No. 25-6813

IN THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

EMALEE R. WAGONER,

Plaintiff-Appellee,

v.

JENNIFER WINKELMAN, Commissioner of Alaska Department of Corrections,

Defendant-Appellant,

ON APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF ALASKA

BRIEF OF GLMA: HEALTH PROFESSIONALS ADVANCING LGBTQ+ EQUALITY AS *AMICUS CURIAE* IN SUPPORT OF PLAINTIFF-APPELLEE EMALEE R. WAGONER

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RULE 26.1 CORPORATE DISCLOSURE STATEMENT

Amicus Curiae GLMA: Health Professionals Advancing LGBTQ+ Equality hereby states that it has no parent corporation and there is no publicly held corporation that owns 10% or more of their stock.

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INTEREST OF THE *AMICUS CURIAE*

Amicus curiae American Association of Physicians for Human Rights, Inc., d/b/a GLMA: Health Professionals Advancing LGBTQ+ Equality ("GLMA") is the world's largest and oldest association of lesbian, gay, bisexual, transgender, queer or questioning, and additional gender identities and sexual orientations ("LGBTQ+") health care professionals. GLMA is a 501(c)(3) national membership nonprofit incorporated in California and headquartered in Washington, D.C. Its mission is to ensure health equity for lesbian, gay, bisexual, transgender, and queer individuals and to secure equality for LGBTQ+ health professionals in their work and learning environments. To advance that mission, GLMA draws on the scientific expertise of its multidisciplinary membership to inform advocacy, education, and research.

GLMA represents the interests of tens of thousands of LGBTQ+ and allied health professionals and the millions of LGBTQ+ patients and families they serve. Its membership of approximately 1,000 includes physicians, nurses, physician assistants, researchers, behavioral health specialists, health-profession students, and other health professionals practicing across the United States and abroad in disciplines including endocrinology, internal medicine, family practice, psychiatry, obstetrics and gynecology, emergency medicine, neurology, and infectious diseases.

GLMA has a direct and substantial interest in the questions presented by this appeal. Its members include health professionals who provide medical care to transgender patients with gender dysphoria, including those who are incarcerated.

All parties consented to the filing of this brief, and GLMA is therefore permitted to file under Rule 29(a)(2) of the Federal Rules of Appellate Procedure. Pursuant to Federal Rules of Appellate Procedure 29(a)(4)(E), GLMA states that no party's counsel authored this brief, and no party, party's counsel, or anyone other than amicus curiae funded its preparation or submission.

INTRODUCTION

This appeal concerns whether the Alaska Department of Corrections ("DOC") may refuse to provide gender-affirming genital surgery to an incarcerated person. After a five-day bench trial, the district court concluded that the Alaska DOC acted with deliberate indifference to Ms. Wagoner's serious medical need in violation of the Eighth Amendment. GLMA: Health Professionals Advancing LGBTQ+ Equality writes as an organization of physicians, mental health clinicians, and other health professionals to confirm that the district court's conclusion rests on settled medical science.

Gender dysphoria is a serious, diagnosable medical condition, and the medical profession has reached a consensus, reflected in clinical guidelines, that it is treated through individualized, evidence-based gender-affirming care. For many adults, that care includes hormone therapy; for some, it includes surgery, including genital surgery, or both. Appellant's effort to recast this established field of medicine as experimental or unsettled is not supported by the clinical literature. Gender-affirming hormone therapy and surgery are safe and effective treatments for gender dysphoria in adults, grounded in decades of clinical studies, the leading clinical practice guidelines, and epidemiological data. The studies used to suggest otherwise do not show that gender-affirming care harms patients. Indeed, the studies fail to make clinically correct analysis and comparisons. Read in light of their design and

purpose, they show that the patients who seek care tend to have a larger baseline of distress—fully consistent with the effectiveness of the care they receive.

Nothing about incarceration alters this analysis. The governing standards of care apply with equal force inside a correctional facility, as the leading professional organizations and this Court have recognized. *See Edmo v. Corizon, Inc.*, 935 F.3d 757 (9th Cir. 2019). When correctional authorities fail to provide individualized care or withhold medically necessary gender-affirming care, the resulting harm—worsening dysphoria, depression, suicidality, and acts of surgical self-treatment—is severe, well documented, and preventable. The record in this case reflects precisely those harms.

The district court's findings are in line with the medical consensus, the applicable standards of care, and this Court's precedent, and they should be affirmed.

ARGUMENT

I. What It Means to Experience Gender Dysphoria.

Gender identity refers to a person's innate sense of oneself as being a particular gender. Am. Psychological Ass'n, *Guidelines for Psychological Practice with Transgender and Gender Nonconforming People*, 70(9) American Psychologist 832, 834 (2015). Most people are "cisgender," meaning that their gender identity aligns with their sex assigned at birth—*i.e.*, the designation of sex typically noted on a person's birth certificate shortly after birth (or during ultrasound), which is often

based on the appearance of the newborn's external genitalia. *Id.* at 861–62. Transgender people, on the other hand, have a gender identity that does not align with their sex assigned at birth. *Id.* at 863. Leading medical authorities recognize that gender identity has a durable biological basis and is not subject to voluntary change. *See* Katherine A. O'Hanlan et al., *Biological origins of sexual orientation and gender identity: Impact on health*, 149 Gynecologic Oncology 33 (2018); Endocrine Soc'y, Transgender Health: An Endocrine Society Position Statement (2020), https://www.endocrine.org/advocacy/position-statements/transgender-health.

There is broad recognition in the medical community that transgender status is a "normal variation[] of human identity and expression." *See, e.g.*, Letter from James L. Madara, CEO, Executive Vice President, AMA, to Bill McBride, Executive Director, Nat'l Governors Ass'n (Apr. 26, 2021), https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2F2021-4-26-Bill-McBride-opposing-anti-trans-bills-Final.pdf

Many transgender people, however, experience gender dysphoria, a formal diagnosis under the American Psychiatric Association's Diagnostic and Statistical Manual (DSM-5-TR). *See* Am. Psychiatric Ass'n, *Diagnostic and Statistical Manual of Mental Disorders: DSM-5-TR* at 512–20 (2022). This serious medical condition is characterized by clinically significant distress or functional impairment—including

in social, occupational, and other important life contexts—in a patient, caused by a marked incongruence between that patient's experienced or expressed gender and their sex assigned at birth. Am. Psychological Ass'n, *Guidelines for Psychological Practice with Transgender and Gender Nonconforming People*, 861 (2015).

A. The Diagnostic Criteria for and Seriousness of Gender Dysphoria.

Per the DSM-5, gender dysphoria is appropriately diagnosed when a patient experiences a marked incongruence between their experienced or expressed gender and sex assigned at birth, for at least six months, as manifested by at least two of the following criteria: (1) a marked incongruence between the patient's experienced or expressed gender and primary and/or secondary sex characteristics; (2) a strong desire on the part of the patient to be rid of their primary and/or secondary sex characteristics because of said marked incongruence; (3) a strong desire for the primary and/or secondary sex characteristics of a gender different from the patient's assigned gender; (4) a strong desire to be of a gender different from the patient's assigned gender; (5) a strong desire to be treated as a gender different from the patient's assigned gender; (6) a strong conviction on the part of the patient that they have the typical feelings and reactions of a gender different from the patient's assigned gender. Am. Psychiatric Ass'n, *Diagnostic and Statistical Manual of Mental Disorders: DSM-5-TR* at 512–13 (2022). In addition, diagnosis requires that

such marked incongruence is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning. *Id.*

Gender dysphoria requires individualized treatment. While mental health conditions like anxiety and depression often are comorbid and overlap with gender dysphoria, gender dysphoria is itself a separate condition requiring a discrete form of treatment. Am. Psychiatric Ass'n, *A Guide for Working With Transgender and Gender Nonconforming Patients* (2017), https://www.psychiatry.org/psychiatrists/diversity/education/transgender-and-gender-nonconforming-patients/gender-dysphoria-diagnosis ("There are no studies indicating that psychiatric illness causes gender dysphoria as a consistent condition over time."); Am. Psychological Ass'n, *Guidelines for Psychological Practice with Transgender and Gender Nonconforming People*, 845–46 ("[P]sychologists are encouraged to neither ignore mental health problems a [transgender] person is experiencing, nor erroneously assume that those mental health problems are a result of the person's gender identity or gender expression.").

B. The Accepted Treatment Protocols for Gender Dysphoria.

The professional medical community agrees that the appropriate treatment for gender dysphoria is gender-affirming care, a comprehensive, multidisciplinary therapeutic approach consisting largely of bringing the patient's social interactions, appearance, expression, and body into closer alignment with the patient's gender

identity. Wylie C. Hembree et al., *Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline*, 102 J. Clin. Endocrinology & Metabolism 3869, 3875 (2017) (hereinafter "Endocrine Soc'y Guidelines"). Gender-affirming care is effective in alleviating the distress associated with gender dysphoria. *See generally Endocrine Soc'y* Guidelines.

Gender-affirming care may involve social transition, non-surgical voice therapy, hormone therapy with estrogen or testosterone, and a wide variety of surgical treatment. *See generally id.*

1. Treatment is Individualized.

The medical community agrees that gender-affirming care is not a "one-size-fits-all" methodology; it is a highly individualized approach, with different forms of care for each patient depending on that patient's needs. Liem Snyder et al., *WPATH Standards of Care 8: Update for Urology*, AUA News (Feb. 2023), https://auanews.net/issues/articles/2023/february-2023/world-professional-association-for-transgender-health-standards-of-care-8-update-for-urology; Eli Coleman et al., *Standards of Care for the Health of Transgender and Gender Diverse People, Version 8*, 23 Int'l J. Transgender Health S1 (2022). Gender-affirming care may thus consist of any combination of treatments—*e.g.*, social transitioning, hormone therapy, surgical operations, and/or other forms of treatment—none

requiring any other. One patient may require hormone therapy but not surgery, while another may require surgery but not hormone therapy.

2. The Guidelines for Treatment of Gender Dysphoria Underwent Robust, Thorough Deliberation of the Same Scientific Rigor Underlying Other Medical Guidelines.

The leading clinical practice guidelines—principally the World Professional Association for Transgender Health's Standards of Care for the Health of Transgender and Gender Diverse People, Version 8 (SOC-8) and the Endocrine Society's Guidelines —were developed through systematic review of the evidence by the relevant medical specialties and recognize hormonal and surgical interventions alike as established treatments for patients whose dysphoria indicates them. World Prof'l Ass'n for Transgender Health, *Standards of Care for the Health of Transgender and Gender Diverse People* (8th Version, 2022), https://doi.org/10.1080/26895269.2022.2100644 (hereinafter "WPATH SOC"); Endocrine Soc'y Guidelines at 3885–95.

These guidelines were developed by clinicians and researchers with years of experience treating gender dysphoria. They are thus the product of thorough, exacting deliberation, following the same methods and subject to the same evidentiary requirements as guidelines in other areas of medicine, such as cancer, cardiovascular disease, and diabetes.

The Endocrine Society developed their guidelines by imposing strict evidentiary conditions predicated on the Grading of Recommendations Assessment, Development and Evaluation (GRADE) system, an internationally recognized framework for evaluating scientific evidence. *See* Endocrine Soc'y Guidelines at 3872–73; Gordon Guyatt et al., *GRADE Guidelines: 1. Introduction - GRADE Evidence Profiles and Summary of Findings Tables*, 64 J. Clinical Epidemiology 383 (2011). That GRADE assessment then underwent three separate reviews by independent groups of professionals. *Endocrine Society Guidelines Methodology*, Practice Guidelines, https://www.endocrine.org/clinical-practice-guidelines/methodology.

The WPATH Standards of Care, first published in 1979 and currently in their 8th edition, were developed across a thorough drafting, comment, and review process over five years. WPATH SOC at S247–51. Researchers reviewed the draft guidelines vigorously, and WPATH opened the draft guidelines for public discussion and debate, a process that elicited over 2,500 comments. *See id.* The final draft of the guidelines involved nearly 120 scientific authors and included feedback from experts in the field. *See id.* WPATH formally approved each recommendation in the guidelines using the Delphi process, one of the widely used and endorsed development processes for clinical practice guidelines in the medical context. *See*

id.; *see* National Academy of Sciences, *Clinical Practice Guidelines We Can Trust* at 88 (2011), https://www.ncbi.nlm.nih.gov/books/NBK209539/.

II. Gender-Affirming Medical Care for Adults Is Safe and Effective.

The medical question at the heart of this appeal remains well established within medicine: gender-affirming care, including hormone and surgical care, is a safe and effective treatment for gender dysphoria in adults. As WPATH SOC explains, "[t]here is strong evidence demonstrating the benefits in quality of life and well-being of gender-affirming treatments, including endocrine and surgical procedures, properly indicated and performed as outlined by the Standards of Care." WPATH SOC at S18. Precisely because these interventions "are based on decades of clinical experience and research," they "are not considered experimental, cosmetic, or for the mere convenience of a patient." WPATH SOC at S18. This care is fundamentally individualized. For adults for whom it is indicated, gender-affirming surgery, including gender-affirming genital surgery, is a recognized and effective means of relieving the clinically significant distress that defines gender dysphoria. WPATH SOC at S128, S130.

A. Hormone Therapy Is an Established and Effective Treatment.

Hormone therapy is among the most well-established treatments in gender-affirming medicine, with a clinical history spanning decades and a foundation in detailed, evidence-based practice guidelines. WPATH SOC at S18. Its use is

supported by the two most authoritative clinical guidelines in the field—WPATH's Standards of Care and the Endocrine Society's Clinical Practice Guideline—both of which provide detailed, evidence-based protocols for its administration. It reflects the multidisciplinary judgment of the medical specialties responsible for treating gender dysphoria. WPATH SOC; Endocrine Soc'y Guidelines at 3888.

Hormone therapy works to treat gender dysphoria by bringing a patient's secondary sex characteristics into alignment with their gender identity. Endocrine Soc'y Guidelines at 3885–86. As WPATH explains, "there is no one-size-fits-all approach and [transgender and gender diverse] people may need to undergo all, some, or none of these interventions to support their gender affirmation." WPATH SOC at S7. These regimens are individualized to each patient and adjusted over time. Endocrine Soc'y Guidelines at 3888–89 ("Tailoring current protocols to the individual may be done within the context of accepted safety guidelines using a multidisciplinary approach").

The therapeutic benefits of hormone therapy are well documented. Ankit Rastogi et al., *Health and Wellbeing: A Report of the 2022 U.S. Transgender Survey,* Advocates for Transgender Equality 7 (2025), https://transequality.org/sites/default/files/2025-06/USTS_2022Health%26WellbeingReport_WEB.pdf. (98% of respondents who were on gender-affirming hormone therapy "were more satisfied with their lives.")

By reducing the incongruence between a patient's body and gender identity, hormone therapy directly relieves the distress that characterizes gender dysphoria, and it is associated with measurable improvements in psychological functioning, including reductions in depression and anxiety and gains in overall quality of life. Joshua D. Safer and Vin Tangpricha, *Care of the Transgender Patient*, 171 Annals of Internal Medicine 1 (2019)*; see also* WPATH SOC at S111, S126; Endocrine Soc'y Guidelines at 3885-89. WPATH SOC accordingly recommends that health care professionals "initiate and continue gender-affirming hormone therapy for eligible transgender and gender diverse people who require this treatment due to demonstrated improvement in psychosocial functioning and quality of life." WPATH SOC at S111. It also recognizes that "withholding hormone therapy based on the presence of depression or suicidality may cause harm." WPATH SOC at S126.

The safety profile of hormone therapy is likewise well characterized. The risks are known, monitorable, and broadly comparable to those of hormone treatments prescribed for other widely accepted indications. The Endocrine Society recommends regular clinical evaluation and laboratory monitoring of sex steroid hormone levels during the first year of treatment and periodically thereafter, including assessments of cardiovascular risk factors, bone density, and the impact upon reproductive organs. Endocrine Soc'y Guidelines at 3889. As the guideline

explains, "[h]ormone therapy for transgender males and females confers many of the same risks associated with sex hormone replacement therapy in nontransgender persons," and those risks are managed through the same routine clinical oversight—pretreatment screening and appropriate regular medical monitoring. Endocrine Soc'y Guidelines at 3889.

B. Surgical Care, Including Gender-Affirming Genital Surgery, Is a Recognized, Safe, and Effective Treatment for Adults.

Gender-affirming surgery is also a recognized medical treatment for gender dysphoria in adults. Endocrine Soc'y Guidelines at 3893. WPATH SOC defines medically necessary gender-affirming surgery as "a constellation of procedures designed to align a person's body with their gender identity," and organizes the medically necessary procedures into three regions: the face, the chest or breasts, and the genitalia. WPATH SOC at S125, S128. Genital procedures recognized by WPATH SOC include vaginoplasty, vulvoplasty, metoidioplasty, phalloplasty, orchiectomy, and hysterectomy, among others. *Id.* at S18. These are evidence-based treatment options, and WPATH SOC confirms that "[i]n appropriately selected TGD individuals, the current literature supports the benefits of GAS." *Id.* at S128.

This care is individualized rather than sequential: a patient need not exhaust hormone therapy and "graduate" to surgery, because the medically appropriate intervention is simply the one that addresses the particular patient's dysphoria. WPATH SOC at S7, S86; *see also* Titia F. Beek et al., *Partial Treatment Requests*

and Underlying Motives of Applicants for Gender Affirming Interventions, 12 J. Sexual Med. 2201 (2015). WPATH SOC reflects this through a rigorous, patient-specific assessment process. Before recommending surgery, clinicians consider a "TGD person's unique anatomic, social, or psychological situation[.]" WPATH SOC at S6, S256. Under WPATH SOC-8, the assessment criteria for gender-affirming surgical surgery include: (1) the patient's marked and sustained gender incongruence; (2) the diagnostic criteria for gender incongruence prior to surgical intervention; (3) the patient's capacity to consent to the specific surgical intervention; (4) other possible causes of apparent gender incongruence; (5) any mental or physical health conditions that could negatively impact the outcome of the surgical intervention, with risks and benefits discussed; and (6) the patient's stability on their gender-affirming hormonal treatment regimen. *Id.* at S256 (stating the guidelines "are intended to be flexible in order to meet the diverse health care needs of TGD people" and that "individual health care professionals and programs, in consultation with the TGD person, may modify them"). For many adults, gender-affirming genital surgery is a medically necessary intervention, and the resolution of bodily incongruence it achieves is, for those patients, a safe and effective treatment for their condition. Christienne Javier et al., *Surgical Satisfaction and Quality of Life Outcomes Reported by Transgender Men and Women at Least One Year Post Gender-Affirming Surgery: A Systematic Literature Review*, 23 Int'l J. Transgender

Health (2022); Bao Ngoc N. Tran et al., *Gender Affirmation Surgery: A Synopsis Using American College of Surgeons National Surgery Quality Improvement Program and National Inpatient Sample Databases*, 80 Annals of Plastic Surgery S229, S234 (2018); Jordan D. Frey et al., *A Historical Review of Gender-Affirming Medicine: Focus on Genital Reconstruction Surgery*, 14 J. Sexual Med. 991, 991 (2017); Mehrdad Eftekhar Ardebili et al., *Quality of Life in People with Transsexuality After Surgery: A Systematic Review and Meta-Analysis*, 18 Health & Quality of Life Outcomes 264 (2020).

The recognition of surgical care rests on clinical evidence, not merely on professional consensus. WPATH SOC at S18, S128; Endocrine Soc'y Guidelines at 3893; Frey, *A Historical Review*; Tran, *Gender Affirmation Surgery* at S229, S234. Qualitative research with patients who seek gender-affirming care describes the experience of obtaining it as "coming home to my body," capturing the profound resolution of incongruence that the treatment provides. Teddy G. Goetz and Amanda C. Arcomano, *"Coming Home to My Body": A Qualitative Exploration of Gender-Affirming Care-Seeking and Mental Health*, 27(4) J Gay Lesbian Ment Health 380, 392 (2023). Population-level data point in the same direction, with large surveys of transgender adults documenting improved health and well-being following access to the care they need. Chantal M. Wiepjes et al., *The Amsterdam Cohort of Gender*

Dysphoria Study (1972–2015): Trends in Prevalence, Treatment, and Regrets, 15 J. Sexual Med. 582 (2018); Rastogi, *Health and Wellbeing* at 50.

C. The Primary Treatment Goal is to Relieve Gender Dysphoria, With Potential Secondary Mental-Health Benefits.

The purpose of gender-affirming surgery is to treat gender dysphoria—the clinically significant distress that arises from the incongruence between a person's experienced gender and their sex characteristics. WPATH SOC at S128. Consistent with that purpose, WPATH SOC reports that "[g]ender-affirming surgical procedures have been shown to relieve symptoms of gender dysphoria and improve mental health." WPATH SOC at S173; Ashli A. Owen-Smith et al., *Association Between Gender Confirmation Treatments and Perceived Gender Congruence, Body Image Satisfaction, and Mental Health in a Cohort of Transgender Individuals*, 15 J. Sexual Med. 591 (2018); Tim C. Van de Grift et al., *Effects of Medical Interventions on Gender Dysphoria and Body Image: A Follow-Up Study*, 79 Psychosomatic Med. 815 (2017). The relief of co-occurring conditions such as depression and anxiety is a potential *secondary* benefit of resolving that dysphoria; it is not the treatment's primary indication or purpose. Walter Pierre Bouman et al., *Transgender and Anxiety: A Comparative Study Between Transgender People and the General Population*, 18 Int'l J. Transgenderism 16 (2016); Gunter Heylens et al., *Psychiatric Characteristics in Transsexual Individuals: Multicentre Study in Four European Countries*, 204 Brit. J. Psychiatry 151 (2014); Gemma L. Witcomb et al.,

Levels of Depression in Transgender People and Its Predictors: Results of a Large Matched Control Study with Transgender People Accessing Clinical Services, 235 J. Affective Disorders 308 (2018); Laurence Claes et al., *Non-Suicidal Self-Injury in Transsexualism: Associations with Psychological Symptoms, Victimization, Interpersonal Functioning and Perceived Social Support*, 12 J. Sexual Med. 168 (2015). Gender-affirming care is not prescribed as a freestanding cure for suicidality, depression, or other conditions. Each of these other conditions have their own independent root causes. And they each have their own individualized methods of treatment. Evaluating gender-affirming care by whether it eliminates every co-occurring psychiatric symptom therefore misunderstands what the treatment is designed to do. WPATH SOC at S36–37.

1. The Few Studies Reporting Continuing Mental Health Concerns Following Surgery Are Frequently Misread.

Studies reporting elevated rates of depression or anxiety among individuals who have undergone gender-affirming surgery do not show that surgery causes those outcomes. Those studies typically compare transgender individuals who received surgical care with cisgender populations, or with transgender individuals who did not undergo surgery, even if they did not need or desire surgery—not with transgender individuals with comparable dysphoria who *needed* or *desired* indicated surgical care. As such, the studies lack the apples-to-apples comparison to evaluate or quantify any adverse post-surgical outcomes. Joshua E. Lewis et al., *Examining*

Gender-Specific Mental Health Risks after Gender-Affirming Surgery: A National Database Study, 22 J. Sexual Med. 645 (2025); Cecilia Dhejne et al., *Long-Term Follow-Up of Transsexual Persons Undergoing Sex Reassignment Surgery: Cohort Study in Sweden* 6 PLoS One e16885 (2011) (excluding trans individuals who were denied surgery from the study); Anthony N. Almazan et al., *Association Between Gender-Affirming Surgeries and Mental Health Outcomes* 156 JAMA Surg. 611 (2021) (control group consisted of individuals who expressed a desire for surgery but had not yet received it, not individuals who were *denied* surgical care). Only a comparison between transgender individuals with comparable dysphoria who *received* and who did not receive indicated surgical care could support a claim that surgery worsens mental-health outcomes. It is precisely this comparison that these mischaracterized studies do not make. Finding elevated rates of mental health conditions in a post-surgical cohort, measured against a comparison group that never sought surgery at all, reveals nothing about whether surgery helped or harmed the patients who received it. As one study found there is "no increased risk of body dysmorphic disorder following surgery, suggesting that these individuals generally experience satisfaction with their body image and surgical outcomes." Lewis, *Examining Gender-Specific Mental Health.* at 648.

Patients who seek and obtain gender-affirming surgery are, as a group, those experiencing the most severe and persistent dysphoria—precisely the population one

would expect to carry a heavier baseline burden of depression and anxiety. That is exactly what the Lewis study found, "Transgender individuals . . . face a heightened risk of psychological distress and related challenges, including suicidal tendencies." Lewis, *Examining Gender-Specific Mental Health*, at 645. But none of the mischaracterized studies account for pre-surgery diagnoses beyond gender dysphoria. Indeed, notwithstanding such critical omission, the Lewis study used the fact that transgender individuals experienced mental health issues post-surgery to conclude that surgery negatively impacted mental health without even knowing if these patients had pre-existing mental health issues. *Id.* at 649 (The data set "restricts patient-level linkage for multiple diagnoses or tracking individual health trajectories, which limits [the study's] ability to perform true longitudinal or within-person analyses.") The Lewis study's failure to conduct a longitudinal analysis of changes in mental health from pre- to post-surgery makes the study an unreliable source for the impact of surgery on mental health.

These studies also do not account for a lack of access to mental health care post operation. Lewis, *Examining Gender-Specific Mental Health*; Dhejne, *Long-Term Follow-up*; Almazan, *Association Between Gender-Affirming Surgeries*. Many transgender people do not receive any continuing mental healthcare after surgery. *See* Maeghan B. Ross et al., *Voices from a Multidisciplinary Healthcare Center: Understanding Barriers in Gender-Affirming Care — A Qualitative*

Exploration, 20 Int'l J. Envtl. Res. & Pub. Health 6367 (2023). "Of the participants who had received gender-affirming surgeries, all reported that the mental health check-ups ceased post-operatively." *Id.* The studies do not account for the discontinuation of mental health care and the resulting harm. These data limitations undermine any use of these studies to assert that surgery is associated with adverse mental health outcomes. In any event, co-occurring mental health conditions in transgender individuals, whether or not they have had surgery, are unsurprising. The medical literature recognizes that stigma contributes to the psychological distress many transgender individuals face and that many suffer from mental health conditions beyond gender dysphoria. *Id.* at 6367; Bouman, *Transgender and Anxiety;* Heylens, *Psychiatric Characteristics;* Witcomb, *Levels of Depression;* Claes, *Non-Suicidal Self-Injury*.

2. Providers Individualize Care by Weighing All the Science and the Specific Patient.

The medical literature, in context, supports individualized clinical judgment rather than the categorical denial of surgical care. Treating providers do not determine care by extracting decontextualized statistics from database studies and applying them uniformly to every patient. They weigh the full body of scientific evidence together with the specific needs, history, presentation of the individual patient, and their own clinical experience. WPATH SOC embodies exactly this approach, directing that the surgeon and patient "participate in a shared decision-

making approach" encompassing the patient's goals and expectations, a discussion of surgical options and associated risks and benefits, and an informed plan for aftercare, all "designed to facilitate an individualized approach to care." WPATH SOC at S130. That is how the established guidelines instruct clinicians to proceed, and it is why the same body of evidence can yield hormone therapy for one patient, surgery for another, and both for a third.

To declare an entire field of established adult care "unsettled" on the basis of a single correlational study and a set of complication rates is not how medicine evaluates the safety and effectiveness of a treatment. The weight of the adult clinical evidence—reflected in SOC-8 and the other leading clinical practice guidelines, the experiences reported by patients themselves, and population-level health data—establishes that hormone therapy and gender-affirming surgical care are safe and effective treatments for gender dysphoria in adults. Read in light of their design and purpose, the studies concerning surgical complications and post-operative mental health are fully consistent with that conclusion, not contrary to it.

III. Denying Appropriate Treatment to Incarcerated Transgender Individuals Endangers Their Health, Safety, and Well-Being.

The district court found that the Alaska DOC violated the Eighth Amendment when it acted with deliberate indifference to Ms. Wagoner's serious medical need for gender-affirming genital surgery. That holding is supported by two settled principles. First, the established medical standards governing the treatment of

gender dysphoria apply with equal force in correctional settings, so incarceration does not diminish a transgender individual's right to medically necessary, individualized gender-affirming care. Second, there are serious, well-documented harms that follow when such care is withheld, and these harms are only heightened by confinement. Because the district court's findings reflect these principles—and the medical consensus, standards of care, and this Court's precedent that underlie them—they should be affirmed.

A. The Standards for Gender-Affirming Genital Surgery Apply Fully in the Correctional Context.

The correctional context, while presenting unique challenges for transgender individuals, does not alter the medical standards governing the treatment of gender dysphoria. U.S. Const. amend. VIII. The widely accepted treatment protocols discussed above—including, when medically necessary, gender-affirming genital surgery—apply with equal force to individuals in correctional institutions. This principle is firmly established in the standards of care, endorsed by the leading professional organizations, and recognized by this Court.

WPATH's Standards of Care unequivocally recommend that health care professionals responsible for providing gender-affirming care to individuals residing in institutions "recognize [that] the entire list of recommendations of the SOC-8[] apply equally to [TGD] people living in institutions." WPATH SOC, Statement 11.1. All people "should have access to these medically necessary treatments irrespective

of their housing situation within an institution." *Id.* at S104. The Standards specifically recommend that staff and professionals charged with providing health care to transgender individuals living in institutions "recommend and support gender-affirming surgical treatments in accordance with the SOC-8 when sought by the individual, without undue delay." *Id.*; Statement 11.4.

As discussed in Section II above, the criteria for gender-affirming genital surgery requires an individualized assessment. These are clinical criteria, designed to ensure appropriate patient care. They are not altered, nor should they be, by the fact that a patient resides in a correctional facility. In fact, transgender inmates are often subjected to harassment and violence, and denied the autonomy to manage their transition. *See* WPATH SOC at S108 (noting transgender individuals in carceral settings "are far more likely than other prisoners to be sexually harassed, assaulted, or both"). Under such circumstances, the need for appropriate medical intervention, including surgery when indicated, may be even greater.

The principle that incarceration should not alter a patient's access to medically indicated care is rooted in health care ethics and the recognition that incarcerated individuals, who cannot secure care on their own, must be supported in receiving the standard of care. *See Estelle v. Gamble*, 429 U.S. 97, 103 (1976) ("An inmate must rely on prison authorities to treat his medical needs…indifference is manifested by prison doctors in their response to the prisoner's needs or by prison guards in

intentionally denying or delaying access to medical care or intentionally interfering with the treatment once prescribed."). As the WPATH Standards of Care explain, "[c]are for an institutionalized person must consider the individual does not have the access that non-institutionalized persons have to securing care on their own. For that reason, institutionalized persons must be supported in being able to receive the Standards of Care established by the World Professional Association for Transgender Health." WPATH SOC at S104.

Moreover, individualized care, without restrictions due to housing, is a fundamental principle of the medical profession. Treatment for gender dysphoria "is not one-size-fits-all; rather, it is tailored to meet each patient's medical needs through individualized determinations made with a patient's team of health care providers in accordance with accepted, evidence-based standards of care." Caleb Smith & Haley Norris, *Transgender Medical Care: What You Should Know and How To Preserve Access to Care*, Center for American Progress (2024), https://www.americanprogress.org/article/transgender-medical-care-what-you-should-know-and-how-to-preserve-access-to-care/. Healthcare providers themselves identify individualized, patient-centered decision-making as central to delivering this care well. Kodiak Ray Sung Soled et al., *Interdisciplinary Clinicians' Attitudes, Challenges, and Success Strategies in Providing Care to Transgender People: A Qualitative Descriptive Study*, 22 BMC Health Servs. Rsch. 1134, 9–11

(2022); *see also* Nat'l Comm'n on Corr. Health Care, *Transgender and Gender Diverse Health Care in Correctional Settings* (2020), https://ncchc.org/wp-content/uploads/Transgender-and-Gender-Diverse-Health-Care-in-Correctional-Settings-2020.pdf. Thus, denying surgery to an incarcerated patient for whom it is clinically indicated—because of their housing or incarceration—departs from both the ethical considerations of medicine and the individualized standard that governs the treatment of gender dysphoria everywhere else.

The Ninth Circuit has upheld these principles. In *Edmo v. Corizon, Inc.*, this Court held that "the broad medical consensus in the area of transgender health care requires providers to individually diagnose, assess, and treat individuals' gender dysphoria, including for those individuals in institutionalized environments. Treatment can and should include GCS when medically necessary." 935 F.3d 757, 771, 803 (9th Cir. 2019); *see also Jett v. Penner*, 439 F.3d 1091 (9th Cir. 2006) (stating that deliberate indifference may appear where officials deny, delay, or interfere with medically indicated treatment); *Colwell v. Bannister*, 763 F.3d 1060 (9th Cir. 2014) (holding that categorical denial of medically necessary care under a prison policy may constitute deliberate indifference). The court also noted "[t]he weight of opinion in the medical and mental health communities agrees that GCS is safe, effective, and medically necessary in appropriate circumstances." *Edmo*, 935 F.3d at 770. Further, this Court has recognized that prison officials violate the Eighth

Amendment when they categorically refuse to consider or provide gender-affirming surgery that is medically indicated for an incarcerated person with gender dysphoria. *See Rosati v. Igbinoso*, 791 F.3d 1037, 1039–40 (9th Cir. 2015).

Because gender-affirming care must be individualized, the applicable standards of care are not diminished by incarceration, and because this principle is endorsed by medical professionals and recognized by this Court, correctional authorities should not be permitted to categorically deny, refuse to consider, or indefinitely delay medically necessary gender-affirming surgery for incarcerated individuals with gender dysphoria.

B. Withholding Medically Necessary Gender-Affirming Care Inflicts Preventable Harm.

Withholding medically necessary gender-affirming care from incarcerated transgender individuals causes severe, well-documented, and often life-threatening harm. The medical consensus, epidemiological data, and this Court's own precedent establish that denial or indefinite delay of appropriate treatment for gender dysphoria inflicts psychological and physical harm—including harm in violation of the Eighth Amendment. Prompt, gender affirming care is necessary to prevent the unnecessary suffering of cruel and unusual punishment in withholding medical care.

Clinical and epidemiological studies both have a clear finding: leaving gender dysphoria untreated is associated with depression, anxiety, and increased suicidality. *See* WPATH SOC at S171 ("studies have shown a higher prevalence of depression,

anxiety, and suicidality, among TGD people than in the general population, particularly in those requiring medically necessary gender-affirming medical treatment.") (citation modified). Withholding or delaying indicated gender-affirming care may cause harm by prolonging distress associated with gender dysphoria and by exacerbating mental-health symptoms. Owen-Smith, *Association Between Gender Confirmation Treatments* at 8. Epidemiological data underscore the severity of these harms. The 2022 U.S. Transgender Survey found that forty-four percent of respondents met the criteria for serious psychological distress, compared to less than four percent of the general U.S. population, and that seventy-eight percent had considered suicide at some point in their lifetime. Rastogi, *Health and Wellbeing* at 12. Critically, these mental health disparities are not inherent to being transgender; they are driven by experiences of discrimination, victimization, and denial of access to appropriate care. WPATH SOC at S126, S171. And research has demonstrated that "prompt access to GAC reduces anxiety, depression, and suicidal ideation." Teresa A. Graziano, *Access to Gender-Affirming Care and Alternatives to That Care Among Transgender Adults*, JAMA Network Open (2025); *see also* WPATH SOC at S171. The harm, in other words, is not only foreseeable but preventable.

These risks are exacerbated in the correctional setting, where transgender individuals face heightened vulnerability. Incarcerated transgender people

experience sexual harassment and assault at rates far exceeding those of other prisoners. Studies have demonstrated "clinically significant health and mental health disparities for justice-involved transgender people compared to matched groups of transgender people who have not been incarcerated or jailed." WPATH SOC at S104 (citing George R. Brown and Kenneth T. Jones, *Health Correlates of Criminal Justice Involvement in 4,793 Transgender Veterans*, 2 LGBT Health 4 (2015), 297-305). The hostile environment of incarceration, combined with the powerlessness inherent in confinement, can exacerbate gender dysphoria. Where gender-affirming surgery has been determined to be medically necessary but is withheld, the consequences may include "substantial worsening of gender dysphoria symptoms, depression, anxiety, suicidality, and the possibility of surgical self-treatment (e.g., autocastration or autopenectomy)." WPATH SOC at S106–7. Indeed, research on incarcerated transgender populations specifically demonstrates that individuals with severe gender dysphoria "may resort to life-threatening surgical self-treatments when persistently denied access to psychiatric evaluation and cross-sex hormonal treatment." George R. Brown, *Autocastration and Autopenectomy as Surgical Self-Treatment in Incarcerated Persons with Gender Identity Disorder*, 12 Int'l J. Transgenderism 31, 31 (2010). Although done without suicidal intent, these self-surgeries can be fatal. *Id.* at 32.

Given these circumstances, withholding medically necessary affirmative care harms the patient. This Court has recognized as much. In *Edmo*, the Ninth Circuit held that "[f]ailure to follow an appropriate treatment plan can expose transgender individuals to a serious risk of psychological and physical harm." 935 F.3d at 771. Indeed, the record in this very case confirms these risks. The Medical Advisory Committee acknowledged that Ms. Wagoner "continue[d] to express feelings of dysphoria despite cross-sex hormone interventions and cognitive behavioral therapies," and the record documents prior episodes of genital self-mutilation—precisely the type of desperate self-treatment the clinical literature warns against when surgery is withheld. MAC Review and Authorization of Gender Dysphoria Individual Treatment Plan (Oct. 23, 2023), Defs.' Trial Ex. 2045; Findings of Fact and Conclusions of Law, *Wagoner v. Winkelman*, No. 3:18-cv-00211-MMS (D. Alaska Sept. 26, 2025) ("Dkt. 366"). The professional consensus, the epidemiological data, and this Court's precedent all support the conclusion that when surgery is medically indicated and appropriate clinical criteria are met, correctional authorities cannot deny that care without placing the patient in serious jeopardy.

C. The District Court's Findings Align With These Principles.

The district court's findings of fact and conclusions of law in this case confirm the principles set forth above and demonstrate precisely the type of harm that results when correctional authorities refuse to provide medically necessary gender-

affirming surgery. After a five-day bench trial, the district court found that DOC acted with deliberate indifference to Ms. Wagoner's serious medical need for gender-affirming genital surgery, in violation of the Eighth Amendment. The court's findings are well-supported by the record and entirely consistent with the medical consensus, the applicable standards of care, and this Court's precedent in *Edmo*.

First, the district court found that Ms. Wagoner suffers from severe and persistent gender dysphoria. *See* Dkt. 366. The parties stipulated to Ms. Wagoner's diagnosis, and DOC itself confirmed that diagnosis. Dkt. 366 at p. 36 ¶ 31. The evidence showed that, despite almost three years of hormone therapy, Ms. Wagoner "continue[d] to experience severe emotional and psychological symptoms of gender dysphoria." *Id.* ¶ 32. This finding is consistent with the literature establishing that hormone therapy, while effective for some patients, is not sufficient to treat gender dysphoria in all cases. *See generally* E.K. Lindqvist et al., *Quality of Life Improves Early After Gender Reassignment Surgery in Transgender Women*, 40 Eur. J. Plastic Surg. 223 (2017); Shirley Shue et al., Comparing Gender Congruency in Nonsurgical versus Postsurgical Top Surgery Patients*: A Prospective Survey Study*, PRS Global Open (2024); Anthony N. Almazan and Alex S. Keuroghlian, *Association Between Gender-Affirming Surgeries and Mental Health Outcomes*, 156 JAMA Surg. (2021).

Second, the district court found that DOC acted with deliberate indifference in refusing to substantively consider its own treating physician's recommendation for surgical referral. Dkt. 366 at p. 37 ¶¶ 37, 40. In April 2023, after an individualized assessment, Dr. Rachel Samuelson, Ms. Wagoner's physician, recommended that Ms. Wagoner be referred to a surgeon for evaluation for gender-affirming surgery and subsequently recommended genital surgery. *Id.* p. 21 ¶ 72; *see also* Transcript of Bench Trial at 194, *Wagoner v. Dahlstrom*, No. 3:18-cv-00211-MMS (D. Alaska May 12, 2025); *id.* at 174–75 (Dr. Samuelson testifying that her February 2025 note continued to recommend gender-affirming genital surgery as reflected in her 10/28/24, 6/18/24, 1/25/24, and 4/11/23 chart notes); *id.* at 191–92 (testifying that she continued to recommend gender-affirming bottom surgery because she believed it would improve Ms. Wagoner's mental health). In October 2023, the MAC denied that referral. Dkt. 366 p. 21 ¶ 73. The court concluded that the MAC's denial was, in substance, "a categorical denial of GCS" that failed to apply criteria supported by medical standards of care. *Id.* pp. 37-38 ¶¶ 40, 42. The court found that while "DOC's policies technically left room for [GCS] to occur, as a practical and functional matter, it was opposed to GCS in every circumstance." *Id.* p. 38 ¶ 41. This finding aligns with the medical standards, which state that "[t]he denial of medically necessary evaluations for and the provision of gender-affirming

surgical treatments and necessary aftercare is inappropriate[.]" WPATH SOC at S107.

Third, the district court correctly recognized that providing partial treatment does not immunize correctional authorities from a finding of deliberate indifference when additional medically necessary treatment is withheld. The court held that "Ninth Circuit precedent is clear that the provision of partial treatment for a medical condition does not foreclose a finding of deliberate indifference where additional treatment is required to avoid further substantial risk of serious harm." Dkt. 366 at p. 37 ¶ 38. Thus, although DOC had provided Ms. Wagoner with hormone therapy and certain accommodations, this did not "satisfy its obligations to her, when evidence shows that she continues to suffer from gender dysphoria, for which GCS is a medically indicated treatment that DOC has refused to approve." *Id.* ¶ 39.

These findings confirm that the principles articulated in Sections III.A and III.B apply directly to Ms. Wagoner's case. The district court recognized that gender dysphoria is a serious medical need, that the standards of care requiring individualized care apply fully in the correctional context, and that when correctional authorities categorically refuse to provide individualized care or refuse to provide medically necessary surgery, they violate the Eighth Amendment. The record before this Court demonstrates exactly the harms the medical literature predict: an incarcerated patient whose gender dysphoria persists despite hormone therapy, and

as a result, then engaged in acts of genital self-mutilation because correctional custodians refused to provide proper care. The district court's determination that DOC acted with deliberate indifference is supported by the record and should be affirmed.

CONCLUSION

For the foregoing reasons, and those stated by Plaintiff-Appellee, amicus GLMA respectfully urges this Court to affirm the judgment of the district court. The medical consensus is clear: gender dysphoria is a serious medical condition and individualized gender-affirming care, including hormone therapy and surgery, is a safe and effective treatment for adults. The district court faithfully applied these principles in finding that the Alaska DOC acted with deliberate indifference to Ms. Wagoner's serious medical need for gender-affirming surgery. The district court's judgment should be affirmed.

Dated: June 24, 2026 Respectfully submitted,

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CERTIFICATE OF COMPLIANCE

I certify that this brief contains 6,964 words and excludes items exempted by Federal Rule of Appellate Procedure 32(f). The brief's type size and typeface comply with Federal Rule of Appellate Procedure 32(a)(5) and (6), as it has been prepared in a proportional typeface in 14-point Times New Roman font.

I further certify that this is an amicus brief and complies with the word limit of Federal Rule of Appellate Procedure 29(a)(5), Circuit Rule 29-2(c)(2) or Circuit Rule 29-2(c)(3), as it contains 6,964 words.

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CERTIFICATE OF SERVICE

I hereby certify that on June 24, 2026 I electronically filed the foregoing document with the Clerk of the Court for the United States Court of Appeals for the Ninth Circuit by using the appellate CM/ECF system.

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UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

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9th Cir. Case Number(s) 25-6813

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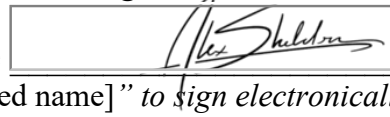
Signature  **Date** June 23, 2026

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