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Gender-Affirming Care, Incarceration, and the Eighth Amendment

Jennifer Aldrich, MD, Jessica Kant, MSW, LICSW, MPH, and Eric Gramszlo

Abstract

As outlined in *Estelle v Gamble* (1976), the 8th Amendment to the US Constitution requires that states provide adequate care for people who are incarcerated—but what constitutes "acceptable" care under professional guidelines is frequently at odds with the standard of care used by clinicians outside of carceral facilities. Outright denial of standard care runs afoul of the Constitutional prohibition on cruel and unusual punishment. As the evidence base that undergirds standards of care in transgender health has evolved, people who are incarcerated have sued to expand access to mental health and general health care, including hormonal and surgical interventions. Carceral institutions must transition from lay administrative to licensed professional oversight of patient-centered, gender-affirming care.

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Transgender Care in Carceral Settings

Transgender people, especially those who are Black, Indigenous, and people of color, are disproportionately incarcerated, with 16% of all respondents in a 2011 national survey of transgender people reporting having a history of incarceration in jail or prison; the rate for Black respondents was 47% compared to a general population rate of 2.7%, although the latter figure is limited to state and federal prison systems.[1] It is estimated that there are nearly 5000 transgender people residing in US state prisons[2] and that another 1200 are incarcerated in the federal system.[3]

In the United States, no unified policy exists for the housing of and the delivery of health care to transgender and nonbinary prisoners in carceral settings. Variation can be found in state policies pertaining to where transgender and nonbinary prisoners are housed and with whom, what medical care they can access, and under which circumstances they are eligible for said care.[4] The policies governing jails and detention centers also vary by agency and county. Although policies vary, clinicians' ethical imperative to advocate for stronger protections for transgender people who are incarcerated and for best practices with respect to their care does not. In this paper, we seek to establish that, for transgender people who experience significant distress related to their inability

to access gender-affirming hormonal and surgical therapy while incarcerated, legal protection under the Eighth Amendment provides remedy. We also show that the United States regularly fails to meet the needs of transgender people who are incarcerated notwithstanding this legal standard and that remedy requires a lengthy judicial process to which few people who are incarcerated have access.

Standards

The state's responsibility to provide health care to people who are incarcerated rests largely on the Eighth Amendment prohibition on cruel and unusual punishment.[4,5] The judicial standard underpinning this claim was established in *Estelle v Gamble* (1976), which held that the state has a legal obligation to provide medical care for people who are incarcerated that is "reasonably commensurate with modern medical science" and guidelines and of "a quality acceptable within prudent professional standards."[6] Proof of violation of the Eighth Amendment under *Estelle* requires 2 criteria to be met: that the care be medically necessary and that failure to provide such care constitutes "deliberate indifference" by a prison administration that is aware of the suffering resulting from that lack of treatment.[4,5,7]

The World Professional Association for Transgender Health (WPATH) has published widely accepted standard of care guidelines for the medical treatment of gender minorities.[8] While it is recognized that not all transgender people experience gender dysphoria, or "the distress that may accompany the incongruence between one's experienced or expressed gender and one's assigned gender,"[9] many do suffer from such distress until they receive treatment. Access to gender-affirming care is associated with increased quality of life and decreased rates of self-harm, including 44% and 73% lower odds of suicidality in transgender adults[10] and youth,[11] respectively, compared to cohorts who do not receive gender-affirming-care. WPATH,[8] the American Medical Association,[12] and the American Academy of Family Physicians,[13] among other organizations, have recognized that gender-affirming mental health care, hormone therapy, and gender-affirming surgical procedures are medically necessary interventions that can relieve the distress of gender dysphoria. For some, gender-affirming surgery may be the only effective treatment.

Deliberate indifference, the second criterion that must be demonstrated in Eighth Amendment cases, requires awareness on the part of the prison officials that their conduct or lack of intervention will cause significant harm or risk of harm to a prisoner. While medical necessity of care is often fairly simple to prove, deliberate indifference is a subjective assessment that represents a much higher legal hurdle.

Why Gender Affirmation Doesn't Happen in Carceral Settings

There are many barriers to gender affirmation in carceral settings. The first is staff bias and a lack of training. Qualitative studies of both correctional and clinical staff[14] and transgender people with a history of incarceration[15] show that lack of staff competency regarding gender-affirming care presents a barrier to access, resulting in inadequate or complete denial of care. In particular, clinical staff report a lack of training and unfamiliarity with transgender care,[14] a finding replicated in other institutional settings such as the military.[16]

Housing is the second barrier to gender affirmation. Although under the federal Prison Rape Elimination Act (PREA), prisoners are legally entitled to be housed in a prison in accordance with their gender identity regardless of their anatomy,[17] in reality this

practice is concerningly rare. A 2020 survey found that only 15 of 4890 transgender people were housed according to their gender identity in state prisons.[2] Many state prisons rely on a binary system of classification that rests largely on genital morphology, seeking to house only transgender prisoners who have had genital surgeries in accordance with their gender.[18,19,20] Yet data show that transgender women who are incarcerated in men's prisons have a vastly heightened risk for sexual assault than prisoners as a whole.[21] Conversely, transgender women housed in women's facilities have substantially lower rates of victimization than transgender women housed in men's facilities.[19] Prison administrators have responded to violence against transgender people by remanding them to "protective" custody (ie, solitary confinement), but this practice is notorious for exacerbating isolation, psychological distress, and exclusion from prison programming. This practice is not only legally precarious but also highlights an ethical failing of states that do not readily provide gender-affirming care. For if prisoners are only eligible for transfer to facilities in accordance with their gender upon achieving specific milestones in transition, and if housing in accordance with gender—not anatomy—is a predictor of violence against transgender people in prison, then the decision to provide or not provide gender-affirming care ultimately determines whether or not the state takes decisive action to mitigate some of the worst harms associated with incarceration for gender minority prisoners.

The third barrier to gender affirmation in prison settings is lack of medical and surgical intervention. *Estelle v Gamble* established that by neglecting essential medical care, prisons inflicted punishment beyond society's penological interests.[6] Prisoners, who must rely on the state for their medical needs, should receive adequate treatment. However, in *Maggert v Hanks* (1997), the prison psychiatrist disputed the very diagnosis of gender dysphoria, and the US Court of Appeals for the Seventh Circuit stated: "except in special circumstances that we do not at present foresee, the Eighth Amendment does not entitle a prison inmate to curative treatment for his gender dysphoria."[22] There was concern that if gender-affirming therapy became the norm in prisons, transgender people would purposely commit crimes in order to receive said treatment. Several legal challenges to carceral institutions' denial of gender-affirming hormone therapy have resulted in gender-affirming care being extended to people who are incarcerated. The decision of the US Court of Appeals for the Seventh Circuit in *Meriwether v Faulkner* (1987) recognized gender dysphoria as a serious medical condition constituting a valid Eighth Amendment claim as established in *Estelle* but emphasized that the plaintiff, a transgender woman denied estrogen, was entitled to "some" kind of medical intervention meeting minimal standards of adequacy though not necessarily the intervention she was requesting.[23] It was not until the landmark case of *Fields v Smith* (2011), in which the US Court of Appeals for the Seventh Circuit struck down a 2005 Wisconsin law barring all access to gender-affirming hormones or surgeries for people in the custody of the Department of Corrections as a violation of the prohibition of cruel and unusual punishment, that courts began to rule favorably for transgender plaintiffs.[24] In 2015, the Department of Justice's statement of interest in *Diamond v Owens* issued a directive to all state prisons to evaluate all persons seeking hormone therapy and to continue the hormone regimen they were on at the time of incarceration.[25]

In several other court cases, the Eighth Amendment argument has been extended to include gender-affirming surgeries.[26,27,28,29] As previously noted, some transgender people experience severe dysphoria even after counseling, nonmedical affirmation, and hormone therapy. Prisoner access to gender affirmation surgery remains extremely rare, although blanket bans on these procedures have been ruled unconstitutional under

Eighth Amendment claims.[30] The handful of successful petitioners have had their surgical requests fulfilled only after expressions of extreme self-harm and only after extensive litigation.[27,29,30,31] The plaintiff in *Kosilek v Spencer* filed her first claim in 1992, but the decision of the district court ordering the commissioner of the Massachusetts Department of Corrections to provide her with surgery didn't come until 2014.[26] This decision was immediately reversed by the First Circuit,[26] and the Supreme Court declined to hear her appeal.[32] She didn't receive surgery until 2021, after *Kosilek* was heavily scrutinized in the landmark case, *Edmo v Corizon* (2019),[29] a full 27 years after Kosilek initially sought remedy. Other people who are incarcerated who have sought gender affirmation surgery have lost their cases on a variety of grounds, including disagreement over WPATH guidelines representing standard of care,[28] safety considerations for other prisoners,[27]and prison-hired medical experts denying the necessity of the plaintiff's surgery.[33]

Removing Barriers

Despite legal advances, structural barriers to adequate gender-affirming care remain for transgender people who are incarcerated. Under *Estelle*, correctional institutions have an obligation to deliver gender-affirming care if "medically necessary" to transgender people who are incarcerated in accordance with "professional standards,"[6] such as the WPATH guidelines, which are widely accepted as representing the current medical and scientific consensus.[34] Even when this obligation is acknowledged, however, artificial administrative delays can prevent timely and adequate treatment,[35] effectively blocking access to appropriate care. Often, prisoners must meet a certain threshold (ie, a "serious" condition) to be eligible for medical intervention.[36] In order to gain access to gender-affirming care, prisoners have resorted to extreme measures to make their cases known, including self-surgery, such as autocastration.[5,7]

We hold that gender-affirming care for transgender and gender nonconforming people—which is required under the prevailing legal standard if it is medically necessary for alleviation of gender dysphoria—should be patient-centered. In light of the barriers noted above, patient-centered gender-affirming care within carceral institutions requires a multifaceted approach. Specifically, there are 3 foci that jails, prisons, and detention facilities must address to ensure a standard of care comparable to that available in the community: affirmation, custodial policy, and clinical competence.

Establishment of gender affirmation in jails, prisons, and detention centers should be formal and explicit, with medical and custodial staff receiving competency training. Custodial policy includes housing assignments, which, under PREA standards, shall be decided on a case-by-case basis with serious consideration given to the transgender person's views on their safety.[17] The use of solitary confinement for purported protection must end. This practice has always been a dangerous and inhumane solution, which can be avoided with adequate attention to the safety of transgender people. Other practices, including custodial staff conducting strip searches to determine genital status, should not be performed or should be performed in accordance with the person's gender, such as name and pronoun use and access to appropriate commissary items.[37] Carceral staff are often outwardly hostile to transgender people, exacerbating the distress they already experience from unjust housing assignments and lack of medical care.[38] Protocols must be established for managing staff who continue to violate the human rights of people who are incarcerated.

Finally, clinical competence in gender-affirming care is as crucial as it would be for any other medical presentation. On-site staff should receive training to fill in gaps or correct practices that create barriers to care for transgender people.[39] In institutions with inadequate or unsuitable staff, outside care should be obtained, just as it would be for other forms of specialized medical care.[40] The use of nonclinical staff for "gender identity disorder review panels" must end, with external medical professionals, not prison officials, leading the process. Clinical guidelines produced by a professional entity, such as WPATH[8] or the University of California, San Franciso,[41] should be used to guide care. As these guidelines for medical and surgical interventions are widely used in community practice and are lifesaving and effective, their use should not be limited in carceral institutions.

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Jennifer Aldrich, MD is a professor of clinical medicine at the Lewis Katz School of Medicine at Temple University in Philadelphia, Pennsylvania, who is board certified in internal medicine and infectious disease and regularly lectures about incarceration and gender-affirming care.

Jessica Kant, MSW, LICSW, MPH is a lecturer at the Boston University School of Social Work in Massachusetts and a licensed independent clinical social worker at the Center for Gender Surgery at Boston Children's Hospital.

Eric Gramszlo is a student at the Lewis Katz School of Medicine at Temple University in Philadelphia, Pennsylvania, pursuing a dual MD/MA degree in urban bioethics.

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