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A History of Sex Reassignment Surgery Access for Transgender Prisoners in the United States

Transgender rights issues have exploded into prominence over the last two decades. However, while bathroom bills and bans on participation in sports are at the forefront of public debate, something that has largely gone unexplored in larger forums is the issues transgender people face in prison. Because of increased risks of poverty, homelessness, and descrimination, transgender people are incarcerated disproportionately compared with the general population, with the most vulnerable group being transgender women of color (Nat'l Ctr. for Trans. Equality). Once in prison, transgender people are more likely to be verbally, physically, and sexually abused (Nat'l Ctr. for Trans. Equality). A 2013 study of federal prisons found that transgender inmates were ten times more likely to be sexually assaulted than the general prison population (Nat'l Ctr. for Trans. Equality). Fortunately, the Prison Rape Elimination Act (PREA), amended in 2012 to address these issues has now seen widespread adoption, if not necessarily enforcement (Oberholtzer)(Cloward). However, an aspect of being transgender that has not been adequately addressed by the prison system is medical care. While the PREA does dictate that transgender prisoners should be referred to medical staff, what medical care inmates can, and have been able to receive varies greatly by state. While there are many types of care that transgender inmates may need, this paper will provide a legal history of access to sex reassignment surgery in the United States.

To examine what appropriate healthcare for incarcerated transgender people is, we much first define the problem this care seeks to address. Gender dysphoria (GD), previously known as gender identity disorder (GID) (World Prof. Assn. for Trans. Health) is what the World Professional Association for Transgender Health (WPATH) defines as

> "discomfort or distress that is caused by a discrepancy between a person's gender identity and that person's sex assigned at birth (and the associated gender role and/or primary and secondary sex characteristics)" (World Prof. Assn. for Trans. Health).

The American Psychological Association has a similar definition, saying that GD is "a marked incongruence between one's experienced/expressed gender and assigned gender" (Cloward).

Sex reassignment surgery (SRS) can be a treatment for gender dysphoria. This is a surgical intervention in which one's chosen genitals are reconstructed. While this treatment is not necessary for all transgender people, there are cases where it is absolutely required to effectively treat gender dysphoria. In version seven of its Standards of Care, the WPATH says

> "many individuals need both hormone therapy and surgery to alleviate their gender dysphoria, others need only one of these treatment options and some need neither" (World Prof. Assn. for Trans. Health).

As such, states should make SRS available to inmates, even if not every inmate needs it.

Several states have policies relating to whether the surgery can be performed for those in prison. Colorado has a vague policy that could allow an inmate to receive SRS. Gregory Cloward, writing for the Nevada Law Journal, says that "the procedures may be read to imply that SRS could be granted in certain cases" (Cloward). As of the fall of 2020, these rules had yet to be put to the test as "there is no evidence that the department has ever granted SRS, or denied it" (Cloward). Oklahoma is only slightly more specific, saying that SRS would only be

performed in “extraordinary circumstances” (Cloward). California and Delaware however have much clearer policies. Both consider whether SRS is necessary for inmates on a case-by-case basis (Cloward). In California, these requests are reviewed by three panels of physicians and psychologists before their findings are passed off to the statewide medical authorization review team, who make the final decision. These laws allowing SRS are fairly new though. Before they were implemented, inmates turned to the courts to grant them SRS.

These cases by inmates all allege eighth amendment violations: that not being provided with SRS constitutes cruel and unusual punishment (Cloward).This is supported by the fact that many inmates attempt to kill or castrate themselves while being imprisoned. Despite their psychological distress, courts have also ruled against transgender inmates receiving SRS.[1] The 2019 Fifth Circuit Court of Appeals decision Gibson v. Collier resulted in a blanket ban on SRS within the circuit (Cloward). The case seems to have been mishandled though, with procedural missteps in lower courts, and Michelle Gibson’s lawyer arguing that SRS was universally accepted[2] as treatment (Cloward). Correctional departments will also parole inmates to avoid providing care. In one case in 2014, the Virginia Department of Corrections paroled Ophelia De’lonta 30 years into her 73 year sentence for bank robbery (Acevedo). This came just after a district court judge had ordered that De’lonta be examined by a gender specialist (Acevedo). De’lonta had been fighting to receive SRS for 15 years (Acevedo). Another example of the usage of parole to avoid treating transgender inmates came in 2017, in the case of Norsworthy v. Beard. The California Department of Corrections and Rehabilitation (CDCR) lost its initial battle at the district court level, where they were ordered to provide Norsworthy with SRS (Cloward). The CDCR scheduled the surgery, but then appealed the decision, and pushed back the date that it would take place (Acevedo). One day before the appeals court ruling, the CDCR pardoned

Norsworthy (Assoc. Press. LA). She had been fighting to receive SRS for 15 years (Acevedo). However, a case settled later that same year would finally turn the tide[3]: Quine v. Beard.

Shiloh Quine had been convicted of kidnapping, robbery, and first degree murder in 1981 (Assoc. Press. LA)(Assoc. Press. NBC). Because of these convictions, she had no possibility of parole (Assoc. Press. LA). On April 28th, 2017, the Northern District California district court ruled that it was medically necessary for Quine to receive SRS. While the ruling granted SRS specifically to Quine, and did not discuss the constitutionality of SRS, Quine's settlement forced the CDCR to make "structural changes" to its treatment of transgender prisoners (Cloward). In response to this, California created the system discussed earlier, allowing for medical review of SRS requests (Acevedo). As of January 6, 2017, Quine became the first US inmate to receive SRS while in prison (Assoc. Press. LA). There were still issues though. After Quine received the surgery, she was transferred to a women's prison. Here, she went through the initial inmate intake process, and was denied "privileges like razors" (Assoc. Press. NBC). This meant that her facial hair regrew, which, along with being housed alone, had a significant negative impact on her mental health (Assoc. Press. NBC). However, Quine's settlement, and the changes it caused to CDCR's policy have meant that, as of February this year, 65 requests for SRS have been approved, nine of which have been completed (Miller).

It took until 2020 for the second US inmate to receive SRS[4]. In 2012, Andre Edmo was convicted of sexually abusing a 15 year old boy (Assoc. Press. CBS)(Cloward). After being taken into custody by the Idaho department of corrections, she was diagnosed with gender dysphoria, and granted access to hormones (Cloward). Despite these having their full effect, Edmo continued to experience gender dysphoria, resulting in habitual cutting, two attempts at self-castration, and suicidal ideation (Cloward). After a trial[5] where the objections of the Idaho

department of corrections were soundly dismissed, Edmo became the second inmate in the United States to undergo SRS while incarcerated on July 10, 2020 (Cloward)(Assoc. Press. CBS).

From all of this, it's clear that transgender inmates often don't get the healthcare that they need. While policies have improved, these improvements are frequently the result of decades-long legal battles rather than lawmaker or correctional department motivation. There is much more research to be done in terms of how other parts of the criminal justice system treat transgender inmates. A 2015 national transgender survey found that, while only 6% of respondents had been in a state prison within the last year, 64% had been held in a local jail [19]. Enforcement of provision of care on a local level is a high priority for future research. Because of the difficulties transgender women face in Mexico, it would also be worth examining their treatment in migrant detention facilities, as NPR's The California Report has done (Khokha). Research into other types of transgender-related medical care would also be warranted. Access to hormone therapy, that allows transgender people to undergo changes associated with their preferred puberty, is more common than access to SRS, but is far from being universally guaranteed (Deutsch)(Oberholtzer). As hormone therapy does not reduce breast size however, access to mastectomies is a priority for many transgender men (Deutsch). However, prison policies often wrongly assume that "the only transgender individuals who end up incarcerated are trans women" (Oberholtzer) forgoing transmasculine specific treatments. Access to psychotherapy is also particularly relevant to transgender people, as they experience mental distress at eight times the rate of the general population [19]. Despite its potential to help a wide range of inmates, it was not commonly provided as of 2017 (Oberholtzer). Ultimately, despite the advances in recent years, transgender prison healthcare still has a long way to go.

Notes

1. In this section, I do not mention Kosilek v. Spencer, in which was another key case in 2014 where a court found it not medically necessary for Michelle Kosilek to receive SRS (Cloward)
2. There is a vocal minority of doctors who still believe SRS is cosmetic, and not medically necessary, despite its endorsement by the WPATH (Cloward).
3. Technically Gibson v. Collier happened after Quine v. Beard. I say the case "turned the tide" because of the policy changes the settlement required.
4. The nine procedures mentioned in the previous paragraph took place after Edmo's, indicating a recent spike in the number of procedures completed. This is probably why (Oberholtzer) doesn't list California as providing SRS: the changes ordered by the Quine ruling don't seem to have become official policy until after it was published.
5. This trial was also significant because it took place in the ninth circuit court of appeals, and rebuked the 5th circuit decision of Gibson v. Collier (Cloward).

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