

TRANS MODELS IN PRISON: THE MEDICALIZATION OF GENDER IDENTITY AND THE EIGHTH AMENDMENT RIGHT TO SEX REASSIGNMENT THERAPY

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I. INTRODUCTION

Donna Konitzer entered the Wisconsin prison system in 1994 and will not be eligible for parole until 2026.¹ A trans² woman, she has been diag-

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¹ Gina Barton, *Prisoner Sues State over Gender Rights*, MILWAUKEE J. SENTINEL, Jan. 23, 2005, at A1, available at <http://www.jsonline.com/story/index.aspx?id=295581>.

² Throughout this Note, I use the term “trans” to refer to all people who feel that the sex they were assigned at birth does not accurately or adequately describe their present gender. I do not use “trans” as an abbreviation for any specific term, such as transgender or transsexual; rather, I use it as a broad and inclusive umbrella term that applies to the entire spectrum of people who identify or are labeled as transgender, transsexual, gender-queer, androgynous, or any other term meant to express non-conformity to sex assigned at birth. I acknowledge that, because much of this Note focuses on a medicalized conception of gender identity, it may seem that I am only discussing trans people who wish to receive medical treatment. I want to emphasize, therefore, that when I refer to trans people, I am referring broadly to *all* trans people, regardless of whether or not they seek medical intervention.

nosed with Gender Identity Disorder (“GID”)³ and, because of her forced exclusion from society, must rely on prison officials for treatment.⁴

Recognizing their Eighth Amendment obligation to provide inmates with health care⁵ and recognizing that medical professionals essentially agree that treatment for GID should involve some combination of psychotherapy, hormones, and gender-related surgery,⁶ Wisconsin prison officials enacted a policy in 2002 stating that those diagnosed with GID should be given access to hormone therapy while incarcerated.⁷ The policy, however, explicitly barred trans inmates from ever accessing gender-related surgery.⁸ Thus, knowing that her medical needs might remain unmet given the policy’s limitations, Konitzer sued the prison officials, alleging that a blanket denial of gender-related surgery constituted cruel and unusual punishment under the Eighth Amendment.⁹

After the suit was reported in the press,¹⁰ Wisconsin lawmakers expressed outrage over the notion that state funds could be used to pay for such

³ According to the American Psychiatric Association, GID is a rare mental condition characterized by “strong and persistent cross-gender identification . . . [accompanied by] persistent discomfort about one’s assigned sex.” AM. PSYCHIATRIC ASS’N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 576–82 (4th ed., text rev. 2000) (hereinafter “DSM-IV-TR”). For a more in-depth discussion of GID and its diagnostic criteria, see *infra* notes 41–43 and accompanying text.

⁴ See *Estelle v. Gamble*, 429 U.S. 97, 103–04 (1976) (“An inmate must rely on prison authorities to treat his medical needs; if the authorities fail to do so, those needs will not be met. . . . ‘(i)t is but just that the public be required to care for the prisoner, who cannot by reason of the deprivation of his liberty, care for himself.’” (quoting *Spicer v. Williamson*, 132 S.E. 291, 293 (N.C. 1926))).

⁵ Prison officials have an affirmative obligation under the Eighth Amendment to provide inmates with health care for objectively serious medical needs. See *infra* Part III.

⁶ See generally Walter Meyer III et al., *The Harry Benjamin International Gender Dysphoria Association’s Standards of Care for Gender Identity Disorders, Sixth Version*, 13 J. PSYCHOL. & HUM. SEXUALITY 1 (2001), available at <http://wpath.org/Documents2/socv6.pdf> (hereinafter “Standards of Care”) (setting forth recommended standards of medical care for patients with GID). While health professionals generally agree that treatment for GID should involve some combination of psychotherapy, hormones, and gender-related surgery, it is important to point out that trans health care is not monolithic; thus, there is no magic “one-size-fits-all” medical regimen that all trans people follow. See Gianna E. Israel & Donald E. Tarver, *Transgender Hormone Administration*, in *TRANSGENDER CARE: RECOMMENDED GUIDELINES, PRACTICAL INFORMATION, AND PERSONAL ACCOUNTS* 56, 62–68 (Gianna E. Israel & Donald E. Tarver II eds., 1997) (describing different hormone regimens used to treat different trans individuals); R. NICK GORTON, JAMIE BUTH & DEAN SPADE, *MEDICAL THERAPY AND HEALTH MAINTENANCE FOR TRANSGENDER MEN: A GUIDE FOR HEALTH CARE PROVIDERS* 33–38 (2005), available at http://www.nickgorton.org/Medical%20Therapy%20and%20HM%20for%20Transgender%20Men_2005.pdf (describing different gender-related surgeries used to treat different trans men).

⁷ Barton, *supra* note 1 (describing the prison policy regarding GID-related treatment).

⁸ *Id.*

⁹ See *id.* The Eighth Amendment states: “Excessive bail shall not be required, nor excessive fines imposed, nor cruel and unusual punishments inflicted.” U.S. CONST. amend. VIII. For a more in-depth discussion of what is required and what is proscribed by the Amendment’s prohibition on cruel and unusual punishment, see *infra* Part III.

¹⁰ See, e.g., Barton, *supra* note 1.

procedures.¹¹ This outrage, arguably rooted in skepticism toward and general ignorance of gender-related health care,¹² soon catalyzed a coalition within the Wisconsin legislature that ultimately spearheaded the passage of the Inmate Sex Change Prevention Act.¹³ The Act, which was signed into law in January 2006, forbids the use of any state or federal funds for inmates' sex reassignment therapy,¹⁴ including hormone treatments like the ones Donna Konitzer had previously been receiving under the 2002 policy.¹⁵ Given that prisoners rely on such funds to pay for their medical needs, the practical effect of the Act is to prevent trans inmates from ever receiving gender-related health care while in Wisconsin prisons.¹⁶ While the Act is generally thought to be the only state law of its kind,¹⁷ a review of Eighth Amendment jurisprudence throughout the country reveals that trans inmates,

¹¹ See, e.g., *id.* (“‘This is the most absurd thing I’ve ever heard of,’ said state Rep. Mark Gundrum ‘The taxpayers should not be spending one dime for something like that.’”); Thomas Leece, *State-Funded Sex Changes Face Opposition*, BADGER HERALD, Feb. 11, 2005, at 1, available at http://badgerherald.com/news/2005/02/11/statefunded_sex_chan.php (“‘We don’t think that it is an appropriate use of public funds, to spend it on sex-change operations for inmates,’ [state Senator] Kanavas said. ‘The notion that state taxpayers should be paying for this guy’s treatment is completely outrageous.’”).

¹² In the official press release announcing the passage of the Inmate Sex Change Prevention Act, state legislators skeptically characterized GID as “a condition in which people *claim* to feel ‘uncomfortable’ with their biological sex” (emphasis added); further, the legislators referred to hormone therapy and gender-related surgery as “bizarre treatments,” “experimental,” and, in the prison context, amounting to “extreme prison make-overs.” Press Release, Wisconsin Legislature, Suder/Kanavas “Inmate Sex Change Prevention Act” Becomes Law (Jan. 6, 2006), <http://www.legis.state.wi.us/assembly/asm69/news/Press.Suder%20Inmate%20Sex%20Change%20Gov.%20Signing.1-6-06.htm>.

¹³ See WIS. STAT. § 302.386(5m) (2007).

¹⁴ I use the term “sex reassignment therapy” to refer to hormone therapy and gender-related surgery. I sometimes interchangeably use the terms “trans-specific health care” and “gender-related health care” to refer to the same type of treatment. I acknowledge that trans people often receive non-medicinal therapeutic care, such as counseling, that is also important; however, because I wish to focus on the ability of trans inmates to gain access to specific types of treatment in prison, namely sex reassignment therapy, such non-medicinal therapeutic care is outside the scope of this Note.

¹⁵ The Act states: “The department may not authorize the payment of any funds or the use of any resources of this state or the payment of any federal funds passing through the state treasury to provide or to facilitate the provision of hormonal therapy or sexual reassignment surgery for a resident or patient.” WIS. STAT. § 302.386(5m) (2007). It defines “hormonal therapy” as “the use of hormones to stimulate the development or alteration of a person’s sexual characteristics in order to alter the person’s physical appearance so that the person appears more like the opposite gender.” *Id.* It defines “sexual reassignment surgery” as “surgical procedures to alter a person’s physical appearance so that the person appears more like the opposite gender.” *Id.*

¹⁶ See *Pls.’ Corrected Trial Br.* at 6, *Sundstrom v. Frank*, No. 06-C-0112 (E.D. Wis. Oct. 18, 2007) (“Although the Act is directed at the funding of [sex reassignment therapy], the result, in light of [prison officials’] policy against allowing inmates to pay for or seek insurance coverage to pay for their health care, is a complete bar on these treatments in [Wisconsin] prisons.”). *Sundstrom v. Frank* is a lawsuit involving a facial challenge to the constitutionality of the Inmate Sex Change Prevention Act. See *id.* It is currently being litigated by the American Civil Liberties Union and Lambda Legal. See *id.*

¹⁷ See John Diedrich, *Gender Not a Disorder, Court Told: Psychologist Testifies in Hormones Case*, MILWAUKEE J. SENTINEL, Oct. 25, 2007, at B7, available at <http://www>.

whether through non-statutory prison policies or simply poor doctoring, are often similarly denied access to sex reassignment therapy.¹⁸

Withdrawing or withholding sex reassignment therapy can cause serious medical consequences for people with GID, including anxiety, depression, suicidal ideation, and self-induced genital mutilation.¹⁹ Thus, trans advocates have challenged denials of trans-specific care in prison by pointing to medical evidence that demonstrates the necessity of such care for those with GID.²⁰ Many of these challenges have met with some success, as most courts now acknowledge that GID constitutes a serious medical need within the meaning of the Eighth Amendment.²¹

Such use of medical evidence, however, has created a great deal of controversy within the trans community as well as among advocates and scholars who advocate for trans rights.²² Many complicated questions now arise: Does the use of medical evidence create or perpetuate an image of trans people as mentally diseased or somehow ill-fitted to participate in “normal” society? Does the use of medical evidence in trans advocacy induce courts and legislatures to *expect* that such evidence will always be available to trans people when, in reality, it is not? More fundamentally, is a medicalized vision of gender identity even accurate? If not, does the use of medical evidence actually do more to harm than help the trans community?

This Note explores these issues generally and also specifically examines their relationship to trans prisoners’ right to sex reassignment therapy while incarcerated. Through this examination, it argues that the criticisms of a medicalized conception of gender identity are either generally refutable or irrelevant to the trans-specific prison health care context. It goes on to argue that employing such a medicalized conception is both justified and compelled by unique aspects of the prison context. Part II outlines the various discursive models that have been developed to conceptualize what gender identity really is: Part II.A describes the origins of a medicalized conception of gender identity as well as its current implications for trans health care, Part II.B explains the relationship between this medicalization and the law, Part II.C outlines the various criticisms of this medicalization, and Part II.D

jsonline.com/story/index.aspx?id=678732 (“The Inmate Sex Change Prevention Act is believed to be the only law of its kind in the nation.”).

¹⁸ See, e.g., *De’Lonta v. Angelone*, 330 F.3d 630, 632 (4th Cir. 2003) (trans inmate’s sex reassignment therapy terminated due to non-statutory official prison policy against administration of such treatment); *Supre v. Ricketts*, 792 F.2d 958, 960 (10th Cir. 1986) (trans inmate requested sex reassignment therapy but was denied access due to prison doctors’ apparently unfounded skepticism over the safety of such therapy). For a more thorough catalog of cases in which trans inmates were denied gender-related health care, see *infra* notes 114–117.

¹⁹ See DSM-IV-TR, *supra* note 3, at 578–79 (explaining that such consequences constitute features associated with untreated GID); GORTON, BUTH & SPADE, *supra* note 6, at 27–28 (discussing the risks of untreated GID).

²⁰ See *infra* notes 114–117 and accompanying text.

²¹ See *infra* note 116 and accompanying text.

²² See *infra* Part II.C.

discusses a “self-determinative” alternative to a medicalized conception of gender identity. Part III explains the development of Eighth Amendment jurisprudence and how it came to be applied to trans prisoners’ right to gender-related health care. Part IV offers a limited defense of the use of medical evidence in trans advocacy: Part IV.A refutes some of the various criticisms of medicalized gender identity, both generally and as applied to the trans inmate health care context, and Part IV.B argues that unique aspects of the prison context legitimize and compel the use of medical evidence when advocating for trans prisoners’ right to sex reassignment therapy. Finally, Part V calls for broad-based, multifaceted advocacy whereby trans advocates employ a number of varied approaches to solving the obstacles faced by the trans community.

II. TRANS MODELS

In the recent history of trans identities, various discursive models have been employed to conceptualize who exactly is *trans*. Much of the current legal and social understanding of trans people is intertwined with a medico-scientific model (“the medical model”) created and developed by sexologists, psychologists, and endocrinologists over the past century.²³ The medical model persists today largely in the form of GID, which, as mentioned earlier, is a trans-specific mental disorder recognized in the fourth and most current edition of the American Psychiatric Association’s *Diagnostic and Statistical Manual of Mental Disorders* (“DSM-IV”).²⁴ In recent years, the medical model has engendered a great deal of controversy within the trans community as well as among scholars and activists who advocate on behalf of trans rights.²⁵ Those who criticize the medical model have articulated a “self-determinative model” of trans identity that rejects the medical model’s perceived pathologization and that, instead, adopts a flexible, inclusive, and non-binary view of gender identity.²⁶

A. *The Medical Model: Origins and Current Applications in Health Care*

Although trans identities have arguably existed throughout history, much of society’s current understanding of trans communities is rooted in a medico-scientific discourse begun by sexologists in the late nineteenth cen-

²³ See *infra* Part II.A. See generally BERNICE L. HAUSMAN, CHANGING SEX: TRANSSEXUALISM, TECHNOLOGY, AND THE IDEA OF GENDER 111–40 (1995) (detailing the history of medico-scientific studies of trans people).

²⁴ See DSM-IV-TR, *supra* note 3, at 576–82. For the sake of ease and readability, I refer to the DSM-IV-TR as the DSM-IV throughout the text of this Note.

²⁵ See *infra* Part II.C.

²⁶ See *infra* Part II.D.

ture.²⁷ These early sexologists “occupied themselves with teasing out the fine distinctions between ‘sexual aberrations’ that have come to be called homosexuality, transvestism, and transsexuality.”²⁸ Those who conducted this research expressed concern over the criminality of so-called sexual deviances given that they believed such behavior to have medico-scientific etiologies; indeed, early sexological research was driven largely by benevolent desires to shift these sex paradigms from discourse around moral culpability to discourse around medicalized study.²⁹ Research during this era of trans discourse fixated upon classification of discrete sexological conditions and ultimately resulted in a sort of sexualized taxonomy that, in large part, persists today.³⁰

The medical model of trans identity as it is understood today was largely originated by Harry Benjamin, an American endocrinologist who first defined transsexualism³¹ as a mental syndrome in 1966.³² Benjamin “believe[d] in somatogenic theories of human behavior” and was motivated by a desire “to look toward medicine’s future when perfected technologies would offer the truth of the transsexual enigma.”³³ Channeling earlier sexologists’ classificatory fixation, Benjamin distinguished nonsurgical transsexuals, who did not request surgery, from moderate and high intensity “true” transsexuals, who did request surgery.³⁴ This Benjaminian taxonomy remains noteworthy because it first introduced the still prevalent notion that demand for gender-related surgery is a central signifier of transsexualism.³⁵ Benjamin’s work was also significant in that it established still prevalent treatment structures that paralleled the gradations of his taxonomical classifications of trans people: he concluded that, in general, psychotherapy was

²⁷ See HAUSMAN, *supra* note 23, at 111.

²⁸ *Id.*

²⁹ See *id.* at 112.

³⁰ See generally *id.* at 113–16 (explaining that early sexologists’ efforts to classify sexological conditions on the basis of various medical theories had an impact on current theorists’ classificatory impulses).

³¹ The terms “transsexuality” and “transsexualism” were the diagnostic predecessors to GID. See *infra* notes 39–40 and accompanying text. I use these terms throughout this section for the sake of historical perspective. It is important to note, however, that the term “transsexual” is still commonly used to refer to a person who closely fits GID’s descriptive diagnosis. See Gianna E. Israel & Donald E. Tarver II, INTRODUCTION TO TRANSGENDER CARE: RECOMMENDED GUIDELINES, PRACTICAL INFORMATION, AND PERSONAL ACCOUNTS 3, 14 (Gianna E. Israel & Donald E. Tarver II eds., 1997) [hereinafter TRANSGENDER CARE] (defining transsexuals).

³² Nikko Harada, Comment, *Trans-Literacy Within Eighth Amendment Jurisprudence: De/Fusing Gender and Sex*, 36 N.M. L. REV. 627, 641 n.150 (2006) (citing Dallas Denny, *Changing Models of Transsexualism*, in TRANSGENDER SUBJECTIVITIES: A CLINICIAN’S GUIDE 25, 26 (Ubaldo Leli & Jack Dreschler eds., 2004)).

³³ HAUSMAN, *supra* note 23, at 119.

³⁴ HARRY BENJAMIN, THE TRANSEXUAL PHENOMENON, 22, 30–31 (1966).

³⁵ See HAUSMAN, *supra* note 23, at 119; see also *infra* note 43 and accompanying text.

often sufficient for milder cases of transsexuality, whereas surgical and hormonal interventions were necessary for more severe cases.³⁶

Throughout the past several decades, the medico-scientific community has continued this trend of medicalizing gender identity by coining the terms “gender dysphoria” and “GID.”³⁷ Scholars have argued that the emergent predominance of these new terminologies represents a total abandonment of the earlier pre-sexological “deviance” framework and has ultimately resulted in a legitimization of trans-specific health care.³⁸ Indeed, the American Psychiatric Association’s use of the terms transsexuality and GID mirrors this shift, as the Association first codified transsexuality as a mental disorder in the third edition of its *Diagnostic and Statistical Manual of Mental Disorders* in 1980³⁹ but has now abandoned that term in favor of GID as its official diagnostic classification.⁴⁰

In defining GID, the DSM-IV states

There are two components of Gender Identity Disorder, both of which must be present to make the diagnosis. [1] There must be evidence of a strong and persistent cross-gender identification, which is the desire to be, or the insistence that one is, of the other sex [2] There must also be evidence of persistent discomfort about one’s assigned sex or a sense of inappropriateness in the gender role of that sex.⁴¹

The DSM-IV elaborates on both criteria, stating that the first “is manifested by symptoms such as a stated desire to be the other sex, frequent passing as the other sex, desire to live or be treated as the other sex, or the conviction that he or she has the typical feelings and reactions of the other sex.”⁴² The second criterion, according to the DSM-IV, “is manifested by symptoms

³⁶ HAUSMAN, *supra* note 23, at 123; *see also infra* note 48 and accompanying text (explaining current gradations between transsexuality that result in varying approval requirements for hormonal and surgical treatment).

³⁷ HAUSMAN, *supra* note 23, at 126.

³⁸ *See id.* at 128–29; Dwight Billings & Thomas Urban, *The Socio-Medical Construction of Transsexualism: An Interpretation and Critique*, 29 SOC. PROBS. 266, 275–76 (1982).

³⁹ Noa Ben-Asher, *The Necessity of Sex Change: A Struggle for Intersex and Transsex Liberties*, 29 HARV. J.L. & GENDER 51, 79 (2006) (citing AM. PSYCHIATRIC ASS’N, *DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS* 261–64 (3d ed. 1980)).

⁴⁰ *See* DSM-IV-TR, *supra* note 3, at 576–82.

⁴¹ *Id.* at 576. The DSM-IV also states that a diagnosis of GID should not be given to an individual with a “concurrent physical intersex condition” and that a diagnosis of GID requires that there “be evidence of clinically significant distress or impairment in social, occupational, or other important areas of functioning.” *Id.* This latter criterion is required for most mental illness diagnoses listed in the DSM-IV, as “the criteria sets for most disorders include a clinical significance criterion (usually worded ‘. . . causes clinically significant distress or impairment in social, occupational, or other important areas of functioning’)”. *Id.* at 8.

⁴² *Id.* at 581. This elaboration applies to adults and adolescents but not to children. *Id.*

such as preoccupation with getting rid of primary and secondary sex characteristics (e.g., request for hormones, surgery, or other procedures to physically alter sexual characteristics to simulate the other sex) or belief that he or she was born the wrong sex.⁴³

The World Professional Association for Transgender Health, formerly known as the Harry Benjamin International Gender Dysphoria Association, has produced medical guidelines for health care professionals who work with GID patients.⁴⁴ These guidelines, known generally as the Standards of Care, also set forth the eligibility criteria that patients must meet in order to obtain certain kinds of treatment.⁴⁵ For example, the Standards of Care state that patients seeking genital surgery should “live full time in the preferred gender for twelve months prior to genital surgery.”⁴⁶ This is known as the “real-life experience.”⁴⁷ Further, the Standards of Care state that patients seeking hormone therapy must obtain one letter of recommendation from a mental health professional indicating that she has evaluated the patient and has concluded that a hormone treatment program is appropriate; patients seeking genital surgery must obtain two such letters.⁴⁸

B. *The Medical Model and the Law*

Courts and legislatures have generally held a static, binary view of sex in which the possibility of gender transition is seldom acknowledged.⁴⁹ Judges that adopt this static view seem to operate on the assumption that biological inherency governs sex and social sex conformity.⁵⁰ Indeed, many courts have taken this assumption to its logical conclusion in stating that sex, notwithstanding medical intervention, is ultimately immutable.⁵¹ Because of this, those who have advocated on behalf of legal recognition of trans identi-

⁴³ *Id.*

⁴⁴ See Standards of Care, *supra* note 6 (setting forth gender-related health care specialists’ recommended standards of medical care for patients with GID).

⁴⁵ See *id.*

⁴⁶ *Id.* It is worth reiterating that ‘genital surgery’ does not refer to a single, “one-size-fits-all” treatment for all trans people but, instead, a variety of options in a broad range of trans-specific treatment. See survey discussion *supra* note 6.

⁴⁷ Standards of Care, *supra* note 6, at 17–18.

⁴⁸ See *id.* at 7–8.

⁴⁹ See Dean Spade, *Resisting Medicine, Re/Modeling Gender*, 18 BERKELEY WOMEN’S L.J. 15, 30 (2003) (“The history of legal struggles for trans rights, of course, has been dominated by judicial decisions which would not recognize gender transition at all.”).

⁵⁰ This assumption was most famously expounded by Justice Bradley in *Bradwell v. Illinois*, 83 U.S. 130 (1872). In his concurring opinion in the case, Justice Bradley stated: “The natural and proper timidity and delicacy which belongs to the female sex evidently unfits it for many of the occupations of civil life The paramount destiny and mission of woman are to fulfil [sic] the noble and benign offices of wife and mother. This is the law of the Creator.” *Id.* at 141 (Bradley, J., concurring).

⁵¹ See, e.g., *Kantaras v. Kantaras*, 884 So. 2d 155, 161 (Fla. Dist. Ct. App. 2004) (“[T]he common meaning of male and female, as those terms are used statutorily, . . . refer to immutable traits determined at birth.”); *Anonymous v. Weiner*, 270 N.Y.S.2d 319, 320–24 (N.Y. Sup. Ct. 1966) (upholding Health Department’s denial of trans wo-

ties have had to introduce judges and lawmakers to the idea that sex and gender are, perhaps, not such rigid designations.⁵² Owing to these efforts, some courts have adopted more flexible views of sex and gender and, consequently, have acknowledged that trans people need and deserve basic legal rights.⁵³

Many situations that demand such rights involve legal sex designation. These designations play seminal roles in people's day-to-day interaction with society and government and, thus, have the potential to create complicated obstacles in trans people's lives: They are used on identity documents such as drivers' licenses,⁵⁴ they can govern who a person is allowed to marry,⁵⁵ and what bathrooms one is allowed to use,⁵⁶ and they can affect how one is required to dress at work or at school.⁵⁷ In much of the litigation that has been brought around these issues, trans individuals have succeeded in persuading courts to recognize a change in sex or gender by providing medical

man's request to change the sex designation on her birth certificate given that she was still chromosomally male).

⁵² See Spade, *supra* note 49, at 30.

⁵³ See, e.g., *M.T. v. J.T.*, 355 A.2d 204, 211 (N.J. Super. Ct. App. Div. 1976) (holding that marriage between man and trans woman was valid); *Richards v. U.S. Tennis Ass'n*, 400 N.Y.S.2d 267, 272–73 (Sup. Ct. 1977) (holding that a trans woman could compete in women's tennis tournament).

⁵⁴ When an individual's identity document does not comport with her present gender expression, she can face discriminatory harassment when "obtaining employment, applying to educational programs, getting medical care, or even getting a speeding ticket or buying alcohol." GORTON, BUTH & SPADE, *supra* note 6, at 79–80.

⁵⁵ The vast majority of jurisdictions in the United States have defined marriage as a union between a man and a woman. See NAT'L CONFERENCE OF STATE LEGISLATURES, SAME SEX MARRIAGE, CIVIL UNIONS AND DOMESTIC PARTNERSHIPS (2008), <http://www.ncsl.org/programs/cyf/samesex.htm> (showing that forty-one states, either through statute or state constitutional amendment, have affirmatively defined marriage as a union between a man and a woman). Even in these jurisdictions, however, trans people are often prohibited from marrying members of the "opposite" sex. See *infra* note 60.

⁵⁶ There is very little case law on the issue of trans bathroom use. THE RIGHTS OF LESBIANS, GAY MEN, BISEXUALS, AND TRANSGENDER PEOPLE 176 (Nan D. Hunter, Courtney G. Joslin, & Sharon M. McGowan eds., 4th ed. 2004). In one of the only opinions from a state's highest court on the issue, the Minnesota Supreme Court held that "Minnesota's antidiscrimination law does not prohibit employers from requiring a transgender person to alter her biological sex before being permitted to use the restroom consistent with her gender identity." *Id.* (citing *Goins v. West Group*, 635 N.W.2d 717 (Minn. 2001)). Despite the limited case law on the issue, it has been widely documented that trans people face persistent harassment in bathrooms, both from law enforcement officers and private individuals. See, e.g., Spade, *supra* note 49, at 17 n.5 (detailing the author's own experience facing bathroom harassment); SAN FRANCISCO HUMAN RIGHTS COMMISSION, GENDER NEUTRAL BATHROOM SURVEY (2001), available at <http://www.makezine.org/bathroomsurvey.htm> (reporting survey responses from trans people, nearly all of which recounted negative experiences in bathrooms).

⁵⁷ Sex-specific dress codes enforced by employers and schools have been upheld by courts. See, e.g., *Jespersen v. Harrah's Operating Co., Inc.*, 444 F.3d 1104, 1112–13 (9th Cir. 2006) (holding that terminating an employee for failure to adhere to employer's sex-specific dress code did not amount to sex discrimination); *Olesen v. Bd. of Educ.*, 676 F. Supp. 820, 822–23 (N.D. Ill. 1987) (upholding school's dress code policy that prohibited male students from wearing earrings).

evidence that they have undergone sex reassignment procedures.⁵⁸ Perhaps as a result of this, many jurisdictions now require a showing of medical evidence in order to obtain legal recognition of sex or gender transition; this is true, for example, when a trans individual petitions to change the sex designation on her birth certificate⁵⁹ and when the validity of a trans person's marriage is questioned.⁶⁰

Perhaps buoyed by the effectiveness of medical evidence in obtaining such rights for trans people, trans advocates have begun employing the medical model in other legal contexts. Such efforts have also met with success, as trans litigants have won suits against states and employers for disability discrimination,⁶¹ suits against state Medicaid programs requesting payment for gender-related surgery,⁶² and, of particular significance for this Note,

⁵⁸ See Spade, *supra* note 49, at 15–18 (offering a thorough catalog of trans legal rights contingent upon a showing of medical evidence).

⁵⁹ Most, if not all, states that permit a trans individual to amend the sex designation on her birth certificate require that she have undergone gender-related surgery. See, e.g., ALA. CODE § 22-9A-19(d) (2007); ARIZ. REV. STAT. ANN. § 36-337(A)(3) (2007); ARK. CODE ANN. § 20-18-307(d) (2007); CAL. HEALTH & SAFETY CODE §§ 103425, 103430 (West 2007); COL. REV. STAT. § 25-2-115(4) (2007); D.C. CODE ANN. § 7-217(d) (LexisNexis 2008); GA. CODE ANN. § 31-10-23(e) (2007); HAW. REV. STAT. § 338-17.7(4)(B) (2007); 410 ILL. COMP. STAT. 535/17(1)(d) (2007); LA. REV. STAT. ANN. § 40:62 (2007); MASS. GEN. LAWS ch. 46, § 13(e) (2006); MICH. COMP. LAWS SERV. § 333.2831(c) (LexisNexis 2007); MO. REV. STAT. § 193.215(9) (2007); N.J. STAT. ANN. 26:8-40.12 (West 2007); N.M. STAT. ANN. § 24-14-25(D) (LexisNexis 2008); N.C. GEN. STAT. 130A-118(b)(4) (2007); OR. REV. STAT. § 432.235(4) (2007); VA. CODE ANN. § 32.1-269(E) (2007).

⁶⁰ Many courts presented with this issue have invalidated marriages between a trans individual and a member of the “opposite” sex. See, e.g., *In re Estate of Gardiner*, 42 P.3d 120, 136–37 (Kan. 2002) (holding that marriage between trans individual and member of the “opposite” sex was invalid); *Littleton v. Prange*, 9 S.W.3d 223, 231 (Tex. App. 1999) (same); *Anonymous v. Anonymous*, 325 N.Y.S.2d 499, 501 (Sup. Ct. 1971) (same); *In re Ladrach*, 513 N.E.2d 828, 832 (Ohio P. Ct. 1987) (same). Of the very few courts that have held such marriages to be valid, all have looked to medical evidence that the trans individual had undergone gender-related surgery. See, e.g., *M.T. v. J.T.*, 355 A.2d 204, 206 (N.J. Super. Ct. App. Div. 1976) (examining medical evidence in determining the validity of a marriage between man and trans woman); *Kantaras v. Kantaras*, 884 So. 2d 155, 156 (Fla. Dist. Ct. App. 2004) (explaining that the trial court below, in an unpublished and ultimately overturned opinion, had declared marriage between a trans person and a member of the “opposite” sex to be valid based on a review of medical evidence).

⁶¹ See, e.g., *Doe v. Bell*, 754 N.Y.S.2d 846, 853–56 (Sup. Ct. 2003) (holding that GID constitutes a disability for the purposes of New York disability discrimination law and that the state failed to properly accommodate trans plaintiff); *Lie v. Sky Publ'g Corp.*, 15 Mass. L. Rptr. 412 (Super. Ct. 2002) (allowing disability discrimination suit where employer had prohibited trans employee from wearing clothes consistent with her gender identity).

⁶² See *Pinneke v. Preisser*, 623 F.2d 546, 550 (8th Cir. 1980) (holding that Iowa's statutory ban on gender-related surgery under state Medicaid program removed treatment decisions from physicians and placed them in the hands of government personnel); *J.D. v. Lackner*, 145 Cal. Rptr. 570, 572 (Ct. App. 1978) (overturning Health Department's determination that gender-related surgery was merely cosmetic and thus ineligible for coverage under state Medicaid program); *Doe v. Dep't of Pub. Welfare*, 257 N.W.2d 816, 820 (Minn. 1977) (holding that state could not categorically deny coverage of gender-related surgery under state Medicaid program). *But see* *Smith v. Rasmussen*, 249 F.3d

suits against prison officials requesting access to hormone therapy while incarcerated.⁶³ Indeed, scholars and advocates have frequently remarked on the general effectiveness of the medical model in advocating for trans rights.⁶⁴

C. Criticisms of the Medical Model

The medicalization of gender identity that has occurred over the past several decades has caused considerable controversy within the trans community and among advocates and scholars of trans rights.⁶⁵ Those who are opposed to widespread use of the medical model offer several criticisms of it, most of which align with one of the following four arguments: 1) the medical model pathologizes and thus stigmatizes trans people; 2) the medical model heavily disfavors low-income trans people; 3) the medical model is diagnostically and descriptively underinclusive; and 4) the medical model reinforces the oppressive gender binary. The rest of this section will elaborate on each of these criticisms in turn.

The most prominent of these criticisms from within the trans community is that the medicalized discourse surrounding gender identity implies that trans individuals “are somehow flawed people.”⁶⁶ Being labeled dis-

755, 760–62 (8th Cir. 2001) (upholding Iowa’s most recent ban on Medicaid coverage of gender-related surgery).

⁶³ See *infra* notes 115–116 and accompanying text.

⁶⁴ See, e.g., Spade, *supra* note 49, at 30 (“[Compromises over the use of medical evidence in trans cases] are necessitated by the fact that most of the successful legal claims for trans equality have come through strategic use of the medical model of transsexuality.”); Paisley Currah, *Gender Pluralisms Under the Transgender Umbrella*, in *TRANSSEXUAL RIGHTS* 3, 7–13 (Paisley Currah, Richard M. Juang & Shannon Price Minter eds., 2006) (comparing two cases involving student dress code violations and arguing that the use of trans-specific medical evidence likely helped one student’s disability discrimination claim succeed where the other student’s sex discrimination claim did not); Jennifer Levi, *The Interplay Between Disability and Sexuality: Clothes Don’t Make the Man (or Woman), but Gender Identity Might*, 15 *COLUM. J. GENDER & L.* 90, 99–104 (2006) (explaining that dress code violation cases invoking disability discrimination claims on behalf of plaintiffs with GID have been more successful than dress code violation cases invoking sex discrimination claims on behalf of plaintiffs without GID).

⁶⁵ See JUDITH BUTLER, *Undiagnosing Gender*, in *Undoing Gender* 75, 75 (2004) (“In recent years there have been debates about the status of the *Diagnostic and Statistical Manual of Mental Disorders*’ diagnosis of gender identity disorder . . .”). See generally, e.g., GID Reform Advocates, <http://www.gidreform.org/> (last visited Apr. 5, 2008) (website of organization dedicated to the “reform of the classification of gender diversity as mental disorder”); Ken Hausman, *Controversy Continues to Grow Over DSM’s GID Diagnosis*, 38 *PSYCHIATRIC NEWS* 25 (2003), available at <http://pn.psychiatryonline.org/cgi/content/full/38/14/25> (outlining the debate over the medical model); Joanne Herman, *The Trans Catch-22*, *THE ADVOCATE*, June 12, 2006, http://www.advocate.com/print_article.asp?id=32405 (last visited Apr. 5, 2008) (same).

⁶⁶ Spade, *supra* note 49, at 34 (“The first response that always comes up [in the context of the medical model] . . . is the argument that trans people do not want to be seen as ‘disabled.’”).

abled or disordered is deeply offensive to many⁶⁷ and can be especially objectionable to those who do not feel physically or mentally limited in any way.⁶⁸ As described by some, “[t]o be diagnosed with [GID] is to be found, in some way, ill, sick, wrong, out of order, abnormal”⁶⁹ Scholars have described a diagnosis of GID as “an instrument of pathologization” that ultimately results in “a certain stigmatization as a consequence of the diagnosis being given at all.”⁷⁰

A second criticism of the medical model that has emerged is that it heavily disfavors low-income trans people because they do not have the economic means to access the sophisticated health care involved with diagnosing and treating GID.⁷¹ The economic access criticism thus has special significance in the context of legal rights that are conditional upon medical evidence: for example, if a trans individual cannot afford gender-related surgery, then she is most likely legally forbidden from changing the sex designation on her birth certificate⁷² or marrying her opposite-sex partner.⁷³ Thus, requirements of medical evidence in order to obtain basic legal rights place low-income trans people “in a particularly precarious situation” given that they will “have limited recourse to [certain] legal protections”⁷⁴

Scholars have articulated a third criticism of the medical model that it is diagnostically and descriptively underinclusive; this underinclusivity argument is, at least conceptually, based on the broader criticism that GID itself is grounded in overly rigid and formalistic diagnostic standards.⁷⁵ The argument goes that, given this rigidity, trans people are forced to perform re-

⁶⁷ See Levi, *supra* note 49, at 104 (“[T]he criticisms of [the incorporation of disability claims into discrimination claims] stem principally from the stigma of disability”).

⁶⁸ See Jerry L. Dasti, *Advocating a Broader Understanding of the Necessity of Sex-Reassignment Surgery Under Medicaid*, 77 N.Y.U. L. REV. 1738, 1764 (2002) (“One objection to the classification of sex-reassignment surgery as medically necessary is the implication that transgender identities are disorders requiring treatment.”).

⁶⁹ BUTLER, *supra* note 65, at 76; see also Laura K. Langley, *Self-Determination in a Gender Fundamentalist State: Toward Legal Liberation of Transgender Identities*, 12 TEX. J. C.L. & C.R. 101, 109 (2006) (“Transgender people are thus understood not only as socially deviant; their deviations are read as abnormal and unnatural.”).

⁷⁰ BUTLER, *supra* note 65, at 76; see also Dasti, *supra* note 68, at 1743 (“In order to establish a legal identity, transsexuals have to pathologize their social identity.”).

⁷¹ See Spade, *supra* note 49, at 35 (“[GID] diagnoses are not accessible to many low income people.”). The problem of economic access to sophisticated health care is dramatically exacerbated by the fact that trans people, due to widespread institutional and systemic discrimination in education, employment, and housing, are disproportionately likely to live in poverty. See Sylvia Rivera Law Project, *Systems of Inequality: Poverty & Homelessness*, http://www.srlp.org/documents/disproportionate_poverty.pdf (last visited Apr. 5, 2008).

⁷² See *supra* note 59 and accompanying text.

⁷³ See *supra* note 60 and accompanying text.

⁷⁴ Franklin H. Romeo, *Beyond a Medical Model: Advocating for a New Conception of Gender Identity in the Law*, 36 COLUM. HUM. RTS. L. REV. 713, 736 (2005).

⁷⁵ See *id.* at 731 (“Because the experiences of many gender nonconforming people do not match the diagnostic criteria of GID . . . the medical model of gender does not serve the vast majority of gender nonconforming people.”).

heard narratives that may not accurately depict their experiences,⁷⁶ and any failure to perform such a narrative will result in a denial of trans-specific health care.⁷⁷ Even medical professionals have acknowledged this tension in noting that the provision of trans health care often involves an adversarial element between the patient and the caregiver, mostly stemming from mental-health professionals' roles as "gatekeepers" to gender-related treatment.⁷⁸ The obvious legal concern stemming from the underinclusivity argument is that those trans people who do not perfectly fit the DSM-IV's precise definition of GID, as well as those trans people who do not wish to undergo any sex reassignment therapy, will, like low-income trans people, have limited access to all rights conditioned upon medical proof.⁷⁹

A fourth criticism that has emerged from scholarly discourses is that, given that gender is socially constructed, the medical model actually works to reinforce the oppressive gender binary.⁸⁰ The scholars who set forth this postmodern criticism are, in many ways, synthesizing the pathology and underinclusivity criticisms: the argument goes that the medical model pathologizes gender nonconformity while at the same time creating only a small, insular diagnostic category for certain trans individuals who, if treated, will ultimately end up in one gender category or the other.⁸¹ These scholars point out that, as a consequence, the medical model "hold[s] transgender people to hyper-normative standards of masculinity or femininity,"⁸² such that GID actually serves as an instrument for funneling trans people into one gender or the other rather than allowing them to exist somewhere in between.⁸³

D. *The Self-Determinative Model*

Stemming from the perceived inadequacy of the medical model,⁸⁴ trans scholars and advocates have articulated a more flexible discursive frame-

⁷⁶ See Spade, *supra* note 49, at 19–23 (offering the author's personal account of the frustration involved with trying to convince a doctor that his experience fit the mold of traditional GID and that, thus, he should be entitled to medical treatment).

⁷⁷ See Romeo, *supra* note 74, at 732 ("Gender nonconforming people who do not articulate their experiences of gender in a manner that comports with the diagnostic criteria for GID are often refused hormone treatments, surgeries, or other gender-related health care.").

⁷⁸ See Barbara F. Anderson, *Ethical Implications for Psychotherapy with Individuals Seeking Gender Reassignment*, in *TRANSGENDER CARE*, *supra* note 31, at 185, 186.

⁷⁹ See Romeo, *supra* note 74, at 733 ("The many gender nonconforming people whose experiences do not conform to [the medical model's] norms therefore do not gain the access to legal rights that the medical model of gender affords.").

⁸⁰ See Spade, *supra* note 49, at 24–25.

⁸¹ *Id.* at 25 ("The diagnostic criteria for GID produces a fiction of natural gender in which normal, non-transsexual people grow up with minimal to no gender trouble.").

⁸² Romeo, *supra* note 74, at 732.

⁸³ See Spade, *supra* note 49, at 24–29.

⁸⁴ Scholars have discussed the need for a self-determinative model in the context of the inadequacy of the medical model. See, e.g., JASON CROMWELL, *TRANSMEN AND FTMS:*

work of trans identity that can be coined the “self-determinative model.”⁸⁵ The self-determinative framework generally envisions what its term implies: that an individual should decide for herself whether she is trans rather than being forced to have doctors and scientists decide for her.⁸⁶ Proponents of the self-determinative model conceive of a world in which gender transgression is regarded as “freeing [trans people] to express more of themselves, and enabling more comfortable and exciting self understandings and images.”⁸⁷

Trans scholars have devised innovative legal frameworks consistent with the self-determinative model, and such frameworks can form the basis of workable legal theories that do not necessarily employ medical evidence. Many of these theories involve substantive due process protection of some sort of constitutional liberty or privacy right. For example, Laura Langley argues for a fundamental liberty right “to gender self-determination, rooted in the Due Process Clause of the Fourteenth Amendment.”⁸⁸ Franklin Romeo makes a similar argument, stating that “[a]nalagizing gender self-determination to the right to determine reproductive choices may provide an opportunity for courts to consider a self-determination model of gender.”⁸⁹ Other scholars have articulated legal theories grounded in the Equal Protection Clause,⁹⁰ and still others have begun developing the notion that the First Amendment’s free speech protections encompass gender-expressive activity.⁹¹ Trans advocates have begun employing these self-determinative legal theories in court, and there is at least some evidence that such efforts have

IDENTITIES, BODIES, GENDERS, AND SEXUALITIES 24–25 (1999). Indeed, empirical evidence supports the notion that many trans people feel that the medical model does not adequately describe their experiences. See SALLY HINES, *TRANSFORMING GENDER: TRANS-GENDER PRACTICES OF IDENTITY, INTIMACY AND CARE* 78–83 (2007).

⁸⁵ The term “self-determinative model” is not necessarily one in common use but one that I feel is accurately descriptive for the purposes of this Note and sufficiently similar to parallel terms used by others. For example, Christine Peek discusses the self-determinative model in terms of “self-definition” and “individual perception of identity.” Christine Peek, *Breaking out of the Prison Hierarchy: Transgender Prisoners, Rape, and the Eighth Amendment*, 44 SANTA CLARA L. REV. 1211, 1217 (2004). Jason Cromwell frames self-determination similarly, stating that “[b]eing trans-anything is a self-diagnosis.” CROMWELL, *supra* note 84, at 25.

⁸⁶ Many trans health professionals certainly agree with the fundamental premise that trans identity is ultimately an autonomous choice. See Israel & Tarver, *supra* note 31, at 16 (“Neither transgenderist nor androgyne individuals should be required to conform to transvestite, transsexual, or other stereotypes or support models Support for these individuals provides an opportunity to define their place within the gender spectrum, reduce isolation, and focus on options correlating with their unique needs.”).

⁸⁷ Spade, *supra* note 49, at 28.

⁸⁸ Langley, *supra* note 69, at 114. More specifically, Langley argues that “Justice Kennedy’s reasoning in *Lawrence* [*v. Texas*] may be imported to the gender self-determination context.” *Id.* at 117 (citation omitted in original).

⁸⁹ Romeo, *supra* note 74, at 746.

⁹⁰ Nikko Harada has analyzed the doctrinal obstacles involved with pleading equal protection theories in trans advocacy. See Harada, *supra* note 32, at 649–58.

⁹¹ See Currah, *supra* note 64, at 18 (“What about using the First Amendment’s free speech clause as the basis of rights claims against the state . . . conceptualizing gender nonconformity as an expressive activity worthy of constitutional protection?”).

met with success. For example, in a New York case involving trans women's bathroom use, the judge, in ruling on a discovery motion, stated that information about the plaintiff's anatomical sex was irrelevant to her status as a trans person.⁹²

It should be noted, however, that medicine and self-determination are not always antithetical, mutually exclusive frameworks. Indeed, an example of an area in which self-determination intersects with, and perhaps trumps, medical judgment involves the administration of contraceptive hormones. Birth control pills are largely given upon patient demand without extensive examination or inquiry by health care professionals.⁹³ Thus, one could say that patients who seek birth control largely self-determine, or more specifically self-diagnose, their need for particular medical treatment.

III. THE EIGHTH AMENDMENT: BACKGROUND AND APPLICATION TO TRANS PRISONERS' RIGHT TO SEX REASSIGNMENT THERAPY

In thinking about the conceptual and practical implications of employing various trans models in the prison health care context, it is important to understand the history of Eighth Amendment jurisprudence as well as how the Eighth Amendment has come to be applied to trans prisoners' claims for sex reassignment therapy.

The Eighth Amendment provides that "[e]xcessive bail shall not be required, nor excessive fines imposed, nor cruel and unusual punishments inflicted."⁹⁴ The Amendment's somewhat ambiguous prohibition on "cruel and unusual punishments" has engendered a great deal of debate and uncertainty throughout American history, and the Supreme Court has accordingly acknowledged the difficulty of interpreting the prohibition's fundamentally subjective terms.⁹⁵

⁹² See *Hispanic AIDS Forum v. Bruno*, 759 N.Y.S.2d 291, 295 (Sup. Ct. 2003).

⁹³ See, e.g., *Hill v. Searle Labs.*, 884 F.2d 1064, 1070–71 (8th Cir. 1989) (recognizing that a patient "makes an independent decision as to whether she desires a prescription drug for birth control"); *MacDonald v. Ortho Pharm. Corp.*, 475 N.E.2d 65, 69 (Mass. 1985) ("Whereas a patient's involvement in decision making concerning use of a prescription drug necessary to treat a malady is typically minimal or nonexistent, the healthy, young consumer of oral contraceptives is usually actively involved in the decision to use 'the pill,' as opposed to other available birth control products, and the prescribing physician is relegated to a relatively passive role.").

⁹⁴ U.S. CONST. amend. VIII.

⁹⁵ See *Furman v. Georgia*, 408 U.S. 238, 258 (1972) (Brennan, J., concurring) ("The Cruel and Unusual Punishments Clause . . . is not susceptible of precise definition."); *Wilkerson v. Utah*, 99 U.S. 130, 135–36 (1879) ("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 . . ."). The Supreme Court's apparent difficulty interpreting the prohibition has also manifested itself in the Court's admissions that its Eighth Amendment jurisprudence has not produced abundantly clear guidelines as to what exactly is proscribed by the prohibition. See, e.g., *Trop v. Dulles*, 356 U.S. 86, 99 (1958) ("The exact scope of the constitutional phrase 'cruel and unusual' has not been detailed by this Court.").

Scholars have noted that the prohibition on cruel and unusual punishments was originally understood only to proscribe certain methods of inhumane punishment,⁹⁶ a view confirmed by early Supreme Court cases that focused primarily on whether a particular mode of punishment was cruel and unusual for the purposes of the Eighth Amendment.⁹⁷ Throughout the past century, however, courts have expanded the scope of the prohibition such that it now proscribes much more than was originally understood to fall within its reach.⁹⁸ In doing so, courts have cited a progressive principle articulated by the Supreme Court: that the Eighth Amendment “must draw its meaning from the evolving standards of decency that mark the progress of a maturing society.”⁹⁹ This hallmark principle has led courts to scrutinize the constitutionality of much more than just methods of punishment, such as disproportionately severe prison sentences¹⁰⁰ and inhumane prison conditions.¹⁰¹

This progressive evolution of Eighth Amendment jurisprudence has also led to an affirmative right to health care while incarcerated.¹⁰² This right was first established in *Estelle v. Gamble*, a Supreme Court case involving an inmate who alleged that he had suffered a serious back injury and

⁹⁶ See Anthony F. Granucci, “*Nor Cruel and Unusual Punishments Inflicted*” *The Original Meaning*, 57 CAL. L. REV. 839, 841–42 (1969); Stephen T. Parr, *Symmetric Proportionality: A New Perspective on the Cruel and Unusual Punishment Clause*, 68 TENN. L. REV. 41, 49 (2000) (arguing that the Eighth Amendment’s prohibition against cruel and unusual punishments was intended to bar certain modes of punishment but not much else).

⁹⁷ See, e.g., *In re Kemmler*, 136 U.S. 436, 447 (1890) (holding that death by electrocution did not constitute cruel and unusual punishment for the purposes of the Eighth Amendment); *Wilkerson*, 99 U.S. at 134–35 (holding that death by shooting did not constitute cruel and unusual punishment for the purposes of the Eighth Amendment).

⁹⁸ See, e.g., *Estelle v. Gamble*, 429 U.S. 97, 102 (1976) (noting that the Eighth Amendment originally proscribed only certain methods of punishment but that “more recent cases . . . have held that the Amendment proscribes more than physically barbarous punishments”).

⁹⁹ *Trop*, 356 U.S. at 101. The Court has further acknowledged that it has interpreted the Eighth Amendment “in a flexible and dynamic manner.” *Gregg v. Georgia*, 428 U.S. 153, 171 (1976).

¹⁰⁰ See, e.g., *Ewing v. California*, 538 U.S. 11, 20 (2003) (plurality opinion) (stating that the Eighth Amendment contains a narrow proportionality principle with regard to prison sentencing); *Solem v. Helm*, 463 U.S. 277, 281, 303 (1982) (holding that a sentence of life imprisonment without possibility of parole was significantly disproportionate to the crime of uttering a “no account” check for \$100 such that the sentence violated the Eighth Amendment).

¹⁰¹ See, e.g., *Rhodes v. Chapman*, 452 U.S. 337, 347 (1981) (“[Prison c]onditions must not involve the wanton and unnecessary infliction of pain . . .”). Justice Brennan filed a concurring opinion in *Rhodes* in which he catalogued various federal courts’ findings of unconstitutional prison conditions “in at least 24 States.” *Id.* at 353 n.1 (Brennan, J., concurring). See also MALCOLM FEELEY & EDWARD RUBIN, *JUDICIAL POLICY MAKING AND THE MODERN STATE: HOW THE COURTS REFORMED AMERICA’S PRISONS* 39–41 (1998) (discussing federal courts’ findings of unconstitutional prison conditions throughout the country).

¹⁰² See, e.g., *Estelle*, 429 U.S. at 103 (“[Eighth Amendment] principles establish the government’s obligation to provide medical care for those whom it is punishing by incarceration.”).

that prison officials had failed to provide him with adequate medical care to treat it.¹⁰³ Reasoning that inmates, isolated from society, are forced to rely on prison officials for medical care and that inadequate care could produce unnecessary pain and suffering,¹⁰⁴ the Court held that “deliberate indifference to serious medical needs of prisoners” violates the Eighth Amendment.¹⁰⁵

Subsequent Supreme Court case law has specified that its holding in *Estelle* sets forth a two-prong inquiry in the prison health care context: an *objective* prong, whereby an Eighth Amendment plaintiff must show that he has an objectively serious medical need, and a *subjective* prong, whereby an Eighth Amendment plaintiff must show that prison officials were aware of such need and nonetheless responded with “deliberate indifference.”¹⁰⁶ Health conditions that courts have held to be serious enough to satisfy the objective prong of the *Estelle* inquiry have included paralysis,¹⁰⁷ unwanted pregnancy,¹⁰⁸ psychological and psychiatric conditions,¹⁰⁹ and, most broadly, any “medical condition . . . that has been diagnosed by a physician as mandating treatment.”¹¹⁰ Lower courts have analyzed the subjective prong as containing both objective and subjective elements: on the one hand, responses to serious medical needs must be objectively adequate according to “prudent professional standards in the [medical] community,”¹¹¹ and on the other hand, responses must be examined from the point of view of the prison official to determine the culpable level of intent that informed the allegedly inadequate care.¹¹²

The right to medical care in prisons, and specifically to care relating to mental health conditions, is of special import for some trans prisoners who seek sex reassignment therapy while incarcerated.¹¹³ Although courts were

¹⁰³ See *id.* at 99–102 (stating facts of case).

¹⁰⁴ See *id.* at 103.

¹⁰⁵ See *id.* at 104.

¹⁰⁶ See *Helling v. McKinney*, 509 U.S. 25, 35–36 (1993).

¹⁰⁷ *Weeks v. Chaboudy*, 984 F.2d 185, 187 (6th Cir. 1993).

¹⁰⁸ *Monmouth County Corr. Inst. Inmates v. Lanzaro*, 834 F.2d 326, 348 (3d Cir. 1987).

¹⁰⁹ *Bowring v. Godwin*, 551 F.2d 44, 47 (4th Cir. 1977).

¹¹⁰ *Greeno v. Daley*, 414 F.3d 645, 653 (7th Cir. 2005).

¹¹¹ *Barrett v. Coplan*, 292 F. Supp. 2d 281, 285 (D.N.H. 2003).

¹¹² See *Greeno*, 414 F.3d at 653 (“To satisfy the subjective component, a prisoner must demonstrate that prison officials acted with a ‘sufficiently culpable state of mind.’” (citations omitted)); see also *Estelle v. Gamble*, 429 U.S. 97, 106 (“[A] complaint that a physician has been negligent in diagnosing or treating a medical condition does not state a valid claim of medical mistreatment under the Eighth Amendment. Medical malpractice does not become a constitutional violation merely because the victim is a prisoner. In order to state a cognizable claim, a prisoner must allege acts or omissions sufficiently harmful to evidence deliberate indifference to serious medical needs.”).

¹¹³ Eighth Amendment theories based on *Estelle* are not the only possible legal avenues in which trans inmates can argue for access to sex reassignment therapy, but they have been the most successful thus far. See *infra* notes 115–116 and accompanying text. For a discussion of some alternative legal frameworks devised by trans rights scholars, see *supra* notes 88–91.

initially unsympathetic to trans prisoners' right-to-care claims brought in the mid-1980s,¹¹⁴ such prisoners have recently had more success in courts.¹¹⁵ Within the past fifteen to twenty years, most courts that have considered this issue have acknowledged that GID constitutes a serious medical need under the objective prong of the *Estelle* inquiry,¹¹⁶ so many trans prisoners' right-to-care claims have ultimately proceeded to trial to resolve factual issues involved with the subjective culpability component of the *Estelle* inquiry.¹¹⁷

IV. DEFENDING THE MEDICAL MODEL IN THE PRISON HEALTH CARE CONTEXT

Although some criticisms of the medical model are undoubtedly valid, many of them are conceptually refutable or simply inapplicable to the prison context. Furthermore, unique aspects of incarceration and prison health care

¹¹⁴ See, e.g., *Supre v. Ricketts*, 792 F.2d 958, 963 (10th Cir. 1986) (holding that prison officials' medical decision not to administer hormone therapy to trans inmate did not constitute cruel and unusual punishment, given that such therapy was controversial and required further study); *Lamb v. Maschner*, 633 F. Supp. 351, 353–54 (D. Kan. 1986) (holding that inmate had received some mental health treatment such that inmate was not constitutionally entitled to any sex reassignment therapy).

¹¹⁵ See, e.g., *De'Lonta v. Angelone*, 330 F.3d 630, 635–36 (4th Cir. 2003) (reversing district court's dismissal of trans inmate's Eighth Amendment right-to-care suit for failure to state a claim); *Brown v. Zavaras*, 63 F.3d 967, 970 (10th Cir. 1995) (same); *White v. Farrier*, 849 F.2d 322, 325 (8th Cir. 1988) (stating that GID constitutes a serious medical need); *Phillips v. Mich. Dep't of Corr.*, 731 F. Supp. 792, 799–801 (W.D. Mich. 1990) (holding that GID constitutes a serious medical need and that plaintiff was entitled to preliminary injunction to continue hormone therapy that she had begun pre-incarceration). The success of Eighth Amendment right-to-care claims depends on many factual considerations. Because the focus of this Note is on the practical and theoretical implications of using the medical model of gender identity in the Eighth Amendment right-to-care context and not on the contours of trans Eighth Amendment right-to-care jurisprudence generally, I have omitted any evaluation of the merits of such claims as well as any analysis as to the legal hurdles that trans prisoners must overcome in order to succeed on such claims. See generally Matthew A. Stoloff, *Dual Prongs for the Doubly Imprisoned: Transsexual Inmates & the Eighth Amendment Right to Treatment* (August 2007), <http://ssrn.com/abstract=1012980> (assessing the merits of transsexual inmates' Eighth Amendment claims and the elements necessary to prove such claims).

¹¹⁶ *Wolfe v. Horn*, 130 F. Supp. 2d 648, 652 (E.D. Pa. 2001) ("Courts have consistently considered [GID] a 'serious medical need' for purposes of the Eighth Amendment." (citations omitted)); see also *Cuoco v. Moritsugu*, 222 F.3d 99, 106 (2d Cir. 2000) (stating that GID is a serious medical need for the purposes of the Eighth Amendment); *White*, 849 F.2d at 325 (same); *Meriwether v. Faulkner*, 821 F.2d 408, 413 (7th Cir. 1987) (same). Even before asking a court to assess whether GID is a serious medical need, however, a trans inmate must obtain a diagnosis of GID from a prison doctor. See Stoloff, *supra* note 115, at 22–24. This, of course, implicates the diagnostic underinclusivity criticism of the medical model. See *supra* notes 75–79 and accompanying text.

¹¹⁷ See, e.g., *White*, 849 F.2d at 327 ("The level of the prison officials' personal involvement in the medical staff's decision that no medical need existed is a question of fact to be determined at trial."); *Wolfe*, 130 F. Supp. 2d at 653 ("[T]here is at least a fact question as to whether each of the defendants was deliberately indifferent to treating Wolfe's gender identity disorder. Accordingly, the Eighth Amendment claim will proceed to trial.").

justify and indeed compel the use of the medical model when advocating for trans prisoners' right to sex reassignment therapy.

A. *Refuting the Criticisms of the Medical Model*

As already mentioned, the primary criticism of the medical model from within the trans community is that it is pathologizing and stigmatizing.¹¹⁸ This criticism, however, is largely the product of ableist attitudes that have been adopted from society's unjust biases against disabilities in general.¹¹⁹ The label "disabled" in a vacuum is itself not stigmatizing; instead, it is the negative association that society imposes upon disabilities that is stigmatizing. Indeed, the entire aim of disability advocacy in this country has been to demonstrate that "disabled people are capable of equal participation" *but for* the ableist attitudes that unfairly deny them access to such participation.¹²⁰ As trans scholars and advocates have begun to point out, the conceptual overlap between the trans community and the disability community should not in and of itself be troubling and should, instead, unite the two communities toward the common cause of reducing ableist stigmas associated with disabilities generally.¹²¹

The second criticism of the medical model discussed earlier is that it largely disfavors low-income trans people.¹²² Although it is difficult to imagine a wholesale refutation of the economic access criticism,¹²³ especially as applied to the predication of basic rights such as legal sex designation upon a showing of medical evidence,¹²⁴ the criticism is largely irrelevant in the prison context: the provision of health care in prisons is predicated not upon the ability to purchase it but upon its objective seriousness for a particular patient.¹²⁵ This is because Eighth Amendment jurisprudence indicates that prisoners have a right to health care for objectively serious medical

¹¹⁸ See *supra* notes 66–70 and accompanying text.

¹¹⁹ See Spade, *supra* note 49, at 34.

¹²⁰ See *id.*; see also Jennifer L. Levi & Bennett H. Klein, *Pursuing Protection for Transgender People through Disability Laws*, in *TRANSGENDER RIGHTS*, *supra* note 64, at 74, 77–78 (detailing the history of disability discrimination and disability advocacy in the United States).

¹²¹ Spade, *supra* note 49, at 34 (“[T]rans people could use the disability rights framework to argue that we are fully capable of participating equally, but for artificial conditions that bar our participation Like others in the disability rights movement, trans people are fighting against entrenched notions about what ‘normal’ and ‘healthy’ minds and bodies are, and fighting to become equal participants with equal access and equal protection from bias and discrimination.”).

¹²² See *supra* notes 71–74 and accompanying text.

¹²³ Jennifer Levi has offered a refutation of the economic access criticism in the limited context of disability discrimination law. See Levi, *supra* note 64, at 106–07 (explaining that in order to plead a disability discrimination claim in most states, a plaintiff need only demonstrate that she was regarded as having a disability and need not demonstrate that she has actually been diagnosed with a disability).

¹²⁴ See *supra* notes 54–60 and accompanying text.

¹²⁵ See *supra* notes 106–110 and accompanying text.

needs without making any reference to prisoners' ability to pay for it.¹²⁶ Indeed, given that inmates are in fact incarcerated and, thus, unlikely to be able to purchase outside health care even if they want to, an argument that economic considerations advantage or disadvantage otherwise similarly situated prisoners is conceptually unsound with regard to health care. This is not to suggest that prisoners, whether trans or not, receive excellent or even adequate health care while incarcerated, but it is to suggest that any deficiency in the provision of health care in prison is likely not attributable to differences in wealth from inmate to inmate.

The third aforementioned criticism, that the medical model is diagnostically and descriptively underinclusive,¹²⁷ is somewhat belied by the fact that self-determinative principles are built into the definitions of transsexualism and GID: Harry Benjamin originally stated that desire for sex reassignment therapy is one of the central signifiers of transsexualism,¹²⁸ and the DSM-IV's diagnostic criteria explicitly state that a "request for hormones, surgery, or other procedures to physically alter sexual characteristics to simulate the other sex" is probative of the existence of GID.¹²⁹ Indeed, trans-specific health care specialists have noted that such self-determinative principles are to be honored and respected in the responsible administration of sex reassignment therapy.¹³⁰ Thus, the argument that a diagnosis of GID is inaccessible to a significant segment of trans people who wish to access it is not very forceful. The claim that adherence to strict diagnostic criteria and rehearsed narratives dictates who can and cannot access a diagnosis of GID seems somewhat inconsistent with the fact that, to a large extent, merely requesting sex reassignment therapy is seen as a central, probative indication that an individual has GID. Indeed, in this sense, GID and access to sex reassignment therapy share much in common with the birth control example outlined earlier:¹³¹ people with GID play a large role in self-determining, or more specifically in self-diagnosing, their need for sex reassignment therapy by initially requesting it. In fact, if desire for birth control were deemed a mental health condition called "Contraceptive Need Disorder" and access to it were predicated upon a showing of diagnostic evidence that the patient actually wanted it, then the birth control example would be almost identical to the provision of GID-related health care.¹³²

¹²⁶ See *supra* notes 106–110 and accompanying text.

¹²⁷ See *supra* notes 75–79 and accompanying text.

¹²⁸ See *supra* notes 34–35 and accompanying text.

¹²⁹ DSM-IV-TR, *supra* note 3, at 581; see also *supra* note 43 and accompanying text.

¹³⁰ See Israel & Tarver, *Transgender Hormone Administration*, *supra* note 6, at 57 ("The decision to initiate a regimen of hormone treatment should be balanced between the physician and patient so as to ensure informed consent and professional responsibility by the physician, yet still enable self-determination by the transgender individual.") (emphasis added).

¹³¹ See *supra* note 93 and accompanying text.

¹³² This analogy is not to argue that trans people do not face more obstacles in seeking sex reassignment therapy than women do in seeking birth control. It is to argue, however, that differences in the relative accessibility of the treatments is not attributable

Further, the underinclusivity criticism seems to operate on the assumption that the medical model is inherently rigid and inflexible.¹³³ This assumption, however, is simply not supported by the medical model's textual underpinnings: the introduction to the DSM-IV states that its diagnostic definitions are to be used as mere guidelines and should not be applied mechanically or in "cookbook fashion."¹³⁴ Similarly, the Standards of Care state that they are "intended to provide flexible directions" for trans-related health care and that they should be departed from when an individual's unique health concerns necessitate such particularized decision-making.¹³⁵ Given that the medical model calls for such individualized discretion, responsible health care practitioners are ethically charged with individually assessing each patient's unique medical concerns rather than relying on overly strict, textualist readings of GID.¹³⁶

Thus, in the prison context, it makes little sense to argue that inmates will be precluded from receiving trans-specific health care because of some broad-based underinclusivity inherent in a medicalized conception of gender identity. Indeed, for those trans prisoners who do request sex reassignment therapy but are nonetheless denied access, such problems could very well be caused not by the medical model's underinclusivity but, instead, by systemic or institutional problems with the administration of health care in prisons.¹³⁷ Trans health experts have frequently noted that misinformed, transphobic doctoring has permeated the history of trans-specific medical care in this country.¹³⁸ So to the extent that systemic or institutional problems with prison health care stem from misinformed doctoring by prison personnel, one could argue that the medical model, and proper education surrounding it, would actually *help* trans prisoners gain access to sex reassignment therapy.

to a lack of self-determinative principles in a medicalized conception of gender identity and is, instead, attributable to other factors.

¹³³ See *supra* notes 75–77 and accompanying text.

¹³⁴ DSM-IV-TR, *supra* note 3, at xxxii ("It is important that DSM-IV not be applied mechanically by untrained individuals. The specific diagnostic criteria included in DSM-IV are meant to serve as guidelines to be informed by clinical judgment and are not meant to be used in a cookbook fashion.").

¹³⁵ Standards of Care, *supra* note 6, at 1–2.

¹³⁶ See GORTON, BUTH & SPADE, *supra* note 6, at 13–14.

¹³⁷ For discussions of systematic deficiencies of prison health care, see generally Ellen M. Barry, *Bad Medicine: Health Care Inadequacies in Women's Prisons*, 16 CRIM. JUST. 38 (2001); Amy Petré Hill, *Death Through Administrative Indifference: The Prison Litigation Reform Act Allows Women to Die in California's Substandard Prison Health Care System*, 13 HASTINGS WOMEN'S L.J. 223 (2002); Richard Siever, *HMOs Behind Bars: Constitutional Implications of Managed Health Care in the Prison System*, 58 VAND. L. REV. 1365 (2005).

¹³⁸ See GORTON, BUTH & SPADE, *supra* note 6, at 14–16 (discussing the history of misinformed trans-specific health care); Israel & Tarver, *Transgender Hormone Administration*, *supra* note 6, at 57 (discussing why trans-specific health care is so often misinformed); Anne Vitale, *The Therapist Versus the Client: How the Conflict Started and Some Thoughts on How to Resolve It*, in TRANSGENDER CARE, *supra* note 31, at 251, 252–53 (same).

Finally, with regard to the postmodern argument that the medical model stems from and ultimately reinforces the oppressive gender binary,¹³⁹ it should be pointed out that, regardless of the medical model's origins or its effect in the abstract, there are trans people who believe that it accurately describes their experiences.¹⁴⁰ There are undoubtedly members of the trans community for whom the medical model is inaccurate or inadequate,¹⁴¹ but dismissing the medical model simply because it stems from or bolsters a fictional gender binary disserves those trans people who believe that the gender-related discomfort they have felt throughout their lives is best described in medicalized terms. In other words, discounting the medicalization of gender identity would discount the medicalized narratives of anxiety and discomfort to which many people with GID lay claim. Indeed, some trans rights advocates have characterized the postmodern criticism as, when "taken to its logical conclusion, [positing] that transsexualism does not exist."¹⁴² These advocates have fundamentally rejected this criticism as well as "the premise that there is nothing essential about gender identity."¹⁴³ Arguing that GID is diagnostically and descriptively accurate for a significant subsection of the trans community, trans rights lawyers such as Jennifer Levi have pointed out that postmodern skepticism over the legitimacy of GID is both unfair for those who feel it accurately describes their experiences as well as "deeply offensive to many transsexuals."¹⁴⁴

B. Affirmative Arguments for the Medical Model in the Prison Context

Many unique characteristics of the prison right-to-care context justify and indeed compel the use of the medical model when advocating for gender-related health care. The first and most obvious is that, when trying to secure trans-specific health care for inmates, trans advocates are specifically requesting *medical care*. The prison right-to-care context is, at its core, about medicine, so it seems counterintuitive to argue that advocates should abandon the use of medical evidence in their attempts to gain access to medical care. Admittedly, it makes little sense to require medical evidence in

¹³⁹ See *supra* notes 80–83 and accompanying text.

¹⁴⁰ See Rachel Pollack, *What is to be Done? A Commentary on the Recommended Guidelines*, in *TRANSGENER CARE*, *supra* note 31, at 229, 232 (arguing that, from trans author's perspective, a medicalized conception of gender identity is highly appropriate for many trans people). Further, some members of the medico-scientific community maintain that GID is not socially imposed and has a biological etiology. See, e.g., Eugene A. Schrang, *Genital Reassignment Surgery: A Source of Happiness for My Patients*, in *TRANSGENER CARE*, *supra* note 31, at 236, 236 (offering the author's opinion that GID is congenital); Anne Vitale, Notes on Gender Role Transition (2005), <http://www.avitale.com/hbbigdataalkplus2005.htm> (discussing the potential biologic etiology of GID).

¹⁴¹ See *supra* note 84.

¹⁴² Levi, *supra* note 64, at 108.

¹⁴³ *Id.*

¹⁴⁴ *Id.*

order to procure basic legal rights completely unrelated to medicine,¹⁴⁵ but it is difficult to imagine how one could engage in effective advocacy for access to medicine without resorting to the use of some sort of medical evidence.

Further, the prison right-to-care context is distinguishable from many other trans legal contexts in that it is not unique to trans people. Some legal contexts discussed earlier, such as sex designation on birth certificates,¹⁴⁶ *uniquely* concern trans people given that they simply do not apply in any significant way to most non-trans people. The struggle of prisoners in gaining access to health care, however, is not uniquely applicable to the trans community given that many non-trans inmates suffer from non-trans-specific medical neglect.¹⁴⁷ Trans advocates, therefore, do not have the luxury of arguing for the creation of an altogether novel legal standard based solely on trans-specific policy considerations and must, instead, work within a pre-existing legal framework that they then *apply* to trans people. To that end, trans advocates should actually be commended, not criticized, for the depth of their insight in employing medical evidence; they have succeeded in carving out trans-specific protections from the decidedly non-trans-specific doctrinal contours of Eighth Amendment jurisprudence.¹⁴⁸

Another way in which the prison context is unique is that the purpose of prisons is to restrict people's liberty.¹⁴⁹ Indeed, courts have repeatedly held that prisoners are not entitled to the same level of rights as people outside of prisons are.¹⁵⁰ The Supreme Court's announcement in *Estelle* that prisons are only required to provide inmates with health care for *objectively serious* medical needs manifests this general principle of incarceration in the prison right-to-care context.¹⁵¹ One can argue that such a standard is indeed quite

¹⁴⁵ Examples of rights that are completely unrelated to medicine include marriage and, arguably, sex designation. For a discussion of how courts and legislatures have nonetheless required medical evidence to be presented in these contexts, see *supra* notes 54–60 and accompanying text.

¹⁴⁶ See *supra* note 59 and accompanying text.

¹⁴⁷ For examples of cases in which non-trans inmates were requesting health care in prison, see *supra* notes 102–108.

¹⁴⁸ For a discussion of these non-trans-specific doctrinal contours of Eighth Amendment jurisprudence, see *supra* Part III.

¹⁴⁹ See, e.g., *Overton v. Bazzetta*, 539 U.S. 126, 131 (2003) (“The very object of imprisonment is confinement. Many of the liberties and privileges enjoyed by other citizens must be surrendered by the prisoner.”).

¹⁵⁰ See, e.g., *id.* (“An inmate does not retain rights inconsistent with proper incarceration And, as our cases have established, freedom of association is among the rights least compatible with incarceration.”); *Shaw v. Murphy*, 532 U.S. 223, 229 (2001) (“We nonetheless have maintained that the constitutional rights that prisoners possess are more limited in scope than the constitutional rights held by individuals in society at large.”); *Jones v. N.C. Prisoners’ Labor Union, Inc.*, 433 U.S. 119, 125–26 (1977) (“Perhaps the most obvious of the First Amendment rights that are necessarily curtailed by confinement are those associational rights that the First Amendment protects outside of prison walls.”).

¹⁵¹ See *Estelle v. Gamble*, 429 U.S. 97, 104 (1976); see also *supra* notes 106–110 and accompanying text.

high given that some of the medical care people receive outside of prison is not for an objectively serious medical need but is simply elective. But as long as courts adhere to the general principle that individual liberties should be restricted in prison and as long as they continue to construe this principle to require the Eighth Amendment's high standard of objective seriousness, then trans advocates will have to demonstrate that the care they are requesting is indeed serious and necessary and not merely preventive or elective.¹⁵² It follows, of course, that the best way to make such demonstrations is through the use of medical evidence.

V. CONCLUSION: FOR BROAD-BASED ADVOCACY

Although this is sometimes overlooked in the academic debate surrounding these issues, trans advocates ultimately have an ethical obligation to serve the community effectively; for lawyers, this translates into employing legal strategies that will be the most likely to result in positive outcomes for their clients.¹⁵³ Wholesale demedicalization of gender identity would have disruptive short-term consequences for these ethical obligations given that the medical model has thus far proven to be the most successful tool in advocating on behalf of trans people.¹⁵⁴

This is not to say that trans advocates should rely solely on the medical model. The trans advocacy community has devised a broad range of strategies aimed at reversing and eliminating trans oppression,¹⁵⁵ so it makes sense to adopt a broad-based, multifaceted approach to advocacy in which many different avenues of achieving social change are utilized.¹⁵⁶ Indeed, in the legal context, such an approach is facilitated by the fact that attorneys are free to plead multiple theories in a single case and judges are similarly free

¹⁵² This is not meant as an endorsement of these general principles of incarceration. Rather, it is meant to communicate that society maintains certain views of incarceration that, whether good or bad, somewhat limit the range of advocacy within which trans advocates can work.

¹⁵³ See MODEL RULES OF PROF'L CONDUCT pmbl. (2002) ("As advocate, a lawyer zealously asserts the client's position under the rules of the adversary system. As negotiator, a lawyer seeks a result advantageous to the client but consistent with requirements of honest dealings with others.").

¹⁵⁴ See *supra* Part II.B.

¹⁵⁵ Advocacy strategies that have implications for the prison health care context include prison abolition activism, see Critical Resistance, <http://www.criticalresistance.org/> (last visited Apr. 5, 2008) (website of organization "committed to ending society's use of prisons and policing as an answer to social problems"); problematizing a liberal "rights-based" framework of striving for social change, see Currah, *supra* note 64, at 6–7; and advocating for alternative sentencing of trans people, see TGI Justice Project: Programs, <http://www.tgijp.org/programs.html> (last visited Apr. 5, 2008) (website of organization seeking to reduce the number of transgendered going into prison by diverting them "into plans that would connect them to needed health, social and economic services").

¹⁵⁶ See Spade, *supra* note 49, at 36–37.

to choose which theories to use in resolving it.¹⁵⁷ Thus, employing a particular trans model in court does not necessarily foreclose the possibility that a judge will decide the case on grounds wholly unrelated to that model.¹⁵⁸

This is also not to argue that trans advocates should rely blindly or uncritically on any particular avenue of achieving social change. But while it is important to maintain a critical perspective on any legal or advocacy strategy, it is equally important to ensure that effective strategies are not prematurely dismissed without careful, particularized evaluations of their merits: yes, the medical model has serious deficiencies in some trans rights contexts, but its deficiencies in some contexts should not automatically disqualify it as a legitimate strategy in others, particularly where it has a proven ability to help people in need.

Trans advocates are not bereft of effort or ideas. Their tirelessness and ingenuity continually contribute to a common, well-intentioned goal of bettering trans peoples' lives. A collective and cooperative spirit amongst advocates can only help in achieving this goal. Conversations questioning the legitimacy of the medical model and of all trans advocacy strategies are important. But however these conversations are resolved, trans advocates should always remember that each member of the community, each legal theory, and each trans model can play a significant and vital role in eliminating trans oppression.

¹⁵⁷ *Id.* at 35 (“[B]ecause we can plead multiple claims and judges can pick and choose on what basis to rule, perhaps it is best to plead all possible bases for victory.”).

¹⁵⁸ *See id.*

