No. _____

In the Supreme Court of the United States

IDAHO DEPARTMENT OF CORRECTION, HENRY ATENCIO, in his official capacity as Director of the IDOC; JEFF ZMUDA, in his official capacity as Deputy Director of the IDOC; AL RAMIREZ, in his official capacity as Warden of the Idaho State Correctional Institution; and SCOTT ELIASON, M.D.

Applicants,

v.

ADREE EDMO, AKA MASON EDMO,

Respondent.

On Application to Stay the Order of the U.S. District Court for the District of Idaho

Application For Reinstatement of Stay Issued by the Ninth Circuit Pending Disposition of A Petition for Writ of Certiorari

DYLAN A. EATON
J. KEVIN WEST
BRYCE JENSEN
PARSONS BEHLE & LATIMER
800 West Main Street
Suite 1300
Boise, Idaho 83702

Counsel for Applicant Scott Eliason, M.D.

LAWRENCE G. WASDEN
ATTORNEY GENERAL STATE OF IDAHO
BRIAN KANE
Assistant Chief Deputy
MEGAN A. LARRONDO
Deputy Attorney General
BRADY J. HALL
Special Deputy Attorney General
Counsel of Record
Moore Elia Kraft & Hall, LLP
P.O. Box 6756
Boise, Idaho 83707
Telephone: (208) 336-6900
brady@melawfirm.net

Counsel for Applicants Idaho Department of Correction, and Henry Atencio, Jeff Zmuda, and Al Ramirez, in their official capacities

May 6, 2020

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Constitution and Statutes

Other Authorities

To the Honorable Elena Kagan, Associate Justice of the Supreme Court of the United States and Circuit Justice for the Ninth Circuit:

INTRODUCTION

Applicants seek reinstatement of the Ninth Circuit's stay of a district court order requiring the State of Idaho to provide sex reassignment surgery to transgender inmate Adree Edmo pending final disposition of their Petition for Writ of Certiorari filed on May 6, 2020. This requested stay is needed to avoid mooting the appeal and to allow this Court to resolve a circuit split and address the Ninth Circuit's failure to apply this Court's binding precedent. Edmo's presurgical preparations are set to begin around the middle of June and surgery is scheduled for early July 2020.

The Ninth Circuit held that prison psychiatrist, Dr. Scott Eliason, inflicted cruel and unusual punishment upon Edmo in violation of the Eighth Amendment when he recommended that her gender dysphoria be treated with hormone therapy and counseling, and not irreversible sex reassignment surgery. It is the first circuit in the nation to reach such a conclusion, which it reached by adopting an advocacy organization's requirements as constitutional minima, causing a circuit split, and disregarding this Court's binding precedent. As a result of the order issued by the district court and affirmed by the Ninth Circuit, the State of Idaho is required to provide sex reassignment surgery to Edmo. While the Ninth Circuit determined that a stay was merited during the pendency of the appeal before the circuit court, it declined to issue a stay to ensure this Court's ability to review its decision. The Applicants, several Idaho prison officials and Dr. Eliason, now respectfully and urgently request that this Court stay the district court's order pending this Court's disposition of their Petition for Writ of Certiorari.

Edmo was incarcerated in 2012 for sexually assaulting a sleeping boy. Soon after, Dr. Eliason began treating Edmo for gender dysphoria with hormone therapy and counseling (to the

extent she was willing to participate). Hormone therapy helped clear her head and improved her dysphoria. In April 2016, Dr. Eliason evaluated Edmo for sex reassignment surgery. At the time of his evaluation, Dr. Eliason did not see any signs of significant dysphoria.

Dr. Eliason consulted with multiple other health care and prison professionals. He ultimately concluded, with universal agreement, that Edmo was best served by continued conservative treatment in the form of hormone therapy and counseling, and not sex reassignment surgery. He reached this conclusion for three reasons: (1) he felt the degree of Edmo's distress did not warrant administering the most aggressive—and permanent—gender dysphoria treatment; (2) he was concerned that, as a result of her other mental health conditions, Edmo lacked the coping skills necessary to deal with the stress of the surgery and transition; and (3) knowing that Edmo would soon be parole eligible, he felt that Edmo would be best served by having the procedure done after her release and after she had a chance to live as a woman in her "real world" and to ensure she could develop a social network that would support her transition. Dr. Eliason was concerned about the risk that Edmo might commit suicide after the surgery. He considered Edmo's prior self-castration attempt, but his concerns about performing irreversible sex reassignment surgery outweighed that risk, and he took action to deter Edmo from further attempts at self-castration.

The district court concluded that Dr. Eliason's decision not to recommend sex reassignment surgery was deliberately indifferent because he did not apply a transgender advocacy group's controversial treatment guidelines. The Ninth Circuit affirmed, implicitly adopting the advocacy group's guidelines as constitutional requirements to find Dr. Eliason's treatment decision "medically unacceptable." The Ninth Circuit then concluded Dr. Eliason was deliberately indifferent because he knew that there was a risk that Edmo would attempt self-

castration if sex reassignment surgery was not performed. The Ninth Circuit failed to consider Dr. Eliason's subjective reasoning for not recommending sex reassignment surgery, as well as the risks he considered for and against surgery, in analyzing whether he knew of and disregarded a substantial risk of serious harm.

Applicants have now filed a Petition for Writ of Certiorari seeking this Court's review of the Ninth Circuit's decision. The Petition asks this Court to grant certiorari for two compelling reasons: (1) to resolve a clear split between the Ninth and the First, Fifth, Tenth, and Eleventh Circuits as to whether the advocacy group's guidelines set the constitutional minima for the treatment of gender dysphoria and (2) because the Ninth Circuit violated this Court's binding precedent in *Estelle v. Gamble*, 429 U.S. 97 (1976), by adopting a negligence standard to determine deliberate indifference, and in *Farmer v. Brennan*, 511 U.S. 825 (1994), by failing to properly consider Dr. Eliason's subjective state of mind and the risks he weighed both for and against surgery. Ten judges dissented from the Ninth Circuit's order denying rehearing *en banc* for these very reasons.

Reinstatement of the stay order that was issued during the Ninth Circuit appeal is warranted because there is a reasonable probability that four Justices will consider these issues sufficiently meritorious to grant certiorari, a fair prospect that a majority of the Court will vote to reverse the judgment below, and this Court's stay order is necessary to prevent irreparable harm and to preserve the issues for this Court's review if certiorari is granted.

JURISDICTION

On December 13, 2018, the district court entered a permanent injunction requiring Applicants to provide Edmo with sex reassignment surgery. (Ex. A.) The district court denied Applicants' motion to stay the injunction pending appeal to the Ninth Circuit. (Ex. B.) On

March 20, 2019, the Ninth Circuit stayed the injunction pending appeal. (Ex. C.) On August 23, 2019, the Ninth Circuit issued its opinion affirming the injunction, in part, and declared that the stay "shall automatically terminate upon issuance of the mandate." (Ex. D.) On September 6, 2019, the Applicants filed a petition for rehearing *en banc*, which temporarily stayed the mandate. On October 10, 2019, the Ninth Circuit partially lifted the stay to allow Edmo to receive pre-surgical hair removal, but left the injunction to provide the surgery in place. (Ex. E.) The Ninth Circuit denied the petition for rehearing *en banc* on February 10, 2020. (Ex. F.) On February 13, 2020, the Applicants filed a request with the Ninth Circuit to stay the mandate pending certiorari review by this Court, which again temporarily stayed issuance of the mandate. That request was denied and the mandate issued on February 19, 2020. (Ex. G.) Edmo is scheduled to undergo the irreversible sex reassignment surgery in early July 2020. This Court has jurisdiction to reinstate the stay ordered by the Ninth Circuit of the district court's injunction to allow for its review of a petition for writ of certiorari pursuant to 28 U.S.C. §§ 1254(1) and 2101(f).

STATEMENT OF THE CASE

A. Dr. Eliason treated Edmo for gender dysphoria in prison; in 2016, he made the medical decision not to recommend sex reassignment surgery for Edmo.

Dr. Scott Eliason is a board-certified psychiatrist who is experienced and trained in treating prisoners, including those with gender dysphoria. ER[1] 797 (Tr. 401:4-25), ER 802 (Tr. 406:3-6, 16-21), ER 816 (Tr. 420:8-13). He is the Regional Psychiatric Director for Corizon, a company that provides certain medical services for inmates in Idaho Department of Correction ("IDOC") custody. Ex. D at 9 n.1; ER 797 (Tr. 401:3-4).

[1] All citations to "ER" are to the Excerpt of Record filed in the Ninth Circuit by the Defendants-Appellants.

In 2012, Dr. Eliason was assigned a new patient, Adree Edmo (who was then known as Mason Edmo), who had recently pled guilty to sexually assaulting a sleeping 15 year-old boy. Ex. D at 20; ER 1513. Well before her 2012 incarceration, Edmo suffered from abuse, trauma, and profound mental illness and was repeatedly non-compliant with treatment. Ex. D at 22; ER 880, 882, 884-86. Edmo attempted suicide at least twice in the years prior to her arrest. Ex. D at 22; ER 602 (Tr. 206:14-16).

Dr. Eliason diagnosed Edmo with gender identity disorder, now known as gender dysphoria, in June 2012. Ex. D at 20. Shortly after, prison doctors started Edmo on hormone therapy. *Id*. at 21. She now has the same circulating hormones and secondary sexual characteristics of an adult female. *Id*. The hormones have "alleviate[ed] her gender dysphoria to some extent." *Id*.

Dr. Eliason and other prison providers also recommended that Edmo participate in mental health treatment and counseling to reduce her gender-related dysphoria and co-existing mental health conditions. *Id*. at 22; Ex. A at 27-28. However, Edmo repeatedly refused to attend treatment and declined to fully participate in counseling, which the district court found "troubling." Ex. D at 22; Ex. A at 27.

Dr. Eliason met with Edmo regularly following her diagnosis. ER 811 (Tr. 415:4-12). In April 2016, Dr. Eliason evaluated Edmo for sex reassignment surgery. Ex. D at 22. At that time, no prisoner in the United States had ever received such a surgery.[2] Dr. Eliason noted that Edmo reported she was "doing alright." *Id.* Edmo reported that hormone therapy had improved her

[2] As of the 2018 evidentiary hearing, only one other prisoner in the U.S. had received sex reassignment surgery. ER 208 (Tr. 514:9-11), ER 1088 (Tr. 110:9-12); *California murder convict becomes first U.S. inmate to have state-funded sex reassignment surgery*, L.A. TIMES (Jan. 6, 2017), https://www.latimes.com/local/lanow/la-me-ln-inmate-sex-reassignment-20170106-story.html

dysphoria, but she remained frustrated by her genitalia; she had attempted self-castration months earlier. *Id*. Dr. Eliason correctly indicated in his charting that "Medical Necessity for Sexual Reassignment Surgery is not very well defined and is constantly shifting." *Id*. at 23; ER 1730. He noted that one indicator of medical necessity for sex reassignment surgery was "severe and devastating dysphoria that is primarily due to genitals[.]" Ex. D at 23. Dr. Eliason "did not see significant dysphoria" at his April 2016 evaluation of Edmo. *Id*. "[I]nstead, she 'looked pleasant and had a good mood.'" *Id*. Dr. Eliason also spoke to prison staff, who confirmed Edmo had "animated affect and no observed distress." *Id*. Dr. Eliason was concerned, in the absence of more severe distress, about the risks of pursuing the most aggressive—and permanent—gender dysphoria treatment: surgery. ER 1730; ER 189 (Tr. 495:10-12); ER 826-28 (Tr. 430:22-432:11); ER 229 (Tr. 535:1-13).

There were two additional reasons underlying Dr. Eliason's decision.[3] Ex. D at 24; Ex. A at 24-25. First, Dr. Eliason concluded that Edmo's separate mental health conditions—including major depressive disorder and substance abuse—were not adequately controlled. Ex. D at 24. Dr. Eliason was concerned about Edmo's ability to cope with the stressful process of the life-changing surgery and transition. ER 180-81 (Tr. 486:5-487:11); ER 237 (Tr. 543:1-11); ER 827-28 (Tr. 431:3-432:11).

Second, Dr. Eliason was concerned that Edmo had not yet had an opportunity to live as a woman in an out-of-prison social setting. Ex. D at 24-25. Dr. Eliason was aware of reports of high suicide rates for postoperative patients and concerned that Edmo might be at a greater risk of suicide given the potential lack of support from family, friends, and her social network during

[3] The Ninth Circuit suggested that these were post-hoc explanations, but the district court made no such finding and only determined that Dr. Eliason did not follow the advocacy group's treatment guidelines. Ex. D at 60; Ex. A at 25-26.

her transition. ER 827-28 (Tr. 431:3-432:11). He knew Edmo would be parole eligible in 2016 and would soon have the opportunity to live as a woman in her community before undergoing the irreversible procedure; Dr. Eliason was gravely concerned that "it was not doing Ms. Edmo any service to rush through getting gender reassignment surgery in that current social situation."[4] *Id.*; ER 180 (Tr. 486:6-13), ER 827 (Tr. 431:3-6); Ex. A at 25.

Prior to making a final decision, Dr. Eliason researched how entities like Medicare and Medicaid handled sex reassignment surgery and he sought input from providers and mental health colleagues with different backgrounds and viewpoints. ER 821 (Tr. 425:2-5), ER 823 (Tr. 427:20-24). Dr. Eliason staffed the evaluation with Dr. Jeremy Stoddart (for another psychiatric viewpoint) and Dr. Murray Young, Corizon's Regional Medical Director (for a medical perspective), as well as Jeremy Clark, an IDOC clinical supervisor and member of the World Professional Association for Transgender Health ("WPATH") (for a WPATH perspective). Ex. D at 24; ER 821 (Tr. 425:7-14); ER 717 (Tr. 321:17-22). He also presented the evaluation to the prison Management and Treatment Committee ("MTC"), a multi-disciplinary team of medical, mental health, and security professionals that regularly discusses how best to meet the unique needs of prisoners diagnosed with gender dysphoria. Ex. D at 24. There was universal agreement with Dr. Eliason's treatment plan. *Id*.

Ultimately, Dr. Eliason decided not to refer Edmo for sex reassignment surgery and to maintain the treatment that had already been helpful for Edmo, including hormone therapy and counseling. *Id*. at 23-24. He left the door open to revisit the decision. *Id*. To deter any future

[4] Edmo has not been granted parole due to her refusal to complete Sex Offender Treatment Programming and significant disciplinary history, which includes multiple offenses for assault, theft, and sexual contact. ER 3149-51, ER 1113 (Tr. 135:12-18), ER 3401. Edmo will complete her current sentence in July 2021 and will be released at that time. ER 626 (Tr. 230:2-10), ER 3401.

self-castration attempts, Dr. Eliason explained to Edmo the importance of having intact genitals for any future sex reassignment surgery. ER 818 (Tr. 422:21-24).

By September 2016, Dr. Eliason had stopped treating Edmo because she had moved off the Behavioral Health Unit. ER 798-99 (Tr. 402:22-403:5), ER 811 (Tr. 415:6-12), ER 186 (Tr. 492:21-493:3); ER 1759. Edmo continued to be monitored by the MTC and treated by other providers and clinicians. ER 186-87 (Tr. 492:21-493:3). Dr. Eliason reviewed her case in the context of the MTC meetings, but he was never asked to reevaluate her for sex reassignment surgery. ER 187 (Tr. 493:3-9).

Edmo attempted self-castration for a second time in December 2016. Ex. D at 25. Dr. Eliason felt Edmo's self-castration attempts were reflective of her poor coping response to stressors, such as discipline, rather than indicia of an immediate need for sex reassignment surgery. ER 180-81 (Tr. 486:22-487:11). His informed medical opinion continues to be that if sex reassignment surgery is ever indicated, doing so "on the outside [of prison] would best suit Ms. Edmo." ER 180 (Tr. 486:12-13).

B. Edmo filed a lawsuit alleging her treatment for gender dysphoria was constitutionally inadequate.

About a year after the 2016 evaluation, Edmo filed suit under 42 U.S.C. § 1983 against Dr. Eliason, the IDOC, Corizon, and several other prison medical providers and staff, alleging that the denial of sex reassignment surgery had, among other things, violated her Eighth Amendment right to be free from cruel and unusual punishment. Ex. D at 26. She filed a motion for a preliminary injunction to compel the provision of sex reassignment surgery. *Id*. at 26-27.

In October 2018, following four months of discovery, the district court held an evidentiary hearing on the requested preliminary injunction. *Id*. at 27. Dr. Eliason, Clinician

Clark, and Edmo testified at the hearing. *Id*. at 27-28. Four expert witnesses also testified at the hearing. *Id*. at 28.

Edmo's experts were Dr. Randi Ettner, a psychologist, and Dr. Ryan Gorton, an emergency room physician. *Id*. at 28, 31. Both doctors are heavily involved in WPATH. *Id*.

WPATH is an advocacy organization dedicated to "developing best practices and supportive policies worldwide that promote health, research, education, respect, dignity, and equality for transsexual, transgender, and gender nonconforming people in all cultural settings." ER 2938 (WPATH, Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People, 1 (7th ed. 2011) ("Standards")). WPATH promulgates guidelines, which it calls "Standards of Care" (referred to herein as "Standards"), that provide treatment recommendations.[5] *See* Ex. D at 15; Ex. A at 6-7.

The term "Standards of Care" is a misnomer. The WPATH Standards do not reflect accepted standards of care in the medical community. The Centers for Medicare and Medicaid Services ("CMS") have refused to adopt them as controlling and at least one medical group has expressed concern regarding their scientific underpinnings. CMS, DECISION MEMO FOR GENDER DYSPHORIA AND GENDER REASSIGNMENT SURGERY (Aug. 30, 2016), https://go.cms.gov/36yMrxX; *see also* ER 544-81 (William Byne et al., *Report of the American Psychiatric Association Task Force on Treatment of Gender Identity Disorder*, 41 Archives of Sexual Behav. 759, 783 (2012)). Even WPATH itself states that the Standards are intended to be "flexible clinical guidelines" from which providers may deviate. Ex. D at 15.

[5] While Applicants use the shorthand "Standards" to refer to the WPATH Standards to be consistent with the terminology used by the courts of appeals, they do not concede that the WPATH Standards equate with a medically-accepted and endorsed standard of care.

The WPATH Standards set forth six suggested criteria for male-to-female sex reassignment surgery:

> (1) persistent, well documented gender dysphoria;
>
> (2) capacity to make a fully informed decision and to consent for treatment;
>
> (3) age of majority. . .;
>
> (4) if significant medical or mental health concerns are present, they must be well controlled;
>
> (5) 12 continuous months of hormone therapy as appropriate to the patient's gender goals; and
>
> (6) 12 continuous months of living in a gender role that is congruent with their gender identity.

Id. at 17-18 (quoting Standards at 60 (ER 2997)) (internal quotation marks omitted).

Dr. Ettner and Dr. Gorton testified that, in their opinion, Edmo needed sex reassignment surgery, in part, because she met the suggested criteria for sex reassignment surgery in the Standards and because she was unlikely to have further improvement in her gender dysphoria without surgery. *Id*. at 29-33.

Defendants' experts were Dr. Keelin Garvey, MD, the former Chief Psychiatrist of the Massachusetts Department of Correction (MADOC) and Chair of its Gender Dysphoria Treatment Committee, and Dr. Joel Andrade, Ph.D, a clinical social worker who served as MADOC's Clinical Director and member of the same Gender Dysphoria Treatment Committee. *Id*. at 33-35.

Dr. Garvey and Dr. Andrade disagreed with Edmo's experts. Dr. Garvey testified that she did not regard the WPATH Standards as definitive treatment criteria, let alone reflective of medical consensus. ER 225-28 (Tr. 531:5-534:7). She testified the evidence underlying the Standards was not sufficiently developed, particularly as to the treatment of gender dysphoric

prisoners. *Id.* Dr. Garvey opined Dr. Eliason had used "his clinical judgment to apply decision-making[.]" ER 221 (Tr. 527:5-7).

Both Dr. Garvey and Dr. Andrade agreed with Dr. Eliason that sex reassignment surgery was not appropriate for Edmo. Ex. D at 33-37. They raised concerns that she would have problems transitioning after surgery because her co-existing mental health concerns were not well controlled. *Id*. And they were concerned that she had not yet lived as a woman outside of prison, meaning that she did not yet know if she and her social network were ready for the post-surgery challenges. *Id*.

C. The district court issued an injunction ordering Idaho to provide Edmo with sex reassignment surgery.

The district court analyzed the evidence in the context of a motion for preliminary injunction. *See* Ex. A at 29-31.

In analyzing Edmo's likelihood of success on the merits, the district court first looked at whether sex reassignment surgery was medically necessary for Edmo. *Id*. at 35-39. As a critical threshold issue, the district court found the WPATH Standards to be the standard of care for the treatment of gender dysphoria in incarcerated patients. *Id*. at 36. Using the Standards as its touchstone, the district court found the State's experts "unconvincing" and gave their opinions "virtually no weight." *Id*. at 36-39. The district court then found the "Defendants" as a whole had been deliberately indifferent to Edmo's medical needs (focusing on findings it felt suggested bias by IDOC and Corizon against providing sex reassignment surgery). *Id*. at 39-41.

The district court never found or concluded that Dr. Eliason himself was deliberately indifferent, nor did it find that Dr. Eliason was not credible. *See id*. at 4-44. The district court's only conclusion specific to deliberate indifference by Dr. Eliason was that, in the court's view,

he "did not apply the WPATH criteria" or his evaluation "failed to accurately apply the WPATH" guidelines. *Id*. at 40.

The district court granted Edmo's motion for preliminary injunction and ordered Defendants to provide Edmo with sex reassignment surgery. *Id*. at 45. In a footnote, the district court suggested it had "effectively converted" the evidentiary hearing into a final trial on the merits. *Id*. at 31 n.1. The district court denied the Defendants' motion to stay the injunction pending appeal to the Ninth Circuit. Ex. B at 4.

D. The Ninth Circuit panel affirmed the injunction issued by the district court.

The Defendants timely appealed the district court's decision to the Ninth Circuit. The Ninth Circuit stayed the injunction pending the outcome of the appeal, with the exception of an already scheduled pre-surgical consultation. Ex. C at 2; Ex. D at 40.

Before issuing its opinion, the panel remanded the case to the district court on the limited question of whether the injunction was preliminary or permanent. Ex. D at 40. In response, the district court issued an order stating it had granted permanent injunctive relief and that it had found Edmo succeeded on the merits of her Eighth Amendment claim. *Id*.

Three months later, the Ninth Circuit panel issued its opinion affirming the district court's finding that Dr. Eliason violated Edmo's Eighth Amendment rights and the order instructing Idaho prison officials to provide Edmo with sex reassignment surgery.[6] *Id*. at 72, 85.

The Ninth Circuit applied the following test to determine whether there was deliberate indifference: (1) whether "the course of treatment the [official] chose was medically

[6] The panel reversed and vacated the injunction as to all Defendants named in their individual capacities, other than Dr. Eliason, as there was insufficient evidence to conclude they were deliberately indifferent. Ex. D at 75-77. The panel affirmed the injunction against several IDOC officials named in their official capacities whom the panel held would be responsible for implementing the injunction. *Id*. at 75-76.

unacceptable under the circumstances" and (2) whether "the [official] chose this course in conscious disregard of an excessive risk to the plaintiff's health." *Id*. at 49.

To answer the first question, the Ninth Circuit affirmed the district court's expert credibility determinations, using compliance with the WPATH Standards as its touchstone. *Id*. at 50-51, 53-59 ("[T]he district court did not err in crediting the opinions of Edmo's experts over those of the State because aspects of Dr. Garvey's and Dr. Andrade's opinions ran contrary to the established standards of care in the area of transgender health care—the WPATH Standards"). The panel approved the district court's decision to "credit[] the opinions of Edmo's experts" because it agreed Edmo's experts' testimony was the most consistent with the WPATH Standards. *Id*. at 53-59. And it refused to give any deference to the judgment of the prison doctors. *Id*. at 50. With that baseline, the panel concluded the "credited expert testimony established that [sex reassignment surgery] is medically necessary to alleviate Edmo's gender dysphoria." *Id*. at 59.

The panel then held that Dr. Eliason's decision not to recommend sex reassignment surgery was unreasonable because he "did not follow" or "reasonably deviate" from the WPATH Standards. *Id*. at 59-63 ("Dr. Eliason did not follow accepted standards of care in the area of transgender health care. . . . [The criteria he applied bore] little resemblance to the widely accepted, evidence-based criteria set out in the WPATH's Standards . . . "; "Dr. Eliason's criteria . . . are so far afield from the WPATH standards that we cannot characterize his decision as a flexible application of or deviation from those standards."). The panel discounted the agreement of Dr. Stoddart, Dr. Young, Clinician Clark, and the MTC with Dr. Eliason's assessment because "general agreement in a medically unacceptable form of treatment does not somehow make it reasonable." *Id*. at 63 n.18.

In applying the second part of its test—whether the treatment was chosen in conscious disregard to an excessive risk to Edmo's health—the panel held that Dr. Eliason was deliberately indifferent simply because he "knew . . . that Edmo had attempted to castrate herself" and "continued with Edmo's . . . treatment plan" and he knew of Edmo's second attempt at self-castration in December 2016 but did not "change his mind or the treatment plan regarding surgery." *Id*. at 63-64. The panel did not discuss whether Dr. Eliason knew his treatment decision was medically unacceptable nor did it consider that Dr. Eliason stopped being Edmo's treating physician prior to the second self-castration attempt. Further, the panel did not consider that Dr. Eliason took steps to avert the risk of self-castration or that Dr. Eliason's treatment decision was the result of his effort to balance multiple risks to Edmo's well-being.

The Ninth Circuit declared that the stay ordered on March 20, 2019 "shall automatically terminate upon issuance of the mandate." *Id.* at 85.

E. The Ninth Circuit denied Defendants' request for rehearing *en banc*, despite the disagreement of ten circuit judges.

The Defendants timely petitioned for rehearing *en banc* on September 6, 2019, which temporarily stayed the issuance of the mandate. Shortly thereafter, on October 10, 2019, the Ninth Circuit expanded its partial lift of the district court's stay order to include all pre-surgical treatments and related corollary appointments or consultations necessary for sex reassignment surgery. Ex. E at 2.

The Ninth Circuit denied the petition for re-hearing *en banc* on February 10, 2020. Ex. F at 5.

Judge O'Scannlain, joined by eight other judges, opined in a statement respecting the denial of rehearing *en banc* that the panel first erred in analyzing what it meant for medical treatment to be "unacceptable" under the Eighth Amendment by (1) defining "constitutionally

acceptable medical care" by the "standards of one organization"; (2) adopting the guidelines of "a controversial self-described advocacy group that dresses ideological commitments as evidence-based conclusions"; and (3) failing to recognize the case was one of "dueling experts." *Id*. at 15. Even if this were not error, Judge O'Scannlain continued, the panel erred in its deliberate indifference inquiry by disregarding risks that Dr. Eliason addressed and by fixating on just one risk when Dr. Eliason made a considered treatment choice in a complex situation that he believed "would mitigate overall risk." *Id*. at 27 (emphasis omitted). Judge O'Scannlain warned that the panel's approach had created a circuit split. *Id*. at 29.

Judge Collins dissented from the denial of rehearing *en banc*, opining that the panel failed to apply this Court's binding precedent in *Estelle v. Gamble* by watering the analysis down to a "mere negligence" test. *Id*. at 34-35.

Finally, Judge Bumatay, joined by five other judges in full and six in part, also dissented from rehearing *en banc*, and opined that Dr. Eliason's conduct was not a violation of the Eighth Amendment based on the text and original understanding of the Constitution because of the yet unproven, contested, and evolving nature of the WPATH Standards, the lack of medical consensus, and the particular circumstances of the case. *Id*. at 35-43. Judge Bumatay further maintained that the panel's decision had departed from this Court's precedent by diluting the deliberate indifference standard to mere negligence and erasing the subjective component of the deliberate indifference standard through circular reasoning. *Id*. at 43-48.

On February 13, 2020, the Defendants-Appellants filed a request with the Ninth Circuit to stay the mandate pending certiorari review by this Court, which again temporarily stayed issuance of the mandate. That request was denied and the mandate issued on February 19, 2020. Ex. G at 2.

Edmo is scheduled to undergo the irreversible sex reassignment surgery in early July 2020.

REASONS FOR REINSTATING THE STAY

"To obtain a stay pending the filing and disposition of a petition for a writ of certiorari, an applicant must show (1) a reasonable probability that four Justices will consider the issue sufficiently meritorious to grant certiorari; (2) a fair prospect that a majority of the Court will vote to reverse the judgment below; and (3) a likelihood that irreparable harm will result from the denial of a stay." *Hollingsworth v. Perry*, 558 U.S. 183, 190 (2010). A stay is particularly appropriate where it is necessary, as it is here, to prevent mootness and preserve a party's ability to seek appellate review. *John Doe Agency v. John Doe Corp.*, 488 U.S. 1306, 1309 (1989) (Marshall, J., in chambers).

This case meets each of these requirements.

I. There is a reasonable probability that this Court will grant certiorari.

In order to justify a stay, Applicants only need to show a reasonable probability that four Justices will consider the issues sufficiently meritorious to grant certiorari. Applicants have filed a Petition for Writ of Certiorari with this Court that presents two questions, both of which independently justify a grant of certiorari.

First, as multiple Ninth Circuit judges have identified in dissents from the denial of re-hearing *en banc*, the Ninth Circuit panel's decision created a clear circuit split with the First, Fifth, Tenth, and Eleventh Circuits by adopting an advocacy group's guidelines as constitutional requirements. Second, the analysis the Ninth Circuit applied is in direct conflict with this Court's precedent in two seminal cases. The decision is in conflict with *Estelle v. Gamble*, 429 U.S. 97 (1976), because the Ninth Circuit found deliberate indifference based on a provider's

medical decision that, at most, was mere negligence, which *Estelle* proscribed. It is also in conflict with this Court's precedent in *Farmer v. Brennan*, 511 U.S. 825 (1994), because the Ninth Circuit found deliberate indifference solely based on its determination that Dr. Eliason's treatment decision was unreasonable, failing to properly consider his subjective reasoning and the risks he weighed both for and against providing the surgery.

A. There is at least a reasonable probability that four Justices will find certiorari warranted on the first Question Presented.

The first Question Presented asks whether the Ninth Circuit erred in "concluding that the guidelines set by an advocacy organization constitute the constitutional minima for inmate medical care under the Eighth Amendment, when the First, Fifth, Tenth, and Eleventh Circuits have all concluded that they do not." Br. for Petitioner at i. There is at least a reasonable probability that four Justices will find certiorari warranted on this question, which is grounded in a clear circuit split and in conflict with this Court's precedent.

With its decision here, the Ninth Circuit elevated the WPATH Standards to constitutional canon and found Dr. Eliason deliberately indifferent merely because he did not adhere to the advocacy organization's guidelines. As Judge O'Scannlain, joined by eight other judges, identified, the Ninth Circuit's "novel approach . . . conflicts with every other circuit to consider the issue." Ex. F at 29. The Ninth Circuit's decision also conflicts with this Court's precedent, which established that the views of professional organizations and special interest groups do not set constitutional requirements for prison conditions. *See Bell v. Wolfish*, 441 U.S. 520 (1979).

1. The Ninth Circuit's adoption of guidelines set by an advocacy organization creates a circuit split with the First, Fifth, Tenth, and Eleventh Circuits.

Five courts of appeals have directly addressed the question of what constitutes cruel and unusual punishment in the context of gender dysphoria treatment in prison. Four of those courts,

the First, Fifth, Tenth, and Eleventh Circuits, have rejected efforts to chain the determination of whether prison officials and providers acted with deliberate indifference to an inmate's serious medical needs to their adherence to the treatment guidelines set by the advocacy organization WPATH and its predecessors. The Ninth Circuit stands alone.

As Judge O'Scannlain explained, the Ninth Circuit "enshrine[d] the WPATH Standards as an enforceable 'medical consensus,' effectively putting an ideologically driven private organization in control of every relationship between a doctor and a gender dysphoric patient within [the Ninth] circuit." Ex. F at 33. The Ninth Circuit held that prison psychiatrist Dr. Eliason was deliberately indifferent because, it concluded, Dr. Eliason's medical decision not to recommend sex reassignment surgery did not follow or "reasonably deviate" from the WPATH Standards. Ex. D at 59-64. The Ninth Circuit reached its conclusion by affirming the district court's decision to discount any testimony that did not adhere to the WPATH Standards. *Id.* at 51-59. To quote Judge O'Scannlain, "[b]y rejecting any expert not (in the court's view) appropriately deferential to WPATH, the district court and . . . the panel . . . effectively decided ab initio that only the WPATH Standards could constitute [constitutionally] . . . acceptable treatment."[7] Ex. F at 18.

The Ninth Circuit's decision is in direct conflict with the decisions of the First, Fifth, Tenth, and Eleventh Circuits, which have declined to adopt the advocacy organization's guidelines as the constitutional minima for medical treatment under the Eighth Amendment.

[7] The panel incorrectly stated that the parties agreed that the appropriate benchmark for treatment of gender dysphoria was the WPATH Standards. *See* Ex. D at 8-9. Defendants never contended or admitted that prison medical providers were required to base their treatment decisions on the WPATH Standards. *See* Ex. F at 18 n.6 ("[B]efore the district court and before our court, the State clearly rejected the notion that any particular treatment criteria defines what is medically acceptable[.]"). In fact, Defendants presented evidence of significant deficiencies in the WPATH Standards. *See* ER 225-28 (Tr. 531:5-534:7), ER 544-81.

Just months before the Ninth Circuit issued its decision, the Fifth Circuit held it could *never* be deliberate indifference to deny sex reassignment surgery as treatment for gender dysphoria. In *Gibson v. Collier*, 920 F.3d 212 (5th Cir. 2019), *cert. denied*, 140 S. Ct. 653 (2019), the Fifth Circuit rejected a transgender inmate's argument, which relied exclusively on the WPATH Standards, that prison doctors were deliberately indifferent when they denied the inmate's request for sex reassignment surgery. *Id.* at 218, 221-23. Unlike the Ninth Circuit, the Fifth Circuit refused to conclude the advocacy organization's guidelines were constitutional mandates, stating "the WPATH Standards . . . reflect not consensus, but merely one side in a sharply contested medical debate over sex reassignment surgery." *Id.* at 221. "The [Fifth Circuit] panel majority . . . wasn't prepared to accept the [WPATH] Standards as authoritative." *Campbell v. Kallas*, 936 F.3d 536, 547 n.3 (7th Cir. 2019) (citing *Gibson*, 920 F.3d at 221-24). The Ninth Circuit has acknowledged that "its decision is in tension" with the Fifth Circuit's decision. Ex. D at 67.

Similarly, in *Kosilek v. Spencer*, 774 F.3d 63 (1st Cir. 2014), *cert. denied*, *Kosilek v. O'Brien*, 135 S. Ct. 2059 (2015), the First Circuit rejected the argument that the "only constitutionally sufficient treatment regimen [was] to adhere to the Standards of Care's [treatment] sequence in full, including the provision of [sex reassignment surgery]."[8] *Id.* at 86. There, a transgender inmate with gender dysphoria (then called gender identity disorder) was treated with conservative therapies, including mental health therapy and hormones, but she was denied sex reassignment surgery. *Id.* at 68-74. Like the district court here, the district court in

[8] In *Kosilek*, the court was asked to apply an earlier version of the Standards issued by WPATH's predecessor, the Harry Benjamin International General Dysphoria Association. *See Kosilek*, 774 F.3d at 70 n.3. The treatment options in the earlier version of the Standards are essentially the same as the version of the WPATH Standards at issue here. *Id.* at 70 n.4; Ex. D at 15-16.

Kosilek discounted the evidence of the providers who did not adhere to its interpretation of the WPATH Standards. *Id.* at 76-77, 81, 87-88. For example, the trial court refused to credit the prison's expert psychiatrist's testimony in large part because he did not "follow" the guidelines that preceded the WPATH Standards. *Id.* at 76-77, 81, 87-88. Unlike the Ninth Circuit, the First Circuit deemed this error, concluding that the district court put too much "weight" on the WPATH Standards and substituted its own beliefs for multiple medical experts. *Id.* at 87-88. The First Circuit ultimately "held that medically acceptable treatment of gender dysphoric prisoners is not synonymous with the demands of WPATH." Ex. F at 30.

The Tenth Circuit has also twice refused to adopt the WPATH Standards as constitutionally mandated. In *Lamb v. Norwood*, 262 F. Supp. 3d 1151, 1156-57 (D. Kan. 2017), an inmate claimed that prison medical providers and officials violated "her Eighth Amendment rights by treating her in a manner that [fell] short of WPATH standards" and that she was entitled to a number of gender dysphoria treatments, including sex reassignment surgery. Contrary to this case, the district court concluded that the prison medical provider's medical judgment that weighed the costs and benefits of sex reassignment surgery against more conservative therapies precluded a finding of deliberate indifference, in spite of the provider's deviation from the WPATH Standards. *Id.* at 1157-59. The Tenth Circuit affirmed, implicitly adopting the district court's refusal to enshrine the WPATH Standards as constitutional minima. *See Lamb v. Norwood*, 899 F.3d 1159, 1163 (10th Cir. 2018), *cert. denied*, 140 S. Ct. 252 (2019). Moreover, three years prior, the Tenth Circuit, in an unpublished opinion, affirmed the district court's denial of a preliminary injunction sought by an inmate ordering the prison defendants to raise her hormone levels to the levels recommended by the WPATH Standards. *See Druley v. Patton*, 601 Fed. App'x 632, 633 (10th Cir. 2015). The Tenth Circuit concluded that simple

deviation from the WPATH Standards, without more, was insufficient to even demonstrate a substantial likelihood of success on the merits of the deliberate indifference claim. *Id.* at 635.

Most recently, the Eleventh Circuit similarly refused to find that the WPATH Standards set the constitutional minima for medical care for transgender inmates. In *Keohane v. Florida Department of Corrections Secretary*, 952 F.3d 1257 (11th Cir. 2020), a transgender inmate diagnosed with gender dysphoria sought social transitioning—"in particular, to wear long hair, makeup, and female undergarments." *Id.* at 1262. Just like the district court here, the district court in *Keohane* erroneously refused to credit medical testimony that did not follow the WPATH Standards. *See Keohane v. Jones*, 328 F. Supp. 3d 1288, 1312 (N.D. Fla. 2018). It found deliberate indifference, in part, because the prison did not apply the WPATH Standards. *Id.* at 1316. The Eleventh Circuit rejected the district court's reasoning, implicitly concluding that the failure to adhere to the WPATH Standards did not render the denial of sex reassignment surgery cruel and unusual punishment. *Keohane*, 952 F.3d at 1277, 1278 n.15. The dissent pointed out the split with the Ninth Circuit, citing the Ninth Circuit's decision for the proposition that other courts "have found" the WPATH Standards "authoritative for treating gender dysphoria in prison" and using the Ninth Circuit's decision to "highlight[] the ways the majority ha[d] gone wrong." *Id.* at 1296, 1300 (Wilson, J., dissenting) (citations omitted).

The above decisions demonstrate that a clear circuit split exists as to whether an advocacy organization's guidelines constitute constitutional mandates.

2. *The Ninth Circuit's adoption of guidelines set by an advocacy organization conflicts with this Court's precedents*.

The Ninth Circuit's decision to adopt the guidelines of an advocacy organization as the constitutional minima for prison medical care also conflicts with this Court's precedent. In *Bell v. Wolfish*, this Court refused to adopt the correctional standards issued by various advocacy and

special interest groups as constitutional requirements for the purposes of an Eighth Amendment challenge to the space provided to pre-trial detainees. 441 U.S. at 543 n.27. "[R]ather, they establish goals recommended by the organization in question." *Id.*

This Court's reasoning compels the conclusion that the WPATH Standards similarly do not establish the constitutional requirements for the treatment of inmates with gender dysphoria. WPATH is "an advocacy group for the transgendered" and the Standards are "not a politically neutral document." *Kosilek*, 774 F.3d at 78. As the Fifth and First Circuits have recognized, "the WPATH Standards . . . reflect not consensus, but merely one side in a sharply contested medical debate over sex reassignment surgery." *Gibson*, 920 F.3d at 221 (discussing the First Circuit's conclusions in *Kosilek*). Reflective of this, CMS declined to adopt the WPATH Standards due to inadequate scientific backing. CMS, DECISION MEMO FOR GENDER DYSPHORIA AND GENDER REASSIGNMENT SURGERY (Aug. 30, 2016), https://go.cms.gov/36yMrxX.

Judge O'Scannlain correctly identified that "[t]he pressure to be advocates appears to have won the day in the WPATH Standards' recommendations regarding institutionalized persons," as demonstrated by the fact that WPATH recommends sex reassignment surgery for inmates who have no experience living as their chosen gender outside of prison despite the "totally undeveloped" "medical knowledge about how such surgery might differ [for incarcerated persons]." Ex. F at 20. The evidentiary basis for the WPATH Standards is insufficient to justify constitutionally mandated compliance. For example, the Standards "lack the evidence-based grading system that characterizes archetypal treatment guidelines[.]" *Id*. at 21-22 (citing William Byne et al., *Report of the American Psychiatric Association Task Force on Treatment of Gender Identity Disorder*, 41 Archives of Sexual Behav. 759, 783 (2012)

(concluding that "the level of evidence" supporting WPATH Standards' criteria for sex reassignment surgery "was generally low")).

3. The first Question Presented involves recurring issues of national importance.

The Petition for Writ of Certiorari filed by Applicants is also likely to be granted because it raises questions of vital importance to prison systems, medical and mental health providers, administrators, governments, and inmates nationwide.

Under the Ninth Circuit's interpretation, medical decision-making that conflicts with the views of advocacy organizations is enough to establish an Eighth Amendment violation. This amounts to a deeply troubling expansion of the Eighth Amendment's Cruel and Unusual Punishments Clause. "[T]he primary concern of the drafters [of the Eighth Amendment] was to proscribe 'torture(s)' and other 'barbar(ous)' methods of punishment." *Estelle*, 429 U.S. at 102 (quoting Anthony F. Granucci, *"Nor Cruel and Unusual Punishment Inflicted:" The Original Meaning*, 57 Cal. L. Rev. 839, 842 (1969)). While this Court has recognized that the Amendment proscribes more than just barbarous treatment, even subpar treatment cannot constitute cruel and unusual punishment. *Id.*, 429 U.S. at 105-06 ("an inadvertent failure to provide adequate medical care cannot be said to" violate the Eighth Amendment). Yet the Ninth Circuit's approach guarantees inmates cutting-edge and unproven treatments that even individuals on Medicare are not guaranteed. *See* CMS, DECISION MEMO FOR GENDER DYSPHORIA AND GENDER REASSIGNMENT SURGERY (Aug. 30, 2016), https://go.cms.gov/36yMrxX. And this issue is not limited to gender dysphoria treatment. Similar arguments are playing out across the country in the context of treatment for other medical conditions in prison, such as Hepatitis C. *See, e.g., Atkins v. Parker*, 412 F. Supp. 3d 761, 782 (M.D. Tenn. 2019).

The Ninth Circuit's decision threatens to have a detrimental and destabilizing effect on the administration of prisons in other ways, as well. This Court, as well as the First and Eleventh Circuits, have acknowledged that the medical treatment provided to inmates, particularly transgender inmates, impacts the administration of prisons. *See Farmer*, 511 U.S. at 848-49 (summarizing evidence that a prison's refusal to provide segregated housing to a pre-operative male-to-female transsexual could pose significant safety concerns); *Kosilek*, 774 F.3d at 93 ("[r]ecognizing that reasonable concerns would arise regarding a post-operative, male-to-female transsexual being housed with male prisoners takes no great stretch of the imagination"); *Keohane*, 952 F.3d at 1275 ("an inmate dressed and groomed as a female would inevitably become a target for abuse in an all-male prison"). By constitutionalizing a right to controversial medical treatments with complex practical ramifications simply based on the views of an advocacy organization, the Ninth Circuit has tied the hands of prison providers and administrators.

Even if the import of this case were limited to the treatment of gender dysphoria in prison (and it is not), the issue of constitutionally appropriate treatment for gender dysphoric inmates is arising with increasing frequency across the country. The First Circuit addressed this question in 2014 and, in just the last two years, four more courts of appeal have faced this question. The issue continues to reoccur. Subsequent to the Ninth Circuit's decision alone, the district courts have seen a flurry of cases alleging deliberate indifference related to gender dysphoria treatment, including a putative class action.[9] The WPATH Standards are fundamental to many, if not all, of the claims.

[9] *See, e.g.*, *Clark v. LeBlanc*, No. 3:19-00512-BAJ-RLB, 2019 WL 5085425, at *2 (M.D. La. Oct. 10, 2019); *Monroe v. Baldwin*, No. 18-CV-00156-NJR-MAB, 2019 WL 6918474, at *17 (S.D. Ill. Dec. 19, 2019), *on recon. in part sub nom. Monroe v. Meeks*, No. 18-cv-00156-NJR,

This case is an ideal vehicle for resolving the circuit split and the issues discussed above. Unlike in many prison litigation cases, the plaintiff in this case has been represented by counsel from nearly the start. The district court allowed the parties to conduct several months of discovery and held a multi-day hearing before issuing its decision. Thus, the factual record is more developed in this case than in many others, and it is ripe for review. *Compare* Ex. D, *with Lamb*, 899 F.3d at 1163 (noting the "sparseness of the summary judgment record") *and Gibson*, 920 F.3d at 221-23 (relying on the record created in the First Circuit's decision in *Kosilek*).

There is a high likelihood that this Court will grant certiorari to resolve the circuit split as to whether an advocacy group's aspirations for medical treatment set constitutional requirements for medical treatment in prison and to clarify that the principle established in *Bell* holds in the context of medical treatment for prisoners.

B. There is at least a reasonable probability that four Justices will find certiorari warranted on the second Question Presented.

The second Question Presented asks "[w]hether the Ninth Circuit's holding that a prison health care provider's individualized medical decision was unreasonable and therefore constituted deliberate indifference, regardless of his subjective reasoning, conflicts with *Estelle v. Gambl*e, 429 U.S. 97 (1976) (holding that mere negligence does not establish deliberate indifference), and *Farmer v. Brennan*, 511 U.S. 825 (1994) (holding the provider must have

---

2020 WL 1048770 (S.D. Ill. Mar. 4, 2020); *Armstrong v. Mid-Level Prac. John B. Connally Unit*, No. SA-18-CV-00677-XR, 2020 WL 230887, at *5 (W.D. Tex. Jan. 15, 2020); *Avilez v. Barr*, No. 19-cv-08296-CRB, 2020 WL 570987, at *4 (N.D. Cal. Feb. 5, 2020); *Porter v. Crow*, No. 18-CV-0472-JED-FHM, 2020 WL 620284, at *9 (N.D. Okla. Feb. 10, 2020); *Murillo v. Godfrey*, No. 2:18-cv-02342-JGB-JC, 2020 WL 1139811, at *14 (C.D. Cal. Mar. 9, 2020); *Jackson v. Kallas*, No. 17-cv-350-bbc, 2020 WL 1139769, at *2 (W.D. Wis. Mar. 9, 2020); *Dana v. Tewalt*, No. 1:18-cv-00298-DCN, 2020 WL 1545786, at *9 (D. Idaho Apr. 1, 2020); *Gonzales v. Cal. Dep't of Corrs. & Rehab.*, No. 1:19-cv-01467BAM (PC), 2020 WL 1847491, at *6 (E.D. Cal. Apr. 13, 2020).

known of and disregarded a substantial risk of serious harm to find deliberate indifference)." Br. for Petitioners at i-ii. There is at least a reasonable probability that four Justices will find certiorari warranted on this question as well, which is grounded in the direct conflict between the Ninth Circuit's decision and this Court's binding precedent.

1. The Ninth Circuit's deliberate indifference analysis conflicts with Estelle v. Gamble by imposing liability for what could, at most, be mere medical negligence.

As Judge Bumatay, joined by six other judges, and Judge Collins identified in their dissents to the denial of rehearing *en banc*, the Ninth Circuit disregarded this Court's precedent in *Estelle* by watering down *Estelle*'s deliberate indifference standard into a "mere negligence" test. Ex. F at 34, 47. The Ninth Circuit's decision is squarely in conflict with *Estelle*.

In *Estelle*, the Court held that deliberate indifference by prison doctors in responding to the serious medical needs of prisoners was proscribed by the Eighth Amendment. *Estelle*, 429 U.S. at 104 (citation omitted). However, the Court held, "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." *Id.* at 106. The "inadvertent failure to provide adequate medical care" is not "an unnecessary and wanton infliction of pain" or "repugnant to the conscience of mankind." *Id.* at 105-06.

In the years since *Estelle* and later *Farmer v. Brennan* (discussed further below), this Court has repeatedly reaffirmed that mere negligence, inadvertence or good-faith error cannot establish deliberate indifference. *See Hope v. Pelzer*, 536 U.S. 730, 738 (2002); *Minneci v. Pollard*, 565 U.S. 118, 130 (2012) ("[T]o show an Eighth Amendment violation a prisoner must typically show that a defendant acted, not just negligently, but with 'deliberate indifference.'" (Citation omitted.)); *Corr. Servs. Corp. v. Malesko*, 534 U.S. 61, 73 (2001) (discussing how the

heightened deliberate indifference standard set by *Estelle* and *Farmer* "would make it considerably more difficult for respondent to prevail than on a theory of ordinary negligence").

The facts of the *Estelle* decision demonstrate how deliberate indifference differs from ordinary negligence. There, the inmate was treated for a back injury by multiple doctors and with multiple modalities. *Estelle*, 429 U.S.at 107. Yet, he contended additional treatment should have been provided and that his condition had worsened absent that treatment. *Id.* at 107; *id.* at 109 (Stevens, J., dissenting). The court of appeals agreed, concluding that additional testing could have led to an appropriate diagnosis and treatment. *Id.* at 107. But this Court disagreed, holding that "[a] medical decision not to order an X-ray, or like measures, does not represent cruel and unusual punishment. At most, it is medical malpractice[.]" *Id.* Whether additional "forms of treatment is indicated is a classic example of a matter of medical judgment." *Id*. Treatment decisions derived from an exercise of medical judgment do not amount to cruel and unusual punishment. *Id*.

Contrary to *Estelle*, the Ninth Circuit found deliberate indifference based solely on Dr. Eliason's decision not to recommend the course of treatment that the district court and the panel found preferable. Ex. D at 49-65. Dr. Eliason recommended treating Edmo with hormone therapy and counseling, but, based on his medical judgment, Dr. Eliason did not recommend sex reassignment surgery. *Id*. at 22-25; Ex. A at 22-25. At worst, Dr. Eliason made a mistaken judgment; *Estelle* teaches that this is not cruel and unusual punishment.

At the time of his 2016 evaluation, Dr. Eliason concluded in his chart note that the medical necessity for sex reassignment surgery was "not very well defined and [was] constantly

shifting[.]"[10] Ex. D at 23. He noted that hormone therapy had resulted in an improvement in Edmo's gender dysphoria and that she did not exhibit significant distress. *Id*. at 22-23. He, joined by other clinicians and mental health staff, felt Edmo had other mental health conditions that were not well controlled and which were not sufficiently stabilized to handle the life-changing surgery. *Id*. at 21-22, 24; Ex. A at 24. Given that Edmo would soon be parole eligible, Dr. Eliason strongly believed that it was in Edmo's best interests to wait until she had experience living as a woman outside of prison before deciding to undergo surgery. Ex. A at 24-25; ER 827-28 (Tr. 431:3-432:11), ER 180 (Tr. 486:6-13). Dr. Eliason researched how other organizations handled the issue and consulted with multiple professionals with multiple backgrounds, who universally agreed with his assessment. ER 821 (Tr. 425:2-5), ER 823 (Tr. 427:20-24); Ex. D at 24; Ex. A at 23. Dr. Eliason's medical judgment was also supported by expert testimony and studies. *See, e.g.*, ER 221 (Tr. 527:5-7).

In short, Dr. Eliason arrived at an individualized medical judgment that analyzed the risks inherent in the potential treatments available and decided that the conservative approach was most appropriate for Edmo's particular circumstances. He also took action to investigate the risk of self-harm by Edmo and took action to mitigate it. ER 818 (Tr. 422:21-24). Yet, because the courts found Dr. Eliason deviated from the controversial WPATH Standards, the Ninth Circuit affirmed the finding that Dr. Eliason was deliberately indifferent.

In so doing, the Ninth Circuit replicated the mistake from the *Estelle* decision. As Judge Collins recognized, the Ninth Circuit did just what *Estelle* proscribed: "by narrowly defining the

[10] Sex reassignment surgery is so controversial and the medical necessity and efficacy of the procedure so disputed that the Fifth Circuit has held that the Eighth Amendment does not require the performance of the procedure in any circumstance. *Gibson*, 920 F.3d at 223; *see also Kosilek*, 774 F.3d at 79 (noting "the treatment of [gender dysphoria] [is] an evolving field, in which practitioners could reasonably differ in their preferred treatment methods").

range of 'medically acceptable' options that the court believe[d] a prison doctor may properly consider in a case such as this one, and by then inferring deliberate indifference from Dr. Eliason's failure to agree with that narrow range, the district court and the panel . . . applied standards that look much more like negligence than deliberate indifference." Ex. F at 34 (citation omitted). At bottom, the Ninth Circuit analyzed the reasonableness of Dr. Eliason's decision. This amounts to a negligence standard and is foreclosed by this Court's decision in *Estelle*.

That the Ninth Circuit actually applied a negligence standard is confirmed by the court's repeated express references to reasonableness. *See, e.g.*, Ex. D at 62 (Dr. Eliason did not "reasonably deviate from" the WPATH Standards), 63 n.18 (the Ninth Circuit discounted the agreement of Dr. Stoddart, Dr. Young, Clinician Clark, and the MTC with Dr. Eliason's assessment with the statement that "general agreement in a medically unacceptable form of treatment does not somehow make it *reasonable*" (emphasis added)), 70 n.19 ("By choosing to rely upon a medical opinion which a *reasonable person* would likely determine to be inferior, the prison officials took actions which may have amounted to . . . the unnecessary and wanton infliction of pain." (Emphasis added) (internal quotation marks omitted)).

The decisions of the First, Tenth, and Eleventh Circuits discussed above illustrate how grievously the Ninth Circuit deviated from this Court's precedent. These decisions adhered to *Estelle* by requiring more than just negligence to find deliberate indifference. As the First Circuit explained, "[t]he law is clear that where two alternative courses of medical treatment exist, and both alleviate negative effects within the boundaries of modern medicine, it is not the place of our court to 'second guess medical judgments' or to require that the [Department of Correction] adopt the more compassionate of two adequate options." *Kosilek*, 774 F.3d at 90

(citations omitted); *see also Keohane*, 952 F.3d at 1277-78 (holding that arguably subpar medical care provided to an inmate by prison providers who did not have particularized experience or training in treatment for gender dysphoria did not violate the Eighth Amendment); *Lamb*, 899 F.3d at 1162 (finding no deliberate indifference when the prison provider exercised his medical judgment to determine a course of treatment).

The Ninth Circuit's disregard of this Court's binding precedent in *Estelle* warrants the requested grant of certiorari.

2. The Ninth Circuit's deliberate indifference analysis conflicts with Farmer v. Brennan by ignoring the subjective component of deliberate indifference.

The Ninth Circuit's decision also squarely conflicts with the Court's seminal decision in *Farmer*, as multiple Judges identified in the statement and dissents from the denial of rehearing *en banc*. Ex. F at 26, 44-46.

In *Farmer*, the Court clarified the subjective component of deliberate indifference: a prison official only acts with deliberate indifference when "the official knows of and disregards an excessive risk to inmate health or safety; the official must both be aware of facts from which the inference could be drawn that a substantial risk of serious harm exists, *and he must also draw the inference.*" *Farmer*, 511 U.S. at 837 (emphasis added). The course of treatment must have been criminally reckless or worse. *Id.* at 839-40. Anything less, such as "an official's failure to alleviate a significant risk that he should have perceived but did not, . . . cannot under our cases be condemned as the infliction of punishment." *Id.* at 838.

For this reason, deliberate indifference cannot solely be "premised on obviousness or constructive notice." *Id.* at 841 (citation omitted). To support a finding of deliberate indifference based on an obvious risk, there must have been strong evidence suggestive of risk available to the provider and the provider must have deliberately refused to confirm it. *Id.* at 842-43 n.8. "It

is not enough merely to find that a reasonable person would have known, or that the defendant should have known[.]" *Id*.

This Court has affirmed that *Farmer*'s deliberate indifference standard is still good law. *See Ortiz v. Jordan*, 562 U.S. 180, 190 (2011) (restating *Farmer*'s articulation of the deliberate indifference standard and noting that *Farmer*'s deliberate indifference standard was not in controversy).

The deliberate indifference analysis that the Ninth Circuit employed plainly contradicts this binding precedent. As Judge Bumatay, joined by six other judges, identified, "the panel's analysis effectively erases the subjective deliberate indifference requirement with its circular reasoning." Ex. F at 46.

Neither the district court nor the panel examined whether Dr. Eliason subjectively knew he was making a medically unacceptable choice.[11] The district court's sole conclusion related to Dr. Eliason's subjective deliberate indifference was that Dr. Eliason failed to apply the WPATH criteria. Ex. A at 40. Implicitly acknowledging the insufficiency of this analysis, the Ninth Circuit applied a different (also insufficient) analysis that analyzed Dr. Eliason's reasoning only in the context of concluding that Dr. Eliason made a subpar medical choice. *See* Ex. D at 59-63. The Ninth Circuit did not conclude that Dr. Eliason was deliberately indifferent because he *knew* that the only appropriate treatment for Edmo was sex reassignment surgery, nor did it conclude that Dr. Eliason *deliberately avoided* that knowledge. *Id*. at 63-64. "Such an approach is particularly troublesome because" it infers deliberate indifference "solely from a finding of a 'medically unacceptable' treatment." Ex. F at 47.

[11] There is not a single explicit finding in the district court's opinion as to Dr. Eliason's state of mind. Ex. A at 39-41.

Second, the Ninth Circuit concluded its analysis by finding that Dr. Eliason knew there was a risk of self-castration and dysphoria inherent in the course of treatment he had chosen. Ex. D at 63-64. But as Judge O'Scannlain correctly pointed out, the Ninth Circuit fixated on just one risk when Dr. Eliason made a considered treatment choice in a complex situation that he believed "would mitigate overall risk." Ex. F at 27 (emphasis omitted). As discussed above, Dr. Eliason made an informed medical decision to opt for a more conservative approach to treating Edmo's gender dysphoria in light of Edmo's particular circumstances. As to the risk of self-castration, he considered this risk, he took steps to avert further self-castration attempts, and he continues to believe Edmo, as a whole person, would be best served by undergoing surgery after her release.

Despite the Ninth Circuit's fig-leaf citation to *Farmer*, the standard the Ninth Circuit actually applied was, at most, the very "should have known" negligence standard that this Court explicitly rejected in *Farmer*. *Farmer*, 511 U.S. at 843 n.8. As Judge Bumatay warned, "the ultimate effect of the panel's analysis is to dilute the heightened, subjective culpability required for deliberate indifference, into mere negligence[.]" Ex. F at 47 (first citing *Farmer*, 511 U.S. at 839-40; then citing *Estelle*, 429 U.S. at 105-06).

Again, the decisions by other circuits that have adhered to this Court's precedent demonstrate how badly the Ninth Circuit erred. As the First Circuit has aptly stated "a later court decision—ruling that the prison [officials] were wrong in their estimation of the treatment's reasonableness—does not somehow convert that choice into one exhibiting the sort of obstinacy and disregard required to find deliberate indifference." *Kosilek*, 774 F.3d at 92 (citation omitted); *see also Druley*, 601 Fed. App'x. at 635 (rejecting a gender dysphoric inmate's argument that her constitutional rights would be violated if she was not treated with the hormone levels suggested by WPATH because the inmate presented no evidence that the defendants

"failed to consider the WPATH's flexible guidelines, failed to make an informed judgment as to the hormone levels appropriate for her, or otherwise deliberately ignored her serious medical needs").

The Ninth Circuit's disregard of this Court's binding precedent in *Farmer* separately warrants review.

3. The second Question Presented also involves recurring issues of national importance.

The same recurring issues of national importance discussed above that justify a grant of certiorari on the first Question Presented justify a grant of certiorari on the second Question Presented.

Further, the Ninth Circuit's analysis impermissibly inserts the federal courts into the day-to-day treatment decisions of prison medical and mental health providers, who are already tasked with the very challenging job of treating prisoners experiencing complex and co-existing health conditions within the prison environment. Despite this Court having stressed that judicial inquiries into cruel and unusual punishment claims "spring from constitutional requirements and . . . judicial answers to them must reflect that fact rather than a court's idea of how best to operate a detention facility," the federal judiciary now holds the role of prison medical committee in the Ninth Circuit. *Rhodes v. Chapman*, 452 U.S. 337, 351 (1981) (quoting *Bell*, 441 U.S. at 539).

Moreover, if the Ninth Circuit's decision is allowed to stand in violation of *Estelle* and *Farmer*, inmates will be allowed to pursue state-law negligence claims disguised as constitutional claims. Inmates will be granted an end-run around the tort claim requirements that govern every other litigant. This will deter qualified medical professionals from working in

prisons because of the constant threat of litigation. The Ninth Circuit's decision unlocks a Pandora's Box of all manner of inmate medical negligence lawsuits.

II. There is at least a fair prospect that the Ninth Circuit's decision will be overturned.

Given the reasonable probability that four Justices would grant certiorari, it is doubtful that the prospects of reversal even need to be considered. *See In re Roche*, 448 U.S. 1312, 1314 n.1 (1980) (Brennan, J., in chambers) ("[T]he consideration of prospects for reversal dovetails, to a great[] extent, with the prediction that four Justices will vote to hear the case. Thus, it may be that the 'fair prospect'-of-reversal criterion has less independent significance in a stay determination when review will be sought by way of certiorari."). Even so, the second factor justifying the issuance of a stay pending disposition of the petition for certiorari is also present here.

There is at least a fair prospect that the Ninth Circuit's decision will be overturned.

On the first Question Presented, this Court has already strongly signaled how it will resolve the split between the Ninth Circuit and the First, Fifth, Tenth, and Eleventh Circuits. It has sounded the death knell for the Ninth Circuit's decision.

This Court indicated in *Bell v. Wolfish*, 441 U.S. 520 (1979), that it would refuse to adopt an advocacy group's guidelines as constitutional requirements. While that case involved prison conditions, the Court's rationale in refusing to adopt the standards of outside groups as hard-and-fast constitutional requirements applies just as strongly here. As Judge O'Scannlain identified, the WPATH Standards' recommendations are most accurately viewed as the product of advocacy, rather than of evidence-based medicine. Ex. F at 19-21. The Court's reasoning in *Bell* is even more compelling here, as medical decision-making involves an individualized balancing of risk and other considerations that cannot be reduced to compliance versus non-

compliance to an advocacy group's guidelines, particularly given the additional complexities present in prison.

As discussed above, the other three courts of appeals to have directly confronted this issue have recognized this and refused to adopt the WPATH Standards as constitutional requirements. The Ninth Circuit is the outlier. There is at least a fair prospect that this Court will adhere to its own precedent and agree with the other three circuits that have addressed the issue. Given that the Ninth Circuit's key holding that Dr. Eliason was deliberately indifferent turned on first the district court and then the Ninth Circuit's refusal to credit any testimony that did not adhere to the WPATH Standards and its finding that Dr. Eliason's treatment decision was not reasonably aligned with the WPATH Standards, it is highly likely that the Ninth Circuit's opinion will be overturned if certiorari is granted.

On the second Question Presented, as discussed above, the analysis that the Ninth Circuit employed to find Dr. Eliason deliberately indifferent is in direct violation of this Court's binding precedent and, thus, there is at least a fair chance that the Ninth Circuit's decision will be reversed upon review.

First, in *Estelle*, this Court clearly established that a provider's mere negligence in treatment decisions does not violate the Eighth Amendment. But, as discussed above, the Ninth Circuit applied a mere negligence standard to determine whether there was a constitutional violation here. The Ninth Circuit found Dr. Eliason deliberately indifferent because he, at worst, made what the Court found to be an unreasonable treatment decision. This is sufficient grounds to warrant reversal of the Ninth Circuit's decision.

Second, in *Farmer*, this Court clarified that a provider only acts with deliberate indifference to serious medical needs, the standard required to violate the Eighth Amendment, if

he subjectively knows of and disregards an excessive risk to inmate health or safety. Yet the Ninth Circuit only considered Dr. Eliason's reasoning in the context of concluding he made what the court believed to be the wrong treatment decision.

As discussed above, the Ninth Circuit failed to consider the steps Dr. Eliason took to reach his treatment decision or whether Dr. Eliason knew his treatment decision was medically unacceptable. It effectively failed to consider his reasoning at all. The panel also fixated on one risk to Edmo—the risk of self-castration—and ignored all the other risks that Dr. Eliason balanced in reaching his treatment decision—most notably, the risk of suicide post-surgery. As to the risk of self-castration, the Ninth Circuit failed to consider that Dr. Eliason considered this risk, he took steps to avert further self-castration attempts, and he continues to believe Edmo, as a whole person, would be best served by undergoing surgery after her release. In short, the Ninth Circuit applied a standard grossly different than that required by *Farmer*.

The Ninth Circuit's disregard of this Court's binding precedent in *Farmer* also demonstrates at least a fair chance that the Ninth Circuit's decision will be overturned.

III. Applicants will suffer irreparable harm if the requested stay is not granted.

A party suffers irreparable harm if its appeal becomes moot before it exhausts its right to appellate review. *John Doe Agency v. John Doe Corp.*, 488 U.S. 1306, 1309 (1989) (Marshall, J., in chambers); *see also Republican State Cent. Comm. of Ariz. v. Ripon Soc. Inc.*, 409 U.S. 1222, 1225 (1972) (Rehnquist, J., in chambers). Indeed, preserving a party's ability to achieve appellate review of an erroneous decision is one of the principle purposes of granting a stay. *Nken v. Holder*, 556 U.S. 418, 427 (2009). "[J]udicial review would be an idle ceremony if the situation were irreparably changed before the correction could be made." *Scripps-Howard Radio v. F.C.C.*, 316 U.S. 4, 10 (1942).

If Edmo receives the irreversible sex reassignment surgery before final disposition of the petition for certiorari, a substantial likelihood exists that this appeal will become moot "because the terms of the injunction . . . [will] have been fully and irrevocably carried out." *Univ. of Tex. v. Camenisch*, 451 U.S. 390, 398 (1981). In short, there will no longer be a live controversy for the Court to review. *Id.* at 394.

This cannot be allowed to happen. Dr. Eliason will suffer severe harm because he will be unable to challenge the Ninth Circuit's conclusion that he acted with deliberate indifference, a serious and personal charge that is tantamount to criminal recklessness, despite the fact that the Ninth Circuit's holding was contrary to this Court's binding precedent.

Idaho will sustain irreparable harm because Idaho taxpayers will have been forced to fund a controversial surgery that Edmo's treating doctor determined in good faith was not medically necessary. Edmo, an indigent prisoner, does not have the financial ability to reimburse Idaho taxpayers for the expenses associated with the surgery. While payment of money generally does not alone amount to irreparable harm, this Court has recognized that requiring the government to pay money that it likely cannot recoup is. *Ledbetter v. Baldwin*, 479 U.S. 1309, 1310-11 (1986) (Powell, J., in chambers); *Heckler v. Turner*, 468 U.S. 1305, 1308 (1984) (Rehnquist, J., in chambers).

In a broader context, Idaho will suffer irreparable harm to its prison system if the Ninth Circuit's decision is allowed to stand. For example, (1) inmates will be able to bring state-law medical negligence claims disguised as constitutional claims against Idaho officials; (2) qualified medical professionals will be deterred from working in Idaho's prisons by the threat of litigation and court-imposed findings of deliberate indifference merely for exercising their professional judgment; (3) Idaho will have to operate its prisons with the knowledge that the federal courts

have effectively been placed in the role of prison medical review committee; (4) Idaho could be forced to treat the medical conditions of inmates according to the guidelines and suggestions promulgated by agenda-driven advocacy groups even when they conflict with the treating physician's clinical and professional judgment regarding the best course of treatment for an individual inmate; (5) Idaho prison officials and administrators will be forced into making medical decisions regarding the medical care of gender dysphoric prisoners without regard for any risk that those treatments could destabilize their prisons; and (6) Idaho will face the very real harm that any inmate who desires tax-payer funded sex reassignment surgery will be found entitled to such surgery, regardless of their compliance with treatment, their treating physician's judgment, and other medical considerations, simply because he or she threatens self-harm, which could have enormous financial ramifications for states and prison systems.

"[I]n a close case it may be appropriate to balance the equities–to explore the relative harms to applicant and respondent, as well as the interests of the public at large." *Rostker v. Goldberg*, 448 U.S. 1306, 1308 (1980) (Brennan J., in chambers) (quotation marks omitted) (citations omitted). Even if the need to reinstate the stay is not clear, the equities weigh heavily in favor of Applicants, as well as prison administrators, medical providers, and the general public, which all have an interest in this case being resolved on the merits.

Implicit in the Ninth Circuit's eleven-month stay pending appeal was recognition that the harm a stay poses to Edmo, if any, does not outweigh the competing interests warranting a stay to allow full appellate review. Reinstating the stay will not forever preclude Edmo from receiving the surgery. Edmo may receive the surgery if this Court affirms the injunction or upon her release from prison in July 2021. Notably, neither the district court nor the Ninth Circuit determined that Edmo must undergo the surgery immediately. Indeed, Edmo's own expert

witness testified that it would be "kind of absurd" to consider sex reassignment surgery as an emergency medical issue. ER 697 (Tr. 301:21-23). Edmo will continue to receive hormone therapy during the stay and is encouraged to participate in the mental health counseling and therapy recommended by her treating providers.

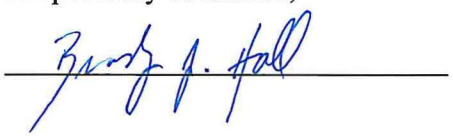
The district court's concern that Edmo may re-attempt self-castration has proven unfounded since the injunction was entered in December 2018. Edmo has not made any attempts to self-castrate since 2016. It is worth noting that giving undue weight to Edmo's subjective statements of such a risk here creates a perverse incentive for inmates to threaten self-harm to gain a litigation advantage and to manipulate the prison environment. Regardless, Edmo testified in 2018 that she remains committed to not re-attempting self-castration because the tissue plays a critical role in a successful future sex reassignment surgery. ER 614 (Tr. 218:2-14).

The strong likelihood of irreparable harm to Applicants that will result from the denial of this motion for stay demonstrates that a stay is appropriate here. Even if the question of whether to grant the stay is close enough to balance the equities, this balancing further demonstrates the stay that was issued by the Ninth Circuit during the pendency of the appeal below should be reinstated to allow this Court to consider the Petition for Writ of Certiorari without the imminent risk that this appeal will be mooted by Edmo's rapidly approaching surgery date.

CONCLUSION

Applicants respectfully request that this Court reinstate the Ninth Circuit's stay of the district court's injunction, including staying the ordered sex reassignment surgery, pending final disposition of the Petition for Writ of Certiorari.

Respectfully submitted,



LAWRENCE G. WASDEN
ATTORNEY GENERAL STATE OF IDAHO
BRIAN KANE
Assistant Chief Deputy
MEGAN A. LARRONDO
Deputy Attorney General
BRADY J. HALL
Special Deputy Attorney General
Counsel of Record
Moore Elia Kraft & Hall, LLP
P.O. Box 6756
Boise, Idaho 83707
Telephone: (208) 336-6900
brady@melawfirm.net

Counsel for the Idaho Department of Correction and Henry Atencio, Jeff Zmuda, and Al Ramirez, in their official capacities

DYLAN A. EATON
J. KEVIN WEST
BRYCE JENSEN
PARSONS BEHLE & LATIMER
800 West Main Street
Suite 1300
Boise, Idaho 83702

Counsel for Scott Eliason, M.D.

May 6, 2020

EXHIBIT A

UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF IDAHO

ADREE EDMO, Plaintiff, v. IDAHO DEPARTMENT OF CORRECTION, *et al.*, Defendants.	Case No. 1:17-cv-00151-BLW **FINDINGS OF FACT, CONCLUSIONS OF LAW, AND ORDER**

INTRODUCTION

For more than forty years, the Supreme Court has consistently held that consciously ignoring a prisoner's serious medical needs amounts to cruel and unusual punishment in violation of the Eighth Amendment. *See Estelle v. Gamble*, 429 U.S. 97, 103 (1976). After all, inmates have no choice but to rely on prison authorities to treat their medical needs, and "if the authorities fail to do so, those needs will not be met." *Id.* Prison authorities thus treat inmates with all manner of routine medical conditions – broken bones are set; diabetic inmates receive insulin; inmates with cancer receive chemotherapy; and so on. This constitutional duty also applies to far less routine, and even controversial, procedures – if necessary to address a serious medical need. And so it is here. Plaintiff Adree Edmo alleges that prison authorities violated her Eighth Amendment rights by refusing to provide her with gender confirmation surgery. For the

reasons explained below, the Court agrees and will order defendants to provide her with this procedure, a surgery which is considered medically necessary under generally accepted standards of care.

The Court will explain its reasoning below but will first pause to place this decision in a broader context. The Rule of Law, which is the bedrock of our legal system, promises that all individuals will be afforded the full protection of our legal system and the rights guaranteed by our Constitution. This is so whether the individual seeking that protection is black, white, male, female, gay, straight, or, as in this case, transgender. This decision requires the Court to confront the full breadth and meaning of that promise.

Adree Edmo is a male-to-female transgender prisoner in the custody of the Idaho Department of Correction ("IDOC"). She has been incarcerated since April 2012. In June 2012, soon after being incarcerated, an IDOC psychiatrist diagnosed Ms. Edmo with gender dysphoria. An IDOC psychologist confirmed that diagnosis a month later.

Gender dysphoria is a medical condition experienced by transgender individuals in which the incongruity between their assigned gender and their actual gender identity is so severe that it impairs the individual's ability to function. The treatment for gender dysphoria depends upon the severity of the condition. Many transgender individuals are comfortable living with their gender identity, role, and expression without surgery. For others, however, gender confirmation surgery, also known as gender or sex reassignment surgery ("SRS"), is the only effective treatment.

To treat Ms. Edmo's gender dysphoria, medical staff at the prison appropriately

began by providing Ms. Edmo with hormone therapy. This continued until she was hormonally confirmed – meaning she had the same circulating sex hormones and secondary sex characteristics as a typical adult female. Ms. Edmo thus achieved the maximum physical changes associated with hormone treatment. But, Ms. Edmo continued to experience such extreme gender dysphoria that she twice attempted self-castration. For her second attempt, Ms. Edmo prepared for weeks by studying the anatomy of the scrotum and took steps to diminish the chance of infection by boiling a razor blade and scrubbing her hands with soap. She was successful in opening the scrotum and exposing a testicle. But because there was too much blood, Ms. Edmo abandoned her second self-castration attempt and sought medical assistance. She was transported to a hospital where her testicle was repaired.

As already noted, an inmate has no choice but to rely on prison authorities to treat their medical needs. For this reason, the United States Supreme Court has held that deliberate indifference to a prisoner's serious medical needs constitutes cruel and unusual punishment in violation of the Eighth Amendment to the United States Constitution. *See, e.g., Estelle v. Gamble*, 429 U.S. 97, 103 (1976). To show such deliberate indifference, Ms. Edmo must establish two things. First, she must show a "serious medical need" by demonstrating that failure to treat a medical condition could result in significant further injury or the "unnecessary and wanton infliction of pain." Second, she must show that the prison officials were aware of and failed to respond to her pain and medical needs, and that she suffered some harm because of that failure.

Ms. Edmo's case satisfies both elements of the deliberate indifference test. She has presented extensive evidence that, despite years of hormone therapy, she continues to experience gender dysphoria so significant that she cuts herself to relieve emotional pain. She also continues to experience thoughts of self-castration and is at serious risk of acting on that impulse. With full awareness of Ms. Edmo's circumstances, IDOC and its medical provider Corizon refuse to provide Ms. Edmo with gender confirmation surgery. In refusing to provide that surgery, IDOC and Corizon have ignored generally accepted medical standards for the treatment of gender dysphoria. This constitutes deliberate indifference to Ms. Edmo's serious medical needs and violates her rights under the Eighth Amendment to the United States Constitution. Accordingly, for the reasons explained in detail below, IDOC and Corizon will be ordered to provide Ms. Edmo with gender confirmation surgery. Thus, the Court will grant in part Plaintiff's Motion for Preliminary Injunction (Dkt. 62).

In so ruling, the Court notes that its decision is based upon, and limited to, the unique facts and circumstances presented by Ms. Edmo's case. This decision is not intended, and should not be construed, as a general finding that all inmates suffering from gender dysphoria are entitled to gender confirmation surgery.

FINDINGS OF FACT

I. Transgender and Gender Dysphoria

1. Transgender is an umbrella term for a person whose gender identity is not congruent with their assigned gender. Tr. 50:5-11. A transgender person suffers

from gender dysphoria when that incongruity is so severe that it impairs the individual's ability to function. Tr. 50:12-14.

2. The American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders ("DSM-5") sets forth specific criteria which must exist before a diagnosis of gender dysphoria is appropriate. Specifically, two conditions are required:

   a. First, there must be marked incongruence between one's experienced/expressed gender and assigned gender, of at least six month's duration, as manifested by at least two of the following:

      i. A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics.

      ii. A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender.

      iii. A strong desire for the primary and/or secondary sex characteristics of the other gender.

      iv. A strong desire to be of the other gender.

      v. A strong desire to be treated as the other gender.

      vi. A strong conviction that one has the typical feelings and reactions of the other gender.

   b. Second, the individual's condition must be associated with clinically

significant distress or impairment in social, occupational, or other important areas of functioning. Exh. 1001 at 3-4.

3. "Clinically significant distress" means that the distress impairs or severely limits the person's ability to function in a meaningful way and has reached a threshold that requires either medical or surgical interventions, or both. Tr. 51:3-8.

4. Not every person who identifies as transgender has gender dysphoria. Tr. 50:5-11.

II. WPATH

5. The World Professional Association of Transgender Health ("WPATH") Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People were first promulgated in 1979 and are the internationally recognized guidelines for the treatment of individuals with gender dysphoria. Tr. 42:6-20; Exh. 15. WPATH Standards of Care are "flexible clinical guidelines." Tr. 118:16-24, 119:1-7, 8-25, 288:7-23, and "are intended to be flexible in order to meet the diverse health care needs of transsexual, transgender, and gender nonconforming people." Exh. 15 at 8.

6. The WPATH Standards of Care have provided treatment guidelines for incarcerated individuals since 1998. Tr. 54:11-21; Exh. 15 at 73. The current WPATH Standards of Care apply equally to all individuals "irrespective of their housing situation" and explicitly state that health care for transgender people "living in an institutional environment should mirror that which would be available to them if they were living in a non-institutional setting within the same

community." Tr. 54:11-21; Exh. 15 at 73. The next update to the WPATH Standards of Care will also apply to an individual regardless of where that person is housed, including in a prison setting. Tr. 54:25-55:12.

7. The WPATH Standards of Care indicate that options for psychological and medical treatment of gender dysphoria include:

   a. changes in gender expression and role,

   b. hormone therapy to feminize or masculinize the body,

   c. surgical changes of primary or secondary sex characteristics, and

   d. psychotherapy. Exh. 15 at 15-16.

8. The WPATH Standards of Care suggest options for social support and changes in gender expression, including:

   a. offline and online peer support resources, groups, or community organizations that provide avenues for social support and advocacy;

   b. offline and online support resources for families and friends;

   c. voice and communication therapy to help individuals develop verbal and non-verbal communication skills that facilitate comfort with their gender identity;

   d. hair removal through electrolysis, laser treatment, or waxing;

   e. breast binding or padding, genital tucking or penile prostheses, padding of hips or buttocks; and

   f. changes in name and gender marker on identity documents. Exh. 15 at 16.

9. The WPATH Standards of Care provide that the purposes of psychotherapy include "exploring gender identity, role, and expression; addressing the negative impact of gender dysphoria and stigma on mental health; alleviating internalized transphobia; enhancing social and peer support; improving body image; or promoting resilience." Exh. 15 at 16.

10. Cross-sex hormone therapy results in development of secondary sex characteristics of the other sex and provides an increase in the overall level of well-being of a person with gender dysphoria. Tr. 60:8-22. For a transgender woman, hormone treatment has physical effects such as breast growth, thinning of facial hair, redistribution of fat and muscle, and shrinkage of the testicles. Tr. 246:7-20. The maximum physical effects of hormone therapy will typically be achieved within two to three years. Exh. 15 at 42; Tr. 60:23-61:5, 246:7-247:1.

11. Surgery – particularly genital surgery – is often the last and the most considered step in the treatment process for gender dysphoria. Exh. 15 at 60.

12. Many transgender individuals find comfort with their gender identity, role, and expression without surgery. Exh. 15 at 60. For many others, however, surgery is essential and medically necessary to alleviate their gender dysphoria. Exh. 15 at 60. For the latter group, relief from gender dysphoria cannot be achieved without modification of their primary or secondary sex characteristics to establish greater congruence with their gender identity. Exh. 15 at 60.

13. For individuals with severe gender dysphoria, where hormone therapy is insufficient, gender confirmation surgery is the only effective treatment and is medically necessary. Tr. 168:23-169:15; *see also* Ettner Decl. ¶ 51.

14. The WPATH criteria for genital reconstruction surgery in male-to-female patients include the following:

    a. Persistent, well documented gender dysphoria;

    b. Capacity to make a fully informed decision and to consent for treatment;

    c. Age of majority in a given country;

    d. If significant medical or mental health concerns are present, they must be well controlled;

    e. 12 continuous months of hormone therapy as appropriate to the patient's gender goals; and

    f. 12 continuous months of living in a gender role that is congruent with their gender identity. Exh. 15 at 66.

15. Regarding the first criterion, "persistent, well documented gender dysphoria" is deemed to exist when the person has a well-established diagnosis of gender dysphoria that has persisted beyond six months. Tr. 55:21-56:3.

16. Regarding the fourth criterion, the WPATH Standards of Care make clear that the presence of co-existing mental health concerns does not necessarily preclude possible changes in gender role or access to feminizing/masculinizing hormones or surgery. Exh. 15 at 31. But these concerns need to be optimally managed prior to,

or concurrent with, treatment of gender dysphoria. Exh. 15 at 31.

a. It is often difficult to determine whether coexisting mental health concerns are a result of gender dysphoria or are unrelated to that medical condition. Tr. 171:1-14, 24-25, 172:1-5; 387:20-25, 388:1, 398:2-18, 601: 11- 602: 2; Campbell Decl., Dkt. 101-4, ¶¶ 30-33. Co-existing mental health issues directly tied to an individual's gender dysphoria should not be considered in assessing whether an individual meets the fourth WPATH criterion that significant medical or mental health concerns must be well controlled. Tr. 387:6 to 388:6.

17. Regarding the sixth criterion – a twelve-month experience of living in an identity-congruent role – the WPATH Standards of Care provide that this is intended to ensure that the individual has had the opportunity to experience the full range of different life experiences and events that may occur throughout the year (e.g., family events, holidays, vacations, season-specific work or school experiences). During this time, patients should present consistently, on a day-to-day basis and across all settings of life, in their desired gender role. This includes coming out to partners, family, friends, and community members (e.g., at school, work, and in other settings). Exh. 15 at 67.

18. An individual in prison can satisfy the criterion of living in a gender role congruent with their gender identity. Tr. 62:16-63:4, 584:16-25.

III. Expert Testimony

A. Plaintiff's Experts

19. Dr. Ettner is one of the authors of the WPATH Standards of Care, version 7. Tr. 42:21-24. Dr. Ettner has been a WPATH member since 1993 and chairs its Committee for Institutionalized Persons. Tr. 43:2-16; Exh. 1003.

a. Dr. Ettner has treated approximately 3,000 individuals with gender dysphoria, including evaluating whether gender confirmation surgery is necessary for certain patients. She has referred approximately 300 patients for gender confirmation surgery and assessed approximately 30 incarcerated individuals with gender dysphoria. Tr. 43:17-44:1, 44:9-13.

b. Dr. Ettner has extensive experience treating patients who have undergone gender confirmation surgery. Tr. 44:2-8.

c. Dr. Ettner is an author or editor of numerous peer-reviewed publications on treatment of gender dysphoria and transgender healthcare. Dr. Ettner is an editor for the textbook, "Principles of Transgender Medicine and Surgery," which was revised in 2017 and is the textbook used in medical schools. Tr. 44:14-45:1; Exh. 1003.

d. Dr. Ettner also trains medical and mental health providers on treating people with gender dysphoria, including assessing whether gender confirmation surgery is appropriate, through the global education initiative of WPATH and other presentations. Tr. 41:8-16, 45:17-46:18.

e. Dr. Ettner has been appointed by a federal court as an independent expert related to evaluation of an incarcerated patient for gender confirmation surgery. Tr. 46:19-22.

f. However, Dr. Ettner is not a Certified Correctional Healthcare Professional, and she has not treated inmates with gender dysphoria. Tr. 106:21-24, 107:11-18.

20. Dr. Gorton is an emergency medicine physician who practices at a federally qualified healthcare center that primarily services uninsured patients or those with Medicare or Medicaid. Exh. 1004; Tr. 234:24-235:2. Dr. Gorton also works with Project Health, which has provided training for numerous clinics regarding the provision of transgender health care in California. Tr. 233:5-21. Dr. Gorton is a member of WPATH and is on WPATH's Transgender Medicine and Research Committee and its Institutionalized Persons Committee. Tr. 238:4-6; Exh. 1004.

a. Dr. Gorton has been the primary care physician for approximately 400 patients with gender dysphoria and is currently the primary care physician for approximately 100 patients with gender dysphoria. Exh. 1004; Tr. 237:4-12. Dr. Gorton currently provides follow-up care for about thirty patients who have had vaginoplasty. Exh. 1004; Tr. 249:20-250:3.

b. Dr. Gorton has published peer-reviewed articles regarding treatment of gender dysphoria. Tr. 239:16-18, Exh. 1004.

c. Dr. Gorton has been qualified as an expert in multiple cases involving transgender healthcare. Tr. 239:19-240:19; Exh. 1004.

d. However, Dr. Gorton has no experience treating inmates with gender dysphoria. Tr. 269:17-23. Dr. Gorton is not a Certified Correctional Healthcare Professional. Tr. 270:9-16.

B. Defendants' Experts

21. Dr. Garvey is a psychiatrist and Certified Correctional Healthcare Professional under the National Commission on Correctional Health Care. Tr. 525:15-23. As the Chief Psychiatrist in the Massachusetts Department of Corrections, Dr. Garvey served as the chair of the Gender Dysphoria Treatment Committee. Tr. 508:10-11. Dr. Garvey directly treated patients in the Massachusetts Department of Correction who had gender dysphoria. Tr. 508:13-509:1.

a. Prior to evaluating Ms. Edmo, Dr. Garvey had never conducted an in-person evaluation to determine whether a patient needed gender confirmation surgery. Tr. 558:10-14.

b. Dr. Garvey has never recommended that a patient with gender dysphoria receive gender confirmation surgery or done long-term follow-up care with a patient who has had gender confirmation surgery. Tr. 556:20-557:9.

22. Dr. Andrade is a licensed independent clinical social worker and is a Certified Correctional Healthcare Professional with an emphasis in mental health. Tr. 626:1-21. Dr. Andrade has over a decade of experience providing and supervising the

provision of correctional mental health care, including directing and overseeing the treatment of all inmates diagnosed with gender dysphoria in the custody of the Massachusetts Department of Corrections in his role as clinical director, chair of the Gender Dysphoria Supervision Group, and member of the Gender Dysphoria Treatment Committee. Tr. 627:22-23.

a. Over the last decade, Dr. Andrade has provided treatment to gender dysphoria inmates in his role on the treatment committee and has evaluated and confirmed diagnoses of gender dysphoria for over 100 inmates. Tr. 627:2-14. But Dr. Andrade has never provided direct treatment for patients with gender dysphoria and has never been a treating clinician for a patient who has had gender confirmation surgery. Tr. 647:8-14, 651:10-12.

b. As part of a committee, Dr. Andrade has recommended gender confirming surgery for incarcerated inmates on two occasions. Tr. 627-629:1-10. But the recommendation was contingent upon the requirement that the inmates first live in a women's prison for approximately twelve months. Tr. 647:19-648:25. The Massachusetts Department of Corrections houses prisoners according to their genitals, so the inmates were not allowed to move to a women's prison. Tr. 649:1-650:11. To Dr. Andrade's knowledge, the inmates had not been moved to a women's prison at least seven months after his recommendation. Tr. 649:1-650:11. Thus, the twelve-month period of living in a women's prison could not have started. Tr. 650:6-11.

c. As a licensed independent clinical social worker, Dr. Andrade does not qualify under IDOC's former gender dysphoria policy as a "gender identity disorder evaluator" who could assess someone for surgery. Tr. 660:11-17; Exh. 8 at 3.

23. Dr. Campbell is IDOC's Chief Psychologist. He has provided mental health services to incarcerated inmates since 2012. Campbell Decl., Dkt. 101-4, ¶¶ 2-7. Dr. Campbell is a member of WPATH and is familiar with the WPATH Standards of Care regarding gender dysphoria offenders and transgender inmates as provided by the National Commission on Correctional Healthcare ("NCCHC"), the National Institute of Corrections, and the Federal Bureau of Prisons. Campbell Decl., Dkt. 101-4, ¶¶ 8-10.

a. Dr. Campbell serves as chair of the Management and Treatment Committee ("MTC"), a multidisciplinary committee that meets monthly to discuss and evaluate the needs of inmates who have been diagnosed with gender dysphoria. Campbell Decl., Dkt. 101-4, ¶¶ 13-14.

b. Dr. Campbell has directly conducted six gender dysphoria assessments and has overseen the treatment and assessment of approximately fifty inmates who have requested gender dysphoria evaluations, through his role as chair of the Management and Treatment Committee and as the Chief Psychologist. Campbell Decl., Dkt. 101-4, ¶¶ 13-14.

c. There is no evidence that Dr. Campbell has ever recommended gender confirmation surgery for an inmate.

IV. NCCHC

24. The NCCHC endorses the WPATH Standards of Care as the accepted standards for the treatment of transgender prisoners. Exh. 1041 at 2, 4, n.1; Tr. 477:14-478:22.

V. Defendants' Policies and Practices Regarding Gender Dysphoria

A. Corizon's Policies and Practices

25. Corizon is a private corporation that contracts to provide health care to prisons and jails throughout the country. Corizon providers have never recommended gender confirmation surgery to a patient at any of the prisons where it provides medical services. Tr. 489:20-23.

26. Corizon's only written policy regarding gender dysphoria treatment does not include gender confirmation surgery as a form of treatment. Tr. 482:25-483:9; Exh. 14.

B. IDOC's Policies and Practices

27. The IDOC MTC is a multiple-disciplinary team that addresses treatment, planning, and security issues associated with IDOC inmates who have gender dysphoria. Tr. 322:12-20. The Management and Treatment Committee reviews the treatment of all inmates with gender dysphoria but does not make medical decisions. Tr. 323:4-13, 324:9-14.

28. There are currently 30 prisoners with gender dysphoria in IDOC custody. Tr. 322:21-323:3. No individual in IDOC custody has ever been recommended for, or received, gender confirmation surgery. Tr. 376:23-377:4.

29. IDOC's operative gender dysphoria policy when Ms. Edmo was assessed for surgery defined a "qualified gender identity disorder (GID) evaluator as '[a] Doctor of philosophy (PhD) level practitioner licensed by an appropriate state licensing authority as a psychologist, or a physician licensed by a state Board of Medicine, who has demonstrated an indicia of basic competence related to the diagnosis and treatment of GID and related mental or emotional disorders through their licensure, training, continuing education, and clinical experience.'" Exh. 8 at 3; Tr. 388:16-389:1.

30. This policy stated that gender confirmation surgery "will not be considered for individuals within the Idaho Department of Correction (IDOC), unless determined medically necessary by the treating physician." Exh. 8 at 8.

31. On October 5, 2018, shortly before the hearing in this matter, IDOC implemented a new gender dysphoria policy that would allow prisoners at Idaho State Correctional Institute ("ISCI") diagnosed with gender dysphoria to order and possess female commissary items and present in a manner consistent with their gender identity. Tr. 347:18-348:23; Exh. 9.

a. The new policy also states that "to avoid a sexually charged atmosphere in IDOC facilities . . .. [n]o provocative or sexually charged clothing or behavior will be permitted." Exh. 9 at 6.

b. IDOC's new gender dysphoria policy continues to state that gender confirmation surgery "will not be considered for individuals within the Idaho Department of Correction (IDOC), unless determined medically necessary by the treating physician." Exh. 9 at 8-9.

c. The policy further states that prisoners will be housed "based upon the inmate's primary physical sexual characteristics." Exh. 9 at 4.

V. Adree Edmo's Gender Dysphoria

32. Adree Edmo is a male-to-female transgender prisoner in the custody of IDOC. Ms. Edmo has been incarcerated at ISCI since April 2012. Tr. 192:19-20; *see also* Edmo Decl. ¶ 12. She is 30 years of age. Tr. 192:17-18.

33. From the age of 5 or 6, Ms. Edmo has viewed herself as female. In her words, "my brain typically operates female, even though my body hasn't corresponded with my brain." Tr. 193:7-8.

34. While others viewed her as being gay, that is not how she perceived herself. Tr. 193:18-23. While, she struggled with her gender identity as a child and teenager, she began living as a woman at age 20 or 21. Tr. 211:1-11. She views herself as a woman with a heterosexual attraction to men. Tr. 193:15-17.

35. Prior to being incarcerated, and learning about gender identity and transgender, Ms. Edmo struggled with her own identity and sexual orientation. On two occasions in 2010 and 2011, she attempted suicide. Tr. 206:12-15.

36. In June 2012, soon after being incarcerated, Ms. Edmo was diagnosed with gender identity disorder by Corizon psychiatrist Dr. Eliason. Exh. 1 at 321. In July 2012, Corizon psychologist Claudia Lake confirmed Ms. Edmo's diagnosis of gender identity disorder. Exh. 1 at 323-27. There is no dispute that Ms. Edmo suffers from gender dysphoria. Tr. 69:20-70:3, 251:23-252:3, 518:16-18, 635:1-7.

37. Ms. Edmo legally changed her name to Adree Edmo in September 2013. Tr. 192:6-9. Ms. Edmo has also changed her sex to "female" on her birth certificate to further affirm her gender identity. Tr. 203:13-22; Exh. 1002.

38. Ms. Edmo has consistently presented as feminine throughout her incarceration by wearing her hair in traditionally feminine hairstyles when able to do so, wearing makeup when able to do so, and acting in a feminine demeanor. Tr. 194:24-195:5, 411:1-7, 463:11-464:21. Ms. Edmo's feminine presentation has been documented by Defendants' medical providers since 2012. *See, e.g.*, Exh. 1 at 321, 347, 425, 452, 538. Ms. Edmo has also held two jobs while in prison and has presented as feminine at her places of employment. Tr. 201:24-202:10.

39. Ms. Edmo has continually sought to present herself as feminine despite receiving multiple disciplinary offense reports related to wearing makeup, styling her hair in a feminine manner, and altering her male-issued undergarments into female

panties. Tr. 195:11-20; Exh. 5 at 8, 9, 21-22, 25, 27-28, 33-34, 41-43, 48-57, 62-65; Yordy Dep. 47:4-49:15, 85:22-87:11; Edmo Decl. ¶ 19.

40. Ms. Edmo testified that hormone therapy helped treat her gender dysphoria to some extent. Tr. 223:9-14. The hormones "cleared her mind," and resulted in breast growth, body fat redistribution, and changes in her skin consistency. Tr. 196:15-25. As a result of hormone therapy, Ms. Edmo is hormonally confirmed, which means she has the same circulating sex hormones and secondary sex characteristics as a typical adult female. Tr. 72:14-21; Ettner Decl. ¶ 59.

41. Ms. Edmo has achieved the maximum physical changes associated with hormone treatment. Tr. 602:1-603:4. However, Ms. Edmo continues to experience distress related to gender incongruence, which is mostly focused on her male genitalia. She testified she feels "depressed, embarrassed, and disgusted" by her male genitalia and that this is an "everyday reoccurring thought." Tr. 197:7-24.

42. Ms. Edmo first attempted self-castration to remove her testicles in September 2015 using a disposable razor blade. She wrote a note to let the officers know she was not trying to commit suicide and was only trying to help herself. She attempted to cut her testicle sac open but was unsuccessful. Edmo Decl. ¶ 31; Tr. 197:25-198:8.

43. In January 2016, Ms. Edmo reported to Dr. Eliason that she was having difficulty sleeping due to thoughts of self-castration. In response, Dr. Eliason prescribed Ms. Edmo sleeping medication. Tr. 458:5-10, 461:18-24.

44. Ms. Edmo also reported her frequent thoughts of self-castration to her assigned clinician, Krina Stewart, in November 2016. Ms. Stewart testified that none of the interventions she identified for Ms. Edmo at that visit would alleviate her gender dysphoria or desire to self-castrate. Stewart Dep. 58:15-59:16; Exh. 1 at 584-85.

45. Ms. Edmo attempted self-castration a second time in December 2016. She prepared for weeks by studying the anatomy of the scrotum and took steps to diminish the chance of infection by boiling the razor blade and scrubbing her hands with soap. Ms. Edmo made more surgical headway on this attempt and was able to cut open the testicle sac and remove the testicle. Gorton Decl. ¶ 74. Because there was too much blood, Ms. Edmo abandoned her attempt and sought medical assistance. Tr. 198:9-16. She was transported to a hospital where her testicle was repaired. Tr. 198:25-199:13.

46. Ms. Edmo was receiving hormone therapy both times she attempted to self-castrate. Tr. 228:20-25.

47. After the procedure, Ms. Edmo felt disappointed in herself because she felt she had come so close to removing her testicle but had not succeeded. Tr. 199:17-23. Ms. Edmo continues to actively experience thoughts of self-castration. Tr. 197: 21-24. In an effort to avoid acting on them, when she has experienced extreme episodes of gender dysphoria in the past year, Ms. Edmo "self-medicat[es]" by using a razor to cut her arm. The physical pain she feels from

cutting helps her release the emotional torment and mental anguish she feels at the time. Tr. 199:24-200:15.

48. Ms. Edmo will likely be released from prison sometime in 2021. Tr. 201:14-15, 230:3-10.

VI. Defendants' Treatment of Ms. Edmo for Gender Dysphoria

49. On April 20, 2016, Dr. Eliason evaluated Ms. Edmo for sex reassignment surgery. Jt. Exh. 1 at 538. Dr. Eliason noted that Ms. Edmo reported she was "doing alright," that she was eligible for parole, but it had not been granted because of multiple Disciplinary Offense Reports ("DORs"). Jt. Exh. 1 at 538. The DORS were related to her use of makeup and feminine appearance. Jt. Exh. 1 at 538.

50. Dr. Eliason noted that Ms. Edmo had been on hormone replacement for the last year and a half, but that she felt she needed more. Jt. Exh. 1 at 538. Dr. Eliason specifically noted that Ms. Edmo stated an improvement in gender dysphoria on hormone replacement but had ongoing frustrations stemming from her current anatomy. Jt. Exh. 1 at 538. He also recognized Ms. Edmo's multiple attempts to "mutilate her genitalia" because of the severity of her distress. Jt. Exh. 1 at 538. He also noted that he spoke to prison staff about Ms. Edmo's behavior, "which is notable for animated affect and no observed distress." Jt. Exh. 1 at 538. Dr. Eliason then stated that he also personally observed Ms. Edmo in these settings and did not observe significant dysphoria. Jt. Exh. 1 at 538.

51. Nevertheless, Dr. Eliason noted that Ms. Edmo appeared feminine in demeanor and interaction style. Jt. Exh. 1 at 538. He concluded that Ms. Edmo had Gender Dysphoria, Alcohol Use disorder, and Depression, Jt. Exh. 1 at 538, but his ultimate conclusion was that Ms. Edmo "[d]oes not meet criteria for medical necessity for sex reassignment surgery." Jt. Exh. 1 at 538.

52. In assessing Ms. Edmo's need for gender confirmation surgery, Dr. Eliason indicated that he staffed her case with Dr. Jeremy Stoddart, Dr. Murray Young, and Jeremy Clark LCPC (clinical supervisor and WPATH member). Each of these individuals agreed with his assessment. Jt. Exh. 1 at 538.

53. Dr. Eliason indicated he would continue to monitor and assess Ms. Edmo for the medical necessity of gender confirmation surgery. Jt. Exh. 1 at 538. He further determined that the combination of hormonal treatment and supportive counseling is sufficient for Ms. Edmo's gender dysphoria for the time being.

54. To justify his conclusion, Dr. Eliason noted that while medical necessity for gender confirmation surgery is not very well defined and is constantly shifting, the following situations could constitute medical necessity for the surgery:

    a. Congenital malformations or ambiguous genitalia;

    b. Severe and devastating dysphoria that is primarily due to genitals; and

    c. Some type of medical problem in which endogenous sexual hormones were causing severe physiological damage. Jt. Exh. 1 at 538.

55. He also explained that there may also be other situations where gender confirmation surgery is medically necessary as more information becomes available. Jt. Exh. 1 at 538.

56. Although not noted in his April 20, 2016 progress notes, Dr. Eliason testified that Ms. Edmo's mental health concerns were not "fully in adequate control." Tr. 430:22-431:2. He testified that not all of Ms. Edmo's mental health issues, such as her major depression and alcohol use disorders, stemmed from her gender dysphoria. His testimony, however, is contradicted by his April 20, 2016 clinician notes. Tr. 451:1-12.

57. Ms. Edmo has received mental health treatment from a psychiatrist and mental health nurse practitioner since she began her incarceration in 2012. Tr. 225:8-227:2. However, she has not consistently attended therapy to help her work through serious underlying mental health issues and a pre-incarceration history of trauma, abuse, and suicide attempts. Tr. 134:8-25, 135:1-23, 218:21-25, 219:1-14, 220:17-20; 221:16-19; Campbell Decl. Dkt., 101-4, ¶¶24, 29; Stewart Decl., Dkt. 101-1, ¶12; Watson Decl., Dkt. 101-3, ¶18; Clark Decl., Dkt. 101-7, ¶14).

58. Dr. Eliason testified that there were two primary reasons why sex reassignment surgery was not medically necessary at the time:

    a. Ms. Edmo had not satisfied the 12-month period of living in her identified gender role under WPATH standards. Tr. 430: 25-431:2; and

b. "[I]t was not doing Ms. Edmo any service to rush through getting gender reassignment surgery in that current social situation." Tr. 431:3-6.

59. Dr. Eliason's evaluation was the only time IDOC and Corizon evaluated Ms. Edmo for gender confirmation surgery prior to this lawsuit. Exh. 1 at 538; Tr. 419:1-10.

60. In concluding that surgery was not medically necessary for Ms. Edmo, Dr. Eliason did not review her prior criminal record, disciplinary history, or her presentence investigation reports. Tr. 468:4-18. The only information Dr. Eliason relied upon was Ms. Edmo's medical record, staff observations, and her therapist's notes. Tr. 469:16-25. Dr. Eliason testified that when he assessed her for surgery, he was aware of Ms. Edmo's prior self-surgery attempt. He believed Ms. Edmo's gender dysphoria had risen to another level, but he made no change to her treatment plan. Tr. 471:7-22.

VII. Ms. Edmo's Medical Necessity for Gender Confirmation Surgery

61. Plaintiff's and Defendants' experts disagree on whether Ms. Edmo meets all the WPATH standards criteria for gender confirmation surgery. Specifically, Defendants' experts believe that Ms. Edmo does not meet the fourth and sixth criteria – that any significant mental health concerns be well controlled and that she live twelve months in a fully gender-congruent role. Tr. 75:9-78:3; 252:13-254:11; 607:2-10, 639:14-640:25.

62. Notably, however, Dr. Eliason did not rely upon any finding that Ms. Edmo did not meet the WPATH criteria in concluding in his April 2016 assessment that she did not meet the criteria for gender confirmation surgery. Tr. 462:3-463:10.

63. With regard to the fourth criterion, Ms. Edmo has been diagnosed with Major Depressive Disorder, Alcohol Use Disorder, and Gender Dysphoria. *See, e.g.*, Exh. 1 at 538. These diagnoses were generally confirmed by each of the experts, with observation that any substance use disorder has been in remission while Ms. Edmo has been incarcerated. Tr. 67:16-18, 253:3-9, 518:16-219:6, 603:22-604:5.

   a. Plaintiff's experts testified that Ms. Edmo's depression and anxiety are as controlled as they can be and do not impair her ability to undergo surgery. Tr. 76:13-25, 123:14-124:11, 253:3-9; Exh. 15 at 30. In their view, the clinical significance of Ms. Edmo's self-surgery attempts and recent cutting of her arm is that she has severe genital-focused gender dysphoria and is not getting medically necessary treatment to alleviate it. Tr. 254:15-19, 98:11-22. Ms. Edmo's self-surgery attempts are not acts of mutilation or self-harm, but are instead attempts to remove her target organ that produces testosterone, which is the cure for gender dysphoria. Tr. 80:3-13. Ms. Edmo's gender dysphoria, not her depression and anxiety, is the driving force behind her self-surgery attempts. Tr. 254:20-255:8.

   b. Thus, Ms. Edmo's self-surgery attempts and cutting do not indicate she has mental health concerns that are not well controlled. Tr. 98:11-22. Rather,

Ms. Edmo's recent cutting is attention-reduction behavior that she uses to prevent herself from cutting her genitals. Tr. 98:16-22. Her self-surgery attempts indicate a need for treatment for gender dysphoria. Tr. 98:11-15.

c. In the more than six years she has spent in IDOC custody, no Corizon or IDOC provider has ever diagnosed Ms. Edmo with borderline personality disorder. Tr. 361:18-362:3, 470:4-6. Defense expert Dr. Andrade is the first person to ever diagnose Ms. Edmo with borderline personality disorder, and he was unable to identify his criteria for this diagnosis of Ms. Edmo during his testimony. Tr. 652:21-24, 638:16-22. None of the other experts, including Defense expert Dr. Garvey, diagnosed Ms. Edmo with borderline personality disorder. Tr. 131:24-132:3, 139:19-24.

d. One of the primary concerns underlying the fourth criterion is that the individual be able to properly participate in postsurgical care. Ms. Edmo has demonstrated the capacity to follow through with the postsurgical care she would require. Tr. 99:3-8, 169:23-170:25.

e. Although it is troubling that Ms. Edmo has declined to fully participate in the mental health treatment and counseling sessions recommended by Dr. Eliason and others, Dr. Ettner made clear that, "Psychotherapy is neither a precondition for treatment or a condition -- a precondition for surgery." Tr. 98:23-99:2.

f. Dr. Ettner concludes that Ms. Edmo meets the fourth criterion, since she has no unresolved mental health issues that would prevent her from receiving gender confirmation surgery. Tr. 98:3-10.

64. With respect to the sixth criterion, both Plaintiff's experts testified that Ms. Edmo meets and exceeds the condition of social role transition by living as a woman to the best of her ability in a male prison.

a. For the six-plus years she has lived in prison, Ms. Edmo has consistently sought to present as feminine, despite living in an environment hostile to her efforts, and despite the disciplinary consequences she faces. Tr. 77:9-78:3, 254:4-11.

65. Dr. Ettner testified that gender confirmation surgery would eliminate Ms. Edmo's gender dysphoria and significantly attenuate much of the attendant depression and symptoms she is experiencing. Tr. 104:24-105:9. She testified that gender confirmation surgery is the cure for gender dysphoria and will therefore result in therapeutic and beneficial effects for Ms. Edmo. Tr. 81:13-19.

66. Dr. Gorton testified that it is highly unlikely that Ms. Edmo's severe gender dysphoria will improve without gender confirmation surgery. Tr. 267:19-22.

67. The risks of not providing gender confirmation surgery to Ms. Edmo include surgical self-treatment, emotional decompensation, and risk of suicide given her high degree of suicide ideation. Tr. 80:24:81:8, 264:13-22. If she is not provided with surgery, Ms. Edmo has indicated that she will try self-surgery again to deal

with her extreme episodes of gender dysphoria. Tr. 199:24-200:5. Given that Ms. Edmo made increasing progress on her first two self-surgery attempts, it is likely that Ms. Edmo will be successful if she attempts self-surgery again. Tr. 264:13-22.

68. Scientific studies indicate that the regret rate for individuals who have had gender confirmation surgery is very low and generally in the range of one percent of patients. Tr. 103:25-12, 165:16-166:4. Ms. Edmo does not have any of the risk factors that make her likely to regret undergoing gender confirmation surgery. Tr. 266:1-267:1.

CONCLUSIONS OF LAW

I. Injunction Standard

1. Ms. Edmo asks for a preliminary injunction. A preliminary injunction is only awarded upon a clear showing that the plaintiff is entitled to the requested relief. *Winter v. Natural Resources Defense Council, Inc.*, 555 U.S. 7, 22 (2008).

2. To make this showing, the plaintiff must establish: (1) a likelihood of success on the merits; (2) a likelihood of irreparable harm to the moving party in the absence of preliminary relief; (3) that the balance of equities tips in favor of the moving party; and (4) that an injunction is in the public interest. *Id*.

3. The requirements are stated in the conjunctive so that all four elements must be established to justify injunctive relief. The court may apply a sliding scale test, under which "the elements of the preliminary injunction test are balanced, so that a

stronger showing of one element may offset a weaker showing of another." *Alliance for the Wild Rockies v. Cottrell*, 632 F.3d 1127, 1131 (9th Cir. 2011).

4. A more stringent standard is applied where mandatory, as opposed to prohibitory, injunctive relief is sought. Prohibitory injunctions restrain a party from taking action and effectively "freeze[ ] the positions of the parties until the court can hear the case on the merits." *Heckler v. Lopez*, 463 U.S. 1328, 1333 (1983). Mandatory injunctions go well beyond preserving the status quo, as they order a party to take some action. *See Marlyn Nutraceuticals, Inc. v. Mucos Pharma GmbH & Co.*, 571 F.3d 873, 879 (9th Cir. 2009).

5. Although the same general principles inform the court's analysis in deciding whether to issue mandatory or prohibitory relief, courts should be "extremely cautious" about ordering mandatory relief. *Martin v. Intl Olympic Comm.*, 740 F.2d 670, 675 (9th Cir. 1984). Mandatory preliminary relief should not issue unless both the facts and the law clearly favor the moving party and extreme or very serious damage will result. *See Marlyn Nutraceuticals*, 571 F.3d at 879. Mandatory injunctions are not issued in doubtful cases, or where the party seeking an injunction could be made whole by an award of damages. *Id*.

6. The Court agrees with defendants that Edmo seeks mandatory relief. Thus, the Court will apply the more stringent standard.[1]

7. The Prison Litigation Reform Act ("PLRA") requires any preliminary injunction to be "narrowly drawn, extend no further than necessary to correct the harm the court finds requires preliminary relief, and be the least intrusive means necessary to correct the harm. The court shall give substantial weight to any adverse impact on public safety or the operation of a criminal justice system." 18 U.S.C. § 3626(a)(2).

II. Eighth Amendment Claim

A. Likelihood of Success on the Merits

8. The Eighth Amendment to the United States Constitution protects prisoners against cruel and unusual punishment. To state a claim under the Eighth

---

[1] In discussions with counsel before the evidentiary hearing, the Court expressed the concern that the nature of the relief requested in this case, coupled with the extensive evidence presented by the parties over a 3-day evidentiary hearing, effectively converted these proceedings into a final trial on the merits of the plaintiff's request for permanent injunctive relief. Neither party addressed the Court's concern, and both parties appear to have treated the evidentiary hearing as a final trial of Ms. Edmo's claims.

In an abundance of caution, the Court has considered the standard for the issuance of a permanent injunction, which would have required the plaintiff to show (1) she has suffered an irreparable injury, (2) monetary damages would not compensate her for that injury, (3) after balancing the hardships between the parties, a remedy of equity is warranted, and (4) the public interest would not be disserved by a permanent injunction. S*ee, eBay Inc. v. MercExchange, L.L.C.,* 547 U.S. 388, 391 (2006). That standard appears to be no more rigorous than that applicable to a claim for preliminary mandatory relief. The Court concludes that under either standard Ms. Edmo is entitled to relief.

Amendment, Ms. Edmo must show that she is "incarcerated under conditions posing a substantial risk of serious harm," or that she has been deprived of "the minimal civilized measure of life's necessities" as a result of Defendants' actions. *Farmer v. Brennan*, 511 U.S. 825, 834 (1994) (internal quotation marks omitted).

9. An Eighth Amendment claim requires a plaintiff to satisfy "both an objective standard – that the deprivation was serious enough to constitute cruel and unusual punishment – and a subjective standard – deliberate indifference." *Snow v. McDaniel*, 681 F.3d 978, 985 (9th Cir. 2012).

10. The Eighth Amendment includes the right to adequate medical care in prison, and prison officials or prison medical providers can be held liable if their "acts or omissions [were] sufficiently harmful to evidence deliberate indifference to serious medical needs." *Estelle v. Gamble*, 429 U.S. 97, 106 (1976).

11. Regarding the objective standard for prisoners' medical care claims, the Supreme Court of the United States has explained that "[b]ecause society does not expect that prisoners will have unqualified access to health care, deliberate indifference to medical needs amounts to an Eighth Amendment violation only if those needs are 'serious.'" *Hudson v. McMillian*, 503 U.S. 1, 9 (1992) (quoting *Estelle v. Gamble*, 429 U.S., 97, 103 (1976)).

12. The Ninth Circuit has defined a "serious medical need" in the following ways: failure to treat a prisoner's condition [that] could result in further significant injury or the unnecessary and wanton infliction of pain [;] ... [t]he existence of an injury

that a reasonable doctor or patient would find important and worthy of comment or treatment; the presence of a medical condition that significantly affects an individual's daily activities; or the existence of chronic and substantial pain . . . ." *McGuckin v. Smith*, 974 F.2d 1050, 1059–60 (9th Cir. 1992) (internal citations omitted), overruled on other grounds, *WMX Techs., Inc. v. Miller*, 104 F.3d 1133 (9th Cir. 1997) (en banc).

13. As to the subjective standard, a prison official or prison medical provider acts with "deliberate indifference . . . only if the [prison official] knows of and disregards an excessive risk to inmate health and safety." *Gibson v. Cnty. of Washoe, Nev.*, 290 F.3d 1175, 1187 (9th Cir. 2002) (citation and internal quotation marks omitted). "Under this standard, the prison official must not only 'be aware of facts from which the inference could be drawn that a substantial risk of serious harm exists,' but that person 'must also draw the inference.'" *Toguchi v. Chung*, 391 F.3d 1051, 1057 (9th Cir. 2004) (quoting *Farmer*, 511 U.S. at 837).

14. "If a [prison official] should have been aware of the risk, but was not, then the [official] has not violated the Eighth Amendment, no matter how severe the risk." *Gibson*, 290 F.3d at 1188 (citation omitted). However, "whether a prison official had the requisite knowledge of a substantial risk is a question of fact subject to demonstration in the usual ways, including inference from circumstantial evidence, . . . and a factfinder may conclude that a prison official knew of a substantial risk from the very fact that the risk was obvious." *Farmer*, 511 U.S. at

842; *see also Lolli v. County of Orange*, 351 F.3d 410, 421 (9th Cir. 2003) (deliberate indifference to medical needs may be shown by circumstantial evidence when the facts are sufficient to demonstrate that defendant actually knew of a risk of harm).

15. In the medical context, a conclusion that a defendant acted with deliberate indifference requires that the plaintiff show both "a purposeful act or failure to respond to a prisoner's pain or possible medical need and . . . harm caused by the indifference." *Jett v. Penner*, 439 F.3d 1091, 1096 (9th Cir. 2006).

16. Deliberate indifference can be "manifested by prison doctors in their response to the prisoner's needs or by prison guards in intentionally denying or delaying access to medical care or intentionally interfering with the treatment once prescribed." *Estelle*, 429 U.S. at 104–05 (footnotes omitted).

17. Non-medical prison personnel are generally entitled to rely on the opinions of medical professionals with respect to the medical treatment of an inmate. However, if "a reasonable person would likely determine [the medical treatment] to be inferior," the fact that an official is not medically trained will not shield that official from liability for deliberate indifference. *Snow*, 681 F.3d at 986; *see also McGee v. Adams*, 721 F.3d 474, 483 (7th Cir. 2013) (stating that non-medical personnel may rely on medical opinions of health care professionals unless "they have a reason to believe (or actual knowledge) that prison doctors or their

assistants are mistreating (or not treating) a prisoner") (internal quotation marks omitted).

18. Differences in judgment between an inmate and prison medical personnel regarding appropriate medical diagnosis and treatment are not enough to establish a deliberate indifference claim. *Sanchez v. Vild*, 891 F.2d 240, 242 (9th Cir.1989). "[T]o prevail on a claim involving choices between alternative courses of treatment, a prisoner must show that the chosen course of treatment 'was medically unacceptable under the circumstances,' and was chosen 'in conscious disregard of an excessive risk' to the prisoner's health." *Toguchi*, 391 F.3d at 1058, (alteration omitted) (quoting *Jackson v. McIntosh*, 90 F.3d 330, 332 (9th Cir. 1996)).

19. Mere indifference, medical malpractice, or negligence will not support a cause of action under the Eighth Amendment. *Broughton v. Cutter Labs.*, 622 F.2d 458, 460 (9th Cir.1980) (per curiam). Likewise, a delay in treatment does not constitute a violation of the Eighth Amendment unless the delay causes further harm. *McGuckin*, 974 F.2d at 1060.

1. Serious Medical Need

20. There is no dispute that Ms. Edmo suffers from gender dysphoria. And there is no dispute that gender dysphoria is a serious medical condition recognized by the DSM-5.

21. WPATH Standards of Care are the accepted standards of care for treatment of transgender patients. These standards have been endorsed by the NCCHC as applying to incarcerated persons.

22. There are no other competing, evidence-based standards that are accepted by any nationally or internationally recognized medical professional groups.

23. The Court finds credible the testimony of Plaintiff's experts Drs. Ettner and Gorton, who have extensive personal experience treating individuals with gender dysphoria both before and after receiving gender confirmation surgery. Plaintiff's experts found that Ms. Edmo satisfied all six WPATH medical necessity criteria for surgery.

24. Defendants' experts, by contrast, have opined that surgery is not medically necessary for Ms. Edmo. However, neither Dr. Garvey nor Dr. Andrade has any direct experience with patients receiving gender confirmation surgery or assessing patients for the medical necessity of gender confirmation surgery. Defendants' experts also have very little experience treating patients with gender dysphoria other than assessing them for the existence of the condition.

25. Defendants' experts appear to misrepresent the WPATH Standards of Care by concluding that Ms. Edmo, despite presenting as female since her incarceration in 2012, cannot satisfy the WPATH criteria because she has not presented as female outside of the prison setting. But there is no requirement in the WPATH Standards of Care that a "patient live for twelve months in his or her gender role outside of

prison before becoming eligible for SRS." *Norsworthy v. Beard*, 87 F. Supp. 3d 1164 (N.D. Cal. 2015),

26. Indeed, Plaintiff's experts opine that Ms. Edmo exceeds this criterion because she has not only presented as female for far longer than twelve months, but has done so in an environment arguably more hostile to these efforts than the non-custodial community, and despite the disciplinary consequences of doing so. The WPATH Standards of Care explicitly provide that they apply "in their entirety . . . to all transsexual, transgender, and gender-nonconforming people, irrespective of their housing situation," and "including institutional environments such as prisons." Exh. 15 at 73. The Standards of Care make clear that "[d]enial of needed changes in gender role or access to treatments, including sex reassignment surgery, on the basis of residence in an institution are not reasonable accommodations." Exh. 15 at 74.

27. Defendants' evidence to the contrary is unconvincing and suggests a decided bias against approving gender confirmation surgery.

28. In 2016, Dr. Eliason contacted Dr. Steven Levine to lead a training for IDOC and Corizon providers on medical necessity for gender confirmation surgery. Tr. 433:23-434:24. Dr. Levine's training presentation was titled "Medical Necessity of Transgender Inmates: In Search of Clarity When Paradox, Complexity, and Uncertainty Abound." Exh. 17 at 1. Dr. Levine trained Corizon and IDOC staff that gender confirmation surgery is "not conceived as lifesaving as is repairing a

potentially leaking aortic aneurysm but as life enhancing as is providing augmentation for women distressed about their small breasts." Exh. 17 at 43; Exh. 16.

29. Dr. Levine is considered an outlier in the field of gender dysphoria and does not ascribe to the WPATH Standards of Care. Tr. 176:14-21. His training materials do not reflect opinions that are generally accepted in the field of gender dysphoria. Tr. 176:22-179:1.

30. Dr. Levine's training includes additional criteria proposed by Cynthia Osborne and Anne Lawrence that incarcerated individuals must meet in order to receive gender confirmation surgery. Exh. 17 at 39-41, 51; Exh. 19. These requirements are not part of the WPATH criteria and are in opposition to the WPATH Standards of Care. Tr. 101:15-22, 103:14-20. There are no scientific studies that support these additional requirements, and no professional associations or organizations have endorsed Osborne and Lawrence's proposed requirements for prisoners. Tr. 103:4-13. The NCCHC has not adopted Osborne and Lawrence's additional requirements. Tr. 480:12-16. Like Dr. Levine, Osborne and Lawrence are considered outliers in the field of gender dysphoria treatment, are not WPATH members, and do not ascribe to the WPATH Standards of Care. Tr. 101:2-14.

31. A decision of the U.S. District Court in the Northern District of California, *Norsworthy v. Beard*, 87 F. Supp. 3d 1164 (N.D. Cal. 2015), is noteworthy here. Dr. Levine was retained as a defense expert by the California Department of

Corrections and Rehabilitation in a suit filed by a transgender plaintiff in that case. In ordering the prison to provide the plaintiff gender confirmation surgery, the *Norsworthy* court afforded Dr. Levine's opinions "very little weight," stating: "To the extent that Levine's apparent opinion that no inmate should ever receive SRS predetermined his conclusion with respect to Norsworthy, his conclusions are unhelpful in assessing whether she has established a serious medical need for SRS." *Norsworthy*, 87 F. Supp. 3d at 1188. The court also determined that Dr. Levine's opinion was not credible because of illogical inferences, inconsistencies, and inaccuracies," including misrepresentations of the WPATH Standards of Care, overwhelming "generalizations about gender dysphoric prisoners" and Dr. Levine's fabrication of a prisoner anecdote. *Id*.

32. Under these circumstances, the Court gives virtually no weight to the opinions of Defendants' experts that Ms. Edmo does not meet the fourth and sixth WPATH criteria for gender confirmation surgery.

2. Deliberate Indifference

33. Defendants misapplied the recognized standards of care for treating Ms. Edmo's gender dysphoria.

34. Defendants insufficiently trained their staff with materials that discourage referrals for surgery and represent the opinions of a single person who rejects the WPATH Standards of Care.

35. Defendants' sole evaluation of Ms. Edmo for surgery prior to this lawsuit failed to accurately apply the WPATH Standards of Care. Specifically, Dr. Eliason's assessment that Ms. Edmo did not meet medical necessity for surgery did not apply the WPATH criteria.

36. Defendants have been deliberately indifferent to Ms. Edmo's medical needs by failing to provide her with available treatment that is generally accepted in the field as safe and effective, despite her actual harm and ongoing risk of future harm including self-castration attempts, cutting, and suicidal ideation.

37. Evidence also suggests that Ms. Edmo has not been provided gender confirmation surgery because Corizon and IDOC have a *de facto* policy or practice of refusing this treatment for gender dysphoria to prisoners.

38. In *Norsworthy*, the court found that the prison had a blanket policy barring surgery in light of evidence that the prison's "guidelines for treating transgender inmates, which do not mention SRS as a treatment option, and the 2012 training provided to CDCR staff by Levine, which indicated that SRS should never be provided to incarcerated patients." *Norsworthy*, 87 F. Supp. 3d at 1191.

39. Here, the only guidelines Corizon issued to assist its providers in treating gender dysphoria likewise do not include surgery as a treatment option. Moreover, Dr. Levine's training provided to Corizon and IDOC staff, and incorporated into further Corizon and IDOC training, discourages providing surgery to incarcerated persons with gender dysphoria.

40. Significantly, no Corizon or IDOC provider has ever recommended that gender confirmation surgery is medically necessary for a patient in IDOC custody. In fact, Corizon has never provided this surgery at any of its facilities in the United States.

41. As was the case in *Norsworthy*, "[t]he weight of the evidence demonstrates that for [Ms. Edmo], the only adequate medical treatment for her gender dysphoria is [gender confirmation surgery], that the decision not to address her persistent symptoms was medically unacceptable under the circumstances, and that [Defendants] denied her the necessary treatment for reasons unrelated to her medical need." *Norsworthy*, 87 F. Supp. 3d at 1192.

42. Accordingly, Ms. Edmo is likely to succeed on the merits of her Eighth Amendment claim.

B. Likelihood of Irreparable Harm

43. The Ninth Circuit has repeatedly held that serious psychological harm, in addition to physical harm and suffering, constitutes irreparable injury. *See, e.g.*, *Chalk v. U.S. Dist. Ct. Cent. Dist. of California*, 840 F. 2d 701, 709 (9th Cir. 1988) (plaintiff's "emotional stress, depression and reduced sense of well-being" constituted irreparable harm); *Thomas v. Cnty. of Los Angeles*, 978 F. 2d 504, 512 (9th Cir. 1992) ("Plaintiffs have also established irreparable harm, based on this Court's finding that the deputies' actions have resulted in irreparable physical and emotional injuries to plaintiffs and the violation of plaintiffs' civil rights.").

44. Ms. Edmo's gender dysphoria results in clinically significant distress or impairment of functioning.

45. Both Plaintiff's and Defendants' experts agree that Ms. Edmo is properly diagnosed with gender dysphoria and continues to experience serious distress from this condition.

46. Ms. Edmo has received hormone treatment and achieved the maximum feminizing effects years ago.

47. Other district courts have recognized that the significant emotional pain, suffering, anxiety, and depression caused by prison officials' failure to provide adequate treatment for gender dysphoria constitute irreparable harm warranting a preliminary injunction. *See, e.g.*, *Hicklin v. Precynthe*, 2018 WL 806764, at *9 (E.D. Missouri 2018); *Norsworthy*, 87 F. Supp. 3d at 1192.

48. Ms. Edmo has twice attempted self-castration resulting in significant pain and suffering.

49. The Court is persuaded by Plaintiff's experts that, without surgery, Ms. Edmo is at serious risk of life-threatening self-harm.

50. Thus, Ms. Edmo has satisfied the irreparable harm prong by showing that she will suffer serious psychological harm and will be at high risk of self-castration and suicide in the absence of gender confirmation surgery.

C. Balance of Equities

51. "Courts 'must balance the competing claims of injury and must consider the effect on each party of the granting or withholding of the requested relief.'" *Winter*, 555 U.S. at 24 (quoting *Amoco Production Co.*, 480 U.S. 531, 542 (1987)).

52. The balance of equities tips in a plaintiff's favor where the plaintiff has established irreparable harm in the form of unnecessary physical and emotional suffering and denial of her constitutional rights. *See, e. g.*, *Hicklin*, 2018 WL 806764, at *13; *Norsworthy*, 87 F. Supp. 3d at 1193.

53. Ms. Edmo has established that Defendants' refusal to provide her with gender confirmation surgery causes her ongoing irreparable harm.

54. Defendants have made no showing that an order requiring them to provide treatment that accords with the recognized WPATH Standard of Care causes them injury.

D. The Public Interest

55. The Court finds that a mandatory preliminary injunction is in the public interest. "[I]t is always in the public interest to prevent the violation of a party's constitutional rights." *See Melendres v. Arpaio*, 695 F. 3d 990, 1002 (9th Cir. 2012).

56. "In addition, 'the public has a strong interest in the provision of constitutionally adequate health care to prisoners.'" *McNearney v. Wash. Dep't of Corr.*, 2012 WL 3545267, at *16 (W.D. Wash. 2012).

57. Accordingly, a mandatory preliminary injunction should issue because both the facts and the law clearly favor Ms. Edmo and extreme or very serious damage will result if it is not issued. *See Marlyn Nutraceuticals*, 571 F.3d at 879.

III. FOURTEENTH AMENDMENT AND ACA CLAIMS

58. Plaintiff has not met her burden for a preliminary injunction on her Fourteenth Amendment and Affordable Care Act claims at this time.

59. As explained above, to make this showing for preliminary injunction, the plaintiff must establish: (1) a likelihood of success on the merits; (2) a likelihood of irreparable harm to the moving party in the absence of preliminary relief; (3) that the balance of equities tips in favor of the moving party; and (4) that an injunction is in the public interest. *Winter*, 555 U.S. at 22.

60. While Ms. Edmo may ultimately prevail on her Fourteenth Amendment and Affordable Care Act claims, she is unable to show that she is entitled to injunctive relief at this time. Given the Court's ruling on her Eighth Amendment claim, there is no likelihood of irreparable harm to Ms. Edmo in the absence of injunctive relief on these two claims.

61. Moreover, the balance of equities tips in favor of Defendants because a more developed record on Defendants' treatment of transgender inmates is necessary before making a broader ruling based upon the Fourteenth Amendment or the Affordable Care Act.

62. Likewise, a more developed record is necessary to assess the public's interest in granting such injunctive relief. *Id*.

ORDER

IT IS ORDERED:

1. Plaintiff's Motion for Preliminary Injunction (Dkt. 62) is **GRANTED IN PART**. Defendants are ordered to provide Plaintiff with adequate medical care, including gender confirmation surgery. Defendants shall take all actions reasonably necessary to provide Ms. Edmo gender confirmation surgery as promptly as possible and no later than six months from the date of this order. However, given IDOC's implementation of an updated gender dysphoria policy on October 5, 2018 that appears to provide Plaintiff's requested injunctive relief related to accessing gender-appropriate underwear, clothing, and commissary items, the Court will not address that relief at this time. This is without prejudice to the plaintiff's right to raise the issue in the future, should IDOC revoke the new policy or if the implementation of the policy results in ongoing violations.

2. The Court's Deputy, Jamie Bracke, is directed to set a telephonic status conference in this case no later than two weeks after this decision issues.

DATED: December 13, 2018

B. Lynn Winmill
Chief U.S. District Court Judge

EXHIBIT B

UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF IDAHO

ADREE EDMO, Plaintiff, v. IDAHO DEPARTMENT OF CORRECTION, et al., Defendants.	Case No. 1:17-cv-00151-BLW MEMORANDUM DECISION AND ORDER

INTRODUCTION

Before the Court is Defendants' Joint Motion to Stay Order [Dkt. 149] Pending Appeal. Dkt. 156. For the reasons set forth below, Defendants' motion is denied.

BACKGROUND

The Court issued its Findings of Fact, Conclusion of Law, and Order in this case after a three-day evidentiary hearing. Dkt. 149. During that hearing, Ms. Adree Edmo established that she was entitled to gender confirmation surgery by June 13, 2019. The Court will not repeat all the factual and legal conclusions that led to its decision, but will highlight the following portion of the Court's order:

> The risks of not providing gender confirmation surgery to Ms. Edmo include surgical self-treatment, emotional decompensation, and risk of suicide given her high degree of suicide ideation. Tr. 80:24:81:8, 264:13-22. If she is not provided

> with surgery, Ms. Edmo has indicated that she will try self-surgery again to deal with her extreme episodes of gender dysphoria. Tr. 199:24-200:5. *Given that Ms. Edmo made increasing progress on her first two self-surgery attempts, it is likely that Ms. Edmo will be successful if she attempts self-surgery again.* Tr. 264:13-22.

Edmo v. Idaho Dep't of Correction, No. 1:17-CV-00151-BLW, 2018 WL 6571203, at *12 (D. Idaho Dec. 13, 2018) (emphasis added).

LEGAL STANDARD

Granting a stay is "an exercise of judicial discretion" that is "dependent upon the circumstances of the particular case." *Nken v. Holder*, 556 U.S. 418, 433, (2009). The Supreme Court suggested in *Hilton v. Braunskill*, 481 U.S. 770, 776 (1987) that the trial court, in exercising its discretion, should consider four factors: "(1) whether the stay applicant has made a strong showing that he is likely to succeed on the merits; (2) whether the applicant will be irreparably injured absent a stay; (3) whether issuance of the stay will substantially injure the other parties interested in the proceeding; and (4) where the public interest lies."

The Ninth Circuit has suggested that the *Hilton* factors should be applied using a "sliding scale" approach in which a stronger showing of one element may offset a weaker showing of another. *Peck Ormsby Const. Co. v. City of Rigby*, No. CIV. 1:10-545 WBS, 2012 WL 914915, at *3 (D. Idaho Mar. 15, 2012). The moving party bears the burden of showing that the circumstances justify an exercise of the court's discretion and must show at least a minimum threshold for each factor. *Nken*, 556 U.S. at 434. However, the "first two factors ... are the most critical." *Id.*

ANALYSIS

Defendants, in seeking a stay, rehash the arguments they presented during the three-day evidentiary hearing in this case. The Court was unpersuaded by the arguments then, and remains so now. Applying the *Hilton* factors to the findings of fact contained in the Court's prior decision, Defendants have failed to carry their burden to show that a stay is appropriate.

While there is no certainty as to how this case will be viewed on appeal, the Court is firmly convinced that its decision is supported by the facts and law presented during the hearing. I must, therefore conclude that the Defendants have not made a strong showing that they are likely to succeed on appeal.

The Court is not persuaded that the Defendants will be irreparably injured absent a stay. Indeed, it is difficult to see how providing medical treatment to an inmate could ever constitute an irreparable injury.

By comparison, the Court is convinced that issuing the stay will substantially injure Ms. Edmo for the reasons identified in that portion of the Court's decision quoted above. Indeed, given Edmo's past actions, time is of the essence.

Finally, I am also persuaded that there is a strong public interest in ensuring that our prisons are not deliberately indifferent to the serious medical needs of its inmates.

The Court will offer just one more thought: Ms. Edmo's testimony and that of her experts conclusively established, in the Court's opinion, that there is a substantial risk that Ms. Edmo will make a *third* attempt to self-castrate if the Defendants continue to deny her gender confirmation surgery. In short, her medical needs are urgent. The Constitution requires Defendants to act accordingly.

ORDER

IT IS ORDERED:

1. Defendants' Joint Motion to Stay Order [Dkt. 149] Pending Appeal (Dkt. 156) is **DENIED**.

DATED: March 4, 2019

B. Lynn Winmill
U.S. District Court Judge

EXHIBIT C

FILED

MAR 20 2019

MOLLY C. DWYER, CLERK
U.S. COURT OF APPEALS

UNITED STATES COURT OF APPEALS

FOR THE NINTH CIRCUIT

ADREE EDMO, AKA Mason Edmo, Plaintiff-Appellee, v. CORIZON, INC.; et al., Defendants-Appellants, and IDAHO DEPARTMENT OF CORRECTIONS; et al., Defendants, UNITED STATES OF AMERICA, Real-party-in-interest.	No. 19-35017 D.C. No. 1:17-cv-00151-BLW District of Idaho, Boise ORDER

ADREE EDMO, AKA Mason Edmo, Plaintiff-Appellee, v. IDAHO DEPARTMENT OF CORRECTIONS; et al., Defendants-Appellants, and	No. 19-35019 D.C. No. 1:17-cv-00151-BLW

KAM/MOATT

CORIZON, INC.; et al.,

Defendants,

UNITED STATES OF AMERICA,

Real-party-in-interest.

Before: TALLMAN and MURGUIA, Circuit Judges.

Appellants' motion (Docket Entry No. 15 in No. 19-35017) to stay the district court's December 13, 2018 order pending appeal is granted. *See Hilton v. Braunskill*, 481 U.S. 770, 776 (1987).

Appellants' motion to file volume 18 of the excerpts of record under seal (Docket Entry No. 14 in No. 19-35017) is granted. *See* Interim 9th Cir. R. 27-13. The Clerk shall file volume 18 of the excerpts of record under seal, and shall file the consolidated opening brief at Docket Entry No. 11 in No. 19-35017 and volumes 1 through 17 of the excerpts of record publicly. The Clerk shall maintain the motion at Docket Entry No. 14 in No. 19-35017 under seal.

Appellee's request to expedite these appeals, contained in Docket Entry No. 17 in No. 19-35017, is granted. The consolidated answering brief is due April 3, 2019. The optional consolidated reply brief is due within 14 days of service of the answering brief.

The Clerk shall place these cases on the May 2019 oral argument calendar. *See* 9th Cir. Gen. Ord. 3.3(g).

EXHIBIT D

FOR PUBLICATION

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

ADREE EDMO, AKA Mason Edmo, *Plaintiff-Appellee*, v. CORIZON, INC.; SCOTT ELIASON; MURRAY YOUNG; CATHERINE WHINNERY, *Defendants-Appellants*, and IDAHO DEPARTMENT OF CORRECTIONS; AL RAMIREZ, in his official capacity as warden of Idaho State Correctional Institution;[*] HENRY ATENCIO; JEFF ZMUDA; HOWARD KEITH YORDY; RICHARD CRAIG; RONA SIEGERT, *Defendants.*	No. 19-35017 D.C. No. 1:17-cv-00151-BLW
ADREE EDMO, AKA Mason Edmo, *Plaintiff-Appellee*,	No. 19-35019

[*] Al Ramirez is substituted in his official capacity for his predecessor, Howard Keith Yordy, pursuant to Rule 43(c)(2) of the Federal Rules of Appellate Procedure.

v.

IDAHO DEPARTMENT OF CORRECTIONS; AL RAMIREZ, in his official capacity as warden of Idaho State Correctional Institution; HENRY ATENCIO; JEFF ZMUDA; HOWARD KEITH YORDY; RICHARD CRAIG; RONA SIEGERT,
Defendants-Appellants,

and

CORIZON, INC.; SCOTT ELIASON; MURRAY YOUNG; CATHERINE WHINNERY,
Defendants.

D.C. No. 1:17-cv-00151-BLW

OPINION

Appeal from the United States District Court
for the District of Idaho
B. Lynn Winmill, Chief District Judge, Presiding

Argued and Submitted May 16, 2019
San Francisco, California

Filed August 23, 2019

Before: M. Margaret McKeown and Ronald M. Gould, Circuit Judges, and Robert S. Lasnik,** District Judge.

Per Curiam Opinion

** The Honorable Robert S. Lasnik, United States District Judge for the Western District of Washington, sitting by designation.

SUMMARY[***]

Eighth Amendment / Prisoner Rights

The panel affirmed the district court's entry of a permanent injunction in favor of Idaho state prisoner Adree Edmo, but vacated the injunction to the extent it applied to defendants Corizon, Howard Yordy, Rona Siegert, Dr. Young, Dr. Craig, and Dr. Whinnery, in their individual capacities, in Edmo's action seeking medical treatment for gender dysphoria.

The district court concluded that Edmo had established her Eighth Amendment claim. The district court further concluded that gender confirmation surgery ("GCS") was medically necessary for Edmo, and ordered the State to provide the surgery.

The panel credited the district court's factual findings as logical and well-supported, and held that the responsible prison authorities were deliberately indifferent to Edmo's gender dysphoria, in violation of the Eighth Amendment. The panel held that the record, as construed by the district court, established that Edmo had a serious medical need, that the appropriate medical treatment was GCS, and that prison authorities had not provided that treatment despite full knowledge of Edmo's ongoing and extreme suffering and medical needs. The panel rejected the State's position that there was a reasoned disagreement between qualified medical professionals. The panel emphasized that its

[***] This summary constitutes no part of the opinion of the court. It has been prepared by court staff for the convenience of the reader.

analysis was individual to Edmo, and rested on the record of this case.

Addressing further aspects of the appeal, the panel rejected the State's contention that the district court did not make the Prison Litigation Reform Act's requisite "need-narrowness-intrusiveness" findings, causing the injunction to automatically expire and mooting the appeal. The panel held that the district court's order, considered as a whole, made all the findings required by 18 U.S.C. § 3626(a)(1)(A), and Ninth Circuit precedent. The panel also held that the permanent injunction that the district court entered had not expired, and remained in place, albeit stayed. The panel accordingly denied the State's motion to dismiss.

The panel held that the district court did not err in granting a permanent injunction. Specifically, the panel held, based on the district court's factual findings, that Edmo established her Eighth Amendment claim and that she will suffer irreparable harm – in the form of ongoing mental anguish and possible physical harm – if GCS is not provided. The State did not dispute that Edmo's gender dysphoria was a sufficiently serious medical need to trigger the State's obligations under the Eighth Amendment. The panel held that the district court did not err in crediting the testimony of Edmo's experts that GCS was medically necessary to treat Edmo's gender dysphoria and that the State's failure to provide that treatment was medically unacceptable. The panel further held that the district court did not err in discrediting the State's experts because aspects of their opinions were illogical and unpersuasive. Also, the panel held that the record demonstrated that Dr. Eliason acted with deliberate indifference to Edmo's serious medical needs. The panel noted that its decision was in tension with the Fifth Circuit's decision in *Gibson v. Collier*, 920 F.3d 212 (5th

Cir. 2019), and the panel rejected that decision's categorical holding that denying GCS cannot, as a matter of law, violate the Eighth Amendment.

The panel held that the district court did not err in finding that Edmo would be irreparably harmed absent an injunction. The panel rejected the State's contentions as to why the district court erred in this finding.

The panel next considered the State's challenges to the scope of the injunction. The panel held that the injunction was properly entered against Dr. Eliason because he personally participated in the deprivation of Edmo's constitutional rights. The panel also held that because Edmo may properly pursue her Eighth Amendment claim for injunctive relief against Attencio, Zmuda and Ramirez in their official capacities, they were properly included within the scope of the district court's injunction. On remand, the district court shall amend the injunction to substitute the current warden as a party for Yordy. The panel vacated the district court's injunction to the extent it applied to Yordy, Siegert, Dr. Young, Dr. Craig, and Dr. Whinnery in their individual capacities because the evidence in the record was insufficient to conclude that they were deliberately indifferent to Edmo's serious medical needs. The panel vacated the injunction as to Corizon, and remanded with instructions to the district court to modify the injunction to exclude Corizon. Finally, the panel held that the injunctive relief ordered was not overbroad.

The panel considered the State's challenges to the procedure used by the district court. The panel rejected the State's contention that the district court erroneously converted the evidentiary hearing into a final trial on the merits without giving proper notice. The panel held that the State did receive notice, and in any event, the State had not

shown any prejudice. The panel also rejected the State's contention that the district court violated defendants' Seventh Amendment right to a jury trial by converting the evidentiary hearing into a trial on the merits. The panel held that the State's conduct waived its right to a jury trial with respect to issues common to Edmo's request for an injunction ordering GCS and her legal claims.

COUNSEL

Brady J. Hall (argued), Special Deputy Attorney General; Lawrence G. Wasden, Attorney General; Office of the Attorney General, Boise, Idaho; Marisa S. Crecelius, Moore Elia Kraft & Hall LLP, Boise, Idaho; for Defendants-Appellants Idaho Department of Corrections, Henry Atencio, Jeff Zmuda, Howard Keith Yordy, Richard Craig, and Rona Siegert.

Dylan A. Eaton (argued), J. Kevin West, and Bryce Jensen, Parsons Behle & Latimer, Boise, Idaho, for Defendants-Appellants Corizon, Inc.; Scott Eliason; Murray Young; and Catherine Whinnery.

Lori Rifkin (argued), Hadsell Stormer & Renick LLP, Emeryville, California; Dan Stormer and Shaleen Shanbhag, Hadsell Stormer & Renick LLP, Pasadena, California; Craig Durham and Deborah Ferguson, Ferguson Durham PLLC, Boise, Idaho; Amy Whelan and Julie Wilensky, National Center for Lesbian Rights, San Francisco, California; for Plaintiff-Appellee.

David M. Shapiro, Sheila A. Bedi, and Vanessa del Valle, Roderick & Solange MacArthur Justice Center, Chicago, Illinois; Molly E. Whitman, Akin Gump Strauss Hauer &

Feld LLP, Dallas, Texas; for Amici Curiae Andrea Armstrong, Sharon Dolovich, Betsy Ginsberg, Michael B. Mushlin, Alexander A. Reinert, Laura Rovner, and Margo Schlanger.

Molly Kafka and Richard Alan Eppink, ACLU of Idaho Foundation, Boise, Idaho; Devon A. Little and Derek Borchardt, Walden Macht & Haran LLP, New York, New York; Amy Fettig and Jennifer Wedekind, ACLU National Prison Project, Washington, D.C.; Gabriel Arkles and Rose Saxe, ACLU LGBT & HIV Project/ACLU Foundation, New York, New York; for Amici Curiae Former Corrections Officials.

Devi M. Rao and Jason T. Perkins, Jenner & Block LLP, Washington, D.C., for Amici Curiae Medical and Mental Health Professional Organizations.

Sharif E. Jacob, Ryan K. M. Wong, Kristin E. Hucek, and Patrick E. Murray, Keker Van Nest & Peters LLP, San Francisco, California, for Amicus Curiae Jody L. Herman.

Alan E. Schoenfeld, Wilmer Cutler Pickering Hale and Dorr LLP, New York, New York; Michael Posada, Wilmer Cutler Pickering Hale and Dorr LLP, Washington, D.C.; Richard Saenz, Lambda Legal Defense & Education Fund Inc., New York, New York; A. Chinyere Ezie, Center for Constitutional Rights, New York, New York; for Amici Curiae Civil Rights & Non-Profit Organizations.

OPINION

PER CURIAM:

The Eighth Amendment prohibits "cruel and unusual punishments." U.S. Const. amend. VIII. "The Amendment embodies broad and idealistic concepts of dignity, civilized standards, humanity, and decency . . . ." *Estelle v. Gamble*, 429 U.S. 97, 102 (1976) (quotation omitted). Our society recognizes that prisoners "retain the essence of human dignity inherent in all persons." *Brown v. Plata*, 563 U.S. 493, 510 (2011).

Consistent with the values embodied by the Eighth Amendment, for more than 40 years the Supreme Court has held that "deliberate indifference to serious medical needs" of prisoners constitutes cruel and unusual punishment. *Estelle*, 429 U.S. at 106. When prison authorities do not abide by their Eighth Amendment duty, "the courts have a responsibility to remedy the resulting . . . violation." *Brown*, 563 U.S. at 511. We do so here.

Adree Edmo (formerly Mason Dean Edmo) is a male-to-female transgender prisoner in the custody of the Idaho Department of Correction ("IDOC"). Edmo's sex assigned at birth (male) differs from her gender identity (female). The incongruity causes Edmo to experience persistent distress so severe it limits her ability to function. She has twice attempted self-castration to remove her male genitalia, which cause her profound anguish.

Both sides and their medical experts agree: Edmo suffers from gender dysphoria, a serious medical condition. They also agree that the appropriate benchmark regarding treatment for gender dysphoria is the World Professional Association of Transgender Health Standards of Care for the

Health of Transsexual, Transgender, and Gender Nonconforming People ("WPATH Standards of Care"). And the State[1] does not seriously dispute that in certain circumstances, gender confirmation surgery ("GCS") can be a medically necessary treatment for gender dysphoria. The parties' dispute centers around whether GCS is medically necessary for Edmo—a question we analyze with deference to the district court's factual findings.

Following four months of intensive discovery and a three-day evidentiary hearing, the district court concluded that GCS is medically necessary for Edmo and ordered the State to provide the surgery. Its ruling hinged on findings individual to Edmo's medical condition. The ruling also rested on the finding that Edmo's medical experts testified persuasively that GCS was medically necessary, whereas testimony from the State's medical experts deserved little weight. In contrast to Edmo's experts, the State's witnesses lacked relevant experience, could not explain their deviations from generally accepted guidelines, and testified illogically and inconsistently in important ways.

The district court's detailed factual findings were amply supported by its careful review of the extensive evidence and testimony. Indeed, they are essentially unchallenged. The appeal boils down to a disagreement about the implications of the factual findings.

Crediting, as we must, the district court's logical, well-supported factual findings, we hold that the responsible

[1] In addition to IDOC, Edmo sued Corizon, Inc. (a private for-profit corporation that provides health care to inmates in IDOC custody) and various employees of IDOC and Corizon. The defendants briefed the case jointly, and for ease of reference we refer to them collectively as "the State."

prison authorities have been deliberately indifferent to Edmo's gender dysphoria, in violation of the Eighth Amendment. The record before us, as construed by the district court, establishes that Edmo has a serious medical need, that the appropriate medical treatment is GCS, and that prison authorities have not provided that treatment despite full knowledge of Edmo's ongoing and extreme suffering and medical needs. In so holding, we reject the State's portrait of a reasoned disagreement between qualified medical professionals. We also emphasize that the analysis here is individual to Edmo and rests on the record in this case. We do not endeavor to project whether individuals in other cases will meet the threshold to establish an Eighth Amendment violation. The district court's order entering injunctive relief for Edmo is affirmed, with minor modifications noted below.

Our opinion proceeds as follows. In Part I, we provide background on gender dysphoria, the standard of care, and the evidence considered and factual findings made by the district court. Part II explains why this appeal complies with the Prison Litigation Reform Act ("PLRA") and is not moot. In Part III, we turn to the gravamen of the appeal: Edmo's Eighth Amendment claim and showing of irreparable injury. Part IV addresses the State's challenges to the injunction's scope and narrows the injunction as to certain defendants. Part V rejects the State's objections to the procedure employed by the district court. We conclude in Part VI.

I. Background[2]

A. Gender Dysphoria and its Treatment

Transgender individuals have a "[g]ender identity"—a "deeply felt, inherent sense" of their gender—that does not align with their sex assigned at birth.[3] Am. Psychol. Ass'n, *Guidelines for Psychological Practice with Transgender and Gender Nonconforming People*, 70 Am. Psychologist 832, 834 (2015). Recent estimates suggest that approximately 1.4 million transgender adults live in the United States, or 0.6 percent of the adult population. Andrew R. Flores et al., The Williams Inst., *How Many Adults Identify as Transgender in the United States?*, at 2 (2016), http://williamsinstitute.law.ucla.edu/wp-content/uploads/How-Many-Adults-Identify-as-Transgender-in-the-United-States.pdf.

Gender dysphoria[4] is "[d]istress 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'l Ass'n for Transgender Health, *Standards of Care for the Health of Transsexual, Transgender, and Gender-*

[2] The following sections are derived from the district court's factual findings and the record on appeal.

[3] At birth, infants are classified as male or female based on visual observation of their external genitalia. This is a person's "sex assigned at birth," but it may not be the person's gender identity.

[4] Until recently, the medical community commonly referred to gender dysphoria as "gender identity disorder." *See Kosilek v. Spencer*, 774 F.3d 63, 68 n.1 (1st Cir. 2014).

Nonconforming People 2 (7th ed. 2011) (hereinafter "WPATH SOC"). The Fifth Edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders ("DSM-5") sets forth two conditions that must be met for a person to be diagnosed with gender dysphoria.[5]

First, there must be "[a] marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months' duration, as manifested by at least two of the following":

> (1) "a marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics";
>
> (2) "a strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender";
>
> (3) "a strong desire for the primary and/or secondary sex characteristics of the other gender";
>
> (4) "a strong desire to be of the other gender";
>
> (5) "a strong desire to be treated as the other gender"; or

[5] Each expert in the case used these criteria to determine whether Edmo has gender dysphoria.

> (6) "a strong conviction that one has the typical feelings and reactions of the other gender."

Am. Psychiatric Ass'n, *Diagnostic and Statistical Manual of Mental Disorders* 452 (5th ed. 2013) (hereinafter "DSM-5"). Second, the person's condition must be associated with "clinically significant distress"—*i.e.*, distress that impairs or severely limits the person's ability to function in a meaningful way and has reached a threshold that requires medical or surgical intervention, or both. *Id.* at 453, 458. Not every transgender person has gender dysphoria, and not every gender dysphoric person has the same medical needs.

Gender dysphoria is a serious but treatable medical condition. Left untreated, however, it can lead to debilitating distress, depression, impairment of function, substance use, self-surgery to alter one's genitals or secondary sex characteristics, self-injurious behaviors, and even suicide.

The district court found that the World Professional Association of Transgender Health Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People ("WPATH Standards of Care")[6] "are the internationally recognized guidelines for the treatment of individuals with gender dysphoria." *Edmo v. Idaho Dep't of Corr.*, 358 F. Supp. 3d 1103, 1111 (D. Idaho 2018). Most courts agree. *See, e.g.*, *De'lonta v. Johnson*, 708 F.3d 520, 522–23 (4th Cir. 2013); *Keohane v. Jones*, 328 F. Supp. 3d 1288, 1294 (N.D. Fla. 2018), *appeal filed*,

[6] The WPATH Standards of Care were formerly referred to as the "Harry Benjamin Standards of Care" and were promulgated by WPATH under its former name, the "Harry Benjamin International Gender Dysphoria Association." *Kosilek*, 774 F.3d at 70 & n.3.

No. 18-14096 (11th Cir. 2018); *Norsworthy v. Beard*, 87 F. Supp. 3d 1164, 1170 (N.D. Cal.), *appeal dismissed & remanded*, 802 F.3d 1090 (9th Cir. 2015); *Soneeya v. Spencer*, 851 F. Supp. 2d 228, 231–32 (D. Mass. 2012). *But see Gibson v. Collier*, 920 F.3d 212, 221 (5th Cir. 2019) ("[T]he WPATH Standards of Care reflect not consensus, but merely one side in a sharply contested medical debate over [GCS]."); *cf. Kosilek*, 774 F.3d at 76–79 (recounting testimony questioning the WPATH Standards of Care). And many of the major medical and mental health groups in the United States—including the American Medical Association, the American Medical Student Association, the American Psychiatric Association, the American Psychological Association, the American Family Practice Association, the Endocrine Society, the National Association of Social Workers, the American Academy of Plastic Surgeons, the American College of Surgeons, Health Professionals Advancing LGBTQ Equality, the HIV Medicine Association, the Lesbian, Bisexual, Gay and Transgender Physician Assistant Caucus, and Mental Health America—recognize the WPATH Standards of Care as representing the consensus of the medical and mental health communities regarding the appropriate treatment for transgender and gender dysphoric individuals.

Each expert in this case relied on the WPATH Standards of Care in rendering an opinion. As the State acknowledged to the district court, the WPATH Standards of Care "provide the best guidance," and "are the best standards out there." "There are no other competing, evidence-based standards that are accepted by any nationally or internationally recognized medical professional groups." *Edmo*, 358 F. Supp. 3d at 1125.

"[B]ased on the best available science and expert professional consensus," the WPATH Standards of Care provide "flexible clinical guidelines" "to meet the diverse health care needs of transsexual, transgender, and gender nonconforming people." WPATH SOC at 1–2. Treatment under the WPATH Standards of Care must be individualized: "[w]hat helps one person alleviate gender dysphoria might be very different from what helps another person." *Id.* at 5. "Clinical departures from the [WPATH Standards of Care] may come about because of a patient's unique anatomic, social, or psychological situation; an experienced health professional's evolving method of handling a common situation; a research protocol; lack of resources in various parts of the world; or the need for specific harm reduction strategies." *Id.* at 2.

The WPATH Standards of Care identify the following evidence-based treatment options for individuals with gender dysphoria:

> (1) "changes in gender expression and role (which may involve living part time or full time in another gender role, consistent with one's gender identity)";
>
> (2) "psychotherapy (individual, couple, family, or group) for purposes such as exploring gender identity, role, and expression[,] addressing the negative impact of gender dysphoria and stigma on mental health[,] alleviating internalized transphobia[,] enhancing social and peer support[,] improving body image[,] or promoting resilience";

> (3) "hormone therapy to feminize or masculinize the body"; and
>
> (4) "surgery to change primary and/or secondary sex characteristics (e.g., breasts/chest, external and/or internal genitalia, facial features, body contouring)."

Id. at 10. The WPATH Standards of Care state that many individuals "find comfort with their gender identity, role, and expression without surgery." *Id.* at 54. For others, however, "surgery is essential and medically necessary to alleviate their gender dysphoria." *Id.* That group cannot achieve "relief from gender dysphoria . . . without modification of their primary and/or secondary sex characteristics to establish greater congruence with their gender identity." *Id.* at 55; *see also* Jae Sevelius & Valerie Jenness, *Challenges and Opportunities for Gender-Affirming Healthcare for Transgender Women in Prison*, 13 Int'l J. Prisoner Health 32, 36 (2017) ("Negative outcomes such as genital self-harm, including autocastration and/or autopenectomy, can arise when gender-affirming surgeries are delayed or denied."); George R. Brown & Everett McDuffie, *Health Care Policies Addressing Transgender Inmates in Prison Systems in the United States*, 15 J. Corr. Health Care 280, 287–88 (2009) (describing the authors' "firsthand knowledge of completed autocastration and/or autopenectomy in six facilities in four states").

The weight of opinion in the medical and mental health communities agrees that GCS is safe, effective, and medically necessary in appropriate circumstances. *See, e.g.*, U.S. Dep't of Health & Human Servs., No. A-13-87, Decision No. 2576, (Dep't Appeals Bd. May 30, 2014); Randi Ettner, et al., *Principles of Transgender Medicine and*

Surgery 109–11 (2d ed. 2016); Jordan D. Frey, et al., *A Historical Review of Gender-Affirming Medicine: Focus on Genital Reconstruction Surgery*, 14 J. Sexual Med. 991, 991 (2017); Cynthia S. Osborne & Anne A. Lawrence, *Male Prison Inmates With Gender Dysphoria: When Is Sex Reassignment Surgery Appropriate?*, 45 Archives of Sexual Behav. 1649, 1651–53 (2016); *see also De'lonta*, 708 F.3d at 523 ("Pursuant to the Standards of Care, after at least one year of hormone therapy and living in the patient's identified gender role, sex reassignment surgery may be necessary for some individuals for whom serious symptoms persist. In these cases, the surgery is not considered experimental or cosmetic; it is an accepted, effective, medically indicated treatment for [gender dysphoria].").

The WPATH criteria for genital reconstruction surgery in male-to-female patients include the following:

> (1) "persistent, well documented gender dysphoria";
>
> (2) "capacity to make a fully informed decision and to consent for treatment";
>
> (3) "age of majority in a given country";
>
> (4) "if significant medical or mental health concerns are present, they must be well controlled";
>
> (5) "12 continuous months of hormone therapy as appropriate to the patient's gender goals"; and

> (6) "12 continuous months of living in a gender role that is congruent with their gender identity."

WPATH SOC at 60. The parties' dispute focuses on whether Edmo satisfied the fourth and sixth criteria.

With respect to the fourth criterion, the WPATH Standards of Care provide that coexisting medical or mental health concerns unrelated to the person's gender dysphoria do not necessarily preclude surgery. *Id.* at 25. But those concerns need to be managed prior to, or concurrent with, treatment of a person's gender dysphoria. *Id.* Coexisting medical or mental health issues resulting from a person's gender dysphoria are not an impediment under the fourth criterion. It may be difficult to determine, however, whether mental or medical health concerns result from the gender dysphoria or are unrelated.

The WPATH Standards of Care explain that the sixth criterion—living for 12 months in an identity-congruent role—is intended to ensure that the person experiences the full range of "different life experiences and events that may occur throughout the year." *Id.* at 61. During that time, the patient should present consistently in her desired gender role. *Id.*

Scientific studies show that the regret rate for individuals who undergo GCS is low, in the range of one to two percent. *See, e.g.*, Osborne & Lawrence, *Male Prison Inmates With Gender Dysphoria*, 45 Archives of Sexual Behav. at 1660; William Byne, et al., *Report of the American Psychiatric Association Task Force on Treatment of Gender Identity Disorder*, 41 Archives of Sexual Behav. 759, 780–81 (2012). The district court found, and the State does not dispute on appeal, that Edmo does not have any of the risk

factors that would make her likely to regret GCS. *See Edmo*, 358 F. Supp. 3d at 1121.

The WPATH Standards of Care apply equally to all individuals "irrespective of their housing situation" and explicitly state that health care for transgender individuals "living in an institutional environment should mirror that which would be available to them if they were living in a non-institutional setting within the same community." WPATH SOC at 67. The next update to the WPATH Standards of Care will likewise apply equally to incarcerated persons. The National Commission on Correctional Health Care ("NCCHC"), a leading professional organization in health care delivery in the correctional context, endorses the WPATH Standards of Care as the accepted standards for the treatment of transgender prisoners.

In summary, the broad medical consensus in the area of transgender health care requires providers to individually diagnose, assess, and treat individuals' gender dysphoria, including for those individuals in institutionalized environments. Treatment can and should include GCS when medically necessary. Failure to follow an appropriate treatment plan can expose transgender individuals to a serious risk of psychological and physical harm. The State does not dispute these points; it contends that GCS is not medically necessary for Edmo.

B. Edmo's Treatment

Edmo is a transgender woman in IDOC custody. Her sex assigned at birth was male, but she identifies as female. In her words, "my brain typically operates female, even though my body hasn't corresponded with my brain."

Edmo has been incarcerated since pleading guilty in 2012 to sexual abuse of a 15-year-old male at a house party. Edmo was 21 years old at the time of the criminal offense. Edmo is currently incarcerated at the Idaho State Correctional Institution ("ISCI"). At the time of the evidentiary hearing, she was 30 years old and due to be released from prison in 2021.

Edmo has viewed herself as female since age 5 or 6. She struggled with her gender identity as a child and teenager, presenting herself intermittently as female, but around age 20 or 21 she began living fulltime as a woman.

Although she identified as female from an early age, Edmo first learned the term "gender dysphoria" and the contours of that diagnosis around the time of her incarceration. Shortly thereafter, Corizon psychiatrist Dr. Scott Eliason diagnosed her with "gender identity disorder," now referred to as gender dysphoria. Corizon psychologist Dr. Claudia Lake confirmed that diagnosis.

While incarcerated, Edmo has changed her legal name to Adree Edmo and the sex on her birth certificate to "female" to affirm her gender identity. Throughout her incarceration, Edmo has consistently presented as female, despite receiving many disciplinary offense reports for doing so. For example, when able to do so, Edmo has worn her hair in feminine hairstyles and worn makeup, for which she has received multiple disciplinary offense reports.[7] Medical providers have documented Edmo's feminine presentation since 2012.

[7] Before the evidentiary hearing, Edmo tried to receive access to female commissary items, such as women's underwear. Most of her requests were denied. On the eve of the evidentiary hearing, IDOC

Neither the parties nor their experts dispute that Edmo suffers from gender dysphoria. That dysphoria causes Edmo to feel "depressed," "disgusting," "tormented," and "hopeless."

To alleviate Edmo's gender dysphoria, prison officials have, since 2012, provided hormone therapy. Edmo has followed and complied with her hormone therapy regimen, which helps alleviate her gender dysphoria to some extent. The hormones "clear[] [her] mind" and have resulted in breast growth, body fat redistribution, and changes in her skin. Today, Edmo is hormonally confirmed, which means that she has the hormones and secondary sex characteristics (characteristics, such as women's breasts, that appear during puberty but are not part of the reproductive system) of an adult female. Edmo has gained the maximum physical changes associated with hormone treatment.

Hormone therapy has not completely alleviated Edmo's gender dysphoria. Edmo continues to experience significant distress related to gender incongruence. Much of that distress is caused by her male genitalia. Edmo testified that she feels "depressed, embarrassed, [and] disgusted" by her male genitalia and that this is an "everyday reoccurring thought." Her medical records confirm her disgust, noting repeated efforts by Edmo to purchase underwear to keep, in Edmo's words, her "disgusting penis" out of sight.

In addition to her gender dysphoria, Edmo suffers from major depressive disorder with anxiety and drug and alcohol addiction, although her addiction has been in remission

---

amended its policy concerning the treatment of gender dysphoric prisoners to increase transgender women's access to female commissary items.

while incarcerated. Edmo has taken her prescribed medications for depression and anxiety. Prison officials have also provided Edmo mental health treatment to help her work through her serious underlying mental health issues and a pre-incarceration history of trauma, abuse, and suicide attempts. Edmo sees her psychiatrist when scheduled. But Edmo does not see her treating clinician, Krina Stewart, because Edmo does not believe Stewart is qualified to treat her gender dysphoria. Edmo has attended group therapy sessions inconsistently.

In September 2015, Edmo attempted to castrate herself for the first time using a disposable razor blade.[8] Before doing so, she left a note to alert officials that she was not "trying to commit suicide," and was instead "only trying to help [her]self." Edmo did not complete the castration, though she continued to report thoughts of self-castration in the following months.

On April 20, 2016, Dr. Eliason evaluated Edmo for GCS. At the time, IDOC's policy concerning the treatment of gender dysphoric prisoners provided that GCS "will not be considered for individuals within [IDOC], unless determined medically necessary by" the treating physician.[9] Corizon's policy does not mention GCS.

In his evaluation, Dr. Eliason noted that Edmo reported she was "doing alright." He also noted that Edmo had been on hormone replacement therapy for the last year and a half, but that she felt she needed more. He reported that Edmo

[8] She had previously reported thoughts of self-castration to clinicians.

[9] IDOC revised its policy shortly before the evidentiary hearing, but its revised policy contains functionally identical language.

had stated that hormone replacement therapy helped alleviate her gender dysphoria, but she remained frustrated with her male anatomy.

Dr. Eliason indicated that Edmo appeared feminine in demeanor and interaction style. He also indicated that Edmo had previously attempted to "mutilate her genitalia" because of the severity of her distress. Dr. Eliason later testified that, at the time of his evaluation, he felt that Edmo's gender dysphoria "had risen to another level," as evidenced by her self-castration attempt.

But Dr. Eliason also flagged that he had spoken to prison staff about Edmo's behavior and they explained it was "notable for animated affect and no observed distress." He similarly noted that he had personally observed Edmo and did not see significant dysphoria; instead, she "looked pleasant and had a good mood."

As to GCS, Dr. Eliason explained in his notes that while medical necessity for GCS is "not very well defined and is constantly shifting," in his view, GCS would be medically necessary in at least three situations: (1) "congenital malformations or ambiguous genitalia," (2) "severe and devastating dysphoria that is primarily due to genitals," or (3) "some type of medical problem in which endogenous sexual hormones were causing severe physiological damage." Dr. Eliason concluded that Edmo "does not meet any of those . . . criteria" and, for that reason, GCS is not medically necessary for her.

Dr. Eliason instead concluded that hormone therapy and supportive counseling suffice to treat Edmo's gender dysphoria for the time being, despite recognizing that Edmo had attempted self-castration on that regimen. Dr. Eliason

indicated that he would continue to monitor and assess Edmo.

Dr. Eliason staffed Edmo's evaluation with Dr. Jeremy Stoddart, Dr. Murray Young, and Jeremy Clark, who all agreed with his assessment. They did not observe Edmo; rather, they agreed with Dr. Eliason's recommended treatment as he presented it to them. The record is sparse on the qualifications of Dr. Stoddart and Dr. Young, but Clark has never personally treated anyone with gender dysphoria and was not qualified under IDOC policy to assess whether GCS would be appropriate for Edmo.

Dr. Eliason also discussed his evaluation with IDOC's Management and Treatment Committee ("MTC"), a multi-disciplinary team composed of medical providers, mental health clinicians, IDOC's Chief Psychologist, and prison leadership. The MTC meets periodically to evaluate and address the unique medical, mental health, and housing needs of prisoners with gender dysphoria. The committee "does not make any individual treatment decisions regarding" treatment for inmates with gender dysphoria. "Those determinations are made by the individual clinicians or the medical staff employed by Corizon." The MTC agreed with Dr. Eliason's assessment.

Although not mentioned in his April 20, 2016 notes, Dr. Eliason testified at the evidentiary hearing that he considered the WPATH Standards of Care when determining Edmo's treatment. Citing those standards, Dr. Eliason testified that he did not believe GCS was appropriate for two reasons: (1) because mental health issues separate from Edmo's gender dysphoria were not "fully in adequate control" and (2) because Edmo had not lived in her identified gender role for 12 months outside of prison. He explained that Edmo needed to experience

"living as a woman" around "her real social network – her family and friends on the outside" so that she could "determine whether or not she felt like that was her real identity."

Edmo was never evaluated for GCS again, but the MTC considered her gender dysphoria and treatment plan during later meetings. The MTC continues to believe that GCS is not medically necessary or appropriate for Edmo.

In December 2016, Edmo tried to castrate herself for the second time. A medical note from the incident reports that Edmo said she no longer wanted her testicles. Edmo reported to medical providers that she was "feeling angry/frustrated that [she] was not receiving the help desired related to [her] gender dysphoria. Inmate Edmo's actions were reported as a method to stop/cease testosterone production in Edmo's body. Edmo denied suicidal ideation . . . ."

Edmo's second attempt was more successful than the first. She was able to open her testicle sac with a razor blade and remove one testicle. She abandoned her attempt, however, when there was too much blood to continue. She then sought medical assistance and was transported to a hospital, where her testicle was repaired. Edmo was receiving hormone therapy both times she attempted self-castration.

Edmo testified that she was disappointed in herself for coming so close but failing to complete her self-castration attempts. She also testified that she continues to actively think about self-castration. To avoid acting on those thoughts and impulses, Edmo "self-medicat[es]" by cutting her arms with a razor. She says that the physical pain helps

to ease the "emotional torment" and mental anguish her gender dysphoria causes her.

Edmo further testified that she expects GCS to help alleviate some of her gender dysphoria. In particular, she testified that she expects GCS to help her avoid having "as much depression about myself and my physical body. I don't think I will be so anxious that people are always knowing I'm different . . . ." Edmo recognizes, however, that GCS "is not a fix-all": "[i]t's not a magic operation. . . . I'm still going to have to face the same stressors that we all face in everyday life . . . ."

C. Initiation of this Action

Edmo filed a *pro se* complaint on April 6, 2017. She also moved for a temporary restraining order, a preliminary injunction, and the appointment of counsel.

Edmo's motion for appointment of counsel was granted in part, and counsel for Edmo appeared in June and August 2017. Counsel withdrew Edmo's *pro se* motion for preliminary injunction shortly thereafter.

On September 1, 2017, Edmo filed an amended complaint asserting claims under 42 U.S.C. § 1983, the Eighth Amendment, the Fourteenth Amendment, the Americans with Disabilities Act, the Affordable Care Act, and for common law negligence. She named as defendants IDOC, Henry Atencio (Director of IDOC), Jeff Zmuda (Deputy Director of IDOC), Howard Keith Yordy (former Warden of ISCI), Dr. Richard Craig (Chief Psychologist at ISCI), Rona Siegert (Health Services Director at ISCI), Corizon, Dr. Eliason, Dr. Young, and Dr. Catherine Whinnery (Corizon employee).

Through counsel, Edmo filed a renewed motion for a preliminary injunction on June 1, 2018. Among other relief, Edmo sought an order requiring the State to provide her with a referral to a qualified surgeon and access to GCS.

The State moved to extend the time to respond to Edmo's motion. After a status conference, the district court set an evidentiary hearing for October 10, 11, and 12, 2018. The court permitted the parties to undertake four months of extensive fact and expert discovery in preparation for the hearing.

D. The Evidentiary Hearing

At the evidentiary hearing, each side had eight hours to present its case. The district court heard live testimony from seven witnesses over three days. It also considered thousands of pages of exhibits, including Edmo's medical records. With the parties' agreement, the court also permitted the State to submit declarations in lieu of live testimony and permitted Edmo to impeach the declarations with deposition testimony.

At the outset of the hearing, the district court noted that "[w]e're here on a hearing for a temporary injunction," but it explained that "it's hard for me to envision this hearing being anything but a hearing on a final injunction[,] at least as to" the injunctive relief ordering GCS. The court stated that it was unsure whether that made a difference, and it asked the parties to address at some point whether the hearing was for a preliminary injunction or a permanent injunction. Notably, the State did not do so.

The district court heard testimony from three percipient witnesses: Edmo, Dr. Eliason (the Corizon physician), and Jeremy Clark (an IDOC clinician who did not meet IDOC's

criteria to assess Edmo for GCS). Their relevant testimony is largely recounted above.

It also heard testimony from four expert witnesses, two each for Edmo and the State. Dr. Randi Ettner, Ph.D. in psychology, testified first for Edmo. Dr. Ettner is one of the authors of the current (seventh) version of the WPATH Standards of Care. She has been a WPATH member since 1993 and chairs its Institutionalized Persons Committee. Dr. Ettner has authored or edited many peer-reviewed publications on the treatment of gender dysphoria and transgender health care more broadly, including the leading textbook used in medical schools on the subject. She also trains medical and mental health providers on treating people with gender dysphoria. Dr. Ettner has been retained as an expert witness on gender dysphoria and its treatment in many court cases, and she has been appointed as an independent expert by one federal court to evaluate an incarcerated person for GCS.

Dr. Ettner has evaluated, diagnosed, and treated between 2,500 and 3,000 individuals with gender dysphoria. She has referred about 300 people for GCS. She has also refused to recommend surgery for some patients who have requested it. She believes that not everyone who has gender dysphoria needs GCS. Dr. Ettner also has "[e]xtensive experience" treating and providing post-operative care for patients who have undergone GCS.

Dr. Ettner has assessed approximately 30 incarcerated individuals with gender dysphoria for GCS and other medical care, but she has not treated incarcerated patients. She has not worked in a prison and she is not a Certified Correctional Healthcare Professional.

Based on her evaluation of Edmo and a review of Edmo's medical records, Dr. Ettner diagnosed Edmo with gender dysphoria, depressive disorder, anxiety, and suicidal ideation. In Dr. Ettner's opinion, GCS is medically necessary for Edmo and should be immediately performed. She explained that most patients with gender dysphoria do not require GCS, but Edmo requires it because hormone therapy has been inadequate for her and Edmo has attempted to remove her own testicles. Dr. Ettner further explained that GCS would give Edmo congruent genitalia, eliminating the severe distress Edmo experiences due to her male anatomy.

Dr. Ettner further opined that Edmo meets the WPATH criteria for GCS. She explained that Edmo has "persistent and well-documented long-standing gender dysphoria"; Edmo "has no thought disorders and no impaired reality testing"; Edmo is the age of majority in this country; although Edmo has depression and anxiety, those conditions do not "impair her ability to undergo surgery" because they are "as controlled as [they] can be"; Edmo has had six years of hormone therapy; and Edmo has lived for more than one year "as a woman to the best of her ability in a male prison."

More specifically, as to the fourth criterion, Dr. Ettner opined that Edmo does not have mental health concerns that would preclude GCS. She explained that Edmo's depression and anxiety are as "controlled as can be" because Edmo "is taking the maximum amount of medication that controls depression." Dr. Ettner noted that Edmo has complied with taking her prescribed medications and that psychotherapy is not "a precondition for surgery" under the WPATH Standards of Care. She also flagged that Edmo has the capacity to comply with her postsurgical treatment, as evidenced by her compliance with her hormone therapy to date.

As to the clinical significance of Edmo's self-castration attempts and cutting behaviors, Dr. Ettner explained that neither behavior indicates that Edmo has inadequately controlled mental health concerns. Rather, those behaviors indicate "the need for treatment for gender dysphoria." Dr. Ettner explained that

> when an individual who is not psychotic or delusional attempts what we call surgical self-treatment – because we don't regard removal of the testicles or attempted removal of the testicles as either mutilation or self-harm – we regard it as an intentional attempt to remove the target organ that produces testosterone, which, in fact, is the cure for gender dysphoria.

In Dr. Ettner's opinion, Edmo's depression and anxiety "will be attenuated post surgery."

Dr. Ettner opined that Edmo satisfies the sixth criterion because she has lived "as a woman to the best of her ability in a male prison." Dr. Ettner based her opinion on Edmo's "appearance . . . , her disciplinary records, which indicated that she had attempted to wear her hair in a feminine hairstyle and to wear makeup even though that was against the rules and she was – received some sort of disciplinary action for that, and her – the way that she was receiving female undergarments and had developed the stigma of femininity, the secondary sex characteristics, breast development, et cetera."

Dr. Ettner opined that if Edmo does not receive GCS, "[t]he risks would be, as typical in inadequately treated or untreated gender dysphoria, either surgical self-treatment, emotional decompensation, or suicide." Dr. Ettner

explained that Edmo "is at particular risk of suicide given that she has a high degree of suicide ideation." If, on the other hand, Edmo receives surgery, Dr. Ettner opined that

> [i]t would eliminate the gender dysphoria. It would provide a level of wellbeing that she hasn't had previously. It would eliminate 80 percent of the testosterone in her body, necessitating a lower dose of hormones going forward, which would be particularly helpful given that she has elevated liver enzymes. And it would, I believe, eliminate much of the depression and the attendant symptoms that she is experiencing.

Dr. Ryan Gorton, M.D., also testified for Edmo. Dr. Gorton is an emergency medicine physician. He also works pro bono at a clinic serving uninsured patients or those with Medicare or Medicaid. Many of those patients have mental health conditions or have been in prison. He has published peer-reviewed articles on the treatment of gender dysphoria, and he has been qualified as an expert witness in cases involving transgender health care. Dr. Gorton also provides training on transgender health care issues to many groups, is a member of WPATH, and serves on WPATH's Transgender Medicine and Research Committee and its Institutionalized Persons Committee.

Dr. Gorton has been the primary care physician for about 400 patients with gender dysphoria. At the time of the evidentiary hearing, Dr. Gorton was treating approximately 100 patients with gender dysphoria. Dr. Gorton has assessed patients for gender dysphoria, initiated and monitored hormone treatment, referred patients for mental health treatment, and determined the appropriateness of GCS. At

the time of the evidentiary hearing, Dr. Gorton was providing follow-up care for about 30 patients who had vaginoplasty. Dr. Gorton has no experience treating transgender inmates and is not a Certified Correctional Healthcare Professional.

Based on his review of Edmo's medical records and his in-person evaluation of Edmo, Dr. Gorton opined that GCS is medically necessary for Edmo and that she meets the WPATH criteria for GCS. He explained that Edmo has "persistent well-documented gender dysphoria," as shown in her prison medical records; she has the capacity "to make a fully informed decision and to consent for treatment" because "she didn't seem at all impaired in her decision-making capacity"; she is the age of majority; she has depression and anxiety, "but they are not to a level that would preclude her getting [GCS]"; she had 12 consecutive months of hormone therapy; and she has been living in her "target gender role . . . despite an environment that's very hostile to that and some negative consequences that she has experienced because of that."

Dr. Gorton further opined that if Edmo "is not provided surgery, there is a very substantial chance she will try to attempt self-surgery again. And that's especially worrisome given her attempts have been progressive. . . . So I think she might be successful" on her next attempt. He predicted that there is little chance that Edmo's gender dysphoria will improve without surgery. Conversely, Dr. Gorton anticipated that Edmo is unlikely to regret surgery because "her gender dysphoria is very genital-focused" and regret rates among GCS patients are very low.

Dr. Gorton also opined that Edmo's self-castration attempts demonstrate "that she has severe genital-focused gender dysphoria and that she is not getting the medically

necessary treatment to alleviate that." He elaborated that Edmo's depression and anxiety are not driving Edmo's self-castration attempts: "there [are] a lot of people with depression and anxiety who don't remove their testicles."

Finally, Dr. Gorton criticized Dr. Eliason's evaluation of Edmo. He explained that he disagreed with Dr. Eliason's conclusion that Edmo does not need GCS and he also disagreed with the three "criteria" Dr. Eliason gave for when GCS would be necessary. Dr. Gorton criticized Dr. Eliason's first criterion—that GCS could be needed where there is "congenital malformation or ambiguous genitalia"—because that situation "isn't even germane to transgender people"; rather, it relates to "people with intersex conditions." As to the second criterion—that GCS could be needed when a patient is suffering from "severe and devastating gender dysphoria that is primarily due to genitals"—Dr. Gorton pointed out that the WPATH Standards of Care for surgery require only "clear and significant dysphoria." And even applying Dr. Eliason's higher bar, Dr. Gorton explained that Edmo would still qualify for GCS because she has twice attempted self-castration, demonstrating "severe genital-focused dysphoria." Finally, Dr. Gorton characterized Dr. Eliason's third criterion—that GCS could be needed in situations when "endogenous sexual hormones were causing severe physiological damage"—as "bizarre." Dr. Gorton could not conjure "a clinical circumstance where that would be the case that your hormones that your body produces are attacking you . . . . I just don't understand what [Dr. Eliason] is talking about there."

Dr. Keelin Garvey, M.D., testified for the State. Dr. Garvey is a psychiatrist and Certified Correctional Healthcare Professional. As the former Chief Psychiatrist of

the Massachusetts Department of Corrections, Dr. Garvey chaired the Gender Dysphoria Treatment Committee. She directly treated a "couple of patients" with gender dysphoria earlier in her career as Deputy Medical Director, but she has not done so in recent years. Prior to evaluating Edmo, Dr. Garvey had never evaluated a patient in person to determine whether that person needed GCS. Dr. Garvey has never recommended a patient for GCS, and she has not done follow-up care with a person who has received GCS.

Based on her evaluation of Edmo and a review of Edmo's medical records, Dr. Garvey diagnosed Edmo with gender dysphoria, major depressive disorder, alcohol use disorder, stimulant use disorder, and opioid use disorder. She explained that the latter three are in remission.

Relying on the WPATH Standards of Care, Dr. Garvey opined that GCS is not medically necessary for Edmo.[10] Dr. Garvey first explained that Edmo does not meet the first WPATH Standards of Care criterion—"persistent, well documented gender dysphoria"—because of a lack of evidence in pre-incarceration medical records that Edmo presented as female before her time in prison. Dr. Garvey acknowledged, however, that Edmo has been presenting as female since 2012 and that she has been diagnosed with gender dysphoria since that time.

Dr. Garvey then explained that Edmo does not meet the fourth criterion—"medical/mental health concerns must be well controlled"—because Edmo "is actively self-injuring." Dr. Garvey elaborated that "self-injury in any form is never

[10] Dr. Garvey testified that she relies on the WPATH Standards of Care and the NCCHC guidelines adopting those standards when treating inmates with gender dysphoria.

considered a healthy or productive coping mechanism" and that she would like to see Edmo "develop further coping skills that she would be able to use following surgery so that she is not engaging in self-injury after surgery." Dr. Garvey's concern is that GCS is a "stressful undertaking" and Edmo lacks "effective coping strategies" to deal with the stress.

Finally, Dr. Garvey testified that Edmo does not meet the sixth criterion—"12 continuous months of living in a gender role that is congruent with gender identity"—because Edmo has not presented as female outside of prison and "there [are] challenges to using her time in a men's prison as this real-life experience because it doesn't offer her the opportunity to actually experience all those things she is going to go through on the outside."

Dr. Joel Andrade, Ph.D. in social work, also testified for the State. He is a licensed clinical social worker and is a Certified Correctional Healthcare Professional with an emphasis in mental health. Dr. Andrade has over a decade of experience providing and supervising the provision of correctional mental health care, including directing and overseeing the treatment of inmates diagnosed with gender dysphoria in the custody of the Massachusetts Department of Corrections in his roles as clinical director, chair of the Gender Dysphoria Supervision Group, and member of the Gender Dysphoria Treatment Committee.

As a member of the Gender Dysphoria Treatment Committee, Dr. Andrade recommended GCS for two inmates. But the recommendations were contingent on the inmates living in a women's prison for approximately 12 months before the surgery. The Massachusetts Department of Corrections, like IDOC, houses prisoners

according to their genitals, so the inmates had not been moved (nor had their surgery occurred).

Dr. Andrade has never directly treated patients with gender dysphoria, nor has he been a treating clinician for a patient who has had GCS. His "experience with gender dysphoria comes almost exclusively from [his] participation on the Massachusetts Department of Corrections[']s Gender Dysphoria Treatment Committee and Supervision Group." Dr. Andrade did not qualify, under the IDOC gender dysphoria policy in effect at the time of his assessment of Edmo, to assess a person for GCS because he is neither a psychologist nor a physician.

Based on his evaluation of Edmo and a review of her medical records, Dr. Andrade diagnosed Edmo with "major depressive disorder, recurrent, in partial remission," "generalized anxiety disorder," "alcohol use disorder, severe," and gender dysphoria. Dr. Andrade also diagnosed Edmo with borderline personality disorder. The district court did not credit this diagnosis, however, because no other person (including the State's other expert, Dr. Garvey) has ever diagnosed Edmo with borderline personality disorder and Dr. Andrade was unable to identify his criteria for this diagnosis. *Edmo*, 358 F. Supp. 3d at 1120. The record amply supports the district court's finding in this respect.

Dr. Andrade opined that Edmo does not meet the WPATH criteria for GCS. He explained that, based on his review of Edmo's pre-incarceration records, Edmo did not present as female or discuss her gender dysphoria before incarceration. Dr. Andrade testified that he would like to see Edmo live as female outside of a correctional setting before receiving GCS, or, at the least, live in a women's prison first. IDOC, however, houses prisoners according to their genitals. Dr. Andrade also explained that Edmo needs to

work through some of her trauma, particularly sexual abuse that she suffered, and other mental health concerns before receiving surgery. Dr. Andrade opined that Edmo's mental health issues will not be cured by GCS.

At the close of the hearing, the district court reiterated that it was unsure "how we can hear [Edmo's request for GCS] on a preliminary injunction. . . . [I]f I order it, then it's done." The court further suggested that the request for GCS could "only be resolved in a final hearing" and noted that it had, in effect, "treated this hearing as [a] final hearing on the issue."

The court, as it had done at the outset of the hearing, asked the parties to address whether the hearing was for a preliminary or permanent injunction. In response, Edmo contended that the court could order GCS in a preliminary injunction. The State did not address the court's question. It instead contended that the standard for a mandatory injunction—which can be preliminary or permanent—should apply.

E. The District Court's Decision

The district court rendered its decision on December 13, 2018. After recounting the evidence and making extensive factual findings, the district court began its analysis by noting that it was unsure whether the standard for a preliminary injunction or the standard for a permanent injunction applied. The court noted that "the nature of the relief requested in this case, coupled with the extensive evidence presented by the parties over a 3-day evidentiary hearing, [may have] effectively converted these proceedings into a final trial on the merits of the plaintiff's request for permanent injunctive relief." *Edmo*, 358 F. Supp. 3d at 1122 n.1. It also indicated that "both parties appear to have treated

the evidentiary hearing" as a final trial on the merits. *Id.* The district court explained that the difference was immaterial, however, because Edmo was entitled to relief under either standard. *Id.*

On the merits, the district court concluded that Edmo had established her Eighth Amendment claim. The district court first held that Edmo suffers from gender dysphoria, which is undisputedly "a serious medical condition." *Id.* at 1124.

It then concluded that GCS is medically necessary to treat Edmo's gender dysphoria. *See id.* at 1124–26. In a carefully considered, 45-page opinion, the district court specifically found "credible the testimony of Plaintiff's experts Drs. Ettner and Gorton, who have extensive personal experience treating individuals with gender dysphoria both before and after receiving gender confirmation surgery," and who opined that GCS was medically necessary. *Id.* at 1125. The court rejected the contrary opinions of the State's experts because "neither Dr. Garvey nor Dr. Andrade has any direct experience with patients receiving gender confirmation surgery or assessing patients for the medical necessity of gender confirmation surgery," and neither of the State's experts had meaningful "experience treating patients with gender dysphoria other than assessing them for the existence of the condition." *Id.* The district court also noted that the State's "experts appear to misrepresent the WPATH Standards of Care by concluding that Ms. Edmo, despite presenting as female since her incarceration in 2012, cannot satisfy the WPATH criteria because she has not presented as female outside of the prison setting." *Id.* As the district court noted, "there is no requirement in the WPATH Standards of Care that a patient live for twelve months in his or her gender role outside of prison before becoming eligible for" GCS. *Id.* (quotation omitted).

Finally, the district court explained that the State was deliberately indifferent to Edmo's gender dysphoria because it "fail[ed] to provide her with available treatment that is generally accepted in the field as safe and effective, despite her actual harm and ongoing risk of future harm including self-castration attempts, cutting, and suicidal ideation." *Id.* at 1126–27. The district court also stated that the evidence "suggest[ed] that Ms. Edmo has not been provided gender confirmation surgery because Corizon and IDOC have a *de facto* policy or practice of refusing this treatment for gender dysphoria to prisoners," which amounts to deliberate indifference. *Id.* at 1127.

After analyzing the merits, the district court concluded that Edmo satisfied the other prerequisites to injunctive relief. *Id.* at 1127–28. The district court found that, given Edmo's continuing emotional distress and self-castration attempts, "Edmo is at serious risk of life-threatening self-harm" if she does not receive GCS. *Id.* at 1128. The State, on the other hand, had not shown that it would be harmed if ordered to provide GCS, so the equities favored Edmo. *Id.*

Having concluded that Edmo was entitled to an injunction, the court ordered the State "to provide Plaintiff with adequate medical care, including gender confirmation surgery." *Id.* at 1129. It ordered the State to "take all actions reasonably necessary to provide Ms. Edmo gender confirmation surgery as promptly as possible and no later than six months from the date of this order." *Id.*

F. Appellate Proceedings

The State filed timely notices of appeal on January 9, 2019. It also asked the district court to stay its order pending appeal. The district court denied the State's motion on March 4.

The State then filed in this court a motion to stay pending appeal. A motions panel granted that motion. Edmo subsequently moved to amend the stay to allow her to undergo a previously scheduled pre-surgery consultation. The motions panel granted that motion and amended the stay.

On April 3, the State filed an "urgent motion" to dismiss this appeal as moot. We indicated on April 5 that our court would consider that motion with the merits, not on an urgent basis.

After hearing oral argument on May 16, we ordered a limited remand to the district court to clarify three points. Relevant here, we asked the district court to clarify whether it granted Edmo a permanent injunction in its December 13, 2018 order. The district court clarified that it "granted permanent injunctive relief." *Edmo v. Idaho Dep't of Corr.*, No. 1:17-CV-00151-BLW, 2019 WL 2319527, at *2 (D. Idaho May 31, 2019). We also asked the district court to clarify whether it had concluded that Edmo had succeeded on the merits of her Eighth Amendment claim. The district court responded that it had. *Id.*

Having received the district court's response to our limited remand order, we proceed to the issues on appeal. The State challenges the district court's grant of injunctive relief to Edmo on multiple grounds. It contends that this appeal is moot because the injunction did not comply with the PLRA and has, for that reason, automatically expired. It contends that the decision not to provide GCS to Edmo reflects a difference of prudent medical opinion and cannot support an Eighth Amendment claim. It contends that Edmo will not be irreparably harmed absent an injunction. It contends that the injunction is overbroad. Finally, it contends that, to the extent the district court converted the

evidentiary hearing into a final trial on the merits of Edmo's request for GCS, it was provided inadequate notice and the court violated its right to a jury trial.

II. Mootness

"We first address, as we must, the question of mootness . . . ." *Shell Offshore Inc. v. Greenpeace, Inc.*, 815 F.3d 623, 628 (9th Cir. 2016). An appeal is moot "[w]hen events change such that the appellate court can no longer grant 'any effectual relief whatever to the prevailing party.'" *Id.* (quoting *City of Erie v. Pap's A.M.*, 529 U.S. 277, 287 (2000)). In those circumstances, we "lack[] jurisdiction and must dismiss the appeal." *Id.*

The State contends that the injunction does not comply with provisions of the PLRA and, for that reason, has automatically expired under the terms of the statute. Relevant here, the PLRA provides that a

> court shall not grant or approve any prospective relief unless the court finds that such relief is narrowly drawn, extends no further than necessary to correct the violation of the Federal right, and is the least intrusive means necessary to correct the violation of the Federal right. The court shall give substantial weight to any adverse impact on public safety or the operation of a criminal justice system caused by the relief.

18 U.S.C. § 3626(a)(1)(A). Courts often refer to this provision as the "need-narrowness-intrusiveness" inquiry. *Graves v. Arpaio*, 623 F.3d 1043, 1048 n.1 (9th Cir. 2010) (per curiam) (quoting *Pierce v. County of Orange*, 526 F.3d 1190, 1205 (9th Cir. 2008)). The PLRA further provides that

any "[p]reliminary injunctive relief shall automatically expire on the date that is 90 days after its entry, unless the court makes the findings required under subsection (a)(1) [quoted above] for the entry of prospective relief and makes the order final before the expiration of the 90-day period." 18 U.S.C. § 3626(a)(2).

The State contends that the district court did not make the PLRA's requisite need-narrowness-intrusiveness findings or make its order final within 90 days, causing the injunction to expire under 18 U.S.C. § 3626(a)(2). Generally, the expiration of an injunction challenged on appeal moots the appeal. *See Kitlutsisti v. ARCO Alaska, Inc.*, 782 F.2d 800, 801 (9th Cir. 1986); *see also United States v. Sec'y, Fla. Dep't of Corr.*, 778 F.3d 1223, 1228–29 (11th Cir. 2015). The State asserts separate, albeit overlapping, contentions in their motion to dismiss this appeal and in their briefing. We reject those arguments.

A. Need-Narrowness-Intrusiveness Findings

The State first contends that the district court did not make the PLRA's need-narrowness-intrusiveness findings, causing the injunction to automatically expire and mooting this appeal.[11] As we have explained in prior decisions, the PLRA "has not substantially changed the threshold findings and standards required to justify an injunction." *Gomez v. Vernon*, 255 F.3d 1118, 1129 (9th Cir. 2001). When "determining the appropriateness of the relief ordered," appellate "courts must do what they have always done":

[11] We question whether the State's need-narrowness-intrusiveness challenge, properly understood, implicates mootness. But because the result is the same, we accept the State's framing for purposes of our analysis.

"consider the order as a whole." *Armstrong v. Schwarzenegger*, 622 F.3d 1058, 1070 (9th Cir. 2010). District courts must make need-narrowness-intrusiveness "findings sufficient to allow a 'clear understanding' of the ruling," but they need not "make such findings on a paragraph by paragraph, or even sentence by sentence, basis." *Id.* (quotation omitted). "What is important, and what the PLRA requires, is a finding that the set of reforms being ordered—the 'relief'—corrects the violations of prisoners' rights with the minimal impact possible on defendants' discretion over their policies and procedures." *Id.*

Here, the district court made the necessary need-narrowness-intrusiveness findings. At the start of its December 13, 2018 order, the district court explained that any injunction must meet the PLRA's need-narrowness-intrusiveness requirement. *See Edmo*, 358 F. Supp. 3d at 1122. The district court then explained how the relief being ordered, GCS, "corrects the violations of" Edmo's rights. *See Armstrong*, 622 F.3d at 1071. Specifically, the district court explained that GCS is medically necessary to alleviate Edmo's gender dysphoria and that the State's denial of GCS amounts to deliberate indifference in violation of the Eighth Amendment. *See Edmo*, 358 F. Supp. 3d at 1116–21, 1123–27, 1129. The district court limited the relief ordered to have "the minimal impact possible on [the State's] discretion over their policies and procedures." *See Armstrong*, 622 F.3d at 1071. Specifically, the district court limited the relief to "actions reasonably necessary" to provide GCS, cautioned that its conclusion is based on "the unique facts and circumstances presented" by Edmo, and noted that its "decision is not intended, and should not be construed, as a general finding that all inmates suffering from gender dysphoria are entitled to [GCS]." *Edmo*, 358 F. Supp. 3d at

1110, 1129. Finally, the district court rejected the notion that injunctive relief would have "any adverse impact on public safety or the operation of a criminal justice system." 18 U.S.C. § 3626(a)(1)(A). It explained that the State had "made no showing that an order requiring them to provide" GCS to Edmo "causes them injury." *Edmo*, 358 F. Supp. 3d at 1128. The district court's order, considered as a whole, made all the findings required by 18 U.S.C. § 3626(a)(1)(A) and our precedent. *See Armstrong*, 622 F.3d at 1070.

B. Finality

The State next argues that the injunction has automatically expired under the PLRA because the district court did not make its order "final" within 90 days of entering injunctive relief. *See* 18 U.S.C. § 3626(a)(2); *see also Sec'y, Fla. Dep't of Corr.*, 778 F.3d at 1228–29 (holding that an appeal of a preliminary injunction was moot because the district court "did not issue an order finalizing its [preliminary-injunction] order," and "[a]s a result, the preliminary injunction expired by operation of law" 90 days later). The PLRA provision cited by the State applies to preliminary injunctive relief, not permanent injunctive relief. *See* 18 U.S.C. § 3626(a)(2). The permanent injunction that the district court entered has not expired. *See Edmo*, 358 F. Supp. 3d at 1122 n.1 (concluding that Edmo is "entitled to relief" under the permanent injunction standard); *see also Edmo*, 2019 WL 2319527, at *2 (clarifying on limited remand that the district court granted Edmo a permanent injunction). It remains in place, albeit stayed.

There is a live controversy on appeal.[12] We accordingly **DENY** the State's motion to dismiss and proceed to the merits of the appeal.

III. Challenges to the District Court's Grant of Injunctive Relief

An injunction is an "extraordinary remedy never awarded as of right." *Winter v. Nat. Res. Def. Council, Inc.*, 555 U.S. 7, 24 (2008). "To be entitled to a permanent injunction, a plaintiff must demonstrate: (1) actual success on the merits; (2) that it has suffered an irreparable injury; (3) that remedies available at law are inadequate; (4) that the balance of hardships justify a remedy in equity; and (5) that the public interest would not be disserved by a permanent injunction."[13] *Indep. Training & Apprenticeship Program*

[12] Even construed as a preliminary injunction, the district court's December 13, 2018 order is not moot. On May 31, 2019, the district court, incorporating its previous findings, renewed the injunction. *See Edmo*, 2019 WL 2319527, at *2. Because the district court renewed the injunction, we can consider its merits. *See Mayweathers v. Newland*, 258 F.3d 930, 935–36 (9th Cir. 2001) (holding that district courts may renew preliminary injunctions under the PLRA while an appeal is pending, and considering the merits of the renewed injunction). And we have jurisdiction under 28 U.S.C. § 1292(a)(1) regardless of whether the district court's order is considered a preliminary or permanent injunction. *See Hendricks v. Bank of Am., N.A.*, 408 F.3d 1127, 1131 (9th Cir. 2005) (preliminary injunction); *TransWorld Airlines, Inc. v. Am. Coupon Exch., Inc.*, 913 F.2d 676, 680–81 (9th Cir. 1990) (permanent injunction where the "district court retained jurisdiction to determine damages" and to adjudicate a separate claim).

[13] We agree with the State that the injunction is mandatory, as opposed to prohibitory, because it requires the State to act. Based on that distinction, the State argues that Edmo must satisfy a higher burden of

v. Cal. Dep't of Indus. Relations, 730 F.3d 1024, 1032 (9th Cir. 2013) (citing *eBay Inc. v. MercExch., L.L.C.*, 547 U.S. 388, 391 (2006)).

We review for abuse of discretion the district court's decision to grant a permanent injunction. *Ariz. Dream Act Coal. v. Brewer*, 855 F.3d 957, 965 (9th Cir. 2017). We

---

proof to be entitled to injunctive relief, and that the district court failed to hold Edmo to that burden. On that point, we disagree.

The State errs by relying on cases that concern mandatory *preliminary* injunctions. Because mandatory preliminary injunctions go "well beyond simply maintaining the status quo [p]endente lite," they are "particularly disfavored" and "are not issued in doubtful cases." *Marlyn Nutraceuticals, Inc. v. Mucos Pharma GmbH & Co.*, 571 F.3d 873, 879 (9th Cir. 2009) (alteration in original) (quoting *Anderson v. United States*, 612 F.2d 1112, 1114–15 (9th Cir. 1980)). The calculus is different in the context of permanent injunctions. A plaintiff must show actual success on the merits, *see Amoco Prod. Co. v. Village of Gambell*, 480 U.S. 531, 546 n.12 (1987), so there is no concern that a mandatory permanent injunction will upset the status quo only for a later trial on the merits to show that the plaintiff was not entitled to equitable relief. As a result, a plaintiff need not show that "extreme or very serious damage will result," as is required for mandatory preliminary injunctions.

As we have explained, the district court granted Edmo injunctive relief under both the preliminary and permanent injunction standards. *See Edmo*, 358 F. Supp. 3d at 1122 n.1; *see also Edmo*, 2019 WL 2319527, at *2. Because the standard for granting permanent injunctive relief is higher (in that it requires actual success on the merits) and the State contends in its opening brief that we should review the injunction as a permanent injunction, we consider whether the district court erred in granting Edmo permanent injunctive relief. But we would also affirm under the mandatory preliminary injunction standard, because the district court correctly applied the proper standard for mandatory preliminary injunctive relief, and not the lower standard for prohibitory preliminary injunctions. *See Edmo*, 358 F. Supp. 3d at 1122, 1128.

review "any determination underlying the grant of an injunction by the standard that applies to that determination." *Ting v. AT&T*, 319 F.3d 1126, 1134–35 (9th Cir. 2003). Accordingly, the district court's factual findings on Edmo's Eighth Amendment claim are reviewed for clear error. *See Graves*, 623 F.3d at 1048. Clear error exists if the finding is "illogical, implausible, or without support in inferences that may be drawn from the facts in the record." *La Quinta Worldwide LLC v. Q.R.T.M., S.A. de C.V.*, 762 F.3d 867, 879 (9th Cir. 2014) (quoting *Herb Reed Enters., LLC v. Florida Entm't Mgmt., Inc.*, 736 F.3d 1239, 1247 (9th Cir. 2013)). We review de novo the district court's "conclusion that the facts . . . demonstrate an Eighth Amendment violation." *Hallett v. Morgan*, 296 F.3d 732, 744 (9th Cir. 2002).

The State contends that the district court erred in granting an injunction because (1) Edmo's Eighth Amendment claim fails and (2) Edmo has not shown that she will suffer irreparable injury in the absence of an injunction.[14] We disagree. We hold, based on the district court's factual findings, that Edmo established her Eighth Amendment claim and that she will suffer irreparable harm—in the form of ongoing mental anguish and possible physical harm—if GCS is not provided.

A. The Merits of Edmo's Eighth Amendment Claim

"[D]eliberate indifference to serious medical needs of prisoners" violates the Eighth Amendment. *Estelle*, 429 U.S. at 104. Because "society takes from prisoners the means to provide for their own needs," *Brown*, 563 U.S.

[14] Because the State does not contest the other injunction factors, we do not address them.

at 510, the government has an "obligation to provide medical care for those whom it is punishing by incarceration," *Estelle*, 429 U.S. at 103.

To establish a claim of inadequate medical care, a prisoner must first "show a 'serious medical need' by demonstrating that 'failure to treat a prisoner's condition could result in further significant injury or the 'unnecessary and wanton infliction of pain.'" *Jett v. Penner*, 439 F.3d 1091, 1096 (9th Cir. 2006) (quoting *McGuckin v. Smith*, 974 F.2d 1050, 1059 (9th Cir. 1991), *overruled on other grounds by WMX Techs., Inc. v. Miller*, 104 F.3d 1133 (9th Cir. 1997) (en banc)). Serious medical needs can relate to "physical, dental and mental health." *Hoptowit v. Ray*, 682 F.2d 1237, 1253 (9th Cir. 1982), *abrogated on other grounds by Sandin v. Conner*, 515 U.S. 472 (1995).

The State does not dispute that Edmo's gender dysphoria is a sufficiently serious medical need to trigger the State's obligations under the Eighth Amendment. Nor could it. Gender dysphoria is a "serious . . . medical condition" that causes "clinically significant distress"—distress that impairs or severely limits an individual's ability to function in a meaningful way. DSM-5 at 453, 458. As Edmo testified, her gender dysphoria causes her to feel "depressed," "disgusting," "tormented," and "hopeless," and it has caused past efforts and active thoughts of self-castration. As this and many other courts have recognized, Edmo's gender dysphoria is a sufficiently serious medical need to implicate the Eighth Amendment. *See Rosati v. Igbinoso*, 791 F.3d 1037, 1039–40 (9th Cir. 2015); *Kosilek*, 774 F.3d at 86; *De'lonta*, 708 F.3d at 525; *Battista v. Clarke*, 645 F.3d 449, 452 (1st Cir. 2011); *Allard v. Gomez*, 9 F. App'x 793, 794 (9th Cir. 2001); *White v. Farrier*, 849 F.2d 322, 325 (8th Cir. 1988); *Meriwether v. Faulkner*, 821 F.2d 408, 412 (7th Cir.

1987) (and cases cited therein); *Norsworthy*, 87 F. Supp. 3d at 1187; *Konitzer v. Frank*, 711 F. Supp. 2d 874, 905 (E.D. Wis. 2010).

If, as here, a prisoner establishes a sufficiently serious medical need, that prisoner must then "show the [official's] response to the need was deliberately indifferent." *Jett*, 439 F.3d at 1096. An inadvertent or negligent failure to provide adequate medical care is insufficient to establish a claim under the Eighth Amendment. *Estelle*, 429 U.S. at 105–06; *see also Farmer v. Brennan*, 511 U.S. 825, 835 (1994) ("ordinary lack of due care" is insufficient to establish an Eighth Amendment claim). In other words, "[m]edical malpractice does not become a constitutional violation merely because the victim is a prisoner." *Estelle*, 429 U.S. at 106. To "show deliberate indifference, the plaintiff must show that the course of treatment the [official] chose was medically unacceptable under the circumstances and that the [official] chose this course in conscious disregard of an excessive risk to the plaintiff's health." *Hamby v. Hammond*, 821 F.3d 1085, 1092 (9th Cir. 2016) (quoting *Snow v. McDaniel*, 681 F.3d 978, 988 (9th Cir. 2012), *overruled in part on other grounds by Peralta v. Dillard*, 744 F.3d 1076 (9th Cir. 2014) (en banc)).

1. The Medical Necessity of GCS for Edmo

The crux of the State's appeal is that it provided adequate and medically acceptable care to Edmo.

Accepted standards of care and practice within the medical community are highly relevant in determining what care is medically acceptable and unacceptable. *See Allard v. Baldwin*, 779 F.3d 768, 772 (8th Cir. 2015); *Henderson v. Ghosh*, 755 F.3d 559, 566 (7th Cir. 2014) (per curiam). Typically, "[a] difference of opinion between a physician

and the prisoner—or between medical professionals—concerning what medical care is appropriate does not amount to deliberate indifference." *Snow*, 681 F.3d at 987; *see also Gibson*, 920 F.3d at 220. But that is true only if the dueling opinions are medically acceptable under the circumstances. *See Toguchi v. Chung*, 391 F.3d 1051, 1058 (9th Cir. 2004) (a mere "difference of medical opinion . . . [is] insufficient, as a matter of law, to establish deliberate indifference," but not if the "chosen course of treatment 'was medically unacceptable under the circumstances'" (alterations in original) (quoting *Jackson v. McIntosh*, 90 F.3d 330, 332 (9th Cir. 1996))).

"In deciding whether there has been deliberate indifference to an inmate's serious medical needs, we need not defer to the judgment of prison doctors or administrators." *Hunt v. Dental Dep't*, 865 F.2d 198, 200 (9th Cir. 1989). Nor does it suffice for "correctional administrators wishing to avoid treatment . . . simply to find a single practitioner willing to attest that some well-accepted treatment is not necessary." *Kosilek*, 774 F.3d at 90 n.12. In the final analysis under the Eighth Amendment, we must determine, considering the record, the judgments of prison medical officials, and the views of prudent professionals in the field, whether the treatment decision of responsible prison authorities was medically acceptable.

Reviewing the record and the district court's extensive factual findings, we conclude that Edmo has established that the "course of treatment" chosen to alleviate her gender dysphoria "was medically unacceptable under the circumstances." *Hamby*, 821 F.3d at 1092 (quoting *Snow*, 681 F.3d at 988). This conclusion derives from the district court's factual findings, which are not "illogical, implausible, or without support in inferences that may be

drawn from the facts in the record." *La Quinta Worldwide LLC*, 762 F.3d at 879 (quotation omitted).

In particular, and as we will explain, this is not a case of dueling experts, as the State paints it. The district court permissibly credited the opinions of Edmo's experts that GCS is medically necessary to treat Edmo's gender dysphoria and that the State's failure to provide that treatment is medically unacceptable. Edmo's experts are well-qualified to render such opinions, and they logically and persuasively explained the necessity of GCS and applied the WPATH Standards of Care—the undisputed starting point in determining the appropriate treatment for gender dysphoric individuals. On the other side of the coin, the district court permissibly discredited the contrary opinions of the State's treating physician and medical experts. Those individuals lacked expertise and incredibly applied (or did not apply, in the case of the State's treating physician) the WPATH Standards of Care. In other words, the district court did not clearly err in making its credibility determinations, so it is not our role to reevaluate them. The credited testimony establishes that GCS is medically necessary.

a. Expert Testimony

Turning first to the expert testimony offered, the district court credited the testimony of Edmo's experts that GCS is medically necessary to treat Edmo's gender dysphoria and that the State's failure to provide that treatment is medically unacceptable. *See Edmo*, 358 F. Supp. 3d at 1120–21, 1125. Dr. Ettner and Dr. Gorton opined that GCS is medically necessary because Edmo's current treatment has been inadequate, as evidenced by her self-castration attempts. They also opined that if Edmo does not receive GCS, there is little chance that her gender dysphoria will improve and she is at risk of committing self-surgery again, suicide, and

further emotional decompensation. On the other hand, providing GCS to Edmo would, in the opinions of Dr. Ettner and Dr. Gorton, align Edmo's genitalia with her gender identity, thereby eliminating the severe distress Edmo experiences from her male genitalia.

In sharp contrast, the district court gave "virtually no weight" to the opinions of the State's experts. *Edmo*, 358 F. Supp. 3d at 1126. Dr. Garvey and Dr. Andrade, who purported to rely on the WPATH Standards of Care, opined that GCS is not medically necessary for Edmo.

The district court did not err in crediting the testimony of Edmo's experts and discounting the testimony of the State's experts. Dr. Ettner and Dr. Gorton are well-qualified to opine on the medical necessity of GCS. Both have substantial experience treating individuals with gender dysphoria. Dr. Ettner has evaluated, diagnosed, and treated between 2,500 and 3,000 individuals with gender dysphoria, while Dr. Gorton has been the primary care physician for approximately 400 patients with gender dysphoria. Both have substantial experience evaluating whether GCS is medically necessary for patients. Dr. Ettner has evaluated hundreds of people for GCS, referring approximately 300 while refusing others, and Dr. Gorton routinely determines the appropriateness of GCS for patients. They also have experience providing follow-up care for patients who have undergone GCS. And both have published peer-reviewed articles concerning the treatment of gender dysphoria.

The State's experts, by contrast, have substantial experience providing health care in institutional settings, but lack meaningful experience directly treating people with gender dysphoria. Dr. Garvey directly treated a "couple of patients" with gender dysphoria early in her career, while Dr. Andrade has never provided direct treatment for patients

with gender dysphoria. Moreover, prior to evaluating Edmo, neither had ever evaluated someone in person to determine the medical necessity of GCS. Relatedly, Dr. Garvey and Dr. Andrade have never provided follow-up care for a person who has received GCS. Indeed, Dr. Andrade did not even qualify under IDOC policy to assess a person for GCS. And neither Dr. Garvey nor Dr. Andrade has published a peer-reviewed article concerning the treatment of gender dysphoria.

Neither Dr. Ettner nor Dr. Gorton have treated prisoners with gender dysphoria, nor are they Certified Correctional Healthcare Professionals. But both serve on WPATH's Institutionalized Persons Committee, which "looks at the care and the assessment of individuals who are incarcerated and develops standards for treatment" of such individuals. They are thus familiar with medical treatment in prison settings. Moreover, Dr. Ettner has assessed approximately 30 incarcerated persons with gender dysphoria for GCS and other medical care.

More to the point, the more relevant experience for determining the medical necessity of GCS is having treated individuals with gender dysphoria, having evaluated individuals for GCS, and having treated them post-operatively. Such experience lends itself to fundamental knowledge of whether GCS is necessary and the potential risks of providing or foregoing the surgery. Edmo's experts have the requisite experience; the State's experts do not. For that reason alone, the district court did not clearly err in crediting the opinions of Edmo's experts over those of the State.[15] *See Caro v. Woodford*, 280 F.3d 1247, 1253 (9th

[15] The State contends that neither Dr. Ettner nor Dr. Gorton was qualified to offer expert opinions as to the appropriate medical care for

Cir. 2002) (explaining that we "must afford the District Court considerable deference in its determination that the witnesses were qualified to draw [their] conclusions").

Independent of the experts' qualifications, the district court did not err in crediting the opinions of Edmo's experts over those of the State because aspects of Dr. Garvey's and Dr. Andrade's opinions ran contrary to the established standards of care in the area of transgender health care—the WPATH Standards of Care—which they purported to apply.[16] *See Edmo*, 358 F. Supp. 3d at 1125.

Edmo because neither is a psychiatrist. So far as we can discern, the argument is that because a psychiatrist (Dr. Eliason) evaluated Edmo for GCS, only other psychiatrists are qualified to opine as to the medical necessity of GCS and to contradict his assessment. *See* Oral Arg. at 10:00–10:30. We reject that contention. Edmo's experts, as explained, have significant experience evaluating patients for GCS—precisely what Dr. Eliason did. On the basis of their medical experience treating persons with gender dysphoria, they are well-qualified to render an opinion on the medical necessity of GCS and whether failure to provide the surgery is medically acceptable. *See* Fed. R. Evid. 702.

[16] The State contends that the district court erred in requiring strict adherence to the flexible WPATH Standards of Care and in concluding that any deviation from those standards is medically unacceptable. But the district court correctly recognized that the WPATH Standards of Care are flexible, *see Edmo*, 358 F. Supp. 3d at 1111, and it appropriately used them as a starting point to gauge the credibility of each expert's testimony, *see id.* at 1125–26. Tellingly, each expert for Edmo and the State likewise used the WPATH Standards of Care as a starting point. As the district court recognized: "There are no other competing, evidence-based standards that are accepted by any nationally or internationally recognized medical professional groups." *Id.* at 1125. And as the State acknowledged at the evidentiary hearing, the "WPATH standards of care in the seventh edition do provide the best guidance" and "are the best standards out there." For these reasons, the WPATH Standards of Care establish a useful starting point for analyzing the

For example, both Dr. Garvey and Dr. Andrade expressed the view that Edmo does not meet the sixth WPATH criterion, "12 continuous months of living in a gender role that is congruent with gender identity." WPATH SOC at 60. They pointed out that Edmo has not presented as female outside of prison and urged that she needs real-life experiences in the community before undergoing GCS.

These opinions run head-on into the WPATH Standards of Care. The WPATH standards, which the NCCHC endorses as the accepted standards for the treatment of transgender inmates, apply

> in their entirety . . . to all transsexual, transgender, and gender nonconforming people, irrespective of their housing situation. People should not be discriminated against in their access to appropriate health care based on where they live, including institutional environments such as prisons . . . . Health care for transsexual, transgender, and gender nonconforming people living in an institutional environment should mirror that which would be available to them if they were living in a non-institutional setting within the same community.

credibility and weight to be given to each expert's opinion and whether that opinion was consistent with established standards of care. The State does not contest the district court's finding that the WPATH Standards of Care are the "internationally recognized guidelines for the treatment of individuals with gender dysphoria." *Id.* at 1111. They are the gold standard on this issue.

> All elements of assessment and treatment as described in the [Standards of Care] can be provided to people living in institutions. Access to these medically necessary treatments should not be denied on the basis of institutionalization or housing arrangements.

WPATH SOC at 67. Dr. Garvey and Dr. Andrade's view—that GCS cannot be medically indicated for transgender inmates who did not present in a gender-congruent manner before incarceration—contradicts these accepted standards. Dr. Garvey and Dr. Andrade would deny GCS to a class of people because of their "institutionalization," which the WPATH Standards of Care explicitly disavow. They provide no persuasive explanation for their deviation.[17] And nothing in the WPATH Standards of Care or the law supports excluding an entire class of gender dysphoric individuals from eligibility for GCS.

Both Dr. Garvey and Dr. Andrade also relied on Edmo's failure to attend psychotherapy sessions as an indication that her mental health concerns are not well controlled. But psychotherapy is not a precondition for surgery under the WPATH Standards of Care. WPATH SOC at 28–29.

We acknowledge that the WPATH Standards of Care are flexible, and a simple deviation from those standards does not alone establish an Eighth Amendment claim. But the

[17] In concluding that Edmo does not meet the sixth WPATH criterion, Dr. Garvey expressed concern that there is a lack of evidence regarding GCS in prison settings. That rationale acts as self-fulfilling prophecy. If prisons and prison officials deny GCS to prisoners because of a lack of data, the data will never be generated, and the cycle will continue.

State's experts purported to be applying those standards and yet did so in a way that directly contradicted them. These unsupported and unexplained deviations offer a further reason why the district court did not clearly err in discounting the testimony of the State's experts. *See Caro*, 280 F.3d at 1253.

Finally, the district court did not err in discrediting the State's experts because aspects of their opinions were illogical and unpersuasive. For example, Dr. Garvey and Dr. Andrade expressed the view that Edmo does not meet the first WPATH criterion—"persistent, well documented gender dysphoria," WPATH SOC at 60—because of a lack of evidence from pre-incarceration records of Edmo presenting as female. But both experts acknowledged that Edmo has been diagnosed with and treated for gender dysphoria since 2012—*i.e.*, for six years as of the evidentiary hearing. Neither Dr. Garvey nor Dr. Andrade questioned Edmo's diagnosis, and both agree that she currently suffers gender dysphoria. There can be no doubt that Edmo has "persistent, well documented gender dysphoria," so their opinion is inexplicable.

Dr. Garvey's and Dr. Andrade's opinions on this point also ignore that individuals with gender dysphoria do not always experience symptoms early in life or throughout their life, or do not identify them as such. As Dr. Ettner testified, "gender dysphoria intensifies with age." And as with treatment for any other medical condition, treatment for gender dysphoria must be based on a patient's current situation.

The opinions of Edmo's experts are notably devoid of these flaws. Dr. Ettner and Dr. Gorton cogently and persuasively explained why GCS is medically necessary for Edmo and why Edmo meets the WPATH criteria for GCS.

For example, consistent with the WPATH Standards of Care, Dr. Ettner explained that Edmo has lived for "12 continuous months . . . in a gender role that is congruent with gender identity" (the sixth WPATH criterion) because she has lived "as a woman to the best of her ability in a male prison." In support of her opinion, Dr. Ettner cited Edmo's "appearance . . . , her disciplinary records, which indicated that she had attempted to wear her hair in a feminine hairstyle and to wear makeup even though that was against the rules and she was – received some sort of disciplinary action for that, and her – the way that she was receiving female undergarments and had developed the stigma of femininity, the secondary sex characteristics, breast development, et cetera." Dr. Gorton similarly explained that Edmo satisfies the sixth WPATH criterion because she has lived for years in her "target gender role . . . despite an environment that's very hostile to that and some negative consequences that she has experienced because of that."

Moreover, both Dr. Ettner and Dr. Gorton offered reasoned explanations tying Edmo's self-castration attempts to her severe gender dysphoria. Dr. Ettner explained that doctors regard "surgical self-treatment . . . as an intentional attempt to remove the target organ that produces testosterone, which, in fact, is the cure for gender dysphoria." As Dr. Gorton elaborated, Edmo's self-castration attempts demonstrate deficient treatment for "severe genital-focused gender dysphoria." He rejected the notion that Edmo's depression and anxiety drove her self-castration attempts: "there [are] a lot of people with depression and anxiety who don't remove their testicles."

In light of the experts' backgrounds and experience, and the reasonableness, consistency, and persuasiveness of their opinions, the district court did not err in crediting the

opinions of Edmo's experts and giving little weight to those of the State's experts. The district court carefully examined the voluminous record, extensive testimony, and conflicting expert opinions in this case and set forth clear reasons, supported by the record, for relying on the testimony of Edmo's experts. *See La Quinta Worldwide*, 762 F.3d at 879 (a factual finding is clear error if it is "illogical, implausible, or without support in inferences that may be drawn from the facts in the record"); *Caro*, 280 F.3d at 1253; *Beech Aircraft Corp. v. United States*, 51 F.3d 834, 838 (9th Cir. 1995) (per curiam). The credited expert testimony established that GCS is medically necessary to alleviate Edmo's gender dysphoria.

b. Dr. Eliason's Assessment

Turning from the expert testimony offered, the State contends that Edmo's experts, at most, created a dispute of professional judgment with Edmo's treating psychiatrist, Dr. Eliason, who it urges reasonably concluded that GCS is inappropriate for Edmo. If that is the case, the argument goes, then Edmo's Eighth Amendment claim fails because the dispute is merely a "difference of opinion . . . between medical professionals" about "what medical care is appropriate." *Snow*, 681 F.3d at 987. The problem for the State is that Dr. Eliason's decision "was medically unacceptable under the circumstances." *Toguchi*, 391 F.3d at 1058 (quoting *Jackson*, 90 F.3d at 332).

In particular, as the district court found, Dr. Eliason did not follow accepted standards of care in the area of transgender health care. *See Edmo*, 358 F. Supp. 3d at 1126. Dr. Eliason explained in his notes that, in his view, GCS is medically necessary in three situations: "congenital malformation or ambiguous genitalia," "severe and devastating dysphoria that is primarily due to genitals," or "some type of medical problem in which endogenous sexual

hormones were causing severe physiological damage." The conclusion of his notes—"[t]his inmate does not meet any of those [three] criteria"—suggests that he views those as the *only* three scenarios in which GCS would be medically necessary, an impression he did not dispel during his testimony. Those "criteria" (Dr. Eliason's term), however, bear little resemblance to the widely accepted, evidence-based criteria set out in the WPATH's Standards of Care. As Dr. Eliason acknowledged, the NCCHC endorses the WPATH Standards of Care as the accepted standards for the treatment of transgender prisoners. And as the district court found and the State does not contest, "[t]here are no other competing, evidence-based standards that are accepted by any nationally or internationally recognized medical professional groups." *Id.* at 1125. Dr. Eliason did not follow these standards in rendering his decision.

The State challenges the district court's finding that Dr. Eliason "did not apply the WPATH Criteria," *id.* at 1126, on two grounds. First, citing Dr. Eliason's testimony at the evidentiary hearing, it urges that Dr. Eliason concluded that GCS was not medically necessary for Edmo because Edmo's mental health issues were not well controlled (the fourth WPATH criterion) and she had not consistently presented as female outside of prison (the sixth).

The district court's rejection of this post hoc explanation was not clear error. Neither of the explanations offered by Dr. Eliason during the evidentiary hearing appears in Dr. Eliason's notes. Nor did he give these reasons during his deposition. Their absence is conspicuous, given that Dr. Eliason took the time to indicate instances where, in his opinion, GCS is appropriate and to explain that Edmo did not satisfy his "criteria."

Second, the State highlights that Dr. Eliason's notes recommend further "supportive counseling" for Edmo and indicate that Edmo was up for parole. The State construes these notes as shorthand for the fourth and sixth WPATH criteria, respectively. The State's proposed reading of Dr. Eliason's notes is unreasonable. His notes are clear that GCS is not needed because Edmo did not meet his three "criteria," and the district court was well within its factfinding discretion in rejecting the State's strained reading. We therefore conclude that the district court reasonably found that Dr. Eliason "did not rely upon any finding that Ms. Edmo did not meet the WPATH criteria in concluding in his April 2016 assessment that she did not meet the criteria for gender confirmation surgery." *Id.* at 1120.

Notably, neither Dr. Eliason nor the State has offered any explanation or support for Dr. Eliason's "criteria." Dr. Eliason testified that he could not recall where he came up with them.

Nor has Dr. Eliason or the State contended that Dr. Eliason's criteria were a reasonable deviation or modification of the WPATH Standards of Care. In any event, we could not accept that argument. Dr. Eliason's criteria—apparently invented out of whole cloth—are so far afield from the WPATH standards that we cannot characterize his decision as a flexible application of or deviation from those standards. Indeed, as Dr. Gorton explained, two of Dr. Eliason's criteria are inapplicable to the care of transgender individuals. Dr. Eliason's criterion of "congenital malformation or ambiguous genitalia" "isn't . . . germane to transgender people." His statement that GCS could be needed when "endogenous sexual hormones were causing severe physiological damage," is, in Dr. Gorton's

words, "bizarre. I can't think of a clinical circumstance where . . . your hormones that your body produces are attacking you . . . . I just don't understand what [Dr. Eliason] is talking about there."

Dr. Eliason, in short, did not follow the accepted standards of care in the area of transgender health care, nor did he reasonably deviate from or flexibly apply them. Dr. Eliason did not apply the established standards, even as a starting point, in his evaluation.

Putting to the side Dr. Eliason's failure to follow or reasonably deviate from the accepted standards of care, his decision was internally contradictory in an important way. His notes reflect that GCS would be medically necessary if a person is suffering "severe and devastating gender dysphoria that is primarily due to genitals." At his deposition, Dr. Eliason conceded that self-castration could show gender dysphoria sufficiently severe to satisfy that criterion. And at the evidentiary hearing, he acknowledged that Edmo "does primarily meet that criteri[on]." Thus, even under Dr. Eliason's own criteria, Edmo should have been provided GCS. Neither Dr. Eliason nor the State has reconciled this important contradiction between Dr. Eliason's criteria and his determination.

In sum, Dr. Eliason's evaluation was not an exercise of medically acceptable professional judgment. Dr. Eliason's decision was based on inexplicable criteria far afield from the recognized standards of care and, even applying Dr. Eliason's criteria, Edmo qualifies for GCS. Given the credited expert testimony that GCS is necessary to treat Edmo's gender dysphoria, Dr. Eliason's contrary

determination was "medically unacceptable under the circumstances."[18] *Snow*, 681 F.3d at 988.

2. Deliberate Indifference

The State next contends that even if the treatment provided Edmo was medically unacceptable, no defendant acted "in conscious disregard of an excessive risk to [Edmo's] health." *Hamby*, 821 F.3d at 1092 (quoting *Snow*, 681 F.3d at 988). We disagree.

The record demonstrates that Dr. Eliason acted with deliberate indifference to Edmo's serious medical needs. Dr. Eliason knew, as of the time of his evaluation, that Edmo had attempted to castrate herself. He also knew that Edmo suffers from gender dysphoria; he knew she experiences "clinically significant" distress that impairs her ability to function. He acknowledged that Edmo's self-castration attempt was evidence that Edmo's gender dysphoria, in his words, "had risen to another level." Dr. Eliason nonetheless continued with Edmo's ineffective treatment plan.

Edmo then tried to castrate herself a second time, in December 2016. Dr. Eliason knew of that nearly

[18] Dr. Eliason was not alone in his decision. Dr. Stoddart, Dr. Young, and Jeremy Clark agreed with his assessment, as did the MTC. The State contends that such general agreement demonstrates that Dr. Eliason's decision was reasonable. But general agreement in a medically unacceptable form of treatment does not somehow make it reasonable. This is especially so in light of the limited review those individuals performed: Dr. Stoddard, Dr. Young, and Jeremy Clark agreed with Dr. Eliason's recommended treatment as *he* presented it to them and without personally evaluating Edmo, and the MTC "does not make any individual treatment decisions regarding [gender dysphoric] inmates. Those determinations are made by the individual clinicians or the medical staff employed by Corizon," like Dr. Eliason.

catastrophic event, but he did not reevaluate or recommend a change to Edmo's treatment plan, despite indicating in his April 2016 evaluation that he would continue to monitor and assess Edmo's condition. Dr. Eliason continued to see Edmo after that time, and he considered Edmo's treatment as a member of the MTC. At no point did Dr. Eliason change his mind or the treatment plan regarding surgery. Under these circumstances, we conclude that Dr. Eliason knew of and disregarded the substantial risk of severe harm to Edmo. *Farmer*, 511 U.S. at 837.

The State urges that neither Dr. Eliason nor any other defendant acted with deliberate indifference because none acted with "malice, intent to inflict pain, or knowledge that [the] recommended course of treatment was medically inappropriate." The State misstates the standard. A prisoner "must show that prison officials 'kn[e]w [ ] of and disregard[ed]' the substantial risk of harm,' but the officials need not have intended any harm to befall the inmate; 'it is enough that the official acted or failed to act despite his knowledge of a substantial risk of serious harm.'" *Lemire v. Cal. Dep't of Corr. & Rehab.*, 726 F.3d 1062, 1074 (9th Cir. 2013) (alterations in original) (quoting *Farmer*, 511 U.S. at 837, 842). Neither the Supreme Court nor this court has ever required a plaintiff to show a "sinister [prison official] with improper motives," as the State would require. It is enough that Dr. Eliason knew of and disregarded an excessive risk to Edmo's health by rejecting her request for GCS and then never re-evaluating his decision despite ongoing harm to Edmo.

The State also contends that because the defendants provided some care to Edmo, no defendant could have been deliberately indifferent. The provision of some medical treatment, even extensive treatment over a period of years,

does not immunize officials from the Eighth Amendment's requirements. *See Lopez v. Smith*, 203 F.3d 1122, 1132 (9th Cir. 2000) (en banc) (explaining that "[a] prisoner need not prove that he was completely denied medical care" to make out an Eighth Amendment claim); *see also De'lonta*, 708 F.3d at 526 ("[J]ust because [officials] have provided De'lonta with some treatment consistent with the GID Standards of Care, it does not follow that they have necessarily provided her with constitutionally adequate treatment."). As the Fourth Circuit has aptly analogized,

> imagine that prison officials prescribe a painkiller to an inmate who has suffered a serious injury from a fall, but that the inmate's symptoms, despite the medication, persist to the point that he now, by all objective measure, requires evaluation for surgery. Would prison officials then be free to deny him consideration for surgery, immunized from constitutional suit by the fact they were giving him a painkiller? We think not.

De'lonta, 708 F.3d at 526. Here, although the treatment provided Edmo was important, it stopped short of what was medically necessary.

3. Out-of-Circuit Precedent

Our decision cleaves to settled Eighth Amendment jurisprudence, which requires a fact-specific analysis of the record (as construed by the district court) in each case. *See Patel v. Kent Sch. Dist.*, 648 F.3d 965, 975 (9th Cir. 2011) ("Deliberate-indifference cases are by their nature highly fact-specific . . . ."); *see also Rachel v. Troutt*, 820 F.3d 390, 394 (10th Cir. 2016) ("Each step of this [deliberate

indifference] inquiry is fact-intensive." (quoting *Hartsfield v. Colburn*, 491 F.3d 394, 397 (8th Cir. 2007))); *Roe v. Elyea*, 631 F.3d 843, 859 (7th Cir. 2011) ("[I]nmate medical care decisions must be fact-based with respect to the particular inmate, the severity and stage of his condition, the likelihood and imminence of further harm and the efficacy of available treatments."); *Youmans v. Gagnon*, 626 F.3d 557, 564 (11th Cir. 2010) ("Judicial decisions addressing deliberate indifference to a serious medical need, like decisions in the Fourth Amendment search-and-seizure realm, are very fact specific."); *Chance v. Armstrong*, 143 F.3d 698, 703 (2d Cir. 1998) ("Whether a course of treatment was the product of sound medical judgment, negligence, or deliberate indifference depends on the facts of the case.").

Several years ago, the First Circuit, sitting en banc, employed that fact-based approach to evaluate a gender dysphoric prisoner's Eighth Amendment claim seeking GCS. The First Circuit confronted the following record: credited expert testimony disagreed as to whether GCS was medically necessary; the prisoner's active treatment plan, which did not include GCS, had "led to a significant stabilization in her mental state"; and a report and testimony from correctional officials detailed significant security concerns that would arise if the prisoner underwent GCS. *Kosilek*, 774 F.3d at 86–96. "After carefully considering the community standard of medical care, the adequacy of the provided treatment, and the valid security concerns articulated by the DOC," a 3–2 majority of the en banc court concluded that the plaintiff had not demonstrated GCS was medically necessary treatment for her gender dysphoria. *Id.* at 68.

Our approach mirrors the First Circuit's, but the important factual differences between cases yield different outcomes. Notably, the security concerns in *Kosilek*, which the First Circuit afforded "wide-ranging deference," are completely absent here. *Id.* at 92. The State does not so much as allude to them. The medical evidence also differs. In *Kosilek*, qualified and credited experts disagreed about whether GCS was necessary. *Id.* at 90. As explained above, the district court's careful factual findings admit of no such disagreement here. Rather, they unequivocally establish that GCS is the safe, effective, and medically necessary treatment for Edmo's severe gender dysphoria.

We recognize, however, that our decision is in tension with *Gibson v. Collier*. In that case, the Fifth Circuit held, in a split decision, that "[a] state does not inflict cruel and unusual punishment by declining to provide [GCS] to a transgender inmate." 920 F.3d at 215. It did so on a "sparse record"—which included only the WPATH Standards of Care and was notably devoid of "witness testimony or evidence from professionals in the field"—compiled by a *pro se* plaintiff. *Id.* at 220. Despite the sparse record, a 2–1 majority of the *Gibson* panel concluded that "there is no consensus in the medical community about the necessity and efficacy of [GCS] as a treatment for gender dysphoria. . . . This on-going medical debate dooms Gibson's claim." *Id.* at 221.

We respectfully disagree with the categorical nature of our sister circuit's holding. Most fundamentally, *Gibson* relies on an incorrect, or at best outdated, premise: that "[t]here is no medical consensus that [GCS] is a necessary or even effective treatment for gender dysphoria." *Id.* at 223.

As the record here demonstrates and the State does not seriously dispute, the medical consensus is that GCS is

effective and medically necessary in appropriate circumstances. The WPATH Standards of Care—which are endorsed by the American Medical Association, the American Medical Student Association, the American Psychiatric Association, the American Psychological Association, the American Family Practice Association, the Endocrine Society, the National Association of Social Workers, the American Academy of Plastic Surgeons, the American College of Surgeons, Health Professionals Advancing LGBTQ Equality, the HIV Medicine Association, the Lesbian, Bisexual, Gay and Transgender Physician Assistant Caucus, and Mental Health America—recognize this fact. WPATH SOC at 54–55. Each expert in this case agrees. As do others in the medical community. *See, e.g.*, U.S. Dep't of Health & Human Servs., No. A-13-87, Decision No. 2576; Bao Ngoc N. Tran, et al., *Gender Affirmation Surgery: A Synopsis Using American College of Surgeons National Surgery Quality Improvement Program and National Inpatient Sample Databases*, 80 Annals Plastic Surgery S229, S234 (2018); Frey, *A Historical Review of Gender-Affirming Medicine*, 14 J. Sexual Med. at 991; *see also* What We Know Project, Ctr. for the Study of Inequality, Cornell Univ., *What Does the Scholarly Research Say About the Effect of Gender Transition on Transgender Well-Being?*, https://whatweknow.inequality.cornell.edu/topics/lgbt-equality/what-does-the-scholarly-research-say-about-the-well-being-of-transgender-people/ (last visited July 10, 2019) (reviewing the available literature and finding "a robust international consensus in the peer-reviewed literature that gender transition, including medical treatments such as hormone therapy and surgeries, improves the overall well-being of transgender individuals"). The Fifth Circuit is the outlier.

Gibson's broad holding stemmed from a dismaying disregard for procedure. As noted, the "sparse" summary judgment record that the *pro se* plaintiff developed included "only the WPATH Standards of Care." *Gibson*, 920 F.3d at 221. Perhaps that factual deficiency doomed Gibson's Eighth Amendment claim. *See id.* at 223–24. But to reach its broader holding that denying GCS cannot, as a matter of law, violate the Eighth Amendment—in other words, to reject every conceivable Eighth Amendment claim based on the denial of GCS—the Fifth Circuit coopted the record from *Kosilek*, a First Circuit decision that predates *Gibson* by four years. *Id.* at 221–23. We doubt the analytical value of such an anomalous procedural approach.

Worse yet, the medical opinions from *Kosilek* do not support the Fifth Circuit's categorical holding. Dr. Chester Schmidt's and Dr. Stephen Levine's testimony in *Kosilek*, which the Fifth Circuit relied on, do not support the proposition that GCS is never medically necessary. Dr. Schmidt and Dr. Levine testified that GCS was not necessary in the factual circumstances of that case, that is, based on the unique medical needs of the prisoner at issue. *See Kosilek*, 774 F.3d at 76–79.

The only suggestion in *Kosilek* that GCS is never medically necessary is in the First Circuit's recitation of the testimony of Dr. Cynthia Osborne. *See Gibson*, 920 F.3d at 221. The First Circuit recounted that Dr. Osborne testified that she "did not view [GCS] as medically necessary in light of the 'whole continuum from noninvasive to invasive' treatment options available to individuals with" gender dysphoria. *Kosilek*, 774 F.3d at 77. To the extent this vague portrait of Dr. Osborne's testimony conveys her belief that GCS is never medically necessary, she has apparently changed her view in the more than ten years since she

testified in *Kosilek*. Like both sides and all four medical experts who testified here, Dr. Osborne now agrees that GCS "can be medically necessary for some, though not all, persons with [gender dysphoria], including some prison inmates." Osborne & Lawrence, *Male Prison Inmates With Gender Dysphoria*, 45 Archives of Sexual Behav. at 1651. In her and her co-author's words, "[GCS] is a safe, effective, and widely accepted treatment for [gender dysphoria]; disputing the medical necessity of [GCS] based on assertions to the contrary is unsupportable." *Id.* The predicate medical opinions that *Gibson* is premised upon, then, do not support the Fifth Circuit's view that GCS is never medically necessary. The consensus is that GCS is effective and medically necessary in appropriate circumstances.[19]

Gibson is unpersuasive for several additional reasons. It directly conflicts with decisions of this circuit, the Fourth

[19] We do not suggest that every member of the medical and mental health communities agrees that GCS may be medically necessary. There are outliers. But when the medical consensus is that a treatment is effective and medically necessary under the circumstances, prison officials render unacceptable care by following the views of outliers without offering a credible medical basis for deviating from the accepted view. *See Kosilek*, 774 F.3d at 90 n.12 (explaining that it is not enough for "correctional administrators wishing to avoid treatment . . . simply to find a single practitioner willing to attest that some well-accepted treatment is not necessary"); *Hamilton v. Endell*, 981 F.2d 1062, 1067 (9th Cir. 1992) ("By choosing to rely upon a medical opinion which a reasonable person would likely determine to be inferior, the prison officials took actions which may have amounted to the denial of medical treatment, and the unnecessary and wanton infliction of pain." (quotation omitted)), *overruled in part on other grounds as recognized in Snow*, 681 F.3d at 986; *cf. also Bragdon v. Abbott*, 524 U.S. 624, 650 (1998) ("A health care professional who disagrees with the prevailing medical consensus may refute it by citing a credible scientific basis for deviating from the accepted norm.").

Circuit, and the Seventh Circuit, all of which have held that denying surgical treatment for gender dysphoria can pose a cognizable Eighth Amendment claim. *Rosati*, 791 F.3d at 1040 (alleged blanket ban on GCS and denial of GCS to plaintiff with severe symptoms, including repeated self-castration attempts, states an Eighth Amendment claim); *Fields v. Smith*, 653 F.3d 550, 552–53, 558–59 (7th Cir. 2011) (law banning hormone treatment and GCS, even if medically necessary, violates the Eighth Amendment); *De'lonta*, 708 F.3d at 525 (alleged denial of an evaluation for GCS states an Eighth Amendment claim).[20] Relatedly, *Gibson* eschews Eighth Amendment precedent requiring a case-by-case determination of the medical necessity of a particular treatment. *See, e.g.*, *Colwell v. Bannister*, 763 F.3d 1060, 1068 (9th Cir. 2014) (holding that the "blanket, categorical denial of medically indicated surgery solely on the basis of an administrative policy . . . is the paradigm of deliberate indifference" (quotation omitted)); *Roe*, 631 F.3d at 859.

In this latter respect, *Gibson* also contradicts and misconstrues the precedent it purports to follow: *Kosilek*. According to the *Gibson* majority, "the majority in *Kosilek* effectively allowed a blanket ban on sex reassignment surgery." 920 F.3d at 216. Not so. The First Circuit did precisely what we do here: assess whether the record before it demonstrated deliberate indifference to the plaintiff's

[20] The Fifth Circuit unpersuasively attempted to reconcile its decision with *Rosati* and *De'lonta*, pointing out that those decisions "allowed Eighth Amendment claims for [GCS] to survive motions to dismiss, without addressing the merits." *Gibson*, 920 F.3d at 223 n.8. But if *Gibson* is correct that failing to provide GCS cannot amount to deliberate indifference, then a plaintiff cannot state an Eighth Amendment claim based on the denial of GCS. *Rosati* and *De'lonta* would necessarily have been decided differently under *Gibson*'s holding.

gender dysphoria. On the record before it, the First Circuit determined that either of two courses of treatment (one included GCS and one did not) were medically acceptable. *Kosilek*, 774 F.3d at 90. In light of those medically acceptable alternatives, the First Circuit explained that it was not its place to "second guess medical judgments or to require that the DOC adopt the more compassionate of two adequate options." *Id.* (quotation omitted). It expressly cautioned that the opinion should not be read to "create a de facto ban against [GCS] as a medical treatment for any incarcerated individual," as "any such policy would conflict with the requirement that medical care be individualized based on a particular prisoner's serious medical needs." *Id.* at 91 (citing *Roe*, 631 F.3d at 862–63). The Fifth Circuit disregarded these words of warning.[21]

* * *

In summary, Edmo has established that she suffers from a "serious medical need," *Jett*, 439 F.3d at 1096, and that the treatment provided was "medically unacceptable under the circumstances" and chosen "in conscious disregard of an excessive risk" to her health, *Hamby*, 821 F.3d at 1092. She established her Eighth Amendment claim of deliberate indifference as to Defendant-Appellant Dr. Eliason.

[21] *Gibson*'s final, originalist rationale—that it cannot be cruel and *unusual* to deny a surgery that has only once been provided to an inmate, 920 F.3d at 226–28—warrants little discussion. *Gibson*'s originalist understanding of the Eighth Amendment does not control; *Estelle* does, and under *Estelle* a plaintiff establishes an Eighth Amendment claim by demonstrating that prison officials were deliberately indifferent to a serious medical need. 429 U.S. at 106. This standard protects the evolving standards of decency enshrined in the Eighth Amendment.

B. Irreparable Harm

The State next contends that the district court erred in finding that Edmo would be irreparably harmed absent an injunction.

In reaching its conclusion, the district court found that Edmo experiences ongoing "clinically significant distress," meaning "the distress impairs or severely limits [her] ability to function in a meaningful way." *Edmo*, 358 F. Supp. 3d at 1110–11. This finding is supported by Edmo's testimony that her gender dysphoria causes her to feel "depressed," "disgusting," "tormented," and "hopeless"; that she actively experiences thoughts of self-castration; and that she "self-medicat[es]" by cutting her arms with a razor to avoid acting on those thoughts and impulses. The district court also found that in the absence of surgery, Edmo "will suffer serious psychological harm and will be at high risk of self-castration and suicide." *Id.* at 1128. This finding is supported by the credited expert testimony of Dr. Ettner and Dr. Gorton, who detailed the escalating risks of self-surgery, suicide, and emotional decompensation should Edmo be denied surgery.

It is no leap to conclude that Edmo's severe, ongoing psychological distress and the high risk of self-castration and suicide she faces absent surgery constitute irreparable harm. *See Stanley v. Univ. of S. Cal.*, 13 F.3d 1313, 1324 n.5 (9th Cir. 1994); *Thomas v. County of Los Angeles*, 978 F.2d 504, 511 (9th Cir. 1992); *Chalk v. U.S. Dist. Ct. Cent. Dist. of Cal.*, 840 F.2d 701, 709 (9th Cir. 1988). Moreover, the deprivation of Edmo's constitutional right to adequate medical care is sufficient to establish irreparable harm. *See Nelson v. NASA*, 530 F.3d 865, 882 (9th Cir. 2008) ("Unlike monetary injuries, constitutional violations cannot be adequately remedied through damages and therefore

generally constitute irreparable harm."), *rev'd and remanded on other grounds*, 562 U.S. 134 (2011).

The State offers three contentions as to why the district court erred in finding that Edmo would be irreparably injured in the absence of an injunction. None is persuasive.

First, the State argues that the "long delay" of "nearly a year" between Edmo filing her Amended Complaint and her preliminary injunction motion "implies a lack of urgency and irreparable harm." We disagree. The procedural history demonstrates that Edmo did not sit on her rights. Proceeding *pro se*, Edmo moved for preliminary injunctive relief when she filed her original complaint. The court then appointed counsel for Edmo, and shortly after appearing, appointed counsel withdrew Edmo's motion and filed an amended complaint. To assess the urgency of surgery, Edmo's counsel promptly sought access to Edmo's medical records, which the State did not produce until more than six months later. Edmo moved for injunctive relief shortly thereafter. During that time, Edmo and her counsel diligently investigated and compiled the necessary record to move for injunctive relief. That it took them months to do their diligence does not suggest that Edmo will not be harmed absent an injunction.

Second, the State contends that Edmo has not established irreparable injury because both she and her expert, Dr. Gorton, agree that GCS is not an emergency surgery and that the State should have six months to provide such surgery. The State's argument would preclude courts from ordering non-emergent medical care, even if the Eighth Amendment demands it. That is untenable. The State also ignores the rationale for the six-month time period. As Dr. Gorton explained, all patients who receive GCS "are seen, they are evaluated, there is a process you have to go

through." In his experience, that process typically concludes within six months. That Edmo requested relief on a reasonable timeline, based on the medical evidence, does not undermine the strong evidence of irreparable injury.

Third, the State contends that Edmo has not established irreparable harm because she "has not attempted suicide or self-castration for years." That argument overlooks the profound, persistent distress Edmo's gender dysphoria causes, as well as the credited expert testimony that absent GCS, Edmo is at risk of further attempts at self-castration, and possibly suicide. The district court did not err in finding that Edmo would be irreparably harmed in the absence of an injunction.

IV. Challenges to the Scope of the Injunction

We turn to the State's contentions that the district court's injunction was overbroad.

A. Individual Defendants

The State contends that the injunction should not apply to Atencio, Zmuda, Yordy, Siegert, Dr. Young, Dr. Craig, Dr. Eliason, or Dr. Whinnery because the district court did not find that they, individually, were deliberately indifferent to Edmo's medical needs.

As explained in Section III.A, Edmo has established that Dr. Eliason was deliberately indifferent to her serious medical needs. The injunction was properly entered against him because he personally participated in the deprivation of Edmo's constitutional rights. *See Colwell*, 763 F.3d at 1070.

Edmo sued Attencio, Zmuda, and Yordy in their official capacities. An official-capacity suit for injunctive relief is

properly brought against any persons who "would be responsible for implementing any injunctive relief." *Pouncil v. Tilton*, 704 F.3d 568, 576 (9th Cir. 2012). The State does not contest that Attencio, as Director of IDOC, and Zmuda, as Deputy Director of IDOC, would be responsible for implementing any injunctive relief ordered. Edmo properly named them as defendants to her Eighth Amendment claim for injunctive relief, regardless of their personal involvement. *See Colwell*, 763 F.3d at 1070–71 (director of a state correctional system is a proper defendant in an official-capacity suit seeking injunctive relief for Eighth Amendment violations). Yordy is no longer the Warden of ISCI, but, by operation of the Federal Rules, his successor, Al Ramirez, is "automatically substituted as party" in his official capacity. Fed. R. Civ. P. 25(d). Ramirez is properly a defendant to Edmo's Eighth Amendment claim for injunctive relief, regardless of his personal involvement. *See Colwell*, 763 F.3d at 1070–71 (warden is a proper defendant in an official-capacity suit seeking injunctive relief for Eighth Amendment violations). Because Edmo may properly pursue her Eighth Amendment claim for injunctive relief against Attencio, Zmuda, and Ramirez in their official capacities, they are properly included within the scope of the district court's injunction. On remand, the district court shall amend the injunction to substitute Al Ramirez (or the then-current Warden of ISCI) as a party for Yordy.

Edmo also named Yordy as a defendant in his individual capacity. She likewise named Siegert, Dr. Young, Dr. Craig, and Dr. Whinnery as defendants in their individual capacities (though she does not argue on appeal that the injunction properly included them). We hold that the evidence in the current record is insufficient to conclude that they were deliberately indifferent to Edmo's serious medical needs. In particular, the record does not show what they

knew about Edmo's condition and what role they played in her treatment or lack thereof. Edmo has not established their liability, and the district court improperly included them within the scope of the injunction. We vacate the district court's injunction to the extent it applies to Yordy, Siegert, Dr. Young, Dr. Craig, and Dr. Whinnery in their individual capacities. *See California v. Azar*, 911 F.3d 558, 585 (9th Cir. 2018) (vacating in part an overbroad injunction and remanding to the district court). On remand, the district court shall modify the injunction to exclude those defendants from its scope.

B. Corizon

The State also contends that the injunction should not apply to Corizon. It urges that Corizon does not have a policy barring GCS and argues that such a policy is a prerequisite to liability under *Monell v. Department of Social Services*, 436 U.S. 658 (1978). We have not yet determined whether *Monell* applies "to private entities acting on behalf of state governments," such as Corizon. *Oyenik v. Corizon Health Inc.*, 696 F. App'x 792, 794 n.1 (9th Cir. 2017). We leave that issue for another day. Instead, we vacate the injunction as to Corizon and remand with instructions to the district court to modify the injunction to exclude Corizon. *See Azar*, 911 F.3d at 585. Doing so still provides Edmo the relief she seeks at this stage.[22]

[22] For similar reasons, we need not reach Edmo's contention and the district court's finding that "Corizon and IDOC have a *de facto* policy or practice of refusing" GCS to prisoners. *Edmo*, 358 F. Supp. 3d at 1127.

C. Relief Ordered

The State next contends that the injunctive relief ordered is overbroad because it requires the State to provide Edmo all "adequate medical care." The State misconstrues the district court's order. The order, read in context, requires defendants to provide GCS, as well as "adequate medical care" that is "reasonably necessary" to accomplish that end—not every conceivable form of adequate medical care. *Edmo*, 358 F. Supp. 3d at 1129; *see also id.* at 1109 ("Plaintiff Adree Edmo alleges that prison authorities violated her Eighth Amendment rights by refusing to provide her with gender confirmation surgery. For the reasons explained below, the Court agrees and will order defendants to provide her with this procedure, a surgery which is considered medically necessary under generally accepted standards of care."); *id.* at 1110 ("[F]or the reasons explained in detail below, IDOC and Corizon will be ordered to provide Ms. Edmo with gender confirmation surgery.").

The State similarly contends that the injunctive relief ordered is overbroad because it requires the State to provide Edmo surgery even though the defendants are not surgeons and no surgeon has evaluated Edmo. We reject this obtuse reading of the district court's order. The district court ordered the State to "take all actions reasonably necessary to provide Ms. Edmo gender confirmation surgery." *Edmo*, 358 F. Supp. 3d at 1129. That means that the State must take steps within its power to provide GCS to Edmo, such as finding a surgeon and scheduling a surgical evaluation. Indeed, we modified our stay of the district court's order to permit a surgical consultation, which went forward in April 2019. Oral Arg. at 12:00–12:10. The State cannot reasonably understand the district court's December 13, 2018 order to require that the defendants themselves provide

surgery. To the extent there are issues arising from a surgical evaluation, the State can raise those issues with the district court.[23]

V. Challenges to the Procedure Used by the District Court

Finally, the State contends that the district court improperly converted an evidentiary hearing on a preliminary injunction into a final trial on the merits of Edmo's Eighth Amendment claim for GCS without giving them adequate notice and in violation of their Seventh Amendment right to a jury trial. We address and reject each contention.

A. Notice

We first address the State's contention that the district court erroneously converted the evidentiary hearing into a final trial on the merits without giving the State "clear and unambiguous notice." Under Federal Rule of Civil Procedure 65(a)(2), "[a] district court may consolidate a preliminary injunction hearing with a trial on the merits, but only when it provides the parties with clear and unambiguous notice [of the intended consolidation] either before the hearing commences or at a time which will afford

[23] The State contends for the first time in its reply brief that the injunctive relief ordered was inappropriate because the WPATH Standards of Care require two referrals from qualified mental health professionals who have independently assessed the patient before GCS may be provided. It similarly contends for the first time in its reply in support of its motion to dismiss that the order is overbroad because it does not specify the type of GCS ordered. Because the State did not present these arguments in its opening brief, we do not consider them. *See Smith v. Marsh*, 194 F.3d 1045, 1052 (9th Cir. 1999).

the parties a full opportunity to present their respective cases." *Isaacson v. Horne*, 716 F.3d 1213, 1220 (9th Cir. 2013) (second alteration in original) (quotation omitted). "What constitutes adequate notice depends upon the facts of the case." *Michenfelder v. Sumner*, 860 F.2d 328, 337 (9th Cir. 1988).

A party challenging consolidation must show not only inadequate notice, but also "substantial prejudice in the sense that [it] was not allowed to present material evidence." *Michenfelder*, 860 F.2d at 337; *see also* 11A Charles Alan Wright et al., *Federal Practice and Procedure* § 2950 (3d ed. Apr. 2019 update). "We have on occasion upheld a district court's failure to give any notice whatsoever before finally determining the merits after only a preliminary injunction hearing, where the complaining party has failed to show how additional evidence could have altered the outcome." *Michenfelder*, 860 F.2d at 337.

At the outset, we note that the State was provided notice, twice, that the district court considered the evidentiary hearing a final trial on the merits of Edmo's request for GCS. At the beginning of the hearing, the district court explained "it's hard for me to envision this hearing being anything but a hearing on a final injunction at least as to that part of the relief requested [GCS]," and it asked the parties to address by the end of the hearing whether it was for a permanent injunction. At the close of the hearing, the district court again questioned whether it could order GCS in a preliminary injunction. It explained that it had, in effect, "kind of treated this hearing as the final hearing" on Edmo's request for GCS, and it again asked the parties to address in their oral closings or written briefs whether the hearing was one for a permanent injunction. The State never answered the court's question or objected to consolidation, despite the

district court specifically noting it had treated the hearing as final. *Cf. Reilly v. United States*, 863 F.2d 149, 160 (1st Cir. 1988) ("[W]hen a trial judge announces a proposed course of action which litigants believe to be erroneous, the parties detrimentally affected must act expeditiously to call the error to the judge's attention or to cure the defect, not lurk in the bushes waiting to ask for another trial when their litigatory milk curdles."). This is not a case where the district court gave no notice whatsoever.

Regardless, the State has not shown any prejudice. With full awareness of the stakes, the district court permitted the parties four months of discovery and held a three-day evidentiary hearing. The parties called seven witnesses, submitted declarations in lieu of live testimony for other witnesses, and submitted thousands of pages of exhibits and extensive pre- and post-trial briefing. Most importantly, both parties put on extensive evidence concerning the treatment provided to and withheld from Edmo and why it was or was not appropriate—the key issue at the hearing.

When it comes to identifying prejudice, the State is tellingly short on specifics. It indicates that it "would have objected" to consolidation, but it failed to do so despite repeated invitations—indeed, directives—to address the issue. The State also urges that it would have requested that the named defendants be able to testify live, but it stipulated—knowing full well the stakes of the hearing—to submit certain testimony via declaration "[i]n lieu of and/or in addition to live testimony." Moreover, the State fails to identify what testimony those witnesses would have offered or explain how presenting that testimony live, instead of via declaration, "could have altered the outcome." *Michenfelder*, 860 F.2d at 337. The district court did not

commit reversible error in consolidating the evidentiary hearing with a trial on the merits of Edmo's request for GCS.

B. Seventh Amendment

We turn to the State's related contention that the district court violated the defendants' Seventh Amendment right to a jury trial by converting the evidentiary hearing into a trial on the merits. We review that contention de novo. *Palmer v. Valdez*, 560 F.3d 965, 968 (9th Cir. 2009).

The Seventh Amendment guarantees the right to a trial by jury "[i]n Suits at common law, where the value in controversy shall exceed twenty dollars." U.S. Const. amend. VII. In a case such as this, where legal claims are joined with equitable claims, a party "has a right to jury consideration of all legal claims, as well as all issues common to both claims." *Plummer v. W. Int'l Hotels Co.*, 656 F.2d 502, 504 n.6 (9th Cir. 1981) (citing *Curtis v. Loether*, 415 U.S. 189, 196 n.11 (1974)). "Otherwise, the court might limit the parties' opportunity to try to a jury every issue underlying the legal claims by affording preclusive effect to its own findings of fact on questions that are common to both the legal and equitable claims." *Lacy v. Cook County*, 897 F.3d 847, 858 (7th Cir. 2018).

Like other constitutional rights, the right to a jury trial in civil suits can be waived. *See United States v. Moore*, 340 U.S. 616, 621 (1951). It is well established that "[a] failure to object to a proceeding in which the court sits as the finder of fact waives a valid jury demand as to any claims decided in that proceeding, at least where it was clear that the court intended to make fact determinations." *Fillmore v. Page*, 358 F.3d 496, 503 (7th Cir. 2004) (quotation omitted); *see also* 9 Wright & Miller, *Federal Practice and Procedure* § 2321 ("The right to jury trial also may be waived as it has

in many, many cases, by conduct, such as failing to object to or actually participating in a bench trial . . . .").

For example, in *White v. McGinnis*, we held that "[a] party's vigorous participation in a bench trial, without so much as a mention of a jury, . . . can only be ascribed to knowledgeable relinquishment of the prior jury demand." 903 F.2d 699, 703 (9th Cir. 1990) (en banc). We explained that where a party chooses "to argue his case fully before the district judge[,] it is not unjust to hold him to that commitment." *Id.* By contrast, we have held that "[w]hen a party participates in [a] bench trial ordered by the trial court while continuing to demand a jury trial, his 'continuing objection' is 'sufficient to preserve his right to appeal the denial of his request for a jury.'" *Solis v. County of Los Angeles*, 514 F.3d 946, 957 (9th Cir. 2008) (quoting *United States v. Nordbrock*, 941 F.2d 947, 950 (9th Cir. 1991)). "This is because the party in such a case is not seeking 'two bites at the procedural apple' . . . . Rather, when a trial court denies a party a jury trial despite the party's continuing demand, the party has little choice but to accede to the trial court's ruling and participate in the bench trial." *Id.* (citation omitted); *see also Lovelace v. Dall*, 820 F.2d 223, 228 (7th Cir. 1987) ("Another policy justifying the jury demand waiver rule is the view that it is unfair to permit a party to have a trial, discover that it has lost, and then raise the jury issue because it is unsatisfied with the result of the trial.").

The State seeks a second bite at the apple. It vigorously participated in the evidentiary hearing without ever raising the right to a jury trial. The State remained silent in the face of statements from the district court that it was considering treating, and then that it had treated, the hearing as a final trial on the merits, which made it clear that the court "intended to make fact determinations." *Fillmore*, 358 F.3d

at 503. It also remained silent despite the district court asking twice whether the hearing was one for a permanent injunction—as clear a time as any to raise any concerns about a jury trial.

The State raised the issue of a jury trial for the first time on appeal, after the district court ruled against it. Even after the district court's ruling, the State made no objection or claim to a jury trial. This conduct waived the State's right to a jury trial with respect to issues common to Edmo's request for an injunction ordering GCS and her legal claims.

VI. Conclusion

We apply the dictates of the Eighth Amendment today in an area of increased social awareness: transgender health care. We are not the first to speak on the subject, nor will we be the last. Our court and others have been considering Eighth Amendment claims brought by transgender prisoners for decades. During that time, the medical community's understanding of what treatments are safe and medically necessary to treat gender dysphoria has changed as more information becomes available, research is undertaken, and experience is gained. The Eighth-Amendment inquiry takes account of that developing understanding. *See Estelle*, 429 U.S. at 102–03.

We hold that where, as here, the record shows that the medically necessary treatment for a prisoner's gender dysphoria is gender confirmation surgery, and responsible prison officials deny such treatment with full awareness of the prisoner's suffering, those officials violate the Eighth Amendment's prohibition on cruel and unusual punishment.

* * *

We affirm the district court's entry of an injunction for Edmo. However, we vacate the injunction to the extent it applies to Corizon, Yordy, Siegert, Dr. Young, Dr. Craig, and Dr. Whinnery, in their individual capacities, and remand to the district court to modify the injunction accordingly. The district court shall also modify the injunction to substitute Al Ramirez in his official capacity as Warden of ISCI for Yordy.

Although we addressed this appeal on an expedited basis, it has been more than a year since doctors concluded that GCS is medically necessary for Edmo. We urge the State to move forward. We emphatically do not speak to other cases, but the facts of this case call for expeditious effectuation of the injunction.

In light of the nature and urgency of the relief at issue, we will disfavor any motion, absent extraordinary circumstances or consent from all parties, to extend the period to petition for rehearing or rehearing en banc. Our stay of the district court's December 13, 2018 order shall automatically terminate upon issuance of the mandate.

Costs on appeal are awarded to Edmo.

AFFIRMED IN PART, VACATED IN PART, AND REMANDED.

EXHIBIT E

FILED

OCT 10 2019

MOLLY C. DWYER, CLERK
U.S. COURT OF APPEALS

UNITED STATES COURT OF APPEALS

FOR THE NINTH CIRCUIT

ADREE EDMO, AKA Mason Edmo, Plaintiff-Appellee, v. CORIZON, INC.; et al., Defendants-Appellants, and IDAHO DEPARTMENT OF CORRECTIONS; et al., Defendants.	No. 19-35017 D.C. No. 1:17-cv-00151-BLW District of Idaho, Boise ORDER

ADREE EDMO, AKA Mason Edmo, Plaintiff-Appellee, v. IDAHO DEPARTMENT OF CORRECTIONS; et al., Defendants-Appellants, and CORIZON, INC.; et al., Defendants.	No. 19-35019 D.C. No. 1:17-cv-00151-BLW

Before: McKEOWN and GOULD, Circuit Judges, and LASNIK,* District Judge.

We grant Plaintiff-Appellee's motion (Docket Entry No. 101) to partially lift the stay of the district court's order requiring Defendants-Appellants to take all actions reasonably necessary to provide Plaintiff with gender confirmation surgery. Defendants, as the proponents of the stay, have not shown that "irreparable harm is probable" with respect to the limited nature of Plaintiff's request and that they have both "a substantial case on the merits and that the balance of hardships tips sharply" in their favor. *Leiva-Perez v. Holder*, 640 F.3d 962, 970 (9th Cir. 2011) (per curiam). Accordingly, this court's stay of the district court's December 13, 2018 order is partially lifted so that Plaintiff may receive all presurgical treatments and related corollary appointments or consultations necessary for gender confirmation surgery.

* The Honorable Robert S. Lasnik, United States District Judge for the Western District of Washington, sitting by designation.

EXHIBIT F

FOR PUBLICATION

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

ADREE EDMO, AKA Mason Edmo, *Plaintiff-Appellee*, v. CORIZON, INC.; SCOTT ELIASON; MURRAY YOUNG; CATHERINE WHINNERY, *Defendants-Appellants*, and IDAHO DEPARTMENT OF CORRECTIONS; HENRY ATENCIO; JEFF ZUMDA; HOWARD KEITH YORDY; AL RAMIREZ, Warden; RICHARD CRAIG; RONA SIEGERT, *Defendants*.	No. 19-35017 D.C. No. 1:17-cv-00151-BLW

ADREE EDMO, AKA Mason Edmo, *Plaintiff-Appellee*, v. IDAHO DEPARTMENT OF CORRECTIONS; HENRY ATENCIO; JEFF ZUMDA; HOWARD KEITH YORDY; AL RAMIREZ, Warden; RICHARD CRAIG; RONA SIEGERT, *Defendants-Appellants*, and CORIZON, INC.; SCOTT ELIASON; MURRAY YOUNG; CATHERINE WHINNERY, *Defendants.*	No. 19-35019 D.C. No. 1:17-cv-00151-BLW ORDER

Filed February 10, 2020

Before: M. Margaret McKeown and Ronald M. Gould, Circuit Judges, and Robert S. Lasnik,* District Judge.

Order;
Statement by Judge O'Scannlain;
Dissent by Judge Collins;
Dissent by Judge Bumatay

* The Honorable Robert S. Lasnik, United States District Judge for the Western District of Washington, sitting by designation.

SUMMARY**

Prisoner Civil Rights

The panel denied a petition for panel rehearing and denied a petition for rehearing en banc on behalf of the court, in a case in which the panel affirmed the district court's entry of a permanent injunction in favor of an Idaho state prisoner, but vacated the injunction to the extent it applied to certain defendants in their individual capacities, in the prisoner's action seeking medical treatment for gender dysphoria.

Respecting the denial of rehearing en banc, Judge O'Scannlain, joined by Judges Callahan, Bea, Ikuta, R. Nelson, Bade, Bress, Bumatay and VanDyke, stated that with its decision not to rehear this case en banc, this court became the first federal court of appeals to mandate that a State pay for and provide sex-reassignment surgery to a prisoner under the Eighth Amendment. Judge O'Scannlain stated that the three-judge panel's conclusion—that any alternative course of treatment would be "cruel and unusual punishment"—is as unjustified as it is unprecedented. To reach such a conclusion, the court created a circuit split, substituted the medical conclusions of federal judges for the clinical judgments of prisoners' treating physicians, redefined the familiar "deliberate indifference" standard, and, in the end, constitutionally enshrined precise and partisan treatment criteria in what is a new, rapidly changing, and highly controversial area of medical practice.

** This summary constitutes no part of the opinion of the court. It has been prepared by court staff for the convenience of the reader.

Dissenting from the denial of rehearing en banc, Judge Collins stated that whether the defendant doctor was negligent or not (a question on which Judge Collins expressed no opinion), his treatment decisions did not amount to "cruel and unusual punishment," and the court thus strayed far from any proper understanding of the Eighth Amendment.

Dissenting from the denial of rehearing en banc, Judge Bumatay, joined by Judges Callahan, Ikuta, R. Nelson, Bade and VanDyke, and by Judge Collins as to Part II, stated that by judicially mandating an innovative and evolving standard of care, the panel effectively constitutionalized a set of guidelines subject to ongoing debate and inaugurated yet another circuit split. And by diluting the requisite state of mind from "deliberate indifference" to negligence, the panel effectively held that—contrary to Supreme Court precedent—medical malpractice does become a constitutional violation merely because the victim is a prisoner.

ORDER

The full court was advised of the petition for rehearing en banc. A judge requested a vote on whether to rehear the matter en banc. The matter failed to receive a majority of the votes of nonrecused active judges in favor of en banc consideration. Fed R. App. P. 35.

The petition for rehearing en banc is **DENIED**. An opinion respecting denial of rehearing en banc, prepared by Judge O'Scannlain, and dissents from denial of rehearing en banc prepared by Judge Collins and Judge Bumatay are filed concurrently with this order.

O'SCANNLAIN, Circuit Judge,[*] with whom CALLAHAN, BEA, IKUTA, R. NELSON, BADE, BRESS, BUMATAY, and VANDYKE, Circuit Judges, join, respecting the denial of rehearing en banc:

With its decision today, our court becomes the first federal court of appeals to mandate that a State pay for and provide sex-reassignment surgery to a prisoner under the Eighth Amendment. The three-judge panel's conclusion—that any alternative course of treatment would be "cruel and unusual punishment"—is as unjustified as it is unprecedented. To reach such a conclusion, the court creates a circuit split, substitutes the medical conclusions of federal

[*] As a judge of this court in senior status, I no longer have the power to vote on calls for rehearing cases en banc or formally to join a dissent from failure to rehear en banc. *See* 28 U.S.C. § 46(c); Fed. R. App. P. 35(a). Following our court's general orders, however, I may participate in discussions of en banc proceedings. *See* Ninth Circuit General Order 5.5(a).

judges for the clinical judgments of prisoners' treating physicians, redefines the familiar "deliberate indifference" standard, and, in the end, constitutionally enshrines precise and partisan treatment criteria in what is a new, rapidly changing, and highly controversial area of medical practice.

Respectfully, I believe our court's unprecedented decision deserved reconsideration en banc.

I

A

In 2012, Adree Edmo (then known as Mason Dean Edmo) was incarcerated for sexually assaulting a sleeping 15-year-old boy. By all accounts, Edmo is afflicted with profound and complex mental illness. She[1] suffers from major depressive disorder, anxiety, alcohol addiction, and drug addiction. At least two clinicians have concluded that she shares the traits of borderline personality disorder. She abused alcohol and methamphetamines every day for many years, stopping only upon her incarceration. A victim of sexual abuse at an early age, she attempted suicide three times before her arrest for sexual assault—twice by overdose and once by cutting.

A new diagnosis was added in 2012: gender dysphoria. Two months after being transferred to the Idaho State Correctional Institution (a men's prison), Edmo sought to speak about hormone therapy with Dr. Scott Eliason, the Board-certified director of psychiatry for Corizon, Inc. (the prison's medical care provider). In Dr. Eliason's view,

[1] Though Edmo was born a male, Edmo has legally changed the sex listed on her birth certificate to female. I therefore use feminine pronouns throughout, just as the panel does.

Edmo met the criteria for gender dysphoria.[2] After the diagnosis was confirmed by another forensic psychiatrist and the prison's Management and Treatment Committee, Edmo was prescribed hormone therapy. She soon changed her legal name and the sex listed on her birth certificate. As a result of four years of hormone therapy, Edmo experienced physical changes, including breast development, redistribution of body fat, and a change in body odor. She now has the same circulating hormones as a typical adult female.

In April 2016, at Edmo's request, Dr. Eliason evaluated her for sex-reassignment surgery.[3] Ultimately, Dr. Eliason decided to maintain the current course of hormones and supportive counseling instead of prescribing surgery. He staffed Edmo's case with Dr. Jeremy Stoddart (a psychiatrist) and Dr. Murray Young (a physician who served as the Regional Medical Director for Corizon), as well as Jeremy Clark, a clinical supervisor and member of the World Professional Association for Transgender Health ("WPATH"). He also presented the evaluation and vetted it

[2] Gender dysphoria is a diagnosis introduced in the latest, fifth edition of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*. It replaces the now-obsolete "gender identity disorder" used in the previous edition. The gender dysphoric patient experiences "clinically significant distress or impairment in social, occupational, or other important areas of functioning" that is associated with the feeling of incongruence between perceived gender identity and phenotypic sex. *See* Am. Psychiatric Ass'n, *Diagnostic and Statistical Manual of Mental Disorders* 453 (5th ed. 2013).

[3] The panel adopts the question-begging term "gender confirmation surgery," which is preferred by Edmo and her lawyers. I will continue to use the neutral "sex-reassignment surgery."

before the regular meeting of the multidisciplinary Management Treatment Committee.

Dr. Eliason, supported by Dr. Stoddart, Dr. Young, and Clark, opted not to recommend sex-reassignment surgery for several reasons, some of which are described in his chart notes and others of which were elaborated in their testimony. First, Dr. Eliason noted that Edmo reported that the hormone therapy had improved her dysphoria and Eliason "did not observe significant dysphoria." In the absence of more severe distress, Dr. Eliason could not justify the risks of pursuing the most aggressive—and permanent—treatment through surgery. Second, Dr. Eliason observed that Edmo's comorbid conditions—major depressive disorder and alcohol use disorder, among others—were not adequately controlled. Edmo had refused to attend therapy consistently in prison. She also engaged in self harm (including cutting and attempted castration) and exhibited co-dependency and persistently poor sexual boundaries with other prisoners. In Dr. Eliason's view, Edmo's other mental health disorders were not sufficiently stabilized to handle the stressful process of surgery and transition. Finally, Dr. Eliason observed that Edmo—who was parole-eligible and due to be released in 2021—had not lived among her out-of-prison social network as a woman. He noted the high suicide rates for postoperative patients and was concerned that Edmo might be at greater risk of suicide given the potential lack of support from family, friends, coworkers, and neighbors during her transition. Dr. Eliason did not rule out the possibility of Edmo receiving sex-reassignment surgery at some later point. As Dr. Eliason put it in his notes on his consultation with Edmo, "Medical Necessity for Sexual Reassignment Surgery is not very well defined and is constantly shifting." Citing the changing nature of the

science and the contingent nature of his evaluation of Edmo, his recommendations were merely "for the time being."

B

About a year after her evaluation, Edmo filed this § 1983 lawsuit against Dr. Eliason, the Idaho Department of Corrections, Corizon, and several other individuals, alleging that the prison doctors' treatment choice violated her right to be free from cruel and unusual punishment under the Eighth and Fourteenth Amendments. She then moved for a preliminary injunction to require the prison to provide her with sex-reassignment surgery.

The district court held an evidentiary hearing on the motion. At the outset of the hearing, the court commented that it was hard "to envision" how a request to mandate sex-reassignment surgery could be granted through anything other than a permanent injunction. Nonetheless, the district court evaluated Edmo's motion under the preliminary injunction standard and, only out of "an abundance of caution," provided a footnote evaluating whether an injunction was merited under the more demanding standard for a permanent injunction (which the court erroneously described as "no more rigorous than that applicable to a claim for preliminary mandatory relief"). *Edmo v. Idaho Dep't of Corr.*, 358 F. Supp. 3d 1103, 1122 n.1 (D. Idaho 2018); *see Edmo v. Corizon, Inc.*, 935 F.3d 757, 784 n.13 (9th Cir. 2019) ("[T]he standard for granting permanent injunctive relief is higher (in that it requires actual success on the merits) . . . .").

In addition to testimony from Edmo, Dr. Eliason, and Jeremy Clark, the evidentiary hearing featured testimony from four expert witnesses. Edmo presented Dr. Randi Ettner, a psychologist, and Dr. Ryan Gorton, an emergency

room physician. Dr. Ettner is one of the authors of the World Professional Association of Transgender Health's Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People and chairs WPATH's Committee for Institutionalized Persons. Dr. Gorton serves on that committee too. WPATH—formerly the Harry Benjamin International Gender Dysphoria Association—describes itself as a "professional association" devoted "to developing best practices and supportive policies worldwide that promote health, research, education, respect, dignity, and equality for transsexual, transgender, and gender nonconforming people in all cultural settings." World Prof'l Ass'n for Transgender Health, *Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People* 1 (7th ed. 2011) ("WPATH Standards"). One of WPATH's central functions is to promulgate Standards of Care, which offer minimalist treatment criteria for several possible approaches to gender dysphoria, from puberty-blocking hormones to sex-reassignment surgery.

In addition to Dr. Eliason and Mr. Clark, the State presented Dr. Keelin Garvey, the Chief Psychiatrist of the Massachusetts Department of Corrections and chair of its Gender Dysphoria Treatment Committee, and Dr. Joel Andrade, a clinical social worker who served as clinical director for the Massachusetts Department of Corrections and served on its Gender Dysphoria Treatment Committee. Each set of experts had gaps in their relevant experience. Edmo's experts had never treated *inmates* with gender dysphoria, while the State's experts had never conducted long-term follow-up care with a patient who had undergone sex-reassignment surgery.

Edmo's experts testified that, in their opinion, Edmo needs sex-reassignment surgery. They based their conclusion on the latest edition of WPATH Standards of Care, which contain six criteria for sex-reassignment surgery:

(1) "persistent, well documented gender dysphoria,"

(2) "capacity to make a fully informed decision and to consent for treatment,"

(3) "age of majority,"

(4) "if significant medical or mental health concerns are present, they must be well controlled,"

(5) "12 continuous months of hormone therapy as appropriate to the patient's gender goals,"

(6) "12 continuous months of living in a gender role that is congruent with their gender identity."

Id. at 60. In the opinion of Edmo's experts, Edmo met all six criteria and was unlikely to show further improvement in her gender dysphoria without such surgery.

The State's experts disagreed on three main grounds. First, they did not regard the WPATH Standards as definitive treatment criteria, let alone medical consensus. In their analysis, the evidence underlying the WPATH Standards is not sufficiently well developed, particularly when it comes to the treatment of gender dysphoric prisoners. Therefore, they opined that a prudent, competent doctor might rely on clinical judgment that differs from the (already ambiguous) WPATH Standards. Second, the State's experts testified that, even under WPATH, Edmo failed to meet the fourth

criterion for surgery, which requires that the patient's other mental health concerns be well controlled in order to reduce the risks associated with transitioning. In the view of the State's experts, her mental health raised the concern that she would have trouble transitioning. For their part, Edmo's experts argued that Edmo's depression and addiction were controlled enough for surgery and that some current symptoms (such as self-cutting) stem from her gender dysphoria and therefore can be alleviated with surgery. Finally, the State's experts testified that Edmo also failed to meet the WPATH Standards' sixth criterion for surgery, which requires that Edmo live as a woman for twelve months before surgery. In their view, it was essential that Edmo live those twelve months outside of prison—that is, within her social network—in order to be adequately sure that she and her social network are ready for the challenges posed by transitioning. Edmo's experts disagreed, noting that WPATH says treatment in prisons should "mirror" treatment outside of prisons.

C

Although this appeal is from a grant of a preliminary injunction, at some point the evidentiary hearing on the motion for a preliminary injunction was consolidated into a final bench trial on the merits. It is hard to know when (or if) the parties were given the requisite "clear and unambiguous notice" of consolidation. *See Isaacson v. Horne*, 716 F.3d 1213, 1220 (9th Cir. 2013); *see also Univ. of Tex. v. Camenisch*, 451 U.S. 390, 395 (1981).

The district court applied the Supreme Court's oft-cited rule that "deliberate indifference to serious medical needs of prisoners constitutes the 'unnecessary and wanton infliction of pain' proscribed by the Eighth Amendment." *Estelle v. Gamble*, 429 U.S. 97, 104 (1976) (quoting *Gregg v.*

Georgia, 428 U.S. 153, 173 (1976)). The State agreed that gender dysphoria is a serious medical need, so the only question on the merits is whether Dr. Eliason and his team were "deliberately indifferent" as a matter of law.

The district court concluded that the State's experts were "unconvincing" and gave their opinions "virtually no weight." *Edmo*, 358 F. Supp. 3d at 1125–26. Once such expert testimony was set aside, the district court held that any decision not to prescribe sex-reassignment surgery would be "medically unacceptable under the circumstances" and would therefore violate the Eighth Amendment. *Id.* at 1127. Accordingly, the district court entered an injunction ordering the State to "take all actions reasonably necessary to provide Ms. Edmo gender confirmation surgery as promptly as possible." *Id.* at 1129.

D

The panel has now affirmed the injunction. *See Edmo*, 935 F.3d at 803. Concluding that sex-reassignment surgery was "medically necessary" and that the prison officials chose a different course of treatment "with full awareness of the prisoner's suffering," the panel holds that Dr. Eliason and the other prison officials "violate[d] the Eighth Amendment's prohibition on cruel and unusual punishment." *Id.*

To reach its conclusion that sex-reassignment surgery was medically necessary, the panel spends most of its lengthy opinion extolling and explaining the WPATH Standards of Care. Because Dr. Eliason failed to "follow" or "reasonably deviate from" the WPATH Standards, the panel concluded that his treatment choice was "medically unacceptable under the circumstances." *Id.* at 792. To reach the ultimate conclusion—that Dr. Eliason had a deliberately

indifferent state of mind and was consequently in violation of the Eighth Amendment—the panel posited that Dr. Eliason's awareness of the risks that Edmo would attempt to castrate herself or feel "clinically significant" distress "demonstrates that Dr. Eliason acted with deliberate indifference." *Id.* at 793. Each conclusion was legal error.

II

"Deliberate indifference is a high legal standard." *Toguchi v. Chung*, 391 F.3d 1051, 1060 (9th Cir. 2004). It is, after all, under governing precedent one form of the "unnecessary and wanton infliction of pain" that is the sine qua non of an Eighth Amendment violation. *Estelle*, 429 U.S. at 104 (quoting *Gregg v. Georgia*, 428 U.S. 153, 173 (1976)). Simply put, Edmo must prove that Dr. Eliason's chosen course of treatment was the doing of a criminally reckless—or worse—state of mind. *Farmer v. Brennan*, 511 U.S. 825, 839 (1994).

We have stated that a deliberately indifferent state of mind may be inferred when "the course of treatment the doctors chose was medically unacceptable under the circumstances" and "they chose this course in conscious disregard of an excessive risk to plaintiff's health." *Jackson v. McIntosh*, 90 F.3d 330, 332 (9th Cir. 1996). Yet even most objectively unreasonable medical care is not deliberately indifferent. "[M]ere 'indifference,' 'negligence,' or 'medical malpractice'" is not enough to constitute deliberate indifference. *Lemire v. Cal. Dep't of Corr. & Rehab.*, 726 F.3d 1062, 1082 (9th Cir. 2013) (quoting *Broughton v. Cutter Labs.*, 622 F.2d 458, 460 (9th Cir. 1980)). "Even gross negligence is insufficient to establish deliberate indifference . . . ." *Id.* Likewise, "[a] difference of opinion between a physician and the prisoner—or between medical professionals—concerning what

medical care is appropriate does not amount to deliberate indifference." *Snow v. McDaniel*, 681 F.3d 978, 987 (9th Cir. 2012) (citing *Sanchez v. Vild*, 891 F.2d 240, 242 (9th Cir. 1989)), *overruled on other grounds by Peralta v. Dillard*, 744 F.3d 1076, 1083 (9th Cir. 2014) (en banc). Although the panel organizes its opinion according to the dictum we first articulated in *Jackson*, it so contorts the standard as to render deliberate indifference exactly what we have said it is not: a constitutional prohibition on good-faith disagreement between medical professionals.

A

The panel first, and fundamentally, errs by misunderstanding what it means for a chosen treatment to be medically "unacceptable" for purposes of the Eighth Amendment. As did the district court, the panel concludes that the decision to continue hormone treatment and counseling instead of sex-reassignment surgery for Edmo was "medically unacceptable under the circumstances" because, in short, Dr. Eliason failed to "follow" or "reasonably deviate from" the WPATH Standards of Care. *Edmo*, 935 F.3d at 792. Yet such an approach to the Eighth Amendment suffers from three essential errors. First, contrary to the panel's suggestion, constitutionally acceptable medical care is not defined by the standards of one organization. Second, the panel relies on standards that were promulgated by a controversial self-described advocacy group that dresses ideological commitments as evidence-based conclusions. Third, once the WPATH Standards are put in proper perspective, we are left with a "case of dueling experts," compelling the conclusion that Dr. Eliason's treatment choice was indeed medically acceptable.

1

A mere professional association simply cannot define what qualifies as constitutionally acceptable treatment of prisoners with gender dysphoria. In *Bell v. Wolfish*, 441 U.S. 520 (1979), the Supreme Court rejected the argument that prison conditions must reflect those set forth in the American Public Health Association's Standards for Health Services in Correctional Institutions, the American Correctional Association's Manual of Standards for Adult Correctional Institutions, or the National Sheriffs' Association's Handbook on Jail Architecture. *Id.* at 543 n.27. According to the Court, "the recommendations of these various groups may be instructive in certain cases, [but] they simply do not establish the constitutional minima." *Id.* After all, even acclaimed, leading treatment criteria only represent the "goals recommended by the organization in question" and the views of the promulgating physicians,[4] and so, without more, a physician's disagreement with such criteria is simply the "'difference of medical opinion' . . . [that is] insufficient, as a matter of law, to establish deliberate indifference." *Id.*; *Jackson*, 90 F.3d at 332 (quoting *Sanchez*, 891 F.2d at 242); *accord Snow*, 681 F.3d at 987; *see also Long v. Nix*, 86 F.3d 761, 765 (8th Cir. 1996) ("[N]othing in the Eighth Amendment prevents prison doctors from exercising their independent medical judgment.").

In its discussion of the role of treatment standards, the panel fails to cite a single case in which a professional organization's standards of care defined the line between medically acceptable and unacceptable treatment. Instead, the panel cites two cases, one from the Seventh Circuit and

[4] Although, as we will see, only half of the committee that promulgates the WPATH Standards are physicians.

one from the Eighth, for the proposition that professional organizations' standards of care are "highly *relevant* in determining what care is medically acceptable and unacceptable." *Edmo*, 935 F.3d at 786 (emphasis added). That may be. But as those two cases demonstrate, the range of medically acceptable care is defined by *qualities* of that care (or of its opposite) and not by professional associations. Medically unacceptable care is "*grossly incompetent* or inadequate care," *Allard v. Baldwin*, 779 F.3d 768, 772 (8th Cir. 2015), or care that constitutes "such a substantial departure from accepted professional judgment to demonstrate that the person responsible did not base the decision on . . . [accepted professional] judgment," *Henderson v. Ghosh*, 755 F.3d 559, 566 (7th Cir. 2014) (original parenthetical) (quoting *McGee v. Adams*, 721 F.3d 474, 481 (7th Cir. 2013) (stipulating that "medical professionals . . . are 'entitled to deference in treatment decisions unless no minimally competent professional would have so responded'")). For its part, the First Circuit holds in its own sex-reassignment-surgery case that medical care does not violate the Eighth Amendment so long as it is "reasonably commensurate with the medical standards of prudent professionals." *Kosilek v. Spencer*, 774 F.3d 63, 90 (1st Cir. 2014) (en banc). The panel is alone in its insistence that a professional association's standards add up to the constitutional minima.[5]

[5] Far from countering such assertions, the panel's concession that "deviation from [WPATH] standards does not alone establish an Eighth Amendment claim" is just a truism that recognizes that the Eighth Amendment also contains a subjective element. *Edmo*, 935 F.3d at 789. Moreover, such a statement serves simply to repeat the panel's faulty premise that the WPATH Standards are the appropriate reference point in any analysis of medical acceptability.

2

In the words of the panel, speaking for our court, the WPATH Standards are "the gold standard," the "established standards" for evaluations of the necessity of sex-reassignment surgery, the "undisputed starting point in determining the appropriate treatment for gender dysphoric individuals." *Edmo*, 935 F.3d at 787–88, 788 n.16. But such overwrought acclaim is just the beginning of the panel's thorough enshrinement of the WPATH Standards. The district court chose which expert to rely on by looking at which expert hewed most closely to the WPATH Standards of Care. *See Edmo*, 358 F. Supp. 3d at 1124–26. And the panel uncritically approves such an approach, calling the WPATH Standards "a useful starting point for analyzing the credibility and weight to be given to each expert's opinion." *Edmo*, 935 F.3d at 788 n.16. By rejecting any expert not (in the court's view) appropriately deferential to WPATH, the district court and now the panel have effectively decided ab initio that only the WPATH Standards could constitute medically acceptable treatment.[6]

[6] In enshrining the WPATH Standards as the "gold standard" for determining when to provide surgery to a prisoner with gender dysphoria, the panel makes much of the State's comment in its opening statement before the evidentiary hearing that the WPATH Standards are the "best standards out there." *Edmo*, 935 F.3d at 769, 788 n.16. The panel even goes so far as to insist that "[b]oth sides . . . agree that the appropriate benchmark regarding treatment for gender dysphoria is the World Professional Association of Transgender Health Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People." *Id.* at 767. But, contrary to the panel's suggestion, the State's admission that the WPATH Standards are more refined than any alternative hardly means that the State agrees—or the Eighth Amendment requires—that a medical provider must base treatment decisions on WPATH's criteria. Indeed, before the district

One would be forgiven for inferring from the panel's opinion that its bold assertions about the WPATH Standards are uncontroverted truths. But, as the Fifth Circuit has recognized, "the WPATH Standards of Care reflect not consensus, but merely one side in a sharply contested medical debate over sex reassignment surgery." *Gibson v. Collier*, 920 F.3d 212, 221 (5th Cir. 2019). For its part, the First Circuit, sitting en banc, has likewise held that "[p]rudent medical professionals . . . do reasonably differ in their opinions regarding [WPATH's] requirements." *Kosilek*, 774 F.3d at 88. Our court should have done the same.

The WPATH Standards are merely criteria promulgated by a controversial private organization with a declared point of view. According to Dr. Stephen Levine, author of the WPATH Standards' fifth version, former Chairman of WPATH's Standards of Care Committee, and the court-appointed expert in *Kosilek*, WPATH attempts to be "both a scientific organization and an advocacy group for the transgendered. These aspirations sometimes conflict." *Id.* at 78. Sometimes the pressure to be advocates wins the day. As Levine put it, "WPATH is supportive to those who want sex reassignment surgery. . . . Skepticism and strong alternate views are not well tolerated. Such views have been known to be greeted with antipathy from the large numbers of nonprofessional adults who attend each [of] the organization's biennial meetings . . . ." *Id.* (ellipses and

court and before our court, the State clearly rejected the notion that any particular treatment criteria defines what is medically acceptable, stating that Dr. Eliason's choice "should be ratified as long as it is a reasonable choice." The panel erroneously construes the State's refusal to concede that it violated the WPATH Standards as a concession that such standards are the "benchmark" of legally acceptable medical care.

brackets original). WPATH's own description of its drafting process makes this clear. Initially, the sections of the sixth version were each assigned to an individual member of WPATH who then published a literature review with suggested revisions. WPATH Standards, *supra*, at 109. The suggested revisions were then discussed and debated by a thirty-four-person Revision Committee, all before a subcommittee drafted the new document. *Id.* at 109–11. Only about half of the Revision Committee possesses a medical degree. The rest are sexologists, psychotherapists, or career activists, with a sociologist and a law professor rounding out the group. *Id.* at 111.

The pressure to be advocates appears to have won the day in the WPATH Standards' recommendations regarding institutionalized persons. Recall that one central point of contention between the State's witnesses and Edmo's was over whether Edmo's time undergoing hormone therapy in prison provides sufficient guarantee that she could live well outside of prison as a woman without having ever done so before. The district court resolved the debate by citing the WPATH Standards' section on institutionalized persons, *see Edmo*, 358 F. Supp. 3d at 1125, which tersely stipulates that institutionalized persons should not be "discriminated against" on the basis of their institutionalization, WPATH Standards, *supra*, at 67. Such a recommendation is not supported by any research about the similarity between prisoners' experiences with sex-reassignment surgery and that of the general public. Indeed, as Edmo's expert witness and WPATH author, Dr. Randi Ettner, admits, there is only one known instance of a person undergoing sex-reassignment surgery while incarcerated—leaving medical knowledge about how such surgery might differ totally undeveloped.

Instead, WPATH's recommendation for institutionalized persons merely expresses a policy preference. The article from which the recommendations are adapted stipulates upfront that, because WPATH's "mission" is "to advocate for nondiscriminatory" care, it presumes that treatment choices should be the same for all "demographic variables, unless there is a clinical indication to provide services in a different fashion." George R. Brown, *Recommended Revisions to the World Professional Association for Transgender Health's* Standards of Care *Section on Medical Care for Incarcerated Persons with Gender Identity Disorder*, 11 Int'l J. of Transgenderism 133, 134 (2009). Unable to make an evidentiary finding from a sample size of one, the article concludes that its presumption should set the standard of care and then proceeds to recommend revisions with the express purpose of influencing how courts review gender dysphoria treatments under the Eighth Amendment. *Id.* at 133, 135. As a later peer-reviewed study by Dr. Cynthia Osborne and Dr. Anne Lawrence put it, WPATH's institutionalized-persons recommendations follow from an "ethical principle," not "extensive clinical experience." Cynthia S. Osborne & Anne A. Lawrence, *Male Prison Inmates With Gender Dysphoria: When Is Sex Reassignment Surgery Appropriate?*, 45 Archives of Sexual Behav. 1649, 1651 (2016).

Even apart from the concerns over WPATH's ideological commitments, its evidentiary basis is not sufficient to justify the court's reliance on its strict terms. The WPATH Standards seem to suggest as much. In its own words, the WPATH Standards are simply "*flexible* clinical guidelines," which explicitly allow that "individual health professionals and programs may modify them." WPATH Standards, *supra*, at 2. Indeed, the most recent WPATH Standards "represents a significant departure from previous

versions" in part due to significant changes in researchers' conclusions over the preceding decade. *Id.* at 1 n.2. Moreover, the WPATH Standards lack the evidence-based grading system that characterizes archetypal treatment guidelines, such as the Endocrine Society's hormone therapy guidelines. Lacking evidence-based grading, the WPATH Standards leave practitioners in the dark about the strength of a given recommendation. *See* William Byne et al., *Report of the American Psychiatric Association Task Force on Treatment of Gender Identity Disorder*, 41 Archives of Sexual Behav. 759, 783 (2012) (concluding that "the level of evidence" supporting WPATH's Standards' criteria for sex-reassignment surgery "was generally low"). For these reasons, the Centers for Medicare & Medicaid Services, an agency of the United States Department of Health and Human Services, decided, "[b]ased on a thorough review of the clinical evidence," that providers may consult treatment criteria other than WPATH, including providers' own criteria. Ctrs. for Medicare & Medicaid Servs, *Proposed Decision Memo for Gender Dysphoria and Gender Reassignment Surgery* (June 2, 2016); Ctrs. for Medicare & Medicaid Servs, *Decision Memo for Gender Dysphoria and Gender Reassignment Surgery* (Aug. 30, 2016).

3

The panel's disposition results from its failure to put the WPATH Standards in proper perspective. Had the district court understood that Edmo's experts' role in WPATH marks them not with special insight into the legally acceptable care, but rather as mere participants in an ongoing medical debate, they would have acknowledged this case for what it is: a "case of dueling experts." *Edmo*, 935 F.3d at 787. Instead of giving Drs. Garvey and Andrade (to say nothing of Dr. Eliason) "no weight" due to their insufficient

fealty to WPATH, the district court should have recognized them as legitimate, experienced participants in that debate. And had the State's experts' criticisms of and interpretation of the WPATH Standards been given proper weight—any weight at all—the district court would have had to conclude that the State's disagreement with Edmo's experts was a mere "difference of medical opinion," not a constitutional violation. *Jackson*, 90 F.3d at 332.

So too with its assessment of Dr. Eliason's treatment choice. It is instructive that the worst the district court can say about Dr. Eliason is that he "did not apply the WPATH criteria." *Edmo*, 358 F. Supp. 3d at 1126. Focusing the analysis not on whether Dr. Eliason applied the standards of a professional association but rather on whether the treatment choice was within that of a prudent, competent practitioner, the cautious treatment selected by Dr. Eliason is plainly constitutionally acceptable.

As Drs. Garvey and Andrade explain, it is medically acceptable to offer Edmo a treatment of hormone therapy and psychotherapy but not sex-reassignment surgery. The practitioners' fear that sex-reassignment surgery would exacerbate Edmo's other mental illnesses and increase the risk of surgery was a genuine and sound fear. As Dr. Garvey put it, "[b]ased on her current coping strategies, I would be concerned about her suicide risk after surgery." Although the measured "regret rate," which refers to the proportion of postoperative patients who regret their surgery, is "low," *see Edmo*, 935 F.3d at 771, the district court and the panel failed to acknowledge detailed testimony that those studies neglected to follow up with such a high proportion of the observed sample that the stated figure does not "represent the full picture." In Dr. Andrade's opinion, "I think there are things she needs to work out in therapy in the short and long

term before she can make a really well-informed decision about surgery." He raised the concern that Edmo is particularly at risk because of "unresolved trauma" that may stem, not from gender dysphoria, but instead from past sexual abuse.

Dr. Eliason's view that Edmo needed to have lived as a woman outside of prison in order to ensure that she would be able to adapt well after the surgery was also legitimate. Indeed, under the peer-reviewed treatment criteria developed by Drs. Osborne and Lawrence, Edmo was not eligible for sex-reassignment surgery for these exact reasons. Acknowledging the lack of evidence concerning the effects of sex-reassignment surgery on inmates, the unique challenges imposed by the correctional setting, and the significant risk of patient regret, Drs. Osborne and Lawrence proposed criteria that require a prospective patient have "a satisfactory disciplinary record and demonstrated capacity to cooperate" and "a long period of expected incarceration after [surgery]," among others. Osborne & Lawrence, *supra*, at 1661. This latter criterion helps to ensure that male-to-female patients have "a longer period of time to consolidate one's feminine gender identity and gender role." *Id.* at 1660; *see also id.* at 1656 ("[I]nmates with [gender dysphoria] who attempt to live in female-typical gender roles within men's prisons . . . could not effectively prepare" for life after surgery.) The district court disregarded such additional, peer-reviewed treatment criteria because they "are not part of the WPATH criteria and are in opposition to the WPATH Standards of Care." *Edmo*, 358 F. Supp. 3d at 1126. Had the district court taken a step back and considered not whether Osborne and Lawrence were WPATH-compliant but rather whether a competent physician could rely on their reasoning, it would have had to conclude that Dr. Eliason's treatment choice was that of a competent, prudent physician.

Perhaps recognizing such problems with the district court's definition of medical unacceptability, the panel concludes its medical-unacceptability analysis by changing the subject. Instead of considering whether Dr. Eliason's choice of *treatment* was medically unacceptable, the panel fixates on Dr. Eliason's chart notes, which sets forth three general categories in which he believes sex-reassignment surgery may be required: (1) "Congenital malformation or ambiguous genitalia," (2) "Severe and devastating dysphoria that is primarily due to genitals," (3) or "Some type of medical problem in which endogenous sexual hormones were causing severe physiological damage." According to the panel, such categories "bear little resemblance" to the WPATH Standards and therefore "Dr. Eliason's evaluation was not an exercise of medically acceptable professional judgment." *Edmo*, 935 F.3d at 791–92. In the first place, Dr. Eliason's categories are not meant to substitute for treatment standards. Such categories describe three broad pools of eligible patients; whether a particular patient belongs in a certain pool—by having dysphoria sufficiently severe to require sex-reassignment surgery, for instance—would be resolved by more detailed evaluative criteria. In the second place, conformity to WPATH is not the test of constitutionally acceptable treatment of gender dysphoria. But more broadly, the panel simply asks the wrong question. Deliberate indifference may be inferred when "the *course of treatment* the doctors chose was medically unacceptable under the circumstances," not when the doctors' contemporaneous explanation of the choice is incomplete. *Jackson*, 90 F.3d at 332 (emphasis added); *see also Snow*, 681 F.3d at 988; *Toguchi*, 391 F.3d at 1058; *Hamby v. Hammond*, 821 F.3d 1085, 1092 (9th Cir. 2016) (all referring to the "course of treatment," not the rationale). It does not matter that Dr. Eliason's testimony justifies his treatment choice in ways not explicit in his chart notes such that the

panel calls his testimony a "post hoc explanation." *Edmo*, 935 F.3d at 791. So long as the ultimate treatment *choice* was medically acceptable, our precedents tell us, we cannot infer "the unnecessary and wanton infliction of pain" that violates the Eighth Amendment.

B

Even were the panel correct that the only medically acceptable way to approach a gender dysphoric patient's request for sex-reassignment surgery is to apply the WPATH Standards of Care, we still could not infer a constitutional violation from these facts. As the Supreme Court has explained, the Eighth Amendment simply proscribes categories of punishment, and punishment is "a deliberate act intended to chastise or deter." *Wilson v. Seiter*, 501 U.S. 294, 299–300 (1991). "[O]nly the 'unnecessary *and wanton* infliction of pain' implicates the Eighth Amendment." *Id.* at 297 (quoting *Estelle*, 429 U.S. at 104) (emphasis original). Hence the commonplace deliberate-indifference inquiry, which is a culpability standard equivalent to criminal recklessness. *Farmer*, 511 U.S. at 839–40. Simply put, unless the official "knows of and disregards an excessive risk to inmate health and safety," he does not violate the Eighth Amendment. *Id.* at 837.

1

With little explanation, the panel castigates Dr. Eliason for having "disregarded" risks that he directly and forthrightly addressed. *Edmo*, 935 F.3d at 793. Far from disregarding the risk that Edmo would attempt to castrate herself, Dr. Eliason investigated the causes of such a risk and took concrete steps to mitigate it. Edmo's self-harm (including her castration attempts) followed closely after her disciplinary infractions and other severe stressors.

Identifying this causal connection, Dr. Eliason prescribed and encouraged regular counseling to address Edmo's acting out and her ability to cope. Dr. Eliason also sought to further deter self-castration by explaining to Edmo that she will need to have intact genitals for any eventual surgery, something Edmo now understands and articulated in her testimony. Likewise, contrary to the panel's conclusion that he disregarded the risk of continued distress, Dr. Eliason opted for a treatment of continued hormone therapy and more regular supportive counseling precisely because hormone therapy had already substantially ameliorated the distress from the dysphoria.

Furthermore, the panel errs by fixating on such individual risks. Physicians ministrate to whole individuals with whole diseases. Thus, individual risks may—and frequently do—persist for the sake of the overall health of the person. Dr. Eliason and his staff clearly believed their treatment choice would mitigate *overall risk*, including grave risks the panel downplays. Given Edmo's long-term struggles with severe depression and addiction, coupled with the fact that she had not lived as a woman within her social network, Eliason and the other doctors with whom he staffed the evaluation were concerned that she would have trouble adjusting after surgery, which could lead to regret, relapse, or new mood disorders. Ultimately, they worried that she might attempt suicide again. Such risks are not trifling and, in light of them, Dr. Eliason's willingness to accept some risk that Edmo would try to castrate herself or would continue to feel the distress of gender dysphoria (while taking steps to mitigate such risks) is anything but deliberately indifferent.

2

None of this is to acquiesce in the straw-man argument set up by the panel: that, so long as officials provide some care, they are immunized from an Eighth Amendment claim. One may assume that some medical care is indeed so obviously inadequate that, without any direct evidence of the defendant's state of mind, we may infer that the defendant was deliberately indifferent. *See Farmer*, 511 U.S. at 842 (remarking that deliberate indifference is "subject to demonstration in the usual ways, including inference from circumstantial evidence" and may be inferred "from the very fact that the risk was obvious").[7] But that is not this case.

Even in a legal universe in which the WPATH Standards define adequate care, Dr. Eliason's deviations were not deliberately indifferent. He selected a course of treatment that, in light of the complex of diagnoses, the grave risks, and the rapidly evolving nature of the medical research, was

[7] It should, however, be noted that the panel fails to identify a precedent of ours in which we have inferred a physician's deliberate indifference solely from the inadequate nature of the treatment and the persistence of known risks. In the nearest cases, some other circumstantial evidence has suggested the obviousness of the inadequacy such that the physician must have been aware of the inadequacy. *E.g., Snow*, 681 F.3d at 988 (non-specialist refused the recommendation of a treating specialist); *Hamilton v. Endell*, 981 F.2d 1062, 1067 (9th Cir. 1992) (same); *Lopez v. Smith*, 203 F.3d 1122, 1132 (9th Cir. 2000) (same); *Hunt v. Dental Dep't*, 865 F.2d 198, 201 (9th Cir. 1989) (refusal to replace the dentures prisoner had been prescribed); *Jett v. Penner*, 439 F.3d 1091, 1098 (9th Cir. 2006) (prisoner not referred to specialist for reasons unrelated to the prisoner's medical needs and medical records were manipulated); *Colwell v. Bannister*, 763 F.3d 1060, 1070 (9th Cir. 2014) (reliance on arbitrary prison policy). I do not doubt that mere inadequacy may raise the inference of deliberate indifference, but we seem to leave such an inference for cases of genuine quackery.

not obviously inadequate. *Cf. Lemire*, 726 F.3d at 1075 ("A prison official's deliberately indifferent conduct will generally 'shock the conscience' so long as the prison official had time to deliberate before acting . . . ."). He subjected his assessment to a review process intended to surface any possibility he was not considering, a review process that included several doctors and a full committee. And far from being an "unjustifiable" or "gross" deviation from the WPATH Standards, he departed from WPATH by raising the Standards' own concerns for the presence of comorbid conditions and the patient's limited experience as a woman. *See Farmer*, 511 U.S. at 839 (incorporating the Model Penal Code's definition of criminal recklessness); Model Penal Code § 2.02(2)(c) (1985) (stating that the criminally reckless individual "disregards a substantial and unjustifiable risk" and that such disregard "involves a gross deviation from the standard of conduct that a law-abiding person would observe in the actor's situation."). Indeed, the panel concludes that his deviations were simply not "reasonable"—the test for negligent malpractice, not deliberate indifference. *Edmo*, 935 F.3d at 792. "Eighth Amendment liability requires 'more than ordinary lack of due care . . . .'" *Farmer*, 511 U.S. at 835 (quoting *Whitley v. Albers*, 475 U.S. 312, 319 (1986)).

III

The panel's novel approach to Eighth Amendment claims for sex-reassignment surgery conflicts with every other circuit to consider the issue. The panel acknowledges such a circuit split with the Fifth Circuit's opinion in *Gibson v. Collier*, 920 F.3d 212 (5th Cir. 2019), but tries—and fails—to distinguish the First Circuit's en banc opinion in *Kosilek v. Spencer*, 774 F.3d 63 (1st Cir. 2014). *See Edmo*, 935 F.3d at 794–95. The panel does not even address a third

decision: the Tenth Circuit's opinion in *Lamb v. Norwood*, 899 F.3d 1159 (10th Cir. 2018).

Just as in this case, the First Circuit considered an appeal of an injunction mandating sex-reassignment surgery. But, unlike our court, the First Circuit reversed. Though the panel attempts to downplay the direct conflict between its opinion and *Kosilek* by pointing to minor differences between the factual circumstances in each case,[8] the decisive differences are matters of law. As to whether the care was medically unacceptable, the First Circuit held that medically acceptable treatment of gender dysphoric prisoners is not synonymous with the demands of WPATH. *Kosilek* first reversed the district court's finding that one of the State's experts was "illegitimate" because the district court "made a significantly flawed inferential leap: it relied on its own—non-medical—judgment" and put too much "weight" on the WPATH Standards. *Kosilek*, 774 F.3d at 87–88. With that expert now taken seriously, the First Circuit held that the denial of Kosilek's sex-reassignment surgery was medically

[8] The differences between the circumstances in *Kosilek* and those in this case are not substantial enough to distinguish the holdings. The clinical judgments in each case were motivated by concerns about coexisting mental health conditions and the risk of suicide. *Kosilek*, 774 F.3d at 72. Just as in this case, *Kosilek* surfaced expert opinions that the WPATH Standards are best applied flexibly, that in-prison experience in the newly assigned gender is not a sufficient guarantee of ability to transition, and that practitioners face a "dearth of empirical research" on sex-reassignment surgery. *Id.* at 72–73, 76. The "security concerns" over how to house a potential postoperative Kosilek, which the panel considers the foremost difference between the two cases, was not even essential to *Kosilek*'s holding. *See Edmo*, 935 F.3d at 794; *Kosilek*, 774 F.3d at 91–92 (concluding that the officials' "choice of a medical option . . . does not exhibit a level of inattention or callousness to a prisoner's needs rising to a constitutional violation" before even analyzing the security concerns).

acceptable because it was within the bounds of "the medical standards of prudent professionals." *Id.* at 90. On the question of deliberate indifference, the First Circuit applied a test, which, unlike the panel's inference from the practitioners' mere knowledge that a course of treatment carried risks, asked whether the practitioners "knew or should have known" that course of treatment was *medically unacceptable*. *Id.* at 91.

For its part, the Fifth Circuit has held that good faith denial of sex-reassignment surgery *never* violates the Eighth Amendment. Recognizing "large gaps" in medical knowledge and a "robust and substantial good faith disagreement dividing respected members of the expert medical community," the Fifth Circuit concluded that "there can be no claim [for sex-reassignment surgery] under the Eighth Amendment." *Gibson*, 920 F.3d at 220, 222. Indeed, Texas's refusal to even evaluate the inmate for sex-reassignment surgery is, in the words of the Fifth Circuit, not "so unconscionable as to fall below society's minimum standards of decency" and permit an Eighth Amendment claim. *Id*. at 216 (quoting *Kosilek*, 774 F.3d at 96).

Finally, the Tenth Circuit has upheld the entry of summary judgment against a prisoner's Eighth Amendment claim for sex-reassignment surgery. *See Lamb*, 899 F.3d at 1163. As in this case, the doctor who evaluated the prisoner in *Lamb* determined that "surgery is impractical and unnecessary in light of the availability and effectiveness of more conservative therapies." *Id.* Adopting *Kosilek*'s subjective standard—that an Eighth Amendment violation would take place "only if prison officials had known or should have known" that "sex reassignment surgery [was] the only medically adequate treatment"—the Tenth Circuit held that "prison officials could not have been deliberately

indifferent by implementing the course of treatment recommended by a licensed medical doctor." *Id.* at 1163 & n.11 (citing *Kosilek*, 774 F.3d at 91).

Although I am not aware of any other circuits to have directly addressed the questions posed in this case,[9] for its part, the Seventh Circuit has held that it is at least not "clearly established" that there is a constitutional right to gender-dysphoria treatment beyond hormone therapy. *Campbell v. Kallas*, 936 F.3d 536, 549 (7th Cir. 2019). Nor is it "clearly established" that a prison medical provider is prohibited from denying sex-reassignment surgery on the basis of the patient's status as an institutionalized person. *Id.* at 541, 549.

With this decision, our circuit sets itself apart.

IV

I do not know whether sex-reassignment surgery will ameliorate or exacerbate Adree Edmo's suffering. Fortunately, the Constitution does not ask federal judges to put on white coats and decide vexed questions of psychiatric medicine. The Eighth Amendment forbids the "unnecessary and wanton infliction of pain," not the "difference of opinion between a physician and the prisoner—or between medical

[9] The Seventh and Fourth Circuits (along with our own circuit) have also held that arbitrary blanket bans on certain gender dysphoria treatments can violate the Eighth Amendment—an issue not presented here because Idaho evaluates prisoner requests for sex-reassignment surgery on a case-by-case basis. *See Rosati v. Igbinoso*, 791 F.3d 1037, 1040 (9th Cir. 2015); *De'lonta v. Johnson*, 708 F.3d 520, 526 (4th Cir. 2013); *Fields v. Smith*, 653 F.3d 550, 556 (7th Cir. 2011).

professionals." *Snow*, 681 F.3d at 985, 987 (quoting *Estelle*, 429 U.S. at 104).

Yet today our court assumes the role of Clinical Advisory Committee. Far from rendering an opinion "individual to Edmo" that "rests on the record," *Edmo*, 935 F.3d at 767, the panel entrenches the district court's unfortunate legal errors as the law of this circuit. Instead of permitting prudent, competent patient care, our court enshrines the WPATH Standards as an enforceable "medical consensus," effectively putting an ideologically driven private organization in control of every relationship between a doctor and a gender dysphoric prisoner within our circuit. Instead of reserving the Eighth Amendment for the grossly, unjustifiably reckless, the panel infers a culpable state of mind from the supposed inadequacy of the treatment.

We have applied the traditional deliberate-indifference standard to requests for back surgery, kidney transplant, hip replacement, antipsychotic medication, and hernia surgery. Yet suddenly the request for sex-reassignment surgery—and the panel's closing appeal to what it calls the "increased social awareness" of the needs and wants of transgender citizens—effects a revolution in our law! *Id.* at 803. The temptation to stand at what we are told is society's next frontier and to invent a constitutional right to state-funded sex-reassignment surgery does not justify the revision of previously universal principles of Eighth Amendment jurisprudence.

Dr. Eliason and the State's other practitioners were not deliberately indifferent—far from it. And they certainly were not guilty of violating the Eighth Amendment. They confronted the serious risks to Edmo's health, especially the gravest one. They considered the knotty quandary posed by her overlapping illnesses and the vicissitudes of her life.

Mindful of the dictate "first do no harm," these doctors determined that the appropriate treatment would be more cautious and more reversible than the one the patient desired. And they did so in the shadow of the ongoing debate about when the surgical replacement of the genitals is curative and when it is not.

Surely this was not cruel and unusual punishment.

COLLINS, Circuit Judge, dissenting from the denial of rehearing en banc:

The Supreme Court has held that a prisoner claiming that his or her medical treatment is so inadequate that it constitutes "cruel and unusual punishment" in violation of the Eighth Amendment must make the demanding showing that prison officials acted with "deliberate indifference" to the prisoner's "serious medical needs." *Estelle v. Gamble*, 429 U.S. 97, 104 (1976). As judges of an "inferior Court[]," *see* U.S. Const. art. III, § 1, we are bound to apply that standard, but as Judge Bumatay explains, the panel here effectively waters it down into a "mere negligence" test. *See infra* at 47–48 (Bumatay, J., dissenting from denial of rehearing en banc). That is, by narrowly defining the range of "medically acceptable" options that the court believes a prison doctor may properly consider in a case such as this one, and by then inferring deliberate indifference from Dr. Eliason's failure to agree with that narrow range, the district court and the panel have applied standards that look much more like negligence than deliberate indifference. *Id.* at 45–48. Whether Dr. Eliason was negligent or not (a question on which I express no opinion), his treatment decisions do not amount to "cruel and unusual punishment," and we have thus strayed far from any proper understanding

of the Eighth Amendment. I therefore join Part II of Judge Bumatay's dissent, and I respectfully dissent from our failure to rehear this case en banc.

BUMATAY, Circuit Judge, with whom CALLAHAN, IKUTA, R. NELSON, BADE, and VANDYKE, Circuit Judges, join, and with whom COLLINS, Circuit Judge, joins as to Part II, dissenting from the denial of rehearing en banc:

Like the panel and the district court, I hold great sympathy for Adree Edmo's medical situation. And as with all citizens, her constitutional rights deserve the utmost respect and vigilant protection. As the district court rightly stated,

> The Rule of Law, which is the bedrock of our legal system, promises that all individuals will be afforded the full protection of our legal system and the rights guaranteed by our Constitution. This is so whether the individual seeking that protection is black, white, male, female, gay, straight, or, as in this case, transgender.[1]

Adree Edmo is a transgender woman suffering from gender dysphoria—a serious medical condition. While incarcerated in Idaho's correctional facilities, she asked that her gender dysphoria be treated with sex-reassignment

---

[1] *Edmo v. Idaho Dep't of Corr.*, 358 F. Supp. 3d 1103, 1109 (D. Idaho 2018), *order clarified*, No. 1:17-CV-00151-BLW, 2019 WL 2319527 (D. Idaho May 31, 2019), *and aff'd in part, vacated in part, remanded sub nom. Edmo v. Corizon, Inc.*, 935 F.3d 757 (9th Cir. 2019).

surgery ("SRS"). After consultation with a prison doctor, her request was denied. She then sued under the Eighth Amendment.[2]

I respect Edmo's wishes and hope she is afforded the best treatment possible. But whether SRS is the optimal treatment for Edmo's gender dysphoria is not before us. As judges, our role is not to take sides in matters of conflicting medical care. Rather, our duty is to faithfully interpret the Constitution.

That duty commands that we apply the Eighth Amendment, not our sympathies. Here, in disregard of the text and history of the Constitution and precedent, the panel's decision elevates innovative and evolving medical standards to be the constitutional threshold for prison medical care. In doing so, the panel minimizes the standard for establishing a violation of the Eighth Amendment.

After today's denial of rehearing en banc, the Ninth Circuit stands alone in finding that a difference of medical opinion in this debated area of treatment amounts to "cruel and unusual" punishment under the Constitution. While this posture does not mean we are wrong, it should at least give us pause before embarking on a new constitutional trajectory. This is especially true given the original meaning of the Eighth Amendment.

Because the panel's opinion reads into the Eighth Amendment's Cruel and Unusual Clause a meaning in conflict with its text, original meaning, and controlling

[2] Because Judge O'Scannlain thoroughly recites the relevant facts in his opinion respecting the denial of the rehearing en banc, which I join in full, I do not reiterate them here.

precedent, I respectfully dissent from the denial of rehearing en banc.

I.

In holding that Idaho[3] violated the Eighth Amendment, the panel opined that the Constitution's text and original meaning merited "little discussion." *See Edmo*, 935 F.3d at 797 n.21. I disagree.

As inferior court judges, we are bound by Supreme Court precedent. Yet, in my view, judges also have a "duty to interpret the Constitution in light of its text, structure, and original understanding." *NLRB v. Noel Canning*, 573 U.S. 513, 573 (2014) (Scalia, J., concurring). While we must faithfully follow the Court's Eighth Amendment precedent as articulated in *Estelle v. Gamble*, 429 U.S. 97 (1976), and its progeny, "[w]e should resolve questions about the scope of those precedents in light of and in the direction of the constitutional text and constitutional history." *Free Enter. Fund v. Public Co. Accounting Oversight Bd.*, 537 F.3d 667, 698 (D.C. Cir. 2008) (Kavanaugh, J., dissenting), *aff'd in part, rev'd in part and remanded*, 561 U.S. 477 (2010).

Accordingly, the Eighth Amendment's history and original understanding are of vital importance to this case.

A.

The Eighth Amendment provides that "[e]xcessive bail shall not be required, nor excessive fines imposed, nor cruel and unusual punishments inflicted." U.S. Const. amend.

[3] For simplicity, I collectively refer to Defendants below and Appellants here as "Idaho."

VIII. Even just a cursory review of the amendment's original meaning shows that Edmo's claims fall far below a constitutional violation as a matter of text and original understanding.

At the time of the Eighth Amendment's ratification, "cruel" meant "[p]leased with hurting others; inhuman; hard-hearted; void of pity; wanting compassion; savage; barbarous; unrelenting." *Bucklew v. Precythe*, 139 S. Ct. 1112, 1123 (2019) (citing 1 Samuel Johnson, *A Dictionary of the English Language* (4th ed. 1773); 1 Noah Webster, *An American Dictionary of the English Language* (1828) ("Disposed to give pain to others, in body or mind; willing or pleased to torment, vex or afflict; inhuman; destitute of pity, compassion or kindness.")). Even today, "cruel" punishments have been described as "inhumane," *Farmer v. Brennan*, 511 U.S. 825, 838 (1994), involving the "unnecessary and *wanton* infliction of pain," *Whitley v. Albers*, 475 U.S. 312, 319 (1986) (emphasis added) (citations omitted), or involving the "*superadd[ition]* of terror, pain, or disgrace." *Bucklew*, 139 S. Ct. at 1124 (emphasis added) (internal quotation marks and citations omitted).

In the 18th Century, a punishment was "unusual" if it ran contrary to longstanding usage or custom, or had long fallen out of use. *Bucklew*, 139 S. Ct. at 1123 (citing 4 William Blackstone, *Commentaries on the Laws of England* 370 (1769); Stuart Banner, *The Death Penalty: An American History* 76 (2002); *Baze v. Rees*, 553 U.S. 35, 97 (2008) (Thomas, J., concurring); John F. Stinneford, *The Original Meaning of "Unusual": The Eighth Amendment as a Bar to Cruel Innovation*, 102 Nw. U. L. Rev. 1739, 1770–71, 1814 (2008)). This early understanding comports with the plain meaning of "unusual," which has changed little from our

Nation's founding. *See Harmelin v. Michigan*, 501 U.S. 957, 976 (1991) (comparing Webster's American Dictionary (1828) definition of "unusual" as that which does not "occu[r] in ordinary practice" with Webster's Second International Dictionary 2807 (1954) as that which is not "in common use.").

Conversely, customs enjoying a long history of usage were described as "usual" practices. Stinneford, *supra*, at 1770. James Wilson, a key contributor to the Constitution, stated that "long customs, approved by the consent of those who use them, acquire the qualities of a law." 2 James Wilson, *Collected Works of James Wilson* 759 (Kermit L. Hall & Mark David Hall eds., Indianapolis, Liberty Fund 2007); *see also* Stinneford, *supra*, at 1769. Likewise, early American courts construing the term "cruel and unusual" (generally, as used in state constitutions) upheld punishments that were not "unusual" in light of common law usage. Stinneford, *supra*, at 1810–11 (citing *Barker v. People*, 20 Johns. 457, 459 (N.Y. Sup. Ct. 1823), *aff'd*, 3 Cow. 686 (N.Y. 1824); *Commonwealth v. Wyatt*, 27 Va. 694, 701 (Va. Gen. Ct. 1828); *People v. Potter*, 1 Edm. Sel. Cas. 235, 245 (N.Y. Sup. Ct. 1846)). Thus, "[u]nder the plain meaning of the term, a prison policy cannot be 'unusual' if it is widely practiced in prisons across the country." *Gibson v. Collier*, 920 F.3d 212, 226 (5th Cir. 2019).

Finally, various views have been proposed with respect to the original meaning of "punishment" in the Eighth Amendment. Some view the word as being inapplicable to conditions of confinement. *See, e.g.*, *Farmer*, 511 U.S. at 837 ("The Eighth Amendment does not outlaw cruel and unusual 'conditions'; it outlaws cruel and unusual 'punishments.'") (Souter, J.). Some have even suggested

that "punishment" refers only to sentences imposed by a judge or jury. *See Hudson v. McMillian*, 503 U.S. 1, 18 (1992) (Thomas, J., dissenting); *but see Helling v. McKinney*, 509 U.S. 25, 40 (1993) (Thomas, J., dissenting) (recognizing that the "evidence is not overwhelming" on this question). Others believe the term was originally understood to encompass more than sentences called for by statute or meted out from the bench or jury box, but it required deliberate intent. *See, e.g.*, *Wilson v. Seiter*, 501 U.S. 294, 300 (1991) ("The infliction of punishment is a deliberate act intended to chastise or deter. This is what the word means today; it is what it meant in the eighteenth century.") (Scalia, J.) (quoting *Duckworth v. Franzen*, 780 F.2d 645, 652 (7th Cir. 1985)); *see also* Celia Rumann, *Tortured History: Finding Our Way Back to the Lost Origins of the Eighth Amendment*, 31 Pepp. L. Rev. 661, 675, 677 (2004) (presenting historical evidence that the word punishment was "understood at the time to include torturous interrogation") (citing 4 William Blackstone, *Commentaries on the Laws of England*; 3 Jonathan Elliot, The Debates in the Several State Conventions on the Adoption of the Federal Constitution 447–48).

B.

While the foregoing overview does not provide the full contours of the original understanding of the Cruel and Unusual Clause, it demonstrates that Idaho's actions are far from a constitutional violation based on the clause's text and original meaning. Idaho's actions simply do not amount to the "barbarous" or "inhuman" treatment so out of line with longstanding practice as to be forbidden by the Eighth Amendment.

No longstanding practice exists of prison-funded SRS.[4] Indeed, the medical standards at the heart of Edmo's claim are innovative and evolving. The standards of care relied on by Edmo were promulgated by the World Professional Association for Transgender Health ("WPATH") in 2011—only about five years before Edmo's lawsuit. WPATH, *Standard of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People* (7th ed. 2011) ("WPATH standards"). As the standards themselves note, this "field of medicine is evolving." The WPATH standards also call for flexibility, individual tailoring, and wide latitude in treatment options.

Likewise, as recognized by numerous federal courts, the WPATH standards are not accepted as medical consensus. The first circuit court to address the issue ruled that the WPATH standards did not foreclose alternative treatment options, and that a doctor's decision to choose a non-WPATH treatment did not violate the Eighth Amendment. *Kosilek v. Spencer*, 774 F.3d 63, 90 (1st Cir. 2014). The Fifth Circuit also found that the WPATH standards remained controversial and did not reflect a consensus. *Gibson*, 920 F.3d at 223. Similarly, after reciting the WPATH standard's recommended treatment options for gender dysphoria, the Tenth Circuit rejected a claim that prison officials acted with deliberate indifference "by implementing [an alternative] course of treatment recommended by a licensed medical doctor," rather than

[4] *See, e.g.*, *Quine v. Beard*, No.14-cv-02726-JST, 2017 WL 1540758, at *1 (N.D. Cal. Apr. 28, 2017), *aff'd in part, vacated in part, rev'd in part sub nom. Quine v. Kernan*, 741 F. App'x 358 (9th Cir. 2018); Kristine Phillips, *A Convicted Killer Became the First U.S. Inmate to Get State-Funded Gender-Reassignment Surgery*, Wash. Post (Jan. 10, 2017), https://wapo.st/2S21zP3.

SRS. *Lamb v. Norwood*, 899 F.3d 1159, 1163 (10th Cir. 2018), *cert. denied*, 140 S. Ct. 252 (2019).[5]

The debate about the WPATH standards continues even outside prison walls. The Centers for Medicare and Medicaid Services ("CMS") declined to adopt the WPATH standards due to inadequate scientific backing, and instead gives providers discretion to apply either the WPATH standards or their own standards. CMS, Decision Memo for Gender Dysphoria and Gender Reassignment Surgery (August 30, 2016), available at https://go.cms.gov/36yMrx X. Similarly, the American Psychiatric Association expressed concern about the scientific evidence undergirding the WPATH standards. And as recently as 2017, WPATH requested that Johns Hopkins University conduct an evidence-based review of the standards, a review that, at the time of Edmo's lawsuit, was ongoing.

Idaho's actions reflect the uncertainty regarding the WPATH standards throughout the medical field, and do not, under the record, reflect a want of compassion. *See supra* O'Scannlain, J., dissenting at 22–29. Given the lack of medical consensus, Dr. Eliason's decision to pursue an alternative treatment, rather than SRS, cannot constitute the "barbarous" or "inhuman" conduct prohibited by the Eighth Amendment. *See Bucklew*, 139 S. Ct. at 1123. Nothing in the record reflects that Dr. Eliason's diagnosis and treatment of Edmo was tainted by malice or animosity. Notably, Dr. Eliason concluded that Edmo had coexisting mental

[5] In the non-SRS context, the Tenth Circuit also found no Eighth Amendment violation where a doctor prescribed lower hormonal treatment levels for a gender dysphoric inmate than those suggested by the WPATH standards. *Druley v. Patton*, 601 F. App'x 632, 635 (10th Cir. 2015).

health issues that required treatment and counseling prior to considering SRS. The district court itself found Edmo's reluctance to address those issues "troubling." *Edmo*, 358 F. Supp. 3d at 1121. Additionally, Idaho had no blanket policy prohibiting SRS, and Dr. Eliason never definitively ruled it out. Dr. Eliason committed to monitoring Edmo's candidacy for SRS after deciding that Edmo did not meet the criteria for the procedure in 2016. In sum, Dr. Eliason's decision to pursue an alternative treatment to SRS suggests a tailored evaluation of potential risks and does not reflect the hard-hearted or barbarous treatment proscribed by the text of the Constitution.

Given the facts of this case, Dr. Eliason's treatment cannot rise to the infliction of cruel and unusual punishment—not in a sense that bears any resemblance to the original meaning of that phrase. This is not to say that the WPATH standards are not *a* medically acceptable standard. But the innovative, contested, and evolving nature of the WPATH standards, the lack of medical consensus, and the particular circumstances of this case make clear that no constitutional violation occurred under the Constitution's text and original understanding.

II.

In addition to being inconsistent with the original understanding of the Eighth Amendment, I, like Judge O'Scannlain, believe that the panel decision departs from precedent.

A.

Since *Estelle v. Gamble*, the Supreme Court has recognized claims for inadequate medical treatment under the Eighth Amendment when prison officials act with

"deliberate indifference to serious medical needs of prisoners." 429 U.S. at 104. The test for such a claim involves "both an objective standard—that the deprivation was serious enough to constitute cruel and unusual punishment—and a subjective standard—deliberate indifference." *Snow v. McDaniel*, 681 F.3d 978, 985 (9th Cir. 2012), *overruled on other grounds by Peralta v. Dillard*, 774 F.3d 1076 (9th Cir. 2014). Under Ninth Circuit precedent, if a defendant's treatment decision was "medically acceptable," then the court need go no further: the plaintiff cannot show deliberate indifference as a matter of law. *Jackson v. McIntosh*, 90 F.3d 330, 332 (9th Cir. 1996) (citing *Estelle*, 429 U.S. at 107–08).

Deliberate indifference is a high bar, involving an "unnecessary and wanton infliction of pain" or conduct that is "repugnant to the conscience of mankind." *Estelle*, 429 U.S. at 104, 105–06 (citations omitted). An inadvertent failure to provide adequate medical care is neither, so it cannot support an Eighth Amendment claim. *Id*; *see also Farmer*, 511 U.S. at 835 (explaining that deliberate indifference requires "more than ordinary lack of due care for the prisoner's interests or safety") (citation omitted).

A prison official acts with deliberate indifference only where he "knows of and disregards an *excessive* risk to inmate health or safety." *Farmer*, 511 U.S. at 837 (emphasis added). As Justice Thomas describes it, this is the second-highest standard of subjective culpability under the Court's Eighth Amendment jurisprudence—short only of "malicious and sadistic action for the very purpose of causing harm." *Id*. at 861 (Thomas, J., concurring) (internal quotation marks and citations omitted). Such a stringent culpability requirement "follows from the principle that 'only the unnecessary and wanton infliction of pain implicates the

Eighth Amendment.'" *Id.* at 834 (quoting *Wilson*, 501 U.S. at 294).

Our precedent has consistently emphasized the challenging threshold for showing deliberate indifference.[6] Rightfully so, too. In the 44 years since *Estelle*, an unbroken line of Supreme Court cases reaffirmed that mere negligence, inadvertence, or good-faith error cannot establish an Eighth Amendment claim.[7]

B.

The panel's decision here dilutes the otherwise stringent deliberate indifference standard. The panel begins by finding Edmo's gender dysphoria to be a "serious medical

[6] *See Hamby v. Hammond*, 821 F.3d 1085, 1092 (9th Cir. 2016) (explaining that "[a] difference of opinion between a physician and the prisoner—or between medical professionals—concerning what medical care is appropriate does not amount to deliberate indifference," and reiterating the "high legal standard" for showing an Eighth Amendment violation) (citations omitted); *Toguchi v. Chung*, 391 F.3d 1051, 1060 (9th Cir. 2004); *Hallett v. Morgan*, 296 F.3d 732, 745 (9th Cir. 2002); *Wood v. Housewright*, 900 F.2d 1332, 1334 (9th Cir. 1990).

[7] *See Minneci v. Pollard*, 565 U.S. 118, 130 (2012) (noting that "to show an Eighth Amendment violation a prisoner must typically show that a defendant acted, not just negligently, but with 'deliberate indifference'") (citing *Farmer*, 511 U.S. at 825, 834); *Ortiz v. Jordan*, 562 U.S. 180, 190 (2011) (restating *Farmer*'s articulation of the deliberate indifference standard); *Wilson*, 501 U.S. at 297 ("[A]llegations of 'inadvertent failure to provide adequate medical care,' or of a 'negligent . . . diagnosis,' simply fail to establish the requisite culpable state of mind.") (internal citations and alterations omitted); *Whitley*, 475 U.S. at 319 ("To be cruel and unusual punishment, conduct that does not purport to be punishment at all must involve more than ordinary lack of due care . . . . It is obduracy and wantonness, not inadvertence or error in good faith, that characterize the conduct prohibited by the Cruel and Unusual Punishments Clause[.]").

need." *Edmo*, 935 F.3d at 785. It then determines, based solely on the WPATH standards, that Dr. Eliason's failure to recommend SRS was medically unacceptable. *Id.* at 786–92. From there, the panel leaps to conclude that Dr Eliason was "deliberately indifferent" precisely because it viewed his treatment as "ineffective" and "medically unacceptable" under the panel's reading of the WPATH standards. *Id.* at 793. Thus, under the panel's approach, compliance with the court-preferred medical standards (in this case, the WPATH standards) is the beginning and the end of the inquiry. This is not the deliberate indifference inquiry required by precedent.

As an initial matter, and as Judge O'Scannlain aptly points out, the panel errs in holding up *one* medically accepted standard, i.e., the WPATH guidelines, as the constitutional "gold standard," thereby precluding any further debate on the matter. *See supra* O'Scannlain, J., dissenting at 15–22. As discussed above, the WPATH standards do not establish a definitive medical consensus and judges applying Eighth Amendment standards should not and need not take sides in this debate.

More fundamentally though, the panel's analysis effectively erases the subjective deliberate indifference requirement with its circular reasoning. Nowhere does the panel consider any direct evidence of Dr. Eliason's subjective mental state. *Cf. Jett v. Penner*, 439 F.3d 1091, 1098 & n.2 (9th Cir. 2006) (concluding that a doctor's medical note stating "I reviewed xrays which showed no obvious fracture malalignment," written after reviewing a radiology report which specifically indicated a deformity, could evidence deliberate indifference) (alteration in original). Nor does the panel consider the many reasons underlying Dr. Eliason's decision to decline SRS treatment.

See supra O'Scannlain, J., dissenting at 15–22. Once those reasons are swept aside, the panel circularly *infers* deliberate indifference based on its prior determination that Dr. Eliason's treatment plan was "ineffective" or "medically unacceptable" under the WPATH standards. *See Edmo*, 935 F.3d at 793–94 (finding Dr. Eliason deliberately indifferent because his treatment "stopped short of what was medically necessary").

Such an approach is particularly troublesome because, if replicated, deliberate indifference could be inferred solely from a finding of a "medically unacceptable" treatment. For Eighth Amendment claims like Edmo's, a plaintiff must first show the "medically unacceptable" treatment of a "serious medical need[]" and, second, that the doctor's treatment decision reflected "deliberate indifference" to the medical need. *Jackson*, 90 F.3d at 332. The panel's analysis collapses this two-part inquiry into one circular step. If courts follow the panel's reasoning, in every case of medically unacceptable treatment, courts could automatically infer deliberate indifference.

Worse still, because "medical acceptability" is an objective negligence inquiry, the ultimate effect of the panel's analysis is to dilute the heightened, subjective culpability required for deliberate indifference, *see Farmer*, 511 U.S. at 839–40, into mere negligence, which the Supreme Court has repeatedly warned falls short of an Eighth Amendment violation. *See, e.g.*, *Estelle*, 429 U.S. at 105–06. By denying rehearing en banc in this case, we relegate federal judges to the role of referee in medical disputes. This is not what the Constitution or precedent envisions.

* * *

The Eighth Amendment's history and text entreat us to hold the line on the heightened standards for a constitutional deprivation found in our precedent. As Justice Thomas rightly observed, "[t]he Eighth Amendment is not, and should not be turned into, a National Code of Prison Regulation." *Hudson*, 503 U.S. at 28 (Thomas, J., dissenting). By judicially mandating an innovative and evolving standard of care, the panel effectively constitutionalizes a set of guidelines subject to ongoing debate and inaugurates yet another circuit split. And by diluting the requisite state of mind from "deliberate indifference" to negligence, the panel effectively holds that—contrary to Supreme Court precedent—"[m]edical malpractice [*does*] become a constitutional violation merely because the victim is a prisoner." *Estelle*, 429 U.S. at 106 (altered). I respectfully dissent from the denial of rehearing en banc.

EXHIBIT G

FILED

FEB 19 2020

MOLLY C. DWYER, CLERK
U.S. COURT OF APPEALS

UNITED STATES COURT OF APPEALS

FOR THE NINTH CIRCUIT

ADREE EDMO, AKA Mason Edmo, Plaintiff-Appellee, v. CORIZON, INC.; et al., Defendants-Appellants, and IDAHO DEPARTMENT OF CORRECTIONS; et al., Defendants.	No. 19-35017 D.C. No. 1:17-cv-00151-BLW District of Idaho, Boise ORDER

ADREE EDMO, AKA Mason Edmo, Plaintiff-Appellee, v. IDAHO DEPARTMENT OF CORRECTIONS; et al., Defendants-Appellants, and CORIZON, INC.; et al., Defendants.	No. 19-35019 D.C. No. 1:17-cv-00151-BLW District of Idaho, Boise ORDER

Before: McKEOWN and GOULD, Circuit Judges, and LASNIK,* District Judge.

Appellants' motion to stay the mandate pending filing of petition for writ of certiorari, (No. 19-35017, Dkt. 106; No. 19-35019, Dkt. 108), is denied.

* The Honorable Robert S. Lasnik, United States District Judge for the Western District of Washington, sitting by designation.

UNITED STATES COURT OF APPEALS

FOR THE NINTH CIRCUIT

FILED

FEB 19 2020

MOLLY C. DWYER, CLERK
U.S. COURT OF APPEALS

ADREE EDMO, AKA Mason Edmo,

Plaintiff - Appellee,

v.

CORIZON, INC.; et al.,

Defendants - Appellants,

and

IDAHO DEPARTMENT OF CORRECTIONS; et al.,

Defendants.

No. 19-35017

D.C. No. 1:17-cv-00151-BLW
U.S. District Court for Idaho, Boise

MANDATE

ADREE EDMO, AKA Mason Edmo,

Plaintiff - Appellee,

v.

IDAHO DEPARTMENT OF CORRECTIONS; et al.,

Defendants - Appellants,

and

CORIZON, INC.; et al.,

No. 19-35019

D.C. No. 1:17-cv-00151-BLW
U.S. District Court for Idaho, Boise

Defendants.

The judgment of this Court, entered August 23, 2019, takes effect this date.

This constitutes the formal mandate of this Court issued pursuant to Rule 41(a) of the Federal Rules of Appellate Procedure.

Costs are taxed against the appellants in the amount of $292.90.

FOR THE COURT:

MOLLY C. DWYER
CLERK OF COURT

By: Rhonda Roberts
Deputy Clerk
Ninth Circuit Rule 27-7