

2011

Propagating Gender Stasis: Judicial Indifference and the Medical Model of Gender in Requests for State Medical Assistance

D. Andrew Quigley

Follow this and additional works at: <http://digitalcommons.wcl.american.edu/tma>



Part of the [Law Commons](#)

Recommended Citation

Quigley, D. Andrew. "Propagating Gender Stasis: Judicial Indifference and the Medical Model of Gender in Requests for State Medical Assistance." *The Modern American* 7, no. 2 (2011): 40-63.

This Article is brought to you for free and open access by the Washington College of Law Journals & Law Reviews at Digital Commons @ American University Washington College of Law. It has been accepted for inclusion in *The Modern American* by an authorized administrator of Digital Commons @ American University Washington College of Law. For more information, please contact fbrown@wcl.american.edu.

Propagating Gender Stasis: Judicial Indifference and the Medical Model of Gender in Requests for State Medical Assistance

PROPAGATING GENDER STASIS: JUDICIAL INDIFFERENCE AND THE MEDICAL MODEL OF GENDER IN REQUESTS FOR STATE MEDICAL ASSISTANCE

By D. Andrew Quigley¹

Abstract

From the time the American Psychiatric Association (“APA”) first included “transsexualism” in its authoritative *Diagnostic and Statistical Manual* (“DSM”) in 1980, transgender litigants have increasingly relied on medical diagnoses and definitions to bolster their gender-related claims. Relying on this “medical model of gender” requires transgender litigants to adopt essentialist notions of gender and accept conservative gender norms, both of which generally contradict common beliefs within the gender-variant community. While the medical model may have once been justified as a means to achieving otherwise-unattainable legal vindication, the model’s cost-benefit calculus no longer tips in the gender-variant litigant’s favor.

This paper analyzes the current legal framework for individuals diagnosed with Gender Identity Disorder (“GID”) and who rely on the state for medical assistance. The framework reveals an implicit judicial deference to administrative authorities that is inversely related to the patient’s socioeconomic status; that is, as the socioeconomic status of the patient falls — from an individual who does not benefit from government-funded programs to a “categorically needy” Medicaid recipient to a prison inmate — courts increasingly defer to the (mis) judgments of the administrative officials charged with disbursing medical funds.

This paper argues that the implicit judicial deference in this context signals nothing less than indifference to gender and gender expression as concepts distinct from anatomical sex. It follows, then, that, given this judicial indifference, gender-variant litigants should abandon the medical model

because it serves only to freeze gender-variant persons in restrictive conceptions of gender.

Introduction

Gender Identity Disorder (“GID”) is a medical condition marked by a feeling of disjunction between one’s anatomical sex and one’s self-perceived gender.² Since the American Psychiatric Association (“APA”) added “transsexualism” to the third edition of its authoritative *Diagnostics and Statistical Manual* (“DSM”) in the 1980s, gender-variant individuals have increasingly relied on medical definitions and physician testimony to legitimize and bolster their gender-related legal claims. Though this “medical model of gender” requires gender-variant individuals to acknowledge gender boundaries and adopt essentialist definitions of “male” and “female,” many gender-variant individuals accept this requirement in the belief that the legal benefits the model affords outweigh the social costs the model imposes.³

A careful examination of the medical model as it is applied to individuals with GID who depend on the state for medical funding for gender-reassignment surgery (“GRS”) demonstrates that the cost-benefit calculus of the medical model has shifted: today, a medical diagnosis is a necessary but *insufficient* condition for obtaining state funds to treat GID. Once a medical expert determines that GRS is “medically necessary” to treat a gender-variant patient’s severe distress, administrators and judges scrutinize the expert’s determinations and make their own judgments as to the *actual* necessity of the prescribed surgery.

Third-party scrutiny of treatments prescribed for individuals who receive healthcare funding from the state is to be expected to a certain degree

because of the administrative and legal structures governing the individual. A prisoner, for example, must request treatment from the Department of Corrections (“DOC”), which has its own standards for determining what conditions warrant medical treatment.⁴ If the DOC denies the prisoner’s request, the prisoner’s only legal recourse is an Eighth Amendment claim of deliberate indifference to a serious medical need.⁵ The situation is similar for a non-incarcerated “categorically needy” Medicaid recipient: an individual who qualifies as “categorically needy” under a state’s Medicaid statute⁶ must appeal to the state’s Medicaid administrator for treatment and, if the administrator denies the request, the Medicaid recipient can bring a due process claim.⁷ Finally, a non-incarcerated, non-categorically needy individual who can front the cost of a gender-reassignment operation also faces administrative structures: a taxpayer who is not dependent on the state for medical assistance may appeal to the Internal Revenue Service (“IRS”) and may use tax laws as the basis of a claim that a particular medical treatment can be deducted as a medical expense from the taxpayer’s income.⁸

While the prisoner’s burden is greater than the burden faced by both non-incarcerated individuals who can front the cost of a gender-reassignment operation,⁹ there is an aspect to each cause of action that is not written into the law. This unwritten element is the amount of judicial deference courts afford to an administrative authority. The disparity in judicial deference becomes apparent through a comparison of cases addressing the necessity of GRS for individuals in each of these three socioeconomic classes. These cases display an implicit deference to administrative authority that is, perhaps coincidentally, inversely correlated to the gender-variant individual’s socioeconomic status. In other words, as the status of the individual requesting medical treatment sinks — from non-incarcerated, non-categorically needy individual to non-incarcerated categorically needy individual to prisoner — the judicial deference to the authority charged with administering medical funds to such individuals increases.¹⁰

This Note argues that tethering deference to decreased socioeconomic status¹¹ provides an approximate “weight” to the judicial balancing of an individual’s interest in gender expression and the relevant administrative decision-making authority. On the one hand, an individual’s interest in gender

expression is significant enough that GRS paid for by an individual is not characterized as merely “cosmetic” and merits a tax deduction.¹² On the other hand, an individual’s interest in gender expression is not significant enough to hold prison officials accountable for failing to take seriously the extreme distress a prisoner attributes to her inability to obtain GRS.¹³ This differential signals a certain amount of judicial indifference to gender expression — an indifference that cannot be overcome by medical diagnoses and physician testimony. To put it differently, in a case involving tax deductions for gender-reassignment surgery, the gender-variant individual has already deducted the procedure from taxable income, and the judge’s role is merely to approve or disapprove of that deduction: there is relatively little at stake, and medical diagnoses and physician testimony have sufficient authority to overcome the state’s competing interests. In an Eighth Amendment claim, however, the gender-variant individual has not yet undergone gender-reassignment surgery, and his or her only means of obtaining the procedure is through proving fault; thus, the value of gender-reassignment surgery, taking in to account medical diagnoses and physician testimony, is weighed against the cost of finding prison officials liable for acting with deliberate indifference to the prisoner’s medical needs: here, there is more at stake, and medical diagnoses and physician testimony fail to overcome the state’s interests. This paper asserts that this differential converges on the obviousness, and perceived legitimacy, of the condition at issue.¹⁴ Thus, “judicial indifference to gender expression” as it is used in this paper, is shorthand for the perceived illegitimacy of the physical and mental manifestations of frustrated gender expression — a judicial unwillingness to credit GID.

Furthermore, from a strategic standpoint, because the medical model of gender proves mostly ineffective in the framework for state-funding requests, where medical diagnoses and expert opinions apply directly to the issue being decided, the medical model should not be expected to vindicate the rights of gender-variant people in other areas of the law, where the model applies only peripherally — such as in Title VII discrimination claims.

This Note proceeds as follows: Part I introduces the concepts of gender and gender expression and seeks to clarify the important role that one’s physical presentation has in fully realizing one’s

intended gender identity. This Part draws heavily from contemporary feminist theories on gender and identity performance and the social construction of gender identity.

Part II presents the medical perspective on gender and follows the development of the medical model from its nascence in the 1960s and 1970s to its status as a legal fixture today. By providing the history of the medical model, this Part attempts to shed light on how and why the medical model came to be entrenched in gender-based causes of action.

Part III presents in greater detail the framework for state medical assistance claims by gender-variant plaintiffs diagnosed with GID for whom sex-reassignment surgery is prescribed as medically necessary. This Part examines representative case law under the three causes of action constituting the framework: Eighth Amendment claims of deliberate indifference to a serious medical need, due process claims for denied Medicaid funding, and income tax redetermination for medical expenses deducted under I.R.C. § 213. Here, the analysis goes into the structural differences built into each cause of action, the disparate levels of implicit deference applied in each action, and the logical inconsistencies in the court opinions, all of which suggest judicial indifference toward gender expression.

Part IV takes a broader view of the medical model as it is applied in the state medical assistance framework. This Part seeks to demonstrate that the medical model propagates an overall gender stasis. Part IV-A argues that the medical model leaves gender expression in a social stasis because individuals adopting the medical model for their legal claims are forced to adopt an essentialist conception of gender as well as conservative gender norms. Part IV-B extrapolates from the limited legal efficacy of the medical model as it applies to the state medical assistance framework to suggest that the model should not be expected to provide more robust support in other areas of law. Part IV-C looks at the language used in legal discussions of gender issues and determines that using abstract medical concepts as placeholders for more contentious issues of gender identity shelves critical discussion of gender. Finally, Part IV-D argues that, in the context of the state medical assistance framework, the medical model denies gender-variant people agency in determining the physical aspects of their gender expression.

Part V examines the potential interaction of the state medical assistance framework with Title VII “unequal burdens” dress code jurisprudence. The goal of this Part is to demonstrate how case law in the limited setting of state medical assistance claims connects with other areas of the law and ultimately affects the gender-variant community in seemingly unrelated areas.

Part VI concludes by noting that judicial deference to administrative opinions in state medical assistance claims has the inadvertent effect of eroding the traditional male–female gender binary. This is because gender reassignment surgery actually reinforces the binary by moving individuals out of the “gray area” between male and female and into one category or the other. Thus, by denying gender-variant people gender reassignment surgery, courts force them to inhabit the space in between the traditional male and female sex–gender alignment. This Note suggests that gender-variant people work from this gray area to create new tools for expressing gender.

I. Gender and Gender Identity

Traditional conceptualizations of sex and gender merged the two concepts together, and because sex was generally thought to be biologically determined, so too was gender.¹⁵ Contemporary feminist theory explains that sex and gender are two distinct concepts, and that the fusion of sex and gender is a socially constructed phenomenon.¹⁶ The basic idea is that generation upon generation has assigned and enforced societal roles and condoned behaviors based on a newborn’s anatomical sex.¹⁷ The passage of time and the reinforcement of these socially prescribed roles eventually blurred the line between anatomical sex and gender until people began to see gender roles and behaviors as determined by sex, rather than by society.¹⁸

In her pioneering work on gender, Judith Butler explains that gender is “the repeated stylization of the body, a set of repeated acts within a highly rigid regulatory frame that congeal over time to produce the appearance of substance, a natural sort of being.”¹⁹ The idea is that gender is not some concrete, immutable trait; rather, gender is performed and interpreted in a particular way, and the interaction of the performance and the interpretation makes

up one's gender identity. As Butler puts it, "there is no gender identity behind the expression of gender; that identity is performatively constituted by the very expressions that are said to be its results."²⁰

The physical body plays an "inescapable role" in gender expression — it is the two-way filter through which individuals experience the world and the world interprets the individual.²¹ If every performative act is read in the context of the physical body,²² then individuals may choose to manipulate their bodies or otherwise "develop practices that either permanently or semi-permanently mark the body, providing a stable basis for public recognition of their chosen . . . identity."²³ Such is often the case for gender-variant people, who know "what [they are] and how [they need] to look."²⁴ In order to achieve that look, many gender-variant people seek hormone therapy, cosmetic surgery for secondary sex characteristics, or gender reassignment surgery.²⁵

Most gender-variant people are unable to access these treatments because of the costs of the treatments,²⁶ and because of the medical, administrative, and judicial barriers between the individual and the desired treatment.²⁷ This may seem inconsequential if one views these physical alterations as "cosmetic," but inaccessibility of treatment acquires greater meaning when one understands how important the physical body is to a gender-variant person's identity. The medical field has recognized the importance of the physical body to gender-variant gender identities: first when it included the desire for gender reassignment surgery as a necessary diagnostic criteria for "transsexualism,"²⁸ and later when it noted the intense distress that a gender-variant person experiences when that individual's physical body challenges the individual's self-perceived gender.²⁹

II. The Medical Model of Gender: Gender Identity Disorder

A. Definitions

Medical practitioners use the term Gender Identity Disorder ("GID") to describe a feeling of disjunction between one's biologically determined anatomical sex and one's self-perceived gender.³⁰ The APA first recognized the concept known today as GID in the third edition of its *Diagnostic and Statistical Manual (DSM-III)*, published in 1980.³¹

The *DSM-III* labeled the condition "transsexualism" and described it as a "Psychosexual Disorder" characterized by at least two years of "a persistent sense of discomfort and inappropriateness about one's anatomic sex" and a "persistent wish to be rid of one's genitals and to live as a member of the other sex."³² The APA revised the manual in 1987 and reclassified transsexualism in "Disorders Usually First Evidenced in Infancy, Childhood, or Adolescence."³³

The next conceptual revision to transsexualism came in 1994 with the fourth edition of the manual (*DSM-IV*), which renamed the condition "Gender Identity Disorder" and again reclassified the condition, this time as a treatable psychological disorder.³⁴ The only significant diagnostic difference between the third and fourth editions is that the latter requires "evidence of clinically significant distress or impairment in social, occupational, or other important areas of functioning."³⁵ Clinically significant distress was not required under the third edition.

In 2013, the American Psychiatric Association (APA) will release the fifth edition of its *Diagnostic and Statistical Manual (DSM-V)*.³⁶ Among the noteworthy changes proposed to take effect in the new edition is the continued evolution of the terminology used to refer to members of the gender-variant community. In the fifth edition, the APA intends to replace the most recent terminology with "gender incongruence," a term that "better reflects the core problem: an incongruence between, on the one hand, what identity one experiences and/or expresses and, on the other hand, how one is expected to live based on one's assigned gender."³⁷ In support of the new terminology, the APA reports that many members of the gender-variant community reject GID as stigmatizing.³⁸

B. Diagnosis and Treatment

The first step in diagnosing GID involves applying various diagnostic criteria. The *Standards of Care* compiled by the World Professional Association for Transgender Health (WPATH) endorse the criteria used in both the *DSM-IV* and the International Classification of Diseases, both of which employ essentially the same criteria.³⁹ After the preliminary diagnosis, more specified diagnostic procedures are paired with the treatment process.⁴⁰ Many individuals who seek a GID diagnosis do so in order to eventually get gender reassignment surgery.⁴¹

However, because gender reassignment surgery has serious consequences, and because the important determinative information is mostly subjective, self-reported information from the patient, the diagnostic process is long and thorough.⁴²

As GID evolved from a disease to a disorder, practitioners reconceptualized treatment regimens for individuals seeking medical assistance. The first treatments, studied in the 1960s, attempted to alter the patient's self-perception to match the patient's anatomical sex, but these purely therapeutic methods were deemed ineffective.⁴³ Subsequent studies suggested that a combination of psychotherapy, hormone treatment, and gender reassignment surgery would effectively treat gender identity disorder.⁴⁴ Today, medical professionals widely accept this "triadic" approach to treatment and WPATH's *Standards of Care* endorse the triadic approach as well.⁴⁵ The *Standards of Care* emphasize that the goal of treatment is not to "cure" the patient, but to assist in the transition process.⁴⁶ The methods endorsed by the *Standards of Care* are supported by peer-reviewed research and years of successful results, and WPATH asserts that the triadic approach is the only proven treatment for severe GID.⁴⁷

Though studies indicate that the triadic approach effectively treats GID, without insurance, the costs of treating GID are prohibitively expensive. Genital reassignment surgery for transgender men can cost up to \$100,000, while the procedure for transgender women can range from \$7,000 to \$50,000.⁴⁸ The cost of hormone therapy is about \$2,000 per year.⁴⁹ The WPATH *Standards of Care* recommends a year of hormone therapy before gender reassignment; it also provides that extended hormone therapy may be sufficient for individuals who do not wish to undergo surgery.⁵⁰ In the latter case, an individual with GID may be required to pay \$2,000 each year for several decades.⁵¹

III. The Existing Framework for State-Funded Medical Assistance: State-Funded Gender-Reassignment Surgery

Prison inmates, individuals who qualify as "categorically needy" under a state's Medicaid statute,⁵² and non-incarcerated, non-categorically needy taxpayers can appeal to the state for

assistance in funding medical procedures.⁵³ Prison inmates look primarily to prison officials to provide treatment, but when none is provided, inmates may allege deliberate indifference to medical necessity under the Eighth Amendment's prohibition against cruel and unusual punishment.⁵⁴ Categorically needy individuals may have medical procedures funded by the state Medicaid program so long as the condition fits within the state's Medicaid statute.⁵⁵ When Medicaid administrators deny a Medicaid recipient funding, the recipient may bring a due process claim alleging that the funding request was improperly denied.⁵⁶ Finally, non-incarcerated, non-categorically needy individuals who can afford to front the cost of an operation can receive state funding by way of tax deductions for medical procedures so long as the deductions qualify under I.R.C. § 213.⁵⁷ Each of these causes of action involves a different burden of proof, and as the following sections explain, each cause of action also receives a different level of implicit judicial deference to the relevant administrative authorities.

A. Eighth Amendment Claims of Deliberate Indifference

Society does not expect prisoners to have unlimited access to healthcare.⁵⁸ Thus, a prisoner faces a considerable burden in stating that denying the prisoner access to medical treatment constitutes cruel and unusual punishment in violation of the Eighth Amendment of the United States Constitution. A plaintiff who contends that he or she was subjected to cruel and unusual punishment must satisfy both an objective and a subjective element: the prisoner must prove that he or she had an objectively "serious medical need," and that those responsible for the prisoner's care were subjectively "deliberate[ly] indifferen[t]" to those needs.⁵⁹

An inmate can satisfy the objective burden of demonstrating a serious medical need by obtaining a medical diagnosis,⁶⁰ or, in cases where the medical need is "so obvious that even a layperson would easily recognize the necessity for a doctor's attention," the inmate can satisfy this burden without a medical diagnosis.⁶¹ Examples of cases in which a plaintiff has demonstrated a serious medical need without a diagnosis involve major wounds left open and untreated,⁶² or inmate deaths from illness.⁶³

The subjective element — deliberate indifference — is proven by showing that those responsible for the prisoner's care “(1) had subjective knowledge of a risk of serious harm; (2) disregarded that risk; and (3) exhibited conduct that [was] more than gross negligence.”⁶⁴ Case law interpretations of this subjective requirement demonstrate an almost insurmountable amount of deference to the decisions of prison officials. For example, courts have stated that the medical care provided to an inmate need not “even [be] very good,”⁶⁵ so long as prison officials provide some form of treatment deemed adequate by a physician.⁶⁶ Other courts have stated that “[m]edical treatment violates the Eighth Amendment only when it is so grossly incompetent, inadequate, or excessive as to shock the conscience or be intolerable to fundamental fairness.”⁶⁷

1. *Kosilek v. Maloney*⁶⁸

During the more than ten years that Kosilek had been incarcerated, she had been visited by at least four doctors, and all diagnosed her with severe GID requiring treatment.⁶⁹ Kosilek never received “any real treatment” during this time period, however,⁷⁰ and her untreated GID had “prompted h[er] to attempt suicide twice while incarcerated, and to try to castrate [her]self as well.”⁷¹ Kosilek filed an Eighth Amendment claim against the Commissioner of the Department of Corrections (“DOC”), alleging deliberate indifference to her serious medical need.⁷²

In response to the Kosilek's Eighth Amendment complaint, the Commissioner implemented a blanket “freeze-frame” policy for all transsexual prisoners in the DOC's custody.⁷³ The policy provided inmates with the same gender identity-related treatment they received prior to incarceration throughout the course of their incarceration. Because gender reassignment surgery is considered new treatment, even if the need for it has been diagnosed, this policy had the effect of categorically prohibiting GRS for inmates. In Kosilek's case, the policy served to prevent doctors from exercising discretion in prescribing treatments.⁷⁴ At the time the policy was enacted, Kosilek's medical expert and at least three doctors for the DOC agreed that “the likelihood [wa]s exceedingly close to one hundred percent that she w[ould] kill herself” if she did not receive medical treatment.⁷⁵ When the Commissioner enacted the

policy, he was aware that the plaintiff had tried to commit suicide and castrate herself.⁷⁶ He was also aware that at least one doctor thought there was a high risk that the inmate would commit suicide, and he knew that GID could pose serious risks if untreated.⁷⁷ Even so, the Commissioner continued to deny Kosilek treatment.⁷⁸

The District Court of Massachusetts found that the inmate easily met her objective burden of demonstrating a serious medical need.⁷⁹ Turning to the subjective prong, the court required Kosilek to show that her GID was not adequately treated “([1]) because of [the Commissioner's] deliberate indifference; and ([2]) that [that] deliberate indifference is likely to continue in the future.”⁸⁰ The court concluded that the Commissioner “knew many facts from which it could have been inferred that [the plaintiff] was at substantial risk of serious harm if he [sic] did not receive adequate treatment,” but the court relieved the Commissioner of Eighth Amendment liability because he “did not, however, actually draw that inference.”⁸¹ The plaintiff's Eighth Amendment claim failed, but the court suggested that the Commissioner provide the plaintiff with psychotherapy “[a]t a minimum.”⁸²

B. *State Medicaid Funding and Medically Necessary Treatments*

Medicaid is a federal-state cooperative program through which the federal government provides for the medical care of needy individuals by distributing funds to the states, which serve as administrators of the funds.⁸³ Before a state can receive medical funding, the state must submit, for approval, a plan detailing “reasonable standards” for determining the disbursement of funds.⁸⁴ Those reasonable standards prohibit states from denying or reducing the coverage of an individual “solely because of the diagnosis, type of illness, or condition.” Even so, states have discretion to limit coverage based on “medical necessity” and “utilization control procedures,” so long as those limits are “reasonable” and “consistent with the objectives of the Act.”⁸⁵

In the late 1970s and early 1980s, several courts invalidated Medicaid statute that excluded gender reassignment surgery, citing expert testimony that the surgery was the only available treatment for “transsexualism.”⁸⁶ Ironically, as

the scientific community worked to improve the medical understanding and treatment of gender-related disorders, the coverage of the procedures that gender-variant Medicaid recipients wanted became more difficult to access.⁸⁷ The change was not due to increased efforts or new arguments from the Medicaid administrators; rather, the defendant-administrators still proffered the same arguments that courts rejected decades earlier.⁸⁸ But where the administrators' arguments once failed because gender reassignment surgery was thought to be the only known treatment for "transsexualism,"⁸⁹ courts began to defer to the defendant-Medicaid administrators' judgments as to whether gender reassignment surgery *really* is necessary.⁹⁰

The change in the judicial treatment of state decisions to cease funding of gender reassignment surgery is most clearly demonstrated by two cases in the Eighth Circuit Court of Appeals. In *Pinneke v. Preisser*,⁹¹ the court held that excluding gender reassignment surgery was arbitrary, in violation of the Medicaid Act; twenty years later, in *Smith v. Rasmussen*,⁹² the same court heard the same facts, but this time the court upheld a categorical exclusion of gender reassignment surgeries.

1. *Pinneke*

In *Pinneke*, a Medicaid claimant who was diagnosed with transsexualism⁹³ after "extensive testing" challenged a policy in Iowa's state plan that categorically denied Medicaid benefits for gender reassignment surgery.⁹⁴ The exclusion created "an irrebuttable presumption that treatment of transsexualism by alternation of healthy tissue cannot be considered 'medically necessary.'"⁹⁵

The Minnesota Supreme Court had previously ruled on this issue in *Doe v. Department of Public Welfare*.⁹⁶ That court accepted as "given . . . fact" that transsexualism establishes "roots" in childhood and can be treated only by a "radical sex conversion surgical procedure."⁹⁷ The Minnesota Supreme Court lamented the necessity of the surgical route, but concluded that surgery was "second-best to a method of preventing these tragic reversals of gender identity and role"⁹⁸

The *Pinneke* court cited the *Doe* opinion with approval and, after reviewing the available medical resources, concluded that "radical sex conversion

surgery is the only medical treatment available to relieve or solve the problems of a true transsexual[.]"⁹⁹ and enjoined the state from prohibiting the "medically necessary" procedure.¹⁰⁰ *Pinneke* represented an important legal victory for gender-variant people. Many courts within the Eighth Circuit subsequently cited *Pinneke* for the proposition that "[it] is contrary to the objectives of Medicaid [to exclude] the 'only available treatment known at this stage of the art for a particular condition.'"¹⁰¹

2. *Smith v. Rasmussen*¹⁰²

Twenty years after *Pinneke*, the Eighth Circuit Court of Appeals was presented with the same issue: an individual diagnosed with GID challenged an Iowa Medicaid statute that prohibited "plastic surgery for certain purposes and . . . specifically exclude[d] sex reassignment surgery."¹⁰³ Though it appeared that *Rasmussen* called for a direct application of the *Pinneke* precedent, the Circuit Court stated that *Pinneke* was "not outcome determinative," in part because the legislature in *Pinneke* "had not followed a formal rulemaking process, had not consulted medical professionals, and had disregarded the current accumulated knowledge of the medical community."¹⁰⁴

Iowa's Medicaid amendment at issue in *Rasmussen* excluded all "[p]rocedures related to gender identity disorder."¹⁰⁵ The state supported the exclusion with the findings of a panel of physicians, none of whom had experience or expertise relevant to GID, that had been asked to review the efficacy of gender reassignment surgery.¹⁰⁶ The district court determined that the GID exclusion was unreasonable because the state "failed to contact, as sources of pertinent information, or to involve, as decision-makers or advisors, any persons with actual experience in the treatment of gender identity disorder."¹⁰⁷ The Eighth Circuit, reviewing the issue de novo,¹⁰⁸ acknowledged that "it might have been helpful or prudent for the [s]tate to have sought opinions from medical professionals with experience in [treating] gender identity disorder," but affirmed the exclusion because it "involved professional medical judgment."¹⁰⁹

Strangely, while the Eighth Circuit upheld the panel of physician's "professional medical judgment," even after acknowledging that none of the experts involved had "actual experience,"¹¹⁰ the court also sustained the trial court's ruling excluding

the defendant's medical expert's testimony because the doctor "had examined only one patient with gender identity disorder, that examination occurring some eight years prior to trial." After reviewing the issue, the court concluded that there was "no abuse of discretion in the limitation of the testimony of witnesses who, although considered experts in certain areas, *were not well-versed in the particular discipline relevant to their testimony.*"¹¹¹

C. *The Internal Revenue Code and Deductions for Medical Expenditures*

The Internal Revenue Code allows a taxpayer to deduct expenses for medical care from the taxpayer's gross taxable income.¹¹² "Medical care" expenses, as defined by I.R.C. § 213, are those expenses paid toward "the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body."¹¹³ The statute excludes cosmetic surgery, which is defined as "any procedure [that] is directed at improving the patient's appearance and does not meaningfully promote the proper function of the body or prevent or treat illness or disease."¹¹⁴ The cosmetic surgery exclusion applies "unless the surgery is necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or disfiguring disease."¹¹⁵

Under the cosmetic surgery exclusion, the Alabama Court of Civil Appeals disallowed a deduction for a woman requesting breast enhancement surgery in order to make her abnormally small right breast the size of her larger left breast, but allowed the deduction for the same woman for a procedure to decrease the size of her abnormally large left breast to the size of her smaller right breast.¹¹⁶ The court reasoned that the disallowed surgery was cosmetic because it did not improve bodily functions, whereas the allowed surgery "would probably" improve overall bodily function.¹¹⁷

1. *O'Donnabhain v. C.I.R.*¹¹⁸

O'Donnabhain was a case of first impression in the United States Tax Court.¹¹⁹ At issue was whether a transgender woman could deduct her gender-reassignment and breast-augmentation surgeries from her income tax returns pursuant to I.R.C. § 213.¹²⁰ *O'Donnabhain*, the plaintiff-taxpayer, was diagnosed

with GID by a "licensed independent social worker" who prescribed a treatment plan that followed the *WPATH Standards of Care*.¹²¹ After completing hormone therapy and the "real-life experience," *O'Donnabhain* obtained the two medical procedures in order to align her physical appearance with her female gender identity.¹²² The Commissioner of the IRS claimed that the surgeries were "cosmetic . . . because they were [aimed] at improving [*O'Donnabhain's*] appearance and did not treat an illness or disease, meaningfully promote the proper function of the body, or ameliorate a deformity."¹²³

The court, noting that no relevant legal precedent spoke to the issue of what qualifies as "cosmetic" under § 213, formulated the following test: a surgical procedure is not cosmetic if it treats disease.¹²⁴ In order to satisfy this test, *O'Donnabhain* had to show that GID was a disease and that gender reassignment and breast reduction surgeries treat GID;¹²⁵ she did not need to prove that the procedure was "medically necessary."¹²⁶ Influenced by plaintiff's and defendant's medical experts — all of which agreed that untreated GID could result in autocastration, autopenectomy, or suicide¹²⁷ — the court concluded that the severity of the condition, combined with the inclusion of GID in all the authoritative medical texts, indicated that GID was a disease for the purposes of § 213.¹²⁸

Turning to whether *O'Donnabhain's* surgeries treated GID, her expert testified that gender reassignment surgery was the only effective medical treatment for severe GID.¹²⁹ Though the government's experts argued that no such consensus existed within the larger medical community, the court allowed the deduction for the gender reassignment surgery and held that a consensus was not necessary if the "circumstances 'justify a reasonable belief [that] the treatment would work.'"¹³⁰ However, the court denied deductions for breast augmentation surgery, calling the surgery a cosmetic expense because it "merely improved" the patient's appearance and did not treat her GID.¹³¹

D. *Disparate Treatment in the Framework for State-Funded Medical Assistance*

1. Disparate Treatment Due to Structural Differences

The obvious disparity between the burdens that must be met in order to receive state funding

under each cause of action was at least partially intended by the institutions that created each cause of action. The Eighth Amendment, for example, originally considered only whether certain types of punishment were cruel and unusual.¹³² Judicial activism expanded the Eighth Amendment's scope to grant inmates a right to healthcare, and later decisions articulated the two-prong "deliberate indifference to a serious medical need" test.¹³³ But inmates rarely satisfy the subjective prong of the deliberate indifference test,¹³⁴ so the fact that the subjective prong is judicially created and applied suggests that courts have interpreted the Supreme Court's rulings narrowly, as intending to withhold treatment in most cases.

Similarly, the United States Congress created the Medicaid program and conferred discretion on state legislatures to implement the program as they saw fit, so long as the state provides coverage for all "medically necessary" procedures,¹³⁵ and does not exclude procedures "on the basis of the diagnoses or conditions they are designed to treat."¹³⁶ States can, however, remain within these guidelines while also determining for themselves what constitutes "medically necessary" care, provided that that determination has a rational basis.¹³⁷ For instance, a state may limit the number of days that a categorically needy individual may receive subsidized in-patient care, based rationally on the limited funds of the state and the general needs of the population.¹³⁸

The United States Congress also created the avenue for deducting medical expenses from taxable income.¹³⁹ I.R.C. § 213 extends to almost any non-cosmetic medical treatment and even covers some cosmetic procedures.¹⁴⁰ The statute allows the IRS Commissioner to determine which deductions are appropriate on a preliminary basis, but unlike the Medicaid statute, § 213 does not confer broad discretion on the Commissioner to formulate a scheme within those general guidelines.¹⁴¹

These structural differences in the causes of action for state medical funding split along socioeconomic lines. If this framework was created in a single legislative action that assigned different burdens based on socioeconomic status, it would suggest that Congress felt access to state healthcare assistance should be based on a social hierarchy. Though the framework actually consists of three independent causes of action, intuitively, the effect is nearly the same because each cause of action was created

with the affected social group in mind. Medicaid's "medically necessary" standard, for instance, indicates that people on welfare should receive only basic health services that others deem worthy of allocated funds. Likewise, the judicial creation and application of the Eighth Amendment's "deliberate indifference" standard suggests that prisoners should not be granted medical care unless their supervisors know they could die without it. Meanwhile, § 213 provides non-incarcerated, non-categorically needy taxpayers with a tax deduction — which, mathematically, is the same as providing the individual with a government subsidy equal to the product of the individual's tax rate and the cost of the operation — with relative ease, suggesting that the government does not oppose such procedures for individuals who can pay for the initial cost of care.¹⁴²

2. Disparate Treatment Due to Inconsistent Judicial Deference

In addition to the structural disadvantages faced by prisoners and individuals on welfare, the amount of deference the court affords the opinions of the defendant's medical experts in state medical assistance cases seems an implicit stop-gap for Eighth Amendment and Medicaid due process claims. In *Barnhill v. Cheery*, an inmate's Eighth Amendment claim failed when prison officials provided expert testimony that merely challenged the testimony of the plaintiff's medical expert.¹⁴³ The court did not question the wisdom of the medical diagnoses and treatment plans proffered by the doctors on the prison staff; rather, despite the obvious biases of the prison's medical staff, the court accepted each concurring opinion as fact.¹⁴⁴ In *Kosilek*, the court noted that the DOC Commissioner replaced the opinions of DOC doctors with his own opinion, but, paradoxically, the court did not hold the Commissioner accountable for his erroneous judgments because he was not a medical doctor.¹⁴⁵

The *Rasmussen* court was similarly deferential when the court accepted the judgment of a panel of non-expert medical practitioners who determined that not all doctors felt gender reassignment surgery was effective in treating GID.¹⁴⁶ Though medical consensus was never part of the "medically necessary" determination before, the *Rasmussen* court felt that the lack of consensus provided reasonable ground for

a categorical ban on gender reassignment surgery.¹⁴⁷ This deference is more confusing in light of the court's recognition that the testimony from the defendant's expert was properly excluded because the expert was "not well-versed in the particular discipline relevant to [the expert's] testimony."¹⁴⁸

If the plaintiff in *Rasmussen* had had greater financial means, she could have paid for her own gender reassignment surgery and deducted it from her taxes — which is the financial equivalent of a government-subsidy¹⁴⁹ — without having to worry about a medical consensus. Such was the case in *O'Donnabhain*, in which the court essentially disregarded testimony from the defendant-IRS Commissioner's medical experts and held that a consensus was not required so long as the "circumstances justify a reasonable belief" that gender reassignment surgery treats GID.¹⁵⁰

3. Disparate Treatment Due to the Condition Involved

Comparing case law for GID to case law for other conditions under the same causes of action reveals even more judicial inconsistency. Under the Eighth Amendment, for instance, a prison official is deliberately indifferent to a serious medical need if she "knows of [but] disregards an excessive risk to inmate health or safety"¹⁵¹ This requires that the prison official "both be aware of facts from which the inference could be drawn that a substantial risk of serious harm exists, and she must also draw the inference."¹⁵² In *Kosilek*, the court held that the Commissioner of the DOC was not deliberately indifferent to the plaintiff's medical needs, despite his awareness that the plaintiff had twice attempted suicide because she had not received treatment, because the Commissioner "had not actually inferred" that the plaintiff presented a substantial risk if untreated,¹⁵³ and because the Commissioner was "not qualified to make medical judgments."¹⁵⁴

At the time the district court decided *Kosilek*, Eighth Amendment precedent in that circuit suggested a less deferential standard. The First Circuit Court of Appeals had held a prison guard accountable as deliberately indifferent to a prisoner's safety when an inmate was assaulted by another inmate after the first inmate was led out of his holding cell.¹⁵⁵ The prisoner was on "cell feed" status, which meant he received meals in his cell, instead of with the general

prison population.¹⁵⁶ The prison guard knew that "cell feed" status indicated that the prisoner *either* "had a health problem or . . . was in protective custody."¹⁵⁷ The First Circuit held that such knowledge was sufficient to "support[] the inference that [the guard] was aware of a high probability that [the prisoner] was vulnerable to attack" and thus deliberately indifferent to the inmate's safety.¹⁵⁸ That "high probability" that the court referred to was fifty percent — that is, the prisoner either had a health problem or was in protective custody.¹⁵⁹

The threshold applied by the First Circuit in the assault case is far less deferential to prison authorities than the threshold applied by the district court in *Kosilek*. The First Circuit held that knowledge of a fifty percent chance *of a risk* was sufficient to hold a guard accountable as knowing the risk was present; the district court held that the Commissioner's knowledge that GID poses risks if untreated, that the inmate had previously attempted suicide and autocastration, and that at least one medical expert felt there was a high risk that the inmate would attempt suicide again if untreated all were insufficient to hold the Commissioner accountable as if he had actually inferred that a risk was present.¹⁶⁰

The obvious difference between the prison assault case and *Kosilek* is the underlying cause of the risk: assault in the former; GID in the latter. The disparate burdens in the two cases suggest that the court sees the risks associated with GID as less clearly necessitating protection. This is indicated further by the *Kosilek* court's use of a rhetorical technique that subtly relieved the court of its decision-making role, while still appearing to empathize with the plaintiff's situation: the court points out that "[t]he DOC's policy concerning gender identity disorders differs from its policy concerning other serious illnesses [I]f an inmate were depressed because he had cancer, the DOC would . . . attempt to cure, or at least diminish, the cancer by providing care that would be regarded as adequate in the community."¹⁶¹ Here, and elsewhere throughout the opinion, the court recommends that the inmate receive treatment but fails to acknowledge its own role in providing that treatment.

Medicaid jurisprudence raises similar questions. In *Rasmussen*, the court's decision to exclude the expert's testimony because he had treated only one GID patient makes little sense given that the court ultimately upheld a Medicaid exclusion supported

by physicians who, together, had less experience than the defendant's expert. In this context, the court's acknowledgment that the panel of experts did not include anyone "with experience in treating gender identity disorder," trivializes the importance of gender expression to gender-variant individuals. And again, it appears that the court treats GID in a way that it would not treat other conditions. Employing the same sort of thought experiment used by the *Kosilek* court,¹⁶² it seems unlikely that the *Rasmussen* court would have been as deferential to medical opinion if a team of podiatrists and OB-GYNs determined that there was no medical consensus as to the effectiveness of mastectomies in treating breast cancer. But for GID, the court readily accepted the opinions of inexperienced medical professionals.

IV. Gender Stasis: The Consequences of Medical Model

In broad terms, requests for state funding that are based on the medical model of gender follow a path to a predictable result with serious consequences: the individual adopts the medical model along with its essentialist conceptualization of gender and its conservative gender norms; the medical model provides inadequate support for the medical assistance request and the legal claim fails; the parties involved discuss the plaintiff's complex and personal expression as a medical abstraction, and thus fail to recognize that the case involves the larger issue of the plaintiff's gender identity; and, at the end of it all, the plaintiff does not receive medical treatment, is unable to manipulate his or her body to realize his or her desired gender identity, and continues to be read in the context of her congenital body parts. This process ultimately has the effect of freezing gender expression in a social, legal, conceptual, and physical stasis.

A. *Social Stasis: The Medical Model from the Patient's Perspective*

In addition to the institutionalized discrimination based on socioeconomic class and the underlying condition that this framework reveals, the framework also has serious implications when one considers the experience of a gender-variant person moving through the healthcare system. After all, losing the legal battle is only the last step in a long process

that typically spans several years.¹⁶³ In order to make it to trial and have a judge rule on the merits of the case, the gender-variant individual must have a qualified medical professional prescribe gender reassignment surgery as medically necessary.¹⁶⁴ Even before a medical professional will prescribe such treatment, however, the individual must be diagnosed with GID and, in most cases, the individual must complete psychotherapy and the "real life experience" of assuming the desired gender role.¹⁶⁵ These preliminary treatments usually last several months to a year.¹⁶⁶

1. Adopting the Medical Model; Adopting Essentialism

Obtaining the GID diagnosis proves difficult for many gender-variant individuals because it requires adopting the rigid, category-based medical model of gender. In order to fulfill the necessary diagnostic criteria, individuals seeking a GID diagnosis often recite a standard narrative detailing a gender-confused childhood, crushes on children of the same anatomical sex, and a persistent feeling of being a man (or woman) "trapped" in the body of a woman (or man).¹⁶⁷ For several decades, researchers have recognized that patients incorporate the key elements of case studies into their own diagnostic interviews, and that those patients who most successfully appropriate the gender-variant rhetoric "win operations."¹⁶⁸

Writing about his own experience trying to obtain a GID diagnosis, Dean Spade recalls that medical practitioners at the Los Angeles Free Clinic wanted him to explain that, for all of his life, he had been conscious of his status as an outsider with respect to his gender.¹⁶⁹ But for people like Dean Spade, who "reject the narrative of a troubled childhood," appropriating the false narrative often comes at the cost of betraying one's self-concept and one's conception of gender.¹⁷⁰ Spade grappled with the price of a GID diagnosis before he eventually saw a doctor. As Spade recounts, the diagnostic process required that he denounce his long-held views of gender and adopt "a binary gender system that [he] had been working to dismantle since adolescence."¹⁷¹

This standard narrative resembles the long-antiquated code pleading requirements under which the plaintiff in a legal action had to fit his legal claim into a prescribed form of action, no matter how odd

the fit, in order to be heard.¹⁷² Here, the patient seeking medical treatment must fit his or her past into a pre-formulated narrative in order to obtain a GID diagnosis. The form-pleading-style GID diagnosis not only forces patients to rewrite their pasts with a “tranny childhood lens,”¹⁷³ it also contributes to a unitary, essentialist conceptualization of gender-variant people as homogenous and composed of “inherent” characteristics.¹⁷⁴ As the anti-essentialist critique points out, what the medical model and its standard narrative assert as “knowledge, truth, objectivity, and reason are actually merely the effects of a particular form of social power.”¹⁷⁵ That is, the essentialist medical conceptualization of GID as displaying the same set of characteristics in any given case is a product of those institutions and individuals that control access to a GID diagnosis and gender reassignment surgery.

2. Adopting the Medical Model; Adopting Conservative Gender Norms

An additional problem with the standard GID narrative is that it is rooted in, and reinforces, conservative gender norms. Transfeminine people must reveal a childhood desire to play with dolls, and transmasculine women have to recall being tomboyish girls;¹⁷⁶ transfeminine people who identify as butch-lesbian women might appear too aggressive to warrant a diagnosis, and transmasculine people who identify as effeminate gay men might not be aggressive enough.¹⁷⁷ The same gender norms persist post-treatment; support groups provide “passing tips,” which generally recommend that people transitioning from male-to-female avoid short haircuts and that those transitioning from female-to-male wear khaki pants.¹⁷⁸ Reports from the 1970s indicate that clinicians encouraged patients approved for gender-reassignment to enter heterosexual relationships after surgery and to work in a gender-appropriate profession.¹⁷⁹

Dress and grooming tips and recommendations for the patient’s post-operative social life posit the ability to “pass” as an “authentic” member of the patient’s post-operative sex as the ultimate goal of the whole process.¹⁸⁰ Indeed, follow-up studies on post-operative gender-variant people use the patient’s ability to conform to gender norms as an indicator of the procedure’s success.¹⁸¹

However, it seems counterintuitive that an individual who “suffer[ed] clinically significant distress”¹⁸² in social situations — as required for a GID diagnosis — would seek out gender reassignment for the sole purpose of reaffirming the same social strictures that caused the individual’s preoperative distress. Here it is difficult to separate cause and effect: does the post-operative gender-variant person aspire to “pass” in order to fully realize sex–gender alignment, or is that desire a product of years of required participation in the medical model’s conservative norms leading up to gender reassignment?

B. *Legal Stasis: The Medical Model Inadequately Supports Gender-Related Legal Claims*

The framework of requests for state medical funding demonstrates that the medical model is an ineffective tool for sustaining gender-related legal actions. In this framework, the support that the medical model provides directly lines up with the objective of the legal action; that is, the plaintiff has a diagnosis from a medical expert who says treatment is medically necessary, and the plaintiff wants only to receive that prescribed medical treatment.¹⁸³ Though this would seem like a cut-and-dried matter that is easily resolved by reference to authoritative medical texts, as discussed above, courts find ways to discredit the plaintiff’s participation in the medical model by deferring to the judgment of prison officials and medical advisors.¹⁸⁴

Other causes of action in other areas of law are mostly beyond the scope of this Note, but it seems logically unsound to expect the medical model to provide more robust support in areas of the law that rely on the model more peripherally. In equal protection claims, for instance, wherein gender-variant plaintiffs argue that gender-variant people should be a protected class, a medical diagnosis that cannot convince courts to expand a state’s Medicaid provision can hardly be expected to convince courts to expand the coverage of a constitutional provision.

C. *Conceptual Stasis: Medical Rhetoric Shelves Critical Discussions of Gender*

Once the medical model became entrenched in the legal system, medical definitions and terminology became the language of discourse on gender issues.¹⁸⁵ This has had the effect of retarding critical discussion of gender because the medical language employed

in contentious legal issues is both imprecise and superficial. For instance, in both *O'Donnabhain* and the Medicaid line of cases, the plaintiff argued that gender reassignment surgery was “medically necessary,” but the defendant countered that the surgery was “cosmetic.”¹⁸⁶ In common usage, as well as in medical parlance, these evaluative terms are on opposite ends of the spectrum, the former being essential to the plaintiff’s health, and the latter being a luxury. Despite the distance separating these terms, however, courts have not been able to decide, once and for all, that gender reassignment surgery is one or the other.¹⁸⁷

Additionally, in some instances, medical terms become placeholders for more charged issues of gender and identity. While this eases communication about complicated — and sometimes theoretical — ideas on gender, it also detaches what is at issue from what is at stake: the ability to fully express one’s gender. In *Rasmussen*, for example, GID assumes the role of an abstract medical condition for which a particular treatment either is or is not medically necessary. Similarly, in *O'Donnabhain*, the defendant’s medical experts tried to define “disease” in such a way that it would exclude GID.¹⁸⁸ In both of these cases, the defendants attempted to use academic distinctions to undermine the imprecise medical language on which the diagnosis and treatment of GID are built. At that point the case becomes sophistical and is no longer about one’s ability to align his or her body with his or her self-perceived gender.

D. *Physical Stasis: The Medical Model Denies Gender-Variant People Agency*

1. Gatekeepers¹⁸⁹

The gatekeepers are those individuals who stand in between the gender-variant person who requires state funding for medical care and the requested treatment.¹⁹⁰ In every case within this framework, the plaintiffs had to first pass the medical test by convincing a medical professional to diagnose GID.¹⁹¹ The second stage in every case required that the individual appeal to administrators: the inmate had to exhaust all available remedies within the prison system,¹⁹² the categorically needy individual had to submit a request for funding to Medicaid administrators,¹⁹³ and the non-incarcerated, non-categorically needy individual had to submit her

medical deduction to the IRS for the commissioner to approve or disapprove.¹⁹⁴ As previously discussed, the administrators denied funding in every case.¹⁹⁵

Next, a court reviews the administrators’ judgment. The judiciary should not actually represent an additional hurdle beyond the administrators; rather, the court system should be an impartial, but more costly and time-consuming avenue to vindicate the individual’s statutory or constitutional rights. Whether a court vindicates those rights, however, often depends on the cause of action, and even when the court holds in the plaintiff’s favor, the legislature, the most obdurate gatekeeper of all, can pass or amend a law to explicitly exclude funding in future appeals.¹⁹⁶

The majority of individuals who seek gender reassignment surgery do not receive treatment. One study estimated that 10,000 people try to obtain gender reassignment surgery each year, but only 1%–3% of them actually get surgery.¹⁹⁷ Financially able individuals can pay for surgery out of pocket and, if they do not have insurance, they can deduct the cost of the surgery from their taxable income.¹⁹⁸ Individuals that do not have the financial resources to pay for the surgery themselves have little legal recourse.¹⁹⁹

Yet, for gender-variant people who know “what [they are] and how that needs to look,”²⁰⁰ body manipulations that change what their physical form means in social and cultural contexts remain a critical formative aspect of their identities.²⁰¹ Thus, the gatekeepers deny gender-variant people agency in realizing their desired gender expression by denying them the means to shape their bodies: without state funding, the medical procedures or hormones that will align the individuals’ physical and gendered selves are out of reach.²⁰²

2. Diagnosis Fuels Demand

Some scholars argue that the medical model exacerbates the distress that characterizes GID, and fuels demand for gender reassignment surgery.²⁰³ This argument begins with the premise that the disjunction between anatomical sex and gender that underlies GID predates any medical recognition of the condition.²⁰⁴ Before the medical model, some individuals with cross-gender identities probably wanted to alter their bodies or dress in a way that aligned their anatomical sex with their self-perceived gender.²⁰⁵ As gender became fused with sex, however, gender expression

was frustrated because such individuals became deviants who were seen as breaking social norms — a distressful characterization.²⁰⁶

This desire to express one's gender and the distress associated with having that desire denied, however, intensified when sexologists identified the concept of transsexualism, and later when the DSM-III formally recognized transsexualism.²⁰⁷ The classification affected individuals with a cross-gender identification on multiple levels. First, the label told gender-variant people that medical researchers considered the sex–gender disjunction to be significant enough to be the basis of a classification, and the classification was that of an “other”: the label was unambiguous about distinguishing gender-variant people as a discrete “out” group, different from the social majority.²⁰⁸ Secondly, gender-variant people, whether or not previously cognizant of their sex–gender disjunction, adopted the term “transsexual” for its power to explain their ambiguities.²⁰⁹ For many, adopting the transsexual label had the consequence of altering their self-perception because the subtext of the medical diagnosis is that gender-variant people are different in specific ways.²¹⁰ Furthermore, by including a desire for gender reassignment surgery in the diagnosis, the transsexual label posited the surgical procedure as both something every gender-variant person inherently desires and as something with the ability to “cure” transsexualism. In other words, the diagnosis implies that the preoperative gender-variant body *requires* a cure, an idea that causes gender-variant people to “hate their bodies.”²¹¹

The idea that gender-variant people want to alter their physical bodies because they have a GID diagnosis denies agency in a different way than do the gatekeepers. Attributing the desire to manipulate one's body to the GID diagnosis effectively imputes to the medical model an unrealistic explanatory power because it reverses the causal relationship. Gender-variant people want to alter their bodies in order to realize a specific social and cultural meaning; the medical model places the label on that desire after the fact.

V. Implications for Title VII's “Unequal Burdens” Standard

One of the practical consequences of the inability of most gender-variant people to access

state medical funds — and therefore treatment — is that they remain in their anatomically sexed bodies, but may continue to identify with a gender that is not traditionally aligned with that anatomical sex. This has the potential to implicate Title VII, which prohibits discrimination “because of . . . sex,”²¹² and based on gender stereotyping,²¹³ but not always because of gender expression.²¹⁴

A. *Employee Dress Codes: Jespersen v. Harrah's Operating Co.*²¹⁵

The state medical funding framework could have interesting consequence as it relates to Title VII's “equal burdens” standard of employer dress codes. According to the “unequal burdens” test, a sex-differentiated dress code constitutes sex discrimination prohibited under Title VII if it “imposes unequal burdens on men and women.”²¹⁶ This requires weighing the cost and time necessary for employees of each sex to comply with the policy.²¹⁷ Still, the dress code may be upheld if a bona fide occupational qualification justifies the disparate treatment.²¹⁸

The “equal burdens” standard for sex-based dress codes was applied in *Jespersen v. Harrah's Operating Co.*,²¹⁹ in which a casino dress code required that female drink-servers wear stockings and makeup, with their hair “teased, curled, or styled.”²²⁰ The same dress code prohibited males from wearing makeup or their hair below their collars.²²¹ The dress code also required a general “well groomed” appearance of both male and female drink servers.²²² The plaintiff, a female drink-server, refused to accept the makeup requirement because makeup made her feel “‘dolled up,’ like a sexual object.”²²³ The plaintiff alleged that the dress code's makeup requirement constituted sex discrimination prohibited by Title VII.²²⁴

The Ninth Circuit applied the “unequal burdens” test and affirmed the summary judgment ruling for the defendant-casino on the basis that, although the plaintiff opposed the makeup requirement, the requirement did not stereotype or objectify women.²²⁵ Finally, the court noted, the plaintiff was not treated any differently than any other man or woman who refused to follow the dress code.²²⁶

B. *Denied Medical Funding and Employee Dress Codes*

With the “unequal burden” test in mind, imagine that the prisoner, the categorically needy Medicaid recipient, and the non-incarcerated and non-categorically needy taxpayer who can afford to front the cost of gender-reassignment were all born biologically male, but that each has a gender expression of a traditionally gender-conforming female. These three individuals express their gender with a combination of makeup, dress, and mannerisms. In this situation, the state medical funding framework would interact with Title VII’s “unequal burdens” test to deny the prisoner and the categorically needy Medicaid recipient access to jobs with generally applicable dress codes. For example, the prisoner, having been denied medical treatment beyond psychotherapy, leaves prison as a preoperative gender-variant person assigned male at birth. The prisoner, with male anatomy and female gender expression, may be subjected to *legal* employment discrimination based on dress and appearance, so long as the dress code is generally applicable to all employees and imposes an equal burden on males and females.²²⁷ The categorically needy Medicaid recipient faces a similar situation: higher paying jobs are more likely to have dress codes, which would bar the categorically needy individual from obtaining those jobs and their higher wages, which, in turn, has the potential to entrench the Medicaid recipient’s status as “categorically needy.” Meanwhile, the non-incarcerated, non-categorically needy taxpayer who can afford to front the cost of the procedure receives government-subsidized surgery that allows the individual to “pass” as a sex–gender aligned female, free of the dress code requirements that frustrate the prisoner and the Medicaid recipient.

The prisoner and the Medicaid recipient are not without alternatives. For instance, in the example above, they may choose to suppress their gender expression and try to live as gender-conforming males. However, for most gender-variant people this is not a real option. In most cases, the immense distress associated with GID, if untreated, can lead to depression, auto-castration, or suicide.²²⁸

VI. Conclusion

The physical body has an “inescapable role” in the formation of our identities.²²⁹ For gender-variant people, the physical body is especially important because it is the tool that permits or denies access to a socially legible gender identity that matches the individual’s self-perceived gender. But relying on the medical model of gender in state medical assistance claims largely fails to get gender-variant people any closer to the bodies they want; even worse, logical inconsistencies within court opinions suggest a judicial apathy towards gender expression.

In this context, the medical model essentially separates the agent from the object; that is, because medical care that would permit gender-variant people to alter their physical bodies is prohibitively expensive without insurance,²³⁰ and most do not have insurance,²³¹ they must place their bodies under state control — to shape, or, in most cases, to not shape. By denying gender-variant people agency in their pursuit of socially and culturally legible bodies, the medical model freezes gender expression and inhibits progress in medically transitioning.

However, this type of control by the state may actually facilitate a flourishing gender-variant community by forcing gender-variant people to violate social and cultural norms.²³² The decidedly low success rate for claims made by gender-variant Medicaid recipients and gender-variant inmates has had the unintended effect of amassing a community of gender-variant people whose gender expression and anatomically sexed bodies place them in the gray area between the traditional male–female binary. From this position in between the binary, gender-variant people can challenge social and cultural conceptions of gender expression.

This requires pushing back against the medical model’s essentialist conception of gender and the conservative gender norms that it promotes. Many gender-variant people seeking gender reassignment surgery falsely endorse the medical model as a means to their desired ends.²³³ But for the majority of gender-variant people who live in poverty, and for gender-variant prisoners, those desired ends do not follow from the false endorsement. Thus, for most gender-variant people, adopting the medical model in requests for state medical assistance means adopting the model’s strictures without a counterbalancing benefit.

In her formulation of gender identity as inseparable from the social and cultural contexts in which it is formed, Judith Butler explains that

[t]here is no self that is prior to the convergence [of the physical body and social and cultural norms] or who maintains ‘integrity’ prior to its entrance into this conflicted cultural field. There is only a taking up of the tools where they lie, where the very ‘taking up’ is enabled by the tool lying there.^{2,3,4}

Relying on the medical model of gender to the current extent suggests that society lacks the “tools” to interpret bodies that fall outside of the traditional male-female binary. Even if one accepts this as true, it does not follow that the medical model is the only other avenue. Rather, by challenging existing norms of interpretation, gender-variant people as a subculture can seek to reclaim agency by creating new tools of performance.

(Endnotes)

¹ B.A., Dartmouth College, 2008; J.D. University of Southern California Gould School of Law; Editor in Chief, *Southern California Review of Law and Social Justice*. I would like to thank Professor Camille Gear Rich for her guidance and inspiration throughout the process of researching and writing this paper.

² See AMERICAN PSYCHIATRIC ASS’N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 532-38 (4th ed. 1994) [hereinafter *DSM-IV*]; THE HARRY BENJAMIN INTERNATIONAL GENDER DYSPHORIA ASSOCIATION’S STANDARDS OF CARE FOR GENDER IDENTITY DISORDERS, THE WORLD PROFESSIONAL HEALTH ASSOCIATION FOR TRANSGENDER HEALTH, 12-13 (6th ed. 2001), <http://www.wpath.org/Documents2/socv6.pdf> (last visited Mar. 30, 2009) [hereinafter *Standards of Care*].

³ See, e.g., Dean Spade, *Resisting Medicine, Re/Modeling Gender*, 18 BERKELEY WOMEN’S L.J. 15, 23 (2003) (explaining that the author was willing to tell medical professionals whatever they needed to hear in order for the author to obtain the desired sex reassignment surgery).

⁴ See *Kosilek v. Maloney*, 221 F. Supp. 2d 156 (D. Mass. 2002). *Kosilek* is an Eighth Amendment case discussed at greater length in Part III of this Note. See Part III, *infra*, for more of the facts of this case.

⁵ U.S.C.A. Const. Amend. VIII (West 2010) (citing *Keehner v. Dunn*, 409 F. Supp. 2d 1266, 1272 (D. Kan. 2006) for the proposition that the Eighth Amendment is only available to prisoners, but the Fourteenth Amendment “provides the same degree of medical attention to pretrial detainees as the Eighth Amendment does for inmates”); see also, *supra*, note 2.

⁶ 42 U.S.C.A. § 1396 (a) (2006) (defining “categorically needy” as individuals who receive supplemental security income or whose family income does not pass a certain state-determined threshold). This section also includes dozens of other ways to qualify for Medicaid funding, including through pregnancy, poverty and age of minority, an adoption assistance agreement, or proof of a medical disability. *Id.*

⁷ *Id.* § 1396 (a)-(d) (2006); see also *Smith v. Rasmussen (Rasmussen II)*, 249 F.3d 755 (8th Cir. 2000). *Rasmussen II* is a due process case discussed at greater length in Part III of this Note. See Part III, *infra*, for more of the facts of this case.

⁸ I.R.C. § 213 (a); see also *O’Donnabhain v. Commissioner of Internal Revenue*, 134 T.C. 34, 48 (U.S. Tax Ct. 2010). *O’Donnabhain* involved a petition for redetermination of the plaintiff’s income taxes and is discussed at greater length in this Note. See *Infra* Part III.C..

⁹ This issue is discussed further in Part III of this Note. The Eighth Amendment cause of action is judicially created. Alvin Lee, *Trans Models in Prison: The Medicalization of Gender Identity Disorder and the Eighth Amendment Right to Gender Reassignment Therapy*, 31 HARV. J. L. & GENDER 447, 463 (2008). A Medicaid pensioner’s due process claim is partly created by the Fourteenth Amendment, and partly created by judicial interpretation. U.S. Const. amend. XIV § 1; Lee, *supra*, at 460.

¹⁰ Furthermore, it is worth noting that the degree of government control over the individual parallels the degree of judicial deference, so that the judiciary is most likely to defer to the judgment of government administrators where the administrators’ control is most absolute. At the same time, administrative control signals a restriction upon an individual’s

liberty, and greater administrative control is typically associated with lower socioeconomic status.

¹¹ As discussed later in this Note, an estimated seventy percent of transsexuals in the United States are considered socioeconomically disadvantaged. *State of Transgender California, Economic Health of Transgender Californians*, TRANSGENDER LAW CENTER 1, 3 (2009), <http://www.transgenderlawcenter.org/pdf/StateofTransCAFINAL.pdf> (explaining that twenty percent of the individuals responding to the survey report being homeless ever since coming out as transgender); see also Travis Cox, *Medically Necessary Treatments for Transgender Prisoners and the Misguided Law in Wisconsin*, 24 WIS. J. L. GENDER & SOC'Y 341, 361 (2009). The parties in *Sundstrom v. Frank*, No. 06-C-112, 2007 U.S. DIST. LEXIS 76597 (E.D. Wis. 2007), an Eighth Amendment challenge by a class of inmates, compared the cost of gender reassignment surgeries with other procedures that prisons are will to provide, such as kidney transplants (\$33,000) and coronary bypass surgeries (\$37,000).

¹² See *infra* Part III.C (discussing medical deductions under the tax code).

¹³ See *infra* Part III.A (discussing Eighth Amendment claims and GRS).

¹⁴ Consider a case where the patient is inflicted with a mortal wound instead of GID — a gunshot wound, for instance. The medical necessity of a gunshot wound is obvious, and establishing the medical necessity of mending procedures would likely not require a diagnosis or physician testimony, regardless of the victim's status. Now consider a malignant tumor. Although the condition is not visually obvious in the manner that a gunshot wound is, the condition has legitimacy in that, generally speaking, most people recognize that malignant tumors are often fatal. Thus, once it is established that the patient has a malignant tumor, the medical necessity is clear. GID, however, is both unobvious and, to many individuals who are unaware of gender as a separate concept from anatomical sex, counterintuitive, and medical diagnoses and physician testimony does little to shake its perceived illegitimacy.

¹⁵ See, e.g., Andrew Gilden, *Toward a More Transformative Approach: The Limits of Transgender Formal Equality*, 23 BERKELEY J. GENDER L. & JUST. 83, 86–88 (2008) (outlining the development of the sex/gender dichotomy).

¹⁶ *Id.* at 86–88.

¹⁷ *Id.* at 88–90.

¹⁸ *Id.*

¹⁹ JUDITH BUTLER, *GENDER TROUBLE: FEMINISM AND THE SUBVERSION OF IDENTITY* 33 (1990).

²⁰ *Id.* (stating a corollary to Friedrich Nietzsche's idea that "there is no 'being' behind doing, effecting, becoming; 'the doer' is merely a fiction added to the deed — the deed is everything").

²¹ See Gowri Ramachandran, *Against the Right to Bodily Integrity: Of Cyborgs and Human Rights*, 87 DENV. U. L. REV. 1, 36 (2009).

²² *Id.* at 34.

²³ See Camille Gear Rich, *Performing Racial and Ethnic Identity: Discrimination by Proxy and the Future of Title VII*, 79 N.Y.U. L. REV. 1134, 1179 (2004). Professor Rich details the various ways in which physical bodies and their performative acts are identified and categorized in presumably "stable" categories of race and ethnicity. Professor Rich persuasively argues that the Title VII protections should extend to the "voluntary," performative acts "which, by accident or design, communicate[] racial or ethnic identity or status." *Id.* at 1139.

²⁴ Spade, *supra* note 3, at 23.

²⁵ See *Standards of Care*, *supra* note 2, at 11–22.

²⁶ See *infra* Part II.B (discussing the costs of sex-reassignment surgery).

²⁷ See *infra* Part III (detailing the obstacles faced by specific plaintiffs); see also *infra* Part IV (explaining how the medicalization of gender has made many transsexuals dependent on the medical community for diagnoses).

²⁸ DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS, AMERICAN PSYCHIATRIC ASS'N 261–66 (3d ed. 1980) [hereinafter *DSM-III*].

²⁹ See *DSM-IV*, *supra* note 2, at 532–38.

³⁰ See *DSM-III*, *supra* note 28, at 1–5; *DSM-IV*, *supra* note 2, at 532–38.

³¹ *Standards of Care*, *supra* note 2, at 4.

³² See *DSM-III*, *supra* note 28, at 261–62.

³³ Judith S. Stern, Brian L. V. *Administration for Children's Services: Ambivalence Toward Gender Identity Disorder as a Medical Condition*, 30 WOMEN'S RTS. L. REP. 566, 568 (2009).

³⁴ *Id.* at 569.

³⁵ *Id.* This change had the secondary effect of differentiating the terms "transgender," "transsexual," and "gender identity disorder": "transgender" is an umbrella term referring to individuals with cross-

gender identifications, and “gender identity disorder” applies only to transsexuals whose cross-gender identification causes them “clinically significant distress or impairment” in certain situations.

³⁶ DSM-5 Development: Timeline, AMERICAN PSYCHIATRIC ASSOCIATION, (2010), <http://www.dsm5.org/about/Pages/Timeline.aspx>.

³⁷ DSM-5 Development: Gender Identity Disorder in Adolescents or Adults, Rationale, AMERICAN PSYCHIATRIC ASSOCIATION (2010), <http://www.dsm5.org/ProposedRevisions/Pages/proposedrevision.aspx?rid=482#>.

³⁸ *Id.*

³⁹ See *Standards of Care*, *supra* note 2, at 4-5. The Standards of Care summarize the diagnostic process as follows:

A clinical threshold is passed when concerns, uncertainties, and questions about gender identity persist during a person’s development, become so intense as to seem to be the most important aspect of a person’s life, or prevent the establishment of a relatively unconflicted gender identity. . . . These reflect various degrees of personal dissatisfaction with sexual identity, sex and gender demarcating body characteristics, gender roles, gender identity, and the perceptions of others. When dissatisfied individuals meet specified criteria in one of two official nomenclatures . . . they are formally designated as suffering from a gender identity disorder (GID). Some persons with GID exceed another threshold — they persistently possess a wish for surgical transformation of their bodies.

Standards of Care, *supra* note 7, at 2. *Standards of Care* endorse diagnoses from either the DSM-IV or the International Classification of Diseases-10 (ICD-10), which the author of the *Standards of Care* predict will be synthesized in the future. *Id.* at 6. The criteria used to diagnose gender identity disorder in the DSM-IV are as follows:

A. A strong and persistent cross-gender identification (not merely a desire for any perceived cultural advantages of being the other sex).

. . . .

In adolescents and adults, the disturbance is manifested by symptoms such as a stated desire to be the other sex, frequent passing as the other sex, desire to live or be treated as the other sex, or the conviction that he or she has the typical feelings and reactions of the other sex.

B. Persistent discomfort with his or her sex or sense of inappropriateness in the gender role of that sex.

. . . .

In adolescents and adults, the disturbance is manifested by symptoms such as preoccupation with getting rid of primary and secondary sex characteristics (e.g., request for hormones, surgery, or other procedures to physically alter sexual characteristics to simulate the other sex) or belief that he or she was born the wrong sex.

C. The disturbance is not concurrent with a physical intersex condition.

D. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

DSM-IV, *supra* note 2, at 537-38. The seventh edition of the *WPATH*, released in September 2011, makes several significant changes to procedures (psychotherapy is no longer required; nor is it required that the individual live one year as the desired gender; new standards for hormone therapy) and diagnostic criteria (“broader spectrum of identities”), as well as to the general approach (“It’s more about what the professionals have to do’ and not about transgender people having to prove their health needs to the professional”), to gender variance. Dyana Bagby, *WPATH Announces New Standards of Care for Transgender and Gender Nonconforming People*, GAVOICE (Sept. 25, 2011), <http://www.thegavoice.com/index.php/news/national-news/3497-wpath->

announces-new-standards-of-care-for-transgender-and-gender-nonconforming-people.

⁴⁰ *Id.* at 11-22.

⁴¹ *Lee, supra* note 9, at 459.

⁴² *Id.* at 458-59; *see also Standards of Care, supra* note 2, at 12 (describing the role of the psychotherapist as helping patient into long-term transition and making sure patient is ready as well as eligible).

⁴³ Stern, *supra* note 33, at 570-71.

⁴⁴ *Id.* at 571.

⁴⁵ *Id.*; *Standards of Care, supra* note 2, at 3.

⁴⁶ *Standards of Care, supra* note 2, at 1-2, 12.

⁴⁷ *Id.* at 18-19.

⁴⁸ Cox, *supra* note 11, at 361. The parties in *Sundstrom v. Frank*, No. 06-C-112, 2007 U.S. Dist. LEXIS 76597 (E.D. Wis. 2007), an Eighth Amendment challenge by a class of inmates, compared the cost of gender reassignment surgeries with other procedures that prisons are will to provide, such as kidney transplants (\$33,000) and coronary bypass surgeries (\$37,000).

⁴⁹ *Id.*

⁵⁰ *See Standards of Care, supra* note 2, at 20.

⁵¹ *See Casillas v. Daines*, 580 F. Supp. 2d 235, 237 (S.D.N.Y. 2008) (transsexual plaintiff received hormone therapy for more than twenty-five years); *Barnhill v. Cheery*, No. 8:06-CV-922-T-23TGW, 2008 WL 759322, at *1 (M.D. Fla. March 20, 2008) (transsexual plaintiff treated with hormone therapy for more than fifteen years).

⁵² *See supra* notes 12-13 and accompanying text.

⁵³ *See supra* notes 4-6 and accompanying text.

⁵⁴ *See, e.g., Estelle v. Gamble*, 429 U.S. 97, 103 (holding that the Eighth Amendment requires that a prison provide medical treatment to those prisoners in its care).

⁵⁵ 42 U.S.C. § 1396 (a)-(d); *see, e.g., Pinneke v. Preisser*, 623 F.2d 546, 548-49 (8th Cir. 1980).

⁵⁶ *Pinneke*, 623 F.2d at 547.

⁵⁷ I.R.C. § 213; *O'Donnabhain v. Comm'r of Internal Revenue*, 134 T.C. 34, 48 (U.S. Tax Ct. 2010).

⁵⁸ *Barnhill v. Cheery*, No. 8:06-CV-922-T-23TGW, 2008 WL 759322, at *14 (M.D. Fla. March 20, 2008) (quoting *Maggert v. Hanks*, 131 F.3d 670, 671 (7th Cir. 1997), and Judge Posner, who explained that prisons are not required to provide individualized medical evaluations).

⁵⁹ *De'Lonta v. Angelone*, 330 F.3d 630, 634 (4th Cir. 2003) (quoting *Strickler v. Waters*, 989 F.2d 1375, 1379 (4th Cir. 1993)).

⁶⁰ *See, e.g., Gammett v. Idaho Bd. of Corr.*, No. CV05-257-S-MHW, 2007 WL 2186896, at *3 (D. Idaho July 27, 2007) ("The Courts have consistently considered Gender Identity Disorder (including transsexualism or transgenderism) to be a serious medical condition for purposes of the Eighth Amendment.")

⁶¹ *Barnhill*, 2008 WL 759322 at *11 (quoting *Kelley v. Hicks*, 400 F.3d 1282, 1284, n.3 (11th Cir. 2005)).

⁶² *See, e.g., Cooper v. Dyke*, 814 F.2d 941, 945 (4th Cir. 1987) (untreated bullet wound).

⁶³ *See, e.g., Sosebee v. Murphy*, 797 F.2d 179, 180-81 (4th Cir.1986) (guards knew of inmate's serious illness and inmate died).

⁶⁴ *Barnhill*, 2008 WL 759322 at *11 (citing *Bozeman v. Orum*, 422 F.3d 1265, 1272 (11th Cir. 2005)).

⁶⁵ *Id.* (quoting *Harris v. Thigpen*, 941 F.2d 1495, 1510 (11th Cir. 1991)).

⁶⁶ *See, e.g., Meriwether v. Faulkner*, 821 F.2d 408, 413 (7th Cir. 1987).

⁶⁷ *Barnhill*, 2008 WL 759322 at *10 (quoting *Harris v. Thigpen*, 941 F.2d 1495, 1504 (11th Cir. 1991)).

⁶⁸ 221 F. Supp. 2d 156 (D. Mass. 2002).

⁶⁹ *Id.* at 165, 168 n.4.

⁷⁰ *Id.* at 161.

⁷¹ *Id.* at 184.

⁷² *Id.* at 159.

⁷³ *Id.* at 161.

⁷⁴ *Id.* at 160.

⁷⁵ *Id.* at 165.

⁷⁶ *Id.* at 175.

⁷⁷ *Id.* at 190.

⁷⁸ *Id.* at 191.

⁷⁹ *Id.* at 161.

⁸⁰ *Id.* As a preliminary matter, the court recognized that the Commissioner of the DOC was typically not the defendant in Eighth Amendment cases; however, because the Commissioner in this case issued a blanket policy that prohibited doctors from attending to the plaintiff, the Commissioner made most of the medical judgments and was thus properly named as the defendant. *Id.* Later, with respect to the subjective prong, the court excused the Commissioner's poor

judgment because he was “not qualified to make medical judgments.” *Id.* at 191.

⁸¹ *Id.* at 161. Later in the opinion, the court appeared to forgive the Commissioner’s misjudgment, stating that he “knew the underlying facts but believed (albeit unsoundly) that the risk to which the facts gave rise was insubstantial or nonexistent.”

⁸² *Id.* at 162.

⁸³ 42 U.S.C. § 1396; *Smith v. Rasmussen (Rasmussen II)*, 249 F.3d 755, 757 (8th Cir. 2000).

⁸⁴ 42 U.S.C. § 1396 (a) (17).

⁸⁵ *Rasmussen II*, 249 F. 3d at 759 (quoting *Beal v. Doe*, 432 U.S. 438, 444 (1977)). The objectives of the Medicaid Act, according to the Appropriations subsection, 42 U.S.C. § 1396-1, is to “enabl[e] each State, as far as practicable under the conditions in such State, to furnish (1) medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services, and (2) rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care. . . .”

A sparsely reasoned 2009 per curium decision by the Eleventh Circuit Court of Appeals clarified that the state and the treating physician both “have roles in determining what medical measures [are] necessary to ‘correct or ameliorate’” a patient’s condition. *Moore v. Meadows*, 324 Fed. Appx. 773, 774 (11th Cir. 2009) (per curium). Though this could affect an eleventh circuit court’s analysis of future Medicaid claims, this decision does not affect the analysis of the two previously decided Eighth Circuit Medicaid cases discussed below.

⁸⁶ See *Meriwether v. Falkner*, 821 F.2d 408, 412-13 (7th Cir. 1987) (medically necessary treatment for transsexualism); *Pinneke v. Preisser*, 623 F.2d 546, 548 (8th Cir. 1980) (calling surgery the “only [known] medical treatment available to relieve or solve the problems of a true transsexual”); *G.B. v. Lackner*, 145 Cal. Rptr. 555, 558-590 (Ct. App. 1978) (holding that transsexual surgery is not ‘cosmetic surgery’ under provision of Code of State Director of Health disallowing Medi-Cal benefits for ‘cosmetic surgery.’); *J.D. v. Lackner*, 145 Cal. Rptr. 570, 572 (Ct. App. 1978) (holding that Medi-Cal benefits would be available for transsexual surgery to claimant who suffered from severe gender dysphoria or transsexualism for radical sex conversion

surgery); *Doe v. State Dept. of Public Welfare*, 257 N.W.2d 816, 819 (Minn. 1977) (holding total exclusion of ‘transsexual surgery’ void and arbitrary in contravention of Social Security Act).

⁸⁷ See *Ravenwood v. Daines*, No. 06-Cv-6355-CJS, 2009 WL 2163105, at *12 (W.D.N.Y. July 12, 2009) (granting defendants summary judgment on claim that denial of funds for gender reassignment surgery violated due process); *Casillas v. Daines*, 580 F. Supp. 2d 235, 246-47 (S.D.N.Y. 2008) (denying GID plaintiff’s equal protection claim); *Rasmussen II*, 249 F.3d at 761-62 (denying due process claim because medical community questions efficacy of treatment); *Rush v. Johnson*, 565 F. Supp. 856, 869 (N.D. Ga. 1983) (upholding exclusion of gender reassignment surgery because the state determined “there is no authoritative evidence that the surgery is safe and effective”).

⁸⁸ Compare *Rasmussen II*, 249 F.3d at 761-62 (upholding, in 2001, a Medicaid exclusion because defendant’s doctors assert that there is no consensus in medical community as to efficacy of gender reassignment surgery) with *Pinneke*, 623 F.2d at 550 (invalidating the state’s categorical exclusion of gender reassignment surgery because “the decision of whether or not certain treatment or a particular type of surgery is ‘medically necessary’ rests with the individual recipient’s physician and not with clerical personnel or government officials”).

⁸⁹ See cases cited *supra* note 88. These arguments include assertions that gender reassignment surgery is merely “cosmetic,” or “experimental,” see, e.g., *G.B. v. Lackner*, 145 Cal. Rptr. at 556-67, and that it could never be medically necessary to “remove healthy, undamaged organs and tissues,” see, e.g., *Pinneke*, 623 F.2d at 549.

⁹⁰ See cases cited *supra* note 89; see also discussion of *Moore*, *supra* note 89.

⁹¹ 623 F.2d at 549.

⁹² 249 F.3d at 761-62.

⁹³ At the time of this case, in 1980, this term was still used to describe gender-variant individuals.

⁹⁴ 623 F.2d at 547.

⁹⁵ *Id.* at 548.

⁹⁶ 257 N.W. 2d 816, 819-21 (Minn. 1977).

⁹⁷ *Id.* at 819.

⁹⁸ *Id.* Thus, though the *Doe* court ruled in favor of the gender-variant plaintiff and approved medical treatment, the reasoning appears to be grounded

more in pity than in understanding. Furthermore, the Doe court attributes the idea of “preventing transsexualism” to another court, which means that at least two decisions favorable to gender-variant people came from courts that thought of gender variance as something congenital that could be prevented before childbirth. *Id.*

⁹⁹ *Pinneke v. Preisser*, 623 F.2d 546, 548 (8th Cir. 1980).

¹⁰⁰ *Id.* at 550.

¹⁰¹ See, e.g., *Smith v. Rasmussen (Rasmussen II)*, 249 F.3d 755 (8th Cir. 2000); *Smith v. Rasmussen (Rasmussen I)*, 57 F. Supp. 2d 736, 763 (N.D. Iowa 1999) (quoting *Pinneke*, 623 F.2d at 549); see also *Smith v. Palmer*, 24 F. Supp. 955, 967-68 (N.D. Iowa 1998); *Weaver v. Reagan*, 886 F. 2d 194, 199-2000 (8th Cir. 1989) (Missouri).

¹⁰² 249 F.3d 755 *rev'g Rasmussen I*, 57 F. Supp. 2d 736.

¹⁰³ *Rasmussen II*, 249 F.3d at 758.

¹⁰⁴ *Id.* at 760.

¹⁰⁵ *Id.*

¹⁰⁶ *Rasmussen I*, 57 F. Supp. 2d 736, 757 (N.D. Iowa 1999), *rev'd*, *Rasmussen II*, 249 F.3d 755 (8th Cir. 2000).

¹⁰⁷ *Id.* at 758.

¹⁰⁸ *Rasmussen II*, 249 F.3d 755, 760 (8th Cir. 2000).

¹⁰⁹ *Id.* at 761.

¹¹⁰ *Id.*

¹¹¹ *Id.* at 759 (emphasis added).

¹¹² I.R.C. § 213 (a) (2006). Expenses are deductible only to the extent that they exceed 7.5 percent of gross income and the individual has not been otherwise compensated for the expenditures, through private medical insurance, for example. *Id.* § 213 (d) (1) (A) (2008).

¹¹³ *Id.* § 213 (d) (1) (A).

¹¹⁴ *Id.* § 213 (d) (9) (B).

¹¹⁵ *Id.* § 213 (d) (9) (A).

¹¹⁶ *Aetna Life Ins. Co. v. Martin*, 386 So.2d 468, 470-71 (Ala. Civ. App. 1980).

¹¹⁷ *Id.* at 470 (citing testimony of surgeon who opined that breast reduction surgery might ease the taxpayer's back problems).

¹¹⁸ 134 T.C. 34 (U.S. Tax Ct. 2010).

¹¹⁹ *Id.* at 53.

¹²⁰ *Id.* at 34.

¹²¹ *Id.* at 36.

¹²² *Id.* at 40-41.

¹²³ *Id.* at 52.

¹²⁴ *Id.* at 52.

¹²⁵ *Id.* at 64.

¹²⁶ *Id.* at 74-76. The plaintiff did, however, provide expert testimony in support of her claim that her gender reassignment surgery was “medically necessary.” *Id.*

¹²⁷ *Id.* at 42-48, 74.

¹²⁸ *Id.* at 55-63.

¹²⁹ *Id.* at 43.

¹³⁰ *Id.* at 69 (quoting *Havey v. Commissioner*, 12 T.C. 409, 412 (U.S. Tax Ct. 1949)).

¹³¹ *Id.* at 73.

¹³² *Lee*, *supra* note 9, at 462.

¹³³ *Id.* at 463.

¹³⁴ See, e.g., *Barnhill v. Cheery*, No. 8:06-CV-922-T-23TGW, 2008 WL 759322 1, at *11-*12 (M.D. Fla. March 20, 2008).

¹³⁵ Jerry L. Dasti, *Advocating a Broader Understanding of the Necessity of Sex-Reassignment Surgery under Medicaid*, 77 N.Y.U.L. Rev. 1738, 1756 (2002).

¹³⁶ *Id.* at 1757.

¹³⁷ *Id.*

¹³⁸ See, e.g., *Grier v. Goetz*, 402 F. Supp. 2d 876, 912 (citing cases upholding restrictions on inpatient visits and quoting the Supreme Court's decision in *Alexander v. Choate*, 469 U.S. 287, 303 (1985), that “Medicaid programs do not guarantee that each recipient will receive that level of health care precisely tailored to his or her particular needs. Instead, the benefit provided through Medicaid is a particular package of health care services, such as 14 days of inpatient coverage. That package of services has the general aim of assuring that individuals will receive necessary medical care, but the benefit provided remains the individual services offered — not ‘adequate health care.’”)

¹³⁹ I.R.C. § 213.

¹⁴⁰ See § 213 (d) (1) (A).

¹⁴¹ See § 213

¹⁴² In *O'Donnabhain v. Comm'r of Internal Revenue*, 143 T.C. 34, 48 (U.S. Tax Ct. 2010), the plaintiff was allowed to deduct her medical expenditures from her taxable income. *Id.* at 34. This has the same total effect as a government subsidy. For example, if the plaintiff has a taxable income of \$50,000, he or she will pay twenty-five percent in federal income taxes, or \$12,500. If the plaintiff is allowed to deduct her \$25,000 procedure from her taxable income, then

plaintiff has a total taxable income of \$25,000 and pays the government only \$6,250 in taxes. This result is essentially the same as if the government had given the plaintiff \$6,250 (or \$12,500 minus \$6,250) to go toward her surgical procedures. The amount of the “subsidy,” as a proportion of the total cost of the procedure, increases with affluence: an individual with a taxable income of \$250,000 would be in a higher tax bracket and the “subsidy” would equal the tax rate multiplied by the cost of the procedure (e.g., forty percent tax rate and a \$25,000 operation means patient pays \$90,000 in taxes, rather than \$100,000).

¹⁴³ 2008 WL 759322 1, at *14 (M.D. Fla. March 20, 2008).

¹⁴⁴ See *id.* at *12 (“Deference to the informed judgment of the prison officials is especially appropriate here, since there is disagreement among experts regarding the proper treatment for transsexualism, and female hormone therapy is highly controversial due to its health risks.”)

¹⁴⁵ *Kosilek v. Maloney*, 221 F. Supp. 2d 156, 191 (D. Mass. 2002); see *supra* note 81 and accompanying text.

¹⁴⁶ *Smith v. Rasmussen (Rasmussen II)*, 249 F.3d 755, 760-61 (8th Cir. 2000).

¹⁴⁷ *Id.* at 761.

¹⁴⁸ *Id.* at 759.

¹⁴⁹ See *supra* note 142 and accompanying text. — I’m not sure what this is citing to. 141 (below), refers to a different case.

¹⁵⁰ *O’Donnabhain v. Comm’r of Internal Revenue*, 134 T.C. 34, 69 (2010).

¹⁵¹ *Mata v. Saiz*, 427 F.3d 745, 751 (10th Cir. 2005).

¹⁵² *Id.* (quoting *Farmer v. Brennan*, 511 U.S. 825, 837).

¹⁵³ *Kosilek v. Maloney*, 221 F. Supp. 2d 156, 190 (D. Mass. 2002).

¹⁵⁴ *Id.* at 191.

¹⁵⁵ *Giroux v. Somerset County*, 178 F.3d 28, 33-34 (1st Cir. 1999).

¹⁵⁶ *Id.* at 30.

¹⁵⁷ *Id.* at 33.

¹⁵⁸ *Id.*

¹⁵⁹ *Id.* The court stated that “cell feed” indicates that the prisoner is either ill or in protective custody; two options, only one of which suggests that the inmate is “vulnerable to attack.” *Id.*

¹⁶⁰ See *Kosilek v. Maloney*, 221 F. Supp. 2d 156, 190-91 (D. Mass. 2002).

¹⁶¹ *Id.* at 176.

¹⁶² *Id.*

¹⁶³ See, e.g., *id.* at 163-64 (detailing inmate’s lifelong struggle to obtain gender reassignment); see also Spade, *supra* note 3, at 19–22 .

¹⁶⁴ See *supra* note 39 and accompanying text.

¹⁶⁵ See *Standards of Care*, *supra* note 2, at 11-17.

¹⁶⁶ *Id.*

¹⁶⁷ See Spade, *supra* note 3, at 20.

¹⁶⁸ See Susan Etta Keller, *Crisis of Authority: Medical Rhetoric and Transsexual Identity*, 11 YALE J.L. & FEMINISM 51, 54 (1999).

¹⁶⁹ Spade, *supra* note 3, at 19.

¹⁷⁰ See *id.* at 20. In recounting his own experience convincing doctors of his need for gender reassignment Spade writes:

I’ve worked hard to not engage the gay childhood narrative — I never talk about tomboyish behavior as an antecedent to my lesbian identity, I don’t tell stories about cross-dressing or crushes on girls, and I intentionally fuck with the assumption of it by telling people how I used to be straight and have sex with boys like any sweet trashy rural girl. I see these narratives as strategic, and I’ve always rejected the strategy that adopts some theory of innate sexuality and forecloses the possibility that anyone, gender troubled childhood or not, could transgress sexual and gender norms at any time. I don’t want to participate in an idea that only some people have to struggle to learn gender norms in childhood.

¹⁷¹ *Id.* at 24.

¹⁷² See David Marcus, *The Federal Rules of Civil Procedure and Legal Realism as a Jurisprudence of Law Reform*, 44 GA. L. REV. 433, 473 (2010) (“Common law pleading required that the contours of the forms of action, not practical considerations or concerns of justice, dictate the boundaries and progress of suits. [FN213] A nineteenth-century plaintiff, for example, could not obtain relief unless his claims fit one of what amounted to a fourteenth-century writ.”)

¹⁷³ Spade, *supra* note 3, at 20.

¹⁷⁴ See Keller, *supra* note 168, at 53-56.

¹⁷⁵ Demoya R. Gordon, *Transgender Legal Advocacy: What do Feminist Legal Theories Have to Offer?*, 97 CAL. L. REV. 1719, 1747 (2009) (quoting Gary Peller, *Reason and the Mob: The Politics of Representation*, TIKKUN, July/Aug 1987, at 30).

¹⁷⁶ See, e.g., DSM-IV, *supra* note 2, at 535-36.

- ¹⁷⁷ See Spade, *supra* note 3, at 23-24; Keller, *supra* note 168, at 55-56.
- ¹⁷⁸ See *supra* note 177.
- ¹⁷⁹ Keller, *supra* note 168, at 55.
- ¹⁸⁰ Spade, *supra* note 3, at 26-28.
- ¹⁸¹ *Id.*
- ¹⁸² DSM-IV, *supra* note 2, at 532-38.
- ¹⁸³ See, e.g., Pinneke v. Preisser, 623 F.2d 546, 548 (8th Cir. 1980).
- ¹⁸⁴ See, e.g., *id.*; see also *supra* note 88 and accompanying text.
- ¹⁸⁵ See Keller, *supra* note 168, at 51.
- ¹⁸⁶ See *supra* Part III. B-C.
- ¹⁸⁷ See, e.g. Smith v. Rasmussen (*Rasmussen II*), 249 F.3d 755, 760 (8th Cir. 2000) (defendant claims surgery is experimental) and see Pinnke v. Preisser, 623 F.2d 546, 569 (8th Cir. 1980) (defendant claims surgery is experimental).
- ¹⁸⁸ See O'Donnabhain v. Comm'r of Internal Revenue, 143 T.C. 3455-56 (U.S. Tax Ct. 2010).
- ¹⁸⁹ In this Note I adopt Rachel Pollack's term "gatekeepers," the authorities that stand between an individual with GID and the treatment that individual seeks, who Pollack describes as "those who would seize the power of life and death by demanding that transsexuals satisfy an arbitrary standard." A at 20 (quoting Rachel Pollack, *The Varieties of Transsexual Experience*, 7 Transsexual News Telegraph 18, 20 (1997)).
- ¹⁹⁰ See *supra* note 189 and accompanying text.
- ¹⁹¹ See *supra* Part IV.A
- ¹⁹² See Kosilek v. Maloney, 221 F. Supp. 2d 156, 165 (D. Mass. 2002).
- ¹⁹³ See Smith v. Rasmussen (*Rasmussen II*), 249 F.3d 755, 757-58 (8th Cir. 2000).
- ¹⁹⁴ See O'Donnabhain v. Comm'r Internal Revenue, 134 T.C. No. 4 1 (U.S. Tax Ct. 2010).
- ¹⁹⁵ See *supra* Part III.
- ¹⁹⁶ See, e.g., *Rasmussen II*, 249 F.3d at 760.
- ¹⁹⁷ See Cox, *supra* note 11, at 360.
- ¹⁹⁸ See I.R.C. § 213; O'Donnabhain v. Comm'r of Internal Revenue, 134 T.C.34, 48 (U.S. Tax Ct. 2010).
- ¹⁹⁹ See *supra* Part III.
- ²⁰⁰ See Spade, *supra* note 3, at 23.
- ²⁰¹ See Ramachandran, *supra* note 21, at 35.
- ²⁰² See Cox, *supra* note 11, at 359. This is especially true given "poverty plagues the transgender community," and studies indicate as much as "70% of the transgender population in the United States is unemployed." *Id.*
- ²⁰³ Keller, *supra* note 168, at 53.
- ²⁰⁴ *Id.* at 53-54. This assumption is probably a safe one; to say otherwise would suggest that the medical model created the disjunction underlying gender identity disorder, which concedes far more than what these scholars claim.
- ²⁰⁵ *Id.*
- ²⁰⁶ *Id.*
- ²⁰⁷ See Dasti, *supra* note 135, at 1758-60.
- ²⁰⁸ Keller, *supra* note 168, at 56, 59.
- ²⁰⁹ *Id.* at 56.
- ²¹⁰ *Id.* at 59 (explaining that transsexuals are disempowered by the medical model but have few alternatives other than abandoning transsexualism altogether).
- ²¹¹ *Id.* at 54 (citing Gordene Olga MacKenzie, TRANSSEXUAL NATION 71 (1994)).
- ²¹² Title VII of The Civil Rights Act of 1964, 42 U.S.C. § 2000 (e) (2006).
- ²¹³ See Price Waterhouse v. Hopkins, 490 U.S. 228, 258 (1989), *superseded by statute, Civil Right Act of 1991*.
- ²¹⁴ See Jespersen v. Harrah's Operating Co., 444 F.3d 1104,1113 (9th Cir. 2006).
- ²¹⁵ 444 F.3d 1104 (9th Cir. 2006).
- ²¹⁶ Jespersen v. Harrah's Operating Co., 392 F. 3d 1076, 1080 (9th Cir. 2004), *reh'g en banc granted*, 409 F.3d 1061 (9th Cir. 2005), *aff'd*, 444 F.3d 1061 (9th Cir. 2006).
- ²¹⁷ *Id.* at 1081.
- ²¹⁸ *Jespersen*, 444 F.3d at 1114 n.2. (1989) (Pregerson, J., dissenting).
- ²¹⁹ *Id.* at 1109-11.
- ²²⁰ *Id.* at 1117.
- ²²¹ *Id.*
- ²²² *Id.*
- ²²³ Jespersen v. Harrah's Operating Co., 392 F.3d 1076, 1077 (9th Cir. 2004), *reh'g en banc granted*, 409 F.3d 1061 (9th Cir. 2005), *aff'd*, 444 F.3d 1104 (9th Cir. 2006).
- ²²⁴ See *id.*
- ²²⁵ *Jespersen*, 444 F.3d at 1113.
- ²²⁶ *Id.*

²²⁷ *Jespersion v. Harrah's Operating Co*, 392 F.3d 1076, 1080 (9th Cir. 2004); *Schroer v. Billington*, 577 F. Supp. 2d 293, 304 (D.C. Cir. 2006). — Court in *Schroer* distinguishes based on the facts and doesn't discuss generally applicable policies — maybe not the best supporting authority for this premise.

²²⁸ L.M. Lothstein, *The Aging Gender Dysphoria (Transsexual) Patient*, 8 ARCH. SEX. BEHAV. 431, 434-36 (1979).

²²⁹ Ramachandran, *supra* note 21, at 34.

²³⁰ *See supra* p. 14.

²³¹ Dylan Vade, *Expanding Gender and Expanding the Law: Toward a Social and Legal Conceptualization of Gender That Is More Inclusive of Transgender People*, 11 MICH. J. GENDER & L. 253, 269 (2005) (reporting that a number of studies indicate that around half of transgender respondents have health insurance).

²³² *See* Ramachandran, *supra* note 21, at 41 (suggesting that capitalism provided the space for gay and lesbian subcultures to flourish).

²³³ *See, e.g.*, Spade, *supra* note 3.

²³⁴ *See* Butler, *supra* note 19, at 144-45.