Nos. 24-2838 & 24-3240

IN THE
UNITED STATES COURT OF APPEALS
FOR THE SEVENTH CIRCUIT

AUTUMN CORDELLIONE, a.k.a. Jonathan Richardson,

Plaintiff-Appellee,

v.

LLOYD ARNOLD, Commissioner, Indiana Department of Correction, *in his official capacity*,

Defendant-Appellant.

On Appeal from the United States District Court for the Southern District of Indiana, No. 3:23-cv-00135-RLY-CSW, The Honorable Richard L. Young, Judge

OPENING BRIEF FOR DEFENDANT-APPELLANT

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INTRODUCTION

The Eighth Amendment bars Indiana from imposing "cruel and unusual punishment," while the Equal Protection Clause requires Indiana to afford all persons equal protection of law. After considering the serious medical debate regarding treatments for gender dysphoria, Indiana has decided that no prisoners in State custody may receive sexual reassignment surgery. But the district court determined that the opinion of one doctor should overcome all the evidence of a medical debate that the court itself admitted, granting Plaintiff an affirmative right to an experimental medical procedure. Further, the district court adopted a reading of the Fourteenth Amendment explicitly rejected by this Court just a few months ago.

Compounding these issues, the district court renewed its initial faulty injunction without ever hearing from Defendant. In doing so, it failed to consider material developments in this Court's precedent and the facts of this case: yet another doctor has found that Plaintiff is not a candidate for sexual reassignment surgery. This means that the new injunction violates not only Rule 65(a)'s notice requirements, but also the narrow scope of injunctive relief required under the Prison Litigation Reform Act (PLRA). This Court should vacate both injunctions.

JURISDICTIONAL STATEMENT

Plaintiff, whose legal name is Jonathan Richardson but who identifies as Autumn Cordellioné, filed this action for declaratory and injunctive relief under 42 U.S.C. § 1983. Dkt. 1 at 2 (Compl. ¶ 6). Plaintiff alleges that Indiana Code § 11-10-3-3.5(a)—which bars the Indiana Department of Correction from providing or

facilitating sexual reassignment surgeries for offenders—violates the Eighth Amendment's prohibition against cruel and unusual punishment and the Fourteenth Amendment's Equal Protection Clause. Dkt. 1 at 9–10 (Compl. ¶¶ 51–52). The district court had jurisdiction because Plaintiff raised federal questions under 28 U.S.C. §§ 1331 and 1343.

On September 17, 2024, the district court issued a preliminary injunction. Dkt. 96; Dkt. 97. Under the Prison Litigation Reform Act (PLRA), "[p]reliminary injunctive relief shall automatically expire on the date that is 90 days after its entry, unless the court makes the findings required under subsection (a)(1) for the entry of prospective relief and makes the order final before the expiration of the 90-day period." 18 U.S.C. § 3626(a)(2). To avoid automatic expiration, the district court stated that the requirements of subsection (a)(1) were satisfied, finding that its preliminary injunction "is narrowly drawn," "extends no further than necessary," and "is the least intrusive means available and necessary to correct [an] ongoing violation." SA44. On October 16, 2024, Defendant filed a timely notice of appeal from the preliminary injunction. Dkt. 98. This Court has jurisdiction over that appeal under 28 U.S.C. § 1292(a)(1).

After Defendant filed a notice of appeal, Plaintiff asked the district court to renew its preliminary injunction. Dkt. 119. Plaintiff observed that, "[a]rguably," no "extension of the preliminary injunction" was necessary. Dkt. 119 at 2. On December 6, 2024, without waiting for a response from Defendant, the district court granted Plaintiff's motion, "renew[ed] the previously entered preliminary injunction in this

case," and "incorporate[d] verbatim its Preliminary Injunction of September 17, 2024." Dkt. 121. That order does not affect the Court's jurisdiction over Defendant's appeal from the September 17, 2024 preliminary injunction. To the extent that the September 17, 2024 preliminary injunction constitutes a "final" order that does not expire after 90 days, the order remains in force. And appeals of preliminary injunctions entered pursuant to the PLRA do not become moot where the injunction is "renewed." *Edmo v. Corizon, Inc.*, 935 F.3d 757, 783 & n.12 (9th Cir. 2019); *see Ciarpaglini v. Norwood*, 817 F.3d 541, 546 (7th Cir. 2016) (explaining "capable of repetition yet evading review" doctrine). Defendant filed a timely notice of appeal from the renewed injunction on December 9, 2024. Dkt. 123. This Court has jurisdiction over that appeal under 28 U.S.C. § 1292(a)(1).

This Court has since consolidated Defendant's appeals. Doc. 17. Neither appeal is from a decision of a magistrate judge. The merits of Plaintiff's claims remain with the district court.

STATEMENT OF THE ISSUES

1. Whether, consistent with the Eighth Amendment, Indiana may make a reasonable medical judgment to decline to provide sexual reassignment surgery for offenders.

2. Whether, consistent with the Equal Protection Clause, Indiana may prohibit the Department of Correction from providing sexual reassignment surgery to inmates in its custody.

3. Whether the district court improperly renewed the preliminary injunction without hearing from the Department or considering any material factual or legal changes.

4. Whether the district court erred in weighing the equities.

STATEMENT OF THE CASE

I. The Eighth Amendment's Application to Medical Procedures

The Eighth Amendment bars the infliction of "cruel and unusual punishments." U.S. Const. amend. VIII. Rooted in the English Bill of Rights, the Framers adopted this language "to ensure that the new Nation would never resort" to "certain barbaric punishments" like "disemboweling, quartering, public dissection, and burning alive." *City of Grants Pass v. Johnson*, 603 U.S. 520, 542 (2024); *see Ingraham v. Wright*, 430 U.S. 651, 664 (1977); *Furman v. Georgia*, 408 U.S. 238, 259 (1972) (Brennan, J., concurring). As early commentators explained, the Eighth Amendment ruled out "the use of the rack or the stake," or "breaking on the wheel, flaying alive, rending asunder with horses, maiming, mutilating, and scourging to death." *Bucklew v. Precythe*, 587 U.S. 119, 131 (2019) (cleaned up).

Most early litigation over the Eighth Amendment focused on methods of capital punishment. *See, e.g.*, *Wilkerson v. Utah*, 99 U.S. 130, 135–36 (1878) (firing squad); *In re Kemmler*, 136 U.S. 436, 444 (1890) (electrocution); *Louisiana ex rel. Francis v. Resweber*, 329 U.S. 459, 464 (1947) (electrocution). In the 1960s and 1970s, however, the Supreme Court began to expand the Eighth Amendment's reach. *See Estelle v. Gamble*, 429 U.S. 97 (1976). The Court decided that "'the evolving standards of decency that mark the progress of a maturing society' . . . establish the government's

obligation to provide medical care for those whom it is punishing by incarceration." *Id.* at 102–03 (quotation omitted). The Court explained that the Eighth Amendment is violated where prison officials show "deliberate indifference" to prisoners' "serious medical needs." *Id.* at 104.

At the same time, the Court cautioned that not "every claim by a prisoner that he has not received adequate medical treatment states a violation of the Eighth Amendment." *Estelle*, 429 U.S. at 105. Even "[m]edical malpractice" "does not become a constitutional violation merely because the victim is a prisoner." *Id.* at 106. Questions about "whether an X-ray or additional diagnostic techniques or forms of treatment" might be warranted are "classic example[s]" of matters outside the Eighth Amendment's purview. *Id.* at 107. For a prisoner's claim to succeed, he must establish he "suffer[s] from an objectively serious medical condition" and that the "individual defendant was deliberately indifferent to that condition." *Petties v. Carter*, 836 F.3d 722, 727–28 (7th Cir. 2016) (en banc). This "high bar" requires "a showing of something approaching a total unconcern for the prisoner's welfare in the face of serious risks." *Rasho v. Jeffreys*, 22 F.4th 703, 710 (7th Cir. 2022) (cleaned up).

II. Gender Dysphoria and Responses to It[1]

Gender dysphoria is classified as a mental disorder. SA14–SA15 (citing *Diagnostic and Statistical Manual of Mental Disorders,* Am. Psychiatric Ass'n, 5th ed. ("DSM-5")). It is defined by a marked incongruence between one's sex—as determined

[1] The district court admitted all below-cited record information into evidence.

by one's primary and/or secondary sex characteristics—and one's experienced or expressed gender identity. SA17.

Members of the medical community have taken various approaches to gender dysphoria. "Social support and psychotherapy are widely recognized approaches." *K.C. v. Individual Members of the Med. Licensing Bd. of Ind.*, 121 F.4th 604, 610–11 (7th Cir. 2024) (citing Anderson et al., *Gender Dysphoria and Its Non-Surgical and Surgical Treatments*, 10 Health Psych. Rsch., at 4 (2022)). Social transition support in prison includes living in a manner consistent with one's gender identity with respect to clothing, names, pronouns, access to gender neutral commissary items, separate showering facilities and schedules, "and otherwise outwardly presenting oneself through social signifiers of gender consistent with one's gender identity." *See* SA19; Dkt. 54-19 at 44 (Levine Rep. ¶ 79); Dkt. 37-1 at 8 (Ettner Rep.). According to Plaintiff's expert, Dr. Ettner, social transition "is an appropriate and necessary part of identity consolidation. Through this experience, the shame of growing up living as a 'false self' and the grief of being born into the 'wrong body' can be ameliorated." Dkt. 37-1 at 8.

Other non-surgical approaches to gender dysphoria include cross-sex hormones. SA19. This regimen involves "the administration of exogenous endocrine agents to induce feminizing or masculinizing changes" in a person whose natural body does not produce sufficient levels of those agents to result in masculine or feminine sex characteristics. Dkt. 37-1 at 8–9 (quoting WPATH Standards of Care version 7 ("SOC-7")). Administering cross-sex hormones aims to "significantly reduce . . . the

secondary sex characteristics of the individual's sex" and to "replace circulating sex hormones . . . with feminizing or masculinizing hormones" to achieve the patient's "embodiment goals"—i.e., to conform the patient's body to the patient's mental impressions of self. *Id.* at 9 (quoting WPATH Standards of Care version 8 ("SOC-8")).

Sexual reassignment surgeries "replace an individual's existing genitals with approximations of those of the opposite sex." *Campbell v. Kallas*, 936 F.3d 536, 539 (7th Cir. 2019). For males who desire female-appearing genitals, "[t]hree basic [surgical] techniques are used to create female-appearing genital structures: penile inversion, penile scrotal grafting, and intestinal grafting." Dkt. 54-19 at 15 (Levine Rep. ¶ 35). The penile inversion technique "involves dissection of the penile skin from the shaft of the penis, formation of a neovaginal cavity between the rectum and the urethra, and inversion of the penile skin into the cavity to form the introitus vaginalis with a full-thickness scrotum skin graft as the lining of the neovagina." Dkt. 54-80 at 5 (Manrique et al., *Complications and Patient-Reported Outcomes in Male-to-Female Vaginoplasty—Where We Are Today*, 80 Annals of Plastic Surgery 684, 688 (2018)). "Although the penile inversion approach remains the most common technique, its drawbacks include prolonged use of a vaginal dilator, contraction of the neovaginal canal, malodor, and the necessity of lubrication for intercourse. The use of the intestine for reconstruction of the vagina has been proposed as [an] alternative surgical option without these limitations." *Id.* at 6 (at 689).

Sexual reassignment surgery is an irreversible, sterilizing surgery. SA21; *see also* Dkt. 54-63 at 18–19 (Schechter Dep. 17:1–18:3). As discussed above, it is highly

invasive. It also requires significant recovery time, aftercare, and regular postoperative follow-up visits, and may result in short- or long-term complications, including re-hospitalization. Dkt. 54-21 at 6–8 (Buncamper et al. at 1003–05); Dkt. 54-29 at 4 (van der Sluis et al.). Sexual reassignment surgery is not reconstructive of damaged, diseased, or unhealthy tissue; rather, it is performed on healthy tissue to address a mental illness. Dkt. 54-19 at 40 (Levine Rep. ¶ 77); *see also, e.g.*, Dkt. 54-64 at 2 (Schechter Dep. 51:21–25) (purpose is "alignment of one's body with [his/her] identity for treatment of the medical condition gender dysphoria"). It is not performed on an emergent basis. *See* Dkt. 54-63 at 12 (Schechter Dep. 11:13–22).

"There is significant debate within the medical community, based on existing evidence, whether these desired effects [of surgery] are often realized." Dkt. 54-19 at 2 (Levine Rep. ¶ 1). Initially, it was assumed that sexual reassignment surgery "cured" gender dysphoria. *Id.* at 19–20 (¶ 41). "This is no longer widely claimed; instead, [surgery] is simply a patient-requested treatment that is presumed to be ameliorative." *Id.* The "rate, degree, and duration of long-term harms and benefits remain uncertain after 60 years of genital reconstruction of trans women." *Id.* at 2 (¶ 2). Further, "[t]he quality of current guidelines on gender minority/trans health is unclear," because they "tend[] to lack methodological rigour and rely on patchier, lower-quality primary research." Dkt. 54-56 at 2, 6 (Dahlen et al., *International Clinical Practice Guidelines for Gender Minority / Trans People: Systematic Review and Quality Assessment*, 11 BMJ Open 1 (2021)) (examining WPATH's SOC-7).

Some doctors treating transgender patients rely on the Standards of Care promulgated by the World Professional Association of Transgender Health ("WPATH"). SA10. WPATH is a non-profit organization "devoted to transgender health" that aims to "promote evidence-based care, education, research, advocacy, public policy, and respect in transgender health." Dkt. 37-2 at 8 (Schechter Rep. ¶ 24). Although some in the medical community rely on WPATH for treatment guidance, WPATH "[has] not evaded criticism. Some have expressed doubt about whether WPATH's guidelines actually reflect medical consensus as to treatments for gender dysphoria." *K.C.*, 121 F.4th at 611; *Gibson v. Collier*, 920 F.3d 212, 223 (5th Cir. 2019) ("There is no medical consensus that sex reassignment surgery is a necessary or even effective treatment for gender dysphoria."). Other circuit courts have rejected reliance on WPATH because its Standards of Care "reflect not consensus, but merely one side in a sharply contested medical debate over sex reassignment surgery." *Gibson*, 920 F.3d at 221 (5th Cir. 2019); *Eknes-Tucker v. Governor of Ala.*, 114 F.4th 1241, 1267 (11th Cir. 2024) (Lagoa, J., concurring in denial of rehearing en banc) (citing Dr. Hilary Cass of England's NHS for "reasons to question the reliability of WPATH" and its recommendations).

III. Plaintiff and Gender Dysphoria

A. The Department's policies regarding gender dysphoria

This case concerns whether the Eighth Amendment requires a particular approach to addressing gender dysphoria in prisoners. Where prisoners are diagnosed with gender dysphoria, the Indiana Department of Correction offers comprehensive health services in response, including psychotherapy, social transitioning

accommodations, and cross-sex hormones. SA25 (citing Health Care Services Directive 2.17A). The Department allows inmates to use preferred pronouns, access a gender-neutral commissary, and wear cross-gender undergarments. Dkt. 90-2 at 5. The Department also directs the provision of "culturally competent" mental health services in individual treatment plans, addressing topics such as "social role transition, exploration of gender identity, role, and experience, alleviating internal transphobia and promoting resilience." *Id.* In accordance with Indiana law, the Department no longer provides sexual reassignment surgery as a treatment option for gender dysphoria.[2] SA25. This is because "[i]ndividuals may live successfully as transgender persons without [sexual reassignment] surgery." *Id.* (citing Health Care Services Directive 2.17A).

Indiana law does not permit the Department to facilitate sexual reassignment surgeries for inmates. Specifically, the Department "may not authorize the payment of any money, the use of any state resources, or the payment of any federal money administered by the state to provide or facilitate sexual reassignment surgery to an offender patient." Ind. Code § 11-10-3-3.5. "Sexual reassignment surgery" is defined as "any of the following surgical procedures for the purpose of attempting to alter the appearance of, or affirm the offender patient's perception of, his or her gender or sex, if that appearance or perception is inconsistent with the offender patient's sex:

> (A) Surgeries that sterilize, including castration, vasectomy, hysterectomy, oophorectomy, orchiectomy, and penectomy.

[2] Before the effective date of Indiana Code § 11-10-3-3.5, two prisoners in the Department's custody were approved for sexual reassignment surgery. SA24.

> (B) Surgeries that artificially construct tissue with the appearance of genitalia that differs from the offender patient's sex, including metoidioplasty, phalloplasty, and vaginoplasty.
>
> (C) Removing any healthy or non-diseased body part or tissue."

Ind. Code § 11-10-3-1(6).

B. Plaintiff's history

Plaintiff, who is legally known as Jonathan Richardson but prefers to be called Autumn Cordellioné, is a natal male who identifies as a transgender woman. Dkt. 54-69 at 12, 19 (Pl. Dep. 11:12–24, 18:4–9).

Plaintiff was an "egregiously neglected, unloved, abandoned, recurrently physically and sexually abused child and adolescent." Dkt. 54-19 at 8 (Levine Rep. ¶ 23). Plaintiff's mother abandoned Plaintiff as a baby. Dkt. 54-69 at 22 (Pl. Dep. 21:14–23). "[Plaintiff] was taken away from bio parents at age of 3 due to incest in the home." Dkt. 54-32 at 9 (2010 Medical Records). Authorities estimated an approximate birthdate for Plaintiff and named Plaintiff. Dkt. 54-69 at 22–24 (21:14–22:6, 22:20–23:6). Eventually, Plaintiff was adopted and renamed Jonathan Richardson. *Id.* at 23 (22:23–24). The adoptive parents abused Plaintiff. Dkt. 54-32 at 7 (2010 Medical Records).

This childhood meant that Plaintiff "has had limited capacities to recognize and verbally express his subjective sense of being abused and betrayed." Dkt. 54-19 at 8 (Levine Rep. ¶ 23). "Instead, he has acted out his rage, sadness, and disappointments with aggression to others and via self-harm." *Id.* Plaintiff told therapists that "he has a long history of treatment for . . . suicide attempts, cutting on self 'for the thrill' and chronic abuse of toxic inhalants." Dkt. 54-32 at 4 (2010 Medical Records).

Plaintiff "reported several suicide attempts" from this period, "the first at age 8" with antipsychotic medication. *Id.* at 9; *see also* Dkt. 54-70 at 28 (Pl. Dep. 77:6–11) (describing "attempting to cut my wrist with a pair of scissor blades" in "middle school").

In 2001, Plaintiff killed Plaintiff's eleven-month-old stepdaughter. Dkt. 54-69 at 27–28 (Pl. Dep. 26:21–27:9). A jury convicted Plaintiff of murder. *State v. Richardson*, No. 82D02-0110-CF-00738 (Vanderburgh Super. Ct. Aug. 14, 2002), https://perma.cc/9DLU-TRRF. Sentenced to fifty-five years' imprisonment, Plaintiff's earliest possible release date is December 29, 2025. Ind. Dep't of Corr., *Incarcerated Data*, https://www.in.gov/apps/indcorrection/ofs/ofs?offnum=127630&search2.x=0&search2.y=0 (last visited Jan. 21, 2025). Plaintiff now claims that a repressed transgender identity was a motivating factor for this murder. Dkt. 54-70 at 39–40 (Pl. Dep. 88:22–89:1); *see* Dkt. 54-42 at 4 (2020 Medical Records at 1749); Pl. Video Dep. 1:49:55–51:36. Plaintiff did not indicate in the district court that transgender identity was ever discussed as a motivation at the criminal trial.

Plaintiff has attempted suicide at least six times during incarceration. Dkt. 54-70 at 27–30 (Pl. Dep. 76:19–22, 77:14–79:24). Once, Plaintiff lit a cell on fire with the intent to self-harm because Plaintiff heard the deceased victim crying. Dkt. 54-32 at 1 (2010 Medical Records). An evaluating psychologist recorded treatment notes suggesting that Plaintiff's attempts resulted from repressed memories of earlier abuse. *Id.* at 7 ("He attempted suicide in 2002, with about 30 [Elavil]. . . . He believes he has repressed many of his abusive experiences, and later explodes.").

C. Plaintiff's gender dysphoria diagnosis and the Department's response

Plaintiff lived as a man both before and during incarceration. *See* Dkt. 54-54 at 53 (2019 Medical Records); Dkt. 54-30 at 2 (Plaintiff's Trans Protocol Responses). Before 2019, "[n]o evidence of gender dysphoria or feminine behaviors was apparent" in any prison records concerning Plaintiff. Dkt. 54-19 at 11 (Levine Rep. ¶ 29).

In 2019, Plaintiff learned about transgenderism from a fellow inmate who identified as a transgender woman. Dkt. 54-69 at 50 (Pl. Dep. 49:19–25); Dkt. 54-70 at 1–2 (Pl. Dep. 50:1–51:6). The other inmate explained to Plaintiff how to receive hormones from medical staff. Dkt. 54-70 at 1–2 (Pl. Dep. 50:7–9; 51:13–16). A few months after this conversation, Plaintiff announced a new gender identity to mental health staff. Dkt. 54-69 at 50 (Pl. Dep. 49:13–15); Dkt. 54-45 at 2 (7/22/19 Counseling). The evaluating psychologist noted it was not clear how long Plaintiff had identified as a woman. Dkt. 54-45 at 2. Plaintiff told that doctor that Plaintiff's tattoos were expressions of a feminine gender identity. *Id.* But earlier, Plaintiff had told another therapist that these same tattoos related to Plaintiff's Wiccan beliefs. Dkt. 54-77 at 1 (2014 Medical Record).

Given these statements, the Department evaluated Plaintiff for gender dysphoria in April 2020. Dkt. 54-42 at 3. The doctor who conducted this initial assessment, Dr. Corissa Dionisio, M.D., concluded that due to "questions" still unresolved after the assessment, her "advice regarding gender dysphoria diagnosis" was "inconclusive, pending discussion with [the Department's] transgender dysphoria committee." *Id.* Dr. Dionisio declined to diagnose Plaintiff with gender dysphoria. *Id.* at 6.

She expressed concern about Plaintiff's mental health comorbidities: "[Major Depressive Disorder] (previously with and without psychosis), polysubstance dependence, borderline personality disorder, paranoid schizophrenia, antisocial personality disorder . . . PTSD, emotional handicap, megalomania, narcissism, manic depressive, [and] schizophrenia." *Id.* at 5.

Dr. Dionisio was also concerned that Plaintiff's desire "to alter her body through gender affirming treatments is another act of body alteration/mutilation or otherwise, self-harm, associated with borderline personality disorder. For example, one may consider gender affirming bottom surgery as a form of self-harm (penectomy, orchiectomy)." Dkt. 54-42 at 6. Dr. Dionisio grounded this concern in Plaintiff's history of body alteration and self-harm, including burning various parts of the body, burning and biting off the fingers, cutting, and extensive body and facial tattoos. *Id.* Third, Dr. Dionisio noted Plaintiff's history of suicide attempts, which were not related to Plaintiff's gender identity or genitals. *See id.* at 5 ("Reports cut wrists, overdose (4-5x). Boiled fingers in hot pot due to wanting to die. . . Wanted to commit suicide due to being in on 'child murder', was fearful of others killing her. Light cell on fire (lots of burns on body)."). Plaintiff later said that these incidents stemmed from a desire to conform Plaintiff's body to how Plaintiff felt. Dkt. 54-70 at 5 (Pl. Dep. 54:3–21) (tattoos); *id.* at 34, 37 (Pl. Dep. 83:17–24, 86:7–13) (self-harm).

Finally, Dr. Dionisio was concerned because Plaintiff had a self-admitted history of lying to and manipulating doctors. She noted that Plaintiff reported "lying about having [audio-visual hallucinations] in the past to get on medications like

thorazine [and] tegretol. [Plaintiff] recognizes she has a level of manipulative behavior." Dkt. 54-42 at 5. Plaintiff has not disputed that Plaintiff has manipulated doctors to get specific prescriptions. *See, e.g.*, Dkt. 54-70 at 20–21 (Pl. Dep. 69:15–70:3).

In June 2020, a review committee discussed Plaintiff's "continuing request to be started on hormone therapy for gender dysphoria." Dkt. 54-41 at 30–32. The review committee shared Dr. Dionisio's concerns regarding a gender dysphoria diagnosis given Plaintiff's "history of self-harm, self-mutilation, and drastic changes in personal appearance," as well as "manipulat[ion]" of doctors for "secondary gain." *Id.* at 31. But the committee explained that "[t]he potential risks and benefits of recommending hormone treatment were discussed," and despite the concerns detailed above, "it was decided that there would be greater risk in not recommending treatment at this time." *Id.* Accordingly, the committee formally diagnosed plaintiff with gender dysphoria and recommended "evaluation for hormone therapy." *Id.*; *see* Dkt. 54-70 at 41 (Pl. Dep. 90:9–13).

Since then, the Department has taken steps to address Plaintiff's gender dysphoria diagnosis. *See generally* Dkt. 54-33, 54-34, 54-35, 54-36, 54-37, 54-38 (Medical Records 2022–23); Dkt. 54-39, 54-40, 54-41, 54-42 (Medical Records 2020–21); Dkt. 54-53, 54-54 (Medical Records 2019); Dkt. 54-57 (Medical Records Oct. 2023 through Feb. 2024); Dkt. 54-31 (Hormone Admin. Records). The Department permitted social transition and has provided mental health counseling and cross-sex hormones. Dkt. 83 at 108–09 (108:13–109:3); Dkt. 54-19 at 44 (Levine Rep. ¶ 79); Dkt. 54-71 at 4 (Pl. Dep. 104:8–12). Plaintiff receives daily doses of estradiol, an estrogen supplement,

and spironolactone, an anti-androgen, or testosterone blocker. Dkt. 54-70 at 45–47 (Pl. Dep. 94:17–96:10); *see* Dkt. 54-31 (Hormone Admin. Records). The Department refers to Plaintiff by a female name and pronouns, and Plaintiff is permitted to wear female clothing and eliminate facial and body hair. Dkt. 37-1 at 22 (Ettner Rep.). Plaintiff also has a transgender access card, which enables the purchase of female commissary items such as women's undergarments and makeup. Dkt. 54-70 at 49 (Pl. Dep. 98:17–20); Dkt. 54-38 at 13.

IV. Procedural Background

A. Plaintiff seeks a preliminary injunction

In August 2023, Plaintiff filed a complaint for declaratory and injunctive relief in the Southern District of Indiana. Dkt. 1. The complaint alleged that Indiana Code § 11-10-3-3.5(a) prohibits "necessary medical treatment" for transgender prisoners in violation of the Eighth and Fourteenth Amendments. *Id.* at 9–10 (¶¶ 51–52). The complaint requested a declaratory judgment that § 11-10-3-3.5(a) is unconstitutional and a preliminary injunction "enjoining defendant from enforcing Indiana Code § 11-10-3-3.5(a) and requiring defendant to take all steps necessary to provide plaintiff with gender affirming surgery, including the necessary preparatory steps prior to performance of the surgery, and providing the surgery itself." *Id.* at 10.

On March 26, 2024, the district court held a hearing on Plaintiff's request for a preliminary injunction. Dkt. 83. At the hearing, the district court admitted dozens of studies related to gender dysphoria into evidence. *Id.* at 7, 12 (7:11–25, 12:3–6). The Department called Plaintiff and Warden Danny T. Mitchell as fact witnesses. *Id.* at 18–59, 60–70. The court also heard testimony from several doctors on the

suitability of sexual reassignment surgery for Plaintiff. Dr. Michael D. Farjellah, a clinical psychologist formerly on staff at the Department, testified about two meetings he had with Plaintiff after Plaintiff was transferred to the Branchville Correctional Facility. *Id.* at 72, 75–77 (72:1–5, 75:17–77:9). On the basis of "clinical information" gathered in those meetings, Dr. Farjellah concluded that he "didn't think [Plaintiff] was a candidate for possible gender transition surgery because of the diagnosis of borderline personality disorder," because that is "consistent with a serious mental illness." *Id.* at 84 (84:5–11, 17–19). Dr. Adrienne Bedford, the chief medical officer at the Department, also testified about the Department's non-surgical response to Plaintiff's gender dysphoria. *Id.* at 108–09 (108:13–109:14). She concluded that "[a]ccording to the current medical consensus, I do feel that the patient is being treated adequately." *Id.* at 109 (109:13–14).

Expert witnesses testified on the same issue. First, Dr. Stephen Levine, a clinical psychiatrist, opined upon review of Plaintiff's medical records that the Department's non-surgical "alternative treatment options for gender dysphoria fall within the appropriate medical standard of care." Dkt. 83 at 168 (168:16–21). Dr. Levine also opined that he "c[ould not] say" that "surgery would be an effective or safe treatment option for this plaintiff." *Id.* at 170 (170:9–13).

Next, Dr. Randi Ettner testified. She was the only witness Plaintiff called at the hearing. Dkt. 83 at 6 (6:23–25). Dr. Ettner, a psychologist, is a former board member of WPATH, co-author of the two editions of the WPATH Standards of Care (SOC-7 and SOC-8), and chair of the WPATH Committee for Institutionalized Persons. Dkt.

37-1 at 1 (Ettner Rep.). Dr. Ettner had reviewed Plaintiff's medical records and interviewed Plaintiff once via videoconference. Dkt. 83 at 185 (185:23–24). Dr. Ettner reached a different conclusion from Drs. Farjellah and Levine, opining that Plaintiff "requires genital reconstruction surgery, and transfer to a female facility." Dkt. 37-1 at 26 (Ettner Rep.); *see* Dkt. 83 at 188 (188:16–19) (reiterating opinion in report that surgery is "medically necessary" for Plaintiff).

Plaintiff also offered the expert report of Dr. Loren Schechter. Dkt. 37-2. Dr. Schechter, a plastic surgeon, opined on the basis of his clinical experience performing sexual reassignment surgeries that "procedures used to treat gender dysphoria are medically necessary treatments for many transgender people," and that these surgeries are "safe and effective." *Id.* at 8 (¶ 23). Dr. Schechter, like Dr. Ettner, was a contributing author of WPATH's SOC-7 and SOC-8. *Id.* at 3 (¶ 9).

B. The original preliminary injunction

The district court ultimately granted Plaintiff's motion for a preliminary injunction. SA1. It stated that the WPATH Standards of Care "are the internationally recognized guidelines for the treatment of persons with gender dysphoria." SA17. The court then stated that it would "rely on them in reaching its conclusions in this matter." SA18. Based on those standards, the court decided that when "gender dysphoria remains marked and sustained, it is medically necessary to provide" sexual reassignment surgery. SA19.

The district court rejected the opinions of the two doctors who concluded that Plaintiff was a poor candidate for surgery. SA28–SA30. These doctors had raised

concerns about Plaintiff's borderline personality disorder, "sublimated masochism, underexplored erotic life, and willingness to manipulate and mislead doctors." SA29. The court concluded that Dr. Farjellah "does not have any specialization in treating gender dysphoria," including surgery evaluation, and that his concerns about borderline personality disorder are contradicted by his findings that Plaintiff did not display any signs of "major mental illness." SA30–SA31. And the court gave "Dr. Levine's opinion as to [Plaintiff's] suitability for gender-affirming surgery no weight" because Dr. Levine "has never spoken with" Plaintiff or conducted an evaluation. SA31. The court instead relied on Dr. Ettner's opinion. SA32. Dr. Ettner did not discuss Plaintiff's history of lying to doctors, but she opined that Plaintiff was "straightforward and honest" during their two-hour videoconference meeting. SA32. The court relied on this to decide that surgery is "medically necessary" for Plaintiff. SA32.

Based on these findings, the court decided that Plaintiff was likely to succeed on the claims that Indiana Code § 11-10-3-3.5(a) violated both the Eighth and the Fourteenth Amendments. Regarding the Eighth Amendment, the court said that surgery "may be medically necessary to treat inmates with severe gender dysphoria," SA37, because "WPATH's Standards of Care continue to recognize that gender-affirming surgery is medically necessary for some individuals with gender dysphoria," SA39. Because § 11-10-3-3.5(a) forbids the Department from paying for sexual reassignment surgery, the court held that the law "requires deliberate indifference" to inmates' serious medical needs. SA39. It also held that Plaintiff had established that Plaintiff requires such surgery and is at risk of "irreparable injury" due to "engaging

in self-harm, either in the form of another attempt to castrate herself or to die by suicide." SA40.

On the Fourteenth Amendment, the court decided that Plaintiff was likely to succeed on the claim that Indiana's law discriminated "on the basis of transgender status" and is therefore "sex discrimination." SA41. It grounded this determination in the Supreme Court's Title VII decision, *Bostock v. Clayton County*, 590 U.S. 644 (2020), and this Court's decision regarding bathroom access, *Whitaker ex rel. Whitaker v. Kenosha Unified School District*, 858 F.3d 1034, 1051 (7th Cir. 2017). *Id.* The Court stated that the law "prevents transgender inmates from accessing medically necessary care while cisgender inmates still have access to such care." SA42. Given the court's determination that this was sex-based discrimination, it then applied heightened scrutiny. SA41–SA43. The court rejected the State's rationales for the law, including protecting inmates from "invasive, irreversible, and sterilizing genital surgeries." SA43.

The district court decided that Plaintiff had "received a full evaluation of her need for gender-affirming surgery" from Plaintiff's expert, so "it is appropriate for the court to order at this point that this surgery be provided to her at the earliest opportunity." SA45. The court ordered the Commissioner "to take all reasonable actions to secure plaintiff gender-affirming surgery at the earliest opportunity." SA2. The district court also announced that it would "renew th[e] preliminary injunction every 90 days until the surgery is provided," given "18 U.S.C. § 3626(a)(2)." SA46. Defendant filed a timely notice of appeal. Dkt. 101.

C. The renewed preliminary injunction

On December 3, 2024, nearly 90 days after the entry of the original preliminary injunction, Plaintiff asked the district court to renew its preliminary injunction. Dkt. 119. On December 6, without waiting for a response from Defendant, the district court granted Plaintiff's motion, "renew[ed] the previously entered preliminary injunction," and "incorporate[d] verbatim its Preliminary Injunction of September 17, 2024." SA1–SA2. Defendant filed a timely notice of appeal from the renewed injunction. Dkt. 123.

Afterwards, Defendant filed a response in opposition to renewal, attaching a new psychiatric evaluation from psychologist Dr. Kelsey Beers, who concluded that Plaintiff was not a good candidate for surgery. Dkt. 128, 128-1. Dr. Beers interviewed Plaintiff in December 2024 "to assess gender confirmation surgery readiness." Dkt. 128-1 at 1. Dr. Beers asked Plaintiff about Plaintiff's understanding of what surgery would entail, including preoperative requirements, timeline, and postoperative expectations. *Id.* at 1–3. She recorded Plaintiff's answers to additional questions about Plaintiff's physical and mental health. *Id.* at 4–5.

Dr. Beers undertook an extensive review of Plaintiff's medical records. In summarizing her review, Dr. Beers highlighted "significant discrepancies and lying scattered throughout the medical record," *id.* at 5; Plaintiff's "advance[d] ability to manipulate even the highly trained and educated" clinicians who counseled Plaintiff, *id.* at 6; "intentional instances of self-harm or perhaps attempts to obtain certain medications or attention from treatment staff," *id.* at 7; and an "established pattern of

attention-seeking behavior" that was "consistently documented in mental status over the last 18 years," *id.* at 9. Dr. Beers concluded that, because Plaintiff's "primary clinical issues are symptoms of personality disorders," including antisocial personality disorder and borderline personality disorder, "surgery is not the answer to [Plaintiff's] pathology." *Id.* at 11. Accordingly, Dr. Beers affirmed that "[b]ecause the clinical picture is convoluted with overt manipulation and poorly controlled symptoms of personality disorder, this psychologist does not recommend surgery at this time." *Id.* at 12. Plaintiff objected to the report. Dkt. 129 at 1–2; Dkt. 129-1.

SUMMARY OF THE ARGUMENT

The district court improperly decided that the Eighth and Fourteenth Amendments grant Plaintiff an affirmative right to sexual reassignment surgery. This error was compounded when the district court renewed its preliminary injunction without notice to Defendant and without considering material changes in this Court's precedent and the facts.

I. Under the Eighth Amendment, prison officials cannot show deliberate indifference to inmates' serious medical needs. This standard is high—Plaintiffs only succeed on an Eighth Amendment claim if they show that no minimally competent professional would have taken the challenged course of action. This rule does not change when States make an across-the-board medical decision. States are afforded substantial latitude to regulate medicine in areas of scientific disagreement. Here, the Department presented evidence of substantial debate about the efficacy of sexual reassignment surgery in treating gender dysphoria and presented testimony from multiple doctors who did not recommend surgery for Plaintiff. The Department

showed that far more than one "minimally competent professional" agree that sexual reassignment surgery is not effective across the board, and showed that, as applied to Plaintiff, surgery would not address Plaintiff's mental health diagnoses. The district court erred in disregarding this evidence and relying instead on the opinions of a questionable advocacy organization and one doctor to decide that the Eighth Amendment entitled Plaintiff to surgery.

II. Further, Indiana's law is not sex discrimination under the Equal Protection Clause. It does not treat inmates differently based on their sex or even based on their gender identity. The Department cannot provide sexual reassignment surgery to any inmate. The law does not give an opportunity to only one sex or another. And as this Court recently decided, this type of law is not sex-based discrimination. Given that there is no suspect classification, the law easily satisfies rational-basis review. And even if it were subject to intermediate scrutiny, it would survive, because the State's goal of protecting inmates from invasive, sterilizing surgeries can only be achieved through this law.

III. Regardless of whether the district court's initial preliminary injunction was justified, its decision to renew the injunction without input from Defendant was improper and violated Rule 65(a)'s due process guarantee. The renewed injunction failed to account for this Court's decision in *K.C.*, which foreclosed the district court's Fourteenth Amendment conclusion and further undermined the likelihood that Plaintiff would succeed on Plaintiff's Eighth Amendment claim. It also failed to account for a new evaluation of Plaintiff, where yet another doctor declined to

recommend Plaintiff for surgery. And it failed to re-weigh the equities. Without these considerations, the renewed injunction violated the PLRA's requirements for a close means-ends fit between the injunction and the purported violation.

This Court should vacate both injunctions.

STANDARD OF REVIEW

"A preliminary injunction is an extraordinary remedy never awarded as of right." *Winter v. Nat. Res. Def. Council, Inc.*, 555 U.S. 7, 24 (2008). "A plaintiff seeking a preliminary injunction must establish that he is likely to succeed on the merits, that he is likely to suffer irreparable harm in the absence of preliminary relief, that the balance of equities tips in his favor, and that an injunction is in the public interest." *Id.* at 20. Underlying legal conclusions are reviewed de novo, factual findings for clear error, and the balancing of equities for abuse of discretion. *See United Air Lines, Inc. v. Air Line Pilots Ass'n, Int'l*, 563 F.3d 257, 269 (7th Cir. 2009).

ARGUMENT

I. The Eighth Amendment Allows States to Choose How to Treat Medical Conditions

Indiana has reasonably decided not to provide inmates with sexual reassignment procedures whose safety and efficacy are the subject of ongoing debate within the medical community. The Eighth Amendment does not compel States to provide prisoners with procedures within the State's power to regulate. The district court erred in treating an advocacy group—WPATH—as the ultimate arbiter of the Eighth Amendment's meaning. And even assuming that sexual reassignment surgeries might be necessary for some inmates, the fact that multiple doctors have concluded

that Plaintiff is not a candidate for sexual reassignment surgery means that Plaintiff is not entitled to it.

A. The high standard for "deliberate indifference"

The Eighth Amendment bars cruel and unusual punishment. U.S. Const. amend. VIII. Courts have interpreted this to mean that prison officials cannot show "deliberate indifference" to inmates' serious medical needs. *Estelle v. Gamble*, 429 U.S. 97, 104 (1976). "Deliberate indifference" exists only if "no minimally competent professional would have so responded under those circumstances." *Johnson v. Dominguez*, 5 F.4th 818, 825 (7th Cir. 2021).

The Eighth Amendment does not strip States of their power to regulate medicine. The State's "historic" police powers "include the regulation of matters of health and safety." *De Buono v. NYSA-ILA Med. & Clinical Servs. Fund*, 520 U.S. 806, 814 (1997). So States have broad discretion to regulate medical procedures, particularly "'in areas fraught with medical and scientific uncertainties.'" *Dobbs v. Jackson Women's Health Org.*, 597 U.S. 215, 274 (2022). Under the Eighth Amendment, the Supreme Court has long deferred to state legislatures' informed choices based on "modern science." *In re Kemmler*, 136 U.S. 436, 444 (1890).

The Eighth Amendment claim here is far afield from the evils the Eighth Amendment was created to address. The Eighth Amendment was meant to bar "long disused (unusual) forms of punishment that intensified the sentence of death with a (cruel) superaddition of terror, pain, or disgrace." *Bucklew v. Precythe*, 587 U.S. 119, 133 (2019) (cleaned up); *City of Grants Pass v. Johnson*, 603 U.S. 520, 542 (2024). The

Supreme Court's interpretation of the Eighth Amendment expanded in the twentieth century. In 1958, the Supreme Court announced that Eighth Amendment "is not static" and "must draw its meaning from the evolving standards of decency that mark the progress of a maturing society." *Trop v. Dulles*, 356 U.S. 86, 101 (1958). Under this rubric, the Supreme Court then decided that the Eighth Amendment barred prison officials from showing "deliberate indifference to serious medical needs of prisoners." *Estelle*, 429 U.S. at 102–04.

The Court cautioned that this rule does not mean "that every claim by a prisoner that he has not received adequate medical treatment states a violation of the Eighth Amendment." *Estelle*, 429 U.S. at 105. The standard requires more than a "complaint that a physician has been negligent in diagnosing or treating a medical condition." *Id.* at 106. Even if an inmate can prove that a provider committed "[m]edical malpractice," that is not enough for "a constitutional violation merely because the victim is a prisoner." *Id.* The Court later clarified that all Eighth Amendment claims require a two-pronged analysis: first, is the deprivation objectively serious, and second, "[d]id the officials act with a sufficiently culpable state of mind." *Wilson v. Seiter*, 501 U.S. 294, 298 (1991). *Wilson* explained that the subjective element requires examining "some mental element" of "the inflicting officer" because "the Eighth Amendment bans only cruel and unusual *punishment*." *Id.* at 300. Punishments require "a deliberate act intended to chastise or deter." *Id.*

This means that "[a] constitutional violation exists only if no minimally competent professional would have so responded under those circumstances." *Johnson*, 5

F.4th at 825. So if the State identifies at least one minimally competent professional who would have taken the course of action it does (in this case: declining to provide sexual reassignment surgery to prisoners with gender dysphoria), the Eighth Amendment is not violated.

B. Indiana's law is not "deliberate indifference" under the Eighth Amendment

No one disputes that the Department provides comprehensive health services to treat gender dysphoria (including to Plaintiff). These include psychotherapy, social transitioning accommodations, and cross-sex hormones. SA25 (citing Health Care Services Directive 2.17A); Dkt. 83 at 108–09 (108:13–109:3). To succeed on this claim, then, Plaintiff must show that no minimally competent professional would have chosen to address Plaintiff's gender dysphoria with these interventions instead of sexual reassignment surgery. *See Johnson*, 5 F.4th at 825.

1. Sexual reassignment surgery as a treatment for gender dysphoria is a subject of intense debate

The Department presented substantial evidence that the science regarding sexual reassignment surgery is unsettled. Indeed, it presented evidence that treating gender dysphoria with surgery may be ineffective or even harmful. The district court erred when it refused to engage with any of this literature, all of which it admitted without objection. SA4.

For example, in 2016, the Centers for Medicare and Medicaid Services conducted a literature review of studies considering the effectiveness of sexual reassignment surgery. Dkt. 54-47, 54-48, 54-49 (2016 CMS Decision Memo). Of the hundreds of sources reviewed and cited, only six studies provided useful information on the

surgery question. Dkt. 54-48 at 23 to Dkt. 54-49 at 11 (2016 CMS Memo at 73–111). The four best-designed of those six studies "did not demonstrate clinically significant changes or differences in psychometric test results after" the procedures. *Id.* Another meta-analysis of "all studies published on genital [] surgery from 1950 to the present day [2020]" concluded that the "evidence for [post-surgical] complications and functional outcomes is of low level." Dkt. 54-20 at 5–6 (Dunford et al., *Genital Reconstructive Surgery in Male to Female Transgender Patients: A Systematic Review of Primary Surgical Techniques, Complication Profiles, and Functional Outcomes from 1950 to Present Day*, Eur. Urol. Focus 1 (2020)). The authors found that "the literature is deficient" regarding "outcomes of [surgery] for the transwoman." *Id.* at 6.

The science is not just inconclusive—rather, it shows that sexual reassignment surgery can actually harm patients. One 2023 study found that in the few studies that actually collected information about post-surgery pain, patients reported incontinence, vaginal stenosis, vaginal prolapse, and pain unrelated to sexual intercourse. Dkt. 54-17 at 6 (Bishop et al., *Pain and Dysfunction Reported After Gender-Affirming Surgery: A Scoping Review*, 103 PTJ: Physical Therapy & Rehab. J. 1 (2023)).

Nor did the district court address the studies that showed sexual reassignment surgery does not necessarily improve mental health. Studies show that gender dysphoria persists after surgery, and some who undergo surgery regret their decision and request reversal surgery. Dkt. 54-22 (Djordjevic et al., *Reversal Surgery in Regretful Male-to-Female Transsexuals after Sex Reassignment Surgery*, 13 J. Sex Med. 1000 (2016)); Dkt. 54-23 (Littman, *Individuals Treated for Gender Dysphoria with*

Medical and/or Surgical Transition Who Subsequently Detransitioned: A Survey of 100 Detransitioners, 50 Archives of Sexual Behav. 3353 (2021)).

Especially troubling is a 2011 study showing that postoperative transgender patients remained suicidal after surgery at a much higher rate (19.1 times higher) than a control population. Dkt. 54-24 at 6 (Dhejne et al., *Long-Term Follow-Up of Transsexual Persons Undergoing Sex Reassignment Surgery: Cohort Study in Sweden*, 6 PLoS One 1, 5 (2011)). Further, the study "found substantially higher rates of overall mortality, death from cardiovascular disease and suicide, suicide attempts, and psychiatric hospitalizations in sex-reassigned transsexual individuals compared to a healthy control population." *Id.* at 7. The district court addressed none of these studies (all admitted into evidence).

Further, the Department currently effectively treats inmates' gender dysphoria with psychotherapy, social transition, and hormones. SA25. This Court has previously said that administering cross-sex hormones is an effective treatment for gender dysphoria. *Fields v. Smith*, 653 F.3d 550, 556–57 (7th Cir. 2011). The district court did not engage with the evidence showing that there is no greater benefit to surgery as a treatment for gender dysphoria over cross-sex hormones. Dkt. 54-27 at 5 (Heylens et al., *Effects of Different Steps in Gender Reassignment Therapy on Psychopathology: A Prospective Study of Persons with a Gender Identity Disorder*, 11 J. Sex Med. 119–26 (2014)).

Even the evidence that might be presented to support sexual reassignment surgery as a treatment for gender dysphoria has been called into question or

retracted. For instance, a recent study trying to show that surgery was effective was retracted because it was methodologically unsound. Dkt. 54-19 at 23 (Levine Rep. ¶ 48); *see also* Dkt. 54-50 at 8 (Bränström et al., *Reduction in Mental Health Treatment Utilization Among Transgender Individuals after Gender-Affirming Surgeries: A Total Population Study*, 177 Am. J. Psychiatry 727, 734, *Correction* (2020)). After re-analyzing the data, the study reached the exact opposite conclusion from that it had originally published: "the results demonstrated *no advantage of surgery* in relation to subsequent mood or anxiety disorder-related health care visits or prescriptions or hospitalizations following suicide attempts . . . ." Dkt. 54-50 at 8 (Bränström et al. at 734) (emphasis added). Other studies only look at patients' health immediately after surgery—but if the window is expanded to five years post-surgery, quality of life has returned to the preoperative level. Dkt. 54-79 at 2–3 (Lindqvist et al., *Quality of Life Improves Early after Gender Reassignment Surgery*, 40 Eur. J. Plastic Surgery 223, 224–25 (2017)). And others rely only on survey responses, "rather than a validated outcome instrument targeted toward psychosocial assessment." Dkt. 54-25 at 8 (Almazan et al., *Association between Gender-Affirming Surgeries and Mental Health Outcomes*, 156 JAMA Surg. 611 (2021)).

None of these studies address the unique challenges inmates might face after sexual reassignment surgery—indeed, there is no "systematic summary available of [inmates'] post operative adjustment in prison or after their release." Dkt. 54-19 at 4 (Levine Rep. ¶ 8). These challenges include mental and physical illnesses and serious social, developmental, and emotional issues. *Id.* at 4, 29–33 (¶¶ 7, 56–62). In general,

inmates with gender dysphoria have "endured far more egregious adversities than transgendered persons seeking services in the community." *Id.* at 30 (¶ 56). Given all this evidence before the district court, there should be no doubt that a "minimally competent professional" might conclude that sexual reassignment surgery is not a medically necessary treatment for inmates with gender dysphoria.

This Court's decision in *Fields*, 653 F.3d at 557, does not change the outcome. In that case, the Seventh Circuit upheld a district court injunction requiring Wisconsin prisons to provide cross-sex hormones to inmates as medically necessary treatment. *Id.* But there, the defendants "did not present any medical evidence that alternative treatments . . . are effective." *Id.* Since then, this Court has recognized that, at least for children, the "efficacy and risks of the three medical interventions [puberty blockers, cross-sex hormones, and sexual reassignment surgery] are unclear." *K.C.*, 121 F.4th at 611. And here, the Department has presented ample evidence that sexual reassignment surgery is not an effective treatment for gender dysphoria. In these areas of medical debate, the Eighth Amendment does not prohibit States from making the call.

2. States may constitutionally decline to provide certain procedures across the board

The State has taken a position in the serious debate about the efficacy of sexual reassignment surgery for prisoners. The Eighth Amendment generally bars only a narrow category of medical actions (those that *no* minimally competent professional would have recommended, *Johnson*, 5 F.4th at 825). Here, given the vast uncertainty in the medical literature about the effectiveness of sexual reassignment surgery,

multiple competent professionals have reached the conclusion that sexual reassignment surgery is not medically necessary. This tracks with the Fifth Circuit's decision in a similar case that the Eighth Amendment "proscribes only medical care so unconscionable as to fall below society's minimum standards of decency." *Gibson v. Collier*, 920 F.3d 212, 216 (5th Cir. 2019) (quoting *Kosilek v. Spencer*, 774 F.3d 63, 96 (1st Cir. 2014)). Given that "it is indisputable that the necessity and efficacy of sex reassignment surgery is a matter of significant disagreement within the medical community," declining to provide those procedures across the board cannot violate the Eighth Amendment. *Id.* at 216.

Here, the district court inverted that general rule. It implied that States may never bar any procedures so long as someone might decide that procedure is "medically indicated." SA36. The district court dismissed *Gibson* because its dissent critiqued a "lack of record evidence." SA38 n.5. To begin with, "[a] dissenting opinion is generally not the best source of legal advice on how to comply with [or interpret] the majority opinion." *Students for Fair Admissions, Inc. v. President & Fellows of Harvard Coll.*, 600 U.S. 181, 230 (2023). But, more importantly, the Fifth Circuit *did* rely on evidence in making its decision. It considered "the WPATH Standards of Care, which declares sex reassignment surgery both effective and necessary to treat some cases of gender dysphoria." *Gibson*, 920 F.3d at 221. And it concluded that those standards "reflect not consensus, but merely one side in a sharply contested medical debate over sex reassignment surgery." *Id.* The First Circuit reached this same conclusion after hearing testimony from Dr. Chester Schmidt, "a licensed psychiatrist

and Associate Director of the Johns Hopkins School of Medicine," who testified that many doctors in the gender dysphoria field "disagree with [the WPATH] standards"; Cynthia Osborne, a "gender identity specialist employed at the Johns Hopkins School of Medicine," who "did not view [surgery] as medically necessary"; and the Department's expert Dr. Levine, appointed by the district court in *Kosilek*, who explained that "[t]reatment stopping short of [surgery] would be considered adequate by many psychiatrists." *Kosilek*, 774 F.3d at 70, 76–78. The First Circuit agreed that "respected doctors profoundly disagree about whether sex reassignment surgery is medically necessary to treat gender dysphoria." *Gibson*, 920 F.3d at 221 (citing *Kosilek*, 774 F.3d at 90).

The cases the district court cites to the contrary do not even support its new rule (that categorical bans on procedures always violate the Eighth Amendment). *Contra* SA36. The Ninth Circuit case, *Colwell v. Bannister*, concerned whether an inmate should receive cataract surgery. 763 F.3d 1060, 1063 (9th Cir. 2014). The prison in *Colwell* had a policy categorically denying treatment if cataracts only affected one eye because "one eye is good enough for prison inmates." *Id.* That policy did not ban cataract surgery because the State thought the surgery was ineffective, but because it thought inmates did not deserve relief. This is nothing like Indiana's decision that certain procedures are ineffective at treating gender dysphoria. Nor is *Roe v. Elyea*, 631 F.3d 843 (7th Cir. 2011), on point. There, an Illinois prison required inmates to have "at least two years left on their sentence" to receive antiviral therapy to treat hepatitis C. *Id.* at 859. But the policy in that case was set not for "any real

medical reason" but just to "keep it simple for folks." *Id.* at 860 (emphasis omitted). Again, no one in *Roe* disputed that the antiviral therapy was effective—completely unlike the major debate here.[3]

The district court also failed to consider *Gibson*'s explanation for why the Eighth Amendment does not require individualized assessments in every circumstance. For example, the Food and Drug Administration makes "categorical judgments about what medical treatments may and may not be made available to the American people." *Gibson*, 920 F.3d at 225. But what if an inmate "seeks a form of medical treatment . . . favored by some doctors" even if it is "not yet . . . approved by the FDA[?]" *Id.* Could the inmate "challenge this deprivation" under the Eighth Amendment because "it is a categorical prohibition on medical treatment, rather than an individualized assessment? Surely not." *Id.* There is no basis in text, original understanding, or precedent "to conclude that a medical treatment may be categorically prohibited . . . yet require individualized assessment under the Eighth Amendment." *Id.*

If this Court affirms the district court's "individualized assessment" requirement, that would mean that even if the State may constitutionally limit a treatment for citizens generally, inmates would have a special Eighth Amendment right to

[3] The district court also cites *De'lonta v. Johnson*, 708 F.3d 520 (4th Cir. 2013), to support its individualized assessment rule. But that case stands only for the narrow proposition that, in a prison with no policy regarding sexual reassignment surgery, inmates may survive a motion to dismiss if they allege less than "[a] total deprivation of care." *Id.* at 526.

override that decision based on individualized assessments. For example, in *K.C.*, this Court reaffirmed that "federal courts do not mediate medical debates," and that "health and welfare laws" are "entitled to a strong presumption of validity." 121 F.4th at 634 (cleaned up). The Court in *K.C.* decided that Indiana could constitutionally regulate cross-sex hormones for minors. *Id.* at 632. But under the district court's rule, minor inmates with gender dysphoria could now have an independent Eighth Amendment claim that they are entitled to medical interventions regardless of Indiana's general law governing cross-sex hormones. Nothing in the text or history of the Eighth Amendment so limits the State in exercising its regulatory role.

3. An outside advocacy organization, like WPATH, cannot define the constitutional limits of the Eighth Amendment

The district court erred when, instead of analyzing whether *any* minimally competent professional would adopt the Department's position on sexual reassignment surgery, it outsourced that analysis to WPATH. Because "WPATH's Standards of Care continue to recognize that gender-affirming surgery is medically necessary for some individuals," the district court decided that "Indiana Code § 11-10-3-3.5 therefore violates the Eighth Amendment." SA39.

The Supreme Court has already rejected the conclusion that advocacy groups' "standards" may "establish the constitutional minima." *Bell v. Wolfish*, 441 U.S. 520, 543 n.27 (1979); *Dobbs*, 597 U.S. at 48 ("lengthy account[s] of the position of the American Medical Association" and other advocacy groups in the *Roe v. Wade* opinion did not "shed light on the meaning of the Constitution"). In *Bell*, inmates brought an Eighth Amendment claim regarding standards of confinement. Groups like the

American Public Health Association, the American Correctional Association, and the National Sheriffs' Association had all issued standards regarding jail cells. *See* 441 U.S. at 543 n.27. But the Supreme Court decided that those standards were only "instructive." *Id.* Any recommendations, even from the DOJ's "Federal Corrections Policy Task Force," were "not determinative of the requirements of the Constitution." *Id.* So too here—the State's "authority to regulate does not turn on consistency with the views of certain medical groups." *L.W. ex rel. Williams v. Skrmetti*, 83 F.4th 460, 479 (6th Cir. 2023) (cleaned up), *cert. granted sub nom. United States v. Skrmetti*, 144 S. Ct. 2679 (2024).

WPATH, moreover, may be "influential" in some circles, but it has "not evaded criticism." *K.C.*, 121 F.4th at 611. The district court knew that the federal Department of Health and Human Services declined to "endorse exclusive use of WPATH for coverage" for Medicaid and Medicare services. Dkt. 54-19 at 36 (Levine Rep. ¶ 69) (citing 2016 HHS Medical Review). And information continues to become available showing that WPATH is more focused on advancing a particular policy position than providing unbiased recommendations on treatments for gender dysphoria. *See, e.g.*, Amicus Brief of the State of Alabama, *United States v. Skrmetti*, No. 23-477 (Oct. 15, 2024). "WPATH admits it skipped the foundational step of conducting a systematic evidence review" and "routinely suppresses scientific inquiry, silencing scholars who question the WPATH standard of 'care' and censuring members who go public with their concerns." *Id.* at 9. The result is that "WPATH 8 overstates the strength of the evidence in making these recommendations [for medical interventions]." Cass Review

at 132 (2024). Given that WPATH is a biased, outcome-driven advocacy group, it cannot be used to say that *all* competent professionals agree that its standards are the only way to treat patients with gender dysphoria.

Unquestioned reliance on WPATH is one of the reasons why this Court should not follow the reasoning of *Edmo v. Corizon, Inc.*, 935 F.3d 757, 794 (9th Cir. 2019). *Edmo* grounded its decision that the Eighth Amendment required sexual reassignment surgery in the flawed premise that "WPATH Standards of Care" are "the undisputed starting point in determining the appropriate treatment for gender dysphoric individuals." *Id.* at 787. *Edmo*'s problematic reliance on WPATH creates the same issue in the district court's decision here. Instead of asking whether *any* minimally competent professional would make the decision that the Department has in this circumstance, *Edmo* asks what treatments are "generally accepted." *Id.* at 800. But this transforms the Eighth Amendment's ban on cruel and unusual punishment into an affirmative right to "generally accepted" medical treatment, even if denial of that treatment does not evince "deliberate indifference" to an inmate's medical needs. *See Estelle*, 429 U.S. at 105–06 (negligence in "diagnosing or treating a medical condition" does not violate Eighth Amendment).

C. The statute is not deliberately indifferent regarding Plaintiff

Given the divided medical debate about whether sexual reassignment surgery is an appropriate treatment for gender dysphoria, there is no Eighth Amendment problem with the Department declining to provide those surgeries. But even if this Court focused only on whether this surgery is appropriate for Plaintiff, medical professionals disagree that surgery is the correct course of treatment. The district court

improperly held that Indiana Code § 11-10-3-3.5 is unconstitutional "as applied" to Plaintiff. SA1. If the Department identifies a minimally competent medical professional who would treat Plaintiff as the Department has, there is no Eighth Amendment violation. *Johnson*, 5 F.4th at 825.

The district court did not address this standard, nor can Plaintiff meet it. At least one "minimally competent" doctor—Dr. Dionisio—expressed concerns over even diagnosing Plaintiff with gender dysphoria. Dkt. 54-42 at 6. After a panel of doctors decided it was better to diagnose Plaintiff out of an abundance of caution, Dkt. 54-41 at 30–32, at least two more doctors opined that Plaintiff was a poor candidate for surgery. Dkt. 83 at 84 (Dr. Farjellah); *id.* at 170 (Dr. Levine). And since that first injunction was entered, additional professionals have made the reasoned judgment that surgery is not appropriate for Plaintiff. Dkt. 128-1 (Dr. Beers).

"[P]risons aren't obligated to provide every requested treatment once medical care begins. In a deliberate-indifference case challenging the medical judgment of prison healthcare professionals who actually diagnose and treat an inmate's medical condition (as opposed to ignoring it), [the Court] *necessarily* evaluate[s] those discrete treatment decisions." *Campbell v. Kallas*, 936 F.3d 536, 548 (7th Cir. 2019). Courts then must "defer to those decisions 'unless no minimally competent professional would have' made them." *Id.* (quotation omitted). So given the disagreement among medical professionals about how to best treat Plaintiff, the district court erred in deciding that the Department was "deliberately indifferent" to Plaintiff's medical condition.

The district court stated that Plaintiff had established "by a preponderance of the evidence that she is an individual with gender dysphoria for whom gender-affirming surgery is medically necessary" and that "IDOC has chosen a less efficacious course of treatment." SA39. But this is not the legal standard that Plaintiff must meet. Plaintiff must show that *no* "minimally competent professional" would recommend the course of treatment the Department chose. The district court's order inverts the Supreme Court's rule that prisoners do not "have unqualified access to health care," *Hudson v. McMillian*, 503 U.S. 1, 9 (1992), and creates "a constitutional prohibition on good-faith disagreement between medical professionals," *Edmo v. Corizon, Inc.*, 949 F.3d 489, 495 (9th Cir. 2020) (O'Scannlain, J., dissenting from denial of rehearing en banc). This case is substantially different than a case like *Edmo*, where the evidence presented in the district court "unequivocally establish[ed] that [surgery] is the safe, effective, and medically necessary treatment for Edmo's severe gender dysphoria." *Edmo*, 935 F.3d at 794. Here, Plaintiff's suitability for surgery is not uncontested, but rather a matter of intense debate.

In addition, the only medical opinion the district court relied on raises serious concerns. Dr. Ettner did not even consider Plaintiff's borderline personality disorder comorbidity. Dkt. 54-67 at 42 (Ettner Dep. 91:8–16). Nor did Dr. Ettner consider Plaintiff's history of manipulation (for example, Plaintiff admitted to lying to doctors to receive certain diagnoses or drugs, Dkt. 54-70 at 20–22 (Pl. Dep. 69:15–70:3, 71:16–21)). Other evaluators did consider these issues, noting that "the changing of identification with various mental illnesses over the decades of her incarceration, from

schizophrenia to major depression to gender dysphoria and various personality disorders, is concerning given the permanency of surgery." Dkt. 128-1 at 12; Dkt. 54-19 at 4, 9 (Levine Rep. ¶¶ 8, 24). This "convoluted" "clinical picture" meant that at least one psychologist "d[id] not recommend surgery at this time." *Id.*

Further, medical professionals and Plaintiff have shown that the Department's current treatment plan for Plaintiff adequately and effectively addresses Plaintiff's gender dysphoria. Dkt. 54-19 at 44 (Levine Rep. ¶ 79). In fact, the Department's approach to Plaintiff's gender dysphoria, especially the Department's provision of ongoing psychotherapy, has been a stabilizing influence in Plaintiff's volatile mental health history. *Id.* at 4, 8 (¶¶ 8, 22). Even Dr. Ettner acknowledged that the Department's course of action had improved Plaintiff's mental health, noting that Plaintiff's Global Assessment of Functioning scores had improved from 35 in 2006 to 72 in 2022, which was "indicative of significant progress." Dkt. 37-1 at 19 (Ettner Rep.); *see also* Dkt. 83 at 55–56, 187 (55:5–56:4, 187:4–8) (Plaintiff's mental health "stable" as of preliminary injunction hearing).

Regardless of whether this Court agrees that sexual reassignment surgery might be a treatment option for *some* patients with gender dysphoria, or that it may be *a* treatment for Plaintiff, the question before the Court is not whether *some* doctor believes that surgery is proper for this patient. As this Court has made clear, "prisons aren't obligated to provide every requested treatment once medical care begins." *Campbell*, 936 F.3d at 548. "In a deliberate-indifference case," the Court must examine the decisions of "prison healthcare officials who actually diagnose and treat an

inmate's medical condition." *Id.* Given that multiple doctors—who are certainly "minimally competent," *Johnson*, 5 F.4th at 825—have concluded that surgery is not medically necessary for Plaintiff, the Eighth Amendment defers to the State's treatment decision here.

II. Indiana's Decision Not to Provide Sexual Reassignment Surgery for Inmates Does Not Violate the Equal Protection Clause

Neither this Court nor the Supreme Court have equated discrimination based on transgender status with sex discrimination under the Fourteenth Amendment. In fact, since the district court issued its initial preliminary injunction, this Court explicitly declined to draw such a comparison. *K.C.*, 121 F.4th at 617–18. Nevertheless, the district court ruled that Indiana's ban on facilitating sexual reassignment surgeries for inmates was invalid under the Equal Protection Clause of the Fourteenth Amendment. SA39–SA42. It decided that "discrimination based on transgender status is sex discrimination," SA41–SA43, on the assumption that the ban "prevents transgender inmates from accessing medically necessary care while cisgender inmates still have access to such care," SA42. This conclusion is foreclosed by this Court's precedent.

But even if discrimination on the basis of transgender status were the same as sex discrimination, no such discrimination exists here, because inmates are not denied any treatment based on their transgender status. In the absence of a suspect classification, the district court should have applied rational-basis review, which the statute easily satisfies. *See Vance v. Bradley*, 440 U.S. 93, 97 (1979). And even if heightened scrutiny applies, the law survives.

A. Indiana's decision not to facilitate sexual reassignment surgeries for inmates is not sex discrimination

The Equal Protection Clause of the Fourteenth Amendment provides that "[n]o State shall make or enforce any law which shall . . . deny to any person within its jurisdiction the equal protection of the laws." U.S. Const. amend. XIV, § 1. The clause "is essentially a direction that all persons similarly situated should be treated alike." *City of Cleburne v. Cleburne Living Ctr.*, 473 U.S. 432, 439 (1985). Sex-based classifications—those that provide for "different treatment" for individuals "on the basis of their sex"—are subject to heightened scrutiny. *Reed v. Reed*, 404 U.S. 71, 75–76 (1971). But where there is a "lack of identity" between the statutory classification and sex, there is no sex-based classification. *Geduldig v. Aiello*, 417 U.S. 484, 496 n.20 (1974). In that case, rational-basis review applies, *see Vance*, 440 U.S. at 97, and a challenger bears the burden to negate "every conceivable basis which might support [the law]," *FCC v. Beach Commc'ns, Inc.*, 508 U.S. 307, 314–15 (1993).

Indiana's ban on facilitating sexual reassignment surgeries does not prefer one sex to the other or treat the two sexes differently. Under the statute, state resources cannot be used to perform "sexual reassignment surgery" on offenders. Ind. Code § 11-10-3-3.5. It does not matter whether offenders are male or female or with what gender they identify. None may receive "sexual reassignment surgery" from the Department. While the statute bars these surgeries "for the purpose of attempting to alter the appearance of, or affirm the offender patient's perception of, his or her gender or sex, if that appearance or perception is inconsistent with the offender patient's sex," Ind. Code § 11-10-3-1(6), it "does not classify based on sex." *See Skrmetti*, 83 F.4th at 482.

Decades of Supreme Court precedent have recognized that a sex-based classification is one that enforces "different treatment" of individuals "on the basis of their sex." *Reed*, 404 U.S. at 75. When the Court applies intermediate scrutiny, it does so because the law gives a benefit to one sex while withholding it from another or extends benefits to only one sex. *See, e.g.*, *id.* (preferring men over women in assigning estate administrators); *Craig v. Boren*, 429 U.S. 190, 198–99 (1976) (sex-differential legal drinking ages); *United States v. Virginia*, 518 U.S. 515, 534 (1996) (excluding women from state military academy); *Sessions v. Morales-Santana*, 582 U.S. 47, 72 (2017) (fewer residency requirements for unwed citizen mothers than fathers). Sex, standing alone, provided the basis for differential treatment. But here, sex alone never determines whether a particular procedure is barred. To fall into this category, Indiana's law would have to permit sexual reassignment surgeries for men, while prohibiting them for women, or vice versa.

Instead, the statute classifies permissible and impermissible surgeries only by the *type* of surgery—sexual reassignment surgery which sterilizes, constructs artificial genitalia, or removes healthy tissue. Ind. Code § 11-10-3-1(6). By its terms, there are no procedures that are prohibited for men yet permitted for women, or vice versa. Mere recognition that, for example, a sterilizing surgery will be different for male and female biology does not trigger heightened scrutiny. As the Supreme Court has explained, "[t]he regulation of a medical procedure that only one sex can undergo does not trigger heightened constitutional scrutiny unless the regulation is a 'mere

pretex[t] designed to effect an invidious discrimination against members of one sex or the other.'" *Dobbs*, 142 S. Ct. at 2245–46.

Likewise, the statute does not discriminate on the basis of transgender status, which is not a protected characteristic in any event. The statute does not regulate access to procedures based on transgender status. All prisoners can obtain orchiectomies to treat testicular cancer. What Indiana law regulates is a particular type of orchiectomy—one designed to "alter the appearance of" or "affirm [the] perception of" an inmate's gender or sex." Ind. Code § 11-10-3-1(6). And that prohibition applies regardless of whether the inmate identifies with their biological sex or not. Conversely, nothing in the statute limits its application to transgender inmates: if an inmate sought any of these procedures for another reason (perhaps they identified as a eunuch), the Department would not provide the surgeries.

The district court's assertion that "IDOC will provide surgical services for cisgender prisoners that under § 11-10-3-3.5(a) would be banned as gender-affirming care for transgender prisoners," SA25, is simply false. The court claimed that cisgender inmates "may have hysterectomies, testicular removal, fallopian tube removal[,] and ovary removal if deemed medically necessary," with the implication that a transgender inmate could not. *Id.* But that is simply incorrect. The Department provides medically necessary surgeries in the case of pathology or unhealthy tissue without reference to sex or gender identity. Dkt. 37-3 at 29–30 (Bedford Dep. at 29:1–30:20). Transgender status does not affect the availability of certain surgeries; it

merely limits access to sexual reassignment surgery. The statute bars those surgeries for all inmates, regardless of identity or diagnosis. *See* Ind. Code § 11-10-3-3.5(a).

The possibility that only transgender inmates would seek these kinds of procedures does not transform a generally applicable prohibition into a classification based on transgender status. The Supreme Court made this precise point in *Geduldig v. Aiello*, 417 U.S. 484 (1974). There, the Court rejected an equal protection challenge to a California insurance provision focused on pregnancy. *Id.* at 486–87. It did so because there was a "lack of identity" between gender and the provision's classification of pregnant persons and nonpregnant persons. *Id.* at 496 n.20. Just as not all women will become pregnant, not all transgender patients will seek sexual reassignment surgery. "Absent a showing that the distinctions" drawn by regulating a procedure or condition only one sex can undergo "are mere pretexts designed to effect an invidious discrimination," such regulations are not subject to heightened scrutiny. *Id.; see Dobbs*, 597 U.S. at 236.

B. Precedent forecloses the district court's conclusion

The district court cited several cases to support that "discrimination based on transgender status is sex discrimination." SA41. But none of the cases it cites create that rule under the Fourteenth Amendment. And if the district court's ruling were to stand, it will have created a new quasi-suspect class of "transgender status," something that this Court has expressly declined to do. *See K.C.*, 121 F.4th at 620.

First, the district court cited *Whitaker ex rel. Whitaker v. Kenosha Unified School District*, 858 F.3d 1034 (7th Cir. 2017). This case was about whether a natal

female who identifies as a boy may use the boys' restroom at school. *Id.* at 1052. *Whitaker* did not announce the broad rule the district court looks to ("discrimination based on transgender status is sex discrimination"). SA41. Rather, because the policy at issue in *Whitaker* "decide[d] which bathroom a student may use based upon the sex listed on the student's birth certificate," the court decided it was "based upon a sex-classification and heightened review applies." 858 F.3d at 1051. But Indiana's limitation on sexual reassignment surgery does not limit certain procedures based on sex. Rather, it limits sexual reassignment surgery across the board. Ind. Code § 11-10-3-1(6). If even regulating "a medical procedure that only one sex can undergo does not trigger heightened constitutional scrutiny" as sex-discrimination, *Dobbs*, 597 U.S. at 236, then regulating surgeries for everyone should not either. And *Whitaker* expressly stated that it did not "reach the question of whether transgender status is per se entitled to heightened scrutiny." 858 F.3d at 1051.

This Court has already refused to read *Whitaker*'s fact-bound holding as a command that any law that references sex creates a sex-based classification. *See K.C.*, 121 F.4th at 617. Rather, "'[r]eferencing sex' was *how* the school district classified by sex, not *why* its classification was sex-based." *Id.* at 618. *Whitaker* does not control this case any more than it did *K.C.* Neither does *A.C. v. Metropolitan School District of Martinsville*, 75 F.4th 760, 772 (7th Cir. 2023); SA41—a follow-up to *Whitaker* regarding bathroom access—control this case. *A.C.*, 75 F.4th at 768. *A.C.* was careful to clarify that it was "addressing only the issue before [it]," declining to opine on how its ruling might affect "sex-segregated living facilities, educational programs, or sports

teams." *Id.* at 773. If a case about school bathrooms does not address how the Equal Protection Clause regulates other school programs, it certainly does not address the question of whether it requires the State to provide sexual reassignment surgery for Plaintiff.

Finally, the district court cited *Bostock v. Clayton County*, 590 U.S. 644 (2020). SA41–SA42. But that case dealt with the meaning of Title VII, not the Equal Protection Clause. *Id.* at 649–52. The Supreme Court's analysis focused on the meaning of language specific to Title VII that does not appear in the Fourteenth Amendment. *Id.* at 657. And this Court has now concluded that "*Bostock* is of no use when interpreting the Equal Protection Clause" because *Bostock* "turns on the text of Title VII," which was ratified long after the Fourteenth Amendment. *K.C.*, 121 F.4th at 619–20. So "*Bostock*'s sources have little to say about constitutional meaning." *Id.*; *see also Skrmetti*, 83 F.4th at 484 (*Bostock* does not control equal protection analysis); *Eknes-Tucker v. Governor of Ala.*, 80 F.4th 1205, 1228–29 (11th Cir. 2023) (same).

Without support in this circuit or the Supreme Court, the district court relied on one out-of-circuit case, *Kadel v. Folwell*, 100 F.4th 122 (4th Cir. 2024). That case cannot apply here because this Court does not recognize transgender status as a quasi-suspect class, *K.C.*, 121 F.4th at 620 n.3, while the Fourth Circuit does, *Kadel*, 100 F.4th at 143. Further, this Court has rejected *Kadel*'s proposition that courts could "determine whether some patients will be eliminated from candidacy for these surgeries solely from knowing their sex assigned at birth." SA42 (quoting *Kadel*, 100 F.4th at 153). Rather, once an inmate "is diagnosed" with "gender dysphoria," a

physician knows that she cannot use surgical interventions in response to that diagnosis. *K.C.*, 121 F.4th at 618.

At bottom, the district court's conclusion that Indiana's law violates the Fourteenth Amendment is now foreclosed by *K.C.*, 121 F.4th at 604. In *K.C.*, this Court reversed an injunction against Indiana's ban on gender-transition procedures for minors. *Id.* at 634. It clarified that such procedures remained "novel and uncertain." *Id.* at 627. Most importantly, it explained that a law prohibiting certain medications and procedures in response to gender dysphoria was not a sex-based classification, because "the law does not create a class of one sex and a class of another and deny treatment to just one of those classes." *Id.* at 617. Rather, "[n]obody may receive the treatment the state has chosen to regulate." *Id.* "The only way [the law] implicates sex at all is that the treatment is sex-specific—it denies each sex access to the other's hormones." *Id.* at 618. The classification in *K.C.* was based on "age and medical diagnosis," not sex. *Id.* at 621. So too here. The classification is not based on sex, but rather the medical diagnosis and purpose of the procedure.

Without a sex-based classification, the statute here is properly subject to rational-basis review, and it survives unless Plaintiff can show no "conceivable basis" on which the law is related to any legitimate state interest. *Beach Commc'ns*, 508 U.S. at 314–15. Indiana's interest in protecting inmates from novel, invasive, sterilizing surgeries with unknown risks is legitimate. The prohibition denies state facilitation of these surgeries and their unpredictable risks. It easily passes.

C. Indiana's law satisfies intermediate scrutiny

Even if the Court decided that Indiana Code § 11-10-3-3.5 is subject to heightened scrutiny, it still passes constitutional muster. Heightened scrutiny requires the State to show "an exceedingly persuasive justification" for a classification that "serves important governmental objectives," and that the statute is "substantially related to the achievement of those objectives." *United States v. Virginia*, 518 U.S. 515, 524 (1996). Importantly, heightened scrutiny is not a license for a court to reweigh the relative wisdom of legislative choices. Rather, it merely ensures that classifications do not rely on "outmoded notions of the relative capabilities of men and women." *City of Cleburne*, 473 U.S. at 441. Moreover, the "normal rule" commands that courts should "defer to the judgments of legislatures 'in areas fraught with medical and scientific uncertainties.'" *Dobbs*, 597 U.S. at 274; *see Gonzales v. Carhart*, 550 U.S. 124, 164 (2007).

Indiana's decision to opt out of providing or facilitating sexual reassignment surgeries for inmates easily passes muster. Such surgeries are complex and irreversible with unknown risk profiles. *See K.C.*, 121 F.4th at 610–12; *Skrmetti*, 83 F.4th at 466–67; *see also supra*, pp. 7–8. The statute is substantially related to this interest because it limits inmates from obtaining these potentially dangerous surgeries, while the Department offers a robust regime of other interventions for gender dysphoria. *See* SA23 (citing Dkt. 90-2 at 5–6). As applied to Plaintiff, the State's interests are even more clear. Several medical professionals have expressed concern about Plaintiff's gender dysphoria diagnosis in the first place. Dkt. 128-1 at 11. Even if Plaintiff's diagnosis is correct, only one doctor has ever recommended surgical interventions for

Plaintiff. Dkt. 37-1 at 22 (Ettner Rep.). Plaintiff's other mental health diagnoses have raised concerns for multiple doctors. Dkt. 128-1 at 11–12. Further, Plaintiff "does not appear to have a stable support system." *Id.* at 11. Plaintiff has "identified her sister as her primary and sole system of support." *Id.* But Plaintiff's sister "has a history of prostitution and incarceration and their relationship has been tumultuous." *Id.*

The district court's one-sentence rejection of the State's interest was improper. The court said that these surgeries are "medically necessary for some individuals." SA41. In so doing, it ignored the wide-ranging studies showing that the efficacy of these surgeries is in doubt and that recipients' mental health is not improved five years post-surgery. *See supra*, pp. 29–30. And even proponents admit that the evidence for these invasive surgeries is "still developing." *See Kadel*, 100 F.4th at 156. This debate demonstrates that the State is not relying on the "outmoded" stereotypes or "old ideas" that heightened scrutiny is designed to root out. The district court should have followed the "normal rule" that court must "defer to the judgments of legislatures 'in areas fraught with medical and scientific uncertainty.'" *Dobbs*, 597 U.S. at 274.

Even if the district court was correct that Indiana's law violated the Equal Protection Clause, the Clause prevents discrimination. It does not create an affirmative entitlement to surgery. Nor does it allow Plaintiff to bypass the normal surgical evaluation process—and at least three doctors, one as recently as December 2024, have declined to recommend Plaintiff for surgery. Insofar as the injunction can be read to require the Department to "provide[]" surgery to Plaintiff, SA46, it violates

the PLRA's requirement that any injunctive relief be the "least intrusive means necessary." *See* 18 U.S.C. § 3626(a)(1).

Indiana's ban on facilitating sexual reassignment surgeries for inmates protects inmates against invasive, irreversible surgeries with unknown risks. The statute is substantially related to this important interest, and thus Indiana has an "exceedingly persuasive justification" for the statute. It satisfies intermediate scrutiny.

III. The District Court Erred in Renewing the Preliminary Injunction Without Notice and in Weighing the Equities

The district court compounded its error by renewing the preliminary injunction without hearing from the Department or considering whether the criteria for preliminary injunctive relief under the PLRA were still met. A district court must provide "notice" to an adverse party before it issues any preliminary injunction. Fed. R. Civ. P. 65(a)(1). That notice "implies a hearing in which the defendant is given a fair opportunity to oppose the application." *Granny Goose Foods, Inc. v. Bhd. of Teamsters*, 415 U.S. 423, 432 n.7 (1974); *see also Illinois ex rel. Hartigan v. Peters*, 871 F.2d 1336, 1340 (7th Cir. 1989) ("notice should apprise a defendant of a hearing and provide adequate time to prepare a defense"). And, of course, due process requires "notice and the opportunity to be heard." *Knutson v. Vill. of Lakemoor*, 932 F.3d 572, 576 (7th Cir. 2019). But the district court provided no notice here—it simply granted Plaintiff's motion to renew three days after it was filed. Dkt. 119; SA1–SA2.

The district court's error is particularly egregious in light of the PLRA's requirements. The PLRA gives prison officials "wide latitude to set constitutionally adequate procedures" and "give[s] substantial weight to any adverse impact on public

safety or the operation of a criminal justice system caused by the relief." *Monroe v. Bowman*, 122 F.4th 688, 693–94 (7th Cir. 2024). The PLRA accordingly requires a court to make specific findings before imposing injunctive relief and provides that "[p]reliminary injunctive relief shall automatically expire" 90 days after its entry unless it is made "final" before then. 18 U.S.C. § 3626(a)(2). Although this Court has indicated that preliminary injunctions may be renewed, it has made clear that renewal cannot be a rubber stamp. Instead, any "new injunctive relief will need to address the current situation." *Monroe*, 122 F.4th at 697. But the district court did not do so here. It simply "incorporate[d] verbatim its Preliminary Injunction of September 17, 2024," without any analysis of whether the PLRA's requirements were still met. SA1.[4]

If the district court had followed the proper procedure here, it would have learned that continued relief is unwarranted. *See* Dkt. 128. To begin with, Plaintiff's likelihood of success on the equal protection claim had changed significantly after the Seventh Circuit decided *K.C.*, 121 F.4th at 604. As discussed above, that case rejected an equal protection claim like Plaintiff's, foreclosing it. *See supra*, p. 48. Further, *K.C.* undercuts Plaintiff's Eighth Amendment claim significantly. But the district did not even mention *K.C.* in its renewed injunction.

[4] There is some debate about whether it is possible to issue a preliminary injunction that is "final" under the PLRA, or whether only a permanent injunction can be "final." *Ga. Advoc. Off. v. Jackson*, 4 F.4th 1200 (11th Cir. 2021). One of this Court's recent PLRA decisions indicated that preliminary injunctions may be renewed under the PLRA, but did not address finality. *Monroe*, 122 F.4th at 688.

Nor did the district court consider new factual developments when it issued its new injunction. On December 11, 2024, a new provider evaluated Plaintiff for sexual reassignment surgery. Dkt. 128-1. Dr. Kelsey Beers concluded that while Plaintiff "appears to have a great understanding of gender dysphoria, WPATH Standards of Care, and gender confirming surgery, this psychologist concludes her primary clinical issues are symptoms of personality disorders, and surgery is not the answer to her pathology." *Id.* at 11. Therefore, Dr. Beers "d[id] not recommend surgery at this time." *Id.* at 12. The district court did not consider how this new evaluation might change its conclusion that Plaintiff "has established by a preponderance of the evidence that she is an individual with gender dysphoria for whom gender-affirming surgery is medically necessary." SA39.

Because the district court failed to abide by Rule 65(a)(1) or the PLRA, the court never considered these material developments. So, at minimum, the renewed preliminary injunction should be vacated so the district court may determine whether a preliminary injunction is still warranted given "the current situation." *Monroe*, 122 F.4th at 697.

While the district court's errors regarding Plaintiff's likelihood of success on the merits are sufficient to vacate the preliminary injunctions, it also erred in weighing the equities. Enjoining a duly enacted law causes "significant harm to Indiana and the public interest." *K.C.*, 121 F.4th at 632. And it is not clear that Plaintiff will suffer injury absent an injunction, given that multiple doctors have said Plaintiff is a poor candidate for the surgeries Plaintiff seeks.

CONCLUSION

The district court's original preliminary injunction and the renewed preliminary injunction should both be vacated.

Respectfully submitted,

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Attorney General of Indiana

JAMES A. BARTA
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/s/ Jenna M. Lorence
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CERTIFICATE OF COMPLIANCE

1. This document complies with the type-volume limits of Circuit Rule 32(c) because this document contains 13,995 words, excluding the parts exempted by Fed. R. App. P. 32(f).

2. This document complies with the typeface requirements of Circuit Rule 32(b) and the type-style requirements of Fed. R. App. P. 32(a)(6) because this document has been prepared in a proportionally spaced typeface using Microsoft Word in Century Schoolbook 12-point font.

January 21, 2025

/s/ Jenna M. Lorence
JENNA M. LORENCE
Deputy Solicitor General

REQUIRED SHORT APPENDIX

Pursuant to Circuit Rule 30, Appellants submit the following as their Required Short Appendix. Appellants' Required Short Appendix contains all the materials required under Circuit Rule 30(a).

/s/ Jenna M. Lorence
JENNA M. LORENCE
Deputy Solicitor General

No. 24-2838 & 24-3240

IN THE
UNITED STATES COURT OF APPEALS
FOR THE SEVENTH CIRCUIT

AUTUMN CORDELLIONE, a.k.a. Jonathan Richardson,

Plaintiff-Appellee,

v.

LLOYD ARNOLD, Commissioner, Indiana Department of Correction, *in his official capacity*,

Defendant-Appellant.

On Appeal from the United States District Court for the Southern District of Indiana, No. 3:23-cv-00135-RLY-CSW, The Honorable Richard L. Young, Judge

---

REQUIRED SHORT APPENDIX OF DEFENDANT-APPELLANT

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UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF INDIANA
EVANSVILLE DIVISION

AUTUMN CORDELLIONÉ also known as JONATHAN RICHARDSON, Plaintiff, v. COMMISSIONER, INDIANA DEPARTMENT OF CORRECTION, in her official capacity, Defendant.	)	No. 3:23-cv-00135-RLY-CSW

ORDER RENEWING PRELIMINARY INJUNCTION

Plaintiff having filed her Emergency Motion to Renew Preliminary Injunction, and the Court having read the motion and being duly advised finds that good cause exists to renew the previously entered preliminary injunction in this case. (Dkt. 97). The Court there incorporates verbatim its Preliminary Injunction of September 17, 2024. Specifically:

The court finds that plaintiff Autumn Cordellioné has demonstrated a reasonable likelihood of success on the merits of her claim that Indiana Code § 11-10-3-3.5—which bans gender-affirming surgery for transgender inmates—is unconstitutional, both on its face and as applied to her. Specifically, Ms. Cordellioné has shown that her gender dysphoria is a serious medical need, and that, despite other treatments Defendant has provided her to treat her gender dysphoria, she requires gender-affirming surgery to prevent a risk of serious bodily and psychological harm. Thus, she has demonstrated a

reasonable likelihood of success in demonstrating that denying her gender-affirming surgery violates the Eighth Amendment as it denies her necessary medical care to address a serious medical need. Additionally, she has demonstrated a reasonable likelihood of success in demonstrating that denying her gender- affirming surgery represents prohibited sex discrimination in violation of Equal Protection. The surgeries that are banned by the Indiana statute are still available to cisgender inmates who require them for serious medical needs.

The court also finds that Plaintiff has demonstrated that she is suffering irreparable harm and will continue to suffer such harm unless she is provided gender-affirming surgery. When balancing this harm against the harm Defendant would face if preliminary relief were granted, and when the impact of preliminary relief on the public is considered, the court finds that the balance of harms favors the issuance of a preliminary injunction.

IT IS THEREFORE ORDERED that the Commissioner of the Indiana Department of Correction, in her official capacity, is hereby preliminarily enjoined to take all reasonable actions to secure plaintiff gender-affirming surgery at the earliest opportunity. Defendant shall file her status report within 30 days as to all actions taken and the timetable for surgery. No bond shall be required.

Date: 12/06/2024

RICHARD L. YOUNG, JUDGE
United States District Court
Southern District of Indiana

To: All ECF-registered counsel of record

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF INDIANA
EVANSVILLE DIVISION

AUTUMN CORDELLIONÉ, also known as JONATHAN RICHARDSON, Plaintiff, v. COMMISSIONER, INDIANA DEPARTMENT OF CORRECTION, in her official capacity, Defendant.	)	No. 3:23-cv-00135-RLY-CSW

Preliminary Injunction

The court finds that plaintiff Autumn Cordellioné has demonstrated a reasonable likelihood of success on the merits of her claim that Indiana Code § 11-10-3-3.5—which bans gender-affirming surgery for transgender inmates—is unconstitutional, both on its face and as applied to her. Specifically, Ms. Cordellioné has shown that her gender dysphoria is a serious medical need, and that, despite other treatments Defendant has provided her to treat her gender dysphoria, she requires gender-affirming surgery to prevent a risk of serious bodily and psychological harm. Thus, she has demonstrated a reasonable likelihood of success in demonstrating that denying her gender-affirming surgery violates the Eighth Amendment as it denies her necessary medical care to address a serious medical need. Additionally, she has demonstrated a reasonable likelihood of success in demonstrating that denying her gender-affirming surgery represents prohibited sex discrimination in violation of Equal Protection. The surgeries that are banned by the Indiana statute are still available to cisgender inmates who require them for serious medical needs.

The court also finds that Plaintiff has demonstrated that she is suffering irreparable harm and will continue to suffer such harm unless she is provided gender-affirming surgery. When balancing this harm against the harm Defendant would face if preliminary relief were granted,

and when the impact of preliminary relief on the public is considered, the court finds that the balance of harms favors the issuance of a preliminary injunction.

IT IS THEREFORE ORDERED that the Commissioner of the Indiana Department of Correction, in her official capacity, is hereby preliminarily enjoined to take all reasonable actions to secure plaintiff gender-affirming surgery at the earliest opportunity. Defendant shall file her status report within 30 days as to all actions taken and the timetable for surgery. No bond shall be required.

IT IS SO ORDERED.

Date: September 17, 2024

RICHARD L. YOUNG, JUDGE
United States District Court
Southern District of Indiana

Distribution:

All ECF-registered counsel of record

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF INDIANA
EVANSVILLE DIVISION

AUTUMN CORDELLIONÉ, Plaintiff, v. COMMISSIONER, INDIANA DEPARTMENT OF CORRECTION in her official capacity, Defendant.	)	No. 3:23-cv-00135-RLY-CSW

Order Granting Motion for Preliminary Injunction

Plaintiff Autumn Cordellioné, whose birth name is Jonathan Richardson, is an adult transgender female prisoner confined in a male institution within the Indiana Department of Correction ("IDOC").[1] She filed this lawsuit against IDOC Commissioner Christina Reagle in her official capacity ("Defendant" or "IDOC"), challenging the constitutionality of Indiana Code § 11-10-3-3.5(a), which bans gender-affirming surgery for transgender inmates with gender dysphoria. She alleges that the total ban on gender-affirming surgery violates her right to be free from cruel and unusual punishment under the Eighth Amendment and the Equal Protection Clause of the Fourteenth Amendment. She seeks injunctive and declaratory relief.

The court held a hearing on Ms. Cordellioné's motion for preliminary injunction on March 26, 2024. Dkt. 78. Having considered the evidence presented at that hearing and the voluminous evidence in the record, the court concludes that Ms. Cordellioné has established that (1) gender-confirming surgery is a medically necessary treatment option for some individuals

[1] Consistent with the court's ordinary practice, it will refer to Ms. Cordellioné by her preferred name and pronouns. *See Balsewicz v. Pawlyk*, 963 F.3d 650, 652 n. 1 (7th Cir. 2020) (using feminine pronouns in a manner "consistent with the district court's order and the parties' briefing in this case"); *see also Dyjak v. Wilkerson*, Nos. 212012 and 21-2119, 2022 WL 1285221, at *1 (7th Cir. Apr. 29, 2022) (explaining federal courts' "normal practice of using pronouns adopted by the person before [them]").

with gender dysphoria; and (2) Ms. Cordellioné is an individual for whom this procedure is medically necessary. Accordingly, she has established that she is entitled to the sought-after preliminary injunctive relief.

I. Evidentiary Issues

Before the court delves into the merits of the motion, it resolves outstanding objections raised to exhibits and testimony that were raised at the preliminary injunction hearing and in Ms. Cordellioné's motion *in limine* to partially exclude the testimony of Dr. Stephen Levine.

The following exhibits were admitted without objection at the hearing:

Exhibits 1-7	Exhibits 33-43	Exhibits 61-65	Exhibits 82-83
Exhibits 12-13	Exhibit 46	Exhibit 69	Exhibits 85-97
Exhibits 15-16	Exhibit 48	Exhibits 71-72	Exhibits 100-101
Exhibits 18-31	Exhibits 51-56	Exhibits 75-79	Exhibits 105-106

Dkt. 83 at 7, 12−13 (Preliminary Injunction Hearing Transcript).[2] After the hearing, the court admitted exhibits 109 and 110 without objection. Dkts. 90, 90-1, 90-2, 90-3, 91.

Exhibits to which Plaintiff has objected

The court proceeds to evaluate Ms. Cordellioné's objections to various exhibits.

Exhibits 67, 68, 70, 84, 102, and 108

Exhibits 67 (Dkt. 54-51), 68 (Dkt. 54-52), 70 (Dkt. 54-55), 84 (Dkt. 54-78), and 102 (not filed electronically) are various articles that were published in professional journals, and Exhibit 108 (Dkt. 76-3) is a declaration of one of Defendant's attorneys purporting to authenticate these articles. Ms. Cordellioné objected to these exhibits because they were not cited by any of the parties' expert witnesses in their reports, nor were any of them authenticated through the

[2] When citing to the exhibits, the court will generally refer first to the docket number where the exhibit is found on CMECF, and second to the exhibit number wherever doing so is helpful to the reader. Further, where the cited exhibit is a deposition, the court will first cite to the page number as it appears in the PDF, and then to the page of the deposition within parentheses.

experts' depositions. Dkt. 83 at 11. The court preliminarily overruled Ms. Cordellioné's objection to these exhibits, subject to further examination "[w]hen the time comes for those exhibits to be presented." *Id.* at 12. But at no point during the hearing did Defendant present any of these exhibits to any of the witnesses or otherwise rely on the exhibits. For professional publications to be relied on as evidence, a court must have a basis for concluding that "experts in the particular field would reasonably rely on those kinds of [materials] in forming an opinion on the subject." Fed. R. Evid. 703. In the absence of expert testimony regarding or relying on these materials, IDOC has not made the requisite showing, and therefore the objection is **sustained**, and the court **strikes** exhibits 67, 68, 70, 84, 102, and 108 from the record.

Exhibit 81

Exhibit 81 (Dkt. 54-56) is a demonstrative exhibit prepared by IDOC that purports to describe perceived "limitations" in 22 different studies before the court. One of these studies (Exhibit 34) was introduced during the deposition of IDOC's expert witness, and the other 21 studies were cited by Ms. Cordellioné's expert witnesses in support of their opinions. Not one of the 22 studies was cited in the expert report of IDOC's expert witness. (*See, e.g.*, Dkt. 83 at 158). The plaintiff objects to Exhibit 81 as an improper use of a demonstrative exhibit.

A party "may use a summary, chart, or calculation to prove the content of voluminous writings . . . that cannot be conveniently examined in court." Fed. R. Evid. 1006. Defendant's chart, however, does not prove the contents of the 22 studies; instead, it presents the opinions of IDOC's counsel (rather than an expert), who synthesized the information about various articles that are not in evidence. The court therefore **sustains** the objection and **strikes** Exhibit 81 from the record.

Exhibit 80

Exhibit 80 (Dkt. 54-75) is the Declaration of Linda Thomas, Ms. Cordellioné's former spouse and the mother of the victim of her criminal offense. Ms. Cordellioné objected to the relevance of this declaration. The declaration has some, albeit limited, relevance, insofar as Ms. Thomas expressed fear that Ms. Cordellioné's identity could be concealed upon release due to her change in appearance, dkt. *id.* at ¶ 15, so the objection is **overruled**.[3]

Exhibit 107

Exhibit 107 (Dkt. 76-2) is a Motion for Alternative Placement that Ms. Cordellioné filed, pro se, in her criminal case on January 4, 2024. She objected on the basis of the timeliness of its disclosure and its relevance. Dkt. 83 at 13. She, however, indicated that she would remove her objection to the exhibit if this court took "judicial notice of the fact that it was denied by the state court on January 19th." *Id.* The court takes judicial notice of the docket of Ms. Cordellioné's criminal case in Indiana Case number 82D02-0110-CF-00738, available at mycase.in.gov, which reflects that the motion was indeed denied on January 19, 2024. Thus, the objection is **overruled**.

Exhibits 32, 73, and 74

Exhibits 32 (Dkt. 54-19), 73 (Dkt. 54-58), and 74 (Dkts. 54-59 through 54-62) are, respectively, the expert report of Dr. Levine, an e-mail from Dr. Levine to one of IDOC's attorneys, and the transcript of Dr. Levine's deposition. Although IDOC inadvertently failed to move to admit Exhibit 74 at the preliminary injunction hearing, the parties have agreed that it should be deemed to have done so. Dkts. 88, 89. Dr. Levine has been designated by the IDOC as

[3] Ultimately, this affidavit had no bearing on the outcome of Ms. Cordellioné's motion for injunctive relief. First, Ms. Thomas did not testify at trial, so there is no evidence that she in fact could not recognize Ms. Cordellioné. Second, most of Ms. Cordellioné's physical changes have resulted from the treatments that IDOC *does* permit for transgender inmates—namely social transitioning and hormone therapy.

an expert witness in this case, and Ms. Cordellioné has separately filed a motion to partially exclude Dr. Levine's testimony under *Daubert v. Merrell Dow Pharmaceuticals, Inc.*, 509 U.S. 579 (1993), and its progeny, Dkt. 60, which will be addressed below.

In addition to her *Daubert* objections, Ms. Cordellioné objected to both Exhibit 32 and Exhibit 73 insofar as neither exhibit is verified. Dkt. 83 at 15. She further objected to Exhibit 74 as an untimely attempt to supplement the expert report of Dr. Levine. *Id.* During the hearing, Dr. Levine affirmed that the previously unsworn testimony in his expert report (Exhibit 32) is true. *Id.* at 133. He offered no similar testimony about the e-mail at Exhibit 73. "Unsworn expert reports do not qualify as affidavits or otherwise admissible evidence . . . and may be discarded by the court." *Remediation Prods., Inc. v. Adventus Americas Inc.*, 2009 WL 4612290, at *1 (W.D.N.C. Dec. 1, 2009) (cleaned up). The objection to the e-mail at Exhibit 73 is **sustained**, and the court **strikes** Exhibit 73 from the record.

The court **admits** Exhibits 32 and 74 consistent with its rulings on the *Daubert* motion.

The parties' objections under *Daubert* and its progeny

Legal Standard

Federal Rule of Evidence 702 requires the court to "ensure that any and all scientific testimony or evidence admitted is not only relevant, but reliable." *Daubert*, 509 U.S. at 589. The proponent of expert testimony bears the burden of demonstrating its admissibility. *Lewis v. CITGO Petroleum Corp.*, 561 F.3d 698, 705 (7th Cir. 2009).

The court must engage in a three-step analysis when fulfilling its "gatekeeping obligation" under Rule 702 and determine: "whether the witness is qualified; whether the expert's methodology is scientifically reliable; and whether the testimony will 'assist the trier of fact to understand the evidence or to determine a fact in issue.'" *Gopalratnam v. Hewlett–Packard Co.*,

877 F.3d 771, 779 (7th Cir. 2017) (quoting *Myers v. Ill. Cent. R.R. Co.*, 629 F.3d 639, 644 (7th Cir. 2010)). "'Whether a witness is qualified as an expert can only be determined by comparing the area in which the witness has superior knowledge, skill, experience, or education with the subject matter of the witness's testimony.'" *Gayton v. McCoy*, 593 F.3d 610, 616 (7th Cir. 2010) (quoting *Carroll v. Otis Elevator Co.,* 896 F.2d 210, 212 (7th Cir. 1990)). Accordingly, "simply because a doctor has a medical degree does not make him qualified to opine on all medical subjects." *Id.* at 617 (citation omitted).

To determine whether a witness is qualified to render an expert opinion, this court must "consider [the] proposed expert's full range of practical experience as well as academic or technical training when determining whether that expert is qualified to render an opinion in a given area." *Smith v. Ford Motor Co.*, 215 F.3d 713, 718 (7th Cir. 2000).

Dr. Levine has been a licensed psychiatrist for over 50 years. Dkt. 83 at 124. He characterizes his area of expertise as pertaining to what he calls "human sexual concerns"—which he deems to include "love relationships that manifest with sexual life and sexual problems, sexual dysfunction, marital relationships, [or] sexual identity issues." Dkt. 54-59 at 13 9 (Levine Dep., Vol. I) [Ex. 74]. He is not a surgeon. Dkt. 54-60 at 29 (Levine Dep., Vol. 2).

Dr. Levine has treated transgender patients since he completed his residency, and he runs a clinic that has treated about 315 patients with gender identity issues. Dkt. 83 at 125. In 2007, Dr. Levine began consulting for the Massachusetts Department of Corrections as to the treatment of transgender prisoners; he has remained a consultant for 17 years. *Id.* Of the hundreds of patients with gender dysphoria Dr. Levine has treated, most have considered whether to seek gender-affirming surgery. *Id*. at 126-27.

When a patient discusses an interest in gender-affirming surgery, Dr. Levine views his

professional role as conducting a psychiatric evaluation, including taking a developmental history and discussing the patient's motivation for seeking surgery. *Id.* at 127. He also believes that he must participate in the informed consent process insofar as he wants to ensure that any patient he recommends for surgery has the mental and intellectual capacity to understand the consequences of the surgery. *Id.* at 127−28. Thus, over the course of his career, he has read medical literature about gender-affirming surgery, attended conferences at which surgeons have presented, and has written two papers on informed consent. *Id.* at 129−30.

Ms. Cordellioné raises three objections to Dr. Levine's testimony. First, she states that because Dr. Levine is not a surgeon, he is not qualified to testify about the nature, rate, or severity of surgical complications. His only source of "expertise" on these subjects is his review of medical literature. "Courts are suspicious of purported expertise premised solely or primarily on a literature review." *McConnie-Navarro v. Centro de Fertilidad del Caribe, Inc.*, 2007 WL 7652299, at *13 (D.P.R. May 31, 2007) (collecting cases). There is no doubt that Dr. Levine has experience treating patients for gender dysphoria or that his treatment includes consulting with his patients about the risks associated with gender-affirming surgery. On the other hand, he is not an expert in the nitty gritty of the nature, rate, or severity of surgical outcomes as those are not part of his practice. The motion in limine is **granted in part and denied in part**, and the objection is **overruled** to the extent that the court will not exclude Dr. Levine's testimony concerning his concerns about surgical complications, but it gives those opinions very little weight.

Second, Ms. Cordellioné objects based on the fact that Dr. Levine's opinions about the safety and efficacy of gender-affirming surgery are based on cherry-picked excerpts of scientific articles. Speculation may not make up the deficiency in an expert's opinion where

the expert fails to "bridge the analytical gap" between the data and his ultimate conclusion. *See, e.g.*, *Gopalratnam*, 877 F.3d at 786. And "[c]ourts have consistently excluded expert testimony that 'cherry-picks' relevant data because such an approach does not reflect scientific knowledge, is not derived by the scientific method, and is not good science." *In re Lipitor (Atorvastatin Calcium) Mktg., Sales Practices & Prods. Liab. Litig.*, 892 F.3d 624, 634 (4th Cir. 2018) (internal citations and quotations omitted); *see also, e.g.*, *Crain v. McDonough*, 2022 WL 611292, at *7 (S.D. Ind. Feb. 28, 2022) ("[E]xperts who engage in cherry-picking of the evidence fail to satisfy the scientific method and *Daubert*.") (citation omitted), *aff'd*, 63 F.4th 585 (7th Cir. 2023). In her own expert reports, Ms. Cordellioné's experts cited dozens of studies specifically concerning the safety and efficacy of gender-confirming surgery; additional studies are cited in the Standards of Care published by the World Professional Association for Transgender Health ("WPATH"). The majority of this research is ignored by Dr. Levine, and much of the literature he does cite is at best tangentially related to the efficacy of gender-confirming surgery. The court agrees that Dr. Levine's conclusions are not rooted in reliable scientific methodology. Thus, the motion in limine is **granted** to the extent that the portions of Dr. Levine's report that discuss the "six outcome parameters" to determine the safety and efficacy of gender-affirming surgery are **stricken**, and the court has disregarded his testimony about the same.

Finally, Ms. Cordellioné objects to the part of Dr. Levine's report that discusses whether prisoners are capable of providing informed consent to gender-affirming surgery. The court **grants** the motion as it relates to this part of his report. Dr. Levine has recommended gender-affirming surgery as medically necessary for at least four inmates. Dkt. 83 at 175. Thus, his position that inmates are incapable of proving such consent is not well taken.

Finally, the court addresses IDOC's argument that if the court excludes Dr. Levine's opinions about gender-affirming surgery, it must do the same with respect to Dr. Ettner, who is a psychologist. Dr. Ettner has evaluated, diagnosed, and treated 3,000 individuals with gender dysphoria and mental-health issues related to gender variance, has evaluated several hundred of those persons for surgery, and has published extensively in the area (including specifically on the benefits of surgery). Dkt. 37-1 at 1; Dkt. 83 at 184. She also has extensive experience working with patients following gender-affirming surgery, providing treatment and post-operative care to hundreds of them. Dkt. 70-7 at 19 ¶ 35 (Ex. 103, Expert Rebuttal of Dr. Ettner). She is qualified to opine on the benefits and efficacy of gender-affirming surgery, and she does not attempt to opine about the nature, rate, or severity of surgical complications. Thus, the objection to her testimony on this is **overruled**.

Finally, IDOC's objection to any testimony from Dr. Loren Schechter, a board-certified plastic surgeon, about the mental health benefits of gender-affirming surgery is **overruled**. Dr. Schechter's expertise includes academic writing and his contribution to the Seventh Version of WPATH's Standards of Care focused on "the relationship of the surgeon with the treating mental health professional" in addition to several articles about interdisciplinary approaches between surgeons and mental health professionals treating patients with gender dysphoria. Dkt. 37-2 at 3, 11, 16, 19, 33 (Dr. Loren S. Schecter, M.D., Expert Declaration). He is qualified to opine on the mental health benefits of gender-affirming surgery.

II. Findings of Fact

The following facts are found by the Court to be true based on the stipulated facts (dkt. 66) and the testimony and documents presented during the preliminary injunction evidentiary hearing. Any finding of fact is deemed to be a conclusion of law to the extent

necessary and appropriate.

A. The Parties' Experts

Ms. Cordellioné has presented expert testimony from Dr. Randi Ettner, Ph.D., and Dr. Loren Schechter, M.D. Dkt. 37-1 (Ex. 98, Expert Report of Dr. Ettner); Dkt. 83 at 183-190; Dkt. 37-2 (Ex. 99, Expert Declaration of Dr. Schechter); Dkt. 70-7 (Ex. 103, Expert Rebuttal Report of Dr. Ettner); Dkt. 70-8 (Ex. 104, Rebuttal Declaration Dr. Schechter).

Dr. Ettner is a clinical and forensic psychologist with extensive experience in the diagnosis and treatment of gender dysphoria. Dkt. 37-1 at 1. She has published four books related to the treatment of gender dysphoria, including the first and second editions of the medical text *Principles of Transgender Medicine and Surgery*, and numerous peer-reviewed articles. Dkt. 37-1 at 1, 7-10. She is the co-author of both the seventh and eighth versions of the WPATH Standards of Care and served as co-lead author on the eighth version's chapter on the "Applicability of the Standards of Care to People Living in Institutional Environments." *Id.* at 1. She trains medical professionals on healthcare for transgender prisoners and serves as a psychologist at the Weiss Memorial Hospital Center for Gender Confirmation Surgery. *Id.* at 1, 30. During her career, she has diagnosed and treated more than 3,000 persons for gender dysphoria and gender variance and has evaluated hundreds of them for surgery. Dkt. 83 at 184; dkt. 70-7 at 18-19 ¶ 35. She also has extensive experience working with patients following gender-affirming surgery, providing treatment and post-operative care to hundreds of them. Dkt. 70-7 at 19 ¶ 35. She works collaboratively with surgeons and other medical professionals to determine the appropriate care, including surgical and post-operative care, for transgender persons. *Id.* She has evaluated over 100 transgender prisoners in 20 different states and has evaluated 20% to 25% of those for surgery. Dkt. 54-67 at 32 (81) (Ex. 76, Ettner Dep.). She has frequently testified as an

expert concerning gender dysphoria and the need for and efficacy of gender-affirming surgery. Dkt. 37-1 at 2 (listing cases).

Plastic surgeon Dr. Schecter has specialized in gender-affirming surgeries for over 20 years. Dkt. 37-2 at 1, 3 ¶¶ 2, 8. In the past seven years, he has performed about 150 gender-confirming surgeries every year, including on an individual incarcerated by the U.S. Bureau of Prisons and five individuals incarcerated within the Illinois Department of Correction. *Id.* at 3, ¶ 8. He is also a professor of Surgery and Urology at the Rush University Medical Center in Chicago, and he trains other surgeons in performing gender-affirming surgery. *Id.* at 3-5, ¶¶ 7, 13-14. He has published extensively on the subject of gender-affirming surgery, including articles, textbook chapters, and textbooks, including the first reference guide for surgeons on how to perform the surgery. *Id.* at 4, ¶ 11. He also wrote the section in the seventh version of the WPATH Standards of Care on the relationship of the surgeon with the patient's mental health professionals and the doctor prescribing hormone therapy, and in the eighth version he served as the co-lead author of the chapter on surgical and postoperative care. *Id.* at 3-4, ¶ 9. He has repeatedly testified as an expert on issues concerning the nature, necessity, and efficacy of gender-affirming surgery. *See, e.g., C.P. ex rel. Pritchard,* 2022 WL 17092846, *2; *Fain v. Crouch*, 618 F. Supp. 3d 313, 321 (S.D.W. Va. 2022), *aff'd sub nom. Kadel v. Folwell*, 100 F.4th 122 (4th Cir. 2024) (en banc); *Flack v. Wis. Dep't of Health Servs.*, 328 F. Supp. 3d 931, 948 (W.D. Wis. 2018).

The court finds that Dr. Ettner and Dr. Schechter have expertise in the nature, necessity, and efficacy of gender-affirming care, including gender-affirming surgery, for persons suffering from gender dysphoria. The court further finds that Dr. Ettner has expertise in the evaluation, diagnosis, and treatment of gender dysphoria.

IDOC relies on the testimony of Dr. Stephen B. Levine, M.D. Dkt. 54-19 (Ex. 32, Expert Report Dr. Levine); Dkt. 83 at 124−83. Dr. Levine has practiced as a psychiatrist, licensed in Ohio, since the early 1970s. Dkt. 54-59 at 12−14 (Ex. 74, Dep. of Dr. Levine). In 1973 or 1974, Dr. Levine founded the Case Western Reserve Gender Identity Clinic in Cleveland, although in 1993 that clinic dissociated from Case Western Reserve University. *Id.* at 14−17. In the three decades since this disaffiliation, the clinic has diagnosed fifty or sixty patients (a total of less than two a year) with gender dysphoria. *Id.* at 34−35. Over the past decade or so, at any one time, Dr. Levine has had about four gender dysphoric patients. *Id.* at 36.

Beginning in or around 2007, Dr. Levine has also served as a consultant to the Massachusetts Department of Correction. Dkt. 54-60 at 1 (51) (Ex. 74, Dep. of Dr. Levine, Vol. 2). In this role, he has consulted on the treatment of 200 to 300 transgender individuals. Dkt. 83 at 125. He has also consulted on the treatment of a maximum of eight gender dysphoric prisoners in other states. Dkt. 54-60 at 6-7 (56-57).

The court finds that Dr. Levine has expertise in the evaluation, diagnosis, and treatment of gender dysphoria.

B. Gender Dysphoria and Its Treatment

"Gender identity" is the term that refers to a person's sense of belonging to a particular gender. Dkt. 66 at ¶ 1 (Stipulation of Facts). A person who is cisgender has a gender identity—an internal sense of gender—that aligns with his or her birth-assigned sex, while a person who is transgender has a gender identity that does not. *Id.* at ¶ 2. Some transgender individuals are diagnosed with gender dysphoria, a psychiatric condition recognized by the current, fifth edition of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders,* and its text revision (DSM-V-5 and DSM-5-TR). *Id.* at ¶¶ 3−5.

Gender dysphoria in adolescents and adults is defined by the DSM-5-TR as:

> A. A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months' duration, as manifested by at least two of the following.
>
> 1. A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics).
>
> 2. A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender (or in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics).
>
> 3. A strong desire for the primary and/or secondary sex characteristics of the other gender.
>
> 4. A strong desire to be the other gender (or some alternative gender different from one's assigned gender).
>
> 5. A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender).
>
> 6. The strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender).
>
> B. The condition is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Dkt. 66 at ¶ 5.

The WPATH Standards of Care are the internationally recognized guidelines for the treatment of persons with gender dysphoria. Dkt. 37-1 at 6. They are endorsed by the American Medical Association, the Endocrine Society, the American Psychological Association, the American Psychiatric Association, the World Health Organization, the American Academy of Family Physicians, the American Public Health Association, the National Association of Social Workers, the American College of Obstetrics and Gynecology, and the American Society of Plastic Surgeons. *Id.*

The WPATH Standards are also supported by the National Commission of Correctional Health Care, an organization that creates authoritative standards that are used throughout the country by various correctional authorities, including IDOC. Dkt. 70-7 at 12, ¶ 23; dkt. 37-3 at 16. Indeed, IDOC's policies before 2024 recognized that WPATH's Standards of Care "articulate a professional consensus about the psychiatric, psychological, medical and surgical management of gender dysphoria." Dkt. 37-3 at 102 (Rule 30(b)(6) Deposition of Dr. Adrienne Bedford).

Notably, Dr. Levine was once a member of WPATH's predecessor body before disassociating with the organization over professional disagreements. Dkt. 83 at 129−30. Dr. Levine characterizes the WPATH Standards not as a standard of care, but more properly as a guidance document because it does not meet the rigorous standards required for standards of care. Dkt. 54-19 at 36 *et seq.* Dr. Levine notes that WPATH has been "recognized as biased, inherently contradictory, consensus-based, and erroneously claiming to be evidence-based." *Id.* at 36-70, ¶ 70. On this point, other courts have recognized that Dr. Levine has become an "outlier in the field of gender dysphoria." *Edmo v. Idaho Dep't of Corr.*, 358 F. Supp. 3d 1103, 1125 (D. Idaho 2018), *vacated in part on other grounds*, 935 F.3d 757 (9th Cir. 2019); *see also Fain v. Crouch*, 618 F. Supp. 3d 313, 329 (S.D.W. Va. 2022) (describing Dr. Levine's opinions regarding gender dysphoria as "inconsistent with the body of literature on this topic"), *aff'd sub nom. Kadel v. Folwell*, 100 F.4th 122, (4th Cir. 2024); *Hecox v. Little*, 479 F. Supp. 3d 930, 977 n.33 (D. Idaho 2020) (citing *Edmo*). Given the widespread acceptance of WPATH's Standards of Care by other professional medical bodies as well as the National Commission of Correctional Health Care, the court finds that the Standards of Care are credible and reliable and will rely on them in reaching its conclusions in this matter.

WPATH's Standards of Care provide for various treatment for individuals with gender dysphoria including social transition (living in a manner consistent with one's gender identity with respect to clothing, names/pronouns, etc.), counseling and psychotherapy, hormone therapy, and surgical interventions designed to align primary and secondary sex characteristic with the person's gender identity. Dkt. 66 at ¶ 7. Treatment of a transgender person suffering from gender dysphoria is determined based on an individualized assessment of the person's needs. Dkt. 37-1 at 7−8.

While some transgender persons are able to be comfortable with their gender identity without surgery, for some, nonsurgical treatments are not sufficient to relieve their severe gender dysphoria; the WPATH Standards of Care recognize that surgical intervention, *i.e.*, genital reconstruction, is necessary to modify these persons' primary sex characteristics. Dkt. 37-1 at 9; dkt. 37-2 at 10, ¶ 28.

When gender dysphoria remains marked and sustained, it is medically necessary to provide the surgery. Dkt. 37-2 at 14, ¶ 39. Without such surgery, a gender-dysphoric person may suffer increasingly debilitating symptoms of anxiety, depression, hopelessness, suicidal ideation, and other manifestations of psychological decompensation and may resort to suicide. Dkt. 37-1 at 15-16. Transgender females may resort to self-surgery by removing their testicles and penis. *Id.* at 15. For these individuals, surgery is medically necessary and is recognized as such by the American Medical Association, the American Psychiatric Association, the American Psychological Association, the American College of Obstetricians and Gynecologists, and the World Health Organization, among others. Dkt. 37-1 at 7, 10-11.

The WPATH Standards of Care recognize that surgery to change primary or secondary sex characteristics is care that may be necessary for gender dysphoria. Dkt. 37-1 at 7.

While there are various surgical procedures available to align a transgender person's anatomy and physical appearance with his or her gender identity, relevant to this case is an orchiectomy, removal of the testes, and a vaginoplasty, surgery that constructs a vagina. Dkt. 37-2 at 10-11, ¶ 30. Genital reconstruction surgery for transgender women serves two therapeutic purposes: removal of the testosterone-producing testicles and allowing the person to attain congruence with their gender identity by having genital structures that appear and function as are typical for cisgender women. Dkt. 37-1 at 10.

IDOC contends that there is disagreement as to whether there is widespread medical consensus that gender-affirming surgery is "a safe and effective course of treatment for gender dysphoria such that a state's prohibition of [gender-affirming surgery] is a substantial departure from accepted professional judgment, practice or standards." Dkt. 94 at 23. IDOC relies largely on Dr. Levine's Expert Report that questions the need to provide incarcerated individuals with gender-affirming surgery. *See generally* Dkt. 54-19. The court finds, however, that the widespread medical consensus is that gender-affirming surgery is a medically necessary form of care for some individuals with gender dysphoria. *See* Dkt. 37-1 at 7, 10-11. Dr. Levine's own skepticism regarding the need to make such surgery available to incarcerated individuals with gender dysphoria is not credible given his own recommendations that certain incarcerated individuals receive such surgery and his rejection of WPATH's Standards of Care despite their widespread acceptance.

Indeed, extensive research from the past three decades establishes that gender-affirming surgery is a safe, therapeutic, and effective treatment for gender dysphoria and is medically necessary for the treatment of some individuals with severe gender dysphoria. Dkt. 37-1 at 11-13; dkt. 37-2 at 16-21, dkt. 70-7 at 6-7, 14-17. This research includes, among other things,

surveys and studies of thousands of transgender individuals, with one study indicating that 97% of these who underwent at least one gender-affirming surgery reported improved life satisfaction; another indicating that those who underwent surgery had significantly less psychological distress and suicidal ideation than those with no history of surgery; and yet another indicating that gender-affirming surgery positively affects well-being, sexuality, and quality of life in general. Dkt. 70-7 at 14-16.

While all surgery carries risks, gender-affirming surgeries are safe, and surgeons performing them use many of the same procedures used to treat other medical conditions. Dkt. 37-2 at 16, ¶ 42; dkt. 70-8 at 2, ¶ 6. Surgery may be medically necessary despite attendant risks. Dkt. 70-8 at 2-3, ¶¶ 6, 12. IDOC focuses on the fact that gender-affirming surgery sterilizes the individual and is irreversible. Dkt. 94 at 51. While true, a patient seeking gender-affirming surgery would not be approved of such surgery without undergoing the informed consent process, which is in place to ensure that she is able to make the appropriate choice after being informed of the risks and benefits of the surgery. Dkt. 70-8 at 2, ¶ 6. Many people undergo sterilizing procedures for a variety of medical reasons, and the court finds no reason to treat these surgeries any different so long as the patient provides informed consent.

The criteria for gender-affirming genital surgery in male-to-female transgender adult patients are:

1. Gender incongruence is marked and sustained;
2. Meets diagnostic criteria for gender incongruence prior to gender-affirming surgical intervention in regions where a diagnosis is necessary to access health care;
3. Demonstrates capacity to consent for the specific gender-affirming surgical intervention;
4. Understands the effect of gender-affirming surgical intervention on

reproduction and they have explored reproductive options;

5. Other possible causes of apparent gender incongruity have been identified and excluded;

6. Mental health and physical conditions that could negatively impact the outcome of gender-affirming surgical intervention have been assessed, with risks and benefits hav[ing] been discussed;

7. Stable on their gender affirming hormonal treatment regime (which may include at least 6 months of hormone treatment or a longer period if required to achieve the desired surgical result, unless hormone therapy is either not desired or is medically contraindicated).

Dkt. 70-7 at 17, ¶ 31.

Having a coexisting mental health diagnosis does not disqualify a person from receiving medically necessary gender-affirming surgery if the mental illness is stable and does not interfere with a person's ability to provide informed consent. Dkt. 70-7 at 9-10, 17 ¶¶ 19, 31; Dkt. 70-8 at 4 ¶¶ 14-15; Dkt. 54-67 at 42-43 (91-92). This includes the diagnosis of a personality disorder, which is considered to be lifelong, and like other mental health diagnoses does not preclude gender-affirming surgery if the condition is well-controlled. Dkt. 70-7 at 10 ¶ 20.

In order to assess the readiness and eligibility of a person for gender-affirming surgery, the mental health professional must have experience with gender dysphoria, and not just general mental health experience. Dkt. 70-7 at 18 ¶ 32. They must, if new to the field, receive supervision from a person with expertise, and demonstrate the ability to distinguish comorbidities from gender dysphoria. *Id.* This is a subspecialty that requires experience and training. *Id.*

The surgeon is responsible for going through the informed consent process with a patient before surgery. Dkt. 83 at 120. The informed consent process (for all surgeries) involves discussing the specifics of a surgical procedures and the risks. Dkt. 54-63 at 9-10.

The National Commission on Correctional Health Care recognizes that gender-affirming surgery should be provided when determined to be medically necessary for transgender prisoners. Dkt. 37-3 at 38. Transgender prisoners in a number of jurisdictions may receive gender-affirming surgeries. Dkt. 37-1 at 15. These include prisoners within the federal Bureau of Prisons and a number of state correctional institutions including at least those in Illinois, Washington, Idaho, California, and Massachusetts. *Id.*; Dkt. 37-2 at 21 ¶ 53. The assessment process for the appropriateness of surgery is the same as the process for those who are not incarcerated. Dkt. 37-2 at 21, ¶ 52. Incarceration does not render a person incapable of providing informed consent. Dkt. 54-63 at 29−31.

C. Ind. Code § 11-10-3-3.5(a) and IDOC's Policies Related to Healthcare for Transgender Inmates

IDOC is responsible for providing medical and mental health care to its prisoners. Dkt. 66 at ¶ 8. IDOC has currently contracted with Centurion Health Services ("Centurion") to provide medical and mental health care for its prisoners, although IDOC retains the ultimate authority to ensure prisoners receive healthcare. *Id.* at ¶ 9. IDOC limits medical care to what is deemed to be medically necessary, including medically necessary surgical services. *Id.* at ¶¶ 12, 14. The IDOC's Policy and Administrative Procedure 01-02-101 limits the scope of the medical care it provides to "adequate Health Services necessary to address serious medical conditions," requiring "clinical staff [to] distinguish between care that is necessary (and should be provided) and care that is desirable and not necessary (and should not be provided)." *Id.* at ¶ 13. In the contract that the IDOC has executed with Centurion, Centurion agrees to follow the standards established by the National Commission on Correctional Health Care, as does the IDOC itself. Dkt. 37-3 at 16, 21-23.

IDOC recognizes that gender dysphoria can result in clinically significant distress that

causes severe anxiety, depression, self-harm, and suicidality. *Id.* at 35. Before the passage of Indiana Code § 11-10-3-3.5(a), IDOC promulgated IDOC Health Care Services Directive 2.17A (April 1, 2022) ("HCSD 2.17A (2022)"), titled "Health Services for Transgender and Gender Diverse Patients." Dkt. 54-1 at 1. That policy contemplated that inmates with gender dysphoria could "pursue multiple domains of gender affirmation which include social, legal, medical, and/or surgical interventions." *Id.* Under HCSD 2.17A (2022), the treatment provided to gender dysphoric IDOC prisoners was determined by the independent professional judgment of mental health professionals. Dkt. 66 at ¶ 19. A gender review committee reviewed certain decisions made by mental health professionals, such as the decision to diagnose a prisoner with gender dysphoria. *Id.* Inmates seeking gender-affirming surgery would have to be evaluated by two mental health professionals who would make a recommendation to the Gender Dysphoria Review Committee, which would then decide if surgery was warranted. *Id.* at ¶ 20. Before July 1, 2023, two IDOC prisoners were approved for gender-affirming surgery. *Id.* at ¶ 21. The surgeries were not provided by the IDOC's medical provider but rather by an outside surgeon at Eskenazi Hospital in Indianapolis. Dkt. 83 at 119-20.

Indiana Code § 11-10-3-3.5(a) went into effect on July 1, 2023. Dkt. 66 at ¶ 20. This statute provides that "[t]he department [of correction] may not authorize the payment of money, the use of any state resources, or the payment of any federal money administered by the state to provide or facilitate sexual reassignment surgery to an offender patient."

"Sexual reassignment surgery" is defined by Indiana Code § 11-10-3-1(6) as:

> performing any of the following surgical procedures for the purpose of attempting to alter the appearance of, or affirm the offender patient's perception of, his or her gender or sex, if that appearance or perception is inconsistent with the offender patient's sex:
>
> (A) Surgeries that sterilize, including castration, vasectomy, hysterectomy,

oophorectomy, orchiectomy, and penectomy.

(B) Surgeries that artificially construct tissue with the appearance of genitalia that differs from the offender patient's sex, including metoidioplasty, phalloplasty, and vaginoplasty.

(C) Removing any healthy or non-diseased body part or tissue.

In 2024, IDOC modified HCSD 2.17A to reflect the passage of § 11-10-3-3.5(a). Dkt. 90-1 (March 31, 2024, Executive Directive #24-10). The updated version of the policy ("HCSD 2.17A (2024)") provides that IDOC inmates may still engage in psychotherapy, social transitioning, and hormonal therapy. Dkt. 90-2 at 5−6. As it relates to surgery, HCSD 2.17A (2024) now states, "Gender Affirmation Surgery ('GAS'): Individuals may live successfully as transgender persons without surgery. The Department will adhere to all State laws and regulations and will provide the most comprehensive care available." *Id.* at 6.

IDOC will provide surgical services for cisgender prisoners that under § 11-10-3-3.5(a) would be banned as gender-affirming care for transgender prisoners. Dkt. 37-3 at 29. For example, cisgender IDOC prisoners may have hysterectomies, testicular removal, fallopian tube removal and ovary removal if deemed medically necessary. *Id.*

At the preliminary injunction hearing, Dan Mitchell, the warden at Branchville Correctional Facility, testified that there is a transgender review committee at the facility that meets monthly to discuss the needs of transgender prisoners from various professional perspectives. Dkt. 83 at 63−64. He also testified that the prison staff is trained in suicide prevention measures and about the suicide watch protocol at that facility. *Id.* at 64−66; dkt. 55−74 at ¶ 8 (Ex. 79, Mitchell Decl.). While the court appreciates that Warden Mitchell took time to testify at the hearing, the evidence related to the care of transgender and/or suicidal

inmates at Branchville has no bearing on this court's decision, as Ms. Cordellioné is now housed at New Castle Correctional Facility. Dkt. 85 (Notice of change of address).

D. Ms. Cordellioné's Background

Ms. Cordellioné was born in 1982 and is 41 years old. Dkt. 66 at ¶ 24. She was born with anatomy traditionally associated with males. *Id.* at ¶ 25. Ms. Cordellioné has been incarcerated in the IDOC since 2002. Dkt. 66 at ¶¶ 26−27. She is in prison for murdering her infant stepdaughter and was 19 at the time of the crime. *Id.* at ¶¶ 26-27. Her earliest possible release date is December 31, 2027. *Id.* at ¶ 28.

Ms. Cordellioné knew from an early age that she was a girl, but she did not learn about transgender people and possible treatment until she had been imprisoned for some time. *Id.* at ¶ 33. In 2020, Ms. Cordellioné was diagnosed with gender dysphoria by the Gender Dysphoria Review Committee. *Id.* at ¶ 35. Beginning in July 2020, Ms. Cordellioné was prescribed estradiol, an estrogen supplement, and spironolactone, and androgen blocker that lowers the amount of testosterone that her body would otherwise produce, and she has consistently received those medications since that time. *Id.* at ¶¶ 36−37. As a result of the hormone therapy, Ms. Cordellioné's body has changed so that, among other things, she has developed breasts, and her body fat has redistributed in a manner more consistent with the body of a woman. *Id.* at ¶ 38. In addition to hormone therapy, Ms. Cordellioné has used her chosen name as much as possible; has been allowed to purchase female items from commissary (including bras, panties, form-fitting clothing, and make-up); and has been seen by mental health staff. *Id.* at ¶¶ 40−42, 45−46.

Ms. Cordellioné has a lengthy history of being medicated with psychotropic medication, but under the supervision of medical professionals has not been on any psychotropics or other mental health medications since 2010 or 2011. Dkt. 83 at 56; Dkt. 66 at 6, ¶ 32.

Ms. Cordellioné has a history of self-harm and suicide attempts. Dkt. 66 at ¶ 30. These attempts include overdosing on prescription medication, trying to hang herself, lighting her cell on fire, and burning two fingers off in boiling water in an attempt to get gangrene. Dkt. 54-70 at 27−31 (76−80) (Cordellioné Dep.). She engaged in self-harm due to her inability to express her female gender identity, but she did not tell her mental health providers that because she did not understand her transgender identity the time, and she did not want to be placed on suicide watch. *Id.* at 26−27 (75−76).

Ms. Cordellioné has lied to mental health providers, or avoided telling them about her urges to self-harm, in order to avoid being placed on suicide watch. *Id.* at 27 (76); dkt. 83 at 56. While on suicide watch, she was placed in a "rubber room," a suicide cell where a prisoner is placed without clothing, with no mat, and with a hole in the floor to use for the bathroom. Dkt. 83 at 56-57. In that room, she lacked access to toilet paper or the ability to wash her hands. *Id.* The experiences of being placed in suicide watch conditions were very painful for Ms. Cordellioné. *Id.* at 58.

As part of her gender dysphoria, Ms. Cordellioné experiences distress due to her genitals. Dkt. 39-1 at ¶ 16 (Cordellioné Decl.). At times she has soiled herself rather than use the restroom to avoid looking at her genitals, and she often wears underwear in the shower. *Id.* at ¶¶ 16−17. Ms. Cordellioné cannot stand the testicles and penis on her body. Dkt. 54-70 at 36 (85). She has attempted surgical self-treatment by ligation on multiple occasions by putting rubber bands around her genitals, but it was too painful for her to tolerate to accomplish castration. *Id.* at 33, 36-37 (82, 85−86). She also cut her genitals with a razor blade in 2008, but she stopped because the excessive amount of blood caused her to fear that she would be placed on suicide watch. *Id.* at 37-38 (86−87). Ms. Cordellioné does not have the urge to feel pain, but her self-harming

behavior is a way to control her overwhelming emotions. *Id.* at 42−43 (91−92). Dr. Ettner explained that attempts at self-treatment through attempted ligation or genital cutting should not be considered a sign of "uncontrolled mental illness; on the contrary, such behavior represents a rational intention to eliminate testosterone by removal of the androgen-producing target organ. Ideation and attempts to perform self-surgery are *a priori* evidence of inadequate or insufficient care for gender dysphoria." Dkt. 37-1 at 23 n.4. This form of self-harm indicates that hormones are insufficient to treat an individual's gender dysphoria. Dkt. 54−67 at 45−46 (94−95).

Ms. Cordellioné was placed in a single cell in a restrictive housing unit ("RHU") in February 2024 after another inmate stabbed her after she refused to have sex with him. Dkt. 83 at 47−50. In the RHU, she lacked access to most of the accommodations for her gender dysphoria. She could not shave regularly, so hair grew back, and she was forced to wear large clothing. *Id.* at 50−51. This caused the symptoms of her gender dysphoria to increase, and she tried to commit suicide by taking Melatonin pills. She also tried to ligate her penis. *Id.* at 46−47, 50−51. This was the first time she had attempted suicide since she stopped taking mental health medications in 2011. *Id.* at 46.

In addition to her gender dysphoria, Ms. Cordellioné has active diagnoses of borderline personality disorder and recurrent major depressive disorder. Dkt. 66 at 7, ¶ 43. Prisoners within IDOC are given mental health codes ranging from A to F, with an A code meaning the prisoner has no mental health issues, no diagnosis, and no history of mental health issues; a B code meaning that the prisoner may have mental health issues but they are stable and are not causing any significant problems; a C code meaning the prisoner may have moderate to severe issues, is likely on medication, and is likely seen at least every 90 days; and D through F indicating

progressively more severe mental health issues. Dkt. 83 at 54−55. Ms. Cordellioné's mental health code was recently changed from "C" to "B." *Id.* at 55−56.

Evidence of improved mental health functioning does not mean that surgery is not needed if the person's symptoms of gender dysphoria remain severe or non-remitting. Dkt. 37-1 at 20.

E. Ms. Cordellioné's efforts to obtain gender-affirming surgery

When Ms. Cordellioné was diagnosed with gender dysphoria and prescribed hormones, she did not know that gender-affirming surgery was possible while she was still incarcerated. Dkt. 83 at 31−34. Thus, she told her mental health providers that she would like surgery at the earliest opportunity upon her release. Dkt. 54-70 at 8 (57).

When Ms. Cordellioné learned that IDOC provided gender-affirming surgery to eligible transgender inmates, she submitted a healthcare request form in June of 2022 that said, "I would like to request gender reassignment surgery for my gender dysphoria." Dkt. 39-1 at ¶ 22. When she received no response, she submitted additional request forms in November 2022, January 2023, and February 2023. *Id.* at ¶¶ 25−26. After the February 2023 request, a healthcare staff member told Ms. Cordellioné that she was on the list for evaluation. *Id.* at ¶¶ 25−26.

On May 8, 2023, Ms. Cordellioné had a telehealth mental health visit with psychologist Dr. Michael Farjellah. Dkt. 54-73 at ¶¶ 6−7. During this visit, Dr. Farjellah informed Ms. Cordellioné that "IDOC has decided to not go further with transgender surgery." *Id.* at ¶ 7. This telehealth visit did not constitute an evaluation for surgery. Dkt. 37-3 at 59, 62 (Dep. of Dr. Adrienne Bedford). Indeed, Ms. Cordellioné has never been evaluated by IDOC or its contracted medical provider for gender confirmation surgery. *Id.* at 58, 62−63.

After Ms. Cordellioné learned that that she couldn't receive surgery due to the passage of § 11-10-3-3.5, she told a healthcare professional that she wanted her hormones increased so she

could have surgery when she left prison. Dkt. 83 at 39-40. But this was not because she did not want surgery while in prison; she was hoping that her hormones levels were at correct levels in case she won her litigation so that she could be ready for surgery as soon as possible. *Id.*

Ms. Cordellioné wants surgery while she is incarcerated in the IDOC, and as soon as possible, because her gender dysphoria is getting worse. *Id.* at 43. She believes that having gender-affirming surgery (in the form of an orchiectomy and a vaginoplasty) would alleviate her gender dysphoria and allow her to live without constant thoughts of harming or killing herself. *Id.* at 20−21, 54. Ms. Cordellioné agrees that the treatment she has received for her gender dysphoria has allowed her to feel better about her gender identity, but she is not complete and suffers daily. Dkt. 54-71 at 2 (102). She understands that removing her penis and having a vaginoplasty will not solve all her problems, but it will reduce her pain. *Id.* at 32−33 (132−33).

Having reviewed her deposition testimony and observed Ms. Cordellioné during the preliminary injunction hearing, the court finds Ms. Cordellioné to be credible. That is, the court believes that Ms. Cordellioné feels great distress concerning her genitalia and credits her belief that gender-affirming surgery would alleviate some of the pain she experiences from her gender dysphoria and would reduce the likelihood that she engages in self-harm or tries to commit suicide.

The parties' experts and Dr. Farjellah opined about whether Ms. Cordellioné was a good candidate for gender-affirming surgery.

Dr. Farjellah testified that Ms. Cordellioné was not a good candidate for surgery due to her diagnosis of borderline personality disorder. Dkt. 83 at 84. The court does not find this testimony persuasive. Dr. Farjellah does not have any specialization in treating gender dysphoria or conducting evaluations for surgery. *See, e.g. id.* at 94 (acknowledging that when he met with

Ms. Cordellioné in May 2023, he was not using any standard of care to assess her appropriateness for surgery). His short telehealth appointment was not for the purpose of evaluating Ms. Cordellioné as a candidate for gender-affirming surgery. And his conclusion that she was a poor candidate due to her borderline personality disorder is contradicted by his finding after that visit that she exhibited no signs of major mental illness.

Dr. Levine opined that Ms. Cordellioné was not a good candidate for several reasons. Dkt. 54-19. He thinks that more therapeutic efforts should be spent exploring Ms. Cordellioné's sublimated masochism, underexplored erotic life, and willingness to manipulate and mislead doctors (all theories he reached based on his review of her medical records alone). *Id.* at ¶¶ 27−28. Dr. Levine believes that IDOC's other treatments of Ms. Cordellioné have adequately and effectively treated her gender dysphoria, and that IDOC's cautious approach has been appropriate given Ms. Cordellioné's later-in-life disclosure as a transgender person and her vulnerability to sexual exploitation in prison. *Id.* at ¶ 79. The court gives Dr. Levine's opinion as to Ms. Cordellioné's suitability for gender-affirming surgery no weight. Dr. Levine has never spoken with Ms. Cordellioné or conducted an evaluation of her. Dkt. 54-61 at 39-40. In other litigation, Dr. Levine testified that it would not be appropriate under professional ethical standards to render an opinion on whether an inmate was an appropriate candidate for surgery because he had not evaluated her in 22 months. Dkt. 70-9 at 19 (174) (Excerpts from Dep. of Dr. Levine in *Clark v. Quiros*). In his own clinical practice, he meets with clients several times, totaling "at least four to six hours," before determining whether they are a candidate for surgery. Dkt. 54-59 at 40-41. During the preliminary injunction hearing, Dr. Levine indicated that he was unaware that Ms. Cordellioné's mental health code had been upgrade from a C to a B. Dkt. 83 at

178. Given his lack of personal interaction with Ms. Cordellioné, the court finds his opinions about her eligibility for surgery to be completely unpersuasive.

Dr. Ettner is the only mental health professional who has personally evaluated Ms. Cordellioné for appropriateness for gender-affirming surgery. Dkt. 37-1 at 16-26. Dr. Ettner reviewed all of Ms. Cordellioné's medical and mental health records and met with her, via videoconference, for two hours. *Id.* at 3, 16). Dr. Ettner took a thorough history of Ms. Cordellioné and performed a typical mental status exam. Dkt. 54-67 at 24 (73); Dkt. 83 at 187. During the evaluation, Dr. Ettner administered four statistically reliable and valid psychometric tests—the *Beck Depression Inventory-II*, the *Beck Anxiety Scale*, the *Beck Hopelessness Scale*, and the *Traumatic Symptom Inventory-II*—to corroborate her clinical assessment and to provide current and objective information concerning the presence and severity of Ms. Cordellioné's symptoms. Dkt. 37-1 at 16. Dr. Ettner found Ms. Cordellioné to be straightforward and honest during the evaluation, and one of the psychometric tests that Dr. Ettner administered to Ms. Cordellioné has a validity component that detects such things as malingering, fabrication, and dishonesty. Dkt. 54-67 at 23−24 (72−73).

Dr. Ettner made several conclusions based on her evaluation. First, she concluded that after years of taking hormones, Ms. Cordellioné has been "hormonally reassigned," meaning that she has the same circulating sex steroid hormones as her female peers. Dkt. 37-1 at 22. Ms. Cordellioné has also socially transitioned as female to the extent possible given her incarceration. *Id.* Despite her hormonal treatment and social transition, Dr. Ettner concluded that "Ms. Cordellioné continues to suffer from severe gender dysphoria that causes significant distress and prompts thoughts of surgical self-treatment." *Id.* at 22. Thus, Dr. Ettner opined that IDOC was not providing sufficient treatment for Ms. Cordellioné. *Id.* Important to that

conclusion was Ms. Cordellioné's experience that her genitals are "wrong" and her inability to resolve her agony about having male genitalia. *Id.* at 23. Dr. Ettner determined that based on the persistence and severity of Ms. Cordellioné's gender dysphoria, the anatomical dysphoria associated with her genitals from which she suffers, and the information from her medical records, gender-affirming surgery is medically necessary for Ms. Cordellioné. *Id.* at 22. Surgery would attenuate the depression, anxiety, and hopelessness that Ms. Cordellioné experiences with her gender dysphoria. *Id.* at 23.

Based on a review of Ms. Cordellioné's medical records and her evaluation, Dr. Ettner further concluded that Ms. Cordellioné meets the WPATH Standards of Care criteria for surgery including the fact that her gender incongruence is marked and sustained; she demonstrates the capacity to consent to surgery; mental health and physical conditions that could negatively impact surgical outcomes have been assessed; she is stable on her gender-affirming hormone treatment; and other possible causes of her gender incongruity have been identified and excluded. Dkt. 37-1 at 23–26.

Dr. Ettner opined that Ms. Cordellioné's borderline personality disorder and depression would not preclude her from being a good candidate for surgery because she is currently stable, has not been on any psychotropic medications since 2011, has a high Global Assessment of Functioning,[4] and has recently been noted as being free of any major mental health concerns besides her gender dysphoria. Dkt. 83 at 186–87; dkt. 66 at 6, 7 ¶¶ 32, 43–44. Having other mental health diagnoses is not a reason to deny necessary medical treatment if the conditions are well controlled, as are Ms. Cordellioné's borderline personality disorder and depression. Dkt. 83 at 186–87. Rather, the denial of gender-affirming surgery to Ms. Cordellioné places her at risk of

[4] Global Assessment of Functioning ("GAF") is a measure of how much a person's mental health symptoms affect their day-to-day life on a scale of 0 at the low-functioning end to 100 at the high functioning end of the scale. In 2022, Ms. Cordellioné's GAF was 72. Dkt. 37-1 at 19-20 and n.3.

increasing physical and emotional harm. Dkt. 37-1 at 27. In Dr. Ettner's opinion, the surgery should not be delayed because Ms. Cordellioné is suffering now. Dkt. 83 at 189–90. Denying Ms. Cordellioné surgery may lead to emotional decompensation, attempts to remove her genitals, or suicide or suicide attempts. *Id.*

The court finds Dr. Ettner's testimony and conclusions concerning Ms. Cordellioné's need for gender-affirming surgery to be credible and persuasive. The court finds that gender-affirming surgery at this time is medically necessary for Ms. Cordellioné, and without it she faces a substantial risk of harm to her health.

III. Conclusions of Law

A. Standing

Standing is a threshold issue that determines whether the court has jurisdiction over this matter. For the reasons set out by separate Order, the court finds that Ms. Cordellioné has standing to challenge Indiana Code § 11-10-3-3.5(a). That is, she has shown that (1) she is suffering from an injury; (2) that injury was caused by the defendant; and (3) the injury can be redressed by the requested judicial relief. *Choice v. Kohn L. Firm, S.C.*, 77 F.4th 636, 638–39 (7th Cir. 2023).

B. Preliminary Injunction Standard

"A preliminary injunction is an extraordinary equitable remedy that is available only when the movant shows clear need." *Turnell v. Centimark Corp.*, 796 F.3d 656, 661 (7th Cir. 2015). The plaintiff first must show that "(1) without this relief, [she] will suffer irreparable harm; (2) traditional legal remedies would be inadequate; and (3) [she] has some likelihood of prevailing on the merits of [her] claims." *Speech First, Inc. v. Killeen*, 968 F.3d 628, 637 (7th Cir. 2020). Ms. Cordellioné bears the burden of proving each element by a preponderance of the

evidence. *Girl Scouts of Manitou Council, Inc. v. Girl Scouts of U.S.A., Inc.*, 549 F.3d 1079, 1086 (7th Cir. 2008). If she makes this showing, "the court then must weigh the harm the denial of the preliminary injunction would cause the plaintiff against the harm to the defendant if the court were to grant it." *Id*.

In the balancing phase, "the court weighs the irreparable harm that the moving party would endure without the protection of the preliminary injunction against any irreparable harm the nonmoving party would suffer if the court were to grant the requested relief." *Valencia v. City of Springfield*, 883 F.3d 959, 966 (7th Cir. 2018).

Under the Prison Litigation Reform Act ("PLRA"), "[p]reliminary injunctive relief must be narrowly drawn, extend no further than necessary to correct the harm the court finds requires preliminary relief, and be the least intrusive means necessary to correct that harm." 18 U.S.C. § 3626(a)(2). The PLRA's limit on remedies reinforces the rule "that prison administrators have substantial discretion over the institutions they manage." *Rasho v. Jeffreys,* 22 F.4th 703, 711 (7th Cir. 2022).

C. Ms. Cordellioné's Eighth Amendment Claim

The Eighth Amendment's prohibition against cruel and unusual punishment imposes a duty on the states, through the Fourteenth Amendment, "to provide adequate medical care to incarcerated individuals." *Boyce v. Moore*, 314 F.3d 884, 889 (7th Cir. 2002) (citing *Estelle v. Gamble*, 429 U.S. 97, 103 (1976)). "It is well established that the Constitution's ban on cruel and unusual punishment does not permit a state to deny effective treatment for the serious medical needs of prisoners." *Fields v. Smith*, 653 F.3d 550, 556 (7th Cir. 2011). "Prison officials can be liable for violating the Eighth Amendment when they display deliberate indifference towards an objectively serious medical need." *Thomas v. Blackard*, 2 F.4th 716, 721–22 (7th Cir. 2021).

"Thus, to prevail on a deliberate indifference claim, a plaintiff must show '(1) an objectively serious medical condition to which (2) a state official was deliberately, that is subjectively, indifferent.'" *Johnson v. Dominguez*, 5 F.4th 818, 824 (7th Cir. 2021) (quoting *Whiting v. Wexford Health Sources, Inc.*, 839 F.3d 658, 662 (7th Cir. 2016)).

There is no dispute that gender dysphoria is a serious medical condition under the objective prong. *See* dkt. 94 at 48 (IDOC's Proposed Findings of Facts and Conclusions of Law, citing *Campbell v. Kallas*, 936 F.3d 536, 545 (7th Cir. 2019)). Thus, the issue is whether Ms. Cordellioné has shown that IDOC has been deliberately indifferent to her by denying her access to gender-affirming surgery.

Deliberate indifference is present if a "defendant's chosen 'course of treatment' departs radically from 'accepted professional practice.'" *Zaya v. Sood*, 836 F.3d 800, 805 (7th Cir. 2016) (quoting *Pyles v. Fahim*, 711 F.3d 403, 409 (7th Cir. 2014)). "[T]he blanket, categorical denial of medically indicated surgery on the basis of an administrative policy . . . is the paradigm of deliberate indifference." *Colwell v. Bannister*, 763 F.3d 1060, 1063 (9th Cir. 2014); *see also Roe v. Elyea*, 631 F.3d 843, 862–63 (7th Cir. 2011) (blanket policy denying Hepatitis C treatment is "precisely the kind of conduct that constitutes [deliberate indifference]"). Deliberate indifference may be shown if a defendant persists "in a course of treatment known to be ineffective" or "chooses an easier and less efficacious treatment without exercising professional judgment." *Petties v. Carter*, 836 F.3d 722, 729–30 (7th Cir. 2016) (cleaned up). Thus, even when some treatment is provided to an inmate, deliberate indifference can be demonstrated if the treatment "stop[s] short of what is medically necessary." *Edmo v. Corizon, Inc.*, 935 F.3d 757, 794 (9th Cir. 2019) (per curiam).

In 2011, the Seventh Circuit upheld a district court's injunction of a Wisconsin statute that banned both hormone therapy and surgery for inmates suffering from gender dysphoria (referred to in that opinion as gender identity disorder). *Fields*, 653 F.3d at 556. In that case, the plaintiffs were seeking to treat their gender dysphoria with hormones; they were not seeking surgery. In upholding the injunction, the Seventh Circuit stated, "Refusing to provide effective treatment for a serious medical condition serves no valid penological purpose and amounts to torture." *Id.* The Court concluded that the plaintiffs had proven the subjective prong of the deliberate indifference analysis by adducing evidence "that plaintiffs could not be effectively treated without hormones." *Id.*

That case expanded what treatment was deemed to be medically necessary for the treatment of gender dysphoria at that time. When evaluating claims under the Eighth Amendment, the court must consider "'the evolving standards of decency that mark the progress of a maturing society.'" *Rhodes v. Chapman*, 452 U.S. 337, 346 (1981) (quoting *Trop v. Dulles*, 356 U.S. 86, 101 (1958) (plurality opinion)). Since 2011, courts both in and outside the Seventh Circuit have concluded that gender-affirming surgery may be medically necessary to treat inmates with severe gender dysphoria. As the Ninth Circuit explained in affirming a district court's injunction that prison authorities take all steps necessary to provide a plaintiff with gender-affirming surgery:

> We apply the dictates of the Eighth Amendment today in an area of increased social awareness: transgender health care. We are not the first to speak on the subject, nor will we be the last. Our court and others have been considering Eighth Amendment claims brought by transgender prisoners for decades. During that time, the medical community's understanding of what treatments are safe and medically necessary to treat gender dysphoria has changed as more information becomes available, research is undertaken, and experience is gained. The Eighth-Amendment inquiry takes account of that developing understanding.

> We hold that where, as here, the record shows that the medically necessary treatment for a prisoner's gender dysphoria is gender confirmation surgery, and responsible prison officials deny such treatment with full awareness of the prisoner's suffering, those officials violate the Eighth Amendment's prohibition on cruel and unusual punishment.

Edmo, 935 F.3d at 781.

In *Campbell,* the Seventh Circuit concluded that qualified immunity was available to defendants where a prisoner had been denied surgery where there were other alternatives available to the prisoner and not because there was an absolute ban on such surgery. 936 F.3d at 540−41. However, on remand, in deciding the prisoner's injunctive claim, the district court concluded that surgery was in fact medically necessary and ordered that it be provided as "sex reassignment surgery is the only effective treatment" for her "severe unremitting anatomical gender dysphoria." *Campbell v. Kallas*, 2020 WL 7230235, at *6, *8 -*9 (W.D. Wis. Dec. 8, 2020). Other cases in the Seventh Circuit recognize that, if medically necessary, the denial of gender-affirming surgery represents deliberate indifference to a serious medical need. *Monroe v. Meeks,* 584 F. Supp. 3d 643, 680, 685-87 (S.D. Ill. 2022) (granting a preliminary injunction); *Iglesias v. Fed. Bureau of Prisons*, 2021 WL 6112790, *22 (S.D. Ill. Dec. 27, 2021) (granting a preliminary injunction).

In *De'lonta v. Johnson*, 708 F.3d 520, 522 (4th Cir 2013), the court of appeals reversed the dismissal of a transgender prisoner's lawsuit seeking surgery. The court found that although the prison had provided her *some* treatment in the form of hormone treatment, therapy, and some social transitioning, "it does not follow that they have necessarily provided her with *constitutionally adequate* treatment." *Id.* at 526 (emphasis in original).[5]

[5] The only circuit-level case that has approved a blanket denial of gender-affirming surgery for prisoners is *Gibson v. Collier*, 920 F.3d 212, 215 (5th Cir. 2019). That case is of limited utility as the court reached its decision "based on a lack of record evidence," *Campbell*, 936 F.3d at 553 (Wood, C.J., dissenting), and

Like the aforementioned courts, this court readily concludes that Indiana Code § 11-10-3-3.5's blanket denial of access to gender-affirming surgery evinces deliberate indifference because it denies medically necessary care to those inmates suffering from severe forms of gender dysphoria. Notably, IDOC had previously recognized that gender-affirming surgery was medically necessary care for some individuals with gender dysphoria. *See* Dkt. 54-1 at 1, HCSD 2.17A (2022). When IDOC updated the policy in 2024, *see* dkt. 90-2 (HCSD 2.17A (2024)), Commissioner Reagle said the purpose was to "reflect legislation passed by the Indiana General Assembly and signed by the Governor." Dkt. 90-1. That is, it was not because there was a shift in the *medical* community that gender-affirming surgery was not medically necessary care for some people with gender dysphoria. There has been no such shift. Rather, WPATH's Standards of Care continue to recognize that gender-affirming surgery is medically necessary for some individuals with gender dysphoria, including those who are incarcerated. Indiana Code § 11-10-3-3.5 therefore violates the Eighth Amendment as it requires deliberate indifference to what the IDOC has admitted, and the evidence demonstrates, is a serious medical need.

Additionally, Ms. Cordellioné has established by a preponderance of the evidence that she is an individual with gender dysphoria for whom gender-affirming surgery is medically necessary. Thus, she has shown a reasonable probability of success on her Eighth Amendment claim. She has established that IDOC has chosen a less efficacious course of treatment by denying her gender-affirming surgery. Although the treatment IDOC has provided—hormone therapy, psychotherapy, and social transitioning—has afforded Ms. Cordellioné some relief, it has "stopped short" of what is necessary to alleviate her pain and urges to commit self-harm. *Edmo*, 935 F.3d at 794; *Fields*, 653 F.3d at 556.

the record was "devoid of witness testimony of evidence from professionals in the field—compiled by a *pro se* plaintiff," *Edmo*, 955 F.3d at 794 (cleaned up).

Ms. Cordellioné has also shown that she is at a substantial risk of irreparable injury absent injunctive relief. Without the surgery, she is at the risk of engaging in self-harm, either in the form of another attempt to castrate herself or to die by suicide. *See Edmo*, 935 F.3d at 797-98, 800 ("It is no leap to conclude that Edmo's severe, ongoing psychological dress and the high risk of self-castration and suicide she faces absent surgery constitute irreparable harm."). Traditional legal remedies, such as money damages, are insufficient to provide Ms. Cordellioné the medical care she requires. *Orr v. Schicker*, 953 F. 3d 490, 502 (7th Cir. 2020).

In summary, with respect to Ms. Cordellioné's claim, the court concludes that Indiana Code § 11-10-3-3.5 violates the Eighth Amendment insofar as it prohibits medically necessary care for inmates for whom gender-affirming surgery is medically necessary, and Ms. Cordellioné has demonstrated that gender-affirming surgery at the earliest opportunity is medically necessary for her and is the only effective treatment for her condition. The IDOC's denial of surgery to her because of the challenged statute denies her effective and necessary treatment for her serious medical need and represents deliberate indifference to her serious medical need.

The court further finds that the balance of harms weighs in Ms. Cordellioné's favor. The evidence shows that she faces serious risks of severe bodily and psychological harm absent injunctive relief. IDOC would suffer minimal hardship—it would be compelled to provide a form of medical care that it has previously provided, and in doing so, it would uphold its obligation to comply with the Constitution. *United States v. Raines*, 362 U.S. 17, 27 (1960) ("There is the highest public interest in the due observance of all the constitutional provisions.").

D. Ms. Cordellioné's Fourteenth Amendment Claim

The Equal Protection clause of the Fourteenth Amendment provides that "[n]o state shall. . . deny to any person within its jurisdiction the equal protection of the laws." U.S. Const. am XIV.

Both the Seventh Circuit and the Supreme Court have recognized that discrimination based on transgender status is sex discrimination. *Bostock v. Clayton County*, 590 U.S. 644 (2020); *A.C. v. Metro. Sch. Dist. of Martinsville*, 75 F.4th 760, 772 (7th Cir. 2023), *cert. denied*, 144 S. Ct. 683 (2024); *Whitaker ex rel. Whitaker v. Kenosha Unified Sch. Dist. No. 1 Bd. of Educ.,* 858 F.3d 1034, 1051 (7th Cir. 2017), *abrogation on other grounds recognized by Ill. Republican Party v. Pritzker*, 973 F.3d 760 (7th Cir. 2020).

For example, in *Whitaker ex rel. Whitaker*, the Seventh Circuit, in the context of affirming a preliminary injunction, held that a school policy denying a transgender boy the use of boys' restrooms violated equal protection as unlawful sex discrimination. *Id.* at 1051. While cisgender boys were able to use the boys' restrooms, the plaintiff, a transgender boy, was not. This differential treatment represented sex discrimination because "transgender individual[s] do not conform to the sex-based stereotypes of the sex . . . assigned at birth." *Id.* at 1048. In other words, forcing a transgender person to follow rules inconsistent with their gender identity "punishes that individual for his or her gender non-conformance." *Id.* at 1049.

In *Bostock v. Clayton County*, 590 U.S. 644 (2020), the Supreme Court concluded in the context of a Title VII case that discrimination against transgender individuals constituted sex discrimination. The Court reasoned that when "a person identified as male at birth" is penalized "for traits or actions that [are] tolerate[d] in [a person] identified as female at birth," the person's "sex plays an unmistakable" role. *Id*. at 660. Because of that, the Court held, "it is impossible to

discriminate against a person for being . . . transgender without discriminating against that individual based on sex." *Id.*

All sex-based classifications are subject to heightened scrutiny, requiring the government to demonstrate "an exceedingly persuasive justification" for their differential treatment. *United States v. Virginia* ("*VMI*"), 518 U.S. 515, 533 (1996). The government bears the burden of demonstrating that the classification "serves important governmental objectives and that the discriminatory means employed are substantially related to the achievement of those objectives" *Id.* at 524 (quotation and citation omitted). In order to survive this elevated scrutiny, the burden is on IDOC to show a "close means-end fit" between the challenged law and important governmental interests. *Sessions v. Morales-Santana*, 582 U.S. 47, 68 (2017).

Indiana Code § 11-10-3-3.5 violates the Equal Protection Clause because it prevents transgender inmates from accessing medically necessary care while cisgender inmates still have access to such care. In fact, many of the surgeries labelled as prohibited "sexual reassignment surgeries," by Indiana Code § 11-10-3-1(6) are nevertheless available to IDOC prisoners who are not transgender and who have a medical need for them.

In *Kadel v. Folwell*, the Fourth Circuit recognized that allowing certain surgeries for cisgender individuals while classifying them as gender-affirming surgeries that were denied to transgender individuals was "textbook sex discrimination" as "we can determine whether some patients will be eliminated from candidacy for these surgeries solely from knowing their sex assigned at birth" and "conditioning access to these surgeries based on a patient's sex assigned at birth stems from gender stereotypes about how men or women should present." 100 F.4th at 153 (citing *Bostock*, 590 U.S. at 660-74). IDOC counters that cisgender inmates are also unable to access surgeries on healthy tissue. This argument is disingenuous, as the IDOC cites no examples

of what type of surgery a cisgender individual might seek that is *medically* necessary (and not just cosmetic) that is listed in Indiana Code § 11-10-3-1(6). That the statute doesn't call out transgender inmates explicitly does not mean that the statute was not intended to prohibit their access to medical care.

Indiana Code § 11-10-3-3.5 therefore mandates sex discrimination, and the denial of gender-affirming surgery to Ms. Cordellioné represents discrimination on the account of sex and is accordingly subject to heightened scrutiny. *VMI*, 518 U.S. at 533.

IDOC argues that three legitimate interests are served by the statute. "First, the state has an interest in ensuring that the public is kept safe from dangerous prisoners who enter prison with one identity and sex and seek to come out with another identity and sex." Dkt. 94 at 61. This argument is not well taken. IDOC provides transgender inmates with hormones and social transition that change a transgender inmate's outward appearance. An orchiectomy and vaginoplasty do not alter an inmate's outward appearance.

Second, IDOC argues that it has an interest in protecting inmates "from invasive, irreversible, and sterilizing genital surgeries with unknown risks." Dkt. 94 at 62. As the court has discussed at length above, gender-affirming surgery is a medically necessary surgery for some individuals with gender dysphoria, and it has been proven to be a safe and effective treatment.

Finally, IDOC argues that allowing inmates to receive gender-affirming surgery counters the State's interest in prisoner rehabilitation and reintegration into society because it is not clear that an inmate will be able to adjust to his or her new body and successfully reintegrate upon release. This argument is neither persuasive nor supported by evidence. Gender-affirming surgery is necessary for certain gender dysmorphic inmates whose mental health is greatly harmed by the lack of access to surgery.

Thus, the IDOC has failed to carry its burden of demonstrating "the close means-end fit" between Indiana Code § 11-10-3-3.5 and important governmental interests. *Sessions*, 582 U.S. at 68. Ms. Cordellioné is likely to prevail on her claim that the statutory ban on gender-affirming surgery for prisoners, Indiana Code § 11-10-3-3.5, violates equal protection both on its face and as applied to her. As the court has weighed why the factors favor granting injunctive relief to Ms. Cordellioné as to her Eighth Amendment claim, it need not repeat them here.

E. Terms of the Preliminary Injunction

Ms. Cordellioné has shown that injunctive relief is necessary. Despite the language of Federal Rule of Civil Procedure that specifies that a preliminary injunction will not issue without a bond, "[u]nder appropriate circumstances bond may be excused, notwithstanding the literal language of Rule 65(c). Indigence is such a circumstance." *Wayne Chemical, Inc. v. Columbus Agency Serv. Corp.*, 567 F.2d 692, 701 (7th Cir. 1977). Ms. Cordellioné is an indigent person, dkt. 39-1 at 5, and the IDOC has not requested the posting of a bond. Therefore, the injunction will issue without any bond.

The PLRA requires that injunctive relief must be narrowly drawn and the least intrusive means to correct a constitutional harm. 18 U.S.C. § 3626(a)(2). Moreover, 18 U.S.C. § 3626(a)(2) provides that any preliminary injunction automatically expires 90 days after its entry unless the Court makes findings that it continues to meet the standards set out in 18 U.S.C. § 3626(a)(1) for prospective relief, namely "that such relief is narrowly drawn, extends no further than necessary to correct the violation of the Federal right, and is the least intrusive means necessary to correct the violation of the Federal right." In making this determination, "the court shall give substantial weight to any adverse impact on public safety or the operation of a criminal justice system caused by the relief."

Any prospective relief, whether permanent or preliminary, must respect the principles of comity set by 18 U.S.C. § 3626(a)(1)(B), which provides that:

> [t]he court shall not order any prospective relief that requires or permits a government official to exceed his or her authority under State or local law or otherwise violates State or local law, unless --
>
> (i) Federal law permits such relief to be ordered in violation of State or local law;
>
> (ii) the relief is necessary to correct the violation of a Federal right; and
>
> (iii) no other relief will correct the violation of the Federal right.

As the Court noted in *Norsworthy v. Beard*, 87 F. Supp.3d 1164 (N.D. Cal. 2015), in granting a preliminary injunction order that the plaintiff prisoner receive gender-affirming surgery (referred to in the decision as SRS for "sex reassignment surgery"), the plaintiff

> has established that she is likely to succeed on the merits of her Eighth Amendment claim, that she is likely to suffer irreparable harm without an injunction, that the balance of the equities tips in her favor, and that an injunction is in the public interest. An injunction granting her access to adequate medical care, including referral to a qualified surgeon for SRS, is narrowly drawn, extends no further than necessary to correct the constitutional violation, and is the least intrusive means necessary to correct the violation. See 18 U.S.C. § 3626. There is no evidence that granting this relief will have "any adverse impact on public safety or the operation of the criminal justice system." 18 U.S.C. § 3626(a)(2).

Id. at 1194-95.

The same is true here. Inasmuch as Ms. Cordellioné has received a full evaluation of her need for gender-affirming surgery from Dr. Ettner and inasmuch as surgery is medically necessary to alleviate the serious and debilitating symptoms of her gender dysphoria, it is appropriate for the court to order at this point that this surgery be provided to her at the earliest opportunity. This relief is narrowly drawn, extends no further than necessary to correct the violation of Ms. Cordellioné's constitutional rights, and is the least intrusive means available and necessary to correct this ongoing violation. There is no evidence that this preliminary injunction

will have any adverse impact on either public safety or the operation of the criminal justice system.

The court understands that the surgery may take time as it will be provided by a surgeon who is not affiliated with either IDOC or its contracted medical provider. It is therefore the court's intention, given 18 U.S.C. § 3626(a)(2), to renew this preliminary injunction every 90 days until the surgery is provided.

IV. Conclusion

For the foregoing reasons, Ms. Cordellioné's motion in limine, dkt. [60], is **granted in part and denied in part**. Ms. Cordellioné's motion for preliminary injunction, dkt. [10], is **granted**. Pursuant to Federal Rule of Civil Procedure 65(d)(1) and *MillerCoors LLC v. Anheuser-Busch Cos.*, 940 F.3d 922 (7th Cir. 2019), the court will enter the terms of the preliminary injunction set forth in a separate document.

IT IS SO ORDERED.

Date: September 17, 2024

RICHARD L. YOUNG, JUDGE
United States District Court
Southern District of Indiana

Distribution:

All ECF-registered counsel of record

CERTIFICATE OF SERVICE

I hereby certify that on January 21, 2025, I electronically filed the foregoing with the Clerk of the Court for the United States Court of Appeals for the Seventh Circuit by using the CM/ECF system. I certify that all participants in the case are registered CM/ECF users and that service will be accomplished by the CM/ECF system.

s/Jenna M. Lorence
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CERTIFICATE OF SERVICE

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January 21, 2025

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