(D)EVOLVING STANDARDS OF DECENCY: THE UNWORKABILITY OF CURRENT EIGHTH AMENDMENT JURISPRUDENCE AS ILLUSTRATED BY *KOSILEK V. SPENCER*

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I. INTRODUCTION

To live means to suffer, because the human nature is not perfect and neither is the world we live in.

—Buddha, The Four Noble Truths

Michelle (Robert) Kosilek[1] first exhibited signs of gender identity disorder ("GID") at the tender age of three years old.[2] An orphan during most of her early childhood, Kosilek would sneak over to the female side of the Catholic orphanage where she lived so that she could "wear girls' clothing and play with girls"—behaviors for which she received severe physical punishment.[3] Undeterred, Kosilek continued to exhibit signs of

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1. As of this writing, Kosilek is a preoperative transsexual who was born biologically male. Because Kosilek legally changed her name in 1993, and because Kosilek and others refer to her using female pronouns, this writing will refer to Kosilek as Michelle and will similarly use female pronouns.

2. Kosilek v. Maloney, 221 F. Supp. 2d 156, 158 (D. Mass. 2002). For purposes of cohesion, this Note will refer to Kosilek's condition as "gender identity disorder," as that is the named condition referred to in court documents and other sources. It should be noted, however, that the American Psychiatric Association ("APA") recently eliminated gender identity disorder from its diagnostic manual and replaced it with the term "gender dysphoria." The APA made this move in an effort to reduce the social stigma associated with being transgender. *See* Moni Basu, *Being Transgender No Longer a Mental 'Disorder' in Diagnostic Manual*, CNN (Dec. 27, 2012), http://inamerica.blogs.cnn.com/2012/12/27/being-transgender-no-longer-a-mental-disorder-in-diagnostic-manual (explaining the changes to the APA diagnostic manual and the reasons for those changes).

3. Report or Affidavit of Dr. David Seil, M.D., Kosilek v. Clarke, No. 00CV12455 (D. Mass.

GID throughout her childhood and adolescence; she also continued to be abused.[4] As one of her psychiatrist reports stated, "At age 13, [Kosilek] developed what was most likely normal transient gynecomastia. She commented to her mother [who had since removed Kosilek from the orphanage], 'See? I really am a girl.' Her stepfather overheard the remark and assaulted her with a broken beer bottle."[5] After this incident, Kosilek began running away; she left home permanently at age fifteen.[6]

After leaving home, Kosilek continued to struggle with her gender identity. Psychiatrist David Seil explains,

> [A]n underlying theme [of her life] is her attempt to cope with her gender confusion. She has alternately lived as male and female. She also coped by drug usage and prostitution. Certain periods have been more organized. Her first experience with female hormones was at age 18. This was stopped when she was arrested for possession of marijuana and was incarcerated for three years. Upon release, she restarted estrogens and lived full time as a female. She was severely beaten because she cross-dressed, and began using heroin and alcohol. She reports "three or four" prison sentences after that time because she was burgularizing [sic] to support her drug habit.[7]

Kosilek's prison stints did little more than exacerbate her drug and alcohol addiction: by the 1980s, she was a "blackout drinker."[8] Kosilek eventually sought treatment for her drug abuse[9] and went on to earn a Bachelor's degree in psychology from New Hampshire University.[10] Kosilek later married her drug counselor, Cheryl McCaul, who had convinced Kosilek that marrying "a good woman" would cure Kosilek's gender identity disorder.[11] Kosilek recalls that during this time she "managed to suppress her gender needs," though she continued to feel "persistent discomfort" living as a male.[12]

Feb. 23, 2003), 2003 WL 25910594. *See also* Report or Affidavit of Chester W. Schmidt, Jr., M.D. at 3, Kosilek v. Dep't of Corr., No. 00CV12455 (D. Mass. Nov. 23, 2005), 2005 WL 5680039 (reporting that Kosilek recalls "a broken collar bone and broken ribs from punishments carried out by the Nuns").

4. Report or Affidavit of Dr. Chester W. Schmidt, Jr., M.D., *supra* note 3, at 3.

5. Report or Affidavit of Dr. David Seil, M.D., *supra* note 3. "Transient gynecomastia" is the medical term for male breast tissue. George Ansstas, *Gynecomastia*, MEDSCAPE (Mar. 18, 2013), http://emedicine.medscape.com/article/120858-overview.

6. Report or Affidavit of Dr. David Seil, M.D., *supra* note 3.

7. *Id.*

8. *Id.*

9. *Id.*

10. Commonwealth's Brief at 6, Commonwealth v. Kosilek, 668 N.E.2d 808 (Mass. 1996) (No. SJC-06743).

11. Kosilek v. Spencer, 889 F. Supp. 2d 190, 213 (D. Mass. 2012).

12. Report or Affidavit of Dr. David Seil, M.D., *supra* note 3 (reporting that during sexual

Kosilek's marriage to McCaul ended on May 20, 1990, after Kosilek strangled McCaul with a piece of wire.[13] Police discovered McCaul's body in her car in the parking lot of a nearby shopping mall.[14] The first officer to arrive at the scene found McCaul "face up, with her feet partially on the ground and partially on the seat, and with her head positioned on the seat. Some type of afghan covered much of her body."[15] He further observed that her sweatshirt was "pulled up to her neck with her breasts exposed" and that there was a rope around her neck.[16] He also reported blood near her genitals.[17] Police then contacted Kosilek to inform her that a body had been found in the back of McCaul's car.[18] Kosilek responded, "I don't know what you want me to say. How was she killed? Was she shot? Was she awful looking? Was she molested?"[19] At that time, "no one had mentioned the manner of death of the body, nor whether the body was that of Cheryl [McCaul]."[20] Kosilek later admitted on several occasions to murdering McCaul, though she has also claimed that she "went into a blackout" during the altercation and that the murder was "probably in self-defense."[21]

Kosilek first sought treatment for her GID while she was incarcerated awaiting trial at Bristol County Jail.[22] While there, jail officials permitted Kosilek to hire Dr. Nancy Strapko to prepare for trial, but prohibited Strapko from providing Kosilek with any treatment.[23] Eventually, Kosilek began taking birth control pills illegally procured from a prison guard.[24] During this time, Kosilek tried twice to commit suicide and once attempted to self-castrate.[25] She did not report these incidents to the guards or other prison officials.[26] At the murder trial, Kosilek presented expert testimony

intercourse, Kosilek "dissociated and placed herself in the female role of intercourse. Post-coitally she reported intense depression at having to face to [sic] reality of her anatomy.").

13. *See Commonwealth v. Kosilek*, 668 N.E.2d at 811–12.
14. *Id.* at 811.
15. Commonwealth's Brief, *supra* note 10, at 4.
16. *Id.*
17. *Id.*
18. *Id.*
19. *Id.* at 6.
20. *Id.*
21. *Id.* at 13.
22. Kosilek v. Maloney, 221 F. Supp. 2d 156, 164 (D. Mass. 2002) (noting that "[d]espite [her] painful belief that [s]he was truly a female, Kosilek did not seek treatment for [her] gender identity disorder" until she was incarcerated for McCaul's murder).
23. *Id.*
24. *Id.*
25. Report or Affidavit of Chester W. Schmidt, Jr., M.D., *supra* note 3, at 5.
26. *Id.*

of Dr. Strapko, who testified that while she believed that Kosilek suffered from gender dsyphoria, the disorder was "unrelated" to McCaul's murder.[27] A jury convicted Kosilek of first degree murder with extreme atrocity or cruelty,[28] and she was sentenced to life in prison without the possibility of parole.[29]

In 1994, the Massachusetts Department of Corrections ("DOC") transferred Kosilek from Bristol County to MCI-Norfolk, a medium security men's prison.[30] Upon arriving at MCI-Norfolk, Kosilek began living as a woman "to the maximum extent possible."[31] She legally changed her name from Robert to Michelle.[32] She also "[grew her] fingernails and hair long, modulated [her] voice to sound more feminine, had [her] clothing tailored to appear more feminine, and used various products as makeup."[33]

Kosilek also asked the DOC to provide her with medical treatment for her GID according to the World Professional Association for Transgender Health's ("WPATH") "Standards of Care," the internationally accepted medical standards for the treatment of gender identity disorder.[34] Under the Standards of Care, doctors treat patients according to a "triadic sequence" of care comprised of hormone therapy, a year-long "real-life experience" living as the opposite sex, and when necessary, sex reassignment surgery.[35] Eventually, the DOC complied with Kosilek's request and had her examined by an expert on GID.[36] This expert diagnosed Kosilek with gender identity disorder and recommended treatment consistent with the Standards of Care, including female hormones.[37] Nevertheless, the

27. Brief and Record Appendix of Defendant-Appellant at 20, Commonwealth v. Kosilek, 668 N.E.2d 808 (D. Mass. 1996) (No. SJC-06743).

28. *Commonwealth v. Kosilek*, 668 N.E.2d at 810.

29. Kosilek v. Spencer, 889 F. Supp. 2d 190, 214 (D. Mass. 2012).

30. Kosilek v. Maloney, 221 F. Supp. 2d 156, 164 (D. Mass. 2002).

31. *Id.*

32. *Id.*

33. *Id.*

34. *Id.* at 166. Until recently, the WPATH Standards of Care were named the Harry Benjamin International Gender Dysphoria Association's Standards of Care after its founder. Readers should note that the Kosilek cases refer to the former name in discussing the Standards of Care. As the court in *Kosilek v. Spencer* relied on the sixth edition Standards of Care, *Kosilek v. Spencer*, 889 F. Supp. 2d at 197, this Note will also rely on the genital surgery *requirements* of the sixth edition, WALTER MEYER III ET AL., THE HARRY BENJAMIN INTERNATIONAL GENDER DYSPHORIA ASSOCIATION'S STANDARDS OF CARE FOR GENDER IDENTITY DISORDERS, SIXTH VERSION 14–15 (2001) [hereinafter STANDARDS OF CARE]. More information, including a background on the Standards of Care and on its founder, can be found at the WPATH website, http://www.wpath.org/site_home.cfm.

35. *Kosilek v. Maloney*, 221 F. Supp. 2d at 166.

36. *Id.* at 167–68.

37. *Id.* at 168.

Massachusetts DOC and its revolving door of commissioners refused to provide Kosilek with estrogen.[38] The reasons given for denying Kosilek hormone therapy varied in their legitimacy, but were mostly found unacceptable by the District Court Judge in *Kosilek v. Maloney*.[39] The court in *Kosilek v. Maloney* put then-DOC commissioner Maloney on notice that, by denying Kosilek hormone therapy and other treatment under the Standards of Care, the DOC had failed to provide Kosilek with the adequate medical treatment required by the Eighth Amendment.[40] In reaching this decision, the court relied heavily on the many evaluations by medical professionals who had classified Kosilek's gender identity as "severe."[41] In addition, the court relied on statements by Kosilek herself, who has maintained that while she is not currently suicidal, she will kill herself if she is ultimately denied sex reassignment surgery.[42]

In response to the court's decision in *Kosilek v. Maloney*, the DOC started Kosilek on a hormone therapy regimen.[43] Kosilek also began wearing female undergarments.[44] The hormone therapy alleviated many of Kosilek's symptoms of gender identity disorder.[45] Nevertheless, she continued to feel "distressed" and "disgusted" by her male genitalia.[46] Upon reevaluation, her doctors agreed that Kosilek needed and was eligible for sex reassignment surgery.[47] They argued that unless Kosilek received further treatment, there would be a continued risk that she would commit suicide and that sex reassignment surgery was the only medically adequate treatment to reduce that risk.[48] These doctors repeatedly communicated their recommendation to the DOC's newest commissioner, Kathleen Dennehy.[49] Despite these recommendations, however, the Massachusetts

38. *Id.* at 172–75.

39. *Id.* at 191.

40. *Id.* at 185–89.

41. *Id.* at 184.

42. *Id.* at 168. The opinion quotes a March 15, 2000, report on Kosilek by Dr. Forstein:

> [Kosilek] made a pact with himself that if at 50 he had not achieved his goal of becoming truly female, he would consider life hopeless and meaningless. He had no active suicidal ideation, but there was a sense that in the absence of becoming a female, he would not choose to continue living as a male. . . . *One area of concern is the potential suicidality if this last chance [provided by his lawsuit] to achieve his lifelong desire is denied. I believe that he would be a great risk for self harm, perhaps mutilation, if not suicide*.

Id. (second alteration in original).

43. Kosilek v. Spencer, 889 F. Supp. 2d 190, 218–19 (D. Mass. 2012).

44. *Id.* at 219.

45. Report or Affidavit of Marshall Forstein, M.D., Kosilek v. Clarke, No. 1:00CV12455 (D. Mass. Oct. 31, 2005), 2005 WL 6464298.

46. *Kosilek v. Spencer*, 889 F. Supp. 2d at 226 (internal quotation marks omitted).

47. *Id.* at 222.

48. *Id.*

49. *Id.*

DOC neither provided nor attempted to provide Kosilek with sex reassignment surgery.[50]

At the trial of *Kosilek v. Spencer*, prison officials testified that providing Kosilek with sex reassignment surgery would present "insurmountable" security concerns and should preclude Kosilek from receiving the operation.[51] The DOC also presented the testimony of doctors who did not believe Kosilek needed nor should receive sex reassignment surgery.[52] Importantly, in reaching their conclusions, these doctors did not follow the Standards of Care.[53] Finally, while numerous officials maintained that neither cost nor controversy had influenced the DOC's decision to deny Kosilek's operation, Commissioner Dennehy testified that she would "retire rather than obey a Supreme Court order requiring her to provide the sex reassignment surgery to Kosilek."[54]

Finally, after a decades long, costly legal battle between the Massachusetts DOC and Kosilek,[55] on September 4, 2012, the court issued an injunction ordering the Massachusetts DOC to provide Kosilek with sex reassignment surgery.[56] Specifically, the court determined that Kosilek proved that by denying her sex reassignment surgery, the Massachusetts DOC had violated Kosilek's Eighth Amendment right to medically necessary care.[57] In proving the violation, the court argued that Kosilek successfully showed both that (1) she has a "serious medical need";[58] and (2) that DOC officials were aware of, and deliberately indifferent to, Kosilek's serious medical need.[59] In reaching the decision, the court rejected the DOC's repeated claims that providing the surgery would cause substantial security concerns and could "encourage other prisoners to try to manipulate prison officials."[60] The court further rejected as "pretextual" the DOC's argument that since Kosilek would likely need to be transferred

50. *Id.*
51. *Id.* at 228 (internal quotation marks omitted).
52. *Id.* at 227.
53. *Id.*
54. *Id.* at 228.
55. Plaintiff's Motion for Award of Attorneys' Fees and Costs, Kosilek v. Spencer, 889 F. Supp. 2d 190 (D. Mass. 2012) (C.A. No. 00-cv-12455-MLW), *available at* http://cbsboston.files.wordpress.com/2012/10/kosilek-attorney-motion-for-fees1.pdf (requesting $161,873.12 in costs and $644,573.13 in attorney's fees). This fee request applies only to the most recent litigation. Kosilek and the DOC have been in and out of court since 1999, and total costs for the litigation are substantially higher than the number reported here.
56. *Kosilek v. Spencer*, 889 F. Supp. 2d at 251.
57. *Id.* at 230, 251.
58. *Id.*
59. *Id.* at 239–40.
60. *Id.* at 241.

across the country to get the surgery, there was a risk that Kosilek would escape, especially since Kosilek had fled Massachusetts after murdering McCaul.[61]

Unsurprisingly, the district court's highly publicized opinion incited public response ranging from enthusiastic support[62] to concern[63] to unbridled outrage.[64] Transgender advocates acknowledge the ruling as a step toward societal validation both of GID as a real mental illness, and hormone therapy and sex reassignment surgery as legitimate forms of treatment.[65] Conversely, opponents view Kosilek as a manipulative, cold blooded killer who has successfully gotten her way by threatening to kill herself.[66] Lying somewhere in the middle, others accept Kosilek's disorder as valid but argue that compared with other ailments, its seriousness falls short of deserving such an expensive, uncommon, and difficult-to-obtain treatment.[67]

Conflicting public reactions aside, this opinion raises hard questions about the scope of the government's Eighth Amendment duty to provide medical care to prisoners. On the one hand, this protection is vitally necessary, as inmates not only cannot provide medical care for themselves,[68] but also often come from disfavored and otherwise

61. *Id.* at 240–41.

62. *Black and Pink Celebrates Michelle Kosilek's Victory; Healthcare Is a Human Right*, ABOLITION NOW!, http://www.blackandpink.org/revolt/kosilek/ (last visited Jan. 2, 2014).

63. Monica Roberts, *Conflicted Emotions About Kosilek Case*, TRANSGRIOT (Sept. 6, 2012), http://transgriot.blogspot.com/2012/09/conflicted-about-kosilek-case.html.

64. Lawrence Harmon, *Judge Goes Too Far in Sex Change Ruling*, BOS. GLOBE (Sept. 7, 2012), http://bostonglobe.com/opinion/2012/09/06/judges-goes-too-far-ordering-sex-change-operation/OGhfrwf0etlYrrh6Fv9irJ/story.html; Akiba Solomon, *We Can't Afford to Participate in a 'Justice for Some' Culture*, COLORLINES (Sept. 24, 2012, 10:00 AM), http://colorlines.com/archives/2012/09/online_and_in_life_we_simply_cant_afford_to_participate_in_a_justice_for_some_culture.html (providing examples of the negative reaction to the *Kosilek v. Spencer* ruling).

65. *See* Ally Windsor Howell, *A Comparison of the Treatment of Transgender Persons in the Criminal Justice Systems of Ontario, Canada, New York, and California*, 28 BUFF. PUB. INT. L.J. 133, 139 (2010) (noting the "popular belief that transgender persons are a small and insignificant group who 'choose' to be the way they are"). *Cf.* Bradley A. Sultan, Note, *Transsexual Prisoners: How Much Treatment Is Enough?*, 37 NEW ENG. L. REV. 1195, 1226 (2003) (arguing that "no medical evidence exists" showing that GID "by itself is life-threatening").

66. Eileen McNamara, *When Gender Isn't Relevant*, BOSTON GLOBE, June 11, 2006, at B1, *available at* http://www.boston.com/news/local/articles/2006/06/11/when_gender_isnt_relevant/.

67. *See, e.g.*, Sultan, *supra* note 65 (reasoning that "it cannot be argued that [GID] rises to the level of serious heart disease or leukemia, where without a relatively specific treatment . . . the patient will certainly die").

68. *E.g.*, Brown v. Plata, 131 S. Ct. 1910, 1928 (2011) ("To incarcerate, society takes from prisoners the means to provide for their own needs.").

marginalized categories of American society.[69] On the other hand, the reality of finite resources is difficult to ignore.[70] Teetering on the edge of a fiscal cliff, state legislatures are preparing for substantial budget cuts to Medicare and other healthcare programs.[71] Meanwhile, in deciding medical care cases, courts eschew cost considerations.[72] Opinions like *Kosilek v. Spencer* and *De'Lonta v. Johnson*[73] suggest that if an illness has a medically recognized treatment, the Eighth Amendment obligates legislatures to provide it to prisoners.[74] Conversely, government medical programs and private insurers have broad discretion to limit and even prohibit certain services to noninmates based on considerations such as cost.[75] Consequently, the different modes of analysis between current

69. *See, e.g.*, David R. Katner, *The Mental Health Paradigm and the MacArthur Study: Emerging Issues Challenging the Competence of Juveniles in Delinquency Systems*, 32 AM. J.L. & MED. 503, 513 (2006) (citing Richard E. Redding, *Why It Is Essential to Teach About Mental Health Issues in Criminal Law (and a Primer on How to Do It)*, 14 WASH. U. L.J. & POL'Y 407, 408–09 (2004)) (detailing the prevalence of mentally ill persons in adult and juvenile criminal systems); Sydney Tarzwell, Note, *The Gender Lines Are Marked with Razor Wire: Addressing State Prison Policies and Practices for the Management of Transgender Prisoners*, 38 COLUM. HUM. RTS. L. REV. 167, 175 (2006) ("[T]ransgender individuals are disproportionately forced into criminalized economies in order to survive.").

70. Although the effect has not been immediate, people are beginning to realize that contemporaneous increases in state budgets for prison appropriations results in decreases in budgets for other programs. *Compare* Wyatt Buchanan & Marisa Lagos, *CA Budget: Big Cuts to Welfare, Kids' Health Care*, SF GATE (June 27, 2012), http://www.sfgate.com/news/article/CA-budget-big-cuts-to-welfare-kids-health-care-3668717.php (detailing the effects of $92 billion in recent budget cuts to children's healthcare and other programs approved by California Governor Jerry Brown), *with* ACLU, AT AMERICA'S EXPENSE: THE MASS INCARCERATION OF THE ELDERLY 26 (2012), *available at* https://aclu.org/files/assets/elderlyprisonreport_20120613_1.pdf (reporting that "overall state spending on corrections increased from $11 billion in 1988 to $52 billion in 2008").

71. Bruce Japsen, *27% Medicare Pay Cut for Doctors Real Danger in Fiscal Cliff*, FORBES (Dec. 20, 2012, 8:13 AM), http://www.forbes.com/sites/brucejapsen/2012/12/20/27-medicare-pay-cut-for-doctors-real-danger-in-fiscal-cliff/; Parija Kavilanz, *Medicare Doctors' Pay to be Cut*, CNNMONEY (Mar. 3, 2013, 5:34 PM), http://money.cnn.com/m/#!2012/03/02/smallbusiness/medicare-doctors-spending-cuts/index.html (explaining how new budget cuts will make it increasingly difficult for low-income patients to receive medical care).

72. *See infra* Part II.B.

73. De'Lonta v. Johnson, 708 F.3d 520, 526 (4th Cir. 2013) (finding that medical treatment must be adequate).

74. *See* Sharon Dolovich, *Cruelty, Prison Conditions, and the Eighth Amendment*, 84 N.Y.U. L. REV. 881, 892 (2009) ("The state's carceral burden is the price society pays for the decision to incarcerate convicted offenders."); Jessica Wright, Note, *Medically Necessary Organ Transplants for Prisoners: Who Is Responsible for Payment?*, 39 B.C. L. REV. 1251, 1291 (1998) ("Judicial interpretation of [the *Estelle v. Gamble*] standard clearly dictates that prisoners are entitled to medical treatment prescribed by a physician, so long as the physician exercises professional judgment." (citing Estelle v. Gamble, 429 U.S. 97, 104 (1976))).

75. *See, e.g.*, Maggert v. Hanks, 131 F.3d 670, 671–72 (7th Cir. 1997) (suggesting that because many states exclude coverage for hormone therapy and sex reassignment surgery, this means that "[g]ender dysphoria is not, at least not yet, generally considered a severe enough condition to warrant

Eighth Amendment medical care jurisprudence and policies governing medical care for noninmates create treatment decisions that are controversial and incoherent.[76]

This Note proposes that substantial reform to Eighth Amendment medical care analysis will help reduce controversial court decisions and decrease the disconnect between the medical care available to prisoners and noninmates. Specifically, this Note examines how Eighth Amendment medical care jurisprudence has adopted a framework of analysis inconsistent with traditional Eighth Amendment jurisprudence concerning cruel and unusual punishments. It suggests that courts begin analyzing objective indicia of society's standards in medical care cases in a manner consistent with Eighth Amendment punishment cases.

Part II of this Note provides an overview of Eighth Amendment jurisprudence and will examine the difference in analysis between punishment cases and medical care and prison condition cases. Part III uses Part II as a framework to examine the district court's Eighth Amendment

expensive treatment at the expense of others than the person suffering from it"). Of course, the federal government has not made explicit its use of cost consideration in determining Medicare coverage; however, it is not required to do so. A decision to exclude a particular procedure, to reduce the reimbursements available for care, and other decisions that affect service availability demonstrate that the federal government is working with finite resources. Thus, some people will eventually require medically necessary care that they will be unable to procure. *See* Douglas Holtz-Eakin & Ken Thorpe, *Medicare Cuts Are a Giant Step Backward*, POLITICO (Mar. 4, 2013, 9:32 PM), http://www.politico.com/story/2013/03/medicare-cuts-are-a-giant-step-backward-88382.html?hp=r4 (explaining that recent Medicare cuts serve only a cost-cutting purpose). Finally (and notably), Medicare may technically cover a particular service that will be largely precluded in practice. For instance, although Medicare provides partial coverage for certain vital organ transplants, many people eligible for Medicare coverage (those over sixty-five years old) will be medically ineligible for these procedures. *See Heart Transplant: Why It's Done*, MAYO CLINIC, http://www.mayoclinic.com/health/heart-transplant/MY00361/DSECTION=why%2Dits%2Ddone (last visited Jan. 5, 2014) (explaining that patients over sixty-five years old may be precluded from receiving a heart transplant); *Your Medicare Coverage*, MEDICARE.GOV, http://www.medicare.gov/coverage/transplants-adults.html (last visited Jan. 5, 2014) (providing a list of transplant procedures covered under Medicare). It remains to be seen how, or if, the Affordable Care Act ("ACA") will help noninmates procure insurance coverage for treatment related to gender identity disorder. Some GID advocates are cautiously optimistic that the ACA will enable patients to receive treatment for their gender identity disorder that would have been unavailable under a pre-ACA insurance plan. *See, e.g.*, Natasha Vitale, *What the Affordable Care Act Means for Transgender People*, NEV. MEDIA ALLIANCE (Nov. 13, 2013), http://nevadamediaalliance.org/2013/11/13/what-the-affordable-care-act-means-for-transgender-people/. This Note will focus on the currently available case law, which generally refers to the state of the law prior to the enactment of the ACA.

76. *See, e.g.*, Carrie S. Frank, Note, *Must Inmates Be Provided Free Organ Transplants?: Revisiting the Deliberate Indifference Standard*, 15 GEO. MASON U. C.R. L.J. 341, 341–42 (2005) (discussing two recent cases concerning patients who were seeking lifesaving organ transplants: one who died after his insurer dropped him from coverage, and one who received a state-funded heart transplant while incarcerated).

analysis in *Kosilek v. Spencer*. Part IV proposes substantial reform to Eighth Amendment medical care analysis, applies the new analysis to *Kosilek v. Spencer*, and considers the result. Finally, Part V concludes.

II. THE EVOLUTION OF EIGHTH AMENDMENT JURISPRUDENCE

The Eighth Amendment prohibits the infliction of "cruel and unusual punishments."[77] Although originally applied to prohibit only the most extreme punishments,[78] the Supreme Court has slowly expanded the scope of protection to include other types of punishments,[79] punishments "grossly disproportionate" to the offense,[80] and punishments for certain categories of offenders.[81] Significantly, the Court has also expanded Eighth Amendment protections beyond sentencing to impose an affirmative duty on the government to provide inmates with minimally adequate prison conditions and medically necessary care.[82] Notably, however, while the Court considers "objective indicia" of societal standards in its analysis of punishment cases,[83] comparable analysis is largely absent from prison condition and medical treatment cases.[84] Thus, while Eighth Amendment jurisprudence for punishment cases relies heavily on current legislation and sentencing practices to determine permissible sentences for criminals, courts do not comparably analyze legislation to help determine the scope of medical care that should be available to inmates.

77. U.S. CONST. amend. VIII.

78. Wilkerson v. Utah, 99 U.S. 130, 135–36 (1878) ("Difficulty would attend the effort to define with exactness the extent of the constitutional provision which provides that cruel and unusual punishments shall not be inflicted; but it is safe to affirm that punishments of torture . . . and all others in the same line of unnecessary cruelty, are forbidden by that amendment to the Constitution.").

79. *See, e.g.*, Trop v. Dulles, 356 U.S. 86, 101 (1958) ("We believe . . . [the] use of denationalization as a punishment is barred by the Eighth Amendment.").

80. Harmelin v. Michigan, 501 U.S. 957, 997–98 (1991) (Kennedy, J., concurring in part and concurring in the judgment).

81. *See, e.g.*, Graham v. Florida, 560 U.S. 48, 75 (2010) (prohibiting life without parole sentences for juveniles convicted of nonhomicide crimes); Atkins v. Virginia, 536 U.S. 304, 321 (2002) (prohibiting capital punishment of "mentally retarded" offenders).

82. *See, e.g.*, DeShaney v. Winnebago Cnty. Dep't. of Soc. Servs., 489 U.S. 189, 199–200 (1989) (requiring the state to provide "reasonable safety" and medical care to inmates (quoting Youngberg v. Romeo, 457 U.S. 307, 314–25 (1982))); Estelle v. Gamble, 429 U.S. 97, 103, 103–04 (1976) (discussing the government's obligation to provide medical care for inmates).

83. *Graham*, 560 U.S. at 61 (quoting Roper v. Simmons, 543 U.S. 551, 572 (2005)).

84. In *Estelle*, the Supreme Court links the *Trop* standard to objective factors by acknowledging that several states had passed laws recognizing the government's duty to provide medical care to prisoners. *Estelle*, 429 U.S. at 103 n.8. Interestingly, subsequent court decisions do not revisit this step of analysis. *See, e.g.*, *infra* text accompanying note 123. An argument can be made that such a step is unnecessary because the government's obligation to provide medical care is well established. The relevant inquiry, however, should be not whether care should be provided but how much care should be provided.

A. CONTEMPORARY "PUNISHMENT" JURISPRUDENCE CONSIDERS OBJECTIVE FACTORS

Eighth Amendment analysis of contemporary punishment cases begins with an examination of the "evolving standards of decency that mark the progress of a maturing society."[85] Thus, "the Court first considers 'objective indicia of society's standards, as expressed in legislative enactments and state practice' to determine whether there is a national consensus" approving or opposing a particular punishment.[86] In addition to considering state and federal laws, the Court may consider recent trends indicating a "direction of change,"[87] as well as states' "actual sentencing practices."[88] Next, the Court's own independent judgment is "brought to bear" in determining whether the punishment violates the Eighth Amendment.[89] This includes an examination of the "culpability of the offenders at issue," the "severity of the punishment," and whether the punishment "serves legitimate penological goals."[90]

Despite its seemingly holistic Eighth Amendment analysis, the Court's extreme deference to the "legislative prerogative" affords legislatures almost unbridled discretion for punishing crime.[91] This deference means that "[a] person might receive a longer mandatory sentence for drugs than for rape or other violent crimes; there is no need for a legislature to justify the difference."[92] Thus, states like Oklahoma can sentence a person to life

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

86. *Graham*, 560 U.S. at 61 (quoting *Roper*, 543 U.S. at 572). In *Graham*, the Court states that this analysis is used only in cases considering whole categories of offenders. *Id.* However, while the Court does not use the "objective indicia" language in single offender cases, it still analyzes and weighs objective factors heavily in making its decision. *See, e.g.*, Harmelin v. Michigan, 501 U.S. 957, 998 (1991) (Kennedy, J, concurring in part and concurring in the judgment) ("The efficacy of any sentencing system cannot be assessed absent agreement on the purposes and objectives of the penal system. And the responsibility for making these fundamental choices and implementing them lies with the legislature.").

87. *Roper*, 543 U.S. at 566 (quoting Atkins v. Virginia, 536 U.S. 304, 315 (2002)) (internal quotation marks omitted).

88. *Graham*, 560 U.S. at 62 ("Actual sentencing practices are an important part of the Court's inquiry into consensus.").

89. *Atkins*, 536 U.S. at 312 (quoting Coker v. Georgia, 433 U.S. 584, 597 (1977)) (internal quotation marks omitted).

90. *Graham*, 560 U.S. at 67.

91. *Harmelin*, 501 U.S. at 962 (quoting Rummel v. Estelle, 445 U.S. 263, 274 (1980)) (internal quotation marks omitted).

92. Brian J. Foley, *The Mass Incarceration Crisis as an Opportunity to Rethink Blame*, 9 CONN. PUB. INT. L.J. 1, 10 (2009). Brian Foley gives several illustrative examples of the severe sentences upheld by the Supreme Court:

> Mandatory minimum life without parole sentence for a first-time offender who possessed more than 650 grams of cocaine? No violation of the Eighth Amendment. A "three strikes and you're out" state law that puts a man behind bars for a minimum of 25 years to life, no parole,

without the possibility of parole for something as minor as possessing less than a tenth of a gram of marijuana.[93] As a result, the size of the prison population has exploded,[94] and prisoners are more likely than ever to be sentenced to life without the possibility of parole.[95] Consequently, an increasing number of inmates will grow old and die in prison.[96] This means that legislatures will be responsible for increasing amounts of healthcare for a growing number of people.[97] Thus, how courts analyze and decide prison condition and medical care cases will become increasingly important to legislatures who likely will continue to face budget cuts and other institutional limitations.

B. PRISON CONDITION AND MEDICAL CARE JURISPRUDENCE LARGELY IGNORES (AND EVEN PROHIBITS) OBJECTIVE CONSIDERATIONS

As with punishments, the Supreme Court ruled that the Eighth Amendment prohibits prison conditions or denials of medical care that are "incompatible with the evolving standards of decency . . . or which involve the unnecessary and wanton infliction of pain."[98] These principles impose an affirmative duty on governments to "provide humane conditions of confinement" and "adequate" medical care.[99] However, in order to prove an Eighth Amendment violation for failure to provide adequate medical

> for a "wobbler"—a crime that a prosecutor has discretion to charge as a felony or misdemeanor, here, stealing three golf clubs? No violation. Sentence a man under state law to 200 years mandatory minimum, no possibility of parole, for possessing 20 pictures of child pornography? Deny *certiorari*, despite that the man was sentenced more harshly than if he had actually sexually assaulted a child, and despite that under federal law he likely would have been dealt a five-year sentence for possessing the photos.

Id. at 10–11 (footnotes omitted).

93. Interview with Eric Schlosser, *Busted: America's War on Drugs*, PBS FRONTLINE (Dec. 1997), http://www.pbs.org/wgbh/pages/frontline/shows/dope/interviews/schlosser.html. Notably, Ohio treats the same crime as harshly as a parking ticket. JON GETTMAN, MARIJUANA IN OHIO: ARRESTS, USAGE, AND RELATED DATA 1 (2009), *available at* http://www.drugscience.org/States/OH/OH.pdf.

94. ACLU, *supra* note 70, at 41 ("[T]he United States [is] the largest incarcerator in the world." (citing ROY WALMSLEY, INT'L CTR. FOR PRISON STUDIES, WORLD PRISON POPULATION LIST 1 (9th ed. 2011), *available at* http://www.idcr.org.uk/wp-content/uploads/2010/09/WPPL-9-22.pdf)).

95. *Id.* at 44.

96. *See id.* at 5 ("[P]roject[ing] that by 2030, one-third of all prisoners in the United States will be age 55 and older, amounting to over 400,000 prisoners." (citing corrections expert James Austin and the Urban Institute Project)).

97. *Id.* at 27 (finding that "taxpayers pay more than twice as much per year to incarcerate an aging prisoner than they pay to incarcerate a younger one" (citing B. JAYE ANNO ET AL., U.S. DEP'T JUSTICE, NAT'L INST. OF CORR., CORRECTIONAL HEALTH CARE: ADDRESSING THE NEEDS OF ELDERLY, CHRONICALLY ILL, AND TERMINALLY ILL INMATES 10 (2004), *available at* http://static.nicic.gov/Library/018735.pdf)).

98. Estelle v. Gamble, 429 U.S. 97, 102–03 (1976) (citations omitted) (internal quotation marks omitted).

99. Farmer v. Brennan, 511 U.S. 825, 832–33 (1994).

care, a prisoner cannot simply show an "inadvertent failure to provide adequate medical care."[100] Rather, a prisoner must show both that (1) there is a serious medical need; and (2) that prison officials were deliberately indifferent to that need.[101]

1. Serious Medical Need

A serious medical need is one that involves a "substantial risk of serious harm" to a prisoner's health or safety;[102] it can be either mental or physical.[103] Various courts have defined adequate treatment to include treatment "at a level reasonably commensurate with modern medical science"[104] and the "product of sound medical judgment"[105] based on the prisoner's specific needs. Further, "adequate medical care typically requires addressing the cause of the inmate's serious medical need rather than merely providing treatment to reduce the pain it causes."[106] However, a prison official's refusal to provide "ideal care" does not violate the Eighth Amendment.[107]

Quite notably, the Supreme Court's rigid interpretation of serious medical needs as those that involve a "substantial risk of harm"[108] and that are treated according to "sound medical judgment"[109] eliminates states' obligations to provide certain treatments, even though the inmate's underlying condition may cause legitimate physical pain or other adverse consequences.[110] For example, while denying a pregnant inmate an

100. *Estelle*, 429 U.S. at 97.

101. *See, e.g.*, *Farmer*, 511 U.S. at 834; Wilson v. Seiter, 501 U.S. 294, 298–99 (1991).

102. *Farmer*, 511 U.S. at 834 (citing Helling v. McKinney, 509 U.S. 25, 35 (1993)).

103. *See, e.g.*, Clark-Murphy v. Foreback, 439 F.3d 280, 292 (6th Cir. 2006) (noting serious medical needs include mental health needs); Torraco v. Maloney, 923 F.2d 231, 234 (1st Cir. 1991) (same); Greason v. Kemp, 891 F.2d 829, 834 (11th Cir. 1990) (same).

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

105. Chance v. Armstrong, 143 F.3d 698, 703 (2d Cir. 1998).

106. Kosilek v. Spencer, 889 F. Supp. 2d 190, 208 (D. Mass. 2012) (citing Fields v. Smith, 653 F.3d 550, 556 (7th Cir. 2011)). *See, e.g.*, *Fields*, 653 F.3d at 556 (finding inadequate treatment that fails to treat "the underlying disorder"); West v. Keve, 571 F.2d 158, 162 (3d Cir. 1978) (providing aspirin instead of postoperative treatment does not constitute adequate care); NORMAN DANIELS, JUST HEALTH: MEETING HEALTH NEEDS FAIRLY 41 (2008) ("No one suggested that something became a disease by being an unwanted condition.").

107. *Kosilek v. Spencer*, 889 F. Supp. 2d at 208 (citing *DeCologero*, 821 F.2d at 42; DesRosiers v. Moran, 949 F.2d 15, 18 (1st Cir. 1991)).

108. Farmer v. Brennan, 511 U.S. 825, 834 (1994).

109. *Chance*, 143 F.3d at 703.

110. Pregnancy cases are an illustrative example. Many courts, private insurers, and Medicaid programs (as well as prisons) deny abortions to pregnant women despite the possibility that continuing an unwanted pregnancy can have serious, negative psychological and physical consequences. Femi S. Austin, Note, *Limits on State Inmates' Access to Abortion: A Discussion of the Fifth Circuit's Decision*

abortion has the very real consequences of making her continue her pregnancy and give birth to a child, courts have concluded that abortions that do not threaten the life of the mother are not medically necessary and, thus, prisons do not have to provide them.[111] Consequently, because nontherapeutic abortions are not categorized as a serious medical need, prisons can deny treatment despite the relatively easy access and low cost of an abortion procedure.[112] At the other end of the spectrum, how doctors classify a serious medical need will determine the way in which it will be treated. Thus, currently, a medical condition like Body Dysmorphic Disorder, a disorder that causes an individual to feel extreme distress about a part of the individual's body and can lead to suicide, is currently classified as a psychiatric disorder and is treated with psychotherapy.[113]

2. Deliberate Indifference

To prove "deliberate indifference" to a serious medical need, a party must show that a prison official "knows of and disregards an excessive risk to inmate health or safety."[114] The official must be both "aware of facts from which the inference could be drawn that a substantial risk of serious harm exists" and must actually draw the inference.[115] A prison official's deliberate indifference may be inferred from behaviors such as "denial, delay, or interference with prescribed health care."[116] Further, a "series of incidents [denying treatment] closely related in time" may also be evidence of an official's deliberate indifference to prisoners' medical needs.[117]

However, "the known risk of harm is not conclusive"; because prisons

in Victoria W. v. Larpenter, 27 WOMEN'S RTS. L. REP. 87, 96 (2006).

111. *See generally* Avalon Johnson, Note, *Access to Elective Abortions for Female Prisoners Under the Eighth and Fourteenth Amendments*, 37 AM. J.L. & MED. 652 (2011) (discussing *Roe v. Crawford*, 514 F.3d 789 (8th Cir. 2008), and other relevant cases that found elective abortions are not medically necessary).

112. *Id.* at 661.

113. *See Mental Health Center: Body Dysmorphic Disorder*, WEBMD, http://www.webmd.com/mental-health/mental-health-body-dysmorphic-disorder?page=2 (last visited Oct. 18, 2013) (classifying Body Dysmorphic Disorder as a psychiatric disorder that can be treated with various forms of therapy). *Cf.* Mo Costandi, *The Science and Ethics of Voluntary Amputation*, GUARDIAN (May 30, 2012, 1:07 PM), http://www.theguardian.com/science/neurophilosophy/2012/may/30/1 (stating that Body Identity Integrity Disorder, a disorder similar to Dysmorphic Disorder, is not classified as a psychiatric disorder, but is also usually not treated by cutting off the offending limb).

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

115. *Id.*

116. Battista v. Clarke, 645 F.3d 449, 453 (1st Cir. 2011) (quoting DesRosiers v. Moran, 949 F.2d 15, 19 (1st Cir. 1991)) (internal quotation marks omitted).

117. Todaro v. Ward, 565 F.2d 48, 52 (2d Cir. 1977) (quoting Bishop v. Stoneman, 508 F.2d 1224, 1226 (2d Cir. 1974)) (internal quotation marks omitted).

often need to "balance conflicting demands" such as prisoner safety and medical care, balancing judgments "within the realm of reason and made in good faith" will not satisfy the deliberate indifference standard.[118] On the other hand, denials of treatment made "totally without penological justification" will not receive deference from the courts.[119] Importantly, courts have repeatedly rejected cost of treatment and political controversy as legitimate justifications for denying medical treatment.[120]

Significantly, although courts purport to analyze punishment, medical care, and prison conditions cases according to "evolving standards of decency,"[121] which requires an examination of "objective indicia of society's standards,"[122] courts seem to largely ignore objective considerations in medical care cases. Thus, while in punishment cases like *Roper v. Simmons* the Court has relied heavily on majority legislation to determine whether a punishment was unconstitutional, it and lower courts do not use analogous objective indicia in medical care cases to determine if a particular treatment is constitutionally required.[123]

C. WHY PUNISHMENT AND MEDICAL CARE CASES ARE CURRENTLY ANALYZED DIFFERENTLY, AND WHY THEY SHOULD NOT BE

Although the Supreme Court has never explicitly acknowledged the differences in the analyses of punishment and medical care cases, a myriad of arguments (implicit and explicit) have been made to support such a distinction. The next section attempts to organize and present the most

118. *Battista*, 645 F.3d at 454.

119. Hope v. Pelzer, 536 U.S. 730, 737 (2002) (quoting Rhodes v. Chapman, 452 U.S. 337, 346 (1981)) (internal quotation marks omitted).

120. *See, e.g.*, Wilson v. Seiter, 501 U.S. 294, 302 (1991) (noting no indication that prison officials had used cost to avoid the holding in *Estelle v. Gamble*, 429 U.S. 97 (1976)); Harris v. Thigpen, 941 F.2d 1495, 1509 (11th Cir. 1991) (rejecting cost as a consideration in determining the reasonableness of medical care); Jones v. Johnson, 781 F.2d 769, 771 (9th Cir. 1986) ("Budgetary constraints . . . do not justify cruel and unusual punishment." (citing Spain v. Procunier, 600 F.2d 189, 200 (9th Cir. 1979))). *But see* Maggert v. Hanks, 131 F.3d 670, 671 (7th Cir. 1997) ("A prison is not required by the Eighth Amendment to give a prisoner medical care that is as good as he would receive if he were a free person, let alone an affluent free person." (citing Wood v. Housewright, 900 F.2d 1332, 1334 (9th Cir. 1990))).

121. *E.g.*, Graham v. Florida, 560 U.S. 48, 58 (2010) (quoting *Estelle*, 429 U.S. at 102) (internal quotation marks omitted).

122. *Id.* at 48 (quoting Roper v. Simmons, 543 U.S. 551, 563 (2005)) (internal quotation marks omitted).

123. *Compare Roper*, 543 U.S. at 564–65 (finding that thirty states had legislation banning capital punishment for minors tended to show that the punishment was unconstitutional), *with* Kosilek v. Spencer, 889 F. Supp. 2d 190, 198 (D. Mass. 2012) (noting that although "it may seem strange" that noninmates do not have a "constitutional right to adequate medical care," "the Eighth Amendment promises prisoners such care").

prominent and recurring arguments in support of distinctive medical care analysis, followed by rebuttals to those arguments.

1. Arguments by Scholars and Courts Suggest Reasons Why Medical Care Cases Are Analyzed Differently Than Punishment Cases

Courts and legal scholars have offered numerous arguments that could support the distinct Eighth Amendment analysis used in medical care cases. The most prominent of these arguments include the following: (1) because incarceration makes inmates unable to care for themselves, states have an affirmative duty to provide them with necessary medical care; (2) prisoners are unsympathetic individuals and, thus, deserve special constitutional safeguards uninfluenced by the political system; and (3) the only relevant objective criteria is the diagnosis and treatment recommended by a prudent medical professional. Although these arguments often substantially overlap, this section considers each in turn.

First, the Supreme Court has unequivocally held that the Eighth Amendment imposes an affirmative duty on governments to provide inmates with "necessary" and "adequate" medical care.[124] Likewise, scholars argue that this duty is "the price society pays for the decision to incarcerate convicted offenders."[125] Undoubtedly, a prison sentence imposed without access to medical care might often be functionally equivalent to a death sentence or torture and, therefore, unconstitutional.[126] Implicit in this argument, however, is the assumption that but for their incarceration, prisoners would be able to access and afford the medical treatment(s) they seek as inmates. Of course, this is rarely the case,[127] which means that without consideration of objective factors to limit the scope of medical care for prisoners, prisoners will sometimes receive better medical care than members of the public.[128]

However, ignoring objective factors in favor of relying heavily on fact specific and largely academic determinations of whether a medical service is "necessary" and whether a DOC was deliberately indifferent to that need presents its own dangers. For instance, in the interest of settling novel or

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

125. Dolovich, *supra* note 74, at 892.

126. *Brown*, 131 S. Ct. at 1928 ("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." (internal quotation marks omitted)).

127. *See* Travis Wright Colopy, Note, *Setting Gender Identity Free: Expanding Treatment for Transsexual Inmates*, 22 HEALTH MATRIX 223, 231 (2012) (explaining that for most people, the cost of sex reassignment surgery will be "prohibitively expensive" (citing Tarzwell, *supra* note 69, at 174)).

128. *See* Frank, *supra* note 76, at 341–42.

sensational legal questions, courts expend excessive judicial resources on cases that will ultimately affect only a small percentage of inmates.[129] Moreover, this type of adjudication encourages "top down" litigation and unnecessarily skews public perception of prison conditions in the United States, both of which can frustrate or prevent legislative and administrative attempts to improve prison conditions.[130] For instance, public outcry over taxpayer funded sex reassignment surgery unnecessarily led the Wisconsin legislature to pass the now defunct Inmate Sex Change Prevention Act, which would have applied to an infinitesimally small number of inmates had it been upheld.[131] Meanwhile, many inmates live under horrific prison conditions,[132] and likely in violation of international human rights.[133]

Next, arguing that prisoners are unsympathetic individuals and, thus, particularly vulnerable to abuse, courts and scholars avoid objective considerations by removing medical care cases out of any political grasp.[134] The court in *Kosilek v. Spencer* seems to explicitly support this view of the Eighth Amendment as applied to medical care cases, explaining that "[i]t is despised criminals, like Kosilek, who are most likely to need the protection of the Eighth Amendment and its enforcement by the courts."[135] Minimal research shows that many Americans are staunchly opposed to the idea that prisoners receive anything but the most basic care. A few Internet

129. Although the precise number of transgender inmates is unknown, transgenderism occurs in approximately 2–5 percent of the population. Colopy, *supra* note 127, at 228.

130. In other words, this type of analysis allows courts to focus impractically on expanding the range of services potentially available to inmates, while most inmates will continue to experience conditions far below the standards set by courts. Michelle Kosilek perfectly demonstrates the effects of this phenomenon, as she has waited for almost two decades for the Massachusetts federal court to determine whether her gender identity disorder is severe enough to necessitate sex reassignment surgery.

131. Bruce Vielmetti, *State Ban on Inmate Sex-Change Treatment Fails at U.S. Supreme Ct.*, J. SENTINEL (Mar. 26, 2012), http://www.jsonline.com/blogs/news/144230555.html (explaining that three inmates challenged the law).

132. Andrew Freeman, *10 of the Worst Prisons in the World—Only 5 Are American*, TAKEPART.COM (Sept. 26, 2012), http://www.takepart.com/photos/worst-prisons-locked-up/san-quentin-state-prison-marin-california.

133. *U.S. Prison Conditions Worse Than Guantanamo*, RT U.S.A. (Mar. 22, 2011), http://rt.com/usa/usa-prison-conditions-worse-guantanamo/. *See also West Block Opens for the Mainland*, SAN QUENTIN NEWS, Nov. 2011, at 1, *available at* http://sanquentinnews.files.wordpress.com/2011/06/san-quentin-news-november-2011.pdf (describing prison cells covered with feces and nonfunctional electricity, heat, and toilets). San Quentin News also provides information regarding substantial budget cuts and mass layoffs for prison employees.

134. Kosilek v. Spencer, 889 F. Supp. 2d 190, 211 (D. Mass. 2012) ("[T]he right to be free of cruel and unusual punishments, like other guarantees of the Bill of Rights, may not be submitted to vote; it depends on the outcome of no elections." (quoting Furman v. Georgia, 408 U.S. 238, 268 (1972) (Brennan, J. concurring)) (internal quotation marks omitted)).

135. *Id.* at 204.

comments in response to the *Kosilek v. Spencer* ruling are illustrative of public sentiment regarding prisoner medical cases:

> "I am sure those guys in prison can make him feel just like a woman without surgery. Just leave him alone with a few of them on a dark night with a couple candles and a nice bottle of wine. (and maybe some vaselin) [sic]"
>
> "He's in prison for murder and he made two suicide attempts. Wouldn't it be cheaper to let him make a third attempt and let him go through with it?"
>
> "So, isn't MURDER cruel and unusual punishment on the victim? I say cut it off and shove it down his throat!"[136]

Although these few comments hardly demonstrate a national consensus against medical care for prisoners, these sentiments nonetheless illustrate why courts might want to remove medical care determinations from legislatures. Nevertheless, courts would do better to interpret legislation than to make case-by-case determinations of what properly constitutes necessary medical care for inmates.

Finally, courts and scholars could argue that Eighth Amendment medical care analysis does rely heavily on objective considerations, in the form of recommendations and other testimony by medical professionals.[137] Because social understanding often lags behind scientific discovery, the argument that medical professionals are singularly qualified to determine what is medically necessary is strong.[138] Particularly, not only are medical professionals uniquely knowledgeable of the proper treatments for medical conditions, they are also (arguably) less likely to be influenced by nonmedical considerations such as political controversy or cost.[139]

On the other hand, by relying exclusively or even heavily on doctor's treatment recommendations, courts run the risk of eliminating social and other value judgments from consideration when determining what treatments are medically necessary. In a perfect world with unlimited

136. *See* Solomon, *supra* note 64.

137. The court in *Kosilek v. Spencer*, for instance, relies heavily on the medical recommendations of Kosilek's doctors. *Kosilek v. Spencer*, 889 F. Supp. 2d at 201.

138. *See* Nikolas Andreopoulos, Note, Kosilek v. Maloney*: In Prison While Imprisoned in the Body of the Opposite Sex: Examining the Issue of Cruel and Unusual Punishment Presented by an Incarcerated Transsexual*, 27 W. NEW ENG. L. REV. 219, 232–34 (2005).

139. There is, of course, the possibility that doctors will base their recommendations on other biased reasons, such as personal ethical or religious beliefs. Moreover, when the same doctors who make the recommendations for treatment will benefit from making such a recommendation (for example, because the doctor will be paid to provide the treatment or paid a referral fee from another physician), physicians may not be as unbiased as courts might wish to believe.

medical and financial resources, this type of objective analysis would pose no problems. However, legislatures face very real—and increasingly more stringent—resources; thus, they should be permitted to reasonably define and restrict the scope of what is considered medically necessary care.[140] While medical recommendations constitute a particular form of objective criteria relevant to medical necessity determinations, courts should not stop there. Rather, courts should consider several additional objective indicia of medical necessity, including whether a particular treatment is recognized as medically necessary under legislation providing medical coverage to the nation's poor and vulnerable groups.[141] Simultaneously analyzing these additional factors will better accord with traditional Eighth Amendment jurisprudence.

III. AN EXAMINATION OF THE COURT'S ANALYSIS IN *KOSILEK V. SPENCER*

A. KOSILEK'S SERIOUS MEDICAL NEED

To determine whether Kosilek had a serious medical need, the court relied heavily on the medical opinions and conclusions offered by Kosilek's many doctors.[142] Based on their opinions, the court concluded that Kosilek's gender identity disorder was "severe."[143] Then, the court agreed that without further treatment, the severity of Kosilek's gender identity disorder put her at a continued risk of harm.[144] The court accepted the doctors' opinion that sex reassignment surgery was the only adequate treatment available to eliminate the risk of harm.[145] Thus, the court concluded that because Kosilek's severe gender identity disorder continued to put her at risk of self-harm, for Kosilek, sex reassignment surgery was a serious medical need.[146]

In reaching its conclusions, the court seemed completely content with the advice and recommendations provided by Kosilek's doctors as to the likelihood that Kosilek would harm herself if she were denied sex reassignment surgery.[147] The court also accepted as credible the doctors'

140. *See* DANIELS, *supra* note 106, at 33–34 (discussing the moral and ethical considerations implicit in determining who receives health care, and for what conditions).

141. This proposition is discussed extensively in Part IV.

142. *Kosilek v. Spencer*, 889 F. Supp. 2d at 201–03.

143. *Id.* at 202.

144. *Id.*

145. *Id.* at 222–23.

146. *Id.*

147. *See id.* at 202 ("Kosilek has already tried to kill [her]self once while taking Prozac and h[er]

argument that because Kosilek had attempted suicide before, she would attempt it again.[148] Nevertheless, the court failed to consider several important details surrounding Kosilek's past suicide attempts, as well as the future probability of self-harm. First, the court disregarded the length of time since her last attempts at suicide, as well as the seriousness of those attempts. In fact, the DOC's Dr. Schmidt, who the court later renounced as "not a prudent professional,"[149] is the only one who included in his medical report the details of Kosilek's attempts at self-harm.[150] With much brevity, Dr. Schmidt describes Kosilek's three instances of self-harm, which occurred around 1990–1991.[151] He explains that in each instance, Kosilek decided of her own accord to abort the self-harm; on each occasion, she did so before experiencing harm and did not require medical or other prison assistance. Furthermore, Kosilek failed to report any of the incidents to the prison guards.[152]

The court also failed to consider the length of time Kosilek has gone without attempting self-harm, as well as how much (or if) objective factors illustrate how much her mental anguish diminishes her quality of life. By the time the court issued its decision in *Kosilek v. Spencer*, Kosilek had turned fifty-six years old and had not attempted to self-harm for more than twenty years.[153] Moreover, the doctors' reports all suggest that Kosilek is living a well-adjusted, relatively happy life in prison, which weighs against the doctors' unequivocal opinions that Kosilek is in constant anguish over her male genitalia.[154] Rather, Kosilek has her own cell, with a computer she uses to correspond with others with gender identity disorder. She likes to

experts credibly testified that [s]he would remain at high risk of doing so again.").

148. *Id.*

149. *Id.* at 235.

150. Report or Affidavit of Chester W. Schmidt, Jr., M.D., *supra* note 3, at 5.

151. *Id.*

152. *Id.* In his evaluation, Schmidt explained:

> Kosilek reports 3 episodes of self injury prior to coming to Norfolk. The first episode was an attempted castration by tying a shoestring around [her] testicles. She reports the scrotum swelled up and was so painful she cut-off the shoestring. . . . [For the second episode,] Kosilek states she tried to stuff a piece of slipper down her throat . . . . She threw-up the piece of slipper and did not report the episode to the staff. In April of 1991, on her birthday, she tied a plastic bag over her head. She stated it took to[o] long. She got hot and sweaty and decided she would have to deal with her issues and took the bag off.

Id.

153. *Id.* at 5, 8.

154. *Id.* at 5–6; Report or Affidavit of George R. Brown., M.D., Kosilek v. Clarke, No. 1:00CV12455 (D. Mass. Oct. 12, 2005), 2005 WL 6464297 ("Psychologically, the effects of these combined treatments have had the results I predicted[:] . . . resolution of depression, resolution of suicidality and suicide gestures and attempts, improved mood with reduction in irritability, anxiety, and depression.").

write poetry and exercise daily.[155] She also has one of the few prison jobs, for which she makes a stipend.[156] Although these considerations are not conclusive that Kosilek is not still suffering severe mental anguish because of her GID, the court should have analyzed these facts against the doctors' evaluations in determining the magnitude of her anguish and the true likelihood that she would harm herself. Specifically, because the actual harm found here was that Kosilek would hurt herself if she were denied surgery and not because of her gender identity disorder specifically, the court could have determined that since Kosilek has been living a normal, happy life on hormones for the past fifteen years, her mental anguish is not as severe as the doctors suggested.

Additionally, in determining that Kosilek had a serious medical need, the court permitted Kosilek's doctors to ignore or otherwise alter several of the eligibility requirements under WPATH's Standards of Care. First, the court never mentioned the requirement that the patient must have demonstrable knowledge of the cost of the treatment.[157] While Kosilek likely has knowledge of the cost for nonincarcerated patients, this requirement likely means that the patient will need to demonstrate that she knows not just how much the operation will cost, but also how to pay for it. As an inmate, Kosilek could never afford to pay for the operation herself, so the court removed it from consideration.[158] Notably, if a noninmate patient presented with symptoms and other indicia of severe gender identity disorder identical to Kosilek's but could not determine how to pay for the costs of the treatment, under these facts Kosilek would get the surgery but the noninmate patient would not.

Finally, in determining that Kosilek was eligible for sex reassignment surgery under the Standards of Care, Kosilek's doctors also questionably decided that Kosilek had satisfied the "real life experience" requirement, under which the patient must live completely as a member of the desired sex continuously for a minimum of one year.[159] The DOC's doctors argued, and the court rejected, that Kosilek could not meet the "real-life experience" requirement because she is a prisoner.[160] The court countered that "the prison environment has provided Kosilek with . . . an even more stringent 'real life experience' test than many transsexuals have outside

155. Report or Affidavit of Chester W. Schmidt, Jr., M.D., *supra* note 3, at 5.
156. *Id.* at 4.
157. *See* Kosilek v. Spencer, 889 F. Supp. 2d 190, 205–10 (D. Mass. 2012).
158. *Id.* at 227–28.
159. *Id.* at 232 (internal quotation marks omitted).
160. *Id.*

prison, because inmates are constantly under observation and any failure to live as a woman would be readily noted."[161] However, the court failed to consider the irony that Kosilek's incarceration may have actually facilitated her ability to complete the real-life experience: for the first time in her life, MCI-Norfolk gave her the protection that she needed to be able to complete the real-life experience requirement without reverting to living as a male.[162]

B. THE MASSACHUSETTS DEPARTMENT OF CORRECTIONS WAS DELIBERATELY INDIFFERENT TO KOSILEK'S SERIOUS MEDICAL NEED

To prove the "deliberate indifference" prong of the analysis, Kosilek had to show that the DOC "[knew] of and [disregarded] an excessive risk to [Kosilek's] health and safety."[163] The court's opinion explains at significant length all of the reasons why the DOC, including then-Commissioner Dennehy, knew that Kosilek was at a substantial risk of harm without sex reassignment surgery.[164] The court offers as examples numerous letters, reports, evaluations, past court opinions, and email conversations between Kosilek's doctors and DOC officials confirming their belief that Kosilek was at a risk of harm from suicide.[165] In addition, Dennehy testified to the credibility of Kosilek's doctors and "did not dispute that Kosilek's gender identity disorder constituted a serious medical need."[166] From this, the court determined that the DOC "actually knew" that Kosilek was at a substantial risk of harm.[167] However, Dennehy argued that the DOC denied Kosilek's treatment because of "safety and security concerns"[168] that the DOC had regarding transporting and housing Kosilek during surgery, as well as where Kosilek would be housed after.[169] She further testified that because the DOC did not know of anyone in Massachusetts who could perform sex reassignment surgery, Kosilek would likely have to travel to receive the operation, which created a risk that she would escape.[170] Finally, Dennehy testified that she and the DOC had not denied Kosilek because of considerations of cost or political controversy.[171]

The court unequivocally rejected Dennehy's arguments regarding

161. *Id.* at 235.
162. *See supra* Part I for a discussion of Kosilek's patterns of reversion back to living as a male.
163. *Kosilek v. Spencer*, 889 F. Supp. 2d at 237.
164. *Id.* at 237–38.
165. *Id.*
166. *Id.* at 238.
167. *Id.*
168. *Id.*
169. *Id.* at 241–42.
170. *Id.* at 228.
171. *Id.*

prison safety and security,[172] and further determined that Dennehy had denied Kosilek sex reassignment surgery because of the political controversy surrounding the case.[173] In reaching this conclusion, the court provided a letter former Commissioner Clarke had received from several State Senators regarding Kosilek. The letter stated,

> We write to you today to express our concern about recently published reports pertaining to your interest in reviewing the sex-change/hormone therapy case of convicted murderer Robert Kosilek. It is our opinion that taxpayer's money should not be used for such procedures.
>
> Due to the present condition of our state's economic situation, along with our opposition to Mr. Kosilek's argument that the state should bear responsibility for paying for these treatments, we urge you to deny his request.
>
> The granting of this request would not only be an affront to the taxpayers of the Commonwealth, but would also raise a significant security risk. A decision in favor of Mr. Kosilek would lead to negative consequences for his safety and send the wrong message to the citizens of Massachusetts in the ability of their government to effectively use state funds to manage corrections facilities.[174]

The court acknowledged this message as a "veiled threat" from the legislature that Corrections appropriations would be reduced if the DOC provided Kosilek with sex reassignment surgery but, nevertheless, rejected it as a valid reason for failing to provide Kosilek with the surgery.[175]

Finally, the court found that Dennehy incorrectly considered Kosilek's postmurder flight when assessing whether she would attempt to escape during transport or after her surgery.[176] The court suggested in the alternative that Dennehy could sponsor a Chicago-based surgeon to come to Massachusetts to perform the surgery so that the DOC would not need to transport Kosilek out of state.[177] Finally, the court suggested, with respect to the DOC's other security concerns, such as where to house Kosilek after the surgery, that the DOC could figure it out.[178] Thus, the court showed

172. *Id.* at 240–42.

173. *Id.* at 246.

174. *Id.*

175. *Id.* at 246. This conclusion illustrates how little deference the court gave the DOC. Under the facts, the court found that the Commissioner of the DOC was "deliberately indifferent" to Kosilek's need in spite of the fact that (1) she faced a reduction in financing to run the prison and (2) was acting with knowledge that no other Commissioner had ever been required to provide sex reassignment surgery to an inmate. *Id.* at 247.

176. *Id.* at 242.

177. *Id.* at 225, 241.

178. *Id.* at 243.

very little deference to the DOC's concerns about prison safety and about the difficulties the DOC would have in determining where to house Kosilek after the surgery. Tellingly, the court argued with minimal explanation that the DOC's concerns about the "security risk involved in either incarcerating someone who is anatomically a female in a male prison or placing a person who has murdered his wife in a female prison" were unreasonable.[179]

IV. EIGHTH AMENDMENT MEDICAL CARE JURISPRUDENCE REQUIRES SUBSTANTIAL REFORM

Current Eighth Amendment medical care jurisprudence fails to consider objective indicia of current national standards regarding medically necessary treatment. This means that while courts have interpreted the Eighth Amendment to give legislatures broad discretion to determine who can be incarcerated and for how long,[180] they do not give similar deference to legislatures concerning prisoner treatment during incarceration.[181] Consequently, Eighth Amendment medical care analysis is inconsistent with traditional Eighth Amendment punishment jurisprudence, and should be revised. Moreover, recent court decisions regarding medical care for prisoners have highlighted the illogical disconnect between treatments available to prisoners and treatments available to noninmates.[182] Thus, medical care analysis should be reformed in order to achieve results that are more consistent.

Courts should begin the Eighth Amendment medical care analysis by examining available objective indicia to determine whether there is a national consensus favoring or disfavoring using state funds for a particular treatment.[183] Because Medicaid is a state-run healthcare program designed

179. *Id.*

180. *See, e.g.*, Harmelin v. Michigan, 501 U.S. 957, 962 (1991) (affirming a mandatory life without parole sentence for a drug possession, because "the length of the sentence actually imposed is purely a matter of legislative prerogative" (quoting Rummel v. Estelle, 445 U.S. 263, 274 (1980)) (internal quotation marks omitted)).

181. *See, e.g.*, Fields v. Smith, 653 F.3d 550, 557 (7th Cir. 2011) (finding a Wisconsin law banning state-funded hormone therapy or sex reassignment surgery for prisoners unconstitutional).

182. *See, e.g.*, Frank, *supra* note 76, at 362–66 (discussing the difficulty of obtaining life-saving organs and the controversial decision to provide inmates with organs).

183. Like in Eighth Amendment punishment case analysis, identifying whether there is national consensus regarding a particular healthcare treatment means that courts will evaluate cases based on contemporary norms regarding necessary care. Although these value judgments will rely on imperfect information and will ultimately result in some denials of care, courts permit the same result by considering objective indicia in punishment cases. So, for example, legislatures have the discretion to criminalize marijuana based on contemporary norms regarding its use, even though there is little data to suggest that it is any more dangerous than alcohol or tobacco.

to provide funding for medical treatment to the nation's poorest and most vulnerable individuals,[184] it provides a good baseline for courts to begin their analysis.[185] By adopting this step of analysis, courts would still be able to avoid analyzing case-by-case cost considerations; nevertheless, cost would be considered by default since state legislatures have already performed such an analysis.[186]

Next, courts should look to other federal and state legislation to determine whether state laws facilitate or discourage people from undergoing a particular treatment.[187] Thus, if legislation either explicitly or practically precludes the average American from being able to receive the treatment, the law should cut against providing the treatment for prisoners.[188] Then, courts should consider whether most Americans could access a doctor or other medical provider who can administer the treatment.[189] If only a handful of specialists can provide a surgery, it is unlikely that most Americans can obtain it, and this should weigh against providing it to prisoners. Finally, courts should continue to give deference to prison officials regarding matters such as security and safety.[190]

A. *KOSILEK V. SPENCER* REEXAMINED: A LOOK AT OBJECTIVE FACTORS CONCERNING GENDER IDENTITY DISORDER AND SEX REASSIGNMENT SURGERY

Michelle Kosilek's history is shockingly similar to others who suffer

184. U.S. SOC. SEC. ADMIN., ANNUAL STATISTICAL SUPPLEMENT 56 (2011), *available at* http://www.ssa.gov/policy/docs/statcomps/supplement/2011/medicaid.pdf.

185. This is especially true because inmates are increasingly likely to come from a poor socioeconomic background. Prisoners can expect to get, and prison officials can expect to give, the same treatment the inmate would have received if not incarcerated. Heather Ann Thompson, *Why Mass Incarceration Matters: Rethinking Crisis, Decline, and Transformation in Postwar American History*, 97 J. AM. HIST. 703, 707–08 (2010).

186. *See* Melissa Hansen, *Medicaid Spending Is at the Top of Many Legislative Agendas*, ST. LEGISLATURES (June 2012), http://www.ncsl.org/issues-research/health/confronting-costs.aspx (describing state lawmakers attempts to control the rising costs of Medicaid).

187. Graham v. Florida, 560 U.S. 48, 62 (2010) (carrying out Eighth Amendment analysis by considering, in addition to legislation, the nation's "actual sentencing practices"). Here, the analogous inquiry is whether there are other impediments to getting the surgery, even if medical providers technically cover the surgery.

188. Thus, for example, if state and federal employment laws make it difficult for an individual to keep a job or undergo a treatment in preparation for a surgery, this would weigh against there being a national consensus in favor of the treatment.

189. If the treatment is difficult to access because few specialists provide it, this consideration cuts against both national consensus and security considerations because the prison would be responsible for transporting the prisoner to and from the treatment site.

190. *See, e.g.*, Farmer v. Brennan, 511 U.S. 825, 844–45 (1994) (imposing only a reasonableness standard upon prison officials with regard to avoiding harms caused by a substantial risk to inmates).

from gender identity disorder. As Sydney Tarzwell explains,

> For many transgender individuals, the narrowing of opportunities begins in childhood: as soon as a child expresses interest in the clothing or hobbies of the "wrong" gender, . . . she can expect family and community reactions ranging from subtle (shaming or reprimanding in order to educate about appropriate gender roles) to extreme (fear, anger, violence).[191]

As a result of this violence and harassment, transgender youths often feel compelled to drop out of school and run away from home.[192] Discrimination is likely to continue into adulthood and expand to include workplace discrimination, which discourages, limits, and even forecloses the possibility of full access to and participation in the U.S. economy.[193] Thus, transgender individuals are substantially more likely than nontransgender individuals to live in poverty and participate in underground economies such as sex work or selling drugs.[194] Transgender individuals are also far more likely than the average American to abuse drugs and alcohol.[195] Further, transgender individuals are exponentially more likely to attempt suicide.[196]

Because of rigid institutional policies and gender segregated facilities, transgender prisoners face special and heightened dangers during incarceration.[197] These dangers often arise from the moment the inmate enters prison. For instance, because prisoners' placements are determined first by sex in almost every state, transgender inmates will typically be assigned to a prison according to their sexual organs, regardless of whether they identify as the opposite sex.[198] This immediate categorization can be

191. Tarzwell, *supra* note 69, at 171. *See also* Ed Payne & Ashley Fantz, *Parents of Transgender First-Grader File Discrimination Complaint*, CNN (Feb. 28, 2013), http://www.cnn.com/2013/02/27/us/colorado-transgender-girl-school (discussing a public elementary school's decision to prohibit a transgender first grader from using the bathroom of the gender with which she identified).

192. Tarzwell, *supra* note 69, at 171 (citing Dean Spade, *Compliance Is Gendered: Struggling for Gender Determiation in a Hostile Economy*, *in* TRANSGENDER RIGHTS: HISTORY, POLITICS AND LAW 217, 219 (Paisley Currah et al. eds., 2006)).

193. *Id.* at 172.

194. *Id.* at 173.

195. JAIME M. GRANT ET AL., EXECUTIVE SUMMARY: INJUSTICE AT EVERY TURN: A REPORT OF THE NATIONAL TRANSGENDER DISCRIMINATION SURVEY 2 (2011) (reporting that transgender individuals who had lost a job due to bias are 70 percent more likely to abuse drugs and alcohol than those who had not lost a job for such reasons).

196. *Id.* at 1 (reporting that "[a] staggering 41 [percent] reported attempting suicide compared to 1.6 [percent] of the general population").

197. *See generally* Tarzwell, *supra* note 69 (providing a background of states' policies regarding transgender prisoners).

198. *Id.* at 170, 192–94.

particularly dangerous for inmates who had begun to transition before being incarcerated and, thus, physically present as the opposite sex.[199] These initial placement determinations will often result in serious consequences for transgender inmates. Particularly, legal scholars attribute these policies to consequences including humiliation and ridicule, higher incidences of assault and rape, and the likelihood of inconsistent or inadequate medical care.[200]

Extreme barriers to medical care further compound the struggles faced by all transgender individuals, including noninmates. While it is beyond the scope of this Note to discuss all of the many barriers to medical care that transgender individuals face, this section focuses primarily on the barriers faced once a person has been diagnosed as having gender identity disorder.

Physicians who specialize in and treat gender identity disorders follow the guidelines provided by the World Professional Association for Transgender Health ("WPATH"), commonly referred to as the "Standards of Care."[201] The Standards of Care detail the steps patients must complete before becoming eligible for certain stages of treatment. For example, in order for a patient to become eligible for sex reassignment surgery, the patient must: be the legal age of majority; have completed at least twelve continuous months of hormone therapy; complete at least twelve months of full time "real-life experience" living as a member of the desired sex;[202] have "[d]emonstrable knowledge of the cost, required lengths of hospitalizations, likely complications, and post surgical rehabilitation requirements of various surgical approaches"; have an awareness of surgeons who can perform the operation;[203] and obtain two letters from medical professionals who recommend sex reassignment surgery, at least one of whom should have a Ph.D.[204] As these are minimum requirements, physicians are free to require more from their patients before they will approve a desired treatment, including, but not limited to, "regular responsible participation in psychotherapy."[205]

199. *See, e.g.*, Howell, *supra* note 65, at 200–01 (describing the myriad of challenges faced by transgender inmates taking hormones while in prison).

200. *Id.*

201. *See generally* E. Coleman et al., *Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People, Version 7*, 13 INT'L J. TRANSGENDERISM 165 (2011). Until 2011, WPATH was formerly known as the Harry Benjamin International Gender Dysphoria Association. *Id.* at 166 n.1.

202. STANDARDS OF CARE, *supra* note 34, at 12–13.

203. *Id.* at 15.

204. *Id.* at 6.

205. *Id.* at 15.

Not surprisingly, each of these requirements presents a substantial hurdle the patient must overcome before becoming eligible for the procedure; taken together, they constitute a virtual bar to treatment for all but the most privileged transgender patients. For many reasons, the "real-life experience" requirement is particularly onerous.[206] For instance, this requirement means that for at least one years' time, the patient must visibly present as a member of the desired sex while retaining the biological and legal attributes of the unwanted sex.[207] Unfortunately, this behavior is highly likely to result in nonactionable workplace and community discrimination.[208] Thus, many patients seeking sex reassignment surgery will be stuck between a rock and a hard place: if they attempt to complete the real-life experience requirement, there is a chance they could be terminated (without recourse) by their employer, which of course means likely losing the health benefits and income the patient will need to continue treatment;[209] on the other hand, without fulfilling the real-life experience requirement, the patient will remain ineligible for surgery.[210]

Of course, even if the patient manages to meet the stringent requirements of the Standards of Care and thus becomes eligible for the surgery, the patient might still be foreclosed from surgery for reasons such as cost or inability to access surgeons qualified to perform sex reassignment surgery. Currently, patients who seek and are eligible for sex reassignment surgery will most likely have to pay the bill themselves, as many private insurers and most Medicaid and Medicare plans do not cover the surgery.[211] Moreover, patients who can afford to pay for the surgery

206. *Id.* at 13 ("Change of gender role and presentation can be an important factor in employment discrimination, divorce, marital problems, and the restriction or loss of visitation rights with children. These represent external reality issues that must be confronted for success in the new gender presentation.").

207. *Id.* at 15.

208. *See, e.g.*, Charles Thomas Little, Comment, *Transsexuals and the Family Medical Leave Act*, 24 J. MARSHALL J. COMPUTER & INFO. L. 315, 325–29, 338 (2006) (discussing laws that fail to protect transgender individuals as well as laws that frustrate the "real-life" requirement). *But see* Transgender Law & Policy Inst., *U.S. Jurisdictions with Laws Prohibiting Discrimination on the Basis of Gender Identity or Expression*, TRANSGENDERLAW.ORG (Feb. 1, 2012), http://www.transgenderlaw.org/ndlaws/index.htm#jurisdictions (finding that sixteen states, 143 cities and counties, and the District of Columbia currently prohibit gender identity discrimination).

209. *See* Little, *supra* note 208, at 328–30 (describing cases in which courts have found transsexual plaintiffs not protected under Title VII).

210. STANDARDS OF CARE, *supra* note 34, at 15 ("Individuals cannot receive genital surgery without meeting the eligibility criteria.").

211. *See* Maggert v. Hanks, 131 F.3d 670, 672–73 (7th Cir. 1997) (stating that Medicare, most states' Medicaid, and typical insurance plans do not cover the costs of sex reassignment surgery); Hazel Glenn Beh, *Sex, Sexual Pleasure, and Reproduction: Health Insurers Don't Want You to Do Those Nasty Things*, 13 WIS. WOMEN'S L.J. 119, 152–56 (1998) (discussing the mixed results of litigations

themselves (or those lucky few who have private insurance willing to cover the cost of the operation) will probably need to travel to another city or state to receive the surgery; thus, patients will need to factor in the likelihood of substantial travel,[212] as well as the cost and inconvenience of pre- and postoperative care away from home.[213] And finally, if there were not already enough obstacles, even the patient who manages to meet the Standards of Care and can fund the procedure and related costs, will likely have to face the reality that sex reassignment surgery will probably not qualify as a valid leave request under the Family Medical Leave Act.[214]

Collectively, these considerations illustrate the substantial and seemingly impenetrable barriers to sex reassignment surgery that the average person will face. Thus, while gender identity disorder is a medically acknowledged and accepted illness with severe and possibly fatal consequences if left untreated, it is obvious that most individuals suffering from gender identity disorder will be unable to access the only adequate treatment for their disorder.

These objective considerations provide the baseline with which to begin a revised Eighth Amendment analysis of Michelle Kosilek's claim. Currently, a large majority of government funded healthcare excludes sex reassignment surgery from coverage.[215] In addition, a majority of private insurers have similarly refused to fund the procedure.[216] These data strongly suggest that there is no national consensus favoring medical coverage for sex reassignment surgery, which weighs heavily against

regarding private insurance and Medicaid coverage of sex reassignment surgery); Howell, *supra* note 65, at 155–56 (describing the enactment of a law prohibiting state funding of sex reassignment surgeries for prisoners, based on the logic that outside of prison persons must pay for the cost of such treatment themselves).

212. *See* Howell, *supra* note 65, at 153 (explaining that currently, sex reassignment surgery is only available from a handful of surgeons in only seven states).

213. *See* Gerry, *My Nightmare Trip to Thailand: GRS with Dr. Ruch Wongtrungkapon*, DR. ANNE LAWRENCE: ON TRANSEXUALISM & SEXUALITY (Apr. 22, 2004), http://www.annelawrence.com/ruchnarrative.html (describing the medical and other complications endured by a patient who travelled to Thailand in order to undergo sex reassignment surgery).

214. *See* Little, *supra* note 208, at 341–43 (explaining how the language requirements of the FMLA will frustrate or prevent a transgender individual's attempts to get leave in order to be able to undergo sex reassignment surgery). For example, Little suggests that most transgender persons will have a difficult time proving that their conditions are "chronic," since "typically the gender dysphoria is not diagnosed early on in his or her life." *Id.* at 343.

215. *See, e.g.*, *Maggert*, 131 F.3d at 672 (providing an extensive list of government and private medical providers that exclude sex reassignment surgery from coverage); NAT'L CTR. FOR TRANSGENDER EQUAL., MEDICAL BENEFITS AND TRANSGENDER PEOPLE 1 (2011) (explaining that Medicare currently does not cover sex reassignment surgery).

216. *See, e.g.*, Beh, *supra* note 211, at 152–53 (noting that it is "typical, but not universal" for health insurance policies to expressly exclude coverage for transgender health care).

providing Kosilek the treatment.

Next, an examination of other legislation is relevant to determine whether current consensus facilitates or discourages the average American from being able to receive the treatment. Tellingly, current law seems to preclude most people from undergoing sex reassignment surgery.[217] Those who desire to seek the surgery may ultimately choose not to do so for fear that they will be terminated from their employment before, during, or after the surgery.[218] Furthermore, some recently enacted state laws suggest that national consensus is beginning to disfavor providing criminals with sex reassignment surgery.[219]

Finally, sex reassignment surgery is currently a highly specialized, difficult-to-access treatment.[220] Only a handful of surgeons across the country can provide it. Thus, many individuals suffering from gender identity disorder may ultimately travel as far as Thailand in order to procure the treatment.[221] This means not only that most people will not be able to access the treatment, but also that ordering the treatment would require the DOC to either transport Kosilek across the country or ask taxpayers to sponsor an out-of-state surgeon to travel to Massachusetts to perform the surgery.[222]

Taken together, these objective factors demonstrate that there is currently no national consensus favoring state funded sex reassignment surgery for prisoners. Under this analysis, the Massachusetts DOC did not violate the Eighth Amendment by failing to provide Kosilek with sex reassignment surgery.

V. CONCLUSION

Michelle Kosilek is a murderer suffering from a severe gender identity disorder. She is simultaneously a hated criminal, deserving of punishment, and a helpless human being, deserving of constitutionally adequate living conditions and minimally adequate medical care. How courts define the

217. Little, *supra* note 208, at 325–28, 338 (discussing how current laws frustrate or prevent transgender individuals from being able to undergo sex reassignment surgery).

218. *See id.*

219. *See* Howell, *supra* note 65, at 155–56 (discussing Wisconsin's Inmate Sex Change Prevention Act). Although the law has been enjoined, that it was enacted into legislature suggests that there is strong opinion against funding sex reassignment surgery for prisoners.

220. *Id.* at 154–55.

221. *See id.* at 184 (noting that the cost of sex reassignment surgery in Thailand is half of what it costs in Canada and two-thirds cheaper than in the United States).

222. Kosilek v. Spencer, 889 F. Supp. 2d 190, 241 (D. Mass. 2012) (suggesting that the DOC sponsor a doctor from Chicago to come to Massachusetts to perform the operation).

scope of that care is and will continue to be important, since decisions reducing or expanding medical care for prisoners will necessarily cause corresponding reductions or expansions across other sectors of government, including medical programs for noninmates. This Note does not suggest that prison medical care should be reduced to nothing. Rather, by reforming the analysis used in Eighth Amendment cases to consider objective indicia, this Note suggests that courts should affirm or deny medical treatment according to the guidelines used by legislatures to provide medical care for other groups who the government has decided need special assistance: the poor and disabled. This should result in medical care decisions more consistent with evolving standards of decency.