v.

Case No. 06-C-112

WARDEN JUDY P. SMITH,
THOMAS E DWARDS,
JAMES GREER,
ROMAN KAPLAN, MD,
and RICHARD RAEMISCH,

Defendants.

MEMORANDUM DECISION

Following a court trial, in March 31, 2010, this court entered on Jan 31, 2010, this court ent

[1] On October 15, 2007, pursuant to the defendants' motion for partial summary judgment, former plaintiffs Kari Sundstrom and Lindsey Blackwell were dismissed from this case because their claims for injunctive and declaratory relief are moot as they are no longer Plaintiffs,

for their serious health condition, Gender Identity Disorder (GID). Further, plaintiffs assert that the defendants acted without exercising individualized medical judgment and in contrast to the treatment the defendants provide to similarly situated inmates in Wisconsin Department of Corrections (DOC) facilities. Consequently, plaintiffs ask this court to find that the defendants have violated their Fourteenth Amendment right to equal protection and their Eighth Amendment right to be free from cruel and unusual punishment. More

suicide by jumping off a roof. Davison was diagnosed with GID in 2005 and began hormone therapy as treatment for that condition shortly thereafter. The DOC has provided Davison with hormone therapy during incarceration. After arriving at Dodge Correctional Institution, the DOC began to withdraw Davison's hormone therapy because of Act 105. As a result of that withdrawal, Davison experienced increased and darker hair

James Greer is the Director of the DOC Bureau of Health Services. Defendant Judy P. Smith is the Warden at OSCI. Defendant Thomas Edwards was the Health Services Unit Manager of the OSCI Health Services Unit until May 11, 2007. That position is currently vacant.

GID is classified as a psychiatric disorder in the DSM-IV-TR, the current edition of the Diagnostic and

hormone therapy for reasons that do not have to do with GID, such as estrogen replacement therapy in postmenopausal years, or for inmates with a congenital or hormonal disorder that requires the administration of hormone the

The legislative sponsors issued multiple press releases prior to its passage

statin

hormone therapy for inmates with GID costs defendants approximately $300 to $1,000 per inmate per year. A second-generation antipsychotic, Quetiapine, costs approximately $2,555 to $2,920 per inmate per year on average, and, in 2004, the defendants paid approximately $2.5 million for inmates to have Quetiapine. Another second-generation antipsychotic, Risperidone, costs approximately $2,555 per inmate per year on average.

Act 105 has prevented the DOC from undertaking thorough evaluations of at least two inmates to determine whether hormone therapy is medically necessary and appropriate for them. Erik Huelsbeck, a/k/a Erika Huelsbeck, was continuously in facilities administered by the DOC from December 2004 until July 2007, when Huelsbeck was transferred to the Wisconsin Resource Center. Huelsbeck was first diagnosed with GID by the DOC in 2006. Huelsbeck has not been evaluated to determine whether hormone therapy will be prescribed, nor could such treatment be prescri

The DOC does not permit inmates to pay for their own health care or to seek insurance coverage, as non-inmates could, so Act 105 bars the only avenue for inmates with GID to receive hormone therapy and/or sex reassignment surgery. Neither the DOC as a whole nor any of the defendants have had any involvement in the drafting of, or the introduction of, any of the bills that became Act 105.

EVIDENCE PRESENTED AT TRIAL

1. Witnesses

Plaintiffs' witness Dr. Randi Ettner is a clinical psychologist who received a Ph.D. in psychology in 1979. (Trial Tr. vol. 1, 13-14, Oct. 22, 2007; *see also* Ex. 525.) Sh 1.00000()Tj(Pl

[2] WPATH is an international organization of professionals, mainly medical people and attorneys, who work with and give services to individuals who have GID. (Trial Tr. vol. 1, 19, Oct. 22, 2007.) WPATH publishes the Standards of Care ("SOC") which, according to Dr. R. Ettner, is the worldwide acceptable protocol for treating GID. *Id.* at 19-20.

clients and recommends necessary medical treatments. (*Id.* at 22.) Her role is to collaborate with medical caregivers, endocrinologists, and surgeons who implement the treatments. (*Id.*) Dr. R. Ettner assesses the intensity of the GID in a given individual, and determines whether or not a particular treatment would be medically necessary. (*Id.*)

Plaintiffs' witness Dr. Frederic Ettner has been a family medicine physician for the past thirty years. (*Id.* at 83.) In approximately 1994, he started seeing patients with GID in his private practice. Since that time he has seen over 500 GID patients. (*Id.* at 88.) Dr. F. Ettner is a member of WPATH. (*Id.* at 91.) In 2007, Dr. F. Ettner presented a medical education seminar on family medicine and transgender at the WPATH international conference, which was held in Chicago. (*Id*. at 91-92.) Dr. F. Ettner addresses GID in his teaching as a clinical instructor for Northwestern University and the University of Southern California Medical Schools. (*Id.* at 92.) He considers himself an expert in transgender medicine. (*Id.* at 93.)

Vankemah Moaton, incarcerated at JCI, is one of the plaintiffs in this case. Moaton is a 29-year-old biological male who recalls feeling or acting in a feminine way as early as age four. (Trial Tr. vol. 2, 140, Oct. 23, 2007.) As Moaton got older, the feeling intensified, along with feelings of hatred for having a male body. (*Id.* at 140-41.) Moaton felt better when able to act like a girl, dress up in girl clothes, and play with dolls. (*Id.* at 142.) Moaton experienced anger and "lots of depression" as Moaton's body began developing as a man and self-hatred feelings intensified. (*Id.* at 142-43.) Moaton started taking female hormones around age seventeen or eighteen and as a result started seeing less facial hair growth and a skin "glow" and developed breasts. (*Id.* at 144.) These

changes made Moaton feel happier than ever before because steps were being taken toward becoming a woman. (*Id.*

Defendants' witness Dr. David Burnett is the Medical Director of the DOC. (*Id.* at 210.) He has been licensed to practice medicine in Wisconsin since 1980 and is board certified in family medicine. (*Id.* at 211.) Dr. Burnett also has a degree in Masters of Medical Management. (*Id.)* His duties and responsibilities as DOC Medical Director include oversight for care within the Wisconsin prison system, including the primary care physicians; oversight to the mental health director; oversight to the dental area and the pharmacy; and review of medical policy. (*Id.* at 212.) Dr. Burnett is a member of the DOC gender identity disorder committee. (*Id.* at 223.)

Plaintiffs' witness Dr. George Brown is chief of psychiatry at the Mountain Home VA Medical Care Center in Johnson City, Tennessee, and Professor of Psychiatry at East Tennessee State University. (Trial Tr. vol. 3, 245, Oct. 24, 2007.) He is board certified in psychiatry and licensed to practice psychiatry in Tennessee, Texas, and Ohio. (*Id.* at 246.) Dr. Brown's specialized training in the field of GID includes pursuing such training with experts at the University of Rochester, Case Western Reserve University, and the Institute of Living in Hartford, Connecticut. (*Id.*) He has published articles on GID and transgender issues in approximately twenty-six journals and has had about forty abstracts published from scientific meetings. (*Id.* at 246-47.) Dr. Brown has published one scientific abstract on the issue of prison inmates with GID and currently has one paper being considered for publication. (*Id.* at 248.) He has conducted research on "gender phenomenon" since the mid-1980s, s

clinical evaluation of patients with GID for about twenty-six years and evaluated or treated more than 500 patients with gender identity concerns. (*Id.* at 249.) He is a member of WPATH and holds the position of secretary/treasurer for that organization. (*Id.*) Dr. Brown's correctional experience consists of working for one month as a staff psychiatrist in two maximum security prisons in Ohio and working for six months part-time in a forensic psychiatric facility for criminally insane inmates. (*Id.* at 250.) He has evaluated five prison inmates with GID. (*Id.* at 251.)

Defendants' witness Dr. Daniel Claiborn is a psychologist who has been licensed in Missouri and Kansas since 1980. (*Id.* at 335.) He holds a Ph.D. in counseling psychology. (*Id.* at 336.) He is a member of the American Psychological Association and is the chair of the ethics committee of the Kansas Psychological Association. (*Id.* at 339.) Dr. Claiborn has a psychotherapy practice which covers "all the dimensions of psychopathology, basically[,] including depression, anxiety, marital problems, relationship issues, and some unique categories like eating disorders." (*Id.* at 346.) He has a special niche working with gay and lesbian clients in his community and for the past twenty years has had a steady flow of those clients. (*Id.*) Since the early 1980's, Dr. Claiborn has had one to three transgender clients per year. (*Id.*) In his private practice he has had approximately fifty clients who suffer from GID or have transgender issues. (*Id.* at 347.) Dr. Claiborn is trained to treat mental disorders such as anxiety and depression. (*Id.* at 353-54.) Dr. Claiborn has been an expert witness in approximately sixty-six cases between 2004 and October 2006. (*Id.* at 378.) About 20% of his work consists of seeing patients

and 80% is consulting or expert witness work. (*Id.* at 379.) Dr. Claiborn has not done any research on GID and has not published any articles or books on GID. (*Id.* at 379-80.)

Eugene E. Atherton is the defendants' security expert. He is a retiree of the Colorado Department of Corrections, and also acts as a private consultant in criminal areas of criminal justice. (*Id.* at 406.) He has worked in corrections since 1975. (*Id*.) A good portion of Atherton's employment with the correctional system has focused on security issues, including as warden at medium and maximum security institutions, and assistant director of prison operations for the western region of the Colorado Department of Corrections. (*Id.* at 408.) Since 2004, Atherton has worked as an expert witness in various cases. He also published the only book on use of force in corrections. *Id.* at 409. He does technology work for the National Law Enforcement and National Technology Center out of Denver, on a national level, which requires him to communicate with a number of states and agencies on security and safety issues as they relate to technology. (*Id.* at 410.) Atherton works approximately thirty hours per week, visits jails and prisons and interacts with staff, and is currently building an organization in the Rocky Mountain states for viewing and assessing technology among agencies, all related to safety and security. (*Id.* at 410-11.) Approximately once or twice a year, he gets called to the National Institute of Corrections as a subject matter expert on issues of security and safety. (*Id.* at 411.)

[3] Dr. R. Ettner personally interviewed the three plaintiffs in this case, administered psychological testing, and reviewed medical records that she was provided with. (Trial Tr. vol. 1, 43, Oct. 22, 2007). She met with each plaintiffff Ţ

as well as GID. (*Id.*) Davison had previously sought treatment for depression, and Dr. R. Ettner believes that Davison had a personality disorder. (*Id.* at 53.) Davison sought treatment for GID at the Pathways Clinic in Milwaukee. (*Id.*) Davison made several suicide attempts in the past. (*Id.*) Davison is married to a woman and has two children. (*Id.* at 71.)

According to Dr. R. Ettner, plaintiff Vankemah Moaton is "a bona fide transsexual." (*Id*. at 54.) Prior to incarceration, Moaton was living and working as female and everyone, including family, regarded Moaton as a female. (*Id.*) Moaton looks like a female in that Moato

[4] This section sets forth relevant testimony with respect to defining and diagnosing GID from witnesses Dr. R. Ettner, Dr. F. Ettner, Dr. Burnett, Dr. Brown, and Dr. Claiborn.

the other psychiatric disorders that mental health professionals need to familiarize themselves with and treat." (*Id.* at 25.) GID affects one in 11,900 genetic males. (*Id.*) The best way to diagnose it is "that they come in and tell us." (*Id.* at 24.) An individual will seek out a professional and relate a history of gender dysphoria or history of feeling trapped in the wrong body. (*Id.*) "And that's usually causing them distress, at least enough to bring them to a mental health professional." (*Id.*)

The intensity of the distress varies depending on the severity of the disorder. (*Id.)* "For some people the disorder is so intense and so severe, that they simply cannot function unless they do something to correct this disorder. For other people the discomfort is less intense, and they are able to manage the condition over a lifetime." (*Id.*) Taking a history of a client is important in diagnosing GID because the diagnosis is partially based on the duration of the symptoms and the feelings. (*Id*. at 26.)

> Dr. R. Ettner's GID clients have some common characteristics:
>
> > People who have severe Gender Identity Disorder, what we refer to as transsexualism, will give a lifelong history, often beginning as early as three or four. Sometimes they say that they thought they were a girl until they realized at a later age they weren't.
> >
> > They will describe a period of dressing or what we would call cross-dressing, dressing in the desired gender, often taking a mother or sister's clothes when they're young and wearing those.
>
> at

They try to rid themselves of the secondary sex characteristics.

So a male will shave their body hair, oftentimes even before they know the name of this disorder or what it is that they're experiencing. They'll tuck their genitals. They will, you know, try to appear and be perceived as a member of the other sex, if not publicly for fear of being punished or shamed, at least privately when they feel safe they'll try to restore some sense that when they look in the mirror what they're seeing feels like who they really are.

. . . .

Even children, often very young, will show Gender Identity Disorder. They know nothing about hormones, they know nothing about surgery, but they believe that they are or they very much want to be a member of the other sex.

So, for instance, a young boy will put on a dress or nail polish. And oftentimes they're punished or shamed for doing that. They'll continue. They'll play mostly with girls when they have the opportunity. T0000 TD(r o)

(*Id.* at 94.) The medical problems include further depression, morbid depression, and suicidal ideation. (*Id.*) A family physician may diagnose GID. (*Id.*) In practice, Dr. F. Ettner will consult with other experts, namely, gender therapists, psychologists, psychiatrists, or social workers to confirm his suspicions of GID. (*Id.* at 94-95.) GID varies in its severity and is a generally accepted medical condition. (*Id.* at 128.)

c) Dr. Burnett

Dr. Burnett acknowledges GID as a serious health condition that requires evaluation and treatment. (Trial Tr. vol. 2, 227-28, Oct. 23, 2007.)

d) Dr. Brown

Dr. Brown testified that once a person has reached the clinical significance threshold, by definition it becomes a clinical diagnosis that warrants medical attention. (Trial Tr. vol. 3, 259, Oct. 24, 2007.) Once the clinical threshold is reached, a person will have "significant symptomatology that in most cases warrants some type of individualized treatment." (*Id.*) There is no controversy among professionals who work in the GID field that it is a serious health condition. (*Id.* at 260.) On the other hand, there is the following controversy among professionals working in the field of GID:

> There are a lot of things that are in the DSM, a lot of diagnoses in the DSM that have substantial medical components. And again, there's no bright line in medicine between what's so-called medical and so-called psychiatric. And the DSM is very clear on that in the preamble, because there is substantial overlap in most of our conditions.
>
> So, there are some people who believe that because it's likely that there are biological underpinnings to Gender Identity Disorder that that's predominantly a medical disorder and,

But whether it exists at all and whether it’s serious, those things are not controver

e) Dr. Claiborn

WPATH organization and distributed throughout the world to organizations such as World He[alth] Organization and other providers of health care worldwide." (*Id.* at 30-31.)

As a treatment, hormone therapy helps those with GID by providing them with a level of well-being because the effect on the brain is one that restores them to a non-distressed, non-dysphoric level of well-being. (*Id.* at 31.) Dr. R. Ettner's clients who started taking hormones while under her care have experienced remarkable changes in their level of well-being, in their overall mental health, and in the way that they conduct their lives. (*Id.* at 32.) For many people, hormonal treatment is sufficient to manage and reduce the gender dysphoria. (*Id.* at 33-34.) Whether a client should have hormone therapy depends on the intensity of the disorder and the distress that the disorder causes him or her. (*Id.* at 35.) If it impairs the person's functioning, occupationally, socially, or in another major arena, and it cannot be managed without medical treatment, at that point one would recommend medical intervention. (*Id.*)

Hormone therapy is not required for all persons with GID. (*Id.* at 39.) Dr. R. Ettner has refused to recommend hormone therapy for a client. (*Id.* at 36.) One common reason for such a decision is that the person does not have the intensity of the disorder to meet the criteria for that treatment. (*Id.*)

There is a role for psychotherapy in treating GID, which consists of four components: 1) educating the patient about the d 1) educating

reputable physicians and support groups or other venues for assistance. (*Id.* at 37.) However, psychotherapy cannot talk someone out of GID; it is not a cure. (*Id*. at 38.)

If hormone therapy is medically necessary but not provided, the person is at risk for autocastration, suicide, substance abuse, and depression. (*Id.* at 39.) The psychological risks of being taken off of hormone therapy are depression, autocastration, and suicide. (*Id.* at 41.)

b) Dr. F. Ettner

The nature of the treatments that Dr. F. Ettner prescribes depends upon the level of severity of the GID. (Trial Tr. vol. 1, 101, Oct. 22, 2007.) The symptoms of someone that he considers severe enough to need hormone therapy are:

> These are individuals that will present to me and describe a history of depression, anxiety, sleeplessness, inability to concentrate, inability to maintain their job, family conflict.
>
> And no matter what they've done, whether they have cross-dr

> The therapeutic effects of hormones on the body of a patient with GID are:
>
> Patients who have GID and qualify for hormones will experience initially – the organ system that will experience the most benefit initially will be the brain.
>
> The dysphoria will tamp down, dysthymia, the depression, anxiety will all tamp down initially.
>
> Other organ systems that eventually will respond, and it will take a good couple months of therapy, include secondary sexual characteristics, in the case of the male to female, breast development, fat deposition on the hips, decrease in muscle mass on the chest, softening of the skin.

(*Id.* at 107-08.) The birth gender hormones begin to be suppressed, "almost to the point of suppression that is sufficient to represent the gender that that individual is transitioning into." (*Id*. at 108.)

> Whether

(*Id.* at 110-11.) Termination of hormone therapy does not reverse all of the change that occurred to secondary sexual characteristics. (*Id.* at 111.) In a male-to-female person, gynecomastia or increase in breast size will remain, a lot of the fatty deposition will stay, and some of the muscle wasting will stay. (*Id.)* On the other hand, hair growth can come back if there are enough hair follicles still present and the natal hormones may begin to increase and create dysphoria again. (*Id.*) Termination can affect the neurological system and with neuroexcitability, seizure disorder can be seen, and sleeplessness, anxiety, and further depression can occur. (*Id.*) Suicidal ideation, if it was present, would be accelerated. (*Id.)* The effect to the metabolic muscle syste

Based on these risks, it is not medically acceptable to take someone off of hormone therapy if they do not have to come off for some other medical reason. (*Id.*)

Based on a review of plaintiff Fields' medical records, Dr. F. Ettner formed an opinion to a reasonable degree of medical certainty about the likely effects of withdrawing Fields from hormones. (*Id.*) He opines that withdrawal could have serious adverse effects on Fields' health and well-being:

> I think, you know, based on the records and looking at her as a transgendered woman, she's diminutive, she had had breast implants, she had been on hormones for a period of time. All commentary about her in the records declared her as very effeminate. She was on significant amounts of hormone.
>
> She also in her laboratory tests had an elevated cholesterol. Taking her off would certainly upset her lipid balance, her cholesterol balance. It could increase her cholesterol levels to even higher levels than these are, and these are pretty high to begin with, 261. Being that 130 is normal and 261 is abnormal, it would put her at risk for heart disease.
>
> I think also in taking her off of hormones due to her presentation for such a long period of time as a female, the neuroexcitability issues would be very prominent for her, be an increased risk of seizure, increased suicidal ideation.

(*Id.* at 116.)

c) Dr. Kallas

Dr. Kallas testified about the diagnosis of and treatment for GID. He considers the DSM to be an authoritative manual for diagnosing mental health disorders. (Trial Tr. vol. 2, 173, Oct. 23, 2007.) The primary goal of hormone therapy is to reduce gender dysphoria and to improve the psychological adjustment of an individual receiving the hormone therapy. (*Id.* at 174.) Hormones are medically necessary for some

individuals. (*Id.*) Hormone therapy is "probably the most common and accepted treatment for those with severe gender dysphoria" although "it's not the answer for everybody." (*Id.* at 175.) The most widely referenced set of standards for the treatment of severe gender dysphoria is the Standards of Care. (*Id.*)

When asked whether there may be individuals for whom hormones are the only satisfactory route to alleviate their gender dysphoria, Dr. Kallas responded:

I'm hesitant to agree with that statement exactly as wor

To the extent that hormone ther

alone has never been adequate treatment, “not just in my experience but also in the literature over decades.” (*Id.* at 272-73.) With regard to the efficacy of hormone therapy in treating GID, Dr. Brown testified:

> In my clinical practice the patients w

Again, once a person reaches the clinical threshold and they have the diagnosis, I don't consider treatment optional. It's individualized to a given patient, but the treatment itself is not optional.

(*Id.*) Brown says that under the Standards of Care, a patient is ready for hormone therapy under the following circumstances:

> In terms of being ready for hormones you have to first be eligible. So eligibility would involve having a prior real-life experience or, in the alternative, having a minimum of three months of psychotherapy. Being in the age of majority, so we're not treating children in this setting.
>
> And in addition to that, some consolidation of their cross-gender identity and satisfactory control of

So, and similar to homosexuality, you don’t change a person’s sexual orientation by working with them psyc

about how that would play out." (*Id.*) The DOC's policy prior to Act 105 was set forth in Executive Directive 68. (*Id.*)[5]

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[5]Executive Directive 68 provides:

SUBJECT: Scope of Services for the Treatment of Gender Identity Disorder

I. Background

It is the policy of the Wisconsin Department of Corrections (DOC) to provide appropriate treatment services to offenders meeting the criteria for a diagnosis of gender identity disorder (DSM-IV 302.85). Practitioners shall take correctional and community standards of care into consideration when providing treatment services.

II. Definitions

Diagnostic and Statistical Manual, 4th Edition, Revised (DSM-IV): The standard manual of psychiatric diagnoses and classification codes.

Gender Identity Disorder: A psychiatric disorder in which a person is not satisfied and is seriously dysphoric with regard to their anatomical gender. In general, this condition is a stable, nonviolent condition and not due to psychosis, but it may accompany other mental disorders.

Hormonal Therapy: The use of hormones to stimulate the development of secondary sexual characteristics such as enlargement of breasts and which may exert systemic effects such as body hair loss.

Sexual Reassignment Therapy: Treatment for gender identity disorder in which one or more of the following are used: hormonal medications, surgical procedures to alter a person's physical appearance so that he/she appears more like the opposite gender and psychological counseling.

II. [sic] Guidelines

A. No surgical procedures for the purpose of sexual reassignment shall be provided to any offenders incarcerated in the WDOC.

B. After consultation with the Gender Identity Disorder Committee, hormonal therapy for severe gender dysphoria may be initiated by the WDOC physicians. The Gender Identity Disorder Committee will consult with a non-WDOC consultant before approving or denying a request from a WDOC physician for initiating hormonal therapy. If the Committee and the non-WDOC consultant do not agree regarding initiating hormonal therapy for severe gender dysphoria, the DOC Medical Director and non-WDOC Consultant will meet with the Secretary's Office to reach a decision.

C. An offender who is receiving hormonal medications as a part of an established sexual reassignment therapy regimen under the supervision of a medical doctor at the time of incarceration may be continued on hormonal medications provided that the offender cooperates with the DOC in obtaining confirmation of his/her previous treatment. If an offender chooses to discontinue hormonal medications and then wishes to restart hormonal medications, the committee referenced below will evaluate the request and make a determination.

D. The offender must agree to sign DOC-1163, Confidential Information Release Authorization, allowing DOC medical and mental health staff access to medical and mental health records regarding all prior treatment related to gender identity disorder.

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is medically necessary for them. (*Id.*

treatments for medically necessary conditions in individuals or inmates that are barred by law or regulation with the DOC. (*Id.*)

In March 2005, Dr. Kallas testified before the legislature with respect to the bill that became Act 105. (*Id.* at 187-88, Ex. 17.) He informed the legislature that the Standards of Care are considered to be the most authoritative guidelines for the treatment of GID. (*Id.* at 189.) Dr. Kallas emphasized that hormone therapy was a valid treatment on it own, because

> there were some in the legislature who had the belief, or maybe the sponsors of the bill had the belief that starting an individual on hormonal treatment would commit the department to provide surgery.
>
> In other words, that it would start an inmate down the road where there was more of an argument for surgery later on. And this was my effort to try to dispel that notion.
>
> In other words, the individuals, many individuals find successful accommodations just with hormonal treatment and do not desire to go on or need to go on to surgical reassignment.

(*Id.* at 189-90.) He also testified before the legislature that the DOC policy as outlined in Executive Directive 68 was similar to those of many other states and the Federal Bureau of Prisons. (*Id.* at 190.) As for the effect of withdrawing hormones from an individual, Dr. Kallas added:

> [I]f the department were to take away hormones from individuals with gender identity disorder, those individuals may become distressed and despondent, may go to the point of clinical depression or an anxiety disorder or suicidality.
>
> It may result in an increase in staff time for mental health care or placement in WRC, which is the Wisconsin Resource Center, which is our facility for acute care.

It also may lead to disruptive behavior and segregati

would be available to an inmate coming into the system on hormone therapy and had hormone therapy withdrawn under Act 105. (*Id.* at 200.)

b) Dr. Burnett

Dr. Burnett testified about the health services that are available for DOC inmates. (*Id.* at 212.) Most DOC facilities have a health services unit centered around primary care, which includes mental health care. (*Id.* at 213.) Most of these units have nursing staff, a physician, and psychiatry and psychology staff. (Id.) The medical portion is similar to an outpatient clinic in the community. (*Id.*) To obtain care, an inmate puts in a health service request, which is evaluated initially by nursing staff and then addressed by the appropriate person. (*Id.*) There are also ongoing appointments for follow-up care or regularly scheduled visits for those with chronic medical conditions such as high blood pressure, diabetes, and hepatitis. (*Id.* at 213-14.)

Dr. Burnett described the process by which inmates would be withdrawn from hormone therapy pursuant to Act 105. (*Id.* at 214.) First, the primary care physician would meet with the inmate and explain the reason for withdrawal of medication and inform the inmate about the potential side effects. (*Id.*) The physician would then issue an order to taper the medication over a period of about two months. (*Id.*) In addition, the inmate would have an appointment with psychology staff to talk about potential withdrawal symptoms and to seek follow-up case as needed. (*Id.*) The inmate would be monitored by health services staff. (*Id.*)

Inmates in the DOC system may present with a variety of medical problems, including cardiovascular problems, gastrointestinal problems, endocrine problems,

diabetes, osteoporosis, muscle weakness, and poor wound healing/subject to infection. (*Id.* at 216-20.) Treatment is available for these inmates in DOC institutions, or arrangements will be made to have offsite specialty care when necessary. (*Id.*) The DOC health care personnel do not provide medical treatment to inmates if it is not medically necessary. (*Id.* at 228.)

Some inmates are prescribed hormone therapy for conditions other than GID. (*Id.*) However, Act 105 requires the DOC to withdraw hormone therapy only from inmates who are receiving it to treat their GID. (*Id.*) Inmates who are receiving hormone therapy for health conditions other than GID would not be withdrawn from that hormone therapy because of Act 105. (*Id.*)

Dr. Burnett testified that he agreed that medical care should be left to clinicians. (*Id.* at 229.) He does not know of any other Wisconsin laws or DOC policies banning medical treatments for inmates. (*Id.* at 230.) Dr. Burnett does not believe it was medically appropriate to taper and terminate hormone therapy for inmates with GID. (*Id.*)

6. Security

Atherton testified about the correctional environment as it relates to prison security and indicated that it is dangerous:

> It's highly unique in that we have a collection of human beings that have past histories of having committed felony offenses, pas t o

safety

> Inmates can feminize themselves to some extent:
>
> There are times where they can modify their uniform and kind of roll their sleeves in a certain way or bring up the – show their midriff by bringing up the top of their uniform top.
>
> You know, in a certain way that's typically feminine, although there are times where there are rules against that.
>
> There are ways of grooming themselves, and sometimes in violation of contraband rules by using various substances to color, you know, do eyebrow liner and blush on the face and cheeks.
>
> That's often attempted, although in most systems I'm aware that that is prohibited by rule.

(*Id.*) However, further feminization "will raise the level of risk specifically." (*Id.* at 424.)

At deposition, Atherton stated that "hormonal therapy may or may not be something – have something to do with physical appearance which are one of many ingredients that may contribute to something that supports sexual attraction from one inmate to another which may or may not arise in the form of an assault." (*Id.* at 426-27.) He also indicated that "it is possible that allowing inmates to have hormone therapy will not cause an increase in sexual assault." (*Id.* at 428.) Atherton testified that correctional needs, security, and safety must be considered along with medical and mental health concerns. (*Id.* at 431.) One overriding the other "just simply doesn't work . . . in the correctional world." (*Id.)*

The Colorado Department of Corrections has a policy of allowing prisoners with GID to have hormone therapy. (*Id.* at 432.) Atherton believes that the policy is reasonable and has never argued that the policy should be changed. (*Id.*) When asked whether he agreed that the policy does not by itself create security problems, Atherton

testified that the policy had a good histo

1. Eighth Amendment Claim

To establish liability under the Eighth Amendment, a prisoner must show: 1) that his medical need was objectively serious; and 2) that the state official acted with deliberate indifference to the prisoner's health or safety. *Farmer v. Brennan*, 511 U.S. 825, 834 (1994); *Chapman v. Keltner*, 241 F.3d 842, 845 (7th Cir. 2001); *see also Estelle v. Gamble*, 429 U.S. 97, 104-05 (1976); *Zentmyer v. Kendall County, Ill.*, 220 F.3d 805, 810 (7th Cir. 2000).

A serious medical need is "one that has been diagnosed by a physician as mandating treatment or one that is so obvious that even a lay person would easily recognize the necessity for a doctor's attention." *Wynn v. Southward*, 251 F.3d 588, 593 (7th Cir. 2001) (quoting *Gutierrez v. Peters*, 111 F.3d 1364, 1373 (7th Cir. 1997)). Factors that indicate a serious medical need include "the 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." *Gutierrez*, 111 F.3d at 1373 (citations omitted). A medical condition need not be life-threatening to qualify as serious and to support a § 1983 claim, providing the denial of medical care could result in further significant injury or the unnecessary infliction of pain. *See Reed v. McBride*, 178 F.3d 849, 852-53 (7th Cir. 1999); *Gutierrez*, 111 F.3d at 1371.

A prison official acts with deliberate indifference when "the official knows of and disregards an excessive risk to inmate health or safety." *Farmer*, 511 U.S. at 837. Prison officials act with deliberate indifference when they act "intentionally or in a criminally

reckless manner." *Tesch v. County of Green Lake*, 157 F.3d 465, 47

The court turns to a review of cases containing claims brought by prisoners with GID issues to help frame the legal landscape. The Seventh Circuit Court of Appeals has issued two opinions in this regard. In *Meriwether v. Faulkner*, 821 F.2d 408, 413 (7th Cir. 1987), the court held that an inmate stated a valid claim under the Eighth Amendment in connection with denial of medical treatment for transsexualism. The prisoner in that case was a biological male who underwent nine years of estrogen therapy before incarceration. *Id.* at 410. Once incarcerated the inmate was denied all medical treatment - chemical, psychiatric or otherwise - for GID and related medical needs. *Id.* In concluding that the complaint stated a claim, the court first found that transsexualism was a serious medical need. *Id.* at 411-13.

Next, the court determined that the complaint contained allegations indicating that the defendants were deliberately indifferent to that need because they allegedly "failed to provide the plaintiff with any kind of medical treatment, not merely hormone therapy, for her gender dysphoria." *Id.* at 413. The court went on to say,

> We therefore conclude that plaintiff has stated a valid claim under the Eighth Amendment which, if proven, would entitle her to some kind of medical treatment. It is important to emphasize, however, that she does not have a right to any particular type of treatment, such as estrogen therapy which appears to be the focus of her complaint. The only two federal courts to have considered the issue have refused to recognize a constitutional right under the Eighth Amendment to estrogen therapy provided that some other treatment option is made available.

gender dysphoria in prisoners' civil rights litigation." *Id.* First, the court defined gender dysphoria, "the condition in which a person believes that he is imprisoned in a body of the wrong sex, that though biologically9Fk3mgically

Id. at 672. Finally, the court stated: "We conclude that, except in special circumstances that we do not at present foresee, the Eighth Amendment does not entitle a prison inmate to curative treatment for his gender dysphoria." *Id.* at 672.

In *Phillips v. Michigan Department of Corrections*, 731 F. Supp. 792, 801 (W.D. Mich. 1990), the court granted a prisoner's motion for preliminary injunction ordering correctional officials to provide the inmate with estrogen therapy. The prisone

> *Meriwether*, plaintiff has been the subject of ridicule and offensive remarks at the hands of Dr. Opika. Third, this Court characterizes defendant's conduct in this case as conduct which actually reversed the therapeutic effects of previous treatment. It is one thing to fail to provide an inmate with care that would improve his or her medical state, such as refusing to provide sex reassignment surgery or to operate on a long-endured cyst. Taking measures which actually reverse the effects of years of healing medical treatment, as I observe here, is measurably worse, making the cruel and unusual determination much easier.

Id. at 800 (footnote omitted).

In *Kosilek v. Maloney*, 221 F. Supp. 2d 156, 158 (D. Mass. 2002), plaintiff Kosilek was a male-to-female transsexual sentenced to life in prison. Since becoming incarcerated in 1990, Kosilek had tried to access proper diagnosis and treatment, but such claims were consistently denied by the institution. *Id.* at 159. While incarcerated, Kosilek tried to commit suicide on two occasions and also attempted self-castration. *Id.* at 158. Kosilek also complained of being in severe mental anguish. *Id.* The prisoner sued the Massachusetts Department of Corrections and Commissioner Michael Maloney, who in 2000 had adopted a blanket policy regarding the treatment of transsexuals in prisons. *Id.* Under the policy, transsexuals who had received treatment by doctors prior to incarceration could have that treatment continued after incarceration; however, transsexuals taking hormones that had not been prescribed by a doctor were not permitted to continue hormone usage in prison. *Id.* at 159-60. The policy also denied the possibility of any inmate receiving gendery

The court found that Kosilek's GID was a serious medical need. *Id.* at 184. Kosilek's GID "has prompted him to attempt suicide twice while incarcerated, and to try to castrate himself as well. There is a significant risk that he will attempt to kill, mutilate, or otherwise harm himself again if he is not afforded adequate treatment for this disorder." *Id.* Next, the court found that Kosilek had not been offered adequate treatment for the serious medical need in that "[t]he services now being offered Kosilek are not sufficient to diminish his intense emotional distress, and the related risks of suicide and self-mutilation, to the point at which he would no longer be at a substantial risk of serious harm." *Id.* at 185. The court reasoned that "no informed medical judgment has been made by the DOC concerning what treatment is necessary to treat adequately Kosilek's severe gender identity disorder." *Id.* at 186. The Massachusetts Department of Corrections policy, also known as the Guidelines, prevented an individualized medical assessment:

> However, the Guidelines preclude the possibility that Kosilek will ever be offered hormones or sex reassignment surgery, which are the treatments commensurate with modern medical science that prudent professionals in the United States prescribe as medically necessary for some, but not all, individuals suffering from gender identity disorders. The Guidelines, in effect, prohibit forms of treatment that may be necessary to provide Kosilek any real treatment. Maloney's decision to implement the Guidelines precluded the medical professionals and social workers he employs and regularly relies upon from even considering whether hormones should be prescribed to treat Kosilek's severe gender identity disorder.

Id. at 186 (internal citation omitted). Thus, the court concluded that Kosilek satisfied the objective component of the Eighth Amendment. *Id.* at 189.

However, the court found that Maloney's failure to provide Kosilek with adequate care was not due to deliberate indifference. *Id.* at 189-92. Maloney's actions

may have seemed ignorant, if not malicious; however, the court pointed out that his actions were those of "a defendant with a legal problem" and were not done to inflict pain on Kosilek. *Id.* at 162, 191. Finally, the court concluded that Maloney was not likely to be indifferent to Kosilek's serious medical need in the future. *Id.* at 193-95. It reasoned that Maloney "is now on notice that Kosilek's severe gender identity disorder constitutes a serious medical need" and, therefore, "the DOC has a duty to provide Kosilek adequate treatment." *Id.* at 193. The court continued:

> It is permissible for the DOC to maintain a presumptive freeze-frame policy. However, decisions as to whether psychotherapy, hormones, and/or sex reassignment surgery are necessary to treat Kosilek adequately must be based on an "individualized medical evaluation" of Kosilek rather than as "a result of a blanket rule." Those decisions must be made by qualified professionals. Such professionals must exercise sound medical judgment, based upon prudent professional standards, particularly the Standards of Care.
>
> Thus, the court expects that Maloney will follow the DOC's usual policy and practice of allowing medical professional

prescribed to treat Kosilek. Administering female hormones to a male prisoner in a male prison could raise genuine security concerns. Maloney would be entitled to consider whether those concerns make it necessary to deny Kosilek care that the medical professionals regard as required to provide minimally adequate treatment for his serious medical need.

. . . .

As the Standards of Care explain, "hormone therapy alone may provide sufficient symptomatic relief to obviate the need for cross-living or sur200 0.0000 TD(ed to)Tj31.200805.6800 0.0000 TD(iou)Tj16.0800 0

discontinued. *Id.* Following termination of the hormone medication, the prisoner developed an uncontrollable urge to mutilate his genitals. *Id.* Repeatedly, the inmate requested resumption of the hormone therapy and treatment by a gender specialist, however, those requests were denied and the self-mutilation continued. *Id.* As an initial matter, the court held that the plai

The court found that the defendants were deliberately indifferent to the prisoner's serious medical need:

> Defendants do not contest Plaintiff's claim that he was never treated for GID notwithstanding numerous requests for treatment. In addition, Defendants have not provided the Court with any evidence showing that the decision to refuse Plaintiff treatment was based on sound medical judgment. Finally, Defendants have failed to submit any evidence that they were not aware that Plaintiff's health could be jeopardized if treatment was refused. Accordingly, the Court finds that Defendants have failed to establish, as a matter of law, that Plaintiff was provided adequate treatment for his serious medical needs.

Id. at 300 (emphasis added).

> This circuit has not addressed the issue of providing hormone treatment to transsexual inmates. Other circuits that have considered the issue have concluded that declining to provide a transsexual with hormone treatment does not amount to acting with deliberate indifference to a serious medical need. *See, e.g., White v. Farrier*, 849 F.2d 322 (8th Cir. 1988) (acknowledging that transsexualism is a serious medical condition, but holding that declining to provide hormone therapy did not constitute deliberate indifference to that medical need); *Meriwether v. Faulkner*, 821 F.2d 408, 413 (7th Cir. 1987) (holding transsexual prisoner has no constitutional right to "any particular type of treatment, such as estrogen therapy"); *Supre v. Ricketts*, 792 F.2d 958, 963 (10th Cir. 1986) (concluding that declining to provide hormone therapy did not constitute deliberate indifference when prison officials offered alternate treatment). Assuming, without deciding, that transsexualism does present a serious medical need, we hold that, on this record, the refusal to provide hormone therapy did not constitute the requisite deliberate indifference.
>
> In Praylor's case, the record reflects that he did not request any form of treatment other than hormone therapy. Testimony from the medical director at the TDCJ revealed that the TDCJ had a policy for treating transsexuals, but that Praylor did not qualify for hormone therapy because of the length of his term and the prison's inability to perform a sex change operation, the lack of medical necessity for the hormone, and the disruption to the all-male prison. *Cf. De'Lonta v. Angelone*, 330 F.3d 630, 635 (4th Cir. 2003). Moreover, the director testified that Praylor had been evaluated on two occasions and denied eligibility for hormone treatment and that the TDCJ did provide mental health screening as part of its process for evaluating transsexuals. *See Supre*, 792 F.2d at 963. Accordingly, based upon the instant record and circumstances of Praylor's complaint, the denial of his specific request for hormone therapy does not constitute deliberate indifference. *See Meriwether*, 821 F.2d at 413; *Supre*, 792 F.2d at 963.

Id. at 1209.

Plaintiffs contend that the defendants' enforcement of Act 105 to deny them medically necessary treatment violates the Eighth Amendment because it results in

necessary. Act 105 undermines the doctor-patient relationship of DOC physicians and inmates by preventing treatments that those health care pr

prison doctor had a reason to believe that the hormones were inappropriate. *Id.* at 171. When an individual requested to be put on ne

treatment." (Trial Tr. vol. 2, 186, Oct

of the Act. (Stip. FOF ¶ 52, Defs.' Tr. Br. at 2.) However, in determining whether a facial challenge to Act 105 may succeed here, the defendants submit that the court must take into account all inmates in DOC custody for whom hormone therapy or sexual reassignment surgery would be considered as treatment for gender issues. If that is done, they maintain that there are circumstances where Act 105 may be applied without violating the Constitution, and that, as a result, the plaintiffs' facial challenge to the law must fail. Unfortunately, the defendants do not support this point.

"A facial challenge to a legislative Act is, of course, the most difficult challenge to mount successfully, since the challenger must establish that no set of circumstances exists under which the Act would be valid." *United States v. Salerno*, 481 U.S. 739, 746 (1987). In *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505

> say that a law which requires a newspaper to print a candidate's reply to an unfavorable editorial is valid on its face because most newspapers would adopt the policy even absent the law. *See Miami Herald Publishing Co. v. Tornillo*, 418 U.S. 241, 94 S. Ct. 2831, 41 L. Ed. 2d 730 (1974). The proper focus of constitutional inquiry is the group for whom the law is a restriction, not the group for whom the law is irrelevant.
>
> Respondents' argument itself gives implicit recognition to this principle, at one of its critical points. Respondents speak of the one percent of women seeking abortions who are married and would choose not to notify their husbands of their plans. By selecting as the controlling class women who wish to obtain abortions, rather than all women or all pregnant women, respondents in effect concede that § 3209 must be judged by reference to those for whom it is an actual rather than an irrelevant restriction. Of course, as we have said, § 3209's real target is narrower even than the class of women seeking abortions identified by the State: it is married women seeking abortions who do not wish to notify their husbands of their intentions and who do not qualify for one of the statutory exceptions to the notice requirement. The unfortunate yet persisting conditions we document above will mean that in a large fraction of the cases in which § 3209 is relevant, it will operate as a substantial obstacle to a woman's choice to undergo an abortion. It is an undue burden, and therefore invalid.

Id. at 894-95 (internal citation omitted); *see also Gonzales v. Carhart*, 127 S. Ct. 1610, 1639 (2007) (holding that the Partial Birth Abortion Act of 2003's ban "applies to all instances in which the doctor proposes to use the prohibited procedure, not merely those in which the woman suffers from medical complications").

In certain cases, as with the plaintiffs in this case, the effect of Act 105 is to withdraw an ongoing course of treatment, the result of which has negative medical consequences. In other cases, the effect of Act 105 is to prevent DOC medical personnel from evaluating inmates for treatment because such evaluation would be futile in light of

Act 105's ban on the treatment they may determine to be medically necessary for the

consel

l In this case, Act 105 bars the use of hormones "to stimulate the development or alteration of a person's sexual characteristics in order to alter the person's physical appearance so that the person appears more like the opposite gender," as well as sexual reassignment surgery "to alter a person's physical appearance so that the person appears more like the opposite gender." Wis. Stat. § 302.386(5m)(a). The statute applies irrespective of an inmate's serious medical need or the DOC's clinical judgment if at the outset of treatment, it is possible that the inmate will develop the sexual characteristics of the opposite gender. The reach of this statute is sweeping inasmuch as it is applicable to any inmate who is now in the custody of the DOC or may at any time be in the custody of the DOC, as well as any medical professional who may consider hor

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Smith v. City of Chicago, 457 F.3d 643,

to treat GID, and they treat the entire class differently. As stated above, the contr

However, no reasonably conceivable state of facts provides a rational tie between Act 105 and prison safety and security. Atherton testified that he does not think feminizing inmates is consistent with the mission of the DOC because "it raises the level of risk in general populations that manage inmates who have been feminized in the male environment." (Trial Tr. vol. 3, 422, Oct. 24, 2007.) However, he also testified that the policy of the Colorado Department of Corrections, where he has worked for many years, allows prisoners with GID to have hormone therapy, and he be

is not reasonable—instead, defendants' own expert said connecting them was "an incredible stretch."

Defendants' argument that the "evidence supports the obvious" is not sufficient to show that Act 105 is rationally related to prison security. For one thing, DOC policy, Executive Directive 68, allowed for hormone therapy for GID inmates prior to the enactment of Act 105. Also, defendants' security expert was not particularly helpful for the defendants, as described above.

Plaintiffs have satisfied the three elements of an equal protection violation both to the extent that Act 105 applies to them and regarding their facial challenge.

3. Relief

Plaintiffs seek a permanent injunction barring enforcement of Act 105 against them and other inmates. A party seeking a permanent injunction "must demonstrate (1) it has succeeded on the merits; (2) no adequate remedy at law exists; (3) the moving party will suffer irreparable harm without injunctive relief; (4) the irreparable harm suffered without injunctive relief outweighs the irreparable harm the nonprevailing party will suffer if the injunction is granted; and (5) the injunction wi

plaintiffs and on its face, the plaintiffs are entitled to relief. Specific language of the injunction will be discussed at the upcoming status conference.

4. Further Conclusions of Law

Further conclusions of law were addressed in this court's order of March 31, 2010, and are incorporated herein.

Dated at Milwaukee, Wisconsin, this 13th day of May, 2010.

BY THE COURT

/s/ C. N. Clevert, Jr.
C. N. CLEVERT, JR.
CHIEF U. S. DISTRICT JUDGE