Nos. 10-2339 and 10-2446

**IN THE**
**UNITED STATES COURT OF APPEALS**
**FOR THE SEVENTH CIRCUIT**

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| ANDREA FIELDS, *et al*., | ) | Appeals from the United States District |
| | ) | Court for the Eastern District of Wisconsin |
| Plaintiffs-Appellees, | ) | |
| Cross-Appellants, | ) | No. 2:06-cv-00112-CNC |
| v. | ) | |
| | ) | Charles N. Clevert, Jr., Chief Judge |
| JUDY P. SMITH, *et al*., | ) | |
| | ) | |
| Defendants-Appellants, | ) | |
| Cross-Appellees. | ) | |

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# BRIEF OF *AMICI CURIAE* MEDICAL AND MENTAL HEALTH PROFESSIONALS: AMERICAN MEDICAL ASSOCIATION, MENTAL HEALTH AMERICA, NATIONAL COMMISSION ON CORRECTIONAL HEALTH CARE, WORLD PROFESSIONAL ASSOCIATION FOR TRANSGENDER HEALTH, DR. WYLIE HEMBREE, AND DR. LOREN SCHECHTER IN SUPPORT OF PLAINTIFFS-APPELLEES

November 29, 2010

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**CIRCUIT RULE 26.1 DISCLOSURE STATEMENT**

Appellate Court No: 10-2339 & 10-2446

Short Caption: Fields, et al. v. Smith, et al.

To enable the judges to determine whether recusal is necessary or appropriate, an attorney for a non-governmental party or amicus curiae, or a private attorney representing a government party, must furnish a disclosure statement providing the following information in compliance with Circuit Rule 26.1 and Fed. R. App. P. 26.1.

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(1) The full name of every party that the attorney represents in the case (if the party is a corporation, you must provide the corporate disclosure information required by Fed. R. App. P. 26.1 by completing item #3):

American Medical Association, Mental Health America, National Commission on Correctional Health Care, World Professional Association for Transgender Health, Dr. Wylie Hembree, and Dr. Loren Schechter

(2) The names of all law firms whose partners or associates have appeared for the party in the case (including proceedings in the district court or before an administrative agency) or are expected to appear for the party in this court:

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(3) If the party or amicus is a corporation:

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ii) List any publicly held company that owns 10% or more of the party's or amicus' stock:

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## INTERESTS OF *AMICI CURIAE*

*Amici* represent the interests of leading medical and mental health professionals dedicated to providing the proper health care and treatment for all individuals in need. This brief is offered to explain the impact of Wisconsin Act 105 on medical and mental health professionals' ability to provide medically necessary care to each incarcerated patient with Gender Identity Disorder ("GID") and, in particular, the dire effect of Wisconsin's absolute prohibition on the use of hormone therapy and sex reassignment surgery ("SRS") to treat inmates with severe GID. *Amici* represent well-recognized organizations that promulgate the leading standards of care in the field and individual medical professionals charged with ensuring proper treatment for their patients.

The American Medical Association ("AMA") is the largest professional association of physicians, residents, and medical students in the United States. Additionally, through state and specialty medical societies and other physician groups seated in the AMA's House of Delegates, substantially all U.S. physicians, residents, and medical students are represented in the AMA's policy making process. The objectives of the AMA are to promote the science and art of medicine and the betterment of public health, and the AMA is recognized as a leading voice for medical professionals and their patients throughout the country. The AMA has recognized GID as a serious medical condition that can cause intense emotional pain and suffering, and when not properly treated, result in clinically significant psychological distress, dysfunction, debilitating depression, and, for some, self-mutilation, thoughts and attempts of suicide, and death. Based on medical research, the AMA has found that hormone therapy and SRS are medically necessary and effective therapeutic treatments for many people diagnosed with GID.

Mental Health America ("MHA") is a leading nonprofit dedicated to helping all people live mentally healthier lives. With more than 300 affiliates in 41 states and the District of Columbia, MHA represents a voice for mental health professionals and their patients throughout

the nation. MHA has recognized the importance of proper care for incarcerated individuals and supports effective, accessible mental health treatment for all people in adult and juvenile correctional facilities or under correctional control who need it.

The National Commission on Correctional Health Care ("NCCHC") represents the interests of the fields of health (medical, mental, dental), law, and corrections in improving the quality of care in our nation's jails, prisons, and juvenile confinement facilities. NCCHC offers an array of services to help correctional systems provide efficient and effective health care, and publishes health care standards and position statements to help guide correctional facilities in the delivery of health care services. NCCHC's standards have been used by federal courts as well as independent agencies to evaluate the adequacy and quality of care in local, state, and federal correctional systems. NCCHC has been instrumental in setting forth health care policies for individuals with GID in correctional settings, recognizing that significant harm can result from blanket policies that restrict patient-specific medical treatments such as hormone therapy and SRS.

The World Professional Association for Transgender Health ("WPATH") is an interdisciplinary professional association committed to developing the best practices and supportive policies to promote health, research, education, respect, dignity, and equality for transgender people in all settings. WPATH was founded on the principles of Dr. Harry Benjamin, one of the first physicians to work with transgender individuals, and maintains a leading role in setting medically-accepted standards for treatment. WPATH publishes *Standards of Care* and *Ethical Guidelines* that articulate a professional consensus about the medical, psychiatric, psychological, and surgical management of GID. The *Standards of Care* recognize the role of hormone therapy and surgery to change sex characteristics in treating GID.

Dr. Wylie Hembree is an internist specializing in reproductive endocrinology and andrology, the study of the male reproductive system. Dr. Hembree conducted clinical research, clinical teaching, and management of the Student Health Services at Columbia University Medical Center for nearly 40 years, resulting in more than 100 publications. After retiring as Associate Professor in Medicine and in Obstetrics and Gynecology, Dr. Hembree continues to practice and lecture, focusing on issues of transsexualism and andrology. Dr. Hembree served as the Chair of the Endocrine Society's Task Force that published the Clinical Practice Guideline on the Endocrine Treatment of Transsexual Persons in September 2009, which was co-sponsored by the U.S. and European Endocrine Societies and WPATH.

Dr. Loren Schechter is a surgeon with extensive experience in the treatment of individuals with GID. Dr. Schechter holds an associate teaching position at the University of Chicago, where he earned his medical degree, completed his residency, and completed a fellowship in reconstructive microsurgery. Dr. Schechter has extensive experience in both treatment and research regarding patients with GID. He has presented instructional courses and lectures on sex reassignment surgery and authored articles and abstracts on the surgeon's role in the use of hormone therapy and surgical options for patients with severe levels of GID.

## ARGUMENT

The widely-recognized standards of care developed by the medical and mental health communities for GID require individual assessment and treatment of patients with GID to provide medically necessary care. These standards are based on the fundamental principle that medical and mental health professionals must make a case-by-case assessment and treatment plan for each patient in order to identify and treat the severity of each patient's disorder. By creating a blanket prohibition on two of the three recognized treatment elements, hormone therapy and sex reassignment surgery ("SRS"), Wisconsin Act 105 prevents patients with the

most serious levels of the disorder from receiving medically necessary care, placing them at substantially greater risk of serious physical and emotional trauma.

## I. Medical And Mental Health Professionals Have Recognized That Hormone Therapy And Sex Reassignment Surgery Are Medically Necessary Treatment For Certain Individuals With GID.

Gender Identity Disorder is a strong, persistent cross-gender identification condition in which individuals "are cruelly imprisoned in a body incompatible with their subjective gender identity." MERCK Manual OF DIAGNOSIS AND THERAPY 1732 (18th ed. 2006) (hereinafter MERCK MANUAL). Most individuals' internal gender identities are congruent with their bodies and public gender roles. Individuals with GID, in contrast, experience a degree of incongruence that is often severe, disturbing, long-standing, and complete. *See* MERCK MANUAL at 1732. When not properly treated, GID can result in clinically significant psychological distress, dysfunction, debilitating depression and, for some people, self-mutilation, thoughts and attempts of suicide, and death. *See* DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 576-578 (4th ed. 2000) (hereinafter DSM-IV-TR); George M. Brown, *Autocastration and Autopenectomy as Surgical Self-Treatment in Incarcerated Persons with Gender Identity Disorder*, 12 INTERNATIONAL JOURNAL OF TRANSGENDERISM 31-39 (2010); *see also* DN.200, 41:5-14 ("[t]he risks are both physiological and psychological . . . [such as] depression, autocastration, and suicide").

### A. Hormone Therapy and Sex Reassignment Surgery Are Widely-Accepted Treatments for Individuals with High Levels of GID.

The medical and mental health communities have well-established materials for assessing and treating GID, which specifically recognize the importance of the use of hormone therapy and SRS. The American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders recognizes the following diagnostic criteria for GID: 1) evidence of a strong,

persistent cross-gender identification, which is the desire to be, or the insistence that one is, of the other sex; 2) evidence of a persistent discomfort about one's assigned sex or a sense of inappropriateness in the gender role of that sex; 3) the diagnosis is not made if the individual has a concurrent physical intersex condition; and 4) evidence of clinically significant distress or impairment in social, occupational, or other important areas of functioning. DSM-IV-TR 576; *see also* The Endocrine Society, *Endocrine Treatment of Transsexual Persons: An Endocrine Society Clinical Practice Guideline*, 94 JOURNAL OF CLINICAL ENDOCRINOLOGY & METABOLISM 3132 (2009) (applying the DSM-IV criteria to hormone treatment decisions). Similarly, the World Health Organization's International Classification of Diseases recognizes that GID is "characterized by a persistent and intense distress about assigned sex, together with a desire to be (or insistence that one is) of the other sex." World Health Organization, *International Classification of Diseases* F64.2 (2007 ed.), *available at* http://apps.who.int/classifications/apps/icd/icd10online/.

At the core of the assessment of GID are both the persistent cross-gender identification and discomfort and distress as a result of the gender incongruence. Distress from GID can be so pervasive that the lives of some individuals revolve only around those activities that lessen their gender distress. DSM-IV-TR at 578. The World Health Organization has similarly recognized that GID creates a "profound disturbance of the normal gender identity" and "a persistent preoccupation with the dress and activities of the opposite sex and repudiation of the individual's own sex." *Id.* Before treatment begins, individuals with GID "live in a dissociated state of mind and body." David Seil, *The Diagnosis and Treatment of Transgendered Patients, in* TRANSGENDER SUBJECTIVITIES: A CLINICIAN'S GUIDE 99, 115 (2004) (describing the diagnosis

and treatment of 271 transgender patients between 1979 and 2001). In these individuals, "[t]he mind is of one gender, and the body is of the other." *Id.*

As a result of the disorder, some male-to-female individuals with GID resort to self-treatment with hormones or, in some cases, attempt their own castration or penectomy. DSM-IV-TR at 578. In these cases, "[s]uicide attempts and Substance-Related Disorders are commonly associated" as well. *Id.* The literature in the field is replete with accounts of individuals who have taken their own lives or attempted do so because their GID was not properly assessed and treated, with some studies finding as many as one in four males and one in five females attempted suicide before treatment. *See, e.g.,* George M. Brown, *Autocastration and Autopenectomy as Surgical Self-Treatment in Incarcerated Persons with Gender Identity Disorder* at 31-39; Bram Kuiper & Peggy Cohen-Kettenis, *Sex Reassignment Surgery: A Study of 141 Dutch Transsexuals*, 17 ARCHIVES OF SEXUAL BEHAVIOR 439, 451 (1988).

The treatment of individuals with GID involves three principal elements: 1) psychotherapy, 2) hormone therapy and the real-life experience, and 3) SRS. *See* WPATH *Standards of Care*, 2 (6th ed. 2001), *available at* http://www.wpath.org/documents2/socv6.pdf. First published in 1979, WPATH's *Standards of Care for Gender Identity Disorders* are the recognized professional standards of care regarding the treatment of individuals with GID. The WPATH *Standards of Care* emphasize that treatment must consider each patient's unique anatomic, social, and psychological situation. *Id.* at 1-2. Treatment for GID is not a linear process in which one can move through treatment in a set course and be done with treatment for the rest of his or her life. *Id.* Indeed, experts may recommend ongoing comprehensive psychotherapy *in addition to* hormone therapy and, in some cases, SRS to properly alleviate an individual's distress. Walter O. Bockting & Eli Coleman, *A Comprehensive Approach to the*

*Treatment of Gender Dysphoria*, 5 JOURNAL OF PSYCHOLOGY & HUMAN SEXUALITY 131, 150 (1992).

These treatments are particularly vital for individuals with severe GID in correctional settings because they have no other way to lower their gender incongruence. Individuals are commonly placed in correctional facilities according to their genitals or sex assigned at birth, regardless of their gender presentation. Accordingly, prisoners with GID are forced to live in and cope continuously with a gender role that they have rejected throughout their lives. As the NCCHC has specifically stated, because correctional facilities have a responsibility to ensure the physical and mental health and well-being of inmates with GID, correctional health staff should treat these inmates in a manner that respects the medical and psychological aspects of their GID diagnosis. NCCHC, *Position Statement: Transgender Health Care in Correctional Settings, available at* http://www.ncchc.org/resources/statements/transgender.html (hereinafter NCCHC *Transgender Health Care*). Indeed, the NCCHC Position Statement on care for individuals with GID recognizes that the "management of medical (*e.g.*, medically necessary hormone treatment) and surgical (*e.g.*, genital reconstruction) transgender issues should follow accepted standards developed by professionals with expertise in transgender health." *Id.* (citing WPATH *Standards of Care*). Recognizing the importance of these treatments, NCCHC takes the position that "[w]hen determined to be medically necessary for a particular inmate, hormone therapy should be initiated and sex reassignment surgery should be considered on a case-by-case basis." *Id.*

The testimony of Wisconsin Department of Corrections' ("DOC") medical and mental health directors further demonstrates that those in the field, and in these facilities specifically, recognize the medical necessity of providing the appropriate treatment for each individual. Indeed, Dr. Kallas, the Mental Health Director for the DOC, testified that for some individuals

with GID, hormone therapy is "medically necessary." (DN.201, 186:23-187:4.) Accordingly, Dr. Kallas agreed that "Act 105 takes away [the] ability to provide medically necessary treatment in some cases." (*Id.* at 187:5-7.) Dr. Burnett, the Medical Director for the DOC, similarly testified that Act 105 prevents the DOC from providing medical care, a decision that should instead be left to the clinicians. (*Id.* at 229:21-25.) Both Drs. Kallas and Burnett testified that Act 105 was the *only* law or regulation that bans medical treatment to inmates in Wisconsin correctional facilities. (*Id.* at 187:15-20, 230:1-3.)

As the medical and mental health communities have recognized, the need for proper diagnosis and treatment of GID is essential in correctional facilities, and by prohibiting these treatments for all patients, regardless of need, Wisconsin Act 105 results in substantially greater risk of physical and emotional harm.

### B. Individuals with Severe GID Cannot Manage Their GID with Psychotherapy Alone.

Medical and mental health professionals widely recognize that for some individuals, especially those with severe GID, it is impossible to manage their distress with only psychotherapy. *See, e.g.*, David Seil, *The Diagnosis and Treatment of Transgendered Patients* at 115; Yolanda L.S. Smith, *et al*., *Adolescents With Gender Identity Disorder Who Were Accepted or Rejected for Sex Reassignment Surgery: A Prospective Follow-up Study*, 40 JOURNAL OF THE AMERICAN ACADEMY OF CHILD AND ADOLESCENT PSYCHIATRY 472, 473 (2001); Bockting & Coleman, *A Comprehensive Approach to the Treatment of Gender Dysphoria* at 150. By passing Wisconsin Act 105, the State of Wisconsin has decided − contrary to the position of its own medical and mental health professionals − that because psychological therapy may be the proper treatment for some individuals with GID, it should be the only treatment available for every person with GID. The State made this decision without regard to medical necessity and the

demonstrated physical and emotional harm that will result to patients with GID without proper treatment. This position deprives medical and mental health professionals and their patients of medically necessary treatment for those suffering from severe GID and places patients at substantially greater risk of severe physical and emotional trauma.

As medical and mental health professionals have recognized, "[t]here is no recent clinical evidence that the gender identity can be changed through psychotherapy" . . . "[h]owever, the body can be changed, and when a proper transition to the other gender has been completed, the dissociation of GID" may be lessened. Seil, *The Diagnosis and Treatment of Transgendered Patients* at 115. Research has shown that many of those seeking treatment for GID regard their genitals and sexual features with disgust. MERCK MANUAL at 1733. As with the plaintiffs in this case, "[t]heir primary objective in seeking help is not to obtain psychologic treatment but to obtain hormones and genital surgery that will make their physical appearance approximate their gender identity." *Id.* It is the combination of psychotherapy, hormone therapy and, in some cases, SRS that lessens the internal distress regarding the gender incongruence. *Id.* Indeed, the interplay between treatments is critical because hormone therapy is a necessary element of living in one's true gender identity. Giana E. Israel & Donald E. Tarver II, TRANSGENDER CARE: RECOMMENDED GUIDELINES, PRACTICAL INFORMATION & PERSONAL ACCOUNTS 56 (1997). Empirical studies reflect the importance of the interplay between treatments, finding hormone therapy in conjunction with psychotherapy and, for some, SRS, to be necessary elements of treating severe levels of GID. *Id.* For these individuals, like plaintiffs and others similarly situated, psychotherapy alone would be insufficient to address their level of GID.

It is clear that the prohibition against hormone therapy created significant physical and mental distress for the plaintiffs in this case. As a result of being deprived of the prescribed

hormone therapy, plaintiff Andrea Fields suffered from "nausea, muscle weakness, loss of appetite, increased hair growth, skin bumps, and depression." *Fields v. Smith*, 712 F. Supp. 2d 830, 863 (E.D. Wis. 2010). Plaintiff Jessica Davison suffered "increased and darker hair growth, voice deepening, breast reduction and leakage, mood swings, mental and emotional instability, hot flashes, and body aches." *Id.* Plaintiff Vankemah Moaton "grew chest and facial hair, complained of increased tenderness in the chest and groin, and complained of skin breakouts, hot flashes, and depression." *Id.* at 863-64. Plaintiffs' medical and mental health experts provided extensive testimony regarding the impact of Act 105 on the individuals in this case. (*See, e.g.*, DN.200, 41:5-14, 55:5-57:18, 110:4-122:2; DN.202, 272:23-288:19.) As Plaintiffs' expert Dr. Brown testified, for individuals with severe GID, psychotherapy alone has "never been adequate treatment, not just in my experience but also in the literature over decades. If it worked on these patients, I would be one of the first to use it as a psychotherapist." (DN.202, 272:23-273:4.)

Strikingly, the DOC was *aware* that this physical and emotional distress would occur and that the harm created by Act 105 was very real. As Dr. Kallas recognized, the effects of Act 105 on certain individuals with GID may include "depression, anxiety, disruptive behavior or suicidality." (DN.201, 184:20-185:3.) Indeed, "[a]dditional suicides or suicide attempts may occur based on" Act 105, and "[a]dditional resources may be needed for time in segregation, clinical observation, or the Wisconsin Resource Center." *Id.* The State's own experts recognized that to discontinue hormones for certain individuals would be "cruel and irresponsible." (*Id.* at 185:7-13.) As the DOC testimony demonstrated, Act 105 was directly "contrary to the medical judgment of the [DOC] medical director and the medical health director." (*Id.* at 185:22-25.)

Other courts have similarly recognized the mental and physical suffering that can result in correctional settings from a lack of proper treatment for GID. For example, in *Kosilek v. Maloney*, a male-to-female patient with GID "twice attempted suicide" while awaiting trial and "attempted . . . castrat[ion]." 221 F. Supp. 2d 156, 170 (D. Mass. 2002). The court held that the patient had a "serious medical need," which the correctional facility had a duty to treat. *Id.* at 193. The court went on to find that "[i]f psychotherapy, hormones, and possibly psychopharmacology are not sufficient to reduce the anguish caused by Kosilek's gender identity disorder . . . sex reassignment surgery might be deemed medically necessary." *Id.* at 195. Similarly, in *De'Lonta v. Angelone*, a male-to-female patient with GID was abruptly barred from hormone therapy and "developed an uncontrollable urge to mutilate her genitals." 330 F.3d 630, 632 (4th Cir. 2003). The lack of hormone therapy on patients with severe GID, especially one who has previously received treatment, "will wreak havoc on a plaintiff's physical and emotional state . . . [which] is neither compensable nor speculative." *See Phillips v. Michigan Dep't of Corr.*, 731 F. Supp. 792, 800 (W.D. Mich. 1990).

Treatment utilizing hormone therapy and, where necessary, SRS for individuals with severe GID is vital because the literature on GID does not provide evidence that psychotherapy can alter a fixed crossgender identity. Smith, *Adolescents With Gender Identity Disorder Who Were Accepted or Rejected for Sex Reassignment Surgery: A Prospective Follow-up Study* at 473 (analyzing the outcomes in patients who underwent hormone treatment and sexual reassignment surgery compared to patients who did not start hormone therapy). In one study of outcomes, those completing the specific treatment prescribed for their level of GID demonstrated lower levels of anxiety, depression, and hostility following the treatment than they did before. *Id.* at 477. Those who had not gone through the treatment recommended by their medical and mental

health professionals demonstrated lower levels of psychological functioning and more severe levels of GID. *Id.* at 478. Indeed, as Plaintiffs' expert Dr. Brown testified, the literature in the field contains a number of studies describing the "effectiveness of hormone therapy as well as surgical treatment in patients with moderate to severe or profound GID." (*See, e.g.*, DN.202, 298:4-9.)

Wisconsin Act 105 has inflicted physical and emotional damage on the plaintiffs in this case, and more generally, places incarcerated individuals with GID, particularly in its severe forms, at substantially greater risk of physical and emotional harm. As the research and caselaw demonstrate, these individuals cannot manage their disorder with psychotherapy alone, and the consequences of attempting to do so are severe.

## II. Case-By-Case Assessment And Appropriate Treatment Of Incarcerated Individuals With GID Is Necessary To Prevent Physical And Emotional Harm.

Because not all patients require the same therapeutic care, medical and mental health professionals must be able to make treatment decisions on a case-by-case basis. The Appellant's brief acknowledges that "treatment is individualized" (Appellant Br. 6), but Wisconsin Act 105 bars individualized treatment under recognized standards of care by prohibiting hormone therapy and SRS, which are widely-accepted treatments for patients with GID, particularly severe GID. As discussed in more detail in Section I, Wisconsin's blanket rule barring medical and mental health professionals from making treatment decisions based on each patient's level of GID places incarcerated patients at substantially greater risk of physical and emotional harm. Wisconsin Act 105's prohibition of vital treatments is thus fundamentally inconsistent with widely-accepted standards of care.

A fundamental principle of the WPATH *Standards of Care* is the importance of individual assessment and treatment for patients with GID. Similarly, NCCHC's *Standards for*

*Health Services in Prisons* require that "inmates have access to care to meet their serious medical . . . and mental health needs," and, further, that "individual treatment plans [be] developed by a physician or other qualified clinician at the time the condition is identified, and updated when warranted." *See* NCCHC Standard P-A-01 *Access to Care* (2008); NCCHC Standard P-G-02 *Patients With Special Health Needs* (2008). Moreover, NCCHC specifically recognizes the importance of not having a blanket policy that applies to the treatment of all inmates with GID. *See* NCCHC *Transgender Health Care*. Because inmates with GID may be under different stages of care prior to incarceration, the lack of case-by-case assessment and treatment may be especially damaging in correctional facilities. *Id.* Similarly, blanket policies that make treatments available only to those who received them prior to incarceration or that limit GID treatment to psychotherapy alone are especially harmful and inconsistent with the recognized standards of care. *Id.* The American Psychological Association has also recognized the vital role of case-by-case assessment by trained mental health professionals in ensuring that individuals in correctional institutions receive the proper treatment based on their individual level of GID. American Psychological Association, *Policy Statement: Transgender, Gender Identity, & Gender Expression Non-Discrimination* (Aug. 2008), *available at* http://www.apa.org/about/governance/council/policy/transgender.aspx.

Again, as the DOC's own directors testified, and the district court accordingly held, "DOC administrative personnel generally agree that deference on health care matters should be given to DOC health care staff." *Fields*, 712 F. Supp. 2d at 836. Tellingly, prior to the passage of Act 105, the DOC's policy was to not only prescribe hormone therapy for inmates receiving treatment prior to incarceration, but also to *initiate* hormone therapy for those for whom it was found to be medically necessary. *Id.* at 850 (reviewing DOC Executive Directive 68). Indeed,

Dr. Kallas agreed with the need for case-by-case assessment, stating that "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." (DN.201, 186:8-14.) As Dr. Burnett testified, decisions on the medical care for each inmate should be left to the clinicians. (*Id.* at 229:21-25.)

The court in *Kosilek* similarly recognized the importance of individual assessment and treatment in correctional settings and the harm that can result from blanket prohibitions. The court found that "[a]s a result of [the] blanket policy . . . no clinical assessment of Kosilek's individual circumstances and medical needs has been made." *Kosilek*, 221 F. Supp. 2d at 175. Moreover, "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.'" *Id.* at 193. Those individual assessment and treatment decisions must be made "by qualified professionals . . . [and must] exercise sound medical judgment, based upon prudent professional standards, particularly the Standards of Care." *Id.*

Empirical studies of individuals who have undergone the full treatment prescribed by medical and mental health professionals for their level of the disorder further demonstrate that GID "is not a homogenous phenomenon," and it should be treated with "a more varied treatment approach." P.T. Cohen-Kettenis & L.J.G. Gooren, *Transsexualism: A Review of Etiology, Diagnosis and Treatment*, 46 JOURNAL OF PSYCHOSOMATIC RESOURCES 315, 328 (1999) (reviewing empirical studies on those with GID). The importance of individual assessment and treatment has been recognized by a number of other correctional facilities as well. For example, Minnesota's Department of Corrections has created a Transgender Committee, which consists of

medical, mental health, intake, and security officials, as well as the facility warden, to recommend placement and create a treatment plan for each transgender prisoner based on their individual medical history. Similarly, the Michigan Department of Corrections allows the Medical Director to diagnose GID and to develop individual management plans that are then checked by the Chief Medical Officer and a Deputy Director. The policy in Illinois is similarly individual-specific, as each patient is asked questions regarding the individual's own sense of gender identity that would reveal any plans the individual may have with regard to future surgery and lifestyle and that would reflect that the individual has amended or plans to amend his or her original birth certificate.

Public recognition of the importance of individualized treatment for GID, including hormone therapy and SRS where needed, has grown rapidly. In recent years, a number of leading businesses such as AT&T, Coca-Cola, General Motors, Google, Microsoft, Walt Disney, and others have recognized the importance of providing insurance coverage that includes hormone therapy and surgical procedures for those individuals that require it. *See* Human Rights Campaign, Corporate Equality Index, *available at* http://www.hrc.org/issues/workplace/benefits /7644.htm (Dec. 7, 2009). The AMA has similarly recognized and "supports public and private health insurance coverage for treatment of gender identity disorder as recommended by the patient's physician." AMA Policy H-185.950, *available at* http://www.ama-assn.org/ama/pub/about-ama/our-people/member-groups-sections/glbt-advisory-committee/ama-policy-regarding-sexual-orientation.shtml; *see also* AMA Resolution 122 (A-08), *Removing Financial Barriers to Care for Transgender Patients*, *available at* http://www.ama-assn.org/ama1/pub/upload/mm/471/122.doc. Despite actuarial fears of over-utilization and a potentially expensive benefit, programs that have expanded to include coverage of hormone

therapy and SRS have found the economic costs to be minimal compared to other insurance costs. *See* Human Rights Campaign, *San Francisco Transgender Benefit: Actual Cost & Utilization, available at* http://www.hrc.org/issues/workplace/ benefits/14160.htm.

Because of the individual nature and treatment of GID, medical and mental health professionals must evaluate each patient with GID on a case-by-case basis in order to prescribe the proper therapeutic treatment. This is especially true in correctional facilities where individuals with GID have no other access to assessment and treatment. Wisconsin Act 105 precludes case-by-case assessment and treatment of individuals with GID, preventing medical and mental health professionals from prescribing the proper treatment and placing patients at substantially greater risk of physical and emotional harm.

## CONCLUSION

*Amici curiae* respectfully submit that Wisconsin Act 105's prohibition on hormone therapy and SRS deprives certain individuals with GID of medically necessary treatment, without which they face substantially greater risk of physical and emotional harm. The widely-accepted standards of care in the field require that individuals with GID be diagnosed and treated on a case-by-case basis, and further recognize that hormone therapy and SRS are necessary elements of proper therapeutic treatment for some patients with GID. Accordingly, the district court's judgment should be affirmed.

Dated: November 29, 2010

Respectfully submitted,

By: s/David M. Kroeger

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## CERTIFICATE OF COMPLIANCE

Counsel of Record hereby certifies that pursuant to Federal Rule of Appellate Procedure 32(a)(7), Brief of *Amici Curiae* Medical and Mental Health: American Medical Association, Mental Health America, National Commission on Correctional Health Care, World Professional Association for Transgender Health, Dr. Wylie Hembree, and Dr. Loren Schechter complies with the typeface and length requirements and contains 4,645 words.

Dated: November 29, 2010

Respectfully submitted,

s/David M. Kroeger

## CERTIFICATE OF SERVICE

I, Kyle A. Palazzolo, an attorney, hereby certify that I caused copies of the foregoing Brief of *Amici Curiae* Medical and Mental Health: American Medical Association, Mental Health America, National Commission on Correctional Health Care, World Professional Association for Transgender Health, Dr. Wylie Hembree, and Dr. Loren Schechter to be served on the following individuals on November 29, 2010 via the U.S. Postal Service, first class mail postage prepaid:

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