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Gender-Affirming Surgical Care in Carceral Settings

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Transgender and gender-nonconforming (trans) populations are disproportionately incarcerated in the United States, at more than four times the rate in the general population. This disparity is a consequence of extreme socioeconomic marginalization, which leads to participation in illicit activities such as sex work and substance use. Substantial barriers exist within carceral settings to providing gender-affirming clinical care that includes the recommended range of social, psychological, medical, and surgical interventions that affirm a person's gender identity when it differs from their sex assigned at birth.[1] The challenges faced by carceral systems are further complicated by an increasingly charged social and political environment, which has led to restrictions on the provision of gender-affirming clinical care in parts of the United States, including explicit limits in some states on access to gender-affirming surgical care for trans persons who are incarcerated.[2] These restrictions run counter to current clinical guidelines and the medically accepted community standard of care that has resulted in increasing coverage of surgical procedures by both private and public insurers.

Surgical affirmation has been shown to significantly improve the health and well-being of trans people, and the number of people undergoing gender-affirming surgery has substantially increased.[3] Surveys indicate that approximately 1.3 million U.S. adults identify as transgender, and one third of trans persons receive surgical care, with more than 12,000 such procedures performed each year.[4] As the Supreme Court established in the *Estelle v. Gamble* ruling, deliberate indifference to the community standard of health care provision for incarcerated persons violates the U.S. Constitution's Eighth Amendment prohibiting cruel and unusual punishment. Arbitrary limitations on accessing clinically indicated gender-affirming surgical care therefore run afoul of this constitutional protection.[1]

Though access to gender-affirming medical services within state carceral systems has expanded, many states still do not formally offer gender-affirming care, and surgical affirmation has lagged behind approval of other gender-affirming services, even where it's not explicitly prohibited.[1,2] These limitations are particularly concerning given that lack of such access has been linked to self-injurious behavior, including autocastration. We believe that carceral facilities should not only ensure access to gender-affirming surgical care, but also develop health care, housing, and security policies that recognize surgical affirmation, along with other elements of gender-affirming clinical care, as standard clinical practice.

Several U.S. courts have held that access to gender-affirming care during incarceration is a trans person's right. This conclusion is reflected in the Federal Bureau of Prisons (BOP) clinical guidance, which governs clinical care provision within federal carceral facilities, which house an estimated 1200 trans people.[1] The BOP, whose guidance often sets the standard for health care delivery in state and local carceral facilities, recommends provision of gender-affirming care during incarceration, including consideration of surgical procedures. Though the BOP has issued detailed guidance on providing medical gender-affirming care such as hormone therapy, it offers more limited direction on implementing gender-affirming surgical care — a particular problem at the state and local levels, given variability in carceral administra-

tive systems and the availability of such surgical programs.

Carceral facilities should follow international standards of care laid out by the World Professional Association for Transgender Health (WPATH), the most recent of which move away from the historical (and stigmatizing) gate-keeping approach that accepted the outdated classification of trans identities as mental health conditions, making psychiatrists the primary arbiters of the provision of gender-affirming care. Gender-affirming care in carceral settings should be supervised by trained medical providers utilizing the informed-consent approach broadly used for patient-centered clinical decision making, allowing trans persons to develop plans involving medical therapy, surgical therapy, or both. The evaluation process for surgical affirmation should follow WPATH's guidance, including aligning surgical and medical gender-affirming care planning as well as the person's reproductive goals.

To meet these standards, carceral facilities may need to identify, and potentially train, appropriate professionals to complete the mental health assessments recommended as part of presurgical evaluations. Carceral systems can establish relationships with gender-affirming surgeons as they do with other surgical care clinicians who deliver care in carceral settings, with surgical plans developed using the same patient-centered approach used in community settings. These plans include postoperative management, which often requires tailored wound, nursing, and medical care that would have to be supervised and delivered by carceral-facility staff if the person is incarcerated during the postsurgical period. A limited number of surgeons perform the standard compendium of gender-affirming surgeries, and carceral systems must often provide medical care far from the appropriate specialists. The need to ensure delivery of clinical care meeting the community standard has led many carceral systems to contract with academic or private practice groups to meet evolving population health needs.

There is some uncertainty about the minimum anticipated incarceration period or prison sentence required for considering someone for initiation of gender-affirming surgical planning. People serving life sentences obviously have no other options for surgical affirmation than receiving this care while incarcerated. The impetus for offering such care during incarceration is similar for people with sentences of several decades or more. Ultimately, initiation and completion of gender-affirming surgical care during incarceration is likely to be rare. However, with increasing uptake of surgical affirmation in general, trans people are likely to be incarcerated at various stages of the process. Carceral systems should therefore anticipate gender-affirming surgical needs even when the period of incarceration is brief.

Ensuring funding for such services is important, since carceral systems generally finance health care provision using a patchwork of public funding mechanisms, including outsourcing and privatization of administrative activities. The increasing availability of Medicaid coverage within carceral settings, under initiatives such as 1115 state waivers, may allow Medicaid to play a larger role in reimbursement for gender-affirming care in certain situations.

There have been a variety of responses to the unique security and housing considerations for incarceration of trans persons, including those who have undergone or plan to undergo surgical affirmation.[4] The history of physical and sexual violence against trans persons is well documented. The prevalence of violence within carceral facilities, particularly against sexual and gender minority populations, led to passage of the 2003 Prison Rape Elimination Act (PREA),[5] under which carceral facilities are tasked with ensuring the protection and safety of trans persons undergoing gender-affirming surgical care. Provisions for security and housing for people who have undergone such surgery should be aligned with carceral activities related to PREA, whose framework may reduce some of the current uncertainty.

In general, an individualized, patient-centered approach to housing that incorporates each person's preferences, which are often affected by previous gender-affirming medical or surgical care, can help ensure a safe, affirming environment for trans persons during incarceration. An evidence-based approach to developing security policies and training programs related to gender diversity is key to normalizing and destigmatizing gender-affirming care. Identification of clinical experts and champions within carceral institutions can facilitate these activities, although patients receiving gender-affirming care in carceral facilities are entitled to the usual privacy protections under

Roadmap to Implementing Community-Standard Gender-Affirming Clinical Care, Including Surgical Affirmation, in Carceral Settings.*

- Identify a medical provider who can supervise and champion gender-affirming care planning.
- Identify mental health care providers who can perform evaluations as part of gender-affirming surgical care planning.
- Update institutional policies on the initiation and continuity of gender-affirming surgical planning for trans populations that align with WPATH standards of care.
- Incorporate gender-affirming surgical care planning into standard health service policy development.
- Establish a carceral–provider relationship with a gender-affirming surgical team.
- Develop housing and security policies that acknowledge the diversity of medically indicated gender-affirming surgical procedures.
- Ensure that housing and security policies align with HIPAA and PREA standards to avoid stigmatizing or marginalizing trans persons who undergo gender-affirming surgical care.

* HIPAA denotes Health Insurance Portability and Accountability Act, PREA Prison Rape Elimination Act, and WPATH World Professional Association for Transgender Health.

the Health Insurance Portability and Accountability Act (HIPAA).

Although gender-affirming surgical care is a new health service for most carceral facilities, its provision is central to gender-affirming care planning that meets community standards. Given the increasing availability and uptake of such care in community settings, carceral facilities will benefit from planning that acknowledges its growing use in their own populations. Although we recognize the substantial barriers to offering this care — and acknowledge the many complexities, such as preoperative fertility preservation, that we cannot delve into here — we believe gender-affirming surgical care should be viewed as equivalent to other routine surgical and specialty care that is evidence-based, patient-centered, and HIPAA-protected. Training and policy development should aim to normalize and destigmatize it and to align with PREA protections for vulnerable gender minority populations (see box). The action steps we outline are critical to ensuring that this highly marginalized population is protected and supported during a period of extreme vulnerability.

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The Pediatrician's Lament

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"It's your fault!" the renowned infectious disease attending told the cluster of students and residents. In the late 1990s, the varicella vaccine was relatively new, and uptake was disappointingly low. "You pediatricians," he went on, "must correct your wording. Instead of telling parents their child is due for the MMR vaccine and then half-heartedly offering the varicella vaccine, you should include it with the same declarative certainty: 'Your child is due for varicella and MMR vaccines.'"

Though it has been nearly 30 years, I remember that moment as one of those rare crystalline learning moments when a gifted teacher's wisdom solidifies in a recep-