 (N.D. Cal. 2015) (holding that a transgender inmate had the right to access adequate medical care, including SRS).

In *Norsworthy v. Beard*, the inmate petitioner claimed that prison officials violated the Eighth Amendment by denying her medically necessary SRS. *Norsworthy*, 87 F. Supp. 3d at 1175. The U.S. District Court for the Northern District of California granted the petitioner’s motion for a preliminary injunction and ordered prison officials to provide the inmate with medical care—including SRS—for her GD. *Id.* at 1194. Prison officials in *Norsworthy* presented many of the same safety concerns as MDOC did in *Kosilek*, but the court found the concerns unpersuasive. *Id.* at 1193. It is notable that the California correctional officials hired Dr. Stephen Levine to review *Norsworthy*’s case. *Id.* at 1194. The California district court concluded that Dr. Levine was not credible in part because his report misrepresented the SOC. *Id.* In particular, the district court took issue with Dr. Levine’s characterization of the SOC as requiring twelve months of real-life experience in the community and the assertion that SRS is never a medically required treatment, when both of those views are expressly contradicted by the SOC. *Id.* at 1194–95. Lastly, the district court considered the fact that the other expert hired by the correctional department was selected because he attended Dr. Levine’s training, which instructed participants that SRS is never an option for incarcerated individuals. *Id.* at 1194.

285. *Angela Merkel Quotes*, BRAINYQUOTE, http://www.brainyquote.com/quotes/authors/a/angela_merkel.html (last visited Oct. 18, 2015).