No. 14-1120

IN THE

Supreme Court of the United States

MICHELLE KOSILEK,

Petitioner,

v.

CAROL HIGGINS O'BRIEN, COMMISSIONER OF THE MASSACHUSETTS DEPARTMENT OF CORRECTION,

Respondent.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIRST CIRCUIT

BRIEF FOR THE WORLD PROFESSIONAL ASSOCIATION FOR TRANSGENDER HEALTH AS AMICUS CURIAE IN SUPPORT OF PETITIONER

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INTEREST OF AMICUS CURIAE[1]

The World Professional Association for Transgender Health (WPATH), formerly known as the Harry Benjamin International Gender Dysphoria Association, is an international professional association with membership consisting of more than 600 physicians, psychologists, social scientists, and legal professionals dedicated to the treatment of gender identity disorders. WPATH develops and publishes the Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People (Standards of Care), recognized in the medical community as the authoritative standards for the provision of transgender health care. The Standards of Care are informed by current consensus in medical research and clinical practice, and provide treatment protocols specific to the nature and severity of a patient's disorder. Since issuing the first version of the Standards of Care in 1979, WPATH has continued to update the Standards of Care; the most recent version was released in 2011.

As an organization committed to the practice of evidence-based medicine, WPATH has a strong interest in protecting the central role of professional consensus in determining the weight to be given to expert evidence, especially where a party proffers the testimony of an expert who avowedly departs from the established consensus of competent and prudent professionals. That role is undermined by the First Circuit's decision to credit a dissenting expert over well-established

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[1] No counsel for a party authored this brief in whole or in part, and no party or its counsel made a monetary contribution intended to fund the preparation or submission of this brief. Letters from all parties consenting to the filing of this amicus curiae brief have been filed with the Court.

professional standards and factual findings by the district court concerning the appropriate treatment for severe gender dysphoria.

INTRODUCTION AND SUMMARY OF ARGUMENT

There is an established professional consensus in the medical and mental-health communities concerning the medical, psychiatric, psychological, and surgical management of gender dysphoria. One aspect of that consensus is that in appropriate cases, sex reassignment surgery (SRS) is medically necessary. Given the nature of gender dysphoria as a clinical diagnosis, there are dissenting views about the appropriate course of treatment and the necessity of SRS. But those views, like dissenting views concerning any medical treatment, do not reflect the best scientific knowledge and accordingly do not form the basis for the standards of care and ethical guidelines followed by prudent practitioners in the field.

Seven clinicians—several hired by respondent Massachusetts Department of Corrections (MDOC)—diagnosed petitioner Michelle Kosilek with severe gender dysphoria. Consistent with the established treatment protocols, Kosilek first received psychotherapy, access to feminizing treatments (*e.g.*, women's clothing, electrolysis), and hormone therapy. When it became apparent that those approaches were insufficient to treat her symptoms, the clinicians concluded—again consistent with established treatment protocols—that SRS was medically necessary. MDOC found no treating clinicians to support its refusal to provide Kosilek with SRS. Rather, for trial purposes, MDOC enlisted the testimony of Cynthia Osborne, a social worker sympathetic to MDOC's position, and Chester Schmidt, a psychiatrist avowedly opposed to SRS, who "did not

recall ever seeing a case where he thought surgery was medically necessary." Pet. App. 138a.

After carefully evaluating the evidence, including observing testimony from those clinicians, the district court concluded that SRS was the only adequate treatment for Kosilek's gender dysphoria. Consistent with the testimony of both MDOC clinicians and an independent expert appointed by the court, the district court concluded that Dr. Schmidt's recommendation was not supported by prudent professional standards and would not provide adequate treatment for Kosilek. Pet. App. 308a-311a. Accordingly, the district court entered an injunction requiring MDOC to provide Kosilek with SRS.

On appeal, a panel of the First Circuit upheld the district court's conclusion that SRS is the only adequate treatment for Kosilek as supported by ample evidence—namely, the testimony of at least three qualified doctors supported by widely accepted, published standards. Pet. App. 169a-171a. The panel further found that MDOC's dissenting expert Dr. Schmidt repudiated the established medical consensus concerning treatment for gender dysphoria; his views were "not only unsupported by the Standards of Care but also contradicted by the testimony of the other medical providers at trial." *Id.* at 173a-174a. The panel accordingly concluded that the district court acted well within its discretion in crediting the otherwise unanimous testimony given by other MDOC and court-appointed expert clinicians.

By a vote of three to two, the en banc court reversed the district court's order. Departing from the deferential approach the panel had taken, a majority of the en banc court rejected the district court's findings

and concluded that MDOC had simply made a choice between two acceptable medical alternatives, "both of which are reasonably commensurate with the medical standards of prudent professionals, and both of which provide Kosilek with a significant measure of relief." Pet. App. 53a.

The en banc majority ordered judgment for MDOC because MDOC's refusal to allow SRS for Kosilek was supported by a minority view about the appropriateness of SRS as a medical treatment for severe gender dysphoria—even though that dissenting view contradicts the established medical consensus and was rejected by the district court as an outlier in medical opinion. In so ruling, the court of appeals departed from accepted principles for evaluating the propriety of medical evidence. Its decision undermines the critical role that medical and other scientific consensus plays in numerous areas of this Court's jurisprudence.

Moreover, as the two dissenting judges explained, the en banc majority's decision effectively frees governments within its jurisdiction from even considering SRS as the proper treatment for incarcerated individuals. That result is deeply at odds with a fundamental precept of medical and mental-health practice—that treatment decisions must be made on an individualized, case-by-case basis. This Court should grant Kosilek's petition to address the appropriate deference to be afforded to decisions based on medical and scientific consensus, consistent with this Court's precedent concerning the applicable standard of review, and reverse the en banc majority's erroneous ruling.

ARGUMENT

I. THE COURT OF APPEALS' DECISION UNDERMINES THE CRITICAL ROLE THAT SCIENTIFIC AND MEDICAL CONSENSUS PLAYS IN CIVIL LITIGATION

Scientific and medical evidence plays an increasingly important role in cases before the federal courts. Because generalist judges and lay juries are often ill-equipped to distinguish sound scientific reasoning from fringe, unsupported, or outdated conclusions, *General Elec. Co.* v. *Joiner*, 522 U.S. 136, 153 (1997) (Stevens, J., concurring), the courts necessarily rely on the established views of the relevant professional community to assist them in evaluating scientific and medical evidence. In most cases, professional consensus provides an objective anchor for the court's decisions and a reliable benchmark against which factfinders can judge the merits of competing views.

The district court, appropriately relying on an established medical consensus about the proper treatment options for gender dysphoria, declined to credit the position of MDOC's litigation expert in view of his avowed departure from that consensus and his definitive rejection of SRS as the appropriate course of treatment in any case. Pet App. 311a; *see also id.* at 138a (Dr. Schmidt "did not recall ever seeing a case where he thought [SRS] was medically necessary."). The en banc majority's decision to reverse the district court's determination about the proper course of treatment and to rely *solely* on that outlier testimony to rule in MDOC's favor in this case is contrary not only to the ordinary deference afforded a district court's evaluation of expert testimony (*see* Pet. 15-21), but also the critically important role that medical consensus

plays in evaluating the credibility, reliability, and weight accorded to expert testimony.

Where, as here, the factfinder hears expert testimony on a disputed question of scientific or medical fact and determines that a dissenting view ought not be credited in the face of an established medical consensus to the contrary, that finding cannot be disturbed without a compelling and credible scientific basis for deviating from the accepted norm. This rule is particularly important in cases like this one, arising in the Eighth Amendment context, where the government could evade its constitutional obligations by relying on advantageous scientific or medical testimony that runs counter to prudent professional standards—and particularly where that testimony is offered precisely *because* it departs from the established scientific or medical consensus.

A. Professional Consensus Plays A Central Role In Cases Involving Scientific And Medical-Based Claims

1. Courts rely on professional consensus to assess the reliability of scientific evidence

Professional consensus evidence such as WPATH's Standards of Care or the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM) place particular emphasis on ensuring scientific reliability. Professional medical and mental-health organizations like WPATH go through a lengthy, rigorous process to arrive at professional consensus documents relied on by health professionals in treatment. WPATH's process for developing and revising its Standards of Care is illustrative. The latest version of WPATH's Standards of Care, Version 7, was

officially released in 2011 but the revision process commenced five years earlier, in 2006, with the establishment of a "work group." Standards of Care 109. The work group examined each section of Version 6 of the Standards of Care, reviewed existing literature, and recommended further research. *Id.* Over the next number of years, invited papers were written, subjected to peer review, and published for public comment in the *International Journal of Transgenderism*. *Id.* In 2010, a diverse group of dozens of experts and clinicians formed a Revision Committee that debated the background papers, and a subset of that committee created the first draft of Version 7 in consultation with the full committee and with an International Advisory Group of transsexual, transgender, and gender-nonconforming individuals, culminating in a two-day face-to-face expert consultation meeting in 2011. *Id.* at 109-110. Finally, after further debate and review, WPATH's Board of Directors approved the revision in September 2011. *Id.* at 110.

This rigorous and exhaustive process enables "evidence-based care" "based on the best available science and expert professional consensus." Standards of Care 1. It also assists courts in examining issues related to gender-nonconforming individuals, as demonstrated by the fact that numerous courts have relied on the Standards of Care as "the generally accepted protocols for the treatment of" gender dysphoria. *See De'lonta* v. *Johnson*, 708 F.3d 520, 522-523 (4th Cir. 2013); *see also*, *e.g.*, *Norsworthy* v. *Beard*, 2015 WL 1500971, at *15 (N.D. Cal. Apr. 2, 2015); *Soneeya* v. *Spencer*, 851 F. Supp. 2d 228, 231 (D. Mass. 2012); *O'Donnabhain* v. *Commissioner*, 134 T.C. 34, 37 (2010).

Other professional organizations likewise engage in comprehensive processes to create consensus docu-

ments authoritative in the relevant field. For example, the American Psychiatric Association publishes and periodically updates its *Diagnostic and Statistical Manual of Mental Disorders* (DSM), "the handbook used by health care professionals in the United States and much of the world as the authoritative guide to the diagnosis of mental disorders," currently in its fifth iteration.[2] The development and revision process for the Fifth Edition of the DSM spanned fourteen years and involved multiple phases including extensive research and literature review, field trials, data analysis, and drafting among work groups in consultation with leadership.[3] The DSM represents the consensus of expert opinion across the relevant fields, and has been relied on by this Court and others as "one of the basic texts used by psychiatrists and other experts." *Hall* v. *Florida*, 134 S. Ct. 1986, 1990 (2014); *see also*, *e.g.*, *United States* v. *Wooden*, 693 F.3d 440, 452 n.4 (4th Cir. 2012) (DSM is "'the authoritative reference used in diagnosing mental disorders'"); *Young* v. *Murphy*, 615 F.3d 59, 61 n.1 (1st Cir. 2010) (same). The DSM recognizes gender dysphoria as a diagnosis and contemplates the necessity of SRS in certain cases. American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* 451-458 (5th ed. 2013).

Professional consensus evidence such as WPATH's Standards of Care and the DSM also play an important role in ensuring the scientific validity of expert testimony. Under Federal Rule of Evidence 702, expert

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[2] *Frequently Asked Questions*, American Psychiatric Association DSM-5 Development, http://www.dsm5.org/about/Pages/faq.aspx.

[3] *Timeline*, American Psychiatric Association DSM-5 Development, http://www.dsm5.org/about/Pages/Timeline.aspx.

testimony is restricted to "scientific knowledge" that will assist the fact finder in determining a fact in issue. Fed. R. Evid. 702. As this Court has explained—including in the seminal cases of *Daubert* v. *Merrell Dow Pharmaceuticals*, 509 U.S. 579 (1993), and *Kumho Tire Co.* v. *Carmichael, Inc.*, 526 U.S. 137 (1999)—what constitutes admissible "knowledge" is thoroughly grounded in principles of professional consensus.[4] For example "whether the theory or technique has been subjected to peer review and publication" and whether there are "standards controlling the technique's operation" are important considerations under *Daubert*'s evaluative framework. 509 U.S. at 593-594.

2. This Court relies on professional consensus in multiple areas of law, including in the Eighth Amendment context

This Court refers to professional consensus to guide its decision-making in a broad range of cases in which it must evaluate scientific or medical evidence—including the Eighth Amendment.

For example, in *Atkins* v. *Virginia*, this Court referred to the professional consensus of mental-health experts in concluding that the Eighth Amendment prohibits the execution of certain intellectually disabled persons, and relied on clinical definitions of intellectual disability and established research on such individuals' ability to process information and understand the consequences of their actions. 536 U.S. 304, 318 (2002). The Court reached a similar conclusion with respect to

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[4] Even before *Daubert*, professional consensus was the hallmark of admissible expert evidence. *See Frye* v. *United States*, 293 F. 1013, 1014 (D.C. Cir. 1923) (establishing "general acceptance" test for expert evidence).

juveniles in *Roper* v. *Simmons*, relying on established scientific and sociological studies about minors' underdeveloped sense of responsibility, propensity to reckless behavior, and susceptibility to peer pressure to conclude that the Eighth Amendment prohibits the execution of minors. 543 U.S. 551, 570-517, 573 (2005); *see also Baze* v. *Rees*, 553 U.S. 35, 67-69 (2008) (Alito, J., concurring) ("[A]n inmate challenging a method of execution should point to a well-established scientific consensus. Only if a State refused to change its method in the face of such evidence would the State's conduct be comparable to circumstances that the Court has previously held to be in violation of the Eighth Amendment."); *Indiana* v. *Edwards*, 554 U.S. 164, 176 (2008) (relying on the American Psychiatric Association's undisputed position to hold that a defendant may have the capacity to stand trial, but not to represent himself).[5]

Most recently, this Court again relied on published professional standards and the prevailing opinions of the relevant medical community in striking down Florida's threshold IQ requirement for death penalty ineligibility in *Hall* v. *Florida*, 134 S. Ct. 1986 (2014). As the Court explained, it is "proper to consider the psychiatric and professional studies that elaborate on the purpose and meaning of IQ scores" and "to consult the medical community's opinions" in determining how intellectual disa-

[5] Whatever misgivings may be had about relying on professional consensus evidence to deduce legislative facts, *see, e.g.*, *Roper*, 543 U.S. at 596 (Scalia, J., dissenting), none of those concerns is implicated here. This case involves purely adjudicative facts—the district court's determination of what constituted medically necessary treatment for Kosilek at a given point in time—and there should be no dispute that deference is due to a district court's determination of such facts, including whether the State's treatment plan is consistent with prudent professional standards.

bility should be measured and evaluated. *Id.* at 1993-1994 (citing APA Amicus Br. and the DSM); *see also id.* at 1995 ("Florida's rule disregards established medical practice.").

This Court has also recognized that where a professional consensus exists, governmental actors must demonstrate compelling bases for disregarding that professional consensus. For example, in *Massachusetts* v. *EPA*, 549 U.S. 497 (2007), the Court rejected the Environmental Protection Agency's refusal to regulate greenhouse gases, finding that the scientific uncertainty regarding climate change was not so "profound" that the EPA was unable to form a "reasoned judgment." *Id.* at 534. "Residual uncertainty" about the effects of climate change—just like the residual uncertainty about the merits of SRS—was insufficient grounds for ignoring an established professional consensus. *Id.* at 507-510, 534 (referring to "unequivocal" study from the National Academy of Sciences and findings of the Intergovernmental Panel on Climate Change).

B. The Factfinder, Not The Appellate Court, Is Best Situated To Determine The Existence Of Expert Consensus

As this Court has repeatedly explained, "'[t]he trial judge's major role is the determination of fact, and with experience in fulfilling that role comes expertise.'" *Brown* v. *Plata*, 131 S. Ct. 1910, 1929 (2011). That observation carries special weight with respect to complex or technical expert evidence. *See, e.g.*, *Graver Tank & Mfg. Co.* v. *Linde Air Prods. Co.*, 339 U.S. 605, 609-610 (1950) (Issues of fact are "to be decided by the trial court and that court's decision, under general principles of appellate review, should not be disturbed unless clearly erroneous. Particularly is this so in a field

where so much depends upon familiarity with specific scientific problems and principles not usually contained in the general storehouse of knowledge and experience."); *see also Teva Pharm. USA, Inc.* v. *Sandoz, Inc.*, 135 S. Ct. 831, 838 (2015) (clear-error review is especially appropriate in a technical context, where a "district court judge who has presided over, and listened to, the entirety of a proceeding has a comparatively greater opportunity to gain that familiarity than an appeals court judge who must read a written transcript or perhaps just those portions to which the parties have referred").

District courts have the opportunity to ask probing questions of experts to understand the bases for their opinions and the consistency of their positions with accepted professional standards. They see those expert witnesses testify live, and so they can better render judgment on the credibility and persuasiveness of the experts' testimony. The district court may also appoint an independent expert under Rule 706 to help resolve contested issues, especially where the independence of the party-sponsored experts is questionable.[6] Fed. R. Evid. 706; *see generally* Cecil & Willging, *Court-Appointed Experts: Defining the Role of Experts Appointed Under Federal Rule of Evidence 706*, at 12-15 (1993) (explaining use of independent experts to aid decision-making).

The district court is thus best situated to make findings of fact based on "reasonable medical judgments given the state of medical knowledge." *School Bd. of Nassau Cnty., Fla.* v. *Arline*, 480 U.S. 273, 287-289 (1987). That is particularly true when the district

[6] The district court appointed such an expert in this case. Pet. App. 24a-25a, 290a-291a.

court is presented with conflicting views as to what position the best medical evidence supports. A district court must make that determination in full view of the evidence concerning prevailing professional standards and the particular expert's fidelity to, or reasons for departing from, those standards. The district court's conclusions in this regard are entitled to due deference. *See, e.g.*, *Brown*, 131 S. Ct. at 1929; *see also Salve Regina Coll.* v. *Russell*, 499 U.S. 225, 233 (1991) (deference "is warranted when it appears that the district court is 'better positioned' than the appellate court to decide the issue in question or that probing appellate scrutiny will not contribute to the clarity of legal doctrine").

Here, the district court oversaw two separate trials in which it heard live testimony from, and weighed the credibility of, numerous experts. The court reasonably credited the testimony reflecting the prevailing professional consensus and rejected a view that was inarguably out of step with the best medical evidence. Whether and to what extent a dissenting scientific or medical view should be credited were questions entrusted to the factfinder, who was best situated to evaluate the reliability, credibility, and scientific basis for that view. The en banc court's decision improperly inserted the appellate court into this process. The court of appeals' decision to credit a medical position that is decidedly in the minority, without explaining why a professional consensus should be disregarded, displaced the proper role of the district court and undermined the important role of professional consensus in ensuring reliable evaluation of medical evidence.

C. Crediting Dissenting Views Is Especially Problematic When Setting Minimum Standards For Constitutional State Action

Professional consensus is particularly important in cases like this one, where minimum standards for constitutional state action are set by reference to medical norms. *See, e.g.*, *Atkins*, 536 U.S. at 318. The court of appeals' decision to credit the dissenting view of a state-sponsored expert obtained for purposes of litigation—against the judgment of multiple other experts and the well-grounded findings of the district court, both of which are supported by professional consensus—seriously undermines the protections of the Eighth Amendment.

The court of appeals' decision effectively allows state officers to escape a claim of deliberate indifference whenever the State can find some expert to justify its withholding of medical care, even if that expert's opinion is far outside the mainstream of established medical opinion. The en banc majority resisted this conclusion, stating in a footnote that its "holding in no way suggests that correctional administrators wishing to avoid treatment need simply to find a single practitioner willing to attest that some well-accepted treatment is not necessary." Pet. App. 53a n.12. Notwithstanding that disclaimer, that is precisely what occurred: The en banc majority based its decision on a single expert, retained for litigation, whose views contradicted those of the medical community and the other six experts in the case. Pet. 10-11, 14; *see also* Pet. App. 109a (Kayatta, J., dissenting) ("[N]o prison may be required to provide SRS to a prisoner who suffers from gender dysphoria as long as a prison official calls up Ms. Osborne or Dr. Schmidt.").

Indeed, the court of appeals' decision licenses a broad array of government decisions to be based on fringe views, to the detriment of the legal system, the medical and scientific community, and the public more generally. *Cf. Bowen* v. *City of New York*, 476 U.S. 467, 475 n.5, 481-482 (1986) (rejecting agency position that "'relied on bureaucratic instructions rather than individual assessments and overruled the medical opinions of its own consulting physicians'"); *id.* at 475 n.5 ("'The resulting supremacy of bureaucracy over professional medical judgments and the flaunting of published, objective standards is contrary to the spirit and letter of the Social Security Act.'").

II. THE COURT OF APPEALS' DECISION EFFECTIVELY FREES STATE CORRECTIONS OFFICIALS TO DENY SEX REASSIGNMENT SURGERY IN ALL CASES, IN CONTRAVENTION OF THE EIGHTH AMENDMENT AND STANDARDS OF MEDICAL CARE

This Court's Eighth Amendment jurisprudence makes clear that medical decisions must be made on the basis of the prisoner's individual condition and medical needs. For example, in *Estelle* v. *Gamble*, 429 U.S. 97 (1976), the Court focused on the prisoner's particular medical condition and whether the state's treatment protocol—bed rest, muscle relaxants, and pain relievers—sufficiently addressed his symptoms to discharge the State's obligations under the Eighth Amendment. *Estelle*, 429 U.S. at 106.

Consistent with this Court's guidance, the courts of appeals have long recognized that the Eighth Amendment requires individualized treatment decisions, and prohibits categorical bars on forms of treatment that are medically indicated. *See Roe* v. *Elyea*, 631 F.3d 843, 859-860 (7th Cir. 2011) (striking down policy barring

antiviral therapy for classes of inmates with Hepatitis C; "inmate medical care decisions must be fact-based with respect to the particular inmate, the severity and stage of his condition, the likelihood and imminence of further harm and the efficacy of available treatments"); *Fields* v. *Smith*, 653 F.3d 550, 555 (7th Cir. 2011) (striking down policy categorically barring certain forms of treatment for inmates with gender dysphoria); *Monmouth Cnty. Corr. Inst. Inmates* v. *Lanzaro*, 834 F.2d 326, 347 & n.32 (3d Cir. 1987) (striking down policy of denying elective abortions because the policy "denie[d] to a class of inmates the type of individualized treatment normally associated with the provision of adequate medical care."); *see also Colwell* v. *Bannister*, 763 F.3d 1060, 1063 (9th Cir. 2014) (holding as a "paradigm of deliberate indifference" a "one eye policy" prohibiting cataract surgery for prisoners with at least one functioning eye).

The United States recognizes that principle as well. Two weeks ago, the Department of Justice filed a statement of interest in a case brought by a transgender prisoner in Georgia, expressing concern that the State had withheld treatment for the inmate's gender dysphoria "against the advice and recommendations of her treating clinicians." In that submission, the United States stressed that "[f]ailure to provide individualized and appropriate medical care for inmates suffering from gender dysphoria violates the Eighth Amendment's prohibition on cruel and unusual punishment." Statement of Interest of the United States at 1,

Diamond v. *Owens*, No. 5:15-cv-50-MTT-CHW (M.D. Ga. Apr. 3, 2015).[7]

Those decisions and the United States' position accord with the fundamental precept of medical practice—to provide individualized care to patients, according to their particular needs at a given point in time. In contrast, by reversing the order requiring MDOC to provide SRS to Kosilek—a prisoner with a history of severe gender dysphoria, documented recommendations for SRS by the DOC treating clinicians, and an unblemished prison disciplinary record—the en banc majority in effect held that SRS is never constitutionally required. *See* Pet. App. 89a (Thompson, J., dissenting); *see also id.* at 109a n.36 (Kayatta, J., dissenting) ("No prisoner is likely to have a more favorable record than Kosilek.").

The court of appeals' decision inappropriately displaces the judgment of medical professionals in making individualized care determinations. There is nothing unique about gender dysphoria, or about SRS, that warrants such a departure. To the contrary, the Standards of Care emphasize that in treating gender dysphoria, medical and mental health care providers must consider the patient's unique anatomic, social, and psychological situation. Standards of Care 2. That directive applies equally to the treatment of individuals in correctional settings. *See* National Commission on Correctional Health Care, *Position Statement: Transgender Health Care in Correctional Settings* (Oct. 18, 2009); American Psychological Association,

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[7] *Available at* http://www.justice.gov/sites/default/files/opa/press-releases/attachments/2015/04/03/diamond_statement_of_interest.pdf.

Policy Statement: Transgender, Gender Identity, & Gender Expression Non-Discrimination (Aug. 2008).

The court of appeals' decision limits the ability of medical and mental health professionals to prescribe, and prisoners to receive, proper treatment. It places individuals suffering from severe gender dysphoria, who are most in need of SRS, at greater risk of physical and emotional harm. *See, e.g.*, Brown, *Recommended Revisions to the World Professional Association for Transgender Health's Standards of Care Section on Medical Care for Incarcerated Persons with Gender Identity Disorder*, 11 Int'l J. of Transgenderism 133 (2009) (noting failure to provide medically necessary care to incarcerated individuals with gender identity disorder results in increased depression, suicidality, and auto-castration).

The court of appeals' decision greatly increases the likelihood that prisoners diagnosed with gender dysphoria—as well as other prisoners who are diagnosed with serious conditions as to which there are dissenting views—will be denied necessary medical care, in violation of the Eighth Amendment. This Court's review is warranted to ensure that lower courts do not casually reject consensus medical opinion about a prisoner's proper treatement merely because a State has managed to find a litigation expert who supports its position, no matter how far outside the mainstream that position might be.

CONCLUSION

The petition for a writ of certiorari should be granted.

Respectfully submitted.

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