Nos.10-2339 and 10-2466

IN THE UNITED STATES COURT OF APPEALS

FOR THE SEVENTH CIRCUIT

ANDREA FIELDS, et al.,

Plaintiffs-Appellees,
Cross-Appellants

v.

JUDY P. SMITH, et al.,

Defendants-Appellants,
Cross-Appellees.

APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF WISCONSIN, NO. 06-C-112,
THE HONORABLE JUDGE C. N. CLEVERT, JR., PRESIDING

BRIEF AND APPENDIX OF DEFENDANTS-APPELLANTS, CROSS-APPELLEES

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JURISDICTIONAL STATEMENT

The Plaintiffs-Appellees-Cross-Appellants ("plaintiffs") filed a complaint for declaratory and injunctive relief in the United States District Court for the Eastern District of Wisconsin on January 24, 2006, pursuant to 42 U.S.C. §1983, alleging that 2005 Wisconsin Act 105 (hereinafter "the Act" or "Wis. Stat. § 302.386(5m)") violates the

Eighth and Fourteenth Amendments of the United States Constitution. [R.1] The district court had jurisdiction under 28 U.S.C. § 1331. On March 31, 2010, the United States District Court for the Eastern District of Wisconsin entered an Order declaring Wis. Stat. § 302.386(5m) unconstitutional and enjoining enforcement of the statute. [R.206; App. 101] On May 13, 2010, the district court entered a memorandum decision setting forth the findings of fact and conclusions of law. [R.212; App. 104] The Defendants-Appellants-Cross-Appellees ("defendants") filed a timely notice of appeal on June 2, 2010. [R.214] On June 9, 2010, the plaintiffs filed a motion for additional findings pursuant to Fed. R. Civ. P. 52(b). [R.222] On June 16, 2010, the plaintiffs timely filed a notice of cross appeal. [R.228] On June 22, 2010, the district court entered a final judgment. [R.235; App. 172] On June 29, 2010, the plaintiffs made an unopposed motion to amend/correct judgment by making additional findings. [R.237] And on July 9, 2010, the district court granted the plaintiffs' unopposed motion for additional findings and issued a final order disposing of all remaining post judgment motions. [R.239; App. 173] This court has appellate jurisdiction under 28 U.S.C. § 1291, as the appeal is from the final order of a district court.

ISSUES PRESENTED

1. Whether the district court erred in holding that Wis. Stat. § 302.386(5m) violates the Eighth Amendment as-applied to the plaintiffs where the statute only limits certain treatment options.

2. Whether the district court erred in holding that Wis. Stat. § 302.386(5m) violates the Eighth Amendment on its face where the statute is not unconstitutional in all, or most, applications.

3. Whether the district court erred in finding that Wis. Stat. § 302.386(5m) violates the Fourteenth Amendment, both as-applied and on its face, where the statute is rationally related to a legitimate governmental security interest.

STATEMENT OF THE CASE

The plaintiffs, all current inmates in the Wisconsin prison system, filed this action on January 24, 2006, against the defendants, all Wisconsin Department of Corrections (DOC) officials. [R.95 at ¶¶5-15] The plaintiffs have all been diagnosed as suffering from some form of gender identity disorder. In their Third Amended Complaint (Complaint), the plaintiffs challenge the Inmate Sex Change Prevention Act (the Act), Wis. Stat. § 302.386(5m), which prevents state or federal resources to be used to provide hormone therapy or sexual reassignment surgery to Wisconsin prisoners. [R.95 at ¶2] The statute defines "hormonal therapy" as "the use of hormones to stimulate the development or alteration of a person's sexual characteristics in order to alter the person's physical appearance so

that the person appears more like the opposite gender." Wis. Stat. § 302.386(5m)(a)(1). It also defines "sexual reassignment surgery" as "surgical procedures to alter a person's physical appearance so that the person appears more like the opposite gender." Wis. Stat. § 302.386(5m)(a)(2).

The Complaint set forth essentially three claims: (1) the Act, as applied to the plaintiffs, violates the Eighth Amendment; (2) the Act, on its face, violates the Eighth Amendment; and (3) the Act violates the plaintiffs' Fourteenth Amendment equal protection rights both on its face and as-applied. [R.95 at ¶¶62-72] As relief, the plaintiffs requested injunctive relief against DOC's enforcement of the Act against them, along with declaratory relief holding the Act, both on its face and as applied to plaintiffs, violates the Eighth and Fourteenth Amendments to the constitution. [R.95 at page 13]

The defendants moved for summary judgment on July 31, 2007, which the district court granted in part, dismissing plaintiffs Sundstrom and Blackwell, along with Defendants Humphreys and Nygren. [R.175; App. 176] The case proceeded to trial on October 22, 2007, through October 25, 2007. [R.200-203] On March 31, 2010, the court issued an Order declaring the Act unconstitutional under both

the Eighth Amendment and Equal Protection Clause and enjoining its enforcement. [R.206; App. 101] On May 13, 2010, the court issued a Memorandum Decision outlining its findings and conclusions. [R.212; App. 104] On June 22, 2010, the district court entered a final judgment. [R.235; App. 172] On June 29, 2010, the plaintiffs made an unopposed motion to amend/correct judgment and make additional findings. [R.237] And on July 9, 2010, the district court granted the plaintiffs' unopposed motion for additional findings and issued a final order disposing of all remaining post judgment motions. [R.239; App. 173] This appeal followed.

STATEMENT OF THE FACTS[1]

The plaintiffs are all male-to-female transsexuals in DOC custody who have been diagnosed with Gender Identity Disorder (GID). [R.212:2-3; App. 105-106] GID is classified as a psychiatric disorder in the DSM-IV-TR, the current edition of the Diagnostic and Statistical Manual of Mental Disorders ("DSM"). *Id*. In prior editions, the DSM classified "transsexualism" as a psychiatric disorder. *Id*. The following diagnostic criteria are listed in the DSM for GID: 1) a strong and

[1]The district court's memorandum decision, filed May 13, 2010, sets for a detailed recitation of the stipulated facts and trial testimony. That decision accompanies this brief as pages 147 through 214 of the appendix. [R.212; App.147]

persistent cross-gender identification; 2) a persistent discomfort with one's sex or a sense of inappropriateness in the gender role of that sex; 3) the disturbance is not concurrent with a physical intersex condition; and 4) the disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning. [R.212:2-3; App. 105-106] Having a diagnosis in the DSM does not dictate a specific treatment; treatment is individualized. [R.202:256] Hormone therapy and gender reassignment surgery (GRS) are two of the treatment options for GID recommended by the World Professional Association for Transgender Health (WPATH) in their "triadic treatment" approach. [R.200:29-30] Hormone therapy, and especially gender reassignment surgery, are extreme measures reserved for serious cases. [R.202:289 (testimony that Dr. Brown has only seen one inmate that he thought was eligible for sex reassignment surgery); R.200:6 (plaintiffs' counsel arguing that hormone therapy is only required treatment in "severe cases of Gender Identity Disorder" and sex reassignment surgery is required "for an even smaller group."); R.201:175 (Kallas testimony that hormones are one of the central ways to treat those with "severe gender dysphoria."); R.200:118-119 (Dr. F. Ettner testifying that there are lots of alternatives in treatment

therapies); R.201:186 (Dr. Kallas testifying that not all gender dysphoria requires hormones or surgery); R.200:60-61 (Dr. R. Ettner testifying that not all individuals with GID need hormones, a diagnosis of GID does not require treatment in every case, and under the standards of care, therapists are directed to let GID patients simply choose among treatment options); R.200:64 (Dr. R. Ettner testifying that it is possible that inmates may request hormone therapy when it is not an appropriate treatment for them)]

Wis. Stat. § 302.386(5m) (2009) was enacted in 2006 – as 2005 Wisconsin Act 105 ("Act 105" or "the Act") – by the Wisconsin State Legislature to address the use of hormone therapy and gender reassignment in medical care in correctional facilities. The legislative sponsors of Act 105 labeled it the "Inmate Sex Change Prevention Act." Act 105 provides:

> SECTION 1. 302.386(5m) of the statutes is created to read:
>
> 302.386(5m) (a) In this subsection:
>
> 1. "Hormonal therapy" means 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.
>
> 2. "Sexual reassignment surgery" means surgical procedures to alter a person's physical appearance so that the person appears more like the opposite gender.

> (b) The department may not authorize the payment of any funds or the use of any resources of this state or the payment of any federal funds passing through the state treasury to provide or to facilitate the provision of hormonal therapy or sexual reassignment surgery for a resident or patient specified in sub. (1).
>
> SECTION 2. Initial applicability.
>
> (1) PROVISION OF HORMONAL THERAPY OR SEXUAL REASSIGNMENT THERAPY. This act first applies to hormonal therapy, as defined in section 302.386 (5m) (a) 1. of the statutes, as created by this act, or sexual reassignment surgery, as defined in section 302.386 (5m) (a) 2. of the statutes, as created by this act, provided on the effective date of this subsection.

[2005 Wisconsin Act 105]

Hormone treatments feminize inmates by rendering effects on "secondary sexual characteristics such as hair, fatty metabolism, muscle, and . . . breasts." [R.201:197] The Act serves to prevent sexual violence in prison, the risk of which is increased when an inmate presents an effeminate manner. [R.202:412-435]

The plaintiffs challenge the Act because it prevents state or federal resources to be used to provide hormone therapy or sexual reassignment surgery to Wisconsin prisoners. [R.95 at ¶2] As a result of the Act, certain inmates were denied evaluations for determining the suitability of the prohibited treatments. [R.212:7; App. 110] It is undisputed, however, that the psychiatric and psychological services provided by DOC to treat psychoses, adjustment disorders, or mood

disorders like depression or anxiety, would all be available to inmates with GID despite the Act. [R.201:199-200] Additionally, the array of medical treatment available to treat any gastrointestinal problems, cardiovascular problems, muscle weakness, endocrine problems, diabetes, osteoporosis, and healing issues related to withdrawal of hormones would all be available to inmates with GID with the Act in effect. [R.201:216-222]

SUMMARY OF THE ARGUMENT

The Act does not violate the Eighth Amendment on its face because there is no evidence in the record to support a conclusion that there is "no set of circumstances" under which the Act does not effectuate deliberate indifference with regards to inmates with GID who are interested in being evaluated for hormones or surgery. In fact, the vast majority of the evidence supports the opposite conclusion, that the medical experts believe the prohibited treatments are only medically necessary in limited, serious cases. The Act does not violate the Eighth Amendment as applied to the plaintiffs because the Act merely limits treatment options, the State has no constitutional obligation to provide curative treatment, and legislation limiting medical discretion as to treatment options does not effectuate *per se*

deliberate indifference. Finally, the Act does not violate the Equal Protection Clause, either as-applied or on its face, because it is rationally related to legitimate security interests. The district court misapplied the rational basis standard by not affording appropriate weight to the evidence identifying and supporting the State's security interests in preventing sexually motivated violence in prisons.

STANDARD OF REVIEW

On appeal, a decision granting a permanent injunction is reviewed for abuse of discretion. *Knapp v. Northwestern University*, 101 F.3d 473, 478 (7th Cir. 1996). Factual determinations are reviewed under a clearly erroneous standard and legal conclusions are given *de novo* review. *Id.; see also, 3M v. Pribyl*, 259 F.3d 587, 607 (7th Cir. 2001).

ARGUMENT

I. WIS. STAT. § 302.386(5M) DOES NOT VIOLATE THE EIGHTH AMENDMENT OF THE CONSTITUTION AS APPLIED TO THE PLAINTIFFS.

A. The Eighth Amendment Standard

"Cruel and unusual punishment" of individuals is prohibited by the Eighth Amendment and this theory applies to the states through the Due Process Clause of the Fourteenth Amendment. *Robinson v. California*, 370 U.S. 660, 666 (1962); *Redding v. Pate*, 220 F. Supp. 124, 127 (N.D. Ill. 1963). The Eighth Amendment prohibits unnecessary and wanton infliction of pain. *Hudson v. McMillian*, 503 U.S. 1, 5 (1992), *Outlaw v. Newkirk*, 259 F.3d 833, 837 (7th Cir. 2001). The prohibition against unnecessary and wanton infliction of pain has been extended to the treatment of an inmate's serious medical needs. *Estelle v. Gamble*, 429 U.S. 97, 104 (1976); *Wynn v. Southward*, 251 F.3d 588, 593 (7th Cir 2001). 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 doctor's attention. *Wynn,* 251 F. 3d at 593.

To establish an Eighth Amendment violation based on deliberate indifference to a serious medical need, the plaintiffs must first demonstrate that they had an objectively serious medical need. *Walker v. Benjamin*, 293 F.3d 1030, 1037 (7th Cir. 2002). Second, they must

demonstrate that the defendants were subjectively deliberately indifferent to their serious medical condition. *Id.*

1. The serious medical need standard

Deliberate indifference to medical needs is an Eighth Amendment violation only if an inmate's needs are "serious." *Hudson v. McMillian*, 503 U.S. 1, 9 (1992) (citing *Estelle v. Gamble*, 429 U.S. at 103-04). Courts objectively distinguish medical needs that are serious from those that are trivial. *Gutierrez v. Peters*, 111 F.3d 1364, 1372 (7th Cir. 1997) (noting that not every medically recognized condition involving discomfort can support an Eighth Amendment claim). The deprivation alleged must be, objectively, sufficiently serious. *Henderson v. Sheahan*, 196 F.3d 839, 845 (7th Cir. 1999) (explaining that for liability to exist the prison official's act or omission must result in the denial of the minimal civilized measure of life's necessities). An objectively serious medical need is one that has either "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." *Zentmyer v. Kendall County, Ill.*, 220 F.3d 805, 810 (7th Cir. 2000) (an ear infection that inflicted prolonged suffering for months and led to permanent loss of hearing was an objectively serious

medical condition). A condition is objectively serious if "failure to treat [it] could result in further significant injury or unnecessary and wanton infliction of pain." *Reed v. McBride*, 178 F.3d 849, 852 (7th Cir. 1999) (quoting *Gutierrez*, 111 F.3d at 1373).

2. The deliberate indifference standard

The second prong of deliberate indifference requires the plaintiffs to establish that the defendants acted with a specific state of mind. Deliberate indifference to a serious medical need is more than "mere negligence," as it requires that the prison official was "subjectively aware of the prisoner's serious medical needs and disregarded an excessive risk that a lack of treatment posed to the prisoner's health and safety." *Wynn v. Southward*, 251 F.3d at 593 (holding that denial of heart medication after repeated oral and written requests demonstrates deliberate indifference). A prison official is not deliberately indifferent "unless 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 v. Brennan*, 511 U.S. 825, 837 (1994). Thus, "[u]nder the subjective standard, it is not enough to show that a state actor should have known

of the danger his actions created. Rather, a plaintiff must demonstrate that the defendant had actual knowledge of impending harm which he consciously refused to prevent." *Hill v. Shobe*, 93 F.3d 418, 421 (7th Cir. 1996). The Court must examine the totality of the inmate's medical care in determining whether the care demonstrates deliberate indifference of a serious medical need. *Gutierrez*, 111 F.3d at 1375 (holding that isolated delays in treatment over a ten-month period of treatment did not constitute deliberate indifference) (citing *DeMallory v. Cullen*, 855 F.2d 442, 445 (7th Cir. 1988)).

Furthermore, an inmate's disagreement with the course of treatment cannot establish deliberate indifference violating the Eighth Amendment. *Snipes v. DeTella*, 95 F.3d 586, 591 (7th Cir. 1996) (holding that a disagreement over the deliberate decision not to use local anesthetic did not meet the deliberate indifference standard). The Court in *Snipes* approached the inmate's treatment as a whole, refusing to evaluate one specific medical decision for deliberate indifference. *Id*. Medical decisions that may be characterized as classic examples of matters for medical judgment, such as whether one course of treatment is preferable to another, are beyond the Amendment's

purview. *Id*. Such matters are questions of tort, not constitutional law. *Id*.

B. Wis. Stat. § 302.386(5m) Does Not Violate the Eighth Amendment As Applied to the Plaintiffs Because It Does Not Effectuate Deliberate Indifference.

As an initial matter, based on the testimony at trial, the district court found that GID constitutes a serious medical need, thus establishing the first prong of the plaintiffs' Eighth Amendment claim. [R.212:55; App. 158] Although the defendants disagree, they acknowledge that review of such a finding is conducted using the deferential "clearly erroneous" standard. The defendants believe the crux of this appeal relates to the deliberate indifference prong of the analysis and, therefore, are electing not to challenge the lower court's finding as to serious medical need.

1. A legislative act denying some medical discretion does not effectuate *per se* deliberate indifference under the Eighth Amendment.

The district court's decision that the Act violates the Eighth Amendment hinges primarily on its conclusion that "prison officials may not substitute their judgments for a medical professional's prescription." [R.212:62; App. 165] The problem is that that conclusion

has no basis in case law and its extension to legislative acts would produce an absurd result.

Both the Supreme Court and the Seventh Circuit Court of Appeals have repeatedly affirmed the right of the state to limit the discretion of medical professionals both directly (through regulation) and indirectly (through public financing restrictions). *See Gonzales v. Carhart*, 550 U.S. 124, 162-165 (U.S. 2007) ("The Court has given state and federal legislatures wide discretion to pass legislation in areas where there is medical and scientific uncertainty."); *Kansas v. Hendricks*, 521 U.S. 346, 360 (1997) ("[I]t is precisely where such disagreement exists that legislatures have been afforded the widest latitude in drafting such statutes…when a legislature 'undertakes to act in areas fraught with medical and scientific uncertainties, legislative options must be especially broad and courts should be cautious not to rewrite legislation'"); *Washington v. Glucksberg*, 521 U.S. 702 (1997) (upholding a state law criminalizing physician assisted suicide). The Supreme Court's latest foray into this particular question endorsed a broad view of this issue:

> A zero tolerance policy would strike down legitimate abortion regulations, like the present one, if some part of the medical community were disinclined to follow the proscription. This is too exacting a standard to impose on the legislative power, exercised in this instance under the Commerce Clause, to

> regulate the medical profession. Considerations of marginal safety, including the balance of risks, are within the legislative competence when the regulation is rational and in pursuit of legitimate ends. When standard medical options are available, mere convenience does not suffice to displace them; and if some procedures have different risks than others, it does not follow that the State is altogether barred from imposing reasonable regulations. The Act is not invalid on its face where there is uncertainty over whether the barred procedure is ever necessary to preserve a woman's health, given the availability of other abortion procedures that are considered to be safe alternatives.

Gonzales, 550 U.S. 166-167. Speaking directly to the issue of transsexuals in prison, this court noted that many states' Medicaid statutes "contain a blanket exclusion" of coverage for sex-change operations. *Maggert v. Hanks*, 131 F.3d 670, 672 (7th Cir. 1997). Indeed, Wisconsin's own Medicaid program denies coverage of both hormone therapy and gender reassignment surgery. [Wis. Stat. § 49.46(2) (2010); Wis. Stat. § 49.47(6)(a); Wis. Admin. Code § DHS 107.10 (2010); *see also* Burnett Test., R.201:221-222][2] Moreover, Courts have routinely recognized that even a private insurance plan governed by the Employee Retirement Income Security Act may exercise its discretion to cover treatment prescribed by healthcare providers provided that the decision not to cover is intended to be discretionary under ERISA and is not arbitrary and capricious. *Summers v. Touchpoint Health Plan, Inc.*, 2006 WI App 217, 296 Wis.

[2]Record entries 200-203 are the transcripts from the court trial.

2d 566, 723 N.W.2d 784. Finally, a prison official may enact a security measure, even one that impinges on medical needs, if the measure "was applied in a good faith effort to maintain or restore discipline." *Whitley v. Albers,* 475 U.S. 312, 320-21 (1986).

Instead of addressing this considerable reservoir of support for the notion that the state may cabin the discretion of medical professionals, especially when those medical professionals are operating within correctional institutions, the lower court, in insulating the medical profession from all state interference, focused on (and arguably distorted) dicta from *Zentmyer*, which is itself worth quoting at length:

> This is not to say that prison officials may substitute their judgments for a medical professional's prescription. Of course they cannot. *See Ralston v. McGovern*, 167 F.3d 1160, 1162 (7th Cir.1999); *Johnson v. Hay*, 931 F.2d 456, 461 (8th Cir.1991). If a defendant consciously chose to disregard a nurse or doctor's directions in the face of medical risks, then he may well have exhibited the necessary deliberate indifference. But deliberate indifference is an onerous standard for the plaintiff, and forgetting doses of medicine, however incompetent, is not enough to meet it here. Zentmyer cites several cases from other circuits decided before *Estelle* and *Farmer* finding that denial of prescribed medication, when combined with other privations, violated a prisoner's substantive due process rights. None of these cases hold that failure to administer medication exactly as prescribed without additional exacerbating hardships violates the Eighth or Fourteenth Amendment. *See Campbell v. Beto*, 460 F.2d 765 (5th Cir.1972); *Martinez v. Mancusi*, 443 F.2d 921 (2d Cir.1970); *Tolbert v. Eyman*, 434 F.2d 625 (9th Cir.1970); *Edwards v. Duncan*, 355 F.2d 993 (4th Cir.1966).

Zentmyer v. Kendall County, Ill. 220 F.3d 805, 812 (7th Cir. 2000). This passage simply does not support the broad proposition attributed to it by the lower court that a state legislature may not substitute its judgment for that of medical professionals. In fact, it appears to allow even some administrative departures from prescribed treatments, and therefore is not particularly supportive of plaintiffs' case. At most, the passage supports the proposition that prison officials may not substitute their judgment for that of medical professionals in the absence of regulation, but that is not the issue in this case.

Here, the state legislature acted to limit treatment options. The people of the state, through their elected officials, passed a law prohibiting certain treatments for GID using public funds. The Supreme Court in *Gonzales* explicitly stated that state and federal legislatures have wide discretion to pass legislation in areas where there is medical and scientific uncertainty. *Gonzales*, 550 U.S. at 162-165. The record in this case shows that GID is a condition about which there is limited knowledge and vast uncertainty. [R.200:59-60 (testimony by Dr. R. Ettner indicating that the standards of care for GID acknowledge that there is limited knowledge in the area of GID, that there are clinical uncertainties that are hoped to be resolved in the

future, and that the standards of care are evolving and flexible); R.202:357-358 (testimony by Dr. Claiborn that GID is not a mental disease or disorder and that there is a difference of opinion on whether GID is a mental disorder)]

This is a very different situation than a prison official simply disregarding a doctor's recommendation for a legal and medically necessary treatment option, which was the scenario discussed in *Zentmyer*. The passage in *Zentmyer* does not reach the question of whether the state legislature can regulate the judgments of medical professionals, let alone hold that such regulation is improper. This is fortunate since such a limit on the state's power would produce the absurd result that medical professionals contracted by the state would have authority over the state treasury superseding even that of elected officials in state legislatures.

If adopted, the district court's extension of *Zentmyer* to the state legislature – and its extreme position that the Eighth Amendment prohibits a state legislature from placing any limits on a medical professional's discretion – would have far-reaching and unintended consequences. Such an interpretation would elevate the subjective opinions of medical professionals above the legislature and the law.

Individual doctors would have the power to decide what treatments can and cannot be legally regulated. If a vocal group of physicians declared assisted suicide, partial-birth abortions, or medical marijuana medically necessary, the legislature would be barred from prohibiting such treatments under the Eighth Amendment. Notably, in this case, the plaintiffs' expert, Dr. R. Ettner, testified that if a patient has GID and desires hormone treatment, such treatment is medically necessary. [R.200:62] Surely more is required to render the treatment constitutionally necessary and bind the hands of the state legislature.

Moreover, it cannot be the case that any limit on medical discretion at all would be *per se* an instance of deliberate indifference. Such a *per se* rule would be in direct contradiction with the cases recognizing that the Eighth Amendment poses no duty on the state to cure all serious medical ailments and eliminate all serious risks. *See* Section I(B)(2) *infra*. If a physician employed by the state decided to only offer curative treatment, the states would be forced to acquiesce to that decision by the lower court's *per se* rule.

2. The state has no obligation to provide curative treatment to its prisoners in order to comply with the Eighth Amendment.

There is no precedent for imposing the additional requirement under the Eighth Amendment that defendants completely eliminate a risk or cure a serious medical condition, yet that is what the plaintiffs would have this Court do. This Court has explained that the Eight Amendment does not entitle inmates to demand specific care and inmates are not entitled to the best care possible. *Forbes v. Edgar*,112 F.3d 262, 267 (7th Cir. 1997). The Eighth Amendment does not require prevention of all harm, it merely provides a right to "reasonable measures to meet a substantial risk of serious harm." *Id.* (emphasis added).

In *Meriwether v. Faulkner*, 821 F.2d 408, 413 (7th Cir. 1987), this Court held that a transsexual prisoner stated a valid claim under the Eighth Amendment when she was denied treatment of any kind, including hormone therapy, for her GID. *Meriwether*, 821 F.2d at 413. However, the Court made it very clear that the problem was the complete denial of all treatment for a serious medical need and that the outcome would have been different had she been provided "some type of medical treatment." *Id.* at 413. Indeed, the Court broadly concluded that "given the wide variety of options available for the treatment of gender dysphoria and the highly controversial nature of some of those

options, courts should defer to the informed judgment of prison officials as to the appropriate form of medical treatment." *Id*. at 414. The Seventh Circuit has subsequently hewed closely to the analysis in *Meriwether*. In *Jones v. Flannigan*, this court endorsed in dicta the *Meriwether* approach, referring to the administration of "continuous psychological treatment" as enough to satisfy any constitutional requirements and noting that "although a transsexual inmate is entitled to some type of treatment, the inmate 'does not have a right to any particular type of treatment.'" *Jones v. Flannigan,* 949 F.2d 398 (7th Cir. 1991) (quoting *Meriwether*, 821 F.2d at 413). More recently, this court has formulated the same basic concept in terms of "curative treatment:" "it does not follow that the prisons have a duty to authorize the hormonal and surgical procedures that in most cases at least would be necessary to 'cure' a prisoner's gender dysphoria." *Maggert,* 131 F.3d at 671-72.

The lower court's opinion attempted to distinguish this established line of Seventh Circuit precedent, but the attempt was unavailing. First, the opinion notes that here the doctors evaluated the plaintiffs and prescribed the hormone therapy prohibited by the Act. [R.212:55; App. 158] This may be true, but this case is also dealing

with a legislative act limiting treatment options, not merely a prison official disregarding a doctor's medical decision. Maggert is applicable and relevant because it supports the position that the Eighth Amendment does not require that inmates with GID receive hormones or surgery as long as some treatment is provided. As a result, legislation does not effectuate deliberate indifference simply by limiting treatment options. Second, the district court opinion asserts that the fact that the plaintiffs in this case were receiving hormone therapy before incarceration eliminates the concerns voiced in *Maggert* about transsexual individuals committing crimes simply so the state can pay for their care. But it should hardly have to be pointed out that 1) prior use of hormone therapy does not eliminate the incentive to commit crimes to have therapy covered since having this therapy covered by the state is precisely what the plaintiffs wish to happen in this case; and 2) this perverse incentive structure was not the only policy justification noted by the *Maggert* decision. In *Maggert*, the Court relied heavily on the principal that prisons are not required by the Eighth Amendment to give a prisoner medical care that is as good as he would receive if he were a free person, let alone a free affluent person. *Maggert*, 131 F.3d at 671-672. Finally, the opinion asserts that "the

plaintiffs in this case are not arguing entitlement to a specific treatment, rather they are simply contending that Act 105 violates their rights under the Eighth Amendment because it deprives DOC medical personnel of their ability to provide inmates with appropriate treatment." *Id.* As discussed in section I(C)(1) above, however, a denial of some medical discretion does not effectuate a *per se* violation of the Eighth Amendment.

None of the distinguishing features identified by the district court undermines the central position taken by the Seventh Circuit over the years: that the Eighth Amendment does not prohibit prison officials, prison medical personnel, and, most certainly, a state legislature, from denying a small subset of the wide variety of treatments available for a particular diagnosis.

The Seventh Circuit's treatment of the duty of the state vis-à-vis transsexual prisoners is in accord with the treatment given by the overwhelming majority of other circuits. The Fifth Circuit upheld a decision to deny hormone therapy to a particular individual, noting that the denial was based on ineligibility and lack of medical necessity and that the plaintiff had not asked for any other form of treatment. *Praylor v. Texas Dept. of Criminal Justice*, 430 F.3d 1208 (5th Cir.

2005). The Eighth Circuit has likewise held that a denial of hormone therapy is not unconstitutional "provided that some other treatment is made available to him." *White v. Farrier*, 849 F.2d 322, 327 (8th Cir. 1988) (referencing the decision in Meriweather). The Tenth Circuit has also held that, though GID is a serious medical condition, "[A] mere difference in opinion regarding the proper course of treatment is not tantamount to deliberate indifference." *Qz'etax v. Ortiz*, 170 Fed.Appx. 551, 553, 2006 WL 515612 (C.A.10(Colo.)); *see also Supre v. Ricketts*, 792 F.2d 958 (10th Cir. 1986) (holding that the DOC was not required by the Constitution to provide an inmate hormone therapy where such treatments are controversial).

Instead of bowing to this considerable controlling and persuasive precedent, the lower court placed disproportionate emphasis on an analysis of several district court opinions in other circuits. First, the lower court turned to *Phillips v. Michigan Department of Corrections*, which found an Eighth Amendment violation when a prison physician discontinued a prisoner's estrogen treatment, which had begun prior to incarceration, and denied requests for brassieres. *Phillips v. Michigan Dept. of Corrections,* 731 F.Supp. 792, 801 (W.D. Mich. 1990). In particular, the lower court pointed to the *Phillips* court's discussion of

the "measurably worse" decision to "actually reverse the effects of years of healing medical treatment." *Id.* at 800. But it must be noted that this factor was only one of several factors, including the fact that the plaintiff was denied "treatment of any kind," which drove the court to that conclusion. *Id.* at 800. Next, the lower court turned to *Kosilek v. Maloney*, which held that prison officials' policy of denying access to doctors for undiagnosed GID patients was unconstitutional because the treatment offered was "not sufficient" given the circumstances. *Kosilek v. Maloney,* 221 F.Supp.2d 156, 185 (D.Mass. 2002). Again, it must be noted that *Kosilek* ultimately only held that *some* adequate treatment must be given, and it even expressly recognized that "genuine psychotherapy," "psychopharmacology," or some combination of the two "may be sufficient to reduce the anguish caused by Kosilek's gender identity disorder so that it no longer constitutes a serious medical need." *Id.* at 193-195. Notably, neither psychotherapy nor psychopharmacology are barred by Wis. Stat. § 302.386(5m). Next, the lower court turned to *De'Lonta v. Angelone*, which merely reversed a lower court's dismissal of a suit by a GID plaintiff and allowed the case to go forward and is of extremely limited precedential value. *De'Lonta v. Angelone,* 330 F.3d 630 (4th Cir. 2003). Finally, the lower court

considered *Brooks v. Berg*, which found an Eighth Amendment violation when the plaintiff's numerous requests for treatment were ignored, but again the court hewed closely to the Seventh Circuit in noting the problem was simply that the plaintiff had been denied "all medical treatment" and that he was entitled to "at least some treatment." *Brooks v. Berg,* 270 F.Supp.2d 302 (N.D.N.Y. 2003).

In short, all of the persuasive authority relied on by the lower court can be squared with *Meriwether*'s and *Maggert*'s holding that there is no Eighth Amendment violation when some treatment is available to transsexual prisoners.

3. Enforcement of the statute on these plaintiffs is constitutional because it has not denied plaintiffs all or even most of the treatment available to those clinically diagnosed with severe GID.

There is no dispute in this case that other treatment options are available to the plaintiffs. At the close of the trial the plaintiffs expressly admitted that there was no evidence that the defendants were not prepared to treat the plaintiffs using means other than hormone therapy and no evidence that the defendants would provide nothing to the plaintiffs in terms of treatment. [R.203:452] In fact, there is extensive testimony by the DOC medical professionals on the other treatment options available to treat inmates with GID. [*See, e.*g.,

Burnett Test., R.201:215-221; Kallas Test., R.201:197-201] Dr. Kallas testified that the psychiatric and psychological services provided by DOC to treat psychoses, adjustment disorders, or mood disorders like depression or anxiety, would all be available to inmates with GID. [R.201:199-200] Dr. Burnett testified that the array of medical treatment available to treat any gastrointestinal problems, cardiovascular problems, muscle weakness, endocrine problems, diabetes, osteoporosis, and healing issues related to withdrawal of hormones would all be available to inmates with GID. [R.201:216-222]

Additionally, the plaintiffs' expert, Dr. R. Ettner, testified that hormone therapy merely "attenuates psychopathology" by attenuating or remitting anxiety or depression. [R.200:31-32] In fact, Dr. Frederick Ettner testified that starting hormone therapy actually causes certain health risks. Hormone therapy increases propensity to blood clotting, pulmonary embolism, pituitary tumors, infertility, waking, emotional liability, liver disease, gallstone formation, somnolence, hypertension, diabetes, sexual desire, cardiovascular disease. [R.200:123-125]

Dr. Claiborn explained that anxiety and depression are treated separately from GID, [R.202:368], and as just noted above, Dr. Kallas testified that the psychiatric and psychological services provided by

DOC to treat mood disorders like depression or anxiety would all still be available to inmates with GID. [R.201:199-200]

The district court noted that the Act prevented the DOC from undertaking thorough evaluations of two inmates in order to determine if hormone therapy is necessary and appropriate. [R.212:7; App. 110] This discussion is misleading and implies the Act kept inmates from actually getting evaluated for treatment generally. However, while it may be true that the Act made evaluations for hormone treatments unnecessary, it does not mean that the Act prevented inmates with GID from being evaluated with regards to other treatment options, such as psychotherapy and/or mood disorder medications. It is not a surprise that the Act would keep inmates from being evaluated for the specific treatment option it prohibits, but there is no evidence that the Act precluded any inmates with GID from being diagnosed or evaluated for treatment generally.

The fact is that there is a dispute here as to whether hormones and/or surgery are medically necessary to address GID. The plaintiffs' experts' claims of necessity are more accurately views on preferred treatment. For example, as noted above, Dr. R. Ettner testified that if a patient has GID and desires hormone treatment, such treatment is

medically necessary. [R.200:62] Dr. F. Ettner testified that "there are lots of alternatives in treatment therapies" and if a certain treatment is "not acceptable for whatever reason" they go onto another level. [R.200:118] Additionally, the plaintiffs' attorneys tried to get Dr. Kallas to testify that there may be inmates for whom no treatment other than hormone therapy would be satisfactory; but Dr. Kallas did not agree with that characterization. [R.201:175-176] Instead, Dr. Kallas stated that there are individuals for whom it would be difficult to envision that other routes would be "as satisfactory." [R.201:175-176] He also testified that "there are a number of ways in which individuals with gender dysphoria can [sic] accommodate." *Id.* at 175. Finally, Dr. Claiborn testified that GID, like homosexuality, is not actually a mental disease or disorder itself and that there is a difference of opinion on whether GID is a mental disorder. [R.202:357-358]

The Act does not effectuate deliberate indifference merely by barring a treatment option that some medical professionals deem the appropriate treatment. Deliberate indifference only occurs if the only course of treatment available is "blatantly inappropriate." *Edwards v. Snyder*, 478 F.3d 827, 831 (7th Cir. 2007). *See, e.g., Estate of Cole by*

Pardue v. Fromm, 94 F.3d 254, 261 (7th Cir. 1996). As noted above, the Eight Amendment does not entitle inmates to demand specific care and inmates are not entitled to the best care possible. *Forbes v. Edgar*,112 F.3d 262, 267 (7th Cir. 1997). The Eighth Amendment merely provides a right to "reasonable measures to meet a substantial risk of serious harm." *Id*. (Emphasis added).

As the district court noted, most of the medical experts that testified in this case agreed that some treatment is necessary for inmates with severe GID. [Decision, R.212:18-22; App. 121-125; Burnett Test., R.201:227-228; Brown Test., R.202:259, 268; R. Ettner Test., R.200:29] And Dr. Brown and Dr. F. Ettner both testified that psychotherapy alone is not an effective treatment for severe GID. [Decision, R.212:22, 28; App. 125, 131; F. Ettner Test., R.200:103; Brown Test., R.202:272-273] However, there was no evidence, or finding by the court, that the DOC was not prepared to make some form of treatment available to the plaintiffs or that the DOC was limiting the available treatment options to psychotherapy alone. There is no finding, or evidence to support such a finding, that the Act left available only "blatantly inadequate" treatment options. *See Edwards*, 478 F.3d 827, 831 (7th Cir. 2007). There is no basis in the record to

support the district court's finding that the Act effectuates deliberate indifference as to these plaintiffs.

II. WIS. STAT. § 302.386(5M) DOES NOT VIOLATE THE EIGHTH AMENDMENT OF THE CONSTITUTION ON ITS FACE BECAUSE IT IS NOT UNCONSTITUTIONAL IN EVERY APPLICATION OR EVEN IN A LARGE FRACTION OF CASES.

A. The Applicable Test

"[A]s-applied challenges are the basic building blocks of constitutional adjudication." *Gonzales v. Carhart*, 550 U.S. 124, 168 (2007) (quoting Fallon, As-Applied and Facial Challenges and Third-Party Standing, 113 Harv. L. Rev. 1321, 1328 (2000)). Proceeding cautiously, if at all, in facial challenges is appropriate because "exercising judicial restraint in a facial challenge 'frees the Court not only from unnecessary pronouncement on constitutional issues, but also from premature interpretations of statutes in areas where their constitutional application might be cloudy.'" *Wash. State Grange v. Wash. State Republican Party*, 552 U.S. 442, 450 (2008) (quoting *United States v. Raines*, 362 U.S. 17, 22 (1960)).

This posture of avoidance is engrafted into the law of this jurisdiction. While the familiar *Salerno* "no set of circumstances" test is unsettled law at the Supreme Court level, *United States v. Salerno*,

481 U.S. 739, 745 (1987)("[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."); *Planned Parenthood v. Casey*, 505 U.S. 833, 895 (1992)("[I]n a large fraction of the cases in which [the statute] is relevant, it will operate as a substantial obstacle to a woman's choice to undergo an abortion."); *Gonzales*, 550 U.S. at 167 (declining to resolve the debate between the "no set of circumstances" and "large fraction of cases" approach to facial challenges), it has been consistently applied in the Seventh Circuit. *E.g., Joelner v. Village of Wash. Park*, 378 F.3d 613, 621 (7th Cir. 2004); *Doe v. Heck*, 327 F.3d 492, 528 (7th Cir. 2003); *Home Builders Ass'n v. United States Army Corps of Eng'rs*, 335 F.3d 607, 619 (7th Cir. 2003); *Ben's Bar, Inc. v. Village of Somerset*, 316 F.3d 702, 708 (7th Cir. 2003); but see *A Woman's Choice-East Side Women's Clinic v. Newman*, 305 F.3d 684, 687 (7th Cir. 2002). When instruction from the Supreme Court is unclear (e.g., when the Supreme Court has not expressly overruled a line of cases that nevertheless seem somewhat incompatible with Supreme Court precedent), lower courts are to apply their circuit precedent, *Rodriguez de Quijas v. Shearson/American Express, Inc.*, 490 U.S. 477, 484 (1989), and the

balance of precedent appears to be in favor of the *Salerno* "no set of circumstances" approach in the Seventh Circuit. At the very least, "all [justices of the Supreme Court] agree that a facial challenge must fail where the statute has a "'plainly legitimate sweep.'" *Wash. State Grange* at 449 (citing *Glucksberg*, 521 U.S. at 739-740). In considering the sweep of a statute, reviewing courts are not permitted to consider the "worst case scenario" or "hypotheticals" and "imaginary" cases. *Ohio v. Akron Ctr. for Reproductive Health*, 497 U.S. 502, 514 (1990); *Raines*, 362 U.S. at 22.

In this case, the district court properly acknowledged the "no set of circumstances" test outlined in *United States v. Salerno*, 481 U.S. 739, 745 (1987), when analyzing the plaintiffs' facial challenge. [R.212:60; App. 163] Where the court erred, however, is in its application of the test.

B. The Relevant Class

The district court erred in its analysis of the facial challenge by applying the "no set of circumstances" test to too narrow a class of inmates. Here, the relevant class is, at its narrowest, all inmates with GID that are interested in hormone therapy or surgery.

The district court quoted the United States Supreme Court's decision in *Planned Parenthood v. Casey*, 505 U.S. 833, 895 (1992), as support for its conclusion that the relevant class of inmates in this case is limited to those with severe GID for whom hormones or surgery have been prescribed as medically necessary. [R.212:60-62; App. 163-165] Although the Supreme Court's analysis in *Casey* is relevant and instructive, the district court misapplied the Court's mode of analysis, in part, because the district court failed to recognize the differences between the regulation here and the regulation in *Casey*. As a result, the district court applied the "no set of circumstances" test to far too narrow a class. In *Casey*, the relevant provision required married women to sign a statement indicating that they notified their husband of an intended abortion. *Casey*, 505 U.S. at 833. The *Casey* Court held that the relevant class of women for a facial challenge to the notification provision was limited to those women for whom the provision was a relevant restriction; therefore, the class was limited to married women that wanted to have an abortion and would not choose to tell their husbands on their own volition. *Id.* at 894-895. This disputed provision in *Casey* did not ban all abortions, it merely created a spousal notification requirement. The specific nature of the provision

narrowed the affected class. In this case, however, the Act is much broader; it broadly prevents state or federal resources from being used to provide hormone therapy or sexual reassignment surgery to Wisconsin prisoners. Wis. Stat. § 302.386(5m).

As the district court explicitly stated in its decision, the Act prevented the DOC from evaluating inmates in order to determine if hormone therapy was necessary and appropriate. [R.212:62; App. 165] If the Act bars *evaluation* for hormones or surgery, at its most narrow extreme, the relevant class for a facial challenge would be all GID inmates that are interested in being evaluated for hormones or surgery, since the Act prohibits all of them from being evaluated for those specific treatments. Yet the district court goes on to ignore this application of the Act and limit the relevant class to inmates that have already been evaluated for hormones or surgery and for whom such treatments were deemed necessary. [R.212:62; App. 165] The district court cannot have it both ways; it cannot claim the Act affects all GID inmates interested in the prohibited treatments and then argue, for purposes of the facial challenge, that the Act only "applies" to inmates with severe GID who have been prescribed the treatment.

This case is closely analogous to *Gonzales*, where the Supreme Court rejected a facial challenge to the Partial-Birth Abortion Ban Act of 2003, finding that the Act, while banning a particular kind of abortion entirely, left open another "commonly used and generally accepted method" to obtain an abortion. *Gonzales*, 550 U.S. at 165.

As noted above, reading the Act in this case so narrowly as to only apply to the sub-class of extreme cases of GID in which hormone therapy or gender reassignment surgery are prescribed as medically necessary, as the lower court appeared to do, [R.212:32; App. 135], ignores the broad sweep of the language used in that statute. That the affected class is larger than this is illustrated by considering the effect facial invalidity would have: if the statute is facially invalid, then there would at least be the theoretical possibility that a prisoner without GID or with only a minor case of GID would be able to obtain these extreme treatments using the usual institutional procedures for requesting treatment. This possibility is heightened by the fact that the severity of GID is determined largely by the patient simply telling the medical professional what they are feeling. [R.200:24] Notably, as Dr. Claiborn testified, many transgender individuals seek GID treatments such as hormone therapy or surgery simply by choice and as a means of moving

forward with changing their circumstances. [R.202:369] In other words, the statute does serve as a restriction on these larger classes of cases, and so, arguably, the relevant class for the purposes of a facial challenge should either be the whole prison population or at least the subset of prisoners with any degree of GID.

Moreover, it is manifestly illogical to assume that the "denominator" (i.e., the relevant or regulated class) in either the "no set of circumstances" or "large fraction of cases" approach to facial challenges should be so narrowly limited to extreme cases because it would make judicial invalidation of a statute on its face redundant of the as-applied analysis. Had this approach been used by the Supreme Court in *Gonzales*, the ban of the dilation and extraction procedure that the Partial-Birth Abortion Ban Act targeted would have been impossible to square with the Court's findings that the procedure might be necessary, 550 U.S. at 162, and that there need not be an exception for when the procedure is necessary to save the life of the mother. *Id.* at 165-166. The approach taken by the lower court is incompatible with *Gonzales*, for it would have held that the relevant class is only the women for whom the dilation and extraction procedure was medically necessary—a move that would have compelled the conclusion that the

Act was facially unconstitutional as an undue burden on the right to an abortion. Of course, the *Gonzales* Court did not hold the Act facially unconstitutional, and it is almost certainly because of the patent absurdity of limiting the scope of a facial challenge to a relevant class so small.

This Court should avoid the tendency to either view the affected class so narrowly or engage in an inappropriate examination of what might be and focus instead on the overwhelming facts at hand: of the over 20,000 inmates it covers, the Act may at worst only run afoul of the constitution as it applies to a handful of individual inmates' need for hormones. These facts are sufficient to satisfy the statute's validity under any of the approaches to facial challenges available to this Court.

C. The Act is Valid on Its Face Because It Does Not Violate the Eighth Amendment in all cases or in a large fraction of cases.

1. The Act does not implicate an Eighth Amendment right, let alone violate it, as to the majority of inmates it affects because only a handful of inmates have been diagnosed with severe GID and prescribed hormone therapy.

In holding that the Act is facially unconstitutional, the lower court's opinion swept too broadly and ignored the many run-of-the-mill

cases in which the statute will not violate the Eight Amendment. First, the Act applies to all inmates, regardless of their diagnosis status:

> The department may not authorize the payment of any funds or the use of any resources of this state or the payment of any federal funds passing through the state treasury to provide or to facilitate the provision of hormonal therapy or sexual reassignment surgery for a resident or patient specified in sub. (1).

Wis. Stat. § 302.386(5m)(b). Since GID is not a common diagnosis, it is highly unlikely that the prohibition will ever affect the treatment of the vast majority of prisoners in Wisconsin correctional facilities. Second, though the affected class may need to be narrowed to those with gender identity issues, *Casey*, 505 U.S. at 894 ("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."), the trial record shows that even the plaintiffs' witnesses agree that the treatments prohibited by the Act will not be required whenever a prisoner has gender identity issues. On the contrary, hormone therapy and especially gender reassignment surgery are extreme measures reserved for serious cases. [R.202:289 (testimony that Dr. Brown has only seen one inmate that he thought was eligible for sex reassignment surgery); R.200:6 (plaintiffs' counsel arguing that hormone therapy is only required treatment in "severe cases of Gender Identity Disorder" and sex reassignment surgery is required "for an even smaller group."); R.201:175 (Kallas

testimony that hormones are one of the central ways to treat those with "severe gender dysphoria."); R.200:118-119 (Dr. F. Ettner testifying that there are lots of alternatives in treatment therapies); R.201:186 (Dr. Kallas testifying that not all gender dysphoria requires hormones or surgery); R.200:60-61 (Dr. R. Ettner testifying that not all individuals with GID need hormones, a diagnosis of GID does not require treatment in every case, and under the standards of care, therapists are directed to let GID patients simply choose among treatment options); R.200:64 (Dr. R. Ettner testifying that it is possible that inmates may request hormone therapy when it is not an appropriate treatment for them)] Notably, there is no evidence that any inmate currently has any medical need for gender reassignment surgery.

There is simply no evidence in the record to support a conclusion that there is "no set of circumstances" under which the Act does not effectuate deliberate indifference with regards to inmates with GID who are interested in being evaluated for hormones or surgery. Similarly, there is no evidence to support a conclusion that, as to a "large fraction" of inmates with GID that are interested in being

evaluated for hormones or surgery, the Act violates the Eighth Amendment by preventing evaluation for those specific treatments.

2. The Act is facially valid even under the "large fraction" test and where the relevant class of inmates is all inmates with severe GID for whom hormone therapy or surgery have been prescribes as medically necessary.

For the same reasons that the Act is valid as-applied to the plaintiffs, the Act is facially valid even if the test is the "large fraction" test applied in *Casey*, and the relevant denominator is all inmates with severe GID for whom hormone therapy or surgery have been prescribed as medically necessary. The Act is valid under such a test because other treatment options remain available, the Eighth Amendment does not require curative treatment, and a legislative act limiting medical discretion as to specific treatment options does not effectuate per se deliberate indifference. *See* Sections I(C)(1)-(3) *supra*.

D. For the Same Reasons That the Act is Facially Valid, The District Court Improperly Applied the PLRA and The Injunction Should be Lifted.

The district court erred in its determination that the Act violates the Eighth Amendment on its face; and in so doing, the court also violated the requirements of the Prison Litigation Reform Act (PLRA). The PLRA requires that prospective relief:

> [S]hall extend no further than necessary to correct the violation of the Federal right of a particular plaintiff or plaintiffs. The 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).

Here, the district court made after-the-fact findings to comply with the PLRA. [R.239; App. 173-175] In so doing, the court found that enjoining the enforcement of the Act "is narrowly tailored in that enjoining the enforcement of Wis. Stat. § 302.386(5m) prohibits only unconstitutional applications of the statute which this court has found to be unconstitutional any time it is applied." [R.239:1; App. 173]

The court went on to find that:

> [A]n injunction against enforcement of Wis. Stat. § 302.386(5m) extends no further than is necessary to correct the Eighth Amendment and Equal Protection violations because any application of the statute would violate the Eighth Amendment and Equal Protection and enjoining all applications of Wis. Stat. § 302.386(5m) is necessary to prevent constitutional violations.

[R.239:2; App. 174] Finally, The court stated that:

> [A]n injunction against enforcement of Wis. Stat. § 302.386(5m) is the least intrusive means possible to correct Eighth Amendment and Equal Protection violations that would be caused in the future through any application of the facially invalid statute. Lastly, the court concludes that the aforementioned injunctive relief will have no significant

> "adverse impact on public safety or the operation of a criminal justice system." 18 U.S.C. § 3626(a)(1).

[R.239:2-3; App. 174-175]

Although the court made most of the findings required by the PLRA, these findings are based on errors in law. *See* Sections II(B) and (C), *supra*. In particular, the court erred in determining that the Act only applied to inmates with GID for whom surgery or hormones have been prescribed as medically necessary. Additionally, the court did not find that the relief ordered extends "no further than necessary to correct the violation of the Federal right ***of a particular plaintiff or plaintiffs.***" 18 U.S.C. § 3626(a) (emphasis added). This is not a class action and the injunction issued by the court extends well beyond any violation to the plaintiffs. The court enjoined enforcement of the entire Act, which includes a prohibition on gender reassignment surgery. There is no evidence that the plaintiffs have been prescribed gender reassignment surgery or even desire such surgery. In fact, there is no evidence that any inmate in DOC custody has a medical need for sexual reassignment surgery.

Finally, the relief ordered by the district court is impermissibly broad because it enjoins enforcement of the Act as to inmates for whom the barred treatments are not medically necessary. The district court,

by its own argument, claims that the Act is only unconstitutional as to inmates for whom the treatments have been prescribed as medically necessary. [R.212:62 (finding that the Act only applies to inmates for whom a doctor has determined that hormone therapy is medically necessary); R.239:1 (claiming that the Act is unconstitutional in every application)] The Act itself makes no distinction as to medical need and, in fact, expressly applies to all inmates. Therefore, banning enforcement of the Act entirely is not narrowly-drawn relief and goes far beyond that which is "necessary to correct the violation of the Federal right of a particular plaintiff or plaintiffs." 18 U.S.C. § 3626(a).

III. THE ACT DOES NOT VIOLATE THE EQUAL PROTECTION CLAUSE EITHER AS APPLIED OR ON ITS FACE.

The Fourteenth Amendment's guarantee of equal protection of the laws must coexist with the fact that almost all legislation classifies people in one way or another. *Romer v. Evans*, 517 U.S. 620, 624 (1996) (citing Personnel Administrator of *Mass. v. Feeney*, 442 U.S. 256, 271-272 (1979)). These principles have been reconciled by the approach that courts will uphold laws that do not burden a protected class or the exercise of a fundamental right as long as the law can pass rational basis review. *E.g.*, *Romer*, 571 U.S. at 624; *Heller v. Doe*, 509 U.S.

312, 319 (1993); *Kadrmas v. Dickinson Public Schools,* 487 U.S. 450, 462 (1988); *Hodel v. Indiana,* 452 U.S. 314, 331-332 (1981).

A. Transgender individuals are not a suspect class for the purposes of the Equal Protection Clause and the Act, therefore, is subject only to rational basis review.

Even if Wis. Stat. § 302.386(5m) does draw a distinction between those with GID and those without it (which the statute does not, as a matter of language, do), the statute would not be subject to strict or heightened scrutiny. Rational basis scrutiny must be applied in this case because the Act does not target a suspect or quasi-suspect class, such as a race, *see, e.g., Loving v. Va.*, 388 U.S. 1, 11 (U.S. 1967), nor does it affect a fundamental right, such as the right to vote, the right to privacy, or the right to travel between states. *See, e.g., Miller v. Carter*, 547 F.2d 1314, 1320 (7th Cir. 1977). Rather, the statute at most draws a distinction based on sexual orientation, which has never been deemed a suspect classification. *See Nabonzy v. Podlesny*, 92 F.3d 446 (7th Cir. 1996); *Ben-Shalom v. Marsh,* 881 F.2d 454, 464 (7th Cir. 1989), cert. denied, 494 U.S. 1004 (1990). Recent cases striking down state statutes arguably targeting those of a particular sexual orientation have explicitly avoided holding that sexual orientation is a suspect class and have instead focused on the fact that the statutes in

question were "divorced from any factual context from which we could discern a relationship to legitimate state interests." *Romer*, 571 U.S. at 635.

Under rational basis review, a governmental classification "must be upheld against equal protection challenge if there is *any* reasonably conceivable state of facts that could supply a rational basis for the classification." *Heller v. Doe,* 509 U.S. 312, 320, 113 S.Ct. 2637 (1993) (emphasis added); *see also* F*CC v. Beach Communications, Inc.*, 508 U.S. 307, 313 (1993). For both facial and as-applied challenges, the burden is upon the challenging party to eliminate any 'reasonably conceivable state of facts that could provide a rational basis for the classification. *Smith v. City of Chicago*, 457 F.3d 643, 652 (7th Cir. 2006). Rational basis review "is not a license for courts to judge the wisdom, fairness, or logic of legislative choices." *Id.* Similarly, it does not "authorize the judiciary to sit as a superlegislature to judge the wisdom or desirability of legislative policy determinations." *Heller v. Doe by Doe*, 509 U.S. 312, 319, 113 S.Ct. 2637 (1993) (citations omitted). "A legislative choice is not subject to courtroom factfinding and may be based on rational speculation unsupported by evidence or empirical data." *Heller,* 509 U.S. at 320-321. "[C]ourts are compelled under

rational-basis review to accept a legislature's generalizations even when there is an imperfect fit between means and ends. A classification does not fail rational-basis review because it is not made with mathematical nicety or because in practice it results in some inequality." *Id.* "A statute is presumed constitutional, and the burden is on the one attacking the legislative arrangement to negative every conceivable basis which might support it, whether or not the basis has a foundation in the record." *Heller*, 509 U.S. at 320.

Therefore, legislatures must be given a presumption that they acted within their constitutional power. *Nordlinger v. Hahn,* 509 U.S. 1, 10, 112 S.Ct. 2326 (1992). While the Supreme Court has "consistently held, however, that some objectives, such as 'a bare ... desire to harm a politically unpopular group,' are not legitimate state interests," and has "applied a more searching form of rational basis review" in those circumstances, *Lawrence v. Texas*, 539 U.S. 558, 580 (2003) (O'Connor J., concurring) (citing *Department of Agriculture v. Moreno* 413 U.S. 528, 534 (1973); *Cleburne v. Cleburne Living Center* 473 U.S. 432, 446-47 (1985); *Romer*, 571 U.S. at 632), that triggering animus only exists where a law is "inexplicable by *anything* but animus

toward the class that it affects." *City of Chicago v. Shalala*, 189 F.3d 598 (7th Cir. 1999) (quoting *Romer*, 571 U.S. at 632) (emphasis added).

B. The statute is justified by legitimate security and liability concerns and employs means rationally related to furthering those ends.

1. The statute protects the State's interest in the peaceful administration of the State's corrections facilities by ameliorating or preventing gender-motivated violence or abuse.

In conducting rational basis review of a statute governing prison administration, it is of utmost importance that the reviewing court remain cognizant of the special disciplinary and security needs of corrections facilities and assume the traditional posture of deference to the decisions of prison administrators on the frontlines. There can be no dispute that the provision of security must be central to all other prison goals. *Thornburgh v. Abbott*, 490 U.S. 401, 415 (1989). Courts are obligated to defer to prison officials' adoption of policies necessary to preserve security and internal order. *Hewitt v. Helms*, 459 U.S. 460, 474 (1983). In the prison environment, "safety of the institution's guards and inmates is perhaps the most fundamental responsibility of the prison administration." *Id.* at 473. The Seventh Circuit has repeatedly recognized this principle:

> Judges should be cautious about disparaging disciplinary and security concerns expressed by the correctional authorities. American jails are not safe places, and judges should not go out of their way to make them less safe.

Keeney v. Heath, 57 F.3d 579, 581 (7th Cir. 1995).

> Less-restrictive-alternative arguments are too powerful: a prison always can do something, at some cost, to make prisons more habitable, but if courts assess and compare these costs and benefits then judges rather than wardens are the real prison administrators. *Wolfish* emphasized what is *the* animating theme of the Court's prison jurisprudence for the last 20 years: the requirement that judges respect hard choices made by prison administrators.

Johnson v. Phelan, 69 F.3d 144, 145 (7th Cir. 1995), *cert. denied*, 519 U.S. 1006 (1996)(emphasis in original).

In its decision, the lower court did not afford appropriate weight to the evidence identifying and supporting the State's security interests in preventing sexual abuse in prisons. First, there can be no doubt that the prohibited treatments feminize inmates by rendering effects on "secondary sexual characteristics such as hair, fatty metabolism, muscle, and . . . breasts." [R.201:197] There can also be little doubt that taking the plaintiffs off of hormone therapy would result in measurable decreases in their femininity. One of the plaintiffs, Vankemah Moaton, confirmed that he "started growing thicker body hair" and experienced a decrease in breast tissue after being withdrawn from hormone therapy while serving another sentence in

federal prison [R.201:149], and flatly agreed that he could not look as feminine without hormone therapy as he could with them. [R.201:162]

The State of Wisconsin's expert witness, Eugene Atherton, testified that sexual assault is something that needs to be prevented in prisons and is difficult to prevent. [R.202:415] Mr. Atherton also concluded that prisons are highly unique and highly dangerous places which require unusual diligence, oversight, and caution, especially when considering the dangers of sexual activity [R.202:412-414], and that the appearance of femininity makes those inmates an "automatic target for inmates who are interested in sexual aggression or sexual relationships." [R.202:419] Mr. Atherton testified that if an inmate presents an effeminate manner, whether by dress or behavior, that makes the inmate more likely to be sexually victimized. *Id*. Finally, Mr. Atherton testified that the fact that an inmate's physical appearance changes to become more feminine leads to increased security concerns for the institution. [R.202:435] Indeed, the heightened risk created by artificially induced femininity in the prison context is nowhere better demonstrated than in some of the plaintiffs' own personal experiences. Vankemah Moaton testified that he took extra precautions to conceal his femininity, including wearing baggier

clothing, specifically because "I am female and I am in a male's prison so I don't do those type of things, leave myself susceptible of being assaulted or possibly leave myself open for sexual assault." [R.201:155] Though Moaton was confident in believing that withdrawing hormone therapy would not reduce the harassment he was receiving while in prison because "I'm still gonna be female," it is certainly not unreasonable for the State to presume that most prisoners will not be as tactful as Moaton in protecting their own security interests.

2. The district court improperly applied the rational basis standard to the evidence.

The lower court did not give the extensive evidence in support of a rational basis proper weight. [R.212:66-67; App. 169-170] It is this misapplication of the law that the defendants challenge on appeal and which this Court should review *de novo*. *See generally Smith v. City of Chicago*, 457 F.3d 643, 650 fn. 2 (7th Cir. 2006); *U.S. v. Turner*, 93 F.3d 276, 286 (7th Cir. 1996).

First, the lower court concluded that the fact that the State's prison expert had not challenged a Colorado policy allowing hormone therapy because he believed it to be reasonable was enough to negate his other testimony on the inherent dangers of increased feminization in the prison context. [R.212:66; App. 169] However, it is clear that

Atherton's opinion on the matter was merely that the Colorado policy was reasonable, and it had no bearing at all on the reasonableness of Wis. Stat. § 302.386(5m)—indeed, both could be reasonable simultaneously without rendering the Act unconstitutional in this case. As noted above, "that rational-basis review in equal protection analysis "is not a license for courts to judge the wisdom, fairness, or logic of legislative choices…Nor does it authorize 'the judiciary to sit as a superlegislature to judge the wisdom or desirability of legislative policy determinations.'" *Heller v. Doe by Doe*, 509 U.S. 312, 319, 113 S.Ct. 2637 (1993) (internal citations omitted).

Second, the lower court's opinion notes Atherton's comment that he did not think withdrawal of hormone therapy would necessarily lead to a reduction in risk of sexual assaults, as well as a fruitless counterfactual questioning about whether Davison would have been assaulted without hormone therapy, to argue that the causal connection was insufficient. [R.212:66; App. 169] Again, this analysis betrays the spirit of rational basis review. The only relevant question under rational basis review is whether the State could reasonably conceive that withdrawal of hormone therapy would further any legitimate interest. Whether withdrawal would *necessarily* lead to a

reduction in sexual assaults and whether Davison would have *necessarily* been saved from his sexual assault with a withdrawal of hormone therapy are ultimately irrelevant for the purposes of equal protection analysis.

While plaintiffs point to the lack of discussion about security interests during the legislative debate on Wis. Stat. § 302.386(5m) as evidence that the State has not met its burden to demonstrate a rational basis for the statute, the point is inapposite in the context of an equal protection challenge. The State has no obligation to maintain the same rational basis at all times. Rather, as previously noted, it is free to re-articulate its justification for the law even during litigation:

> The government may defend the rationality of its action on any ground it can muster, not just the one articulated at the time of decision (if a reason was given at all.) Our various departments and agencies of government make thousands of decisions every day; not every one will come with an explanation. The absence of an explanation, or even an incomplete, inadequate, or inaccurate explanation will not equate to a lack of rational basis-otherwise "the federal courts would be drawn deep into the local enforcement of ... state and local laws." Accordingly, the reason stated at the time of the challenged action may be relevant but is not dispositive in the application of rationality review.

Smith v. City of Chicago, 457 F.3d 643, 652 (7th Cir. 2006) (internal citations omitted). Nor is it enough to point, as the plaintiffs do, to other prisoners whose characteristics or conditions might lead to

heightened security risks (such as homosexual inmates or inmates with HIV). The legislature need not "strike at all evils at the same time or in the same way." *Sutker v. Illinois State Dental Soc.*, 808 F.2d 632, 635 (7th Cir. 1986) (citing *Semler v. Oregon State Board of Dental Examiners*, 294 U.S. 608, 610 (1935)). It is sufficient that there is a problem "at hand for correction, and that it might be thought that the particular legislative measure was a rational way to correct it." *Williamson v. Lee Optical, Inc.*, 348 U.S. 483, 487-88 (1955).

3. The Act protects the state from civil liability for failure to live up to its duty to provide a safe environment for transsexual prisoners.

Because the State would face civil liability for failure to provide a safe environment for transsexual prisoners, the State should not be denied the ability to adopt a cost-effective mechanism for protecting the constitutional rights of these prisoners. In *Farmer v. Brennan*, the Supreme Court held that a transsexual prisoner who was raped and beaten after being placed in the prison's general population could assert a prima facie case for deliberately indifferent failure to protect prisoner safety. *Farmer v. Brennan*, 511 U.S. 825, 114 S.Ct. 1970 (1994). Though "prison officials who act reasonably cannot be found liable under the Cruel and Unusual Punishments Clause," (*Id.* at 845),

the Supreme Court ultimately found that such action (i.e., treating transsexuals as just like any other prisoner) was not reasonable per se. Rather, the relevant inquiry in determining deliberate indifference was whether the prison officials had subjective knowledge of a substantial risk to the safety of the prisoner, and this inquiry can be satisfied by examining circumstantial evidence of awareness:

> [If] an Eighth Amendment plaintiff presents evidence showing that a substantial risk of inmate attacks was "longstanding, pervasive, well-documented, or expressly noted by prison officials in the past, and the circumstances suggest that the defendant-official being sued had been exposed to information concerning the risk and thus 'must have known' about it, then such evidence could be sufficient to permit a trier of fact to find that the defendant-official had actual knowledge of the risk."

Id. at 842-843. In *Farmer*, that inquiry was satisfied by evidence that the prison officials admitted "there was a high probability that [petitioner] could not safely function" in the prison and that they believed the petitioner's "youth and feminine appearance" made the petitioner "likely to experience a great deal of sexual pressure." *Id.* at 848-849.

Both direct and circumstantial evidence show that the State is subjectively aware of the problems associated with providing a safe environment for transsexual prisoners. The Act was passed largely out of recognition of these difficulties, and even the plaintiffs' experts admit

that there are difficulties and challenges associated with housing transsexual prisoners among gender-segregated prison populations. [*See e.g.,* R.202:318-319] Given this evidence, it is not implausible to conceive of § 1983 actions against prison officials for failure to deal with the special security challenges surrounding transsexual prisoners. In passing the Act, the State of Wisconsin took positive steps to avoid this kind of civil liability. The Act minimizes the ability of prisoners to change their appearance, thereby making it less dangerous for prison officials to place the prisoners in general prison populations. The denial of hormone therapy, in particular, can help reduce or reverse the acquisition of characteristics of the opposite sex. Instead of continuing hormone therapy and permanently utilizing drastic measures such as segregation or isolation to protect these prisoners, the State has chosen to avoid liability by minimizing the vulnerabilities created by hormone therapy and gender reassignment surgery. The State should not be penalized for taking steps to protect the safety of inmates and their corresponding constitutional rights.

CONCLUSION

For the reasons stated above, the defendants respectfully request that the Court REVERSE the district court's decision and judgment

below as to both the Eighth Amendment and Equal Protection claims and DECLARE Wis. Stat. § 302.386(5m) constitutional under both the Eighth Amendment and the Equal Protection Clause of the Fourteenth Amendment.

Dated this 24th day of September, 2010.

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CERTIFICATE OF COMPLIANCE WITH F.R.A.P. RULE 32(A)(7)

The undersigned, counsel of record for the defendants-appellees, furnishes the following in compliance with F.R.A.P. Rule 32(a)(7).

I hereby certify that this brief conforms to the rules contained in F.R.A.P. Rule 32(a)(7) for a brief produced with a proportionally spaced font. The length of this brief is 11,888 words.

Dated this 24th day of September, 2010.

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CIRCUIT RULE 31(E) CERTIFICATION

The undersigned hereby certifies that I have filed electronically, pursuant to Circuit Rule 31(e), a version of the brief that is available in non-scanned PDF format.

Dated this 24th day of September, 2010.

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A P P E N D I X

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APPENDIX PAGE

APPPENDIX CERTIFICATION

The undersigned hereby certifies that this appendix includes all of the materials required by Circuit Rule 30(a) and (b).

Dated this 24th day of September, 2010.

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UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF WISCONSIN

ANDREA FIELDS,
MATTHEW DAVISON, also known as Jessica Davison,
and VANKEMAH D. MOATON,

Plaintiffs,

v. Case No. 06-C-112

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

Defendants.

ORDER DECLARING WIS. STAT. § 302.386(5m) UNCONSTITUTIONAL AND ENJOINING ENFORCEMENT OF STATUTE

The plaintiffs in this case seek declaratory and injunctive relief claiming that the defendants have violated the United States Constitution by enforcing 2005 Wisconsin Act 105, codified as Wis. Stat. § 302.386(5m), and depriving them of medical treatment for their serious health condition, Gender Identity Disorder. Further, the plaintiffs ask the court to find that the defendants enforced the statute without regard for individualized medical judgment and in contrast to the medical treatment that the defendants provide to similarly situated inmates in Wisconsin Department of Corrections (DOC) facilities. Consequently, the 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. Moreover, the plaintiffs ask this court to find that enforcement of the statute evinces deliberate indifference to the serious medical needs of

the plaintiffs as well as the serious medical needs of all other inmates of DOC facilities. Lastly, the plaintiffs seek a declaration that Wis. Stat. § 302.386(5m) is unconstitutional on its face and as applied.

After careful consideration, the court concludes that the defendants' application of Wis. Stat. § 302.386(5m) to these plaintiffs constitutes deliberate indifference to the plaintiff's serious medical needs in violation of the Eighth Amendment inasmuch as enforcement of the statute results in the denial of hormone therapy without regard for the individual medical needs of inmates and the medical judgment of their health care providers.

The court further finds that Wis. Stat. § 302.386(5m) is unconstitutional on its face under the Eighth Amendment because it bans the use of any Wisconsin State resources or federal funds passing through the government to provide hormone therapy and, thereby, requires the withdrawal of any such ongoing hormone therapy for inmates in DOC facilities without regard for the medical need for that treatment.

The court further finds that Wis. Stat. § 302.386(5m) prevents DOC medical personnel from evaluating inmates for treatment because such evaluation would be futile in light of the statute's ban on such hormone therapy. Furthermore, the application of Wis. Stat. § 302.386(5m) to the plaintiffs violates the plaintiffs' constitutional right to equal protection because there is no rational basis for treating the plaintiffs differently than similarly situated inmates.

The court further finds there is no rational basis for Wis. Stat. § 302.386(5m) and that the statute is invalid on its face, as it violates the Equal Protection Clause of the

Fourteenth Amendment. A memorandum decision shall be issued forthwith. Now, therefore,

IT IS ORDERED that enforcement of Wis. Stat. § 302.386(5m) violates the plaintiffs' Eighth Amendment right to be free from cruel and unusual punishment and Fourteenth Amendment right to equal protection.

IT IS FURTHER ORDERED that Wis. Stat. § 302.386(5m) is unconstitutional.

IT IS FURTHER ORDERED that the defendants are permanently enjoined from the enforcement of Wis. Stat. § 302.386(5m).

Dated at Milwaukee, Wisconsin, this 31st day of March, 2010.

BY THE COURT

/s/ C. N. Clevert, Jr.
C. N. CLEVERT, JR.
Chief U.S. District Judge

UNITED STATES DISTRICT COURT

EASTERN DISTRICT OF WISCONSIN

ANDREA FIELDS,
MATTHEW DAVISON, also known as Jessica Davison,
and VANKEMAH D. MOATON,

Plaintiffs,

v. Case No. 06-C-112

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

Defendants.

MEMORANDUM DECISION

Following a court trial, in March 31, 2010, this court entered an order declaring Wis. Stat. § 302.386(5m) unconstitutional and enjoining the enforcement of the statute. The following memorandum constitutes the court's findings of fact and conclusions of law underlying that order in accordance with Federal Rule of Civil Procedure 52.

BACKGROUND

Plaintiffs[1], who are Wisconsin prison inmates, bring this action under 42 U.S.C. § 1983 for declaratory and injunctive relief claiming that the defendants violated the United States Constitution by enforcing 2005 Wisconsin Act 105, codified as Wis. Stat. § 302.386(5m) (Act 105), and abruptly terminating and depriving them of medical treatment

[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 in prison.

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. Moreover, they ask that Wis. Stat. § 302.386(5m) be declared unconstitutional on its face. During the pendency of this case, the DOC has provided hormone therapy to plaintiffs under the terms of a preliminary injunction.

STIPULATED FACTS

Plaintiff Andrea Fields is a male-to-female transsexual in DOC custody at Green Bay Correctional Institution (GBCI). The DOC has diagnosed Fields with GID. Fields has received feminizing hormone therapy continuously since 1996. In 2003, Fields underwent breast augmentation as a component of gender transition. After becoming incarcerated in 2005, the DOC confirmed Fields's GID diagnosis and continued hormone therapy. In 2006, because of the passage of Act 105, the DOC began to taper Fields's hormone therapy by halving the dosage. As a result of the reduction, Fields experienced nausea, muscle weakness, loss of appetite, increased hair growth, skin bumps, and depression. The reinstatement of Fields's hormone therapy following the preliminary injunction in this action abated the withdrawal symptoms.

Plaintiff Matthew Davison, also known as Jessica Davison, is a male-to-female transsexual in DOC custody at Oshkosh Correctional Institution ("OSCI"). The DOC has diagnosed Davison with GID. Prior to receiving hormone therapy, Davison attempted

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 growth, voice deepening, breast reduction and leaking, mood swings, mental and emotional instability, hot flashes, and body aches. The reinstatement of Davison's hormone therapy because of the preliminary injunction in this action led to an abatement of withdrawal symptoms.

Plaintiff Vankemah Moaton is a male-to-female transsexual in DOC custody at Jackson Correctional Institution (JCI). The DOC has diagnosed Moaton with GID. Moaton has experienced suicidal ideation in the past, including after being removed from hormone therapy. Moaton began taking feminizing hormones in the late 1990s, took medically prescribed hormone therapy beginning in 2000, and has continued to receive that treatment during DOC incarceration. After entering DOC custody, the DOC began to withdraw Moaton's hormone therapy because of Act 105. As a result of that withdrawal, Moaton started growing chest and facial hair, developing tenderness in the chest and groin areas, and experiencing skin breakouts, hot flashes, and depression. The reinstatement of Moaton's hormone therapy because of the preliminary injunction in this action led to an abatement of withdrawal symptoms. All of plaintiffs have, to varying degrees, feminine physical characteristics as a result of their hormone usage.

Matthew J. Frank was, at the time this action was filed, the Secretary of the DOC. The current Secretary of the DOC is defendant Richard Raemisch. Defendant

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 Statistical Manual of Mental Disorders ("DSM"). GID has been included in the DSM since the third edition of that manual, which was published in 1980. In prior editions, the DSM classified "transsexualism" as a psychiatric disorder. The following diagnostic criteria are listed in the DSM for GID: 1) a strong and persistent cross-gender identification; 2) a persistent discomfort with one's sex or a sense of inappropriateness in the gender role of that sex; 3) the disturbance is not concurrent with a physical intersex condition; and 4) the disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Matthew Davison, a/k/a Jessica Davison, has used a female name since childhood. Andrea Fields acted like a girl at school, talked like a girl, walked like a girl, wore makeup, and had a feminine hairstyle. Vankemah Moaton started behaving in a feminine manner prior to age eight.

Kenneth Krebs, a/k/a Karen Krebs, a male-to-female transsexual in DOC custody, cross-dressed as a child and adolescent. Erik Huelsbeck, a/k/a Erika Huelsbeck, another male-to-female transsexual held by the DOC, dressed as a girl for "dressed-up" day at school and other times, sometimes publicly.

DOC administrative personnel generally agree that deference on health care matters should be given to DOC health care staff. Sometimes the DOC prescribes

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 therapy.

The legislative sponsors of Act 105 labeled it the "Inmate Sex Change Prevention Act." Act 105 provides:

> SECTION 1. 302.386(5m) of the statutes is created to read:
>
> 302.386**(5m)** (a) In this subsection:
>
> 1. "Hormonal therapy" means 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.
>
> 2. "Sexual reassignment surgery" means surgical procedures to alter a person's physical appearance so that the person appears more like the opposite gender.
>
> (b) The department may not authorize the payment of any funds or the use of any resources of this state or the payment of any federal funds passing through the state treasury to provide or to facilitate the provision of hormonal therapy or sexual reassignment surgery for a resident or patient specified in sub. (1).
>
> SECTION 2. Initial applicability.
>
> (1) PROVISION OF HORMONAL THERAPY OR SEXUAL REASSIGNMENT THERAPY. This act first applies to hormonal therapy, as defined in section 302.386 (5m) (a) 1. of the statutes, as created by this act, or sexual reassignment surgery, as defined in section 302.386 (5m) (a) 2. of the statutes, as created by this act, provided on the effective date of this subsection.

(Ex. 24.)

The legislative sponsors issued multiple press releases prior to its passage stating that it was intended to prevent “bizarre taxpayer-funded sex change procedures” and to stop the DOC policy of “[allowing] pharmacists within the correction system to give hormones to an inmate diagnosed with gender identity disorder.” The only correctional or medical expertise offered during the legislative hearings regarding Act 105 was that of defendants' correctional medical personnel, Dr. Kevin Kallas and Dr. David Burnett. No other DOC representative testified before the legislature regarding Act 105. No one other than legislators spoke in support of the bill that became Act 105. An earlier draft of Act 105 made explicit reference to GID, banning the use of DOC funds "to provide or facilitate the provision of hormonal therapy or sexual reassignment surgery for the treatment of gender identity disorder." Several of the press releases issued by the sponsors of Act 105 noted specifically that the issue of sex reassignment treatment for inmates came to light when they learned that a Wisconsin transgender inmate was receiving treatment that led her to develop “female characteristics, such as breasts.”

While sex reassignment surgery is more expensive than hormone therapy, DOC provides surgeries of equal or greater cost, such as organ transplant and open heart surgical procedures, when medically necessary. Genital sex reassignment surgery costs approximately $20,000. The most expensive surgical procedures provided to inmates by defendants include organ transplants, such as liver, kidney and pancreas transplants, and open heart surgical procedures. In 2005, the defendants paid $37,244.09 for one coronary bypass surgery and $32,897.00 for one kidney transplant surgery. The Fiscal Estimate prepared for AB-184, the bill that became Act 105, noted that the defendants paid a total of $2,300 for cross-gender hormone therapy for two inmates with GID in 2004. Such

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 prescribed, because of Act 105. Similarly, Krebs has been diagnosed with GID by the DOC. However, Krebs has not been evaluated to determine whether hormone therapy will be prescribed, nor could Krebs receive such treatment, because of Act 105.

Plaintiffs have been in DOC general population for most of their sentences. When OSCI identifies inmates who are more likely to be victims of violence by other prisoners, or more likely to perpetrate violence, it takes steps to address that through closer monitoring or placing the inmate in a different housing unit.

OSCI has eleven different housing units. One is a dormitory setting and houses 148 inmates. Two are wet cell units—they have toilet and shower facilities in the cell. The remaining nine have group bathrooms. The non-dormitory units have between 160-200 inmates each. The majority of the inmates in those units are double-celled.

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.) She has evaluated or treated between 2,500 and 3,000 clients with GID since 1976. (Trial Tr. vol. 1, 15, Oct. 22, 2007.) Dr. R. Ettner conducts independent research in the area of GID; has written three books, two of which are peer-reviewed; provides consultation to other mental health professionals; provides in-service or education to physicians, attorneys, and other groups; and collaborates with colleagues in organizations that treat individuals with GID. (*Id.* at 14, 16.) She is the editor of the International Journal of Transgenderism, which is published by Haworth Medical Press. (*Id.* at 17.) Dr. R. Ettner is a member of the scientific committee of the World Professional Association for Transgender Health ("WPATH")[2], known previously as the Harry Benjamin International Gender Dysphoria Association ("HBIGDA"). (*Id.* at 18.) Approximately 70% of her work time is spent seeing clients. (*Id.*) As part of her role as clinician for clients with GID, Dr. R. Ettner examines

[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.* at 144-45.) A year or two after starting hormones, Moaton began dressing as a woman and living life as a female, including in a couple of jobs. (*Id.* at 146.) In addition, Moaton has had electrolysis on the face, as well as silicone injections in cheeks, chin, breasts, and hips. (*Id.* at 147.) Moaton considers Moaton to be a woman and is "completely detached" from the male part or male characteristics. (*Id.* at 148.) Moaton is currently taking feminizing hormones. (*Id.* at 154.)

Plaintiffs' witness Dr. Kevin Kallas is the Mental Health Director for the DOC. (*Id.* at 168.) He is board certified in general psychiatry and forensic psychiatry. (*Id.*) Dr. Kallas is responsible for informing the psychologists and psychiatrists within the DOC about the care of inmates with GID. (*Id.* at 173.) Dr. Kallas's responsibilities include clinical oversight of approximately thirty-five psychiatrists and approximately 100 psychology staff; development of policy for achieving consensus within the department as to what policies ought to be; clinical consultation to the psychologists and psychiatrists; formulating policy for psychotropic medications; and acting as a liaison to outside groups such as advocacy groups. (*Id.* at 196.) He sits on the DOC gender identity committee. (*Id.* at 170.) Dr. Kallas's prior experience in working with persons with GID includes five years at the San Francisco psychiatric emergency room where he saw about a dozen transgender patients, some on a recurring basis. (*Id.* at 171-72.) He also had at least one transgender patient while in private practice and, while working as a psychiatrist at Dodge Correctional Institution, evaluated and treated at least one patient with GID. (*Id.* at 172.)

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, some of which has been specific to GID and transsexualism, some on prison issues with GID, as well as a variety of other transgender phenomenon including transvestism. (*Id.* at 248-49.) Dr. Brown has been involved in the

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.)

2. Plaintiffs

According to Dr. R. Ettner, all three plaintiffs have severe GID.[3] (Trial Tr. vol. 1, 43, Oct. 22, 2007.) Dr. R. Ettner testified that, at a minimum, plaintiffs require hormone therapy to treat their severe GID. (*Id.*) Hormone therapy is medically necessary for the plaintiffs because nothing short of that treatment will provide an attenuation or relief from the severe distress caused by GID at that level. (*Id.* at 55.)

According to Dr. R. Ettner, plaintiff Fields looks like a woman, has large breasts, and is "very feminine in appearance." (*Id.* at 51.) The prison guards refer to Fields as "she, I mean he." (*Id.*) Fields "is fully feminine in her presentation and in her appearance." (*Id.*) Dr. R. Ettner testified:

> Andrea Fields is one of those individuals who thought she was a girl when she was growing up, and always behaved and lived as a girl. She never even tried to live as a boy. Even though, for instance, she was punished for playing with nail polish, she never ever attempted to be anything other than what she thought she was.

(*Id.*)

Dr. R. Ettner says Plaintiff Davison looked "fairly feminine" in appearance. (*Id.* at 52.) Davison had some breast growth and a female hairstyle, and attempted to present with female mannerisms. (*Id.*) As a result of using hormones for a period of time, Davison had some of the physical manifestations of female secondary sex characteristics, which come on with hormone usage. (*Id.*) Davison appeared to have other psychiatric disorders

[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 plaintiff for approximately three and a half hours. (*Id.* at 44.) Most of this section is taken from Dr. R. Ettner's testimony regarding her interviews of the plaintiffs. (*See id.* at 42-58.)

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 Moaton has female bone structure, a female hairstyle, a voice that is entirely female, a waist to hip ratio that appeared female, breast development, no facial or body hair, and a lack of the muscle mass that is characteristic of genetic males. (*Id.* at 58.) Moaton served in the Army Reserves from 1995 to 2003. (*Id.* at 71.)

3. Gender Identity Disorder[4]

a) Dr. R. Ettner

Dr. R. Ettner testified that GID is:

> a rare condition in which an individual has the persistent idea that they are or wish to be a member of the opposite sex, and the persistent feeling that their own body is inappropriate or wrong, and they desire to rid themselves of the characteristics of the sex they were born with and attain the characteristics of the other sex.

(Trial Tr. vol 1, 23, Oct. 22, 2007.) The criteria for the diagnosis is set out in two places, the International Classification of Disease ("ICD"), and the DSM. (*Id.* at 24-25.) The ICD and the DSM "are nomenclature, in one case of all medical and psychiatric disorders, and

[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.
> >
> > Typically they have a dislike of their genitals. Puberty is a very difficult time for these individuals. And they will track along their lifeline various stigmata of gender confusion or gender disorder.
> >
> > . . . .

> 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. They won't like rough and tumble play.

(*Id.* at 26-27.)

According to Dr. R. Ettner, there is no definitive test to say whether someone has GID. (*Id.* at 28.) However, there is no controversy over the existence of the disorder. (*Id.* at 42.)

b) Dr. F. Ettner

Dr. F. Ettner testified that, based on his medical knowledge and experience treating transgender patients, GID is a serious health condition. (*Id.* at 93.) He stated:

> Those individuals, with Gender Identity Disorder who express dysphoria, not being in the right body, where the brain is not in concert with their physical appearance, will have a lot of dysfunction. Initially it may present as depression, lethargy, and they will then come to my attention. If not treated, whether it be by talk therapy and/or hormones, they can develop serious medical problems.

(*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, therefore, should be in the list of medical conditions or neurological conditions as opposed to a psychiatric condition.

> But whether it exists at all and whether it's serious, those things are not controversial. It's a matter of placement.

(*Id.*)

The mental state of a person presenting with GID who is not receiving treatment varies:

> Usually the people that make it to me through referral sources from all over the country, have at least moderate to severe form of the disorder.
>
> And prior to receiving treatment they are very preoccupied with their condition, spend considerable amount of their time, effort, energy and resources trying to obtain treatment in the form of psychotherapy hormones, and in some cases ultimately sex reassignment surgery.
>
> They uniformly have gender dysphoria which is not a diagnosis but an amalgam of symptoms that includes depression, anxiety and irritability mixed together.
>
> Frequently they have suicidal ideation and have had suicide attempts in the past.
>
> They often harbor thoughts of wanting to engage in what I would call surgical self-treatment. In the literature it's sometimes described as genital self-mutilation or autocastration as a way to rid themselves of the hormones associated with the testicles.
>
> They're often very desperate, frantic impaired people who are looking for treatment from someone who knows what they're doing in this area, and unfortunately that's limited to very few people.

(*Id.* at 262.) Generally, Dr. Brown diagnoses GID based on a two- to three-hour face-to-face clinical interview, his experience, and all of the records that he can find. (*Id.* at 263.)

e) Dr. Claiborn

Dr. Claiborn testified that, in his opinion, GID is not a mental disease or disorder. (*Id.* at 357.) He believes that a person who has GID does not typically suffer from an impairment in psychological functions. (*Id.* at 364.) According to Dr. Claiborn, people with GID can have mental disorders such as depression and anxiety, but those disorders are not directly a result of being transgendered. (*Id.* at 367.)

Dr. Claiborn uses the DSM in two main ways, for filling out insurance forms and in some cases for forensic evaluations. (*Id.* at 361.) He testified that the DSM is not constructed to be helpful to therapists because it does not address the causes of disorders. (*Id.* at 361-62.)

4. Treatment for Gender Identity Disorder

a) Dr. R. Ettner

Dr. R. Ettner testified about the treatments for the distress that accompanies severe GID. The treatments are referred to as "triadic treatment," which consists of, 1) a real life experience which helps the person socially take on the role and life that they want in the preferred gender; 2) hormones; and 3) surgical treatments involving genital alteration. (Trial Tr. vol. 1, 29, Oct. 22, 2007.) These treatments are set out in the Standards of Care, which is published by WPATH. (*Id.* at 30.) The treatments are also found in the DSM-IV treatment manual, a book that accompanies the diagnostic manual, as well as in other handbooks for clinicians and for professionals in the medical and mental health fields. (*Id.*) The Standards of Care "are a document that articulates professional consensus about the treatment of gender identity disorders, and it's produced by the

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 disorder; 2) helping the patient understand and navigate some of the social consequences that accompany GID; 3) following up with the patient after some treatments; and 4) offering support, helping the person find

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-dressed secretively, it's not sufficient. They'll then be referred for therapy and maybe the therapy is not gonna be sufficient and the therapist will then refer those clients to me, and those patients will then receive hormonal therapy.

(*Id.* at 101-02.) Hormone therapy is not medically necessary for every GID patient that has come to Dr. F. Ettner; approximately five to ten percent of his GID patients have been able to go without hormone therapy. (*Id.* at 102.) For those patients with severe GID for whom he prescribes hormone therapy—and in some cases surgery—psychotherapy on its own is not effective as a treatment. (*Id.* at 103.)

> 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.)

> When hormone therapy is withdrawn from a GID patient, the following occurs:
>
> > So after being on hormonal therapy for a significant period of time, couple of years, even a year, there could be enough suppression that that testosterone now approaches female levels or the same as female levels withdrawing that hormone, withdrawing estrogens create this cascade of events, the systemic events of stress.
> >
> > And so stress is monitored in our bodies by the amount of hormone that will secrete or prehormone that will secrete in our pituitary glands. And this will stimulate our adrenal glands that create lots of cortisol. And cortisol then affects all these target systems.
> >
> > For example, in muscles we'll see some muscle wasting, in nerves we'll see neuroexcitability. We'll see fatty deposition. There'll be more of a tendency for blood pressure to increase because of water and salt imbalances.
> >
> > And all of these things can lead to diseases – heart disease, hypertension, diabetes.

(*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 system, besides muscle wasting, creates higher glucose levels and can lead to diabetes, more water loss, and higher hypertension. (*Id.* at 112.) Termination can soften the bones. (*Id.*) Termination of hormone therapy also affects the cardiovascular system by way of water retention, which increases plasma volume and increases the pressure within the system, and the release of epinephrine and norepinephrine which stimulates the body and can constrict the blood vessels that convey blood to the organs and make the heart beat faster which increases blood pressure. (*Id.* at 113.) Finally, withdrawal of hormone therapy affects the immune system due to decreased protein. (*Id.)* Lymphocytes made in the lymph system that protect people from infection are suppressed. (*Id.*) Every patient who is taken off hormones will experience these risks chemically. (*Id.* at 114.) Some patients will experience the effects clinically, others subclinically. (*Id.)* All patients taken off hormone therapy need to be followed, and all of these organ systems need to be monitored. (*Id.*)

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 worded.
>
> The Harry Benjamin standards speak to a number of routes for treatment, and those include real life experience, hormonal treatment, surgical reassignment, and – I wouldn't say necessarily that for every single individual with severe gender dysphoria that hormonal treatment is – would be required, but, again, it's a mainstay of treatment, it's one of the primary ways, easily the most common ways that severe gender dysphoria is treated.
>
> I would be hesitant to say that there are individuals where hormones would be the only way that the dysphoria could be – could be alleviated, but there are certainly individuals where it may be difficult to envision that other routes would be as satisfactory.

(*Id.* at 176.) He went on to state:

> I do believe there are individuals where hormonal treatment is medically necessary for the gender dysphoria. Although I would be hesitant to say that it could be the only route in which they could accommodate the gender dysphoria.
>
> There may be individuals – it's difficult to imagine that they could successfully accommodate the gender dysphoria without hormones. I think what I'm saying is very close to what you're saying.

(*Id.* at 177.) By "medically necessary," Dr. Kallas means that there are adverse consequences to psychological well-being if the hormones are not provided. (*Id.*)

To the extent that hormone therapy assists in alleviating gender dysphoria, withdrawal may bring about reemergence of that dysphoria. (*Id.* at 178.) Thus, the person may experience depression, anxiety, difficulty with social or occupational functioning, and suicidal ideation. (*Id.* at 178-79.)

d) Dr. Brown

Dr. Brown testified that some form of treatment is indicated for anyone who reaches the clinical threshold of severity to be diagnosed with GID. (Trial Tr. vol. 3, 269, Oct. 24, 2007.) Severe GID causes distress that can be relieved by following the treatment set forth in the Standards of Care. (*Id.* at 269-70.) As to whether GID is curable, Dr. Brown stated:

> I'll use my personal experience in answering that question. I've had patients that I started treatment, went through the [S]tandards of [C]are sequential treatments that are described, and in individuals that I'm thinking of in this experience these individuals did have sex reassignment surgery, and I've been able to follow them for as long as 15 years after the surgery, and by any definition of the word "cure" from any dictionary or any medical text, they no longer have the diagnosis of GID. Meaning that the symptoms for which they were treated no longer exist for a significant period of follow-up time afterwards.
>
> And cancer examples are usually five years. If a person doesn't have any evidence of that cancer after treatment five years later they're considered cured. Prior to that they'd be called in remission. And certainly if you follow someone who has had all of these treatments for five to 15 years afterwards with no recurrence of any symptoms of GID at all, I think that that would meet the definition of a cure.

(*Id.* at 271-72.) For some patients, GID can be adequately treated with a combination of psychotherapy and hormones. (*Id.* at 272.) For individuals with severe GID, psychotherapy

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 who are properly diagnosed and followed and following [sic] the [S]tandards of [C]are, again, hormonal treatment really has some fairly striking positive results in reversing or ameliorating a lot of the symptomatology that the patient is presented with.
>
> And these are in the domains of their psychiatric functioning as well as in changes in the body. And there's some interrelationship between the two, but there are emotional and psychiatric responses to hormonal medications that actually precede any changes in the body of the person.

(*Id.* at 273.) There is no other equally effective treatment for these patients. (*Id.*)

Inmates whose hormone therapy has been interrupted and have been seen by Dr. Brown have been evaluated as follows:

> It's uniformly a very bad thing to do medically and psychiatrically.
>
> The patients who had gender dysphoria that may have been largely ameliorated or at least partially controlled, that gender dysphoria comes back fairly rapidly, and often it comes back in a more severe and potentially more dangerous form than it was prior to when they received hormones in the first place.
>
> They may develop suicidality for the first time if they didn't have it before. They may again harbor thoughts of surgical self-treatment, which would mean thinking about removing the testicles as a way to self-treat by removing the testosterone from the body.
>
> They certainly would get depression symptoms, anxiety symptoms, irritability symptoms, crying, having difficulty functioning, all of these things would be likely in patients who were previously stabilized on cross-sex hormones.

(*Id.* at 274.) As to whether treatment for GID was optional, Dr. Brown testified:

> 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.
>
> Just as in a patient who has prostate cancer, the urologist will present, well, here are your treatment options. You can get radiation, you can get surgery, you can get a combination of the two, you can get chemotherapy. Here are the probabilities in your given case of the likelihood of success with each individual treatment, but the effects are this, this, and this.
>
> It's really something that you need to work out with me what treatment you want to choose, but the treatment itself is not optional unless the person decides that they don't want to continue to live.

(*Id.* at 278.) Dr. Brown has conducted extensive research in the area of genital self-harm and described his findings as follows:

> [T]hese are tentative conclusion[s] based on my research which is still ongoing, but the first conclusion was that genital self-harm is in fact surgical self-treatment in prison settings or in other institutional settings where a person with GID, usually moderate to severe, is denied or blocked access to cross-sex hormonal treatment and then they take matters into their own hands as it were and surgical self-treat [sic], and that that's much more common in incarcerated institutionalized settings than it is for people who are in the free world.

(*Id.* at 281-82.)

In Dr. Brown's experience, anti-depressants cannot adequately treat GID because they "don't at all treat the underlying condition." (*Id.* at 284.) Also, GID cannot be adequately managed through psychotropic medications:

> No, I don't believe so at all. You may be able to take the edge off of some symptoms by using a variety of medications, but it's like putting a Band-Aid on a burst appendix or giving somebody with a burst appendix pain medication. You know, you might make them feel a little bit better but the underlying condition is what needs to be treated.

(*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 other psychiatric comorbidities that may be present at the same time because there are often other diagnoses present in people who have GID.

(*Id.* at 286-87.) Gender identity cannot be changed:

> Since gender identity is a subjective construct, it's in the brain, it's not in the body, I think people's gender identity is what it is.
>
> Now, their body may not match what their gender identity is in their brain. But there's nothing that I or anyone else can do medically, psychiatrically, or surgically to change someone's gender identity in their brain. And that's why we seek to change the body, because we don't know of any way to change the brain to match the body.

(*Id.* at 297.)

> Psychotherapy is not an acceptable means of treating GID:
>
> Well, for example, if you have a marital problem and you're in therapy for the marital problem, the psychotherapy, the intent of the psychotherapy is to help work through and resolve the marital problem. So it's primary treatment for that problem.
>
> In patients who have GID the psychotherapy is not intended to nor designed to cure or eliminate the symptoms that they have; it's to help them understand more about themselves, it's educational, it's to help them understand the implications of the treatment alternatives that they're being presented with potentially by other physicians or surgeons, and to help them adjust to who it is that they are because that's never gonna change.

> So, and similar to homosexuality, you don't change a person's sexual orientation by working with them psychotherapeutically. You help them to understand that this is who they are and that that's not gonna change no matter how much psychotherapy they get.

(*Id.* at 330-31.) A treatment approach whereby only psychological treatments are available to help GID patients accept their biological sex would be "absolutely inconsistent" with the triadic approach to addressing GID. (*Id.* at 332.)

5. DOC Policy Prior to Act 105; DOC Reaction to Act 105; DOC Medical and Mental Health Treatment

a) Dr. Kallas

Dr. Kallas testified that in approximately 2002 the DOC established the gender identity committee, which consists of Dr. Kallas, Dr. Burnett, Bureau of Health Services Director James Greer, the warden of an institution, and a psychologist of an institution. (Trial Tr. vol. 2, 170, Oct. 23, 2007.) The role of the gender identity committee "is to consult on policy with respect to gender identity disorder, to review individual cases, to make determinations about hormonal treatment, especially starting new treatment, and then to consult in a clinical fashion to the psychologists and psychiatrists who are within the institutions about gender identity disorder matters." (*Id.*) Prior to Act 105, a person who came into the prison system on hormone therapy would continue such therapy unless the prison doctor had a reason to believe that the hormones were inappropriate. (*Id.* at 171.) When an individual came and requested to be put on new hormone therapy, that request would go to the GID committee, "and there's a process that's described in our policies

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.

Act 105 takes away the ability of DOC medical personnel to provide hormone therapy to individuals with GID. (*Id.* at 182.) Also, because of Act 105, the DOC has not evaluated two inmates who may suffer from GID to determine whether hormone therapy

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E. Offenders identified or claiming to suffer from gender identity disorder shall have access to the full range of mental health therapies available through the Wisconsin DOC. They shall have access to therapies in which they may explore their ambivalence, confusion and conflict around sexual identity as well as those services focusing on enabling those with identifiable mental health problems to better adjust to institutional living.

F. Self-inflicted genital mutilation or other forms of self-mutilation are not consistent with successful sexual reassignment therapy.

Facility Placement

A. In the event that an offender who has completed a surgical sexual reassignment treatment program is committed to the DOC, that offender shall be placed in a correctional facility appropriate for his/her reassigned gender.

B. In general, offenders shall be placed in facilities in accordance with their gender as determined by their external genitalia.

Name and Apparel for Inmates with Gender Identity Disorder

A. The DOC shall use the name of the offender as it appears on the Judgement [sic] of Conviction. The only exception to a name change will be through an order of a judge to have the name of the offender legally changed after the Judgement [sic] of Conviction. A new Judgement [sic] of Conviction must be issued or the court order must specifically state "change all records".

B. Property and apparel shall be consistent with the offender's determined gender.

Gender Identity Disorder Management and Treatment Committee

A. *Composition*: The Committee shall be composed of the DOC Medical Director, the DOC Mental Health Director, the Bureau of Health Services Director or designee, an assigned doctoral prepared psychologist, and a Warden or designee. In addition, a medical specialist in the treatment of gender identity disorder from the community may be retained as a consultant on specific cases. If the offender is identified as a sex offender, the Chief Psychologist, Sex Offender Specialist shall participate as a member.

B. *Function*: The committee shall be convened to address issues in the management of individuals with gender identity disorder after review and referral by the medical director, mental health director or Bureau director. Inmates may be referred to the medical director, mental health director or bureau director to address issues of concern through the committee by institution Wardens or their designees.

The committee shall advise the medical director or treating physician on issues such as appropriate diagnoses, complications of treatment, management issues, and/or the design and implementation of a plan of care.

(Tr. Ex. 2.)

is medically necessary for them. (*Id.*) Dr. Kallas had concerns about Act 105 because it takes the medical decision out of the hands of health care practitioners with respect to the provision of hormones. (*Id.* at 183.) He expressed those concerns to his boss, Dr. Burnett, and also to Mr. Margolis, the legislative liaison in the DOC Secretary's office. (*Id.*) In an email in which Dr. Kallas was responding to a request for information about legislation that takes away the ability to provide hormone therapy (which ultimately became Act 105), Dr. Kallas stated in relevant part:

> The cost of discontinuing treatments would vary from inmate to inmate. Overall hormones tend to improve psychological well-being for those with gender identity disorder, thus some inmates may stop hormones with relatively little impact, however, others may experience depression, anxiety, disruptive behavior or suicidality. Additional resources may be needed for time in segregation, clinical observation, or the Wisconsin Resource Center. Additional suicides or suicide attempts may occur based on such a policy.

(*Id.* at 183-85, Ex. 11.) The email also stated: "It would be contrary to the medical judgment of the Wisconsin Department of Corrections medical director and mental health director." (*Id.* at 185, Ex. 11.) When asked why taking away medical decision-making was a concern for him, Dr. Kallas stated: "It's difficult to articulate because it seems so obvious to me, that it's important that doctors are ably [sic] to use their clinical judgment with respect to conditions that are significant, especially when it pertains to medically necessary treatment." (*Id.* at 186.)

Dr. Kallas testified that Act 105 takes away the ability to provide medically necessary treatment in some cases. (*Id.* at 187.) He is unaware of any other mental health

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 segregation time, or an increase in psychotropic medications particularly antidepressants, which would offset any cost savings that would be directly attributable to not prescribing hormones.

(*Id.* at 190-91.)

DOC prisons have mental health resources consisting of psychiatric and psychological care. (*Id.* at 197.) A typical institution with approximately 1000 inmates has a couple of days per week of psychiatric coverage. (*Id.*) It has four or five full-time psychologists who work Monday through Friday and provide on-call coverage over the weekend. (*Id.*) In terms of mental health services available to inmates, psychiatrists perform evaluations for psychotropic medications and follow inmates who are on psychotropic medication. (*Id.)* Psychologists provide evaluations for a number of different purposes and provide treatment which may consist of crisis intervention, counseling, psychotherapy, or monitoring inmates for mental health symptoms. (*Id.*)

It is not uncommon for DOC inmates to have thoughts of suicide. (*Id.* at 198.) Correctional officers and front line staff are trained in suicide prevention annually. (*Id.*) Psychology staff intervenes from a mental health perspective if someone is having suicidal thinking, and staff would be available for counseling or for placing someone on suicide watch. (*Id.*) Psychology staff participates in the decision whether to send an inmate to the Wisconsin Resource Center, which is more like a hospital setting. (*Id.*) These services are available for any inmate who is at risk for harming himself or herself. (*Id.* at 198-99.) The DOC system is also equipped to deal with inmates who have depression, anxiety, psychosis, mood disorders, and adjustment disorders. (*Id.* at 199-200.) These services

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, many of which are violent and highly aggressive in confined and very small spaces, over long periods of time. This is not like a county jail, this is – prisons are for long periods of time.
>
> So the mere fact that we do that and then over the last 20 years we've doubled and tripled populations in fixed spaces in corrections because of bed space explosion, it makes for a very volatile environment in which safety and the application of

> safety systems is absolutely critical seven days 24 hours a day.

(Trial Tr. vol. 3, 412-13, Oct. 24, 2007.) Security concerns include violence, sale and use of drugs, manufacture of weapons, management of the mentally ill, escape, gangs, and inmate relationships including sexual relationships. (*Id.* at 413-14.)

Aside from health issues, sexual activity among inmates has a history of being extremely dangerous and volatile and that is why there are rules prohibiting such conduct. (*Id.* at 414.) Sexual relationships include consensual and non-consensual sexual relationships. (*Id.*) An inmate's personal appearance can make that inmate more vulnerable to sexual assault. (*Id.* at 419.) For example, if an inmate's appearance is sexually suggestive:

> Well, you know, it's hard for me to distinguish between behavior and physical attributes, but if an inmate is small in stature and carries themself in sort of an effeminate way, okay, then that makes that inmate an automatic target for inmates who are interested in sexual aggression or sexual relationships.

(*Id.*) An inmate who is feminized might be a victim of assault and could be a center of conflict among the prison population. (*Id.* at 420.) Atherton does not believe that feminizing male 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." (*Id.* at 422.) The implication is that inmates and staff are going to get hurt. (*Id.* at 423.)

> 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 history and that security is able to implement it fairly well. (*Id.* at 432-33.)

ANALYSIS

Plaintiffs contend that enforcing Act 105 to deny medically necessary treatment to plaintiffs violates their rights under the Eighth Amendment and the Equal Protection Clause, and the rights of all transsexual inmates under the Eighth Amendment and the Equal Protection Clause. They seek a permanent injunction barring enforcement of Act 105.

Defendants submit that the plaintiffs' Eighth Amendment facial challenge fails because Act 105 is not unconstitutional in all circumstances where it would be applied. (Defs.' Trial Br. at 3.) Specifically, not all individuals with GID want or qualify for hormones or reassignment surgery. Next, defendants contend that plaintiffs' Eighth Amendment as-applied challenge to Act 105 fails because the evidence establishes that, "under the holding in *Maggert [v. Hanks*, 131 F.3d 670 (7th Cir. 1997)], Act 105 does not violate the Eighth Amendment by preventing specific forms of 'curative treatment' for gender dysphoria." (*Id.* at 5.) With respect to plaintiffs' Fourteenth Amendment equal protection challenges, defendants assert that hormone therapy results in a more effeminate appearance, and the more effeminate a male inmate looks, the more likely he will be victimized in prison. By eliminating the availability of hormone therapy, the defendants reason that Act 105 is rationally related to the DOC's interests in protecting these inmates from harm and maintaining the safety and security of other inmates, staff, and the institution.

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, 474 (7th Cir. 1998). Neither negligence nor even gross negligence is a sufficient basis for liability. *See Salazar v. City of Chicago*, 940 F.2d 233, 238 (7th Cir. 1991). A finding of deliberate indifference requires evidence "that the official was aware of the risk and consciously disregarded it nonetheless." *Chapman*, 241 F.3d at 845 (citing *Farmer*, 511 U.S. at 840-42).

Mere difference of opinion among medical personnel regarding a plaintiff's appropriate treatment does not give rise to deliberate indifference. *Estate of Cole by Pardue v. Fromm*, 94 F.3d 254, 261 (7th Cir. 1996). However, deliberate indifference may be inferred "when the medical professional's decision is such a substantial departure from accepted professional judgment, practice, or standards as to demonstrate that the person responsible did not base the decision on such a judgment." *Id.*; *see also Steele v. Choi*, 82 F.3d 175, 179 (7th Cir. 1996) (citing as examples "the leg is broken, so it must be set; the person is not breathing, so CPR must be administered").

"[T]o prevail on an Eighth Amendment claim 'a prisoner is not required to show that he was literally ignored.'" *Greeno v. Daley*, 414 F.3d 645, 653-54 (7th Cir. 2005) (quoting *Sherrod v. Lingle*, 223 F.3d 605, 611 (7th Cir. 2000)). On the other hand, a defendant's contention that a medical care claim fails because the prisoner "received some treatment overlooks the possibility that the treatment [the prisoner] did receive was 'so blatantly inappropriate as to evidence intentional mistreatment likely to seriously aggravate' his condition." *Greeno*, 414 F.3d at 654 (quoting *Snipes v. DeTella*, 95 F.3d 586, 592 (7th Cir. 1996) (internal quotations omitted)).

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. *See Supre v. Ricketts*, 792 F.2d 958 (10th Cir.1986); *Lamb v. Maschner*, 633 F. Supp. 351 (D.Kansas 1986). Both of these courts nevertheless agreed that a transsexual inmate is constitutionally entitled to some type of medical treatment.

> In *Supre v. Ricketts*, the plaintiff, an inmate in the Colorado Department of Corrections, was examined by two endocrinologists and a psychiatrist. These doctors considered estrogen treatment, but ultimately advised against it, citing the dangers associated with this controversial form of therapy. Instead they prescribed testosterone replacement therapy and mental health treatment consisting of a program of counseling by psychologists and psychiatrists. Given the wide variety of options available for the treatment of the plaintiff's psychological and physical medical conditions, the Tenth Circuit refused to hold that the decision not to provide the plaintiff with estrogen violated the Eighth Amendment as long as some treatment for gender dysphoria was provided. Similarly, in *Lamb v. Maschner*, the plaintiff, an inmate at the Kansas State Penitentiary, had been evaluated by medical doctors, psychologists, psychiatrists and social workers and was undergoing some type of mental treatment. As a result of this treatment, the court held that the defendant prison officials were not constitutionally required to provide the plaintiff with pre-operative hormone treatment and a sex change operation.
>
> The courts in *Supre* and *Lamb* both emphasized that a different result would be required in a case where there had been a total failure to provide any kind of medical attention at all. That is precisely the type of case before us. We agree with the Tenth Circuit that given the wide variety of options available for the treatment of gender dysphoria and the highly controversial nature of some of those options, a federal court should defer to the informed judgment of prison officials as to the appropriate form of medical treatment. But no such informed judgment has been made here. While we cannot and will not prescribe any overall plan of treatment, the plaintiff has stated a claim under the Eighth Amendment entitling her to some kind of medical care.

Id. at 413-14.

The other Seventh Circuit case to address GID is *Maggert v. Hanks*, 131 F.3d 670 (7th Cir. 1997). In *Maggert*, the court affirmed dismissal of the action because the prisoner failed to create a genuine issue of material fact that he had GID. *Id.* at 671. However, the court then addressed "a broader issue, having to do with the significance of

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 biologically a male (the more common form of the condition) he is 'really a female,'" as a "serious psychiatric disorder." *Id.* Treatment, or "the cure," for transsexualism, was also discussed:

> The cure for the male transsexual consists not of psychiatric treatment designed to make the patient content with his biological sexual identity - that doesn't work - but of estrogen therapy designed to create the secondary sexual characteristics of a woman followed by the surgical removal of the genitals and the construction of a vagina-substitute out of penile tissue.
>
> . . . .
>
> Someone eager to undergo this mutilation is plainly suffering from a profound psychiatric disorder.

Id. However, prisons do not necessarily have a duty to authorize these hormonal and surgical curative procedures:

> Withholding from a prisoner an esoteric medical treatment that only the wealthy can afford does not strike us as a form of cruel and unusual punishment. It is not unusual; and we cannot see what is cruel about refusing a benefit to a person who could not have obtained the benefit if he had refrained from committing crimes. We do not want transsexuals committing crimes because it is the only route to obtaining a cure.
>
> It is not the cost per se that drives this conclusion. For life-threatening or crippling conditions, Medicaid and other public-aid, insurance, and charity programs authorize treatments that often exceed $100,000. Gender dysphoria is not, at least not yet, generally considered a severe enough condition to warrant expensive treatment at the expense of others than the person suffering from it. That being so, making the treatment a constitutional duty of prisons would give prisoners a degree of medical care that they could not obtain if they obeyed the law.

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 prisoner in that case was a thirty-four-year-old male-to-female transsexual who lived as a woman since age seventeen. *Id.* at 793-94. Prior to incarceration, the inmate had a number of "surgeries and other procedures to enhance her appearance as a female, including electrolysis, a brow lift, dermabrasions, a chemical face peel, jaw reduction, a chin implant, and breast implant surgery." *Id.* at 794. In addition, the inmate took estrogen treatment beginning at the age of seventeen or eighteen to slow hair growth, soften skin, and to further develop the breast implants and female characteristics. *Id.* Not long after incarceration, the plaintiff was examined by a Michigan Department of Corrections physician who stopped the hormonal treatments and denied requests for brassieres. *Id.* The prisoner's request for brassieres was later granted, after the physician's supervisor intervened. *Id.* In granting the request for a preliminary injunction, the court found that the prisoner had a serious medical need and that the defendant denied medical care through both intentional conduct and deliberate indifference:

> The denial of medical care in this case stems from at least three sources – which in concert violate plaintiff's right under the constitution to be free from cruel and unusual punishment. A result decried in *Meriwether* and in dicta by the *Supre* and *Lamb* courts is present here: defendant has failed to provide plaintiff with treatment of any kind. And, as was the plaintiff in

> *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 gender reassignment surgery. *Id.* at 160. Since Kosilek's transsexualism was undiagnosed, the policy denied access to doctors for both treatment and diagnosis for GID. *Id.*

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 professionals to assess what is necessary to treat Kosilek. As the DOC does not employ anyone with expertise in treating gender identity disorders, the DOC may decide to follow its regular practice of retaining an outside expert to evaluate Kosilek and to participate in treating, or recommending treatment for him.
>
> The evidence demonstrates that, at a minimum, Kosilek should receive genuine psychotherapy from, or under the direction of, someone qualified by training and experience to address a severe gender identity disorder. It will be Kosilek's obligation to cooperate in establishing a proper relationship with his therapist(s). The Standards of Care indicate that such therapy, or such therapy and pharmacology, may be sufficient to reduce the anguish caused by Kosilek's gender identity disorder so that it no longer constitutes a serious medical need.
>
> If psychotherapy, and possibly psychopharmacology, do not eliminate the significant risk of serious harm that now exists, consideration should be given to whether hormones should be

> 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 surgery." If psychotherapy, hormones, and possibly psychopharmacology are not sufficient to reduce the anguish caused by Kosilek's gender identity disorder to the point that there is no longer a substantial risk of serious harm to him, sex reassignment surgery might be deemed medically necessary. If that occurs, Maloney may consider whether security requirements make it truly necessary to deny Kosilek adequate care for his serious medical need. If and when he makes such a decision, a court may have to determine again whether the Eighth Amendment has been violated.

Id. at 193-95 (internal citations omitted).

In *De'Lonta v. Angelone*, 330 F.3d 630 (4th Cir. 2003), the court of appeals reversed the district court's dismissal of the complaint for failure to state a claim. The plaintiff in that case, a biological male, had GID and was incarcerated in the custody of the Virginia Department of Corrections since 1983. *Id.* at 632. Department of Corrections doctors diagnosed the prisoner with GID and prescribed estrogen from 1993 until 1995, at which time the treatment was terminated pursuant to a new Department of Corrections policy. *Id.* The policy provided that neither medical nor surgical interventions related to gender or sex change would be provided to inmates with GID. *Id.* Inmates entering prison taking hormone medication or already receiving such medication were to be informed of the policy and then the medication would be tapered immediately and afterward

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 plaintiff's "need for protection against continuous self-mutilation constitutes a serious medical need to which prison officials may not be deliberately indifferent." *Id.* at 634 (citing *Lee v. Downs*, 641 F.2d 1117, 1121 (4th Cir. 1981)). Next, it found that the inmate stated an Eighth Amendment claim by alleging inadequate medical treatment to protect the inmate from the compulsion to self-mutilate. *Id.* at 635.

In *Brooks v. Berg*, 270 F. Supp. 2d 302 (N.D.N.Y.), *vacated in part on other grounds,* 289 F. Supp. 2d 286 (N.D.N.Y. 2003), a prisoner, who was a biological male, diagnosed himself with GID. *Id.* at 304. The prisoner sought treatment by writing letters to a Mental Health Satellite Unit and to a supervisor; however, he never received a response. *Id.* The prisoner then filed suit alleging that the defendants failed to provide him with necessary medical treatment for his serious medical need in violation of the Eighth Amendment, and asking the court to force the defendants to allow him to see a doctor qualified to propose a course of treatment. *Id.* at 305, 306. Pursuant to a Department of Corrections policy, inmates who could prove that they received hormone therapy prior to incarceration might be eligible for continued hormone therapy. *Id.* at 305. The policy further stated that transsexual surgical operations were not honored during incarceration. *Id.*

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 310. The court went on to say:

> This blanket denial of medical treatment is contrary to a decided body of case law. Prisons must provide inmates with serious medical needs some treatment based on sound medical judgment. There is no exception to this rule for serious medical needs that are first diagnosed in prison. Prison officials are thus obliged to determine whether Plaintiff has a serious medical need and, if so, to provide him with at least some treatment. Prison officials cannot deny transsexual inmates all medical treatment simply by referring to a prison policy which makes a seemingly arbitrary distinction between inmates who were and were not diagnosed with GID prior to incarceration. In light of the numerous cases which hold that prison officials may not deny transsexual inmates all medical attention, especially when this denial is not based on sound medical judgment, the Court finds that Defendants have failed to establish as a matter of law that their actions were objectively reasonable.

Id. at 312.

In *Praylor v. Texas Department of Criminal Justice*, 430 F.3d 1208, 1208-09 (5th Cir. 2005), a transsexual state prison inmate sought an injunction instructing the Texas Department of Criminal Justice (TDCJ) to provide him with hormone therapy and brassieres. The court concluded that the prisoner was not entitled to such treatment:

> 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

objectively inadequate care for an objectively serious medical need that DOC medical personnel acknowledge is a condition requiring treatment. In response, the defendants maintain that the evidence in this case shows, under the holding in *Maggert*, 131 F.3d at 670, that Act 105 does not violate the Eighth Amendment by preventing specific forms of "curative treatment" for gender dysphoria. The defendants submit that courts have held that transsexual inmates have no constitutional right to a particular type of treatment, and that *Maggert* supports Act 105 and Wisconsin's decision to limit the availability of specific forms of treatment for inmates with GID.

Several courts, including the Seventh Circuit, have considered GID or transsexualism a "serious medical need" for the purposes of the Eighth Amendment. *See Meriwether*, 821 F.2d at 411-13; *Cuoco v. Moritsugu*, 222 F.3d 99, 106 (2d Cir. 2000); *White v. Farrier*, 849 F.2d 322, 325 (8th Cir. 1988); *Wolfe v. Horn*, 130 F. Supp. 2d 648, 652 (E.D. Pa. 2001); *Phillips*, 731 F. Supp. at 792. Based on the evidence presented in the bench trial in this case, this court agrees.

Inasmuch as this court finds that GID is a severe medical condition, it must now consider whether enforcement of Act 105 against these plaintiffs constitutes deliberate indifference to their serious medical needs.

As an initial matter, the defendants' reliance on *Maggert* is misplaced because this case is distinguishable. First, DOC doctors evaluated the plaintiffs clinically and determined that hormone therapy is medically necessary to treat their conditions. Moreover, the evidence establishes that DOC health care personnel provide medical treatment to inmates only after they have concluded that the treatment is medically

necessary. Act 105 undermines the doctor-patient relationship of DOC physicians and inmates by preventing treatments that those health care providers, in their clinical judgment, determined to be warranted. Second, the plaintiffs in this case were receiving hormone therapy prior to their incarceration in DOC institutions; therefore, the concern that transsexuals may commit crimes so the state will pay for their care, expressed in *Maggert*, 131 F.3d at 672, does not pertain to these plaintiffs. Further, the evidence indicates that the cost to the DOC of withdrawing hormone therapy may be greater than the cost of continuing the treatment prescribed by DOC health care professionals. Third,, the plaintiffs in this case are not arguing entitlement to a specific treatment, rather they are simply contending that Act 105 violates their rights under the Eighth Amendment because it deprives DOC medical personnel of their ability to provide inmates with appropriate treatment.

This court is persuaded that the enforcement of Act 105 prevents DOC doctors from providing the treatment that they have determined is medically necessary to treat the plaintiffs' serious conditions. Notably, in approximately 2002, the DOC established a gender identity committee consisting of Dr. Kallas, Dr. Burnett, Bureau of Health Services Director James Greer, the warden of an institution, and a psychologist of an institution. (Trial Tr. vol. 2, 170, Oct. 23, 2007.) The gender identity committee "is to consult on policy with respect to gender identity disorder, to review individual cases, to make determinations about hormonal treatment, especially starting new treatment, and then to consult in a clinical fashion to the psychologists and psychiatrists who are within the institutions about gender identity disorder matters." *Id.* Consequently, a person who came into the prison system on hormone therapy would continue such therapy unless the

prison doctor had a reason to believe that the hormones were inappropriate. *Id.* at 171. When an individual requested to be put on new hormone therapy, that request would go to the gender identity committee, which would process the request in accordance with DOC policies. *Id.*

Plaintiff Fields was incarcerated in 2005 at which time the DOC confirmed Fields' GID diagnosis and continued hormone therapy. It was determined that Fields had received feminizing hormone therapy continuously starting in 1996 and had undergone breast augmentation in 2003. Plaintiff Davison was diagnosed with GID in 2005 and began hormone therapy for treatment, which the DOC has continued during Davidson's incarceration. Prior to receiving hormone therapy, Davison attempted suicide by jumping off a roof. Plaintiff Moaton began taking feminizing hormones in the late 1990s, and commenced medically prescribed hormone therapy in 2000. The DOC continued that treatment after Moaton's incarceration. Moaton experienced suicidal ideation in the past, especially after being removed from hormone therapy.

In 2006, because of the passage of Act 105, the DOC began to taper the hormone therapy of the plaintiffs, all of whom, to varying degrees, had feminine physical characteristics as a result of hormone usage. Following the reduction of hormone therapy, plaintiff Fields experienced nausea, muscle weakness, loss of appetite, increased hair growth, skin bumps, and depression; plaintiff Davison had increased and darker hair growth, voice deepening, breast reduction and leakage, mood swings, mental and emotional instability, hot flashes, and body aches; and plaintiff Moaton grew chest and facial hair, complained of increased tenderness in the chest and groin, and complained of skin breakouts, hot flashes, and depression. All of the symptoms were abated when the

plaintiffs' hormone therapy was reinstated after the court issued the preliminary injunction in this action.

The legislative history of Act 105 demonstrates that the bill was passed despite objections from DOC medical personnel and that the only correctional or medical expertise offered during the legislative hearings was that of Dr. Kallas and Dr. Burnett. Dr. Kallas informed the legislature that the Standards of Care are considered to be the most authoritative guidelines for the treatment of GID, emphasized that hormone therapy was a valid treatment on its own, and stated that if the DOC were to take away hormones from individuals with GID, those persons may become distressed and despondent to the point of clinical depression, anxiety disorder, or suicidality. He also explained that this may result in an increase in staff time for mental health care or placement at the Wisconsin Resource Center, and that it may also lead to disruptive behavior as well as segregation time, or an increase in psychotropic medications, particularly antidepressants, which would offset any cost savings attributable to not prescribing hormones.

At trial, outside physician Dr. R. Ettner testified that the intensity of the distress that people with GID experience varies depending on the severity of the disorder. Some people cannot function because the disorder is so intense and severe while others experience less discomfort. For those with severe GID, symptoms may include depression, anxiety, irritability, suicidal ideation, suicide attempts, and self-mutilation or autocastration. When asked why the taking away of medical decision-making was a concern, Dr. Kallas added: "It's difficult to articulate because it seems so obvious to me, that it's important that doctors are abl[e] to use their clinical judgment with respect to conditions that are significant, especially when it pertains to medically necessary

treatment." (Trial Tr. vol. 2, 186, Oct. 23, 2007.) DOC Medical Director Dr. Burnett further testified that he did not believe it was medically appropriate to taper and terminate hormone therapy for inmates with GID.

Additionally, plaintiffs contend that on its face Act 105 violates the Eighth Amendment and the Equal Protection Clause of the Fourteenth Amendment because it applies in every instance in which a DOC medical provider has prescribed hormone therapy or sexual reassignment surgery. Plaintiffs argue

> that inmates do not dictate what medical care they receive; only DOC medical personnel can determine what treatments are medically necessary and appropriate. Consequently, even if an inmate with GID requested hormones or surgery, DOC's practice - even before the passage of Act 105 - would have been to deny such medical care unless it was medically necessary. The passage of Act 105 did not change this practice. What it did is deny DOC medical personnel the discretion they had before to prescribe hormones or surgery, when, in their own judgment, they were medically necessary.
>
> This blanket denial of medical judgment mandated by Act 105 in all the statute's applications violates the Eighth Amendment, for the same reasons that Act 105's application to Plaintiffs violates that Amendment. Plaintiffs have been taking hormones for many years, so cutting off their hormone therapy is the denial of necessary medical treatment that places them at great risk of harm, and induces certain withdrawal symptoms. The denial of necessary medical care to persons who have had it in the past does not distinguish Plaintiffs under the Eighth Amendment and Equal Protection Clause from transsexuals newly diagnosed with GID and prescribed the treatment for the first time by DOC health care professionals.

(Pl.'s Corrected Tr. Br. at 29-30.) This court agrees.

The defendants acknowledge that Act 105 removes even the consideration of hormones or surgery for inmates with gender issues and that the DOC halted evaluations of inmates with GID for possible administration of hormone therapy because

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 U.S. 833 (1992), the Court described the appropriate class for the purpose of determining the validity of an abortion statute:

> Respondents attempt to avoid the conclusion that § 3209 is invalid by pointing out that it imposes almost no burden at all for the vast majority of women seeking abortions. They begin by noting that only about 20 percent of the women who obtain abortions are married. They then note that of these women about 95 percent notify their husbands of their own volition. Thus, respondents argue, the effects of § 3209 are felt by only one percent of the women who obtain abortions. Respondents argue that since some of these women will be able to notify their husbands without adverse consequences or will qualify for one of the exceptions, the statute affects fewer than one percent of women seeking abortions. For this reason, it is asserted, that statute cannot be invalid on its face. We disagree with respondents' basic method of analysis.
>
> The analysis does not end with the one percent of women upon whom the statute operates; it begins there. Legislation is measured for consistency with the Constitution by its impact on those whose conduct it affects. For example, we would not

> 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 health of the inmate.

It is undisputed that Act 105 has prevented the DOC from undertaking thorough evaluations of inmates Erik, a/k/a Erika, Huelsbeck and Kenneth, a/k/a Karen, Krebs to determine whether hormone therapy is medically necessary for them.

Act 105 bars doctors and other DOC medical personnel from providing treatment, namely, hormone therapy and sex reassignment surgery, that they may determine to be medically necessary. Thus, the possibility that other DOC inmates may have conditions that may not require hormone therapy or the possibility that a particular inmate such as Huelsbeck or Krebs may not medically require hormone therapy does not repel a facial challenge to Act 105. If DOC doctors evaluate any DOC inmate and find that hormone therapy is medically necessary, then that inmate is within the group or class of inmates to whom Act 105 applies. The case law indicates that the controlling class for a facial challenge to a statute is "the group for whom the law is a restriction, not the group for whom the law is irrelevant." *Casey*, 505 U.S. at 894.

It is well established that prison officials may not substitute their judgments for a medical professional's prescription. "Of course they cannot." *Zentmyer v. Kendall County, Ill.*, 220 F.3d 805, 812 (7th Cir. 2000) (citing *Ralston v. McGovern*, 167 F.3d 1160, 1162 (7th Cir. 1999); *Johnson v. Hay*, 931 F.2d 456, 461 (8th Cir. 1991)). If a prison official consciously chooses to disregard a nurse's or doctor's directions in the face of medical risks, then he may well have exhibited the necessary deliberate indifference. *Zentmyer*, 220 F.3d at 812.

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 hormone therapy or gender reassignment as necessary treatment for an inmate.

2. Equal Protection Claim

Recently, the Seventh Circuit Court of Appeals reiterated the standard to be applied in equal protection cases where no fundamental right or suspect classification is at issue:

> The purpose of the Equal Protection Clause of the Fourteenth Amendment is to "secure every person within the State's jurisdiction against intentional and arbitrary discrimination, whether occasioned by express terms of a statute or by its improper execution through duly constituted agents." Where (as here) no fundamental right or suspect classification is at issue, equal protection claims are evaluated under the rational-basis standard of review. To prevail, a plaintiff must prove the following: (1) the defendant intentionally treated him differently from others similarly situated, (2) the defendant intentionally treated him differently because of his membership in the class to which he belonged, and (3) the difference in treatment was not rationally related to a legitimate state interest.

Smith v. City of Chicago, 457 F.3d 643, 650-51 (7th Cir. 2006) (internal citations omitted). Thus, the court applies rational basis review to plaintiffs' equal protection claim.

The defendants contend that by eliminating the availability of hormone therapy and sexual reassignment surgery, Act 105 is rationally related to the DOC's interests in protecting effeminate-appearing inmates from harm and maintaining the safety and security of other inmates, staff, and the institution.

Act 105 takes away the DOC's discretion to provide "hormonal therapy" to the plaintiffs. "'Hormonal therapy' means 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." Wis. Stat. § 302.386(5m)(a). It is undisputed that the DOC sometimes prescribes hormone therapy for reasons that do not have to do with GID, such as estrogen replacement therapy in post-menopausal years, or for congenital or hormonal disorders.

The evidence establishes that GID is the only medically necessary condition for which mental health treatments are barred by law or regulation within the DOC. Act 105 requires the DOC to withdraw hormone therapy only from inmates who are using it to treat their GID. Moreover, there is no evidence of any other Wisconsin laws banning medical treatment for inmates or any DOC policies that ban necessary medical treatment for inmates.

Hence, the plaintiffs have satisfied the first two prongs of an equal protection claim. And they have done so as to both their as-applied challenge and their facial challenge. Defendants treat the plaintiffs themselves differently than others similarly situated because of their membership in the class of persons who need hormonal therapy

to treat GID, and they treat the entire class differently. As stated above, the controlling class for a facial challenge is "the group for whom the law is a restriction, not the group for whom the law is irrelevant," *Casey*, 505 U.S. at 894.

The court now turns to the third prong, whether the difference in treatment is rationally related to the legitimate state interest of safety and security. The rational-relationship test is a lenient standard. *Smith*, 457 F.3d at 652. Under rational basis review, there is no constitutional violation if "any reasonably conceivable state of facts" would provide a rational basis for government action. *FCC v. Beach Commc'ns, Inc.*, 508 U.S. 307, 313 (1993). The challenging party bears the burden of eliminating any reasonably-conceivable set of facts that could provide a rational basis for the difference in treatment. *Smith*, 457 F.3d at 652. In other words, the plaintiffs must prove the government's enactment of Act 105 irrational. *Id.* And this burden is the same whether the plaintiffs challenge a statute on its face or as applied. *Id.* The rational-basis test is not subject to courtroom factfinding and may include rational speculation. *Id.* at 651 (citing *Beach Commc'ns*, 508 U.S. at 315). The government may defend on any ground, not just the one articulated at the time of decision. *Id.* at 652.

Prison safety and security are legitimate penological interests. *See Overton v. Bazzetta*, 539 U.S. 126, 133 (2003) (describing "internal security" as "perhaps the most legitimate of penological goals"). The correctional environment can be dangerous, and one major area of security concern is sexual activity, especially sexual activity among inmates, which has a history of being extremely dangerous and volatile.

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 believes that the policy is reasonable. According to Atherton, the policy has a good history and security staff are able to implement it well.

Furthermore, at his deposition, Atherton was asked whether preventing inmates with GID from getting hormones was a way to prevent sexual assaults from happening in the future. He responded:

> That question is an incredible stretch between hormonal therapy and preventing sexual assaults. As I explained in an answer previously, 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.) Although plaintiff Davison was sexually assaulted, there is nothing in the record to indicate Davison would not been assaulted in the absence of hormone therapy. Also, it is undisputed that inmates can look effeminate without hormone therapy. Furthermore, nothing in the record to support a finding that withdrawing hormone therapy from the plaintiffs will decrease the risk that they will become victims of sexual assault. Thus, a connection between the hormone therapy barred by Act 105 and sexual assaults

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 will not harm the public interest." *Old Republic Ins. Co. v. Employers Reinsurance Corp.*, 144 F.3d 1077, 1081 (7th Cir. 1998) (citations omitted). The Prison Litigation Reform Act provides that a court "shall not 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." 18 U.S.C. § 3626(a)(1). Given the court's finding that Act 105 is unconstitutional, as applied to these

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

Rev. 5/85) Judgment in a Civil Case

United States District Court

EASTERN DISTRICT OF WISCONSIN

ANDREA FIELDS,
MATTHEW DAVISON, also known as Jessica Davison,
and VANKEMAH D. MOATON,

Plaintiffs,

v.

JUDGMENT IN A CIVIL CASE
Case No. 06-C-112

WARDEN JUDY P. SMITH, THOMAS EDWARDS,
JAMES GREER, ROMAN KAPLAN, MD,
and RICHARD RAEMSICH,

Defendants.

This action came before the court for a trial by the court, the issues have been decided, and a decision has been rendered. Now, therefore,

IT IS ORDERED AND ADJUDGED that Wis. Stat. § 302.386(5m) is unconstitutional and invalid.

IT IS FURTHER ORDERED AND ADJUDGED that the defendants and their successors in office and all others acting on behalf of them are permanently enjoined and restrained from enforcing or attempting to enforce Wis. Stat. § 302.386(5m), by direct, indirect, or other means.

IT IS FURTHER ORDERED AND ADJUDGED that the defendants and their successors in office, and all others acting on behalf of them, are permanently enjoined and restrained from enforcing or attempting to enforce the provisions of Wis. Stat. § 302.386(5m), by direct, indirect, or other means, against the plaintiffs.

APPROVED:

s/ C. N. CLEVERT, JR.
C. N. CLEVERT, JR.
Chief U. S. District Judge

JON W. SANFILIPPO
Clerk

6/22/10
Date

s/C. Fehrenbach
(By) Deputy Clerk

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF WISCONSIN

ANDREA FIELDS,
MATTHEW DAVISON, also known as Jessica Davison,
and VANKEMAH D. MOATON,

Plaintiffs,

v. Case No. 06-C-112

WARDEN JUDY P. SMITH, THOMAS EDWARDS,
JAMES GREER, ROMAN KAPLAN, MD,
and RICHARD RAEMSICH,

Defendants.

ORDER GRANTING MOTIONS FOR ADDITIONAL FINDINGS
PURSUANT TO FED. R. CIV. P. 52(b) (DOC. # 222 & # 237)

The plaintiffs have filed two motions for additional findings to supplement the court's Memorandum Decision pursuant to Rule 52(b) of the Federal Rules of Civil Procedure. The defendants do not object to the request.

Now, therefore,

IT IS ORDERED that the plaintiffs' motions are granted. Accordingly, pursuant to Fed. R. Civ. P. 52(b), the court now finds that a permanent injunction that restrains the defendants from enforcing or attempting to enforce the provisions of Wis. Stat. § 302.386(5m), by direct, indirect or other means, against any prisoner to whom the statute would otherwise apply and specifically against the plaintiffs, is warranted in this case. Such relief is narrowly tailored in that enjoining the enforcement of Wis. Stat. § 302.386(5m) prohibits only unconstitutional applications of the statute which this court has found to be unconstitutional any time it is applied. (Mem. Dec. at 62.) *See, e.g.,*

Jordan v. Pugh, 2007 WL 2908931, at *1-2 (D. Colo. Oct. 4, 2007); *Cline v. Fox*, 319 F. Supp. 2d 685, 695-96 (N.D. W. Va. 2004) (finding prison policy facially invalid and enjoining its enforcement).

The court further finds that an injunction against enforcement of Wis. Stat. § 302.386(5m) extends no further than is necessary to correct the Eighth Amendment and Equal Protection violations because any application of the statute would violate the Eighth Amendment and Equal Protection and enjoining all applications of Wis. Stat. § 302.386(5m) is necessary to prevent constitutional violations. (Mem. Dec. at 55-57 (finding that application of statute violates Eighth Amendment prohibition on deliberate indifference to serious medical needs by preventing DOC physicians from providing treatment they determine is medically necessary to treat serious medical condition of Gender Identity Disorder (GID)); 59-60 (finding that the statute violates the Eighth Amendment by removing "even the consideration of hormones or surgery" and thus "halted evaluations of inmates with GID for possible administration of hormone therapy because of the Act"); 61-63 (finding facial violation of Eighth Amendment because statute "withdraw[s] an ongoing course of treatment" for prisoners such as plaintiffs, "prevent[s] the DOC from undertaking thorough evaluations of inmates" who may have GID and require treatment prohibited by the statute, and that the statute applies only to those prisoners "for whom the law is a restriction" (citing *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 894 (1992))); 63-67 (finding violation of Equal Protection, because prisoners with GID are treated differently from prisoners with all other medical conditions, without a rational basis for the differential treatment).)

Furthermore, the court finds that an injunction against enforcement of Wis. Stat. § 302.386(5m) is the least intrusive means possible to correct Eighth Amendment and Equal Protection violations that would be caused in the future through any application of the facially invalid statute. Lastly, the court concludes that the aforementioned injunctive relief will have no significant "adverse impact on public safety or the operation of a criminal justice system." 18 U.S.C. § 3626(a)(1). (*See* Mem. Dec. at 66-67 (rejecting prison security justification for statute).)

Dated at Milwaukee, Wisconsin, this 9th day of July, 2010, nunc pro tunc June 22, 2010.

BY THE COURT

/s/ C. N. Clevert, Jr.
C. N. CLEVERT, JR.
Chief U.S. District Judge

Nos.10-2339 and 10-2466

IN THE UNITED STATES COURT OF APPEALS

FOR THE SEVENTH CIRCUIT

ANDREA FIELDS, et al.,

Plaintiffs-Appellees,
Cross-Appellants

v.

JUDY P. SMITH, et al.,

Defendants-Appellants.
Cross-Appellees

APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF WISCONSIN, NO. 06-C-112, THE HONORABLE JUDGE C. N. CLEVERT, JR., PRESIDING

APPENDIX OF DEFENDANTS-APPELLANTS, CROSS-APPELLEES

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INDEX TO APPENDIX

APPENDIX PAGE

APPPENDIX CERTIFICATION

The undersigned hereby certifies that this appendix includes all of the materials required by Circuit Rule 30(a) and (b).

Dated this 24th day of September, 2010.

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UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF WISCONSIN

KARI SUNDSTROM,
ANDREA FIELDS,
LINDSEY BLACKWELL,
MATTHEW DAVISON,
also known as Jessica Davison,
and VANKEMAH D. MOATON,

Plaintiffs,

v. Case No. 06-C-112

MATTHEW J. FRANK,
WARDEN JUDY P. SMITH,
THOMAS EDWARDS,
JAMES GREER,
ROMAN KAPLAN, MD,
WARDEN ROBERT HUMPHREYS,
and MANAGER SUSAN NYGREN,

Defendants.

ORDER GRANTING IN PART AND DENYING IN PART DEFENDANTS' MOTION FOR PARTIAL SUMMARY JUDGMENT (DOC. #120), GRANTING PLAINTIFFS' MOTION FOR LEAVE TO FILE SURREPLY (DOC. #163), DISMISSING DEFENDANTS HUMPHREYS AND NYGREN, AND DISMISSING PLAINTIFFS SUNDSTROM AND BLACKWELL

Before the court is the defendants' motion for partial summary judgment. Defendants' Statement of the Case follows:

> The plaintiffs, all current or former inmates in the Wisconsin prison system, filed this action on January 24, 2006, against the defendants, all Wisconsin Department of Corrections (DOC) officials. The plaintiffs have all been diagnosed as suffering from some form of gender identity disorder. In their Third Amended Complaint (Complaint), the plaintiffs challenge the Inmate Sex Change Prevention Act (the Act), Wis. Stat. § 302.386(5m), which prevents state or federal resources to be used to provide hormone therapy or sexual reassignment surgery to Wisconsin prisoners. The statute defines "hormonal therapy"

> as "the use of hormones to stimulate the development or alteration of a person's sexual characteristics in order to alter the person's physical appearance so that the person appears more like the opposite gender." Wis. Stat. § 302.386(5m)(a)(1). It also defines "sexual reassignment surgery" as "surgical procedures to alter a person's physical appearance so that the person appears more like the opposite gender." Wis. Stat. § 302.386(5m)(a)(2).
>
> The Complaint sets forth essentially three claims: (1) the Act, as applied to the plaintiffs, violates the Eighth Amendment; (2) the Act, on its face, violates the Eighth Amendment; and (3) the Act violates the plaintiffs' Fourteenth Amendment equal protection rights. As relief, the plaintiffs request injunctive relief against DOC's enforcement of the Act against them, along with declaratory relief holding the Act, both on its face and as applied to plaintiffs, violates the Eighth and Fourteenth Amendments to the constitution.
>
> By this motion, the defendants seek summary judgment on the following claims: (1) Plaintiff Moaton's Eighth Amendment as-applied challenge to the Act; (2) the Eighth Amendment facial challenge to the Act; (3) all claims brought by plaintiffs Sundstrom and Blackwell; (4) all claims brought against defendants Humphreys and Nygren; and (5) the Fourteenth Amendment equal protection claim.

(Defs.' Br. in Support of Mot. for Summ. J. at 2-3.)

STANDARD OF REVIEW

Summary judgment "shall be rendered forthwith if the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law." Fed. R. Civ. P. 56(c); *see also Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 248 (1986); *Celotex Corp. v. Catrett*, 477 U.S. 317, 324 (1986); *McNeal v. Macht*, 763 F. Supp. 1458, 1460-61 (E.D. Wis. 1991). "Material facts" are those facts that, under the applicable substantive law, "might affect the outcome of the suit." *See Anderson*,

477 U.S. at 248. A dispute of "material fact" is "genuine" if "the evidence is such that a reasonable jury could return a verdict for the nonmoving party." *Id.*

The burden of showing the needlessness of trial – (1) the absence of a genuine issue of material fact and (2) an entitlement to judgment as a matter of law – is upon the movant. However, when the nonmovant is the party with the ultimate burden of proof at trial, that party retains its burden of producing evidence which would support a reasonable jury verdict. *Anderson*, 477 U.S. at 267; *see also Celotex Corp.*, 477 U.S. at 324 ("proper" summary judgment may be "opposed by any of the kinds of evidentiary materials listed in Rule 56(c), except the mere pleadings . . . "). "Rule 56(c) mandates the entry of summary judgment, . . . upon motion, against a party who fails to establish the existence of an element essential to that party's case and on which that party will bear the burden of proof at trial." *Celotex Corp.*, 477 U.S. at 322.

In evaluating a motion for summary judgment, the court must draw all inferences in a light most favorable to the nonmoving party. *Johnson v. Pelker*, 891 F.2d 136, 138 (7th Cir. 1989). "However, we are not required to draw every conceivable inference from the record – only those inferences that are reasonable." *Bank Leumi Le-Israel, B.M. v. Lee*k, 928 F.2d 232, 236 (7th Cir. 1991) (citation omitted).

FACTS[1]

[1] In this section, Defendants' Proposed Findings of Fact (DFOF) are set forth first, along with Plaintiffs' Response to Defendants' Proposed Findings (PRDFOF), and Defendants' Reply to Plaintiffs' Response to Defendants' Proposed Findings of Fact (DReply). Next, Plaintiffs' Proposed Findings of Fact (PFOF) are set forth, including Plaintiffs' Amended Proposed Finding of Fact Number 20, along with Defendants' Response to Plaintiffs' Findings of Fact (DRPFOF).

Plaintiff Kari Sundstrom is an anatomical male and was an inmate incarcerated at the Oshkosh Correctional Institution (OSCI). (DFOF ¶ 1.) On December 12, 2006, Sundstrom was released from DOC incarceration. Plaintiff Andrea Fields is an anatomical male and an inmate incarcerated at OSCI. (DFOF ¶ 2.) Plaintiff Lindsay Blackwell is an anatomical male and was previously an inmate incarcerated at the Racine Correctional Institution (RCI). (DFOF ¶ 3.) On October 10, 2006, Blackwell was released from DOC incarceration. Plaintiff Matthew Davison is an anatomical male and an inmate incarcerated at OSCI. (DFOF ¶ 4.) Plaintiff Vankemah Moaton is an anatomical male and an inmate currently incarcerated at the Jackson Correctional Institution. (DFOF ¶ 5.)

Defendant Matthew J. Frank was the Secretary of the State of Wisconsin Department of Corrections when this action was filed. (DFOF ¶ 6.) Defendant James Greer is the Director of the DOC Bureau of Health Services. (DFOF ¶ 7.) Defendant Judy P. Smith is the Warden at OSCI. (DFOF ¶ 8.) Defendant Thomas Edwards is the Health Services Manager of the OSCI Health Services Unit. (DFOF ¶ 9.) Defendant Robert Humphreys is the Warden at RCI. (DFOF ¶ 10.) Defendant Susan Nygren is the Health Services Manager of the RCI Health Services Unit. (DFOF ¶ 11.)

The Harry Benjamin International Gender Dysphoria Association's Standards of Care for Gender Identity Disorders, Sixth Version (Standards of Care) refer to three elements or phases of therapy once a person is diagnosed with gender identity disorder, which include: (1) a real-life experience in the desired role; (2) hormones of the desired gender; and (3) surgery to change the genitalia and other sex characteristics. The Standards of Care refer to these three phases as triadic therapy. (DFOF ¶ 12.)

The Standards of Care state that "the diagnosis of GID invites consideration of a variety of therapeutic options, only one of which is the complete therapeutic triad. Clinicians have increasingly become aware that not all persons with gender identity disorders need or want all three elements of triadic therapy."[2] (Docket No. 5, Dupuis Declaration, Exhibit E, Standards of Care for Gender Identity Disorders, Sixth Version, p. 3) (DFOF ¶ 13.) The Standards of Care state that "[m]any adults with gender identity disorder find comfortable, effective ways of living that do not involve all the components of the triadic treatment sequence." (Doc. No. 5, Dupuis Declaration, Exhibit E, Standards of Care for Gender Identity Disorders, Sixth Version, p. 9).[3] (DFOF ¶ 14.)

Before hormone therapy is administered to a GID patient, the Standards of Care recommend that a letter from a mental health professional be written to the physician who will be responsible for the patient's medical treatment. This letter should succinctly specify: (1) the patient's general identifying characteristics; (2) the initial and evolving gender, sexual and

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[2]Plaintiffs do not dispute that this is an accurate quotation for the Standards of Care. However, plaintiffs dispute defendants' implication that this quotation means that hormone therapy and sex reassignment surgery can never be medically necessary treatments for GID. Based on the standards of care medically necessary treatment for GID most often involves hormone therapy or surgical interventions. Dr. Randi Ettner testified, "[W]e know that untreated as many as 35 percent of patients [with GID] will commit suicide. And the treatment for the disorder most often involves hormones and/or surgical interventions. So those are the appropriate and medically necessary treatment for this disorder." (Knight Decl., Exh. 213, R. Ettner Dep. Tr. at 51.) The process of determining what treatments are medically necessary for a patient with GID involves an individualized evaluation and assessment. The Standards of Care state that, "[i]n persons diagnosed with transsexualism or profound GID, sex reassignment surgery, along with hormone therapy and real-life experience, is a treatment that has proven to be effective. Such a therapeutic regimen, when prescribed or recommended by qualified practitioners, is medically indicated and medically necessary." (Docket No. 5, Dupuis Declaration, Exhibit E, *Standards of Care for Gender Identity Disorders, Sixth Version* at 18.) The only medical treatment that effectively relieves suffering caused by severe GID is hormone therapy or surgery to bring anatomy and appearance into alignment with gender identity. (PRDFOF ¶ 1.)

Defendants dispute plaintiffs additional assertions of fact. In addition, plaintiffs' expert, Dr. Frederic Ettner, testified that not every individual with GID needs to be on hormones.

[3] Plaintiffs incorporate by reference their response to DFOF ¶ 13 above. (PRDFOF ¶ 2.) Defendants incorporate by reference their reply to DFOF ¶ 13 above. (DReply ¶ 14.)

other psychiatric diagnoses; (3) the duration of their professional relationship including the type of psychotherapy or evaluation that the patient underwent; (4) that eligibility criteria have been met and the mental health professional's rationale for hormone therapy; (5) the degree to which the patient has followed the Standards of Care to date and the likelihood of future compliance; (6) whether the author of the report is part of a gender team; and (7) that the sender welcomes a phone call to verify that the mental health professional wrote the letter. (DFOF ¶ 15.) The Standards of Care state that "[g]enital surgery is not a right that must be granted upon request." (Doc. No. 5, Dupuis Declaration, Exhibit E, Standards of Care for Gender Identity Disorders, Sixth Version, p. 18).[4] (DFOF ¶ 16.)

During the deposition of plaintiff Vankemah Moaton on June 21, 2007, plaintiffs' counsel Laurence Dupuis voiced the following objection:

> I'm going to object and actually direct [Moaton] not to answer questions about her interactions with – about her taking hormones prior to 2004 on grounds of Fifth Amendment Privilege.

(Schmelzer Aff., Exhibit 531, p. 18). (DFOF ¶ 17.) During the deposition of plaintiff Vankemah Moaton on June 21, 2007, plaintiffs' counsel, Laurence Dupuis, voiced the

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[4] Plaintiffs do not dispute that this is an accurate quotation from the Standards of Care. However, plaintiffs assert that this proposed finding of fact is immaterial. This action does not seek any particular form of treatment for plaintiffs, nor do plaintiffs claim that genital surgery is a right that must be granted upon request, to them or to anyone else. Rather, plaintiffs seek the treatments that DOC physicians determine to be medically necessary for them based on individualized evaluation. Before the provision of sex reassignment surgery could even be considered, a GID diagnosis must be made, which includes a finding of "clinically significant distress or impairment in social, occupational, or other important areas of functioning." (Knight Decl., Exh. 232, Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition - Text Reference (DSM-IV) at 581.) In addition, the Standards of Care do not permit genital surgery until the patient with GID has met strict eligibility and readiness criteria. Sex reassignment surgery is not cosmetic or elective; rather, for some individuals with severe GID, it is the only effective treatment for their condition. Some such individuals suffer so profoundly without effective GID treatment that they mutilate their own genitals, essentially performing their own makeshift sex reassignment surgery. For anatomic males with severe GID, "having a female anatomy reconstructed is their therapy." (Knight Decl., Exh. 218, F. Ettner Dep. Tr. at 34.) (PRDFOF ¶ 3.)

As to plaintiffs' objections, defendants maintain that this proposed finding is material in that it supports their view that not every application of the Inmate Sex Change Prevention Act, Wis. Stat. § 302.386(5m), is unconstitutional. (DReply ¶ 16.)

following objection to defense counsel's inquiry about feminizing procedures Moaton has had done:

> On these procedures I'm going to direct [Moaton] not to answer any questions after the end of 2000 on the same grounds as before, so she can describe things that happened up until the end of 2000.

(Schmelzer Aff., Exhibit 531, p. 36). (DFOF ¶ 18.) Dr. Randi Ettner's report notes that Moaton "underwent facial and body feminizing procedures to attain an authentic female presentation. She began taking hormones eleven years ago." The report adds that while in prison in Minnesota, Moaton "was able to taper off medication." (Schmelzer Aff., Exhibit 527, pp. 8).[5] (DFOF ¶ 19.)

A portion of Dr. Ettner's report reads: "[g]ender identity disorder, previously known as transexualism, is an extremely rare and misunderstood disorder, with an incidence of 1 in 11,900 natal males and 1 in 30,400 females." (Schmelzer Aff., Exhibit 526, p. 1). (DFOF ¶ 20.) Continuing, Dr. Ettner's report states that, "[h]owever, as the field matured, professionals became aware that not all persons with bona fide gender identity disorders desired or were candidates for sex reassignment surgery." (Schmelzer Aff., Exhibit 526, p. 10). (DFOF ¶ 21.) Another portion of Dr. Ettner's report provides that, "[i]n select cases, incarcerated persons who meet these criteria may be candidates for medically ordained surgical treatment." (Schmelzer Aff., Exhibit 526, p. 13). (DFOF ¶ 22.)

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[5] Plaintiffs do not dispute that these are accurate quotations of portions of Dr. Randi Ettner's report. However, they dispute defendants' suggestion that because plaintiff was taken off hormones for a time several years ago means that they are not medically necessary now. (PRDFOF ¶ 4.)

Defendants dispute plaintiffs' additional assertions of fact. This dispute, however, is not material as it related to the defendants' motion for summary judgment. (DReply ¶ 19.)

Dr. George Brown's report advises that "SRS is a last resort treatment, reserved for those who have not been able to find less invasive ways to treat their condition." (Schmelzer Aff., Exhibit 516, p. 9). (DFOF ¶ 23.) The deposition of Lindsay Blackwell's deposition of May 2, 2006, included the following exchange:

> Q: So you feel that the Department of Corrections should provide you with breast implants?
> A: No, with the proper stages that we're supposed to go through.
> Q: Tell me what those stages are then.
> A: The counseling.

(Schmelzer Aff., Exhibit 534, p. 36).[6] (DFOF ¶ 24.) The following was stated during the May 3, 2006, deposition of Andrea Fields:

> Q: Do you want to have other surgeries?
> A: Yes.
> Q: What other surgeries do you want to have.
> A: I want to do the whole sex change.
> Q: Okay. So that – is that what's known as gender reassignment surgery?
> A: Yes.
> Q: Are you also looking to – strike that. Do you feel like you're ready for that now?
> A: Yes, I am.
> Q: Do you feel that that's something that the Department of Corrections
> should provide for you?

[6] Plaintiffs do not dispute the accuracy of this quotation. However, they take issue with defendants' implication that this quotation means that medically necessary treatment is determined by a transgender inmate evaluation by a medical provider, and that sex reassignment surgery is never medically necessary for inmates. It has been stated that gender dysphoria resulting from GID "appears to intensify over a lifetime, escalating with age." (Knight Decl., Exh. 217, June 28, 2006 R. Ettner Report at 13; Knight Decl., Exh. 216, Kallas Dep. Tr., 7/19/07, at 82.) Several opinions expressed in this case are that the determination that hormones or surgery are medically necessary treatments for some inmates with GID does not take place until after they have been incarcerated. For some individuals with GID, sex reassignment surgery is a medically necessary treatment that eliminates gender dysphoria. (PRDFOF ¶ 5.)

Defendants dispute plaintiffs' additional assertions of fact. The suggestion that hormones or surgery would be imposed upon an inmate with GID who does not want this form of treatment is inconceivable. The Standards of Care expressly require informed consent for initiation of hormone treatment, and further require, at a minimum, patient consent for reassignment surgery. The medical necessity of these forms of treatment is also disputed.

A: No.

(Schmelzer Aff., Exhibit 535, pp. 75-76).[7] (DFOF ¶ 25.) Kari Sundstrom's deposition of May 3, 2006, included the following:

> Q: Do you believe that the Department of Corrections should provide you with gender reassignment surgery?
> A: Do I?
> Q: Yeah.
> A: For me personally? Not for me.

(Schmelzer Aff., Exhibit 536, p. 36)[8] (DFOF ¶ 26.)

Walter Kautzky's report submits that, "Gender Identity Disorder and the presentation of effeminate characteristics create challenges in a prison setting, but those problems are not different than complexity of mental illness or HIV positive inmates." (Schmelzer Aff., Exhibit 533, pp. 15-16).[9] (DFOF ¶ 27.) Walter Kautzky testified on May 31, 2007:

> Q: So let me see if I understand you correctly. If a prisoner is perceived as being sexually available, is it your testimony that that increases the possibility that the prisoner may be sexually assaulted by other prisoners?
> A: That's correct, yes.
> Q: Is it your belief that inmates who cross-dress are perceived as sexually available?

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[7] Plaintiffs incorporate by reference their response to DFOF ¶ 24, *supra.* (PRDFOF ¶ 6.) Defendants incorporate by reference their response to DFOF ¶ 24 *supra.* (DReply ¶ 25.)

[8] Plaintiffs incorporate by reference their response to DFOF ¶ 24 *supra.* (PRDFOF ¶ 7.) Defendants incorporate by reference their response to DFOF ¶ 24 *supra.* (DReply ¶ 26.)

[9] Plaintiffs do not dispute the accuracy of this quotation, but dispute defendants' implication that this quotation means that inmates with GID demand more correctional resources than do other inmates. Mr. Kautzky testified that he has never known inmates with GID to create extra staffing burdens. (PRDFOF ¶ 8.)

Defendants dispute plaintiffs' additional assertions of fact. Atherton has stated that feminization of inmates in a male prison increases the work demand of existing staff, and that this will cause resources to be drawn from attendance to the other operations duties in the institution that are also likely to involve safety and control. Defendants further assert that this is not a dispute of material fact as it relates to the defendants' motion for summary judgment. (DReply ¶ 27.)

> A: Yes.
> Q: Is it your belief that inmates who display effeminate characteristics are viewed as sexually available?
> A: Yes.

(Schmelzer Aff., Exhibit 533, pp. 34-35).[10] (DFOF ¶ 28.) Walter Kautzky testified on May 31, 2007, stating:

> Q: Would it present security concerns for a male inmate to spend a year living as a female inmate?

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[10] Plaintiffs do not dispute the accuracy of this quotation. However, they dispute defendants' implication that this means that inmates who receive medically necessary treatment for GID are perceived as more sexually available by other inmates and will consequently be sexually assaulted following hormone therapy. Any implication regarding the effects of cross-dressing is immaterial, because this lawsuit does not involve clothing. Cross-dressers or transvestites are a distinct category from transsexuals or people with GID. The DSM lists Transvestic Fetishism as a separate diagnosis from GID. Furthermore, individuals with effeminate characteristics do not necessarily have GID. "Femininity is a broad range. Some [feminine inmates] may have GID. Some maybe not." (Knight Decl., Exh. 221, Atherton Dep. Tr. at 35.) In addition, it is impossible to predict or generalize about the amount of external feminization that results from administration of hormone therapy to individuals with GID. "Heredity limits the tissue response to hormones and this cannot be overcome by increasing dosage. The degree of effects actually attained varies from patient to patient." (Docket No. 5, Dupuis declaration, Exhibit E, *Standards of Care* at 14.) The degree to which hormone therapy induces feminization for a particular person with GID cannot be ascertained by prison security experts, but rather can only be determined by medical experts. Defendants produce no evidence indicating that denying medically necessary treatments to an inmate with GID decreases effeminate demeanor or similar characteristics.

Plaintiffs further dispute any implication that this quotation means Kautzky believes that inmates with GID are more vulnerable because they take hormones or that GID treatment cannot be administered in a prison setting. Kautzky testified that prison administrators should follow medical instructions. Moreover, Kautzky testified that, if an inmate was at risk of suicide or self-harm without sex reassignment surgery, and if a prison committee of health care providers recommended that surgery be provided to that inmate, then prison administrators "would have to take those steps based on the best medical advice that they had." (Knight Decl., Exh. 220, Kautzky Dep. Tr. at 185-86.) (PRDFOF ¶ 9.)

As to plaintiffs' additional assertions of fact, defendants submit that plaintiffs' expert describes the feminizing effects hormones have on a male inmate:

> Testosterone is a very potent hormone, and reversing its effects is not entirely possible. However, administering estrogen compounds and anti-androgenic compounds creates changes in the brain, and **visible changes in the body**, of a natal male. These include: **Notable increase in breast size, smoothing and softening of skin, change in subcutaneous fat distribution**, shortening of the penis, loss of size and volume of the testes, reduction in the size of the prostate gland, change in lipid profile, and preservation of bone mass.

(Schmelzer Aff., Docket No. 124, Exhibit 526, p. 11) (emphasis added). To argue male inmates on female hormone therapy do not display effeminate characteristics is nonsensical and contrary to Dr. Ettner's opinion. Indeed, the Act in question ***only*** applies when hormones are used "to simulate 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." Wis. Stat. § 302.386(5m)(a)(1). Similarly, only surgical procedures that "alter a person's physical appearance so that the person appears more like the opposite gender" are prevented under the Act. Wis. Stat. § 302.386(5)(a)(2). (*See also*, PFOF ¶ 6). The remainder of the plaintiffs' assertions are not material facts as it relates to the defendants' motion for summary judgment. (DReply ¶ 28.)

> A: Would it present security concerns. And I think my answer would be there probably would be security concerns for any highly effeminate inmate whether they were undergoing gender identity disorder, real life experience or not. And I think the research from BJS is real clear that inmates who are highly effeminate or known homosexuals or in other cases, you know, known transgender inmates may, you know, not be homosexual, have nothing to do with homosexuality do, in fact, by virtue of presenting themselves as highly effeminate people present additional security concerns, yes.

(Schmelzer Aff., Exhibit 533, p. 155).[11] (DFOF ¶ 29.) Walter Kautzky further testified:

> Q: All other things being equal, is an inmate who is more feminine than another inmate at increased risk of victimization?
> A: According to the research, yes.
> Q: And you agree with that?
> A: Yes, sir.

(Schmelzer Aff., Exhibit 533, p. 161). (DFOF ¶ 30.) Continuing, Kautzky stated:

> Q: Would you agree with me that correctional institutions should not create conditions that make inmates more vulnerable to assault?
> A: Would I agree that institutions should not make – create conditions that would make inmates more vulnerable to assault? Yes, I would agree with that.

(Schmelzer Aff., Exhibit 533, pp. 161-162). (DFOF ¶ 31.)

On June 20, 2007, Matthew Davison was deposed and testified:

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[11] Plaintiffs do not dispute the accuracy of this quotation. However, this proposed finding is misleading because it is taken out of context. This quotation refers to the Real Life Experience, a period of living as a different gender that is recommended by the Standards of Care prior to certain forms of sex reassignment surgery. The Real Life Experience may be possible in a prison setting. Regardless, however, facilitation of the Real Life Experience in a prison setting is not at issue in this case. Furthermore, even if the Real Life Experience were relevant to this case, it is not a prerequisite for administration of hormone therapy. The Standards of Care acknowledge that some forms of sex reassignment surgery can be appropriate even without RLE. Contrary to defendants' implication, provision of hormone therapy or sex reassignment surgery does not necessarily require the prison to facilitate a female gender role for an inmate by providing access to makeup or female clothing, nor do plaintiffs seek this. (PRDFOF ¶ 10.)

Defendants submit that as to plaintiffs' additional assertions, Mr. Kautzky's response speaks for itself. Though asked about the real life experience, Mr. Kautzky's response was clearly broader in scope, and he clearly stated that highly effeminate inmates present additional security concerns. (DReply ¶ 29.)

> Q: Do you think you're able to live as a woman here in prison?
> A: In a male institution, it's hard.
> Q: Why is that?
> A: The men trying to get on you, harass a lot by staff and inmates. I'm pretty much perceived as a female in here.
> Q: Is prison life different than life outside prison?
> A: Yes.
> Q: Is it a lot different?
> A: Yes. You've got to be much more careful.
> Q: Do you think they make you more of a target for men trying to get on you and harass here in prison?
> A: I'm not sure how to answer that.
> Q: Do you think some of the physical effects that you've seen result from – I'll finish for the record. Some of the physical effects that you have seen from female hormones make you more of a target for men trying to get on you and being harassed here in prison?
> A: Yes.
> Q: When you say men trying to get on you, what do you mean by that?
> A: Trying to have sex.

(Schmelzer Aff., Exhibit 532, pp. 43-44). (DFOF ¶ 32.) According to plaintiff Matthew Davison, another inmate raped Davison and, in a separate incident, was also molested by yet another inmate. (DFOF ¶ 33.)

In this action, plaintiffs ask that DOC health care providers be allowed to provide them with medically necessary treatments for their serious health condition, Gender Identity Disorder (GID).[12] (PFOF ¶ 1.)

Gender Identity Disorder and its Treatment

GID is a serious health condition classified in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (4th edition - Text

[12] Defendants dispute that plaintiffs have a serious medical need that requires medically necessary treatments. (DRPFOF ¶ 1.)

Revision).[13] (PFOF ¶ 2.) In its most severe manifestation, GID is referred to as transsexualism. The DSM is the official diagnostic manual used by nearly all mental health providers.[14] (PFOF ¶ 3.) Ordinarily, a GID diagnosis is made when the following criteria are present: 1) a strong and persistent cross-gender identification; 2) a persistent discomfort with one's sex or a sense of inappropriateness in the gender role of that sex; 3) the disturbance is not concurrent with a physical intersex condition; and 4) the disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.[15] (PFOF ¶ 4.) Also, cross-gender identification cannot be reversed through psychotherapy. (PFOF ¶ 5.) According to Dr. Frederic Ettner, M.D.: "Once you're born with gender identity disorder, you stay with gender identity disorder, whether you're withdrawn from therapy or on therapy." (Knight Decl., Exh. 218, F. Ettner Dep. Tr. at 32.)

To alleviate the psychological distress or impairment caused by GID, many male-to-female transsexuals seek to express their female gender identity through appearance, mannerisms, name and pronoun choices, or by otherwise identifying and expressing themselves as women. (PFOF ¶ 6.) Significantly, many do so well before hormone therapy.

Transsexual health experts have determined that hormone therapy and sex reassignment surgery are medically necessary treatments for some individuals with GID. This determination is supported by the Standards of Care, which are accepted worldwide, and

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[13] Defendants dispute that "GID is a serious health condition." (DRPFOF ¶ 2.)

[14] Defendants dispute. (DRPFOF ¶ 3.)

[15] Defendants do not dispute that this is the diagnostic criteria for GID in the DSM-IV. Defendants object to the statement "GID is properly diagnosed when the following criteria are present" as not supported by the evidentiary material cited. (DRPFOF ¶ 4.)

represent the consensus of professionals regarding the psychiatric, medical and surgical management of GID. Untreated GID "will cause disastrous results quite often." (Knight Decl., Exh. 213, R. Ettner Dep. Tr. at 51.) No treatments can substitute for hormone therapy or sex reassignment surgery for people with GID who have a medical need for such treatments.[16] (PFOF ¶ 7.)

DOC medical personnel agree that hormone therapy and sex reassignment surgery are medically necessary treatments for some individuals with GID. As Dr. David Burnett, DOC Medical Director, stated in his deposition of June 12, 2006:

> Q: Is it your professional medical opinion that gender identity disorder is a health condition that requires treatment?
> A: Yes, I would agree with that, that it requires treatment and evaluation.
> Q: To your knowledge, what are the commonly-accepted forms of treatment for gender identity disorder?
> A: My understanding is there is what is referred to as the triad system in terms of hormonal therapy, living in a real-life situation and surgical therapy.

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[16] Defendants dispute. Transgender issues and GID do not result in a serious medical need and do not require treatment. Rather, each transgender individual decides which options to pursue and how far and how fast to go with regard to these life-changing options. Some elect hormone therapy without surgery. Some elect cosmetic surgery. Some cross-dress and cross identify in select circumstances only. Each individual does what they need and can accept and can afford, not what is "required." It is undisputed that the Standards of Care state:

> However, the diagnosis of GID invites the consideration of a variety of therapeutic options, only one of which is the complete therapeutic triad. Clinicians have increasingly become aware that not all persons with gender identity disorders need or *want* all three elements of triadic therapy.
> ....
> The therapist should make clear that it is the patient's right to *choose among many options*.
> ....
> Hormone therapy can provide significant comfort to gender patients *who do not wish to* cross live or undergo surgery, or who are unable to do so.
> ....
> Although professionals may recommend living in the desired gender, the decision as to when and how to begin the real-life experience remains the person's responsibility.

(Docket No. 5, Dupuis Declaration, Exhibit E, *Standards of Care for Gender Identity Disorders, Sixth Version*, pp. 3, 10, 12, 15.) Whether this choice is termed "treatment" by plaintiffs' experts and the SOC or not, it cannot be disputed that a GID patient *chooses* what conditions would sufficiently alleviate distress caused by their condition. (DRPFOF ¶ 7.)

(Knight Decl., Exh. 222, Burnett Dep. Tr. at 35-36.) Dr. Kevin Kallas, DOC Mental Health Director, agrees that "gender identity disorder is a condition that needs treatment, and to prohibit that treatment in a blanket way without taking into account the individual circumstances of offenders is not a good idea." (Knight Decl., Exh. 215, Kallas Dep. Tr., 6/12/06, at 14-15.) He further agrees that the DOC considers treatment necessary for some inmates with GID, and that Act 105 "takes away medically necessary treatment." (Knight Decl., Exh. 215, Kallas Dep. Tr., 6/12/06, at 14-15.)[17] (PFOF ¶ 8.)

DOC medical personnel admit that for some individuals, failure to provide medically necessary hormone therapy could cause adverse consequences to psychological well-being, including ongoing gender dysphoria, depression, anxiety, and, for some, even suicidal ideation. Other risks of not providing hormone therapy to a person with GID include "a higher risk of alcohol and drug use or dependency issues. . . . [and] some increased risk of borderline behaviors which could involve cutting on one's self, as an example." (Knight Decl., Exh. 224, Hull Dep. Tr. at 28.)[18] (PFOF ¶ 9.) Hormone therapy might relieve the desire to self-castrate that is sometimes caused by GID. Hormone therapy is one of the mainstays of treatment for GID.[19] (PFOF ¶ 10.)

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[17] Defendants object to the statement that "sex reassignment surgery" is "medically necessary treatment [] for some individuals with GID" as not supported by the evidentiary materials cited. Defendants do not dispute that these were statements made by Dr. Kallas and Dr. Burnett, but dispute the accuracy of those opinions. (DRPFOF ¶ 8.)

[18] Defendants do not dispute that these were the opinions of Dr. Kallas, Mr. Greer, and Dr. Hull, but dispute the accuracy of those opinions. (DRPFOF ¶ 9.)

[19] Defendants object to the statement "[h]ormone therapy might relieve the desire to self-castrate that is sometimes caused by GID" as not supported by the evidentiary materials cited. Defendant do not dispute that the remainder of this proposed finding is the opinion of Dr. Kallas, but dispute the accuracy of those opinions. (DRPFOF ¶ 10.)

For a treatment to be medically necessary, it does not have to be a treatment for an emergency condition, but could be a chronic condition like gender dysphoria.[20] (PFOF ¶ 11.) DOC personnel agree that, for some prison inmates with GID, sex reassignment surgery could be medically necessary.[21] (PFOF ¶ 12.) Hormone therapy provided by DOC physicians is medically necessary care for the plaintiffs. In the deposition of Dr. David Burnett, DOC Medical Director, taken on June 12, 2006, the following was said:

> Q: Do you have an opinion about whether the hormone therapy that those three inmates are receiving is medically necessary?
> A: Well, I believe that it is.
> Q: Why do you believe that?
> A: Well, I don't believe that our physicians would prescribe it if it wasn't medically necessary.

(Knight Decl., Exh. 222, Burnett Dep. Tr. at 53-54.) Dr. Randi C. Ettner, who conducted evaluations of each plaintiff, agrees that hormone therapy is medically necessary for the plaintiffs that Dr. Ettner examined.[22] (PFOF ¶ 13.)

Removing an individual with GID from existing hormone therapy treatment creates the risk of negative health consequences on one or more body systems, including the brain and the metabolic systems, and can cause loss of bone density, increased risk of infection, and elevated lipids, leading to a heightened risk of heart disease or stroke. In addition to these medical risks and consequences, hormone withdrawal is accompanied by

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[20] Defendants do not dispute that this is the opinion of Dr. Kallas, but dispute the accuracy of those opinions. (DRPFOF ¶ 11.)

[21] Defendants object to this proposed finding as not supported by the evidentiary materials cited. (DRPFOF ¶ 12.)

[22] Defendants do not dispute that this accurately recites Dr. Burnett's deposition testimony, and that Dr. Ettner found a medical necessity for each plaintiff, but dispute the accuracy of those opinions. (DRPFOF ¶ 13.)

psychological and emotional risks and consequences, including depression and suicidal thoughts. (PFOF ¶ 14.)

DOC medical personnel agree that severe mental and physical health risks are associated with removing individuals with GID from hormone therapy treatment. Suicidal ideation is one risk of removing a patient with GID from their hormone therapy. Other medical consequences of hormone withdrawal include risk of self-mutilation; reversal or partial reversal of the changes induced by the hormones (such as breast development or redistribution of body fat); menopause-like symptoms; hot flashes, hair loss, mood swings, depression, and agitation; gender dysphoria, and a sense of loss. "Any preexisting psychiatric condition could worsen on the basis of being off hormones," including depression. (Knight Decl., Exh. 215, Kallas Dep. Tr. 6/12/06, at 33-35.) Some of these risks may require treatment with antidepressants or psychotropic medications. Restoration of hormones reverses these effects.[23] (PFOF ¶ 15.)

DOC administrative personnel agree that on health care matters, deference should be given to DOC health care staff. In the deposition of Judy Smith, Warden of Oshkosh Correctional Institution, taken on August 15, 2007, the following was stated:

> Q: Would it be fair to say that you would defer to prison psychiatrists and psychologists in determining whether or not a particular condition warrants treatment in the prison setting?
> A: Yes.

[23] Defendants object to the statement that DOC medical personnel agree that "severe mental and physical health risks" are associated with removing individuals with GID from hormone therapy treatment, as not supported by the evidentiary materials cited. They do not dispute the remainder of this proposed finding. (DRPFOF ¶ 15.)

(Knight Decl., Exh. 225, Smith Dep. Tr. at 59.) (PFOF ¶ 16.) Prison security experts agree that they should follow the advice of prison health care providers regarding health care issues. (PFOF ¶ 17.)

Male-to-female transsexual inmates who seek hormone therapy in prison, notwithstanding any risks they perceive from any feminizing effects of those hormones, often express their feminine identity even in the absence of treatment or in ways that supplement the effects of the hormones.[24] (PFOF ¶ 18.)

Act 105

Prior to the passage of Act 105, DOC provided hormone therapy where medically necessary for inmates with GID.[25] (PFOF ¶ 19.) Sometimes, DOC prescribes hormone therapy for reasons that do not have to do with GID, such as estrogen replacement therapy in post-menopausal years, or for inmates with a congenital or hormonal disorder that requires the administration of hormone therapy. (PFOF ¶ 20.) Only inmates with GID are singled out for the denial of medically necessary treatment.[26] (PFOF ¶ 20, amended.)

The sponsors of Act 105 labeled it the "Inmate Sex Change Prevention Act." (PFOF ¶ 21.) Press releases were issued by the sponsors of Act 105 prior to passage of the legislation stating that it was intended to prevent "bizarre taxpayer funded sex change procedure," (Knight Decl., Exh. 227, Margolies Dep. Tr. at 29; Knight Decl., Exh. 246,

[24] Defendants object to this proposed finding on the grounds that the evidentiary materials cited herein does not support this general proposition. (DRPFOF ¶ 18.)

[25] Defendants do not dispute that DOC provided hormone therapy to some inmates with GID prior to the passage of Act 105. They dispute that hormone therapy was medically necessary. (DRPFOF ¶ 19.)

[26] Defendants dispute the statement "[o]nly inmates with GID are singled out for the denial of medically necessary treatment." (DRPFOF ¶ 20.)

Margolies Dep. Exh. 266), and to stop the DOC policy of "[allowing] pharmacists within the corrections system to give hormones to an inmate diagnosed with gender identity disorder." (Knight Decl., Exh. 227, Margolies Dep. Tr. at 29; Knight Decl., Exh. 246, Margolies Dep. Exh. 267.) (PFOF ¶ 22.) Several of the press releases noted that the issue of sex reassignment treatment for inmates came to light when they learned that a Wisconsin transgender inmate was receiving treatment that led her to develop "female characteristics, such as breasts." (Knight Decl., Exh. 227, Margolies Dep. Tr. at 27-28; Knight Decl., Exh. 246, Margolies Dep. Exhs. 263, 265.) (PFOF ¶ 23.)

The legislative history of Act 105 shows that it was conceived and intended to prevent administration of treatment for Gender Identity Disorder. The record does not disclose any other medical testimony or arguments based on medical opinion that were presented during the only other hearing concerning Act 105. (Assembly Bill 184)[27] (PFOF ¶ 24.)

Officially, DOC took a neutral position on Act 105.[28] (PFOF ¶ 25.) However, DOC medical personnel oppose Act 105's limitation on medical decision-making. In his March 2005 Senate testimony regarding Act 105, Dr. Kallas stated that the cons of Act 105 "far outweighed the pros" (Knight Decl., Exh. 215, Kallas Dep. Tr., 6/12/06, at 114-15), and that GID "is worthy of treatment in selected cases." (Knight Decl., Exh. 215, Kallas Dep. Tr., 6/12/06, at 129; Knight Decl., Exh. 249, Kallas Dep. Exh. 17.) He advised that taking away

[27] Defendants object because the evidentiary material cited does not support this proposed finding of fact, and because the evidentiary material cited lacks sufficient foundation to support the propositions contained in this proposed finding. (DRPFOF ¶ 24.)

[28] Defendants do not dispute that DOC testified "for information only" of Act 105, and assert that it is rare that DOC "do it any other way." (Knight Decl., Exh. 227, Robert Margolies Dep. Tr. at 79-81.) (DRPFOF ¶ 25.)

hormones from inmates for whom they are medically necessary may cause those inmates to "become distressed or despondent; may go to point of clinical depression or an anxiety disorder, or suicidality; increase in staff time for mental health care, or placement on WRC; may lead to increase in disruptive behavior and segregation time; increase in psychotropic medication (Antidep) (offset any cost savings)." (Knight Decl., Exh. 215, Kallas Dep. Tr., 6/12/06, at 129; Knight Decl., Exh. 249, Kallas Dep. Exh. 17.) (PFOF ¶ 26.)

Dr. David Burnett, DOC Medical Director, testified in his June 12, 2006, deposition:

> A: Well, my opinion on Act 105 is a general one that I don't believe that medical care ought to be legislated and that medical care ought to be left to clinicians. I think it's bad public policy to get into legislating health care in terms of specifics like this.
> Q: When you say "like this," do you mean the prohibition of care to transgender inmates?
> A: Correct . . .

(Knight Decl., Exh. 222, Burnett Dep. Tr. at 90.) (PFOF ¶ 27.)

James Greer, Bureau Director for DOC Health Services, had the following deposition exchange:

> Q: Would you agree that this Act takes away the ability of the Department of Corrections' doctors to rely on their own medical judgment about providing hormones?
> A: Yes.
> Q: Can you tell me your views of the Act, its pros and cons?
> A: I guess the legislature – legislation basically takes away the autonomy of physicians to practice medicine to the best of their ability.
> Q: Do you think that's a good thing or a bad thing?
> A: I think it's a bad thing.
> Q: So in your view the medical judgment ought to remain within the doctors within the Department of Corrections?
> A: That's my opinion, yes.

(Knight Decl., Exh. 223, Greer Dep. Tr. at 33-34.) (PFOF ¶ 28.)

> Dr. Stephen Hull was deposed on June 18, 2007, and said:
>
> Q: Do you believe that Act 105 limits your ability to effectively treat GID?
> A: Yes.

(Knight Decl., Exh. 224, Hull Dep. Tr. at 59.) (PFOF ¶ 29.)

The cost of providing hormone therapy is low, in absolute terms and in terms relative to the cost of providing medical treatment to address problems caused by untreated GID. The cost of sex reassignment surgery is no greater than several other surgical procedures provided to inmates.[29] (PFOF ¶ 30.)

Act 105 has prevented DOC from undertaking thorough evaluation of several inmates to determine what forms of GID treatment are medically necessary and appropriate for them, because such evaluations would be futile under Act 105.[30] (PFOF ¶ 31.)

DOC leadership rejects that notion that refusing to provide medically necessary treatment for inmates with GID increases prison security or saves money. In the deposition of Warden Judy Smith, taken on August 15, 2007, the following was stated:

> Q: Do you think somebody being a transgendered prisoner makes them more likely to be the victim of sexual assault?
> A: No.
> Q: Do you think the fact that somebody is receiving hormone therapy makes them to be more likely to be a victim of sexual assault?
> A: No.

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[29] Defendants object to the statement, "[t]he cost of sex reassignment surgery is no greater than are several other surgical procedures provided to inmates" as not supported by the evidentiary materials cited. Defendants do not dispute that most expensive surgical procedures include organ transplants, such as liver, kidney and pancreas and open heart surgical procedures; that for a coronary bypass – paid $37,244.09; that for a kidney transplant – paid $32,897.00; and that genital reassignment surgery costs approximately $20,000. (DRPFOF ¶ 30.)

[30] Defendants object to the reference to "several inmates" in this proposed finding as not supported by the evidentiary materials cited. They do not dispute the two DOC inmates were not evaluated for hormone therapy given Act 105. (DRPFOF ¶ 31.)

> Q: Do you think a prisoner's effeminate appearance or behavior might make them more likely to be a victim of sexual assault?
> A: No.

(Knight Decl., Exh. 225, Smith Dep. Tr. at 51.)

> Q: Do you consider transgendered inmates to be particularly vulnerable?
> A: No.
> Q: Do you consider gay inmates to be particularly vulnerable?
> A: No.
> Q: Do you view transgendered inmates as being a higher security risk in any way?
> A: No.
> Q: What about gay prisoners?
> A: No.

(Knight Decl., Exh. 225, Smith Dep. Tr. at 44.)

> Q: Are you aware of any situations in which you felt there was an aggressive prisoner – or prisoner who has a risk to be violent – where you felt that that prisoner was likely to target transgendered inmates?
> A: No.
> Q: Have you ever had a potentially aggressive prisoner that you thought only wanted to attack transgendered inmates?
> A: No that I can recall.

(Knight Decl., Exh. 225, Smith Dep. Tr. at 35.)[31] (PFOF ¶ 32.)

In the deposition of Dr. David Burnett, DOC Medical Director, taken on June 12, 2006, the following was said:

> Q: What I'm asking is whether you think that the Department of Corrections has any interests that are furthered by Act 105?
> A: I guess, in my opinion, I don't see interests that are furthered by Act 105.

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[31] Defendants object to the statement "DOC leadership rejects the notion that refusing to provide medically necessary treatment for inmates with GID increase prison security or saves money" as not supported by the evidentiary material cited and that the evidentiary material cited lacks sufficient foundation to support this assertion. They do not dispute that this proposed finding contains accurate excerpts from Smith's deposition testimony. (DRPFOF ¶ 32.)

(Knight Decl., Exh. 222, Burnett. Tr. at 98.) (PFOF ¶ 33.)

The plaintiffs have been in general population for the bulk of their sentences to date.[32] (PFOF ¶ 34.) OCI Warden Judy Smith testified that, during her almost eleven years as warden at OCI, she knows of no substantiated allegations of inmate-on-inmate sexual violence.[33] (PFOF ¶ 35.) In the deposition of OCI Warden Judy Smith taken on August 15, 2007, the following was stated:

> Q: Do you do anything to identify prisoners who are more likely to be victims of violence by other prisoners?
>
> A: No.
>
> Q: I think when we were talking about identifying potentially violent prisoners, you gave a similar answer – that there's not really a formal process. Is there an informal process? I mean, is there observation – the observations of staff about individual inmates – would that potentially go into a determination that somebody is more at risk of being a victim of violence?
>
> A: I think as I answered previously, I expect that staff look at everyone and be looking for signs that an inmate might be victimized – might be assaulted. You know, whichever way that it is, staff are expected to do continual daily observations. And when something – we're seeing any kind of an adjustment issue or an inmate that is not coping well for whatever reason, then we will take steps to address that.

(Knight Decl., Exh. 225, Smith Dep. Tr. at 39.)

> Q: Are you aware of any situations in which a prisoner has been identified as potentially more assaultive than the average prisoner and something was done as a result of that?

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[32] Defendants do not dispute that plaintiff Sundstrom was in general population for the bulk of her DOC prison sentence, but object to the remainder of this proposed finding as not supported by the evidentiary materials cited. (DRPFOF ¶ 34.)

[33] Defendants object to this proposed finding because it is not supported by the evidentiary material cited. Smith testified that she does not recall any instances of prisoner-on-prisoner sexual violence at OSCI, but that she does recall investigations for this type of activity. (DRPFOF ¶ 35.)

> A: Yes.
>
> Q: Can you explain – describe that situation?
>
> A: I can recall a situation where an inmate arrived that had – was known to staff, and was brought to the supervisor's attention. And, you know, we did a little closer monitoring of that particular inmate.

(Knight Decl., Exh. 225, Smith Dep. Tr. at 30.)

> A: If we separate an inmate from another, I just place that inmate in a different housing unit. There's not generally a cost associated with that.

(Knight Decl., Exh. 225, Smith Dep. Tr. at 37.) (PFOF ¶ 36.)

Other vulnerable inmates are provided with medically necessary care that creates even greater security concerns than the feminization due to hormones.[34] (PFOF ¶ 37.) There are no additional security costs associated with protecting prisoners with GID from violence. As Warden Judy Smith testified on August 15, 2007:

> Q: Okay. Are you able to identify any costs associated with protecting inmates with gender identity disorder from violence?
> A: I – no.
> Q: So there are no costs that you're aware of?
> A: I'm not aware of any.

(Knight Decl., Exh. 225, Smith Dep. Tr. at 57.)

> Q: Has having transgendered prisoners at Oshkosh made any difference in terms of how you staff units in which they're living?
> A: No.
> Q: Have you ever had to ask for additional staff because of the presence of transgendered inmates?
> A: No.

[34] Defendants object to this proposed finding because it is not supported by the evidentiary material cited. (DRPFOF ¶ 37.)

(Knight Decl, Exh. 225, Smith Dep. Tr. at 49.)[35] (PFOF ¶ 38.)

Vankemah Moaton

DOC's own medical personnel have diagnosed plaintiff Vankemah Moaton with GID and have prescribed hormone therapy for Moaton repeatedly.[36] (PFOF ¶ 39.) Dr. Randi Ettner, an expert in GID diagnosis and treatment, has confirmed that Moaton has GID, that hormones are medically necessary for Moaton, and that termination of Moaton's hormones would have devastating and potentially life-threatening consequences.[37] (PFOF ¶ 40.) Defendants' expert in another pending case involving a transgender inmate in Wisconsin concluded that termination of hormones for someone already taking them is "cruel and clinically inappropriate."[38] (PFOF ¶ 41.)

Dr. Daniel Claiborn

Defendants' psychology expert, Daniel Claiborn, testified that no one has a medical need for hormone therapy or sex reassignment surgery, because GID is not a valid psychiatric diagnosis and, even if it were, no treatment for it would be medically necessary. In the deposition of Dr. Claiborn taken on June 12, 2007, the following was said:

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[35] Defendants do not dispute these are accurate excerpts from Smith's deposition testimony, however, objects to the statement "[t]here are no additional security costs associated with protecting prisoners with GID from violence" because the evidentiary material cited lacks sufficient foundation to support this broad assertion. While this may be the case at OSCI and Warden Smith's experience, she never testified as to the experiences of GID inmates in other facilities with other security levels, security classifications, and/or different classifications of inmates. (DRPFOF ¶ 38.)

[36] Defendants do not dispute, but assert that hormone therapy is not medically necessary treatment. (DRPFOF ¶ 39.)

[37] Defendants do not dispute that this is Dr. Ettner's opinion, but dispute the accuracy of those opinions. (DRPFOF ¶ 40.)

[38] Defendants do not dispute that this was the opinion of Cynthia S. Osborne, MSW, in another case, but dispute the accuracy of that opinion. (DRPFOF ¶ 41.)

> Q: Who hired you in this case?
> A: The State of Wisconsin.
> Q: Who contacted you first?
> A: Jody Schmelzer.
> Q: And what did Jody ask you to do?
> A: She asked me to review the records on – with regard to these plaintiffs, and offer opinions not so much about these particular plaintiffs, but about the issues having to do with medical necessity and requirement to treat gender identity disorder as a mental illness.

(Knight Decl., Exh. 231, Claiborn Dep. Tr. at 11.)

> A: . . . The opinions I outline in my report are: One, that I don't believe gender identity disorder is a mental disorder or a mental illness. And, secondly, that since it isn't a mental disorder or mental illness, I don't believe that medical treatment is a requirement for people who find themselves in that situation. The third opinion would be that I don't believe that the DSM and the process behind that is scientific or authoritative in the strictest scientific sense in terms of outlining and defining mental disorders. I think those are the primary ones.

(Knight Decl., Exh. 231, Claiborn Dep. Tr. at 13-14.)

> Q: Do you think transgender people who have taken hormone therapy for years have a medical need for those hormones?
> A: No.
> Q: Why not?
> A: Well, I'm not – I don't know – I'm not a medical doctor, and I don't know the physiology of how their bodies are functioning. But speaking in terms of treatment for a disorder, I don't think that they would have a need to start. It's an option, and it's something that they make a decision about continuing to use with the advice of their doctors in terms of the physical effects, but I'm not speaking as an M.D.

(Knight Decl., Exh. 231, Claiborn Dep. Tr. at 226-27.) (PFOF ¶ 42.)

Dr. Claiborn disclaimed any opinion about the validity of any particular plaintiff's diagnosis or need for treatment:

Q: Turning to page 3 of the report, at the top you have a note about plaintiffs Moatan [sic] and Davison. Have you reviewed any records for either Moatan or Davison?
A: No.
Q: And you write, "It is not expected that reviewing their records will change any of the opinions contained herein." Did I read that correctly?
A: Yes.
Q: Why do you not expect, or why did you not expect that reviewing their records would change your opinions?
A: Because my opinions are more general about the issue of diagnosing transgender situations as mental disorders, not so much specifically about the particulars of the plaintiffs in the case.
Q: So in the records of the three plaintiffs that you did review, did you see anything in those records that affected your opinion in this case?
A: I didn't see anything in the records that directly affected my opinion about the general issue of whether transgender situations are mental disorders.
Q: So is it accurate to say that your review of the plaintiffs' records did not affect your opinion about whether GID is a mental disorder?
A: Yes.

(Knight Decl., Exh. 231, Claiborn Dep. Tr. at 18-19.)

Q: Did you form any opinions about the diagnoses of the plaintiffs?
A: I observed in the records what their diagnoses have been, but I didn't independently render a diagnosis on these three plaintiffs.
Q: Did you ask to meet with the plaintiffs?
A: No.
Q: Did you form an opinion based on your review of their records as to whether they had diagnoses of GID?
A: Yes.
Q: What was you opinion?
A: It seems as though each one of them has been diagnosed GID.
Q: And were you able to evaluate or discern whether you agree with that diagnosis?
A: I didn't actually critically examine it. I took it for granted that those diagnoses were warranted.

(Knight Decl., Exh. 231, Claiborn Dep. Tr. at 20-21.)[39] (PFOF ¶ 43.)

Kari Sundstrom and Lindsey Blackwell

Kari Sundstrom has been released from prison, but remains on extended supervision. (PFOF ¶ 44.) The DOC directory, Vinelink, lists Sundstrom as having "absconded."[40] (PFOF ¶ 45.) On April 20, 2007, a criminal complaint against Sundstrom was filed in Dane County Circuit Court. (PFOF ¶ 46.) Consequently, a felony warrant issued the same day. Lindsey Blackwell has been released from prison, but remains on extended supervision. (PFOF ¶ 47.)

ANALYSIS

The defendants contend that, 1) summary judgment is proper on the plaintiffs' facial challenge to the Inmate Sex Change Prevention Act because the Act is not unconstitutional in all applications; 2) plaintiffs Sundstrom and Blackwell should be dismissed inasmuch as the only relief requested is injunctive and declaratory relief; these plaintiffs are no longer in prison; and none of the incarcerated plaintiffs is housed at Racine Correctional Institution; and 3) plaintiffs cannot prevail on their equal protection claim because the Inmate Sex Change Prevention Act is rationally related to DOC's legitimate penological goals of safety and security.[41]

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[39] Defendants dispute the statement that Dr. Claiborn "disclaimed any opinion about the validity of any particular plaintiffs ... need for treatment." (DRPFOF ¶ 43.)

[40] Defendants do not dispute, for the purposes of summary judgment only. (DRPFOF ¶ 45.)

[41] In their brief-in-chief, the defendants also argued that summary judgment was proper on plaintiff Moaton's as-applied challenge to the Inmate Sex Change Prevention Act because no admissible expert testimony supported that hormone therapy was medically necessary to treat plaintiff Moaton's gender identity disorder. However, subsequently plaintiff Moaton agreed to waive the Fifth Amendment privilege and answer questions concerning prior use (and possible withdrawal) of hormone therapy, along with prior feminizing procedures that had been done. Given this stipulation, the defendants withdrew their motion for summary judgment on plaintiff Moaton's as-applied challenge to Wis. Stat. § 302.286(5m). (Defs.' Reply Br. at 1.)

In response, plaintiffs first contend that there are disputed facts material to whether Act 105 is facially unconstitutional. They argue that Act 105 applies only when it bars doctors from prescribing medically necessary health care, and that it categorically prevents DOC medical providers from exercising their medical judgment to provide medically necessary treatment. Second, plaintiffs contend that plaintiffs Sundstrom and Blackwell's claims for declaratory injunctive relief are not moot. Third, plaintiffs submit that there is a genuine dispute of fact whether Act 105 violates the Equal Protection Clause of the Fourteenth Amendment, and that their evidence shows that Act 105 intentionally discriminates between similarly situated classes. Also, plaintiffs assert their evidence shows that Act 105 cannot withstand the constitutionally-mandated level of scrutiny because it is not justified by defendants' interest in maintaining prison security. Specifically, plaintiffs argue that their evidence shows that Act 105 does not rationally further defendants' interest in maintaining prison security; that their evidence shows that prisoners have no alternative means of accessing the medical treatment at issue; that their evidence shows that accessing hormones and surgery has no significant impact on prison guards or other prisoners, or the allocation of prison resources; and that their evidence shows that Act 105 is an exaggerated response to defendants' prison security concern.

1. Facial Challenge to the Inmate Sex Change Prevention Act

The defendants contend that plaintiffs' facial challenge to the Act cannot succeed because the Act is not unconstitutional in all applications. According to the defendants, the Act does not apply to all inmates, because not all inmates have gender issues. For those inmates who do not have a medical need for those procedures because

they do not have gender issues, the Act does not run afoul of the Eighth Amendment. The defendants assert:

> Clearly, the Act is not unconstitutional in all applications. In fact, the plaintiffs have, at best, only presented evidence that of the over 20,000 inmates it covers, the Act may only run afoul of the constitution as it applies to seven (7) individual inmates' need for hormones, . . . (2) two of which [sic] the Act no longer effects . . .

(Defs. Br. in Support of Mot. for Summ. J. at 9) (internal citations omitted).

The plaintiffs contend that disputed facts material to whether the Act is facially unconstitutional preclude granting summary judgment on the facial challenge. According to the plaintiffs, the Act "applies" only when it bars doctors from prescribing medically necessary health care; it does not "apply" to all DOC inmates.

> Supreme Court precedent makes clear that only the *relevant* applications are to be considered, rejecting states' attempts to defend legislation by pointing to the fact that some members of the general public remain unaffected. The Act is unconstitutional in all of its applications because the Act applies only where it makes a difference by actually preventing a DOC doctor from following her own medical judgment and providing medically necessary care. All of those applications violate the Eighth Amendment and the Equal Protection Clause.

(Pls.' Resp. Br. at 6-7.) The plaintiffs offer that there is a dispute over whether the medical care prohibited by the Act is necessary to meet a serious medical need.

In reply, the defendants assert that assuming, *arguendo*, the appropriate class is limited to those inmates who desire hormone therapy and/or sexual reassignment surgery and whose physicians would otherwise prescribe those treatments, plaintiffs cannot show that there is no set of circumstances under which the Act could be applied constitutionally.

> Thus, even for inmates who are diagnosed with GID, and even for those whose physician might otherwise prescribe

> hormonal and surgical procedures as treatment for their GID, there is no violation for Eighth Amendment purposes where prison policy or statute forbids those treatments, as long as the physician evaluates serious medical needs and prescribes an alternate treatment to address the inmate's symptoms.
>
> Here, the plaintiffs could prevail on their facial challenge only if they showed that, for every inmate seeking hormone therapy or surgery, only those treatments – not the myriad of treatments that remain available to inmates – could provide even palliative care. The case law forecloses that claim, and the plaintiffs do not even assert it.

(Defs.' Reply Br. at 3.)

The plaintiffs filed a surreply[42] in which they contend that defendants' argument that the Act has constitutional applications "is simply incorrect as a matter of law." (Pls.' Surreply at 2.) Plaintiffs go on state:

> Plaintiffs have never claimed that they are entitled to hormone therapy or SRS because they "desire" or "choose" it. Nor do they claim it because an outside medical expert believes that the treatment is medically necessary. Instead, they claim that they have a right to the medically necessary care to treat their serious GID, *as determined by DOC health care professionals* in the exercise of their medical judgment. The problem with Act 105 is that it deprives Plaintiffs of medical care that *DOC medical personnel* believe is medically necessary for them. In the case of all of the current Plaintiffs, the undisputed medical judgment of their DOC care providers is that hormone therapy is medically necessary treatment. Defendants' medical personnel will decide that hormone therapy and possibly even surgery in some rare cases are medically necessary for inmates in the future, but Act 105 will impermissibly prevent them from providing it. Each such instance constitutes an application of Act 105.
>
> ...

[42] On September 27, 2007, the plaintiffs filed Plaintiffs' Motion for Leave to File Surreply Brief in Opposition to Defendants' Motion for Summary Judgment. They seek leave to file a surreply addressing arguments raised for the first time in the defendants' reply. Plaintiffs' motion, which is unopposed, will be granted.

> Defendants also argue for the first time that, as long as they provide *some* treatment for prisoners' GID, they have satisfied the Eighth Amendment, even if they do not provide the hormone therapy or SRS that DOC medical staff have prescribed as medically necessary. Reply Br. at 3. This is simply a misstatement of law. If a treatment is necessary to treat a medical condition, a defendant cannot escape Eighth Amendment liability by providing plainly ineffective alternative treatments. *See, e.g., Edwards*, 478 F.3d at 831 (7th Cir. 2007) ("a plaintiff's receipt of *some* medical care does not automatically defeat a claim of deliberate indifference," if fact-finder could determine treatment was "blatantly inappropriate"); *Kelley v. McGinnis*, 899 F.2d 612, 616 (7th Cir. 1990); *Ortiz v. City of Imperial*, 884 F.2d 1312, 1314 (9th Cir. 1989) (Eighth Amendment plaintiff need not prove a "complete failure to treat"); *Harrison v. Barkely*, 219 F.3d 132, 138 (2d Cir. 2000) ("Even if prison officials give inmates access to treatment, they may still be deliberately indifferent to inmates' needs if they fail to provide prescribed treatment"). Again, if some hypothetical prisoners with GID could be effectively treated, in the medical judgment of DOC medical staff, without hormone therapy or SRS (perhaps with psychotherapy alone), the Act would not "apply" to them, because it imposes no restriction on their right to treatment for a serious medical need. However, for Plaintiffs, and for other prisoners for whom hormone therapy and surgery would be prescribed as medically necessary but for Act 105, the Act is unconstitutional in all of its applications.

(Surreply at 2, 4.)

Wisconsin Statute § 302.386 provides in relevant part:

(5m)(a) In this subsection:

> 1. "Hormonal therapy" means 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.
> 2. "Sexual reassignment surgery" means surgical procedures to alter a person's physical appearance so that the person appears more like the opposite gender.
> (b) The department may not authorize the payment of any funds or the use of any resources of this state or the payment of any federal funds passing through the state treasury to provide or to facilitate the provision of hormonal therapy or sexual

> reassignment surgery for a resident or patient specified in sub. (1).

Wis. Stat. § 302.386(5m).

"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 Penn. v. Casey*, 505 U.S. 833 (1992), the Court described the appropriate class for the purpose of determining the validity of an abortion statute:

> Respondents attempt to avoid the conclusion that § 3209 is invalid by pointing out that it imposes almost no burden at all for the vast majority of women seeking abortions. They begin by noting that only about 20 percent of the women who obtain abortions are married. They then note that of these women about 95 percent notify their husbands of their own volition. Thus, respondents argue, the effects of § 3209 are felt by only one percent of the women who obtain abortions. Respondents argue that since some of these women will be able to notify their husbands without adverse consequences or will qualify for one of the exceptions, the statute affects fewer than one percent of women seeking abortions. For this reason, it is asserted, that statute cannot be invalid on its face. See Brief for Respondents 83-86. We disagree with respondents' basic method of analysis.
>
> The analysis does not end with the one percent of women upon whom the statute operates; it begins there. Legislation is measured for consistency with the Constitution by its impact on those whose conduct it affects. For example, we would not 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 894-895; *see also Gonzales v. Carhart*, 127 S. Ct. 1610, 1639 (2007) (holding that 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").

The case law indicates that the controlling class is determined by whom the Act applies to. In this case, the Act applies when it bars doctors from prescribing health care that they have determined to be medically necessary. Thus, according to plaintiffs, the Act is unconstitutional in all applications. However, defendants contend that the Act is not unconstitutional in all instances because DOC doctors could prescribe some other form of treatment. Under these circumstances, according to the defendants, an inmate would be receiving "some treatment" and thus there would be no Eighth Amendment violation.

To establish liability under the Eighth Amendment, a prisoner must show: (1) that his or her medical need was objectively serious; and (2) that the 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 in 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, 474 (7th Cir. 1998). Neither negligence nor even gross negligence is a sufficient basis for liability. *See Salazar v. City of Chi.*, 940 F.2d 233, 238 (7th Cir. 1991). A finding of deliberate indifference requires evidence

"that the official was aware of the risk and consciously disregarded it nonetheless." *Chapman v. Keltner*, 241 F.3d 842, 845 (7th Cir. 2001) (citing *Farmer*, 511 U.S. at 840-42).

Mere differences of opinion among medical personnel regarding a plaintiff's appropriate treatment do not give rise to deliberate indifference. *Estate of Cole by Pardue v. Fromm*, 94 F.3d 254, 261 (7th Cir. 1996). However, deliberate indifference may be inferred "when the medical professional's decision is such a substantial departure from accepted professional judgment, practice, or standards as to demonstrate that the person responsible did not base the decision on such a judgment." *Id.*; *see also Steele v. Choi*, 82 F.3d 175, 179 (7th Cir. 1996) (citing as examples "the leg is broken, so it must be set; the person is not breathing, so CPR must be administered").

"[T]o prevail on an Eighth Amendment claim 'a prisoner is not required to show that he was literally ignored.'" *Greeno v. Daley*, 414 F.3d 645, 653-54 (7th Cir. 2005) (quoting *Sherrod v. Lingle*, 223 F.3d 605, 611 (7th Cir. 2000)). A defendant's contention that a medical care claim fails because the prisoner "received some treatment overlooks the possibility that the treatment [the prisoner] did receive was 'so blatantly inappropriate as to evidence intentional mistreatment likely to seriously aggravate' his condition." *Greeno*, 414 F.3d at 654 (quoting *Snipes v. DeTella*, 95 F.3d 586, 592 (7th Cir. 1996) (internal quotations omitted)).

In this case, DOC doctors have determined that hormone therapy is medically necessary to treat the plaintiffs' GID. However, the parties disagree whether the medical treatments proscribed by the Act, hormone therapy and sex reassignment surgery, are ever medically necessary treatments for inmates with GID. If such treatments are medically necessary when doctors say that they are, and if prisoners do not receive the medically

necessary treatment because of the Act, plaintiffs argue that the denial would violate the Eighth Amendment.

The parties agree that there are a variety of therapeutic options for persons with GID. (DFOF ¶ 13.) However, as plaintiffs point out (and as defendants dispute), that does not mean that the treatments proscribed by the Act are not medically necessary for some individuals with GID. Interfering with a doctor's determination of "medical necessity" is serious; it may qualify as treatment "'so blatantly inappropriate as to evidence intentional mistreatment likely to seriously aggravate' his condition." *Greeno*, 414 F.3d at 654 (citation omitted). At this stage, the court cannot conclude that the Act is not invalid on its face. Thus, the defendants' motion for summary judgment as to this issue will be denied.

2. Plaintiffs Kari Sundstrom and Lindsey Blackwell

The defendants contend that plaintiffs Sundstrom and Blackwell should be dismissed because the only relief is injunctive and declaratory relief and because they are no longer in prison. Moreover, the defendants maintain that because plaintiff Blackwell was the only plaintiff in this suit residing at Racine Correctional Institution, defendants Humphreys and Nygren should be dismissed from this case.

The plaintiffs do not oppose the dismissal of defendants Humphreys and Nygren, but reserve the right to seek amendment of the pleadings should a plaintiff be assigned to Racine Correctional Institution prior to judgment. Regardless, the plaintiffs assert that plaintiffs Sundstrom and Blackwell's claims for declaratory and injunctive relief are not moot because there is a reasonable likelihood that one or both of them might return to prison.

To invoke Article III jurisdiction, a plaintiff seeking injunctive relief must show immediate, personal danger of sustaining direct injury. *City of Los Angeles v. Lyons*, 461 U.S. 95, 105 (1983). In *Knox v. McGinnis*, 998 F.2d 1405, 1413-15 (7th Cir. 1993), the court held that a prisoner lacked standing to seek injunctive relief against the future use of a "black box" on prisoners in segregation because he had been released from segregation and had returned to the general prison population where he was no longer subjected to the use of the "black box." In reaching its decision, the court relied upon *City of Los Angeles v. Lyons*, 461 U.S. 95 (1983) and *O'Shea v. Littleton*, 414 U.S. 488 (1974).

In *Lyons*, the plaintiff sued the City of Los Angeles and several police officers, alleging that the officers stopped him for a routine traffic violation and applied a choke hold without provocation. The plaintiff sought an injunction against future use of the choke hold unless the suspect threatened deadly force. The Supreme Court held that the plaintiff lacked standing to seek injunctive relief because he could not show a real or immediate threat of future harm. *Lyons*, 461 U.S. at 105. The Court relied upon its earlier decision in *O'Shea* in which it stated that "[p]ast exposure to illegal conduct does not in itself show a present case or controversy regarding injunctive relief...if unaccompanied by any continuing, present adverse effects." *O'Shea*, 414 U.S. at 495-96. In *O'Shea*, the plaintiffs had alleged discriminatory enforcement of criminal laws. The Court held that there was no case and controversy because "the threat to plaintiffs was not 'sufficiently real and immediate.'" *Id.* at 496-497. Similarly, in *Lyons*, the Court found that, although an allegation of an earlier choking was sufficient to confer standing for a damage claim, it did "nothing to establish a real and immediate threat" that the plaintiff would again be stopped for a traffic violation and a choke hold put on him. *Lyons*, 461 U.S. at 105.

In the instant case, plaintiffs Sundstrom and Blackwell cannot establish a real and immediate threat that they again will be incarcerated in a DOC institution. The mere possibility that plaintiffs Sundstrom and Blackwell may again be incarcerated in a DOC institution is too speculative and does not establish a real and immediate case or controversy. *Knox*, 998 F.2d at 1413-14; *see also Robinson v. City of Chi.*, 868 F.2d 959 (7th Cir. 1989). In light of the foregoing, plaintiffs Sundstrom and Blackwell lack standing to pursue their claims for injunctive relief. Therefore, they will be dismissed from this action. Defendants Humphreys and Nygren will be dismissed as well.

3. Equal Protection Claim

The defendants contend that the Act is rationally related to DOC's legitimate penological goals of safety and security and that they are entitled to summary judgment dismissing the plaintiffs' equal protection claim. According to the defendants, "[i]t is undisputed that denial of hormone therapy and sex reassignment surgeries is rationally related to prison safety and security." (Defs. Br. in Support of Mot. for Summ. J. at 16.)

> In this case, it is undisputed that limiting prisoners' access to hormone therapy and sexual reassignment surgery makes them less effeminate, and as a result, less likely that they will be victimized by other inmates. DOC has an undisputable security interest in preventing these types of assaults. As this is a 'conceivable state of facts' that provides a rational basis for state action, the defendants are entitled to summary judgment on plaintiffs' equal protection claim.

Id. at 17.

Plaintiffs counter that there is a genuine dispute of fact whether the Act violates the Equal Protection Clause. According to the plaintiffs, their evidence shows that the Act intentionally discriminates between similarly situated classes. In addition, plaintiffs contend

that their evidence shows that the Act cannot withstand the constitutionally-mandated level of scrutiny. Plaintiffs point to the standard of review set forth in *Turner v. Safley*, 482 U.S. 78 (1987), and conclude that "[b]ecause Plaintiffs' evidence shows that Act 105 cannot withstand the *Turner* standard, there are genuine disputes of material fact that preclude summary judgment on plaintiffs' equal protection claim." (Pls.' Resp. at 20.) Plaintiffs assert that their evidence shows that Act 105 is not justified by defendants' interest in maintaining prison security because it is not reasonably related to it. Furthermore, plaintiffs contend that Act 105 cannot withstand even rational basis review.

Recently, the Seventh Circuit Court of Appeals reiterated the standard to be applied in equal protection cases where no fundamental right or suspect classification is at issue.

> The purpose of the Equal Protection Clause of the Fourteenth Amendment is to "secure every person within the State's jurisdiction against intentional and arbitrary discrimination, whether occasioned by express terms of a statute or by its improper execution through duly constituted agents." *Vill of Willowbrok v. Olech*, 528 U.S. 562, 564, 120 S. Ct. 1073, 145 L. Ed. 2d 1060 (2000) (per curiam) (quoting *Sioux City Bridge Co. v. Dakota County, Neb.*, 260 U.S. 441, 445, 43 S. Ct. 190, 67 L. Ed. 340 (1923)); *Martin v. Shawano-Gresham Sch. Dist.*, 295 F.3d 701, 713-14 (7th Cir. 2002). Where (as here) no fundamental right or suspect classification is at issue, equal protection claims are evaluated under the rational-basis standard of review. *Discovery House, Inc. v. Consol. City of Indianapolis*, 319 F.3d 277, 282 (7th Cir. 2003); *Martin*, 295 F.3d at 712; *Hilton v. City of Wheeling*, 209 F.3d 1005, 1007-08 (7th Cir. 2000). To prevail, a plaintiff must prove the following: (1) the defendant intentionally treated him differently from others similarly situated, (2) the defendant intentionally treated him differently because of his membership in the class to which he belonged, and (3) the difference in treatment was not rationally related to a legitimate state interest. *Schroeder v. Hamilton Sch. Dist.*, 282 F.3d 946, 950-51 (7th Cir. 2002); *Discovery House*, 319 F.3d at 282.

Smith v. City of Chi., 457 F.3d 643, 650-51 (7th Cir. 2006). Thus, the court applies rational basis review to plaintiffs' equal protection claim.

The defendants argue that Act 105 is rationally related to the legitimate penological interests of safety and security. *See FCC v. Beach Communications, Inc.*, 508 U.S. 307, 313 (1993) (Under rational basis review, there is no constitutional violation if "any reasonably conceivable state of facts" would provide a rational basis for government action).

> It is undisputed that denial of hormonal therapy and sex reassignment surgeries is rationally related to prison safety and security. Even Plaintiffs' prison security expert, Walter L. Kautzky, acknowledged that "Gender Identity Disorder and the presentation of effeminate characteristics create challenges in a prison system" (DFOF ¶ 27), and there is no question that the intent of hormone therapy and sexual reassignment surgery is to increase the presentation of feminine characteristics. See, Wis. Stat. § 302.386(5m)(a)(1). Kautzky also concedes that inmates who display effeminate characteristics are viewed as sexually available, which increases the possibility that the prisoner may be sexually assaulted by other prisoners (DFOF ¶ 28). There is no dispute that male inmates who appear more feminine are at an increased risk of victimization (DFOF ¶ 30). According to Kautzky, inmates presenting themselves as highly effeminate in a male prison present additional security concerns (DFOF ¶ 29). Kautzky also agrees that institutions should not create conditions that would make inmates more vulnerable to assault. (DFOF ¶ 31).
>
> Plaintiff Matthew Davison, unfortunately, has first-hand knowledge of the effects his hormone therapy has upon his safety in prison. Davison was both raped and molested while in prison, and is constantly harassed by other inmates. (DFOF ¶¶ 32, 33). Davison agrees that he is more of a target for this type of aggression by other male inmates because of the physical effects his body has seen on hormone therapy. (DFOF ¶ 32).
>
> The crux of Kautzky's report is an attempt to mitigate the difficulty posed by inmates who use hormones to increase their femininity by comparing them to other inmates who pose difficulties, such as inmate who have HIV or are mentally ill. However, the fact that other inmates pose security difficulties in

> the prison has no bearing on whether the legislature had a rational basis for passing Wis. Stat. § 302.386(5m). The legislature need not "strike at all evils at the same time or in the same way." *Sutker v. Illinois State Dental Soc.*, 808 F.2d 632, 635 (7th Cir. 1986) (citing *Semler v. Oregon State Board of Dental Examiners*, 294 U.S. 608, 610 (1935)). It is sufficient that there is a problem "at hand for correction, and that it might be thought that the particular legislative measure was a rational way to correct it." *Williamson v. Lee Optical, Inc.*, 348 U.S. 483, 487-88 (1955). In this case, it is undisputed that limiting prisoners' access to hormone therapy and sexual reassignment surgery makes them less effeminate, and as a result, less likely that they will be victimized by other inmates. DOC has an undisputable security interest in preventing these types of assaults. As this is a "conceivable state of facts" that provides a rational basis for state action, the defendants are entitled to summary judgment on plaintiff's equal protection claim.

(Defs.' Br. in Support of Mot. for Summ. J. at 16-17.)

There is no dispute that prison safety and security are legitimate penological interests. *See Overton v. Bazzetta*, 539 U.S. 126, 133 (1993) (describing "internal security" as "perhaps the most legitimate of penological goals). However, according to the plaintiffs, their evidence shows that Act 105 does not rationally further defendants' interest in maintaining prison security.

> Even if transsexual prisoners who present femininely are at risk of assault at the hands of male prisoners, Plaintiffs' evidence shows that denying the medical treatment at issue does not rationally further Defendants' interest in mitigating the risk of assault. By definition, male-to-female transsexuals experience a persistent discomfort with their assigned male sex and a strong female gender identity. (PFOF ¶¶ 2-4.) To alleviate the psychological distress or impairment caused by their GID, many such individuals whose gender identity is female express it through their appearance, mannerism, name and pronoun choices, or by otherwise identifying and expressing themselves as women. (PFOF ¶ 6.) Significantly, many seek to do so even absent surgery or hormone therapy. (PFOF ¶ ¶ 6, 18.) Thus, even without the medical treatments at issue, many male-to-female transsexual prisoners will still identify or present

> themselves femininely, and therefore will still be at risk of assault at the hands of male prisoners. Defendants' mischaracterization of Plaintiffs' expert's testimony does not change the analysis. The relevant inquiry is not whether transsexual prisoners who present femininely are at risk of assault, but rather whether denying hormones or surgery mitigates any such risk. Because denying Plaintiffs hormones or surgery does not reduce any risk of assault, it does not rationally further Defendants' interest in mitigating the risk of assault.

(Pls.' Resp. at 22.)

Based on the foregoing, the court finds that there is a genuine dispute of material fact concerning whether Act 105 is rationally related to prison safety and security. Thus, defendants' motion for summary judgment on plaintiffs' equal protection claim will be denied.

Now, therefore,

IT IS ORDERED that the defendants' motion for partial summary judgment (Doc. #120) is **GRANTED IN PART AND DENIED IN PART** as described herein.

IT IS FURTHER ORDERED that defendants Robert Humphrey and Susan Nygren are **DISMISSED**.

IT IS FURTHER ORDERED that plaintiffs' motion for leave to file surreply brief (Doc. #163) is **GRANTED**.

IT IS FURTHER ORDERED that plaintiffs' motion for leave to file surreply brief (Doc. #163) is **GRANTED**.

Dated at Milwaukee, Wisconsin, this 15th day of October, 2007.

BY THE COURT

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