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**UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF IDAHO**

ADREE EDMO (a/k/a MASON EDMO),

Plaintiff,

v.

IDAHO DEPARTMENT OF
CORRECTION; HENRY ATENCIO, in his
official capacity; JEFF ZMUDA, in his
official capacity; HOWARD KEITH
YORDY, in his official and individual
capacities; CORIZON, INC.; SCOTT
ELIASON; MURRAY YOUNG; RICHARD
CRAIG; RONA SIEGERT; CATHERINE
WHINNERY; and DOES 1-15;

Defendants.

Case No.: 1:17-cv-00151-BLW

**PLAINTIFF'S [PROPOSED] FINDINGS OF
FACT AND CONCLUSIONS OF LAW**

Complaint Filed: April 6, 2017
Discovery Cut-Off: None Set
Motion Cut-Off: None Set
Trial Date: None Set

Pursuant to the Court's September 28, 2018 Order, Plaintiff Adree Edmo hereby submits her Proposed Findings of Fact and Conclusions of Law regarding the evidentiary hearing on Plaintiff's Motion for Preliminary Injunction. ECF No. 110.

FINDINGS OF FACT

Introduction

1. Ms. Edmo identifies as a woman. Preliminary Injunction Hr'g Tr. ("Tr.") 193:4-5.
2. Ms. Edmo first felt different from the male sex assigned her at birth around the age of 5 or 6, although she did not have words for that feeling. Tr. 193:6-14; *see also* Declaration of Adree Edmo in Support of Plaintiff's Motion for a Preliminary Injunction ("Edmo Decl.") ¶ 3.
3. Prior to learning about and being diagnosed with gender dysphoria, Ms. Edmo used identifiers including effeminate and gay, but she did not feel these were the right words to describe the feeling of her gender identity. Tr. 193:18-23.
4. Ms. Edmo has been incarcerated at Idaho State Correctional Institute ("ISCI") since April 2012. Tr. 192:19-20; *see also* Edmo Decl. ¶ 12. Based on the Parole Board's determination that Ms. Edmo is no longer eligible to parole due to her disciplinary record, Ms. Edmo expects to be released from prison at the conclusion of her full term in 2021. Tr. 201:14-15, 230:3-10.
5. Before she was incarcerated, Ms. Edmo expressed her female gender identity by wearing makeup, women's clothing, and styling her hair in a feminine fashion. Tr. 211:1-7; *see also* Edmo Decl. ¶ 7.
6. On June 25, 2012, Ms. Edmo was first diagnosed with gender identity disorder¹ by Corizon psychiatrist Dr. Scott Eliason. Exh. 1 at 321. On July 19, 2012, Corizon psychologist Claudia Lake confirmed Ms. Edmo's diagnosis of gender identity disorder. Exh. 1 at 323-27.

Gender Dysphoria, Treatment, and Standards of Care

7. A person's gender identity is their sense of being either male or female. Every person has a gender identity. Tr. 48:21-49:3.

¹ Gender identity disorder was reclassified as gender dysphoria in 2013 with the release of the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition ("DSM-5"). Exh. 1001 at 2.

8. “Transgender” is an umbrella term for a person whose gender identity is not congruent with their assigned gender, but not every person who identifies as transgender is diagnosed with gender dysphoria. Tr. 50:5-11. Gender dysphoria is the incongruity between an individual’s assigned gender and gender identity so severe that it impairs the individual’s ability to function. Tr. 50:12-14.

9. The American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders (“DSM-5”) defines gender dysphoria as:

- A. A marked incongruence between one’s experienced/expressed gender and assigned gender, of at least 6 month’s duration, as manifested by at least two of the following:
 - 1. A marked incongruence between one’s experienced/expressed gender and primary and/or secondary sex characteristics.
 - 2. A strong desire to be rid of one’s primary and/or secondary sex characteristics because of a marked incongruence with one’s experienced/expressed gender.
 - 3. A strong desire for the primary and/or secondary sex characteristics of the other gender.
 - 4. A strong desire to be of the other gender.
 - 5. A strong desire to be treated as the other gender.
 - 6. A strong conviction that one has the typical feelings and reactions of the other gender.
- B. The condition is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Exh. 1001 at 3-4.

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

11. Gender dysphoria is a serious, but treatable, medical condition that intensifies over time. Tr. 48:14-20, 51:20-8; *see also* Declaration of Randi Ettner in Support of Plaintiff’s Motion for a Preliminary Injunction (“Ettner Decl.”) ¶ 39.

12. The risks of not adequately treating gender dysphoria are serious and include surgical self-treatment, suicide, and severe emotional decompensation. Tr. 52:9-16; *see also* Ettner Decl. ¶ 37.

13. It is common for individuals with gender dysphoria to experience depression or anxiety as a symptom of their gender dysphoria. Tr. 50:15-24. In individuals with both major depressive disorder and gender dysphoria, it is typically difficult to separate the depressive symptoms from

the gender dysphoric symptoms. Tr. 601:18-25.

14. The World Professional Association of Transgender Health (“WPATH”) Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People were first promulgated in 1979 and are the internationally recognized guidelines for the treatment of individuals with gender dysphoria. Tr. 42:6-20; Exh. 15. The WPATH Standards of Care are supported by evidence-based medicine. Tr. 258:8-10. The WPATH Standards of Care are the only developed standards for treating patients with gender dysphoria. Tr. 572:2-9.

15. The WPATH Standards of Care have discussed treatments for incarcerated individuals since 1998, apply equally to all individuals “irrespective of their housing situation” and explicitly state that health care for transgender people “living in an institutional environment should mirror that which would be available to them if they were living in a non-institutional setting within the same community.” Tr. 54:11-21; Exh. 15 at 73. The next update to the WPATH Standards of Care will also apply regardless of where a person is housed, including in prison. Tr. 54:25-55:12.

16. Reference to the Standards of Care as “flexible clinical guidelines” means that for most patients in most situations, the WPATH criteria determine who should be given certain types of treatment and are appropriate to follow, but, in some situations, experienced providers can provide treatment to a patient who has not completely met all those criteria, if there is a good reason. Tr. 241:9-242:16. This is intended to address situations where experienced providers may need to deviate from the criteria due to individual patient circumstances, but is not to be used to bar treatment options to groups or classes of patients such as prisoners. Tr. 244:5-245:12.

17. The National Commission on Correctional Healthcare (“NCCHC”) endorses the WPATH Standards of Care as the accepted standards for the treatment of transgender prisoners. Exh. 1041 at 2 & 4, n.1; Tr. 477:14-478:22, 571:4-10.

18. The NCCHC recognizes that patients with gender dysphoria may try to remove their genitals or engage in genital self-harm in an attempt to self-treat their gender dysphoria. Tr. 479:9-25; Exh. 1041 at 16.

19. Treatment modalities for gender dysphoria include psychotherapy, social role transition,

cross-sex hormonal therapy, and gender confirmation surgery. Exh. 15 at 15-16; Tr. 53:25-54:10. Treatment options are selected based on the severity of the condition, which is evaluated based on the patient's present clinical situation. Tr. 56:23-57:12, 168:10-22.

20. The Standards of Care provide that the purposes of psychotherapy include "exploring gender identity, role, and expression; addressing the negative impact of gender dysphoria and stigma on mental health; alleviating internalized transphobia; enhancing social and peer support; improving body image; or promoting resilience." Exh. 15 at 16. Psychotherapy is not a precondition for gender confirmation surgery. Tr. 98:23-99:2.

21. Social role transition, previously known as the "real life experience," is a critical component of treatment to consolidate the individual's identity and attenuate gender dysphoria. This requires dressing, grooming, and otherwise conveying, via social signifiers, a public face and role consistent with one's gender identity. Tr. 61:6-25; Ettner Decl. ¶ 45.

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

23. Sex reassignment surgery, now generally referred to as gender confirmation surgery, is a well-established, safe, and effective treatment for gender dysphoria. Exh. 15 at 60. There are decades of scientific research supporting the efficacy of gender confirmation surgery for individuals who have severe gender dysphoria. Tr. 74:4-18. For individuals with severe gender dysphoria, where hormone therapy is inadequate to eliminate the gender dysphoria, gender confirmation surgery is the only effective treatment for gender dysphoria and is medically necessary. Tr. 168:23-169:15; *see also* Ettner Decl. ¶ 51.

24. Gender confirmation surgery is the cure for gender dysphoria. Tr. 81:13-19. The primary therapeutic goal of genital reconstruction surgery is to treat gender dysphoria. Secondary effects

include simplifying hormone treatment, diminishing other mental health diagnoses such as depression and anxiety, and allowing patients to focus on other parts of their lives. Tr. 248:8-23, 250:4-24.

25. The WPATH criteria for genital reconstruction surgery in male-to-female patients are:
1. Persistent, well documented gender dysphoria;
 2. Capacity to make a fully informed decision and to consent for treatment;
 3. Age of majority in a given country;
 4. If significant medical or mental health concerns are present, they must be well controlled;
 5. 12 continuous months of hormone therapy as appropriate to the patient's gender goals; and
 6. 12 continuous months of living in a gender role that is congruent with their gender identity.

Exh. 15 at 66.

26. "Persistent, well documented gender dysphoria" means that the person has a well-established diagnosis of gender dysphoria that persisted beyond six months. Tr. 55:21-56:3.

27. The presence of mental health conditions does not negate or obviate an individual's ability to undergo gender confirmation surgery and is not a reason to deny gender confirmation surgery to people for whom surgery is medically necessary. Tr. 59:9-23, 169:16-170:22.

28. An individual's mental health issues that are related to their gender dysphoria should not be considered in assessing whether an individual meets the fourth WPATH criterion that significant medical or mental health concerns must be well controlled. Tr. 387:20-388:6.

29. Plaintiff's expert Dr. Gorton testified that it would be unethical to base a patient's medical necessity for gender confirming surgery on the patient's disciplinary record or criminal actions. Tr. 257:4-23.

30. With respect to the 12-month experience of living in an identity-congruent role, the Standards of Care provide:

The duration of 12 months allows for a range of different life experiences and events that may occur throughout the year (e.g., family events, holidays, vacations, season-specific work or school experiences). During this time, patients should present consistently, on a day-to-day basis and across all settings of life, in their desired gender role. This includes coming out to partners, family, friends, and community members (e.g., at school, work, other settings).

Exh. 15 at 67.

31. An individual in prison can satisfy the criterion of living in a gender role congruent with their gender identity. Living in one's affirmed gender role takes place wherever the individual's "real life" occurs and the individual is living in the gender role to the extent that one can in that context. Tr. 62:16-63:4, 584:16-25.

32. A patient's gender presentation six or more years prior to their evaluation for gender confirmation surgery is not relevant to whether surgery is medically necessary at the time of evaluation. Tr. 97:5-19.

Plaintiff's Experts

33. Dr. Ettner is one of the authors of the WPATH Standards of Care, version 7. Tr. 42:21-24.

34. Dr. Ettner has been a WPATH member since 1993 and chairs its Committee for Institutionalized Persons. Tr. 43:2-16; Exh. 1003.

35. Dr. Ettner has treated approximately 3000 individuals with gender dysphoria, including evaluating whether gender confirmation surgery is necessary for certain patients, and has referred approximately 300 patients for gender confirmation surgery, and assessed approximately 30 incarcerated individuals with gender dysphoria. Tr. 43:17-44:1, 44:9-13. Dr. Ettner has extensive experience treating patients who have undergone gender confirmation surgery. Tr. 44:2-8.

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

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

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

39. Dr. Gorton is an emergency medicine physician and also practices at a federally qualified

healthcare center that primarily services uninsured patients or those with Medicare or Medicaid. Exh. 1004; Tr. 234:24-235:2. Dr. Gorton also works with Project Health, which has trained numerous clinics regarding provision of transgender health care in California. Tr. 233:5-21.

40. Dr. Gorton is a member of WPATH and is on WPATH's Transgender Medicine and Research Committee and its Institutionalized Persons Committee. Tr. 238:4-6; Exh. 1004.

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

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

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

Defendants' Experts

44. Prior to evaluating Ms. Edmo, Defendants' expert Dr. Garvey had never personally evaluated a single patient for gender confirmation surgery. Tr. 558:10-14.

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

46. Dr. Garvey has never previously been qualified as an expert in any case regarding treatment of gender dysphoria. Tr. 550:16-24.

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

48. Dr. Andrade has never provided direct treatment for patients with gender dysphoria and has never been a treating clinician for a patient who has had gender confirmation surgery. Tr. 647:8-14, 651:10-12.

49. As part of a committee, Dr. Andrade recommended gender confirmation surgery for two Massachusetts prisoners contingent upon the requirement that they first live in a women's prison for approximately twelve months. Tr. 647:19-648:25. This requirement is not part of the WPATH criteria for surgery. Exh. 15 at 66. Dr. Andrade made this recommendation despite knowing that the Massachusetts Department of Corrections houses prisoners according to their genitals. The prisoners were not allowed to move to a women's prison, and, at least seven months after the recommendation, had not received surgery. Tr. 649:1-650:11.

50. The majority of Dr. Garvey and Dr. Andrade's training and experience with gender dysphoria is from their participation on the Massachusetts Department of Corrections Gender Dysphoria Treatment Committee, which consisted of four or five individuals, including Dr. Garvey and Dr. Andrade. Tr. 560:7-21, 562:7-12, 644:16-645:18. A third member of the Committee was Dr. Steven Levine, an outside consultant. Tr. 562:13-17, 563:8-24.

51. Dr. Garvey and Dr. Andrade gave a joint presentation they titled, "Tax Dollars at Work: Treating Inmates with Gender Dysphoria," and summarized with the following description:
Advocacy groups call for gender dysphoric inmates to receive treatment that mirrors the community. These advocates emphasize inmate patients' rights and deemphasize important distinctions between community-dwelling gender dysphoric individuals and those serving life sentences for violent crimes. Minimizing the unique context of the correctional setting, they fail to provide correctional clinicians with strategies to determine whether certain irreversible forms of treatment are likely to lead to more benefit or harm.

Exh. 1029 at 2; Exh. 1030.

52. Neither Dr. Garvey nor Dr. Andrade has ever published in any peer-reviewed journal relating to treatment of gender dysphoria or completed peer-reviewed research relating to treatment of gender dysphoria. Tr. 551:7-12, 552:2-6, 658:22-659:2.

53. Dr. Garvey's reliance on a statistic that individuals who undergo gender confirmation surgery have a suicide rate 19 times higher as compared with the general population is not evidence about the effects of surgery on the transgender population. It compares post-surgery suicide rates for transgender individuals against the general population, rather than comparing suicide rates before and after surgery within the transgender population. Tr. 596:22-597:6, 598:13-22.

Corizon's Policies and Practices Regarding Gender Dysphoria

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

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

IDOC's Policies and Practices Regarding Gender Dysphoria

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

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

58. IDOC's operative gender dysphoria policy when Ms. Edmo was assessed for surgery defined a "qualified gender identity disorder (GID) evaluator as "A Doctor of Philosophy (PhD) level practitioner licensed by an appropriate state licensing authority as a psychologist, or a physician licensed by a state Board of Medicine, who has demonstrated an indicia of basic competence related to the diagnosis and treatment of GID and related mental or emotional disorders through their licensure, training, continuing education, and clinical experience." Exh. 8 at 3; Tr. 388:16-389:1. This policy stated that gender confirmation surgery "will not be considered for individuals within the Idaho Department of Correction (IDOC), unless determined medically necessary by the treating physician." Exh. 8 at 8.

59. On October 5, 2018, IDOC implemented a new gender dysphoria policy that would allow prisoners at ISCI diagnosed with gender dysphoria to order and possess female commissary items and present in a manner consistent with their gender identity. Tr. 347:18-348:23; Exh. 9. The new policy also states that "to avoid a sexually charged atmosphere in IDOC facilities [n]o

provocative or sexually charged clothing or behavior will be permitted.” Exh. 9 at 6.

60. IDOC’s new gender dysphoria policy continues to state that gender confirmation surgery “will not be considered for individuals within the Idaho Department of Correction (IDOC), unless determined medically necessary by the treating physician.” Exh. 9 at 8-9. The new policy does not elaborate on determination of medical necessity. *See id.* The policy states that prisoners will be housed “based upon the inmate’s primary physical sexual characteristics.” Exh. 9 at 4.

61. Warden Keith Yordy testified that IDOC’s Prison Rape and Elimination Act (“PREA”) policy operative until 2018 prohibited prisoners from “dressing or displaying feminine or effeminate appearance,” which included hairstyles, shaping eyebrows, face makeup, undergarments, jewelry, and gender opposite clothing. Deposition of Keith Yordy (“Yordy Dep.”) 20:17-21:25, 28:10-15, 42:14-43:2, 48:2-5; Exh. 12 at 6. Yordy testified that this policy prohibited hairstyles considered feminine or effeminate for persons housed at a male prison in Idaho. Yordy Dep. 28:10-15. There was no written definition of feminine or effeminate hairstyles. Yordy provided guidance to staff “using good correctional practice of when you see it, you know it” and specifically, “[t]hat if hairstyles are above and beyond what you believe is appropriate, and it’s an effeminate hairstyle, correct it with the offender.” *Id.* 50:14-51:2. Yordy testified that in 2014, correctional officers were “trying to control the effeminate hairstyles” and were not distinguishing between effeminate hairstyles and sexually provocative hairstyles. *Id.* 27:17-28:1. IDOC’s PREA policy that took effect on April 2, 2018 does not address effeminate or feminine appearance. Yordy Dep. 28:16-30:14; Exh. 13.

Defendants’ Training on Gender Confirmation Surgery

62. In 2016, Dr. Eliason contacted Dr. Steven Levine to lead a training for IDOC and Corizon providers on medical necessity for gender confirmation surgery. Tr. 433:23-434:24. Dr. Levine’s training presentation was titled “Medical Necessity of Transgender Inmates: In Search of Clarity When Paradox, Complexity, and Uncertainty Abound.” Exh. 17 at 1. Dr. Levine trained Corizon and IDOC staff that gender confirmation surgery is “not conceived as lifesaving as is repairing a potentially leaking aortic aneurysm but as life enhancing as is providing augmentation for women

distressed about their small breasts.” Exh. 17 at 43; Exh. 16.

63. Dr. Levine is considered an outlier in the field of treating gender dysphoria and does not ascribe to the WPATH Standards of Care. Tr. 176:14-21. His training materials do not reflect opinions that are generally accepted in the field of gender dysphoria. Tr. 176:22-179:1. His training materials also contain multiple statements evidencing hostility to the WPATH Standards of Care and provision of gender confirmation surgery to incarcerated persons, and negatively characterize providers and courts that rely on these standards. *E.g.*, Exh. 17 at 30 (“[WPATH Standards of Care], which claims to be a scientific and a minority rights document, ignores the profound differences between science and advocacy”); *id.* at 30 (“Judges, who are schooled in civil rights, look to professional societies like WPATH, for guidance. It is an uphill battle to convince them that a professional society is wrong and a dissenting expert in the courtroom is right.”).

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

65. Dr. Levine was retained as a defense expert by the California Department of Corrections and Rehabilitation in a suit filed by a transgender plaintiff. *Norsworthy v. Beard*, 87 F. Supp. 3d 1164 (N.D. Cal. 2015). In ordering the prison to provide the plaintiff gender confirmation surgery, the *Norsworthy* court afforded Dr. Levine’s opinions “very little weight,” stating: “To the extent that Levine’s apparent opinion that no inmate should ever receive SRS predetermined his conclusion with respect to Norsworthy, his conclusions are unhelpful in assessing whether she has

established a serious medical need for SRS.” *Norsworthy*, 87 F. Supp. 3d at 1188. The court also determined that Dr. Levine’s opinion was not credible because of illogical inferences, inconsistencies, and inaccuracies,” including misrepresentations of the WPATH Standards of Care, overwhelming “generalizations about gender dysphoric prisoners” and Dr. Levine’s fabrication of a prisoner anecdote. *Id.*

66. The two witnesses Defendants called to testify other than their experts, Dr. Eliason, and Mr. Clark, both attended Dr. Levine’s 2016 training and subsequently incorporated substantial material from Dr. Levine’s PowerPoint into trainings they then gave on gender dysphoria. The respective portions of Dr. Levine’s PowerPoint that Dr. Eliason and Mr. Clark chose to use in their own PowerPoints included Dr. Levine’s personal theories about gender confirmation surgery that have not been generally accepted in the field of gender dysphoria treatment and evidence hostility to the idea of providing gender confirmation surgery to incarcerated individuals. Tr. 473:8-475:7; Exh. 20 at 1,-2, 27-29; Tr. 369:25-370:16; Exh. 1025 at 5.

Ms. Edmo’s Gender Identity and Presentation

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

68. Ms. Edmo has consistently presented as feminine throughout her incarceration by wearing her hair in traditionally feminine hairstyles, wearing makeup, and acting in a feminine demeanor. Tr. 194:24-195:5, 411:1-7, 463:11-464:21. Ms. Edmo’s feminine presentation has been documented by Defendants’ medical providers since 2012. *E.g.*, Exh. 1 at 321, 347, 425, 452, 538.

69. Ms. Edmo has also held two jobs while in prison and has presented as feminine at her places of employment. Tr. 201:24-202:10.

70. Ms. Edmo has continually sought to present herself as feminine despite receiving multiple disciplinary offense reports related to wearing makeup, styling her hair in a feminine manner, and altering her male-issued undergarments into female panties. Tr. 195:11-20; Exh. 5 at 8, 9, 21-22, 25, 27-28, 33-34, 41-43, 48-57, 62-65; Yordy Dep. 47:4-49:15, 85:22-87:11; Edmo Decl. ¶ 19.

71. IDOC's new policy would still appear to permit the type of discipline Ms. Edmo has received for her gender presentation based on characterizing her feminine appearance as sexualized. For example, Warden Yordy testified that when an officer gave Ms. Edmo a DOR for having her hair in a bun over the ear line in 2015, this was based on a hairstyle that was "over the top," "creating a sexually charged environment, creating a hairstyle that was not appropriate." Yordy Dep. 50:6-13 & Yordy Dep. Ex. 3 at IDOC_C_pg. 27-28.

72. Ms. Edmo feels prepared to live in the community as a woman. She would continue to wear makeup and female clothing, and request surgery even if she lived in the community. Tr. 201:16-23, 202:11-15.

73. Ms. Edmo does not expect gender confirmation surgery to solve all her problems, but believes it will help her better handle the stressors of everyday life and alleviate some of her depression. Tr. 200:21-201:13; Deposition of Krina Stewart ("Stewart Dep.") 78:22-79:25.

Defendants' Treatment of Ms. Edmo for Gender Dysphoria

74. All of the experts in this case testified that Ms. Edmo meets the DSM-5 definition of gender dysphoria. Tr. 69:20-70:3, 251:23-252:3, 518:16-18, 635:1-7.

75. Dr. Ettner testified that Ms. Edmo's treatment providers at ISCI are not qualified to provide her appropriate treatment for gender dysphoria. Tr. 90:22-25.

76. The only treatment Ms. Edmo has received at ISCI for gender dysphoria is hormone replacement therapy and some gender dysphoria process groups. Tr. 196:8-14; Stewart Dep. 84:10-18. Ms. Edmo has received hormone therapy since late 2012, which consists of estrogen and spironolactone, a testosterone suppressant. Tr. 227:19-228:3.

77. Ms. Edmo has been compliant with her prescribed hormone treatment regimen and depression medication since 2012. Tr. 99:9-12, 369:14-19. There is no evidence that Ms. Edmo has refused to meet with members of her treatment team other than her current assigned primary clinician, Krina Stewart, whom she believes to be unknowledgeable about gender dysphoria. Tr. 609:8-12; Stewart Dep. 91:15-18.

78. Ms. Edmo testified that the hormone therapy helped treat her gender dysphoria to some

extent. Tr. 223:9-14. The hormones “cleared her mind,” and resulted in breast growth, body fat redistribution, and changes in her skin consistency. Tr. 196:15-25. As a result of hormone therapy, Ms. Edmo is hormonally confirmed, which means she has the same circulating sex hormones and secondary sex characteristics as a typical adult female. Tr. 72:14-21; Ettner Decl. ¶ 59. Ms. Edmo has achieved the maximum physical changes associated with hormone treatment. Tr. 602:1-603:4.

79. Ms. Edmo continues to experience distress related to gender incongruence, which is mostly focused on her male genitalia. She testified she feels “depressed, embarrassed, and disgusted” by her male genitalia and that this is an “everyday reoccurring thought.” Tr. 197:7-24. This is consistent with reports Ms. Edmo has made to her providers at ISCI. Tr. 460:18-24.

80. Ms. Edmo has repeatedly requested gender confirmation surgery. Ms. Edmo first requested gender confirmation surgery in February 2014. Her request was denied by Defendants at that time, and consistently thereafter. Exh. 1 at 63-64, 195, 538; Exh. 6 at 65-66, 169-70, 187-88.

81. Ms. Edmo first attempted self surgery to remove her testicles in September 2015 using a disposable razor blade. She wrote a note to let the officers know she was not trying to commit suicide and was only trying to help herself. She attempted to cut her testicle sac open but was unsuccessful. Edmo Decl. ¶ 31; Tr. 197:25-198:8. Ms. Edmo was placed on suicide watch after she was found, which exacerbated her depression and gender dysphoria because she was stripped of all clothing and continually confronted with her male anatomy. Prison staff told her she would be sent to maximum security if she tried to self-castrate again. Edmo Decl. ¶ 32.

82. In January 2016, Ms. Edmo reported to Dr. Eliason that she was having difficulty sleeping due to thoughts of self-castration. In response, Dr. Eliason prescribed Ms. Edmo sleeping medication. Tr. 458:5-10, 461:18-24. Ms. Edmo also reported her frequent thoughts of self-castration to her assigned clinician, Krina Stewart, in November 2016. Ms. Stewart testified that none of the interventions she identified for Ms. Edmo at that visit would alleviate her gender dysphoria or desire to self-castrate. Stewart Dep. 58:15-59:16; Exh. 1 at 584-85.

83. Ms. Edmo attempted a second time to perform self surgery in December 2016. She prepared for weeks by studying the anatomy of the scrotum and took steps to diminish the chance

of infection by boiling the razor blade and scrubbing her hands with soap. Ms. Edmo made more surgical headway on this attempt and was able to cut open the testicle sac and remove the testicle. Declaration of Ryan Nicholas Gorton in Support of Plaintiff's Motion for a Preliminary Injunction ("Gorton Decl.") ¶ 74. Because there was too much blood, Ms. Edmo abandoned her attempt and sought medical assistance. Tr. 198:9-16. She was transported to a hospital where her testicle was repaired. Tr. 198:25-199:13. After the procedure, Ms. Edmo felt disappointed in herself because she felt she had come so close to removing her testicle but had not succeeded. Tr. 199:17-23.

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

85. Ms. Stewart met with Ms. Edmo two days after her second self-castration attempt but did not formulate a new treatment plan for Ms. Edmo or add any additional treatments to her plan. Stewart Dep. 65:5-25; Exh. 1 at 597.

86. Ms. Edmo continues to actively experience thoughts of self-castration. In an effort to avoid acting on them, when she has experienced extreme episodes of gender dysphoria in the past year, Ms. Edmo "self-medicate[s]" by using a razor to cut her arm. The physical pain she feels from cutting helps her release the emotional torment and mental anguish she feels at the time. Tr. 199:24-200:15.

Defendants' April 2016 Assessment of Ms. Edmo's Medical Necessity for Surgery

87. IDOC and Corizon evaluated Ms. Edmo for gender confirmation surgery one time prior to this lawsuit. Corizon psychiatrist Scott Eliason conducted this evaluation on April 20, 2016 by Exh. 1 at 538; Tr. 419:1-10.

88. Dr. Eliason's progress note documenting his assessment of Ms. Edmo stated:
Medical Necessity for Sexual Reassignment Surgery is not very well defined and is constantly shifting but the following situations could meet medical necessity: 1) Congenital malformations or ambiguous genitalia would likely required sexual reassignment or reparative surgery. 2) Severe and devastating dysphoria that is primarily due to genitals could potentially meet criteria for gender reassignment surgery as well. 3) Some type of medical problem in which endogenous sexual hormones were causing severe physiological damage. There may also be other situation which could be determine as medically necessary as more information

becomes available. This inmate does not meet any of those above criteria.

Exh. 1 at 538. Dr. Eliason's progress note also stated: "For the time being, it is my opinion that the combination of hormone treatment and supportive counseling is sufficient for her gender dysphoria." Exh. 1 at 538.

89. Dr. Eliason's statement that "[m]edical necessity for sex reassignment surgery is not very well defined and is constantly shifting" is inconsistent with the recognized standard of care and supporting scientific literature which sets forth criteria for gender confirmation surgery and confirms that surgery is an effective treatment for the medical condition of gender dysphoria. Tr. 263:4-17, 74:4-18, 168:23-169:15.

90. Dr. Eliason's three examples of "medical necessity" are not the WPATH criteria. Dr. Eliason was not able to identify any source for these three examples, and neither Plaintiff's nor Defendants' experts identified Dr. Eliason's examples of medical necessity as consistent with the standard of care. Tr. 470:18-20, 470:24-471:2. Nonetheless, Dr. Eliason admitted that attempted self-castration could meet his second example of medical necessity. Tr. 471:3-6.

91. In his April 20, 2016 assessment and at his deposition, Dr. Eliason did not identify uncontrolled mental health concerns or Ms. Edmo's compliance with the 12 continuous months of living in a congruent gender role as bases for finding gender confirmation surgery not medically necessary. Tr. 462:3-463:10.

92. In concluding that surgery was not medically necessary for Ms. Edmo, Dr. Eliason did not review her prior criminal record, disciplinary history, or her presentence investigation reports. Tr. 468:4-18. The only information Dr. Eliason relied upon was Ms. Edmo's medical record, staff observations, her therapist and her therapist's notes. Tr. 469:16-25.

93. Dr. Eliason testified that when he assessed her for surgery, he was aware of Ms. Edmo's prior self-surgery attempt and he believed Ms. Edmo's gender dysphoria had risen to another level, but he made no change to her treatment plan. Tr. 471:7-22.

94. Plaintiff's expert Dr. Gorton found Dr. Eliason's evaluation of Ms. Edmo inconsistent with and far below the standard of care. Tr. 261:15-263:3.

95. While Dr. Eliason testified that he “staffed” his assessment of Ms. Edmo with other providers including Jeremy Clark, a licensed counselor and WPATH member, Mr. Clark testified that the consultation was an informal conversation that happened when they ran into each other in passing at ISCI and lasted no more than 15 to 20 minutes. Mr. Clark did not document the informal consultation, nor did he provide Dr. Eliason with an opinion of what “medically necessary” meant. Tr. 354:25-355:21. Mr. Clark was also not qualified to assess the medical necessity of gender confirmation surgery under IDOC policy. Tr. 391:1-6; Exh. 8 at 3.

96. Although Mr. Clark testified that the MTC should have reviewed Dr. Eliason’s assessment of the medical necessity of surgery for Ms. Edmo, the MTC minutes do not document any such review taking place. Tr. 358:8-361:4; Exh. 7 at 78-80, 86.

Ms. Edmo’s Medical Necessity for Gender Confirmation Surgery

97. Despite six years of hormone therapy, Ms. Edmo continues to have persistent well-documented gender dysphoria. Tr. 72:1-10, 75:11-25, 252:16-22, 668:24-669:15.

98. Plaintiff’s experts agree that Ms. Edmo meets and exceeds the six WPATH criteria for genital reconstruction surgery. Tr. 75:9-78:3; 252:13-254:11. Defendants’ experts dispute that Ms. Edmo meets the fourth and sixth WPATH criteria. Tr. 607:2-10, 639:14-640:25. Dr. Eliason did not cite any of the WPATH criteria as a reason Ms. Edmo did not require surgery in his April 2016 assessment or during his deposition, but stated for the first time during the hearing that she does not meet the fourth and sixth WPATH criteria. Tr. 462:3-463:10. Mr. Clark testified that he does not believe Ms. Edmo meets the fourth WPATH criterion. Tr. 386:19-24.

99. With respect to the fourth criterion, Dr. Ettner testified that Ms. Edmo has no unresolved mental health issues that would prevent her from receiving gender confirmation surgery. Tr. 98:3-10. While at ISCI, Ms. Edmo has been diagnosed with Major Depressive Disorder, Alcohol Use Disorder, and Gender Dysphoria. *E.g.*, Exh. 1 at 538. These diagnoses were generally confirmed by all of the experts, with observation that any substance use disorder has been in remission while Ms. Edmo has been incarcerated. Tr. 67:16-18, 253:3-9, 518:16-219:6, 603:22-604:5. Plaintiff’s experts testified that Ms. Edmo’s depression and anxiety are as controlled as they can be and do

not impair her ability to undergo surgery. Tr. 76:13-25, 123:14-124:11, 253:3-9; Exh. 15 at 30.

100. Dr. Ettner assessed Ms. Edmo's depression as primarily somatic and vegetative, not cognitive, which means that it is not the type of depression that someone can resolve through talk therapy or processing groups. This type of depression is treated with antidepressant medication. Ms. Edmo is prescribed the maximum dose of antidepressant medication and is compliant with her prescription. The fact that these medications have not fully attenuated her depression is an indication that Ms. Edmo's depression is attendant to her gender dysphoria rather than a comorbid or co-occurring disorder on its own. Tr. 67:19-69:16; 76:22-77:4.

101. Dr. Garvey assessed Ms. Edmo with major depressive disorder at the moderate level, did not attribute her gender dysphoria to hysteria, psychosis, malingering, or exaggeration, and believed that Ms. Edmo's substance use disorder is in full sustained remission in a controlled environment. Tr. 603:22-604:5. Dr. Garvey testified that when she evaluated Ms. Edmo, she found no evidence of psychosis or obsessional thinking, found no evidence of psychosis in her records, or any evidence that Ms. Edmo was being uncooperative. Rather, Dr. Garvey found that Ms. Edmo's insight appeared fair and her judgment appeared reasonably intact. Tr. 603:8-21.

102. The clinical significance of Ms. Edmo's self-surgery attempts and recent cutting of her arm is that she has severe genital-focused gender dysphoria and is not getting medically necessary treatment to alleviate it. Tr. 254:15-19, 98:11-22. Ms. Edmo's self-surgery attempts are not acts of mutilation or self-harm but are attempts to remove her target organ that produces testosterone, which is the cure for gender dysphoria. Tr. 80:3-13. Ms. Edmo's gender dysphoria, not her depression and anxiety, is the driving force behind her self-surgery attempts. Tr. 254:20-255:8. Ms. Edmo's self-surgery attempts and cutting do not indicate she has mental health concerns that are not well controlled. Tr. 98:11-22. Rather, Ms. Edmo's recent cutting is attention-reduction behavior that she uses to prevent herself from cutting her genitals. Tr. 98:16-22.

103. Ms. Edmo has demonstrated the capacity to follow through with the postsurgical care she would require. Tr. 99:3-8, 169:23-170:25.

104. In the more than six years she has spent in IDOC custody, no Corizon or IDOC provider

has ever diagnosed Ms. Edmo with borderline personality disorder by any Corizon or IDOC provider. Tr. 361:18-362:3, 470:4-6. Defense expert Dr. Andrade is the first person to ever diagnose Ms. Edmo with borderline personality disorder, and he was unable to identify his criteria for this diagnosis for Ms. Edmo during his testimony. Tr. 652:21-24, 638:16-22. None of the other experts, including Defense expert Dr. Garvey, diagnosed Ms. Edmo with borderline personality disorder. Tr. 131:24-132:3, 139:19-24.

105. With respect to the sixth criterion, both Plaintiff's experts testified that Ms. Edmo meets and exceeds the condition of social role transition by living as a woman to the best of her ability in a male prison. For the six-plus years she has lived in prison, Ms. Edmo has consistently sought to present as feminine, despite living in an environment hostile to her efforts and despite the disciplinary consequences she faces. Tr. 77:9-78:3, 254:4-11.

106. Dr. Ettner testified that gender confirmation surgery would eliminate Ms. Edmo's gender dysphoria and significantly attenuate much of the attendant depression and symptoms that she is experiencing. Tr. 104:24-105:9. She testified that gender confirmation surgery is the cure for gender dysphoria, and will therefore result in therapeutic and beneficial effects for Ms. Edmo. Tr. 81:13-19. Dr. Gorton testified that it is highly unlikely that Ms. Edmo's severe gender dysphoria will improve without gender confirmation surgery. Tr. 267:19-22.

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

108. If she is not provided surgery, Ms. Edmo does not doubt that she will try self surgery to deal with her extreme episodes of gender dysphoria in the future. Tr. 199:24-200:5. Given that Ms. Edmo made increasing progress on her first two self-surgery attempts, it is likely that Ms. Edmo will be successful if she attempts self-surgery again. Tr. 264:13-22.

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

regret. Tr. 266:1-267:1.

CONCLUSIONS OF LAW

I. Legal Standard

110. “A plaintiff seeking a preliminary injunction must establish that [s]he is likely to succeed on the merits, that [s]he is likely to suffer irreparable harm in the absence of preliminary relief, that the balance of equities tips in [her] favor, and that an injunction is in the public interest.” *Winter v. Natural Res. Def. Council, Inc.*, 555 U.S. 7, 20 (2009); *Pimentel v. Dreyfus*, 670 F.3d 1096, 1105 (9th Cir. 2012) (applying *Winter* to claim under 42 U.S.C. § 1983). Under Ninth Circuit law, likelihood of success on the merits is the most important factor. *Garcia v. Google, Inc.*, 786 F.3d 733, 740 (9th Cir. 2015). “[S]erious questions going to the merits and a balance of hardships that tips sharply towards the plaintiff can support issuance of a preliminary injunction, so long as the plaintiff also shows that there is a likelihood of irreparable injury and that the injunction is in the public interest.” *Alliance for the Wild Rockies v. Cottrell*, 632 F.3d 1127, 1135 (9th Cir. 2011) (internal quotation marks omitted).

111. Injunctive relief is treated as a mandatory injunction when “it orders a responsible party to take action.” *Garcia*, 786 F.3d at 740. A plaintiff seeking a mandatory injunction “ must establish that the law and facts clearly favor her position, not simply that she is likely to succeed.” *Id.* at 740. “Mandatory injunctions are most likely to be appropriate when ‘the status quo . . . is exactly what will inflict the irreparable injury upon complainant.’” *Hernandez v. Sessions*, 872 F.3d 976, 999 (9th Cir. 2017) (quoting *Friends for All Children, Inc. v. Lockheed Aircraft Corp.*, 746 F.2d 816, 830 n.21 (D.C. Cir. 1984)).

112. The Prison Litigation Reform Act requires any preliminary injunction to be “narrowly drawn, extend no further than necessary to correct the harm the court finds requires preliminary relief, and be the least intrusive means necessary to correct the harm.” 18 U.S.C. § 3626(a)(2).

113. Plaintiff’s request for a preliminary injunction ordering Defendants to provide her medical care is, unfortunately, not an unusual procedural posture, nor does it seek procedurally inappropriate relief. Courts have authority to grant mandatory preliminary injunctions directing

prisons and medical providers to provide incarcerated plaintiffs medical care where the factors supporting such relief are present. *See, e.g., Mason v. Ryan*, 2018 U.S. Dist. LEXIS 77688 (D. Ariz. May 8, 2018) (granting in part preliminary injunction and ordering Corizon to provide specialist-recommended treatment and medication); *Hicklin v. Precynthe*, 2018 U.S. Dist. LEXIS 21516, at *49-50 (E.D. Mo. Feb. 9, 2018) (“*Hicklin I*”) (granting in part preliminary injunction requesting that defendants provide plaintiff medically necessary treatment for gender dysphoria, including hormone therapy, access to permanent body hair removal, and access to gender-affirming canteen items); *Norsworthy*, 87 F. Supp. 3d at 1195 (ordering defendants to “take all of the actions reasonably necessary to provide [plaintiff] sex reassignment surgery as promptly as possible”); *Hamby v. Hammond*, 2014 U.S. Dist. LEXIS 117346, at *1-2 (W.D. Wash. July 7, 2014) (applying *Winter* factors to plaintiff’s motion for preliminary injunction seeking surgical repair for hernia); *McNearney v. Wash. Dep’t of Corr.*, 2012 U.S. Dist. LEXIS 115802, at *38 (W.D. Wash. June 15, 2012) (granting preliminary injunction and ordering defendant to arrange for plaintiff to be examined by outside specialists and authorize recommended treatment); *Miller v. Bannister*, 2011 U.S. Dist. LEXIS 14858, at *2 (D. Nev. Feb. 14, 2011) (ordering defendants to arrange for plaintiff, who suffered from end-stage liver disease, to be evaluated by a liver transplant specialist); *Rhea v. Wash. State Dep’t of Corr.*, 2010 U.S. Dist. LEXIS 97784, at *5 (W.D. Wash. Sept. 27, 2010) (granting preliminary injunction requiring defendants to arrange for plaintiff to be examined by an outside specialist and to “authorize, perform and/or facilitate any treatment” recommended by the specialist to treat plaintiff’s neuroma).

114. District courts faced with motions for injunctive relief requesting surgery or other forms of irreversible treatment have evaluated these requests under the preliminary injunction standard. *See, e.g., Norsworthy*, 87 F. Supp. 3d at 1184-95 (plaintiff’s motion for preliminary injunction requesting gender confirmation surgery evaluated under preliminary injunction standard); *Hamby*, 2014 U.S. Dist. LEXIS 117346, at *1-2 (applying *Winter* factors to plaintiff’s motion for preliminary injunction seeking surgical repair for hernia). A ruling on a motion for a preliminary injunction “leaves open the final determination of the merits of the case.” *Ranchers Cattlemen*

Action Legal Fund United Stockgrowers of Am. v. U.S. Dep't of Agric., 499 F.3d 1108, 1114 (9th Cir. 2007). “This rule acknowledges that decisions on preliminary injunctions are just that—preliminary—and must often be made hastily and on less than a full record.” *Id.* (internal quotations omitted). While the Court recognizes that an order granting Ms. Edmo’s motion for preliminary injunction may have the effect of granting ultimate relief on some of her claims, the mere fact that Ms. Edmo’s requested relief is surgical and therefore irreversible does not convert her request for urgent relief to a motion for permanent injunction that would result in a final judgment on the merits of her claims.² Accordingly, the Court evaluates Ms. Edmo’s motion under the preliminary injunction standard.

II. Analysis

A. The Law Clearly Favors Plaintiff’s Position on Her Claims

1. Eighth Amendment Claim

115. It is well-established that “[d]eliberate indifference to serious medical needs of prisoners constitutes the ‘unnecessary and wanton infliction of pain’ proscribed by the Eighth Amendment.” *Estelle v. Gamble*, 429 U.S. 97, 104 (1976) (internal citation omitted). Prison officials are liable for violations under the Eighth Amendment when they are deliberately indifferent to a substantial risk of serious harm to a prisoner, which the Supreme Court has described as “the equivalent of recklessly disregarding that risk.” *Farmer v. Brennan*, 511 U.S. 825, 836 (1994); *see also id.* (“Deliberate indifference lies somewhere between the poles of negligence at one end and purpose or knowledge at the other.”). “Much like recklessness in criminal law, deliberate indifference to

² While one district court in the Ninth Circuit reached the opposite conclusion in *Boldon v. Humana Ins. Co.*, 466 F. Supp. 2d 1199 (D. Ariz. 2006), this case is distinguishable. In *Boldon*, the court granted an injunction to an employee seeking a determination that his medical plan should provide him medical treatment coverage. The court concluded that the standard for a final rather than preliminary injunction applied because “the requested injunction . . . is final in substance, with the opportunity for full presentation of material evidence attendant to a final injunction after trial on the merits.” *Id.* at 1208. In the instant case, however, the parties have thus far conducted only limited discovery because of the balance necessary between time for initial discovery and a timely decision on the requested preliminary injunction due to the nature of the medical need alleged. The record before the Court that does not represent all the evidence that would be presented at a full trial on the merits. However, as set forth *infra*, this evidence is more than sufficient for the Court to rule on Plaintiff’s motion for preliminary injunction.

medical needs may be shown by circumstantial evidence when the facts are sufficient to demonstrate that a defendant actually knew of a risk of harm.” *Lolli v. Cnty. of Orange*, 351 F. 3d 410, 421 (9th Cir. 2003); *see also Farmer*, 511 U.S. at 837.

116. A plaintiff establishes deliberate indifference by showing a serious medical need such that failure to treat the condition could result in further significant injury or the unnecessary and wanton infliction of pain, and showing that a defendant engaged in a purposeful act or failure to respond to this medical need such that the plaintiff was harmed. *Jett v. Penner*, 439 F. 3d 1091, 1096 (9th Cir. 2006). Deliberate indifference may be demonstrated “when prison officials deny, delay or intentionally interfere with medical treatment, or it may be shown by the way in which prison officials provide medical care.” *Id.* (internal quotations and citations omitted).

117. The parties do not dispute that gender dysphoria is a serious medical condition for the purposes of the Eighth Amendment and that Ms. Edmo continues to meet the DSM-5 criteria for gender dysphoria even after provision of cross-sex hormone therapy for the past six years. By definition, the condition of gender dysphoria results in ongoing clinically significant distress and/or impairment of functioning. At issue is whether gender confirmation surgery is the medically necessary or appropriate treatment for Ms. Edmo’s ongoing gender dysphoria such that Defendants’ refusal to provide it amounts to deliberate indifference to her serious medical need.

a. Medical need for gender confirmation surgery

118. The Court finds that the law clearly supports that gender confirmation surgery is the medically appropriate and necessary treatment for Ms. Edmo’s ongoing and severe gender dysphoria. She has presented extensive evidence that she continues to experience severe emotional and psychological symptoms of gender dysphoria, despite six years of hormone therapy for gender dysphoria and mental health treatment for her depressive disorder. *See Norsworthy*, 87 F. Supp. 3d at 1186 (plaintiff demonstrated serious medical need where years of hormone therapy and mental health treatment did not alleviate her severe symptoms of gender dysphoria). Ms. Edmo has also presented evidence that her two self-castration attempts, recurring thoughts of self-castration, and recent cutting of her arm to keep from again attempting self-surgery demonstrate

that her gender dysphoria is not being adequately treated.

119. Defendants do not dispute that the WPATH Standards of Care are the accepted standards of care for treatment of transgender patients, that these standards have been endorsed by the NCCHC as applying to incarcerated persons, and that there are no other competing sets of evidence-based standards that are accepted by any nationally or internationally recognized medical professional groups.

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

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

122. Defendants' experts appear to misrepresent the WPATH Standards of Care by concluding that Ms. Edmo, despite presenting as female since her incarceration in 2012, cannot satisfy the WPATH criteria because she has not presented as female in free society. But there is no requirement in the Standards of Care that a "patient live for twelve months in his or her gender role outside of prison before becoming eligible for SRS." *Norsworthy*, 87 F. Supp. 3d at 1193-1194. Indeed, Plaintiff's experts opine that Ms. Edmo exceeds this criterion not only because she has presented as female for far longer than twelve months, but has done so in an environment arguably more hostile to these efforts than the community and despite the disciplinary consequences. Nor is there any evidence that the Standards of Care do not apply to incarcerated individuals. In fact, the Standards of Care explicitly provide that "in their entirety [they] apply to all transsexual, transgender, and gender-nonconforming people, irrespective of their housing

situation,” and “including institutional environments such as prisons.” Exh. 15 at 73. The Standards of Care make clear that “[d]enial of needed changes in gender role or access to treatments, including sex reassignment surgery, on the basis of residence in an institution are not reasonable accommodations.” Exh. 15 at 74.

123. The Court also finds that Defendants’ experts lack credibility because their education and training regarding gender dysphoria is largely based on their work with Dr. Levine at the Massachusetts Department of Corrections. Plaintiff’s expert Dr. Ettner testified that Dr. Levine is an outlier in the gender dysphoria field whose ideas about gender confirmation surgery are not generally accepted. This opinion is consistent with the other evidence before this Court, which includes a PowerPoint authored by Dr. Levine that is inconsistent with and in opposition to the WPATH Standards of Care, and the finding by another district court in this Circuit that Dr. Levine’s report and opinions in that case were not credible, relied on generalizations about gender dysphoric prisoners, included a fabricated anecdote, and were based on his “apparent opinion that no inmate should ever receive SRS.” *Norsworthy*, 87 F. Supp. 3d at 1188-89; *see also id.* at 1192. *Soneeya v. Spencer*, 851 F. Supp. 2d 228, 235 (D. Mass. 2012) (finding Dr. Levine’s opinion regarding sex reassignment surgery contrary to the evidence and Standards of Care showing generally positive outcomes for most patients who have sex reassignment surgery). Consistent with Dr. Levine’s approach that gender confirmation surgery should not be provided for incarcerated individuals, no prisoner in the Massachusetts Department of Corrections, including those whose treatment was overseen by Dr. Garvey and Dr. Andrade, has ever received gender confirmation surgery.

124. Remarkably, both of the witnesses Defendants called at the preliminary injunction hearing, Dr. Eliason and Mr. Clark, were also trained by Dr. Levine, whom Dr. Eliason brought in to do a one-day training for Corizon and IDOC providers. Following this training, both Dr. Eliason and Mr. Clark used Dr. Levine’s training materials—which undermine the medical necessity of gender confirmation surgery in contrast to the WPATH Standards of Care and the opinions of every major medical and mental health organization—in their own trainings on gender dysphoria. Dr. Eliason

testified that Corizon has never recommended gender confirmation surgery to any patient in any of the correctional systems or institutions for which the company is the contracted medical provider. Nor has IDOC ever recommended or provided gender confirmation surgery to any patient in IDOC custody.

Defendants' reasons for denying Ms. Edmo gender confirmation surgery are pretextual

125. With these findings about the parties' experts' credibility in mind, the Court turns to the reasons Defendants have proffered for denying Ms. Edmo surgery—that she cannot meet the fourth and sixth WPATH criteria for surgery—and concludes that these are pretextual.

126. The fourth WPATH criterion states: “If significant medical or mental health concerns are present, they must be well controlled.” Ms. Edmo’s only documented active, significant mental health concern other than gender dysphoria itself is major depressive disorder. It is undisputed that Ms. Edmo is prescribed and compliant with the maximum dosage of anti-depressant medication. None of the experts were able to conclusively opine about the degree to which Ms. Edmo’s depressive symptoms are related to or distinct from her gender dysphoria, but, based on their extensive experience treating patients with gender dysphoria, the Court credits Drs. Ettner and Gorton’s testimony that appropriate treatment of Ms. Edmo’s gender dysphoria is likely to alleviate, if not eliminate, Ms. Edmo’s depression and anxiety.

127. Defendant’s expert Dr. Andrade also posited during the course of this litigation that Ms. Edmo has borderline personality disorder, which he suggested precludes surgery at this time under the fourth criterion. Defendants also filed various declarations from their internal providers suggesting that Ms. Edmo may have borderline personality disorder or traits thereof. Plaintiff’s experts both opined that they did not find Ms. Edmo to have borderline personality disorder, and Defendant’s psychiatrist expert, Dr. Garvey, also did not find this diagnosis appropriate for Ms. Edmo. The evidence is undisputed that, in more than six years of treating Ms. Edmo, at no time prior to Ms. Edmo’s motion for a preliminary injunction did any of Defendants’ own providers diagnose Ms. Edmo with borderline personality disorder or prescribe treatment for this diagnosis.

128. Post hoc rationalizations for the purposes of litigation, unsupported by evidence, cannot be

used retroactively as justification for a medical decision. *See Layton v. Bannister*, 2012 U.S. Dist. LEXIS 158359, at *6 (D. Nev. Nov. 5, 2012) (whether defendant’s decision to deny plaintiff surgery violated the Eighth Amendment should be evaluated based solely on facts available to defendant at the time); *Funderburke v. Canfield*, 2016 U.S. Dist. LEXIS 25456, at *21 (W.D.N.Y. Feb. 29, 2016) (“[A]lthough Defendants now argue that Voltaren and Indocin were sufficient to treat Plaintiff’s nerve pain, a reasonable jury could easily conclude that this argument is simply a post hoc rationalization . . .”). The Court therefore affords no weight to Defendants’ contention that a borderline personality disorder diagnosis—which has never actually been made for Ms. Edmo—must be considered under the Standards of Care.

129. Similarly, Defendants argue that Ms. Edmo’s behavior while incarcerated demonstrates uncontrolled mental health issues, citing to her disciplinary record. However, Defendants’ own documentation of these disciplinary incidents concludes that such behavior was generally not related to mental illness. Tr. 366:1-369:13. Moreover, Defendants’ assertions that Ms. Edmo’s behaviors or refusals to attend various counseling groups demonstrate that she cannot cooperate with post-surgical care requirements are belied by the undisputed evidence showing that Ms. Edmo has complied with hormone therapy and depression treatment for six years and that Ms. Edmo complied with all medical care requirements following her two attempted self-castrations. Accordingly, the Court concludes that Defendants’ assertion that Ms. Edmo cannot receive surgery due to her uncontrolled mental health concerns is pretextual.

130. The sixth WPATH criterion requires “12 continuous months of living in a gender role that is congruent with their gender identity.” Defendants argue that Ms. Edmo has not met this criterion because they do not find corroborating evidence that she presented as a woman prior to her incarceration. However, Defendants’ own records show that Ms. Edmo has consistently presented in her female gender identity for more than six years. Defendants’ witnesses and experts testified on the one hand that it is possible for a transgender patient to satisfy this requirement while living in prison, but on the other hand, asserted that Ms. Edmo cannot meet this criterion despite six years of consistent female gender presentation because she is incarcerated. This conflicting testimony is

not credible and is inconsistent with the WPATH Standards of Care. The Court thus finds that this reason for denying Ms. Edmo surgery is also pretextual.

131. In the absence of any credible evidence offered by Defendants to dispute Ms. Edmo's evidence that gender confirmation surgery is the medically appropriate and necessary treatment for her gender dysphoria, the Court concludes that she has demonstrated that current medical standards require such treatment be provided given her ongoing serious medical need.

b. Deliberate indifference

132. Having established what treatment is medically necessary, the Court turns to the question of whether the law clearly favors Ms. Edmo's claim that Defendants' failure to provide such treatment constitutes deliberate indifference. "Refusing to provide effective treatment for a serious medical condition serves no valid penological purpose and amounts to torture." *Fields v. Smith*, 653 F. 3d 550, 556 (7th Cir. 2011) (holding statute barring Wisconsin corrections officials from providing transgender inmates hormone therapy and sex-reassignment surgery unconstitutional under the Eighth Amendment). Provision of partial treatment for a medical condition does not foreclose a finding of deliberate indifference if there is additional treatment required and available to avoid further substantial risk of serious harm. *See Ortiz v. City of Imperial*, 884 F. 2d 1312, 1314 (9th Cir. 1989) (a plaintiff alleging deliberate medical indifference "need not prove complete failure to treat"); *Keohane v. Jones*, 2018 U.S. Dist. LEXIS 142640, at *57 (N.D. Fla. August 22, 2018) ("[J]ust because Defendant provides some care, like counseling and hormones, doesn't mean this suffices as constitutionally adequate treatment."); *Hicklin v. Precynthe*, No. 4-16-cv-01357-NCC, Dkt. No. 176, at 6 (E.D. Mo. May 22, 2018) ("providing [only] counseling and/or psychotropic medication to a severely gender dysphoric patient whose condition warrants medical intervention is a departure from the [WPATH] standards of care . . . [and] puts a person at serious risk of psychological and physical harm" in violation of the Eighth Amendment); *Norsworthy*, F. Supp. 3d at 1187 ("Just because defendants have provided a prisoner with some treatment consistent with the Standards of Care, it does not follow that they have necessarily provided her with *constitutionally adequate* treatment.") (internal alterations omitted) (quoting *De'lonta v.*

Johnson, 708 F. 3d 520, 526 (4th Cir. 2013)).

133. Ms. Edmo has presented overwhelming evidence that Defendants' refusal to provide her surgery is not merely a reasonable difference of opinion among medical providers. Rather, the evidence demonstrates that Defendants not only knowingly ignored but also affirmatively rejected the recognized standards of care in treating her gender dysphoria; adopted written policies that provide insufficient guidance on assessing medical necessity for surgery; and insufficiently trained their staff with materials that discourage referrals for surgery and represent the opinions of a single person who rejects the WPATH Standards of Care and is an outlier in the field of transgender medicine.

134. The Court also finds that Corizon and IDOC have a *de facto* policy or practice against providing gender confirmation surgery for transgender inmates. Their written policies do not consider genital surgery as a form of care and no person with gender dysphoria has ever been referred for surgery either in IDOC or any prison where Corizon operates. Defendants' sole evaluation of Ms. Edmo for surgery prior to this lawsuit failed to utilize the WPATH criteria and their post-hoc rationalizations for denying surgery are inconsistent with Ms. Edmo's medical records and ignore Ms. Edmo's serious and ongoing harms that result from this denial of medically necessary care.

Defendants' treatment of Ms. Edmo's gender dysphoria is an unacceptable course of treatment

135. The Court finds that Dr. Eliason's assessment that Ms. Edmo did not meet medical necessity for surgery did not utilize the WPATH criteria and therefore did not meet the standard of care. There is also no evidence that the MTC, which exists to review treatment decisions by providers, reviewed his assessment, or re-evaluated Ms. Edmo for surgery after her second self-surgery attempt just a few months later. Ms. Edmo has set forth sufficient evidence to show that Defendants' initial and continued reliance on Dr. Eliason's medically unacceptable course of treatment can establish Eighth Amendment liability. *See, e.g., Jackson v. McIntosh*, 90 F.3d 330, 332 (9th Cir. 1996) (summary judgment improper where jury could find course of treatment was

medically unacceptable under the circumstances and was chosen in conscious disregard of excessive risk to plaintiff); *Hamilton v. Endell*, 981 F.2d 1062, 1067 (9th Cir. 1992) (“By choosing to rely upon a medical opinion which a reasonable person would likely determine to be inferior, the prison officials took actions which may have amounted to the denial of medical treatment, and the ‘unnecessary and wanton infliction of pain.’”), *overruled in part on other grounds as recognized in Colwell v. Bannister*, 763 F.3d 1060, 1069 (9th Cir. 2014). Nor is the Court persuaded that Dr. Eliason’s informal consult with Jeremy Clark, a WPATH member who was not qualified to assess Ms. Edmo under IDOC’s operative policy, meets the standard of care.

136. Defendants have continually denied Ms. Edmo access to a treatment proven to effectively treat gender dysphoria, while at the same time failing to identify or offer her any alternative treatment to adequately alleviate her severe gender dysphoria. *See Fields*, 653 F.3d at 556 (“More importantly here, defendants did not produce any evidence that another treatment could be an adequate replacement for hormone therapy.”); *Rosado v. Alameida*, 349 F. Supp. 2d 1340, 1346 (S.D. Cal. 2004) (strong likelihood of proving that a liver transplant was medically necessary where prison officials failed to “identify an alternative treatment that may save Plaintiff’s life”).

137. Defendants’ treatment providers have asserted without any supporting evidence that counseling and hormone therapy is sufficient to treat Ms. Edmo’s serious medical condition, despite the undisputed evidence showing that it is not. *See Fields*, 653 F.3d at 556 (“Although DOC can provide psychotherapy as well as antipsychotics and antidepressants, defendants failed to present evidence rebutting the testimony that these treatments do nothing to treat the underlying [gender dysphoria].”); *Hicklin I*, 2018 U.S. Dist. LEXIS 21516, at *41 (“[P]sychiatric care and counseling alone are constitutionally inadequate to address Ms. Hicklin’s gender dysphoria.”); *McNearney*, 2012 U.S. Dist. LEXIS 115802, at *38 (by offering plaintiff treatment “shown to be ineffective . . . Defendants have chosen a course of treatment that is medically unacceptable under the circumstances, and have done so in conscious disregard of an excessive risk to Plaintiff’s health”); *Miller*, 2011 U.S. Dist. LEXIS 15116, at *10 (“Plaintiff has shown a likelihood of proving that a liver transplant will save his life, and as such, is medically necessary”); *see*

also *Snow v. McDaniel*, 681 F.3d 978, 987-89 (9th Cir. 2012) (reversing summary judgment on plaintiff's Eighth Amendment claim because a jury could find that the defendants' decision to treat plaintiff "pharmacologically rather than surgically" over a period of years was medically unacceptable), *overruled on other grounds by Peralta v. Dillard*, 744 F.3d 1076 (9th Cir. 2014); *Konitzer v. Frank*, 711 F. Supp. 2d 874, 908 (E.D. Wis. May 10, 2010) (summary judgment inappropriate where plaintiff's repeated self-castration attempts was evidence that "what the defendants were doing to treat [plaintiff's gender dysphoria] was not working").

138. Plaintiff's experts explained why group counseling or psychotherapy is not a medically reasonable alternative to gender confirmation surgery, and none of Defendants' experts or treaters denied that gender confirmation surgery would, in fact, remediate Ms. Edmo's underlying condition of gender dysphoria. Defendants' purposeful and knowing refusal to provide Ms. Edmo available treatment that is generally accepted in the field as safe and effective, despite her actual harm and ongoing risk of future harm including self-castration attempts, cutting, and suicidal ideation, demonstrates deliberate indifference.

Defendants have a de facto ban against gender confirmation surgery

139. The evidence also suggests that Ms. Edmo has not been provided gender confirmation surgery because Corizon and IDOC have a *de facto* policy or practice of refusing this treatment for gender dysphoria to prisoners. Such a ban conflicts with the requirement that medical care be individualized based on a particular patient's needs. *Hicklin I*, 2018 U.S. Dist. LEXIS 21516, at *38 ("The denial of [treatment] based on a blanket rule, rather than an individualized medical determination, constitutes deliberate indifference in violation of the Eighth Amendment."); *Norsworthy*, 87 F. Supp. 3d at 1191.

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

dysphoria do not include surgery as a treatment option. Moreover, Dr. Levine’s training provided to Corizon and IDOC staff, and incorporated into further Corizon and IDOC training, discourages providing surgery to incarcerated persons with gender dysphoria.

141. Consistent with their training, no Corizon or IDOC provider has ever recommended that gender confirmation surgery is medically necessary for a patient in IDOC custody and, in fact, Corizon has never provided this surgery at any facility anywhere in the United States.

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

2. Fourteenth Amendment Claim

143. Plaintiff also moved for a preliminary injunction under the Fourteenth Amendment, arguing that Defendants’ refusal to provide medically necessary care and improper discipline of Plaintiff impermissibly discriminates on the basis of sex, including gender identity and transgender status, in violation of the Equal Protection Clause.

144. Discrimination against transgender people, whether described as being on the basis of sex or gender identity, is subject to heightened scrutiny under the Fourteenth Amendment. *See United States v. Virginia*, 518 U.S. 515, 533 (1996).; *Martin v. Barron*, 286 F. Supp. 3d 1131, 1144-45 (D. Idaho 2018); *see also Whitaker v. Kenosha Unified Sch. Dist. No. 1*, 858 F. 3d 1034, 1051 (7th Cir. 2017); *Glenn v. Brumby*, 663 F. 3d 1312, 1317 (11th Cir. 2011); *Smith v. City of Salem*, 378 F. 3d 566, 572-73 (6th Cir. 2004); *Stockman v. Trump*, No. 5:17-cv-01799-JGB-KK, Dkt. No. 79, at 19 (C.D. Cal. Dec. 22, 2017); *A.H. v Minersville Area School District*, 2017 U.S. Dist. LEXIS 193622 (M.D. Pa. Nov. 22, 2017); *Stone v. Trump*, 280 F. Supp. 3d 747, 768 (D. Md. 2017); *Doe v. Trump*, 275 F. Supp. 3d 167, 208 (D.D.C. 2017); *Evancho v. Pine-Richland Sch. Dist.*, 237 F.

Supp. 3d 267, 288 (W.D. Pa. 2017); *Olive v. Harrington*, No. 1:15-cv-01276, 2016 WL 4899177, at *5 (E.D. Cal. Sept. 14, 2016); *Marlett v. Harrington*, No. 1:15-cv-01382, 2015 WL 6123613, at *4 (E.D. Cal. Oct. 16, 2015); *Adkins v. City of New York*, 143 F. Supp. 3d 134, 140 (S.D.N.Y. 2015); *Norsworthy*, 87 F. Supp. 3d at 1119; *cf. Schwenk v. Hartford*, 204 F. 3d 1187, 1201-02 (9th Cir. 2000) (discrimination against transgender people constitutes sex discrimination).

145. Heightened scrutiny requires Defendants to demonstrate that any policy or practice of assessing or responding differently to the medical needs of transgender persons based on their sex or gender identity is substantially related to an important government interest. *See, e.g., Martin*, 286 F. Supp. 3d at 1142. The asserted governmental justification must be “exceedingly persuasive” and “genuine, not hypothesized or invented *post hoc* in response to litigation.” *Virginia*, 518 U.S. at 533.

146. Here, Plaintiff has demonstrated that she will succeed on her claim that Defendants’ denial of gender confirmation surgery violates the Fourteenth Amendment. Defendants treat medical necessity for gender confirmation surgery differently than they treat medical necessity for other medical conditions not associated with suspect or quasi-suspect groups. Defendants’ briefing and the declarations they submitted in lieu of testimony from the Warden at the prison where Ms. Edmo is housed and other IDOC staff contended that Ms. Edmo should not receive gender confirmation surgery because of, for example, “maladaptive behaviors” that they describe as “unresolved mental health concerns.” Defendants have pointed to no other medical condition for which they deny medically necessary treatment on such a basis.

147. Dr. Levine’s training PowerPoint, which was then embraced by IDOC and Corizon through Dr. Eliason’s and Mr. Clark’s own training materials, equates gender confirmation surgery with elective breast enhancement surgery for women who do not have any associated medical diagnosis. This suggests a belief that gender dysphoria is not a legitimate medical condition and that a prison

should never provide a transgender person gender confirmation surgery, in contrast to the DSM-V and other accepted medical standards.

148. Plaintiff has also presented evidence of discrimination based on sex and gender identity through Defendants' repeated discipline of her for refusing to follow orders when IDOC officers instructed her to change her appearance because it was effeminate or feminine. The declaration and deposition testimony of Warden Yordy, which was submitted as evidence to the Court, confirmed that IDOC policy prohibited persons incarcerated in a male prison from appearing "feminine," including wearing any hairstyle deemed a "women's style" and any makeup whatsoever, which Plaintiff's experts explained to be important elements of treatment for gender dysphoria. IDOC has characterized Ms. Edmo's efforts to feminize her appearance by, for example, wearing her hair in a "high ponytail" or "bun," as "repeated attempts to sexualize her appearance in a male facility." IDOC's equating any display of feminine appearance with being sexually provocative, sexually charged, or an attempt to sexualize appearance—and especially without any consideration of whether the individual has gender dysphoria—strongly suggests impermissible sex stereotyping.

149. The evidence in the record contains admissions by IDOC that these conclusions are not grounded in legitimate penological interests. IDOC's claimed reasons for disciplining Ms. Edmo are further belied by the fact that IDOC's just-adopted policy now seemingly permits the very behaviors for which Ms. Edmo was previously disciplined. There is no legitimate, much less important, governmental interest in denying medically necessary care to a prisoner based on sex or gender identity, or in denying medically necessary treatment to a socially disfavored group of people based on sex stereotyping.

150. This evidence, considered together, demonstrates that Plaintiff is very likely to succeed in demonstrating that Defendants have violated the Fourteenth Amendment by denying her medical

treatment and impermissibly discriminating against her on the basis of sex and gender identity, including sex stereotyping or an impermissible belief about underlying sex and gender roles.

151. Despite IDOC’s adoption of a new gender dysphoria policy on the eve of the hearing, Plaintiff’s requested relief related to Plaintiff’s discipline for wearing gender-appropriate underwear and clothing, and adhering to female grooming standards with regards to makeup and hair styling, are not moot. There is no evidence that IDOC’s new policy, which prohibits “provocative or sexually charged clothing or behavior,” Exh. 9 at 6, will not be used by Defendants to continue to discipline and retaliate against Plaintiff for expressing her gender identity. *See Friends of the Earth, Inc. v. Laidlaw Envtl. Servs. (TOC), Inc.*, 528 U.S. 167, 190 (2000) (in order to show a claim is moot, defendants “bear[] the formidable burden of showing that it is absolutely clear the allegedly wrongful behavior could not reasonably be expected to recur”).

3. Affordable Care Act Claim

152. Section 1557 of the Affordable Care Act prohibits covered entities from discriminating based on sex in the provision of health care services. 42 U.S.C. § 18116. As a health program or activity that receives federal financial assistance, IDOC is a covered entity subject to the nondiscrimination requirement. *See* 45 C.F.R. § 92.4. The anti-discrimination provisions of the ACA are construed consistently with those of other federal sex discrimination laws; accordingly, the ACA’s prohibition of discrimination based on sex prevents differential treatment of transgender patients. *See, e.g., Prescott v. Rady Children’s Hospital-San Diego*, 265 F. Supp. 3d 1090, 1099 (S.D. Cal. 2017). For the same reasons as articulated in the Court’s analysis of Ms. Edmo’s Fourteenth Amendment claim, Plaintiff has demonstrated the law is clearly in her favor on the merits of her ACA discrimination claim.

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B. Irreparable Harm in the Absence of Relief

153. The Ninth Circuit has repeatedly held that serious psychological harm, in addition to physical harm and suffering, constitutes irreparable injury. *See, e.g., Chalk v. U.S. Dist. Ct. Cent. Dist. of California*, 840 F. 2d 701, 709 (9th Cir. 1988) (plaintiff’s “emotional stress, depression and reduced sense of well-being” constituted irreparable harm); *Thomas v. Cnty. of Los Angeles*, 978 F. 2d 504, 512 (9th Cir. 1992) (“Plaintiffs have also established irreparable harm, based on this Court’s finding that the deputies’ actions have resulted in irreparable physical and emotional injuries to plaintiffs and the violation of plaintiffs’ civil rights.”); *see also Hernandez v. Cnty. of Monterey*, 110 F. Supp. 3d 929, 956 (N.D. Cal. 2015) (“[P]ain, suffering and the risk of death constitute irreparable harm sufficient to support a preliminary injunction in prison cases.”) (internal quotations omitted); *Wood v. Cnty. of Alameda*, 1995 U.S. Dist. LEXIS 17514, at *46 (N.D. Cal. Nov. 17, 1995) (finding irreparable injury where plaintiff’s “declaration ma[de] clear that she has suffered feelings of guilt, depression, anxiety, and loss of self-esteem . . .”). It is also well established “that the deprivation of constitutional rights ‘unquestionably constitutes irreparable injury.’” *Melendres v. Arpaio*, 695 F. 3d 990, 1002 (9th Cir. 2012) (quoting *Elrod v. Burns*, 427 U.S. 347, 373 (1976)); *see also Doe v. Harris*, 772 F. 3d 563, 583 (9th Cir. 2014).

154. By definition, Ms. Edmo’s gender dysphoria results in clinically significant distress or impairment of functioning. Indeed, both Plaintiff’s and Defendants’ experts agree that Ms. Edmo is properly diagnosed with gender dysphoria and continues to experience serious distress from this condition. While Ms. Edmo has received hormone treatment, she experienced the maximum feminizing effects years ago. As other district courts have recognized, the significant emotional pain, suffering, anxiety, and depression caused by prison officials’ failure to provide adequate treatment for gender dysphoria constitute irreparable harm warranting a preliminary injunction. *See, e.g., Hicklin I*, 2018 U.S. Dist. LEXIS 21516, at *29 (concluding that plaintiff would suffer “irreparable harm in the absence of a preliminary injunction because she suffers from depression, anxiety, and intrusive thoughts of self-castration as a result of Defendants’ conduct”); *Hicklin*, No. 4:16-cv-02357-NCC, Dkt. No. 176 (granting permanent injunction); *Norsworthy*, 87 F. Supp. 3d

at 1192 (irreparable injury where plaintiff testified that “she suffers continued and ‘excruciating’ ‘psychological and emotional pain’ as a result of her gender dysphoria”).

155. Evidence that an incarcerated person is at “severe risk of self-harm” through self-castration also supports a finding of irreparable injury. *See Hicklin I*, 2018 U.S. Dist. LEXIS 21516, at *31 (irreparable injury where plaintiff was at “severe risk of self-harm” in light of evidence that “she has a history of suicide ideation and has indicated on more than one occasion the inclination to remove her own testicles”). As a result of Defendants’ denial of care, Ms. Edmo has twice risked her life in attempts to self-castrate, resulting in significant pain and suffering.

156. The Court credits the testimony of Plaintiff’s experts that, without surgery, Ms. Edmo is at grave risk of serious and life-threatening self-harm. Indeed, it appears that the only thing assisting Ms. Edmo to hold such harm at bay since her last self-surgery attempt may be the instant lawsuit.

157. Moreover, the fact that Ms. Edmo’s need for this surgery has been ongoing for years does not alter the nature of the irreparable harm analysis for the purposes of a preliminary injunction. *See Norsworthy*, 87 F. Supp. 3d at 1193 (evidence that a plaintiff’s gender dysphoria has not been “properly treated over a period of years,” and that the plaintiff’s need for gender confirmation surgery is “a matter of long-standing, not sudden, urgency . . . constitutes irreparable injury, whether this is the first month she has suffered it or the hundredth.”); *see also McNearney*, 2012 U.S. Dist. LEXIS 115802, at *14.

158. Ms. Edmo has established that she will suffer serious psychological harm and will be at high risk of self-castration and suicide in the absence of gender confirmation surgery. These satisfy the irreparable harm standard for granting a mandatory injunction.

C. Balance of Equities

159. “Courts ‘must balance the competing claims of injury and must consider the effect on each party of the granting or withholding of the requested relief.’” *Winter*, 555 U.S. at 24 (quoting *Amoco Production Co.*, 480 U.S. 531, 542 (1987)). The balance of equities tips in a plaintiff’s favor where the plaintiff has established irreparable harm in the form of unnecessary physical and emotional suffering and denial of her constitutional rights. *See, e. g., Hicklin I*, 2018 U.S. Dist.

LEXIS 21516, at *44 (finding the “balance of harms substantially weighs in favor of granting injunctive relief” because plaintiff demonstrated “she continues to face irreparable injury absent relief . . . including the denial of her constitutional rights”); *Norsworthy*, 87 F. Supp. 3d at 1193 (“The balance of the equities favors [plaintiff’s] requested relief. She has established that she is suffering and is likely to continue to suffer unnecessary pain if she is denied SRS.”); *Rhea*, 2010 U.S. Dist. LEXIS 97705, at *37 (“In light of the medical findings of these physicians that [plaintiff] is suffering and will continue to suffer unnecessary pain, the undersigned finds that the balance of hardships is greater for Ms. Rhea if the injunction were not granted.”).

160. Ms. Edmo has more than adequately established that Defendants’ refusal to provide her with medically necessary treatment for her gender dysphoria, specifically gender confirmation surgery, causes her ongoing irreparable harm.

161. Defendants’ claim of injury, on the other hand, is that an order directing them to provide a “potentially harmful procedure” interferes with their ability to provide medical necessary care on an individualized basis. ECF No. 99 at 19. Defendants have made no showing that this statement is based in anything other than unsupported conjecture. They have offered no credible evidence that surgery for Ms. Edmo is a potentially harmful procedure, nor that an order requiring them to provide treatment that accords with the recognized standard of care impedes their ability to provide medical care on an individualized basis. *See Zepeda v. U.S. I.N.S.*, 753 F.2d 719, 727 (9th Cir. 1983) (defendant “cannot reasonably assert that it is harmed in any legally cognizable sense by being enjoined from constitutional violations”).

162. The irreparable physical and emotional harm facing Ms. Edmo in the absence of surgery outweighs any hypothetical hardship to Defendants, which are a state entity and its private medical provider. *See Rodde v. Bonta*, 357 F. 3d 988, 999 (9th Cir. 2004) (balance of hardships favored disabled plaintiffs, who would be deprived of necessary treatment and suffer increased pain and medical complications without relief); *Hernandez*, 110 F. Supp. 3d at 957 (balance of equities favored inmates given Ninth Circuit law holding “that the interest in protecting individuals from physical harm outweighs monetary costs to government entities”).

D. The Public Interest

163. The Court finds that a mandatory preliminary injunction is in the public interest. “[I]t is always in the public interest to prevent the violation of a party’s constitutional rights.” *See Melendres*, 695 F. 3d at 1002 (citations and internal quotations omitted); *see also United States v. Raines*, 362 U.S. 17, 27 (1960) (“[T]here is the highest public interest in the due observance of all constitutional guarantees.”).

164. “In addition, ‘the public has a strong interest in the provision of constitutionally adequate health care to prisoners.’” *McNearney*, 2012 U.S. Dist. LEXIS 115802, at *44 (quoting *Flynn v. Doyle*, 630 F. Supp. 2d 987, 993 (E.D. Wis. 2009)). There is no public interest in forcing Ms. Edmo to continue to suffer unnecessary and life-threatening harms during this litigation. *See Fields*, 653 F. 3d at 556; *Norsworthy*, 87 F. Supp. 3d at 1194.

CONCLUSION

165. For the foregoing reasons, Plaintiff’s motion for a preliminary injunction is granted in part.³ Defendants are ordered to provide Plaintiff with adequate medical care, including gender confirmation surgery. Defendants shall take all actions reasonably necessary to provide Ms. Edmo gender confirmation surgery as promptly as possible and no later than six months from the date of this order. Defendants are further enjoined from disciplining or punishing Plaintiff for expressions of her gender identity that are reasonably related to her diagnosis of gender dysphoria, including hairstyle and wearing of makeup that are generally permitted in IDOC’s women’s prisons.

166. The Court has considered the mandates of the Prison Litigation Reform Act requiring that a court “shall not grant or approve any prospective relief unless the court finds that such relief is narrowly drawn, extends no further than necessary to correct the violation of the Federal right, and is the least intrusive means necessary to correct the violation of the federal right,” and “shall give substantial weight to any adverse impact on public safety or the operation of a criminal justice

³ Given IDOC’s implementation of an updated gender dysphoria policy on October 5, 2018 that appears to provide Plaintiff’s requested injunctive relief related to accessing gender-appropriate underwear, clothing, and commissary items, the Court will not address this relief at this time. This is without prejudice should IDOC implementation of the policy result in ongoing violations.

system.” 18 U.S.C. § 3626(a)(2). The Court concludes that its order for injunctive relief satisfies the PLRA requirements. It is narrowly drawn, extends no further than necessary, and is the least intrusive means of correcting the violations. Further, there is no evidence that granting this relief will have any adverse impact on public safety or the operation of the criminal justice system. *See Norsworthy*, 87 F. Supp. 3d at 1195; *Fields*, 653 F. 3d at 556.

Dated: October 26, 2018

Respectfully Submitted,
NATIONAL CENTER FOR LESBIAN RIGHTS
FERGUSON DURHAM
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CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on the 5th day of October, 2018, I filed the foregoing electronically through the CM/ECF system, which caused the following parties or counsel to be served by electronic means, as more fully reflected on the Notice of Electronic Filing:

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