Distributive Consequences of the Medical Model

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INTRODUCTION

The "medical model" is the understanding of trans[1] identity as a psychological condition—Gender Identity Disorder ("GID")[2]—that requires medical treatment, including gender-confirming surgery or hormone therapy.[3] This Note examines the distributive consequences[4] of the medical model by demonstrating how legal doctrines affect trans persons' life chances based on the degree to which these doctrines embrace or reject the model.

The medical model has produced conflict within the trans social movement. In an attempt to shift focus from the heated debate, this Note offers a descriptive account of the non-monolithic distributive effects of the medical model. It is imperative that advocates understand these effects, so that a decision to deploy the medical model is not taken as a foregone conclusion, but is adopted and continuously interrogated, with an understanding of the power the model wields[5] and the different costs and benefits it imposes on relevant stakeholders.

Part I identifies stakeholders by offering narratives that depict how the medical model affects the lives of diverse trans individuals. Part II discusses

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[1] I use the word trans to refer to the broad range of people who do not self-identify with the gender assigned to them at birth.

[2] AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 535–38 (4th ed., text rev. 2000) [hereinafter DSM-IV].

[3] Franklin H. Romeo, Note, *Beyond a Medical Model: Advocating for a New Conception of Gender Identity in the Law*, 36 COLUM. HUM. RTS. L. REV. 713, 724–25 (2005) (describing the medical model).

[4] Distributive analysis examines the costs and benefits of the medical model to different stakeholders. The focus on distributive consequences is inspired by a framework originally deployed in welfare economics, and later applied in family law and transnational law. *See, e.g.*, Janet Halley, Prabha Kotiswaran, Hila Shamir & Chantal Thomas, *From the International to the Local in Feminist Legal Responses to Rape, Prostitution/Sex Work, and Sex Trafficking: Four Studies in Contemporary Governance Feminism*, 29 HARV. J.L. & GENDER 335, 337–68 (2006) (applying distributive analysis); Duncan Kennedy, *The Stakes of Law, or Hale and Foucault!*, 15 LEGAL STUD. F. 327, 328–34 (1991) (discussing distributive analysis).

[5] Janet Halley describes how representation through identity politics can function as power, stating "if advocacy constructs identity, if it generates a script that identity bearers must heed, and if that script restricts group members, then identity politics compels its beneficiaries. Identity politics suddenly is no longer mere or simple resistance: it begins to look like power." Janet E. Halley, *Gay Rights and Identity Imitation: Issues in the Ethics of Representation*, *in* THE POLITICS OF LAW: A PROGRESSIVE CRITIQUE 117 (David Kairys ed., 1998).

the medical model and critiques of the model. Part III provides a distributive reading of the medical model in law, examining how legal doctrine distributes costs and benefits to trans persons.

I. The Medical Model in Trans Lives

In order to provide a concrete understanding of how the medical model distributes goods among diverse trans individuals, this section presents four trans narratives representative of individuals affected by the medical model. These characters are fictional, but reflect common trans identities and experiences.[6]

A. Jesse, the trapped man.

Doctors assigned Jesse a female gender at birth, but since childhood, he has experienced himself as male. Because of the lack of congruence between his body and his gender identity, Jesse underwent therapy as an adult. He told the therapist that he felt like he should have been born a boy and that he is trapped in the wrong body. He recalled that during his childhood he cut his hair short, wore his brother's clothes, and enjoyed playing football with boys.[7] The lack of congruence between his gender identity and other people's perceptions of his gender has caused him to live in a state of anxiety and depression. Jesse's therapist diagnosed him with GID, and Jesse used the GID diagnosis to obtain a prescription for testosterone. Although he does not have health insurance, he accessed hormones through a local health clinic.

Jesse presents as male, but has not changed the gender on his identification documents. As in most states, Jesse is required to provide proof of "sex reassignment surgery" in order to change the gender designation on his birth certificate and driver's license. Gender-confirming surgery is well beyond Jesse's meager means,[8] and even if he were able to pay for top surgery[9] out of pocket, the state might still deny his request for a gender change if it

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[6] This method of stakeholder identification in a distributive analysis is drawn from Pascale Fournier's use of Leilas to describe the distributive effects of *mahr*. *See* Pascale Fournier, *Flirting with God in Western Secular Courts: Mahr in the West*, 24 Int'l J.L. Pol'y Fam. 67, 84–92 (2010).

[7] *See* DSM-IV, *supra* note 2, at 577 (listing diagnostic features for female children with GID: "[t]hey prefer boys' clothing and short hair, are often misidentified by strangers as boys, and may ask to be called by a boy's name. Their fantasy heroes are most often powerful male figures, such as Batman or Superman. These girls prefer boys as playmates, with whom they share interests in contact sports, rough-and-tumble play, and traditional boyhood games").

[8] Gender-confirming surgery costs about $77,000 for trans men who undergo chest masculinization and phalloplasty and $37,000 for trans women who undergo breast enhancement and vaginoplasty. *See* Rachel Gordon, *S.F. Set to Add Sex Change Benefits*, S.F. Chron., Feb. 16, 2001, at A1.

[9] The average cost of top surgery (which removes the breasts and reconstructs a masculine chest) is about $8,500. *See* Mary Ann Horton, *The Cost of Transgender Health Benefits, Out*

deems genital surgery necessary to complete "sex reassignment surgery."[10] While Jesse does not see a penis as a necessary part of his gender, the state may.

Without identification that corresponds with his gender presentation, Jesse struggles to secure a job.[11] Each time he applies, his trans identity is exposed by his identity documents. Jesse sought legal counsel, but no one would take his case because he lacked direct evidence of discrimination. Jesse continues to seek non-discriminatory employment, and hopes for reform of the state's policy toward changing the gender on identity documents.

B. Jesse, the spurned youth.

Jesse is a fourteen-year-old self-identified girl who grew up in a wealthy family that loved and supported her throughout her childhood—until Jesse told them that she is trans and hoped to start hormones and eventually have surgery. Jesse was forced to tell her parents after school administrators prohibited her from returning to class presenting as female. Unfortunately, Jesse's parents could not accept that their little boy was growing up to be a young woman. Their rejection of her gender resulted in a constant conflict that made home life intolerable for Jesse.

Rejected by her family and school, Jesse turned to friends, but found their parents equally unreceptive to having a trans girl in their home. Running out of ideas, and needing a place to sleep, Jesse went to a homeless shelter. But the shelter placed Jesse with the cisgender[12] male population because she had not undergone genital surgery.[13] Jesse then turned to the state in search of a foster home, only to be told again that she would be forced to live in sex-segregated spaces among males and would be prohibited from wearing women's clothing.

Jesse saw no better option than to enter into prostitution. This eventually led to arrest and incarceration—where she was placed in a male facility. Once Jesse entered the prison system, she found that the medical model was one of the few tools at her disposal. Because the state must provide inmates with "necessary" medical care, she may receive hormones and surgery in light of the government's current involvement in her life.[14]

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and Equal Workplace Summit 1 (2008), *available at* http://www.tgender.net/taw/thb/THBCost-OE2008.pdf.

[10] Many states require sex-reassignment surgery, but do not define it. *See* Dean Spade, *Documenting Gender*, 59 HASTINGS L.J. 731, 768–69 (2008).

[11] *See generally* JAIME M. GRANT ET AL., INJUSTICE AT EVERY TURN: A REPORT OF THE NATIONAL TRANSGENDER DISCRIMINATION SURVEY (2011), http://endtransdiscrimination.org/PDFs/NTDS_Report.pdf (discussing employment discrimination); *see also* Spade, *supra* note 10, at 752.

[12] Cisgender is a term used in trans and allied communities to refer to non-trans people. *See* Dean Spade, *Be Professional!*, 33 HARV. J.L. & GENDER 71, 76 n.76 (2010).

[13] *See generally* GRANT ET AL., *supra* note 11, at 106 (discussing shelter placement).

[14] *See infra* note 90 and accompanying text; Part III.A.

C. Jesse, the gender chameleon.

Jesse is a college student who grew up comfortable in femininity, but now enjoys defying gender roles. He decided to transition after learning about trans identities in gender studies courses. Jesse self-identifies as trans, and presents as male or female, or genderqueer[15] in different contexts as it fits his needs and desires. He generally prefers male pronouns.

As part of his expression of gender, Jesse wanted to have top surgery, which includes removal of the breasts and a masculine chest reconstruction. He knew that he would need a GID diagnosis to get surgery in the United States, and that he would not meet the criteria for a diagnosis, because his desire to transition was newfound and not based on discomfort with femininity. To avoid being denied the diagnosis, Jesse told the stereotypical gender dysphoric story to his therapist. In this false narrative, Jesse described his experience in terms like those experienced by Jesse, *the trapped man*. After a few sessions, Jesse's therapist diagnosed him with GID and wrote a letter recommending top surgery.[16] With the letter in hand, Jesse underwent top surgery, which was covered under his student health insurance plan.[17]

Jesse deployed his identity opportunistically in order to access the surgery that he desired; but, because he did not have bottom surgery, Jesse did not meet the state's requirement for changing the sex indicator on his identity documents. To remedy this, Jesse went to the DMV, presenting as male, and convinced the DMV employee that the female indicator on his license was a mistake.[18] The employee fixed the "mistake," and issued a "corrected" license.

Jesse does not identify within binary gender structures,[19] but law and medicine work in these terms. Jesse views the system of gender classification as oppressive, believes that gender is socially constructed, and considers his deployment of gender a tool of political opposition to the binary.

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[15] Genderqueer is an umbrella term that includes people who identify outside of the gender binary or do not identify as entirely male or female. *See* Dylan Vade, *Expanding Gender and Expanding the Law: Toward a Social and Legal Conceptualization of Gender that Is More Inclusive of Transgender People*, 11 MICH. J. GENDER & L. 253, 266 n.42 (2005).

[16] *See* Dean Spade, *Resisting Medicine, Re/modeling Gender*, 18 BERKELEY WOMEN'S L.J. 15, 23 (2003) ("I have these great, sad, conversations with these people who know all about what it means to lie and cheat their way through the medical roadblocks to get the opportunity to occupy their bodies in the way they want.").

[17] While most student health insurance plans exclude gender-confirming health care, some universities, including Harvard, Stanford, and the University of Pennsylvania, have recently removed this exclusion. *See* Leah Finnegan, *U of Penn Latest to Offer Transgender Insurance*, HUFFINGTON POST (Apr. 14, 2010, 10:55 PM), http://www.huffingtonpost.com/2010/04/14/u-of-penn-latest-to-offer_n_538035.html.

[18] *See* Spade, *supra* note 10, at 772 (discussing the success of this method).

[19] *See* Vade, *supra* note 15, at 255–56 n.5 ("[I]n a recent . . . survey, about half of the transgender identified people did not identify as strictly female or male."). See S.F. HUMAN RIGHTS COMM'N, GENDER NEUTRAL BATHROOM SURVEY (2001), *available at* http://srlp, for the survey supplying these facts.org/files/documents/toolkit/gnb_survey.pdf), for the survey supplying these facts.

D. Jesse, the muted man.

Jesse is a trans man who identifies as male and is recognized as male among friends and family. He has not undergone hormone therapy or surgery, nor does he want to. At work, Jesse uses female pronouns, and his coworkers identify him as a woman. Jesse believes that he will not be read consistently as male, so rather than attempt to explain his trans identity, he views going to work as a woman as a cost of doing business.

Because he lives in New York, Jesse can change the gender on his driver's license without proof of surgery by presenting a letter from a doctor stating that his male gender predominates over his female gender.[20] In light of a recent court ruling, he can also change his name to a traditionally male name without undergoing surgery.[21] Nevertheless, he declines to change his name or identity documents for two reasons. First, he is afraid that his employer may discover his trans identity if he makes these changes, and he is not willing to risk being outed as trans at work and losing his job. Second, he does not want to lose health insurance coverage. His provider has blanket exclusion on "transsexual care," and a change in name or gender markers may result in a denial of coverage for needed care typically associated with women.[22]

II. The Medical Model and the Trans Movement

The fates of the Jesses play out a political dispute within the trans community on a practical stage. Traditionally, the medical and legal communities viewed trans identity as a pathology consistent with the medical model,[23] but recently advocates have attacked this view.[24] The medical model has produced significant intra-movement conflict, as the law's understanding of trans identity is often in opposition to the social movement's vision.[25] This section explains the medical model and why lawyers deploy it, and then discusses critiques of the model.

A. Trans Identity in Medicine and Psychiatry

Harry Benjamin, an endocrinologist, was among the first doctors to treat patients seeking to change genders with surgery and hormones. In

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[20] State of N.Y. Dep't of Motor Vehicles, Change in Required Documentation for Proof of Sex Change (1987), *available at* http://srlp.org/files/NY%20DMV%20Sex%20Change%20Policy.pdf.

[21] *See* Matter of Winn-Ritzenberg, 891 N.Y.S.2d 220, 221 (N.Y. App. 2009).

[22] *See infra* Part III.A.

[23] *See* Spade, *supra* note 16, at 15–16 ("Everywhere that trans people appear in the law, a heavy reliance on medical evidence to establish gender identity is noticeable.").

[24] *See, e.g.*, Romeo, *supra* note 3, at 730–38; Spade, *supra* note 16, at 18–19.

[25] Some individuals within the movement oppose the medical model on political grounds, yet support its use in legal advocacy. *See* Paisley Currah, *The Transgender Rights Imaginary*, 4 Geo. J. Gender & L. 705, 705–07 (2003).

1966, he defined transsexualism as a mental disorder in the seminal text, *The Transsexual Phenomenon*.[26] He viewed trans people on a continuum, distinguishing between people who do not desire surgery and the "true" trans people who do.[27] The medical community has largely abandoned this limited conception of trans identity,[28] but the notion that "true" trans persons desire gender-confirming surgery remains common in law.[29]

The American Psychiatric Association ("APA") first added transsexualism to the *Diagnostic and Statistical Manual of Mental Disorders-III* ("DSM") in 1980.[30] Trans identity remains in the latest DSM, now under the heading of GID.[31] The current criteria for GID include: (A) "strong and persistent cross-gender identification," (B) "persistent discomfort about one's assigned sex or a sense of inappropriateness in the gender role of that sex," (C) lack of a "physical intersex condition,"[32] and (D) "clinically significant distress or impairment in social, occupational, or other important areas of functioning."[33] These criteria form the basis of the current medical model, which continues to pathologize trans identity.

The World Professional Association for Transgender Health ("WPATH") provides standards of care for the treatment of individuals with GID.[34] While they do not represent the views of all medical professionals, the standards provide guidance to the medical community for treatment and represent the organization's "professional consensus about the psychiatric, psychological, medical, and surgical management of [GID]."[35] These guidelines predicate access to surgery and hormones on a mental health professional's determination that the individual meets the eligibility criteria, which include a GID diagnosis and living full time in one's self-identified

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[26] HARRY BENJAMIN, THE TRANSSEXUAL PHENOMENON 22 (1966).

[27] *Id.*

[28] *See* WORLD PROF'L ASS'N OF TRANSGENDER HEALTH, INC., THE HARRY BENJAMIN INTERNATIONAL GENDER DYSPHORIA ASSOCIATION'S STANDARDS OF CARE FOR GENDER IDENTITY DISORDERS 3–4 (6th ed. 2001) [hereinafter STANDARDS OF CARE], *available at* http://www.wpath.org/documents2/socv6.pdf; DSM-IV, *supra* note 2, at 535 (listing the criteria for GID, which do not require a desire to have sex-reassignment surgery).

[29] *See infra* Part III; *see also* Harper Jean Tobin, Note, *International Justice and Shifting Paradigms: Against the Surgical Requirement for Change of Legal Sex*, 38 CASE W. RES. J. INT'L L. 393, 421 n.167 (2007).

[30] AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (3d ed. 1980).

[31] The APA adopted the term GID in 1994 with the issuance of DSM-IV. *See* DSM-IV, *supra* note 2, at 535.

[32] Intersex persons are born with a reproductive or sexual anatomy that does not comport with the traditional definitions for males and females. THE MERCK MANUAL OF DIAGNOSIS AND THERAPY 2222 (18th ed. 2006).

[33] DSM-IV, *supra* note 2, at 576 (advancing the four criteria).

[34] WPATH is an international professional association of providers who treat GID. WORLD PROF'L ASS'N FOR TRANSGENDER HEALTH, wpath.org (last visited Jan. 31, 2011).

[35] STANDARDS OF CARE, *supra* note 28, at 1. The standards are largely accepted by those who treat trans patients and are often cited in case law. *See, e.g.*, O'Donnabhain v. Comm'r, 134 T.C. 34, 68 (2010) (noting that "[t]he . . . Benjamin standards enjoy . . . substantial acceptance").

gender.[36] Lack of certification from a mental health professional usually precludes trans people from accessing gender-confirming medical care.[37]

A few trans-friendly medical professionals have responded to the movement's resistance to the medical model by shifting to the "transgender model," in which trans identity and other gender variances are not pathologized but considered "natural forms of human variability."[38] Such clinics and providers offer hormone therapy, though not surgery, with informed consent.[39]

B. Medical Model Advocates in Law

Many pro-trans legal advocates advance legal arguments based on the medical model's view of trans identity as a mental disorder, or describe trans clients in these terms.[40] This method of advocacy has become so common for advocates whose clients' own goals and identities can be met through the medical model—clients such as Jesse, *the trapped man* and Jesse, *the spurned youth*—that this medical model rhetoric has taken over much judicial thinking about trans identity.[41] Because this strategy has sometimes been successful, advocates continue to deploy it despite the contrary desires of many members of the trans movement.[42]

Advocates have attempted to explain trans identity as a medical condition primarily in order to maximize access to trans-related health care for those who conform to the model. The model has gained legal traction largely because of its use in litigating claims based on the medical necessity of trans-related health care.[43] Limited access to trans-related care provides incentives to produce and entrench the core idea of the medical model: that trans-identified individuals suffer from a psychological condition, and that this condition requires treatment including hormone therapy and surgery.

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[36] STANDARDS OF CARE, *supra* note 28, at 6–7, 13–20.

[37] *See id.*; Spade, *supra* note 16, at 19–20.

[38] *See* Dallas Denny, *Changing Models of Transsexualism*, *in* TRANSGENDER SUBJECTIVES: A CLINICIAN'S GUIDE 25, 30 (Ubaldo Leli & Jack Drescher eds., 2004); *see also* Dallas Denny, *Transgender Communities*, *in* TRANSGENDER RIGHTS 171, 184–85 (Paisley Currah et al., eds., 2006).

[39] Cities with clinics offering hormone therapy based on informed consent include New York City, San Francisco, Boston, Chicago, Philadelphia, and Washington, D.C. *See* Howard Brown Health Center, *THInC Brochure*, http://howardbrown.org/uploadedFiles/Services_and_Programs/Primary_Care_Medical_Services/THInC%20BROCHURE.pdf.

[40] *See infra* Part III.

[41] *See* Spade, *supra* note 16, at 17–18 ("In almost every trans-related case, whether it be about the legitimacy of a trans person's marriage, the custody of hir children, hir right not to be discriminated against in employment, hir right to wear gender appropriate clothing in school or foster care, hir rights in prison, or whatever other context brings hir to court, medical evidence will be the cornerstone of the determination of hir rights.").

[42] *See infra* Part II.C.

[43] *See infra* Part III.A; *see also* Alvin Lee, Note, *Trans Models in Prison: The Medicalization of Gender Identity and the Eighth Amendment Right to Sex Reassignment Therapy*, 31 HARV. J.L. & GENDER 447, 470 (2008) ("[T]he medical model has thus far proven to be the most successful tool in advocating on behalf of trans people.").

Advocates rely on the medical model outside of medical cases as well, routinely citing medical and psychological evidence to convince courts to categorize their clients in their self-identified gender. Such advocacy is common in employment discrimination and marriage cases, where advocates use medical evidence to establish that gender identity is one of a number of criteria that courts should rely on when determining a litigant's sex.[44]

In other cases, advocates simply describe trans clients by reference to the medical model when introducing them to the court, even where irrelevant to the claim.[45] By doing so, advocates take an idea that is incomprehensible to many people—that an individual's gender could deviate from that assigned at birth—and explain it in a form that has recognized legitimacy as a treatable psychological condition. Such descriptions essentialize gender identity, producing it as immutable and distinguishing it from volitional gendered behavior.[46]

The strategic decisions of one advocate reflect four reasons for adopting the medical model in legal advocacy outside of the health care context.[47] First, when a person *does* experience trans identity as a psychological or medical condition, relying upon the model legitimizes the identity.[48] Second, because these medical arguments are effective, attorneys must sometimes make them to fulfill the ethical obligation to act in the best interests of their clients, despite opposition from the broader trans movement.[49] Third, because advocates have relied heavily on the medical model in the past, it is necessary to cite the model when making legal argument based on precedent.[50] Fourth, the medical model provides a basis for arguing that gender

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[44] *See, e.g.*, In re Estate of Gardiner, 42 P.3d 120, 133 (Kan. 2002) (citing expert's statement that criteria for determining sex include "in addition to chromosomes: 'gonadal sex, internal morphologic sex, external morphologic sex, hormonal sex, phenotypic sex, assigned sex and gender of rearing, and sexual identity,' as well as other criteria that may emerge with scientific advances"); *see also infra* Part III.E (discussing employment discrimination cases); *infra* Part III.D (discussing marriage cases).

[45] *See, e.g.*, *infra* note 140 and accompanying text.

[46] *See* Andrew Gilden, *Toward a More Transformative Approach: The Limits of Transgender Formal Equality*, 23 BERKELEY J. GENDER L. & JUST. 83, 113–15 (2008).

[47] *See* Sharon M. McGowan, *Working with Clients to Develop Compatible Visions of What It Means to "Win" a Case: Reflections on* Schroer v. Billington, 45 HARV. C.R.–C.L. L. REV. 205 (2010) (discussing a case McGowan litigated in which the court held that the Library of Congress violated Title VII's prohibition of discrimination based on sex by revoking an offer of employment once it learned of the plaintiff's trans identity).

[48] McGowan's client conforms to the medical model of trans identity, and the client advocated for its use in her case. *Id.* at 237–38. McGowan extensively cites the medical model in the complaint. Amended Complaint at ¶¶ 13–24, Schroer v. Billington, 577 F. Supp. 2d 293 (D.D.C. 2008) (No. 05-1090).

[49] McGowan acknowledges that her decisions will have effects for the trans movement, and in light of this, she considers critiques of the medical model expressed by Dean Spade and Franklin Romeo. *See* Romeo, *supra* note 3; Spade, *supra* note 16. She ultimately dismisses these critiques, however, after considering them only in the context of disability claims which she considers a valuable litigation tool. McGowan, *supra* note 47, at 220–22 & n.3.

[50] McGowan discusses how she framed her complaint by including the commonly cited Harry Benjamin Standards, GID criteria, and Ms. Schroer's treatment, following, what seems

identity is part of a person's biological sex.[51] These arguments reflect pragmatic reasons for relying on the medical model, but many in the movement continue to oppose such tactics.

C. Opposition to the Medical Model

In response to the medical model's predominance, opponents have voiced concerns regarding its use to explain trans identity.[52] The law is a valuable place for creating legitimacy for an identity-based social movement, but legitimacy based on medicine is not the goal for many. These members of the trans movement seek alternative ways of describing trans identity in order to advance the interests of trans and gender-non-conforming people[53] who do not fit under the umbrella of the medical model, or do fit within the medical model but oppose its use for political reasons. This constituency identifies the relevant community as all gender-non-conforming people, including, but not limited to, those who self-identify as trans.[54]

Critics of the medical model argue that it fails to describe a vast portion of the trans community, and thereby precludes many gender-non-conforming individuals from taking advantage of the movement's legal and social gains.[55] The model advances the myth that all trans people desire medical treatment, while in fact, many trans people, like Jesse, *the muted man*, have no desire to undergo hormone therapy or surgery.[56] Other trans people desire medical intervention, but cannot obtain a GID diagnosis because they do not have, or do not wish to recite, the experience of feeling as though they were "trapped in the wrong body" since childhood.[57] The model also has income-based impact: some are precluded from accessing therapy and

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by now, standard protocol for trans litigation. McGowan, *supra* note 47, at 223–24; *see also infra* Part III (discussing the use of the standards and the GID diagnosis in case law).

[51] McGowan argued, based on expert testimony, that gender identity has a biological etiology and is therefore part of a person's biological sex. While McGowan did not push the court for a ruling on whether gender identity is part of one's biological sex, she states that a ruling in the affirmative on this question would be beneficial for the trans community. Specifically, in the case she was litigating, it would have supported a finding that the term "sex" in Title VII includes gender identity. She notes it would also be useful in cases denying trans people access to sex-segregated spaces based on biological sex. McGowan tempers her argument by acknowledging that not all trans people view their identity as biologically based. McGowan, *supra* note 47, at 239–42.

[52] *See, e.g.*, Spade, *supra* note 16, at 36 ("I do not want to plead cases for clients who have undergone medical procedures in ways that will lead to a victory where the rights of [other] trans people hinge on undergoing those procedures.").

[53] *See* Vade, *supra* note 19, at 255–56 (asserting that not all trans individuals identify as male or female and advocating for a broader understanding of the spectrum of gender identities).

[54] *See, e.g.*, Romeo, *supra* note 3, at 713 n.1; Spade, *supra* note 16, at 15 n.2.

[55] *See, e.g.*, Romeo, *supra* note 3, at 730–31.

[56] *See* Dean Spade, *Elimination of Bias: Trans Formation*, 31 LOS ANGELES LAW. 34, 37 (2008).

[57] *See, e.g.*, Spade, supra note 16, at 19–23 (describing the author's personal experience); *see also* Vade, *supra* note 15, at 271–73.

health care due to financial constraints, a common problem among the most marginalized trans people. While these people may identify with the medical model, they often lack legal recognition.[58] Thus, the medical model leaves many trans persons behind.

In addition to being a poor descriptor of the community and privileging those with means of accessing care, many argue that the medical model fails to establish social authority for trans people because pathologization of trans identity is stigmatizing.[59] As Professor Judith Butler explains: "[t]o be diagnosed with . . . [GID] is to be found, in some way, to be ill, sick, wrong, out of order, abnormal, and to suffer a certain stigmatization as a consequence of the diagnosis being given at all."[60] Advocates for GID reform argue that the stigmatizing effects of the diagnosis outweigh the marginal gains in access to surgery and hormones.[61]

Others, such as Jesse, *the gender chameleon*, advance a more political argument that the medical model reifies the notion that only two genders exist with two discrete sets of stereotypical dress, body, and behavior.[62] The aim of the trans movement, this constituency argues, should be to attack binary constructions of gender, not reinforce them by entrenching the idea that trans identity is a psychological state of feeling "trapped" in the wrong body.[63] While the medical model seeks to normalize trans people by fitting them into existing binary gender structures, this constituency seeks to dismantle gender norms and challenge the state's use of sex as an identity category by which it distributes rights and resources.[64]

These critics of the medical model have suggested alternative approaches to explaining trans identity in law. For example, some argue that advocacy should be based on a theory of choice or self-determinism, which supports recognition of individuals' self-identified gender without medical

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[58] Spade, *supra* note 56, at 37.

[59] *See* Judith Butler, *Undiagnosing Gender*, *in* TRANSGENDER RIGHTS, *supra* note 38, at 274, 275–76 ("[T]he [GID] diagnosis makes many assumptions that undercut trans-autonomy. It subscribes to forms of psychological assessment that assume that the diagnosed person is affected by forces he or she does not understand; it assumes that there is delusion or dysphoria in such people; it assumes that certain gender norms have not been properly embodied and that an error and a failure have taken place; it makes assumptions about fathers and mothers, and what normal family life is and should have been; it assumes the language of correction, adaptation, and normalization; it seeks to uphold the gender norms of the world as it is currently constituted and tends to pathologize any effort to produce gender in ways that fail to conform to existing norms (or to a certain dominant fantasy of what existing norms actually are).").

[60] JUDITH BUTLER, UNDOING GENDER 76 (2004).

[61] *See* Kelley Winters, GID Reform Advocates, *Diagnosis vs. Treatment: The Horns of a False Dilemma*, http://www.gidreform.org/blog2008Jul01.html (last visited Feb. 12, 2011).

[62] *See, e.g.*, Spade, *supra* note 16, at 28–29 ("The medical approach to our gender identities forces us to rigidly conform ourselves to medical providers' opinions about what 'real masculinity' and 'real femininity' mean, and to produce narratives of struggle around those identities that mirror the diagnostic criteria of GID.").

[63] *See, e.g.*, Vade, *supra* note 15, at 271–73.

[64] *See, e.g.*, Gilden, *supra* note 46, at 84–87; Spade, *supra* note 16, at 29.

evidence.[65] Others have suggested that an idea of "social necessity" replace "medical necessity" in the health care context, so that gender-confirming care would be available whenever socially necessary for trans people to exist in society given the reality that without access to care, trans people are denied legal rights and social validity, and often face violence for failing to conform physically to gender norms.[66] Others opposed to the medical model argue that the trans movement should focus on non-legal approaches,[67] while some argue for "gender pluralism," the practice of deploying different ideas of gender in different legal settings.[68]

III. Distributive Consequences of the Medical Model

Reliance on the medical model in law produces distributive consequences in the allocation of social goods to trans people that we can and should interrogate. This section discusses a number of these goods, including health care, identity documents, education, recognition of the family, and protection from employment discrimination.

The distribution of these goods reflects multiple themes. First, distributive consequences flow from the differential resources of trans people. Second, distributive consequences depend on the extent to which one's body and psychology conform to the medical understanding of trans identity. Third, distributive consequences depend on the extent to which one's political conception of trans identities comports with the medical model. Fourth, redistributive benefits accrue to those whose views of gender are so flexible as to allow them to exploit systems grounded in the medical model.

A. Health Care

i. Doctrine

While not all trans people seek medical intervention, access to gender-confirming health care is crucial for many trans people in order to have a

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[65] *See, e.g.*, Laura K. Langley, Note, *Self-Determination in a Gender Fundamentalist State: Toward Legal Liberation of Transgender Identities*, 12 Tex. J. C.L. & C.R. 101, 102 (2006); Romeo, *supra* note 3, at 738–39 n.99 (advancing self-determinism but acknowledging its limits, including the premise that identity comes from within an individual without intermediation by society); Sylvia Rivera Law Project, Mission Statement, http://srlp.org/about (last visited Feb. 12, 2011).

[66] From this view, a social necessity model is superior to the medical model because it does not have the same stigmatizing effects—it accurately identifies the societal bases for the need of gender-confirming care instead of simply pathologizing trans identity, and it highlights the legal and social enforcement of gender. *See* Jerry L. Dasti, Note, *Advocating a Broader Understanding of the Necessity of Sex-Reassignment Surgery Under Medicaid*, 77 N.Y.U. L. Rev. 1738, 1743 (2002); Susan Etta Keller, *Crisis of Authority: Medical Rhetoric and Transsexual Identity*, 11 Yale J.L. & Feminism 51, 72 (1999).

[67] Spade, *supra* note 16, at 35.

[68] *See* Paisley Currah, *Gender Pluralism Under the Transgender Umbrella, in* Transgender Rights, *supra* note 38, at 3, 24.

body that reflects their gender identity. For some trans people, the body provides a meaningful way of performing and expressing gender; for others, having a body that conforms to their gender identity is absolutely necessary to living a life in that body.[69] Secondary sex characteristics produced by hormones are often crucial for trans people to be read as the proper gender in their daily life, and failure to produce them may result in ostracism and violence.[70] Even those who do not identify within the binary may adopt a male or female gender for navigating daily life. Yet many trans people are unable to access comprehensive medical care because they are uninsured and lack the means to pay out-of-pocket, and because they face barriers to care specific to trans identity.[71]

Trans people are often denied coverage for trans-related care, including surgery and hormone therapy. Many state Medicaid programs and private providers expressly exclude trans-related care from coverage, or deny claims for these treatments on an individual basis.[72] Some progressive employers and universities now include gender-confirming surgery in their comprehensive health coverage, but this is not common.[73] While insurance providers routinely exclude coverage for gender-confirming surgery on the grounds that it is cosmetic, medical providers within the United States will not perform the surgery if it is sought for purely aesthetic reasons. Thus, even assuming one has the means to access trans-related care, one still must demonstrate a need for care to the practitioner, usually by obtaining a GID diagnosis.

Furthermore, trans people who have access to health care are often denied general (non-trans-related) care due to their trans identity.[74] Prior to the enactment of the Patient Protection and Affordable Care Act,[75] insurance providers often refused to approve trans people's applications for health in-

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[69] *See* Pooja S. Gehi & Gabriel Arkles, *Unraveling Injustice: Race and Class Impact of Medicaid Exclusions of Transition-Related Health Care*, 4 SEXUALITY RES. & SOC. POL'Y: J. NSRC 7, 12–14 (2007) (reporting that lack of access to medical treatment may result in depression, anxiety, and suicidality); Kari E. Hong, *Categorical Exclusions: Exploring Legal Responses to Health Care Discrimination Against Transsexuals*, 11 COLUM. J. GENDER & L. 88, 92 (2002) (same).

[70] *See* Spade, *supra* note 10, at 751.

[71] The financial barriers to accessing health care are not exclusive to trans people, but are exacerbated by the economic and social marginalization of trans people. *See* TRANSGENDER LAW CTR., TRANSGENDER HEALTH AND THE LAW: IDENTIFYING AND FIGHTING HEALTH CARE DISCRIMINATION (2004), *available at* http://transgenderlawcenter.org/pdf/Health%20Law%20fact%20sheet.pdf [hereinafter TRANSGENDER HEALTH AND THE LAW].

[72] *See id.*; Nick Gorton, *Transgender Health Benefits: Collateral Damage in the Resolution of the National Health Care Financing Dilemma*, 4 SEXUALITY RES. & SOC. POL'Y: J. NSRC 81, 85–89 (2007).

[73] *See, e.g.*, Human Rights Campaign, CORPORATE EQUALITY INDEX: RATING AMERICAN WORKPLACES ON LESBIAN, GAY, BISEXUAL, AND TRANSGENDER EQUALITY 26–29 (2010), *available at* http://www.hrc.org/documents/HRC-CEI-2011-Final.pdf.

[74] TRANSGENDER HEALTH AND THE LAW, *supra* note 71, at 2.

[75] Pub. L. No. 111-148, § 2704, 124 Stat. 119 (2010).

surance due to a history of trans-related care,[76] or denied coverage for non-trans-related care by stating that a health concern was caused by trans-related treatment.[77] As of 2014, the Act will prohibit insurance providers from denying coverage based on a pre-existing condition,[78] but they may continue to deny coverage for what is believed to be gender-specific care, such as gynecological exams or prostate cancer screening, when the insured's gender does not correspond with the provider's classification of gender-specific services.[79]

In addition, some practitioners refuse to provide any treatment to gender-non-conforming patients out of ignorance or bigotry, often stemming from a lack of cultural or professional knowledge of trans identity.[80] Most medical schools do not train students in trans-related care, or teach the ethics of trans patient care.[81] Thus, trans people frequently postpone or neglect to seek care in order to avoid negative responses from medical personnel.[82]

Advocates have invoked the medical model, with varying success, when advancing claims based on the medical necessity of trans-related care. Medical necessity is a term of art, and treatment that is medically necessary is contrasted with elective or cosmetic procedures.[83] By describing their identity in pathological terms, some trans people have been able to convince courts that trans-related health care is medically necessary,[84] but others have not.[85]

The medical necessity of gender-related health care is most commonly litigated in the realm of state-rendered care, not in the area of private health insurance where contract law governs blanket exclusions on trans-related care.[86] For example, in a case adjudicating care for a child in state custody, a

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[76] *See* TRANSGENDER HEALTH AND THE LAW, *supra* note 71, at 2; Hong, *supra* note 69, at 96–99.

[77] *See* TRANSGENDER HEALTH AND THE LAW, *supra* note 71, at 2; Hong, *supra* note 69, at 94–96.

[78] Pub. L. No. 111-148, § 2704, 124 Stat. 119 (2010).

[79] *See* Nat'l Ctr. for Transgender Equality, *Health Care Reform Signed into Law* (Mar. 23, 2010), http://transequality.org/news10.html#hcr (noting that after health care reform legislation was passed, substantial issues involving discrimination in treatment for trans persons remain unresolved).

[80] *See* GRANT ET AL., *supra* note 11, at 72–76; Hong, *supra* note 69, at 98.

[81] TRANSGENDER HEALTH AND THE LAW, *supra* note 71.

[82] *See* GRANT ET AL., *supra* note 11, at 76.

[83] *See, e.g.*, O'Donnabhain v. Comm'r, 134 T.C. 34, 52–53 (2010).

[84] *See, e.g.*, Meriwether v. Faulkner, 821 F.2d 408, 412 (7th Cir. 1987); Pinneke v. Preisser, 623 F.2d 546, 548 (8th Cir. 1980); Doe v. Minn. Dep't of Pub. Welfare, 257 N.W.2d 816, 819 (Minn. 1977).

[85] *See, e.g.*, Rush v. Johnson, 565 F. Supp. 856, 868 (N.D. Ga. 1983) (finding that the plaintiff failed to prove that gender-confirming surgery is accepted in the medical community as a safe and effective treatment).

[86] *See* Hong, *supra* note 69, at 99–100. Recently a court ruled on the deductibility of trans-related care paid for out of pocket. The court, however, relied heavily on the medical model in finding GID to be a disease and its treatment tax deductible. *See O'Donnabhain*, 134 T.C. at 63 ("In view of (1) GID's widely recognized status in diagnostic and psychiatric reference texts as a legitimate diagnosis; (2) the seriousness of the condition as described in learned treatises in evidence and as acknowledged by all three experts in this case; (3) the severity of

New York court overturned the ruling of a family court that had found gender-confirming care medically necessary and ordered that child services provide gender-confirming care to a youth in its custody.[87] In cases challenging bans on gender-confirming care under state Medicaid programs, courts' responses have varied, in some instances finding the care medically necessary to treat GID,[88] and in others upholding bans after finding that the care was not medically necessary.[89] In challenges to denial of care in prison, courts often state that GID is a serious medical condition that may require care,[90] although they are often unwilling to order that care be provided unless the prisoner is engaged in acute self-destructive behavior.[91] Some jurisdictions,

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petitioner's impairment as found by the mental health professionals who examined her; (4) the consensus in the U.S. Courts of Appeal that GID constitutes a serious medical need for purposes of the *Eighth Amendment*, we conclude and hold that GID is a 'disease' for purposes of [26 U.S.C. § 213].").

[87] *See* Mariah L. v. Admin. for Children's Servs., 859 N.Y.S.2d 8 (N.Y. App. Div. 2008); *see also* Judith S. Stern & Claire V. Merkine, Brian L. v. Administration for Children's Services*: Ambivalence Toward Gender Identity Disorder as a Medical Condition*, 30 WOMEN'S RTS. L. REP. 566, 567 (2009) (noting that the lawsuit was filed after "ACS repeatedly sought to avoid its obligation to fund the surgery despite unanimous professional opinions, including those by experts ACS had retained, that the surgery was medically necessary for the adolescent").

[88] *See Pinneke*, 623 F.2d at 549 (rejecting categorical exclusions and finding that "a state plan absolutely excluding the only available treatment known at this stage of the art for a particular condition must be considered an arbitrary denial of benefits based solely on the 'diagnosis, type of illness, or condition' ") (quoting Doe v. Minn. Dep't of Pub. Welfare, 257 N.W.2d 816, 820 (Minn. 1977)); J.D. v. Lackner, 80 Cal. App. 3d 90, 95 (Cal. Dist. Ct. App. 1978) (finding gender-confirming surgery medically necessary under Medi-Cal); *Doe*, 257 N.W.2d at 820 (voiding a state policy that categorically excluded gender-confirming surgery noting that under the policy, such operations were "the only surgical treatment which, if recommended by a physician and related to a patient's health is not covered by the [Minnesota Medicaid] program").

[89] *See* Smith v. Rasmussen, 249 F.3d 755, 761–62 (8th Cir. 2001) (reversing district court's ruling and holding that Iowa's rule denying coverage for SRS was not arbitrary or inconsistent with the Medicaid Act); Rush v. Parham, 625 F.2d 1150, 1152 (5th Cir. 1980) (holding that experimental treatments are not medically necessary and remanding for a determination of whether sex reassignment surgery is experimental).

[90] *See* Allard v. Gomez, 9 Fed. App'x. 793, 794 (9th Cir. 2001) (reversing the district court's summary judgment in favor of prison officials and finding a triable question as to whether inmate's Eighth Amendment rights were violated by failure to provide proper medical treatment by denying hormone therapy); Cuoco v. Moritsugu, 222 F.3d 99, 106 (2d Cir. 2000) (assuming for the purpose of the appeal that transsexualism constitutes a serious medical condition, but dismissing *Bivens* claim for denial of gender-confirming medical care based on qualified immunity and lack of deliberate indifference grounds); Meriwether v. Faulkner, 821 F.2d 408, 411–13 (7th Cir. 1987) (reversing dismissal of trans prisoner's Eighth Amendment action, considering transsexualism a complex medical and psychological problem potentially presenting a serious medical need); Gammett v. Idaho State Bd. of Corr., No. 05-257, 2007 U.S. Dist. LEXIS 55564, at *48 (D. Idaho July 27, 2007) (ordering the department of corrections to provide a trans woman with hormone therapy pending the outcome of her case and relying on medical testimony that hormone therapy is medically necessary and that untreated GID, "is a life-threatening mental health condition").

[91] *See* De'lonta v. Angelone, 330 F.3d 630, 634 (4th Cir. 2003) (reversing dismissal of prisoner's Eighth Amendment claim against prison officials for failing to provide her with proper medical treatment by denying her continued hormone therapy after cessation resulted in self-mutilation of her genitals); Konitzer v. Frank, 711 F. Supp. 2d 874, 908 (E.D. Wis. 2010) ("[A] reasonable jury could find that the defendants were deliberately indifferent to Konitzer's

including federal prisons, provide hormone therapy at the level received prior to incarceration, on the basis that care that the prisoner received prior to incarceration must be continued.[92] In other jurisdictions, the correctional facility's medical department has discretion to decide whether to administer trans-related care to prisoners.[93]

The level of deference courts give to medical evidence that trans-related care is needed often depends on the cost of the necessary care. For example, courts will often defer to medical experts' claims that care is necessary when administering affordable hormones to prisoners,[94] or allowing a tax deduction for medical expenses,[95] but are less deferential to medical determinations of necessity when prisoners[96] or foster children[97] in state custody seek surgery.

ii. Distributive Effects

All cases that find trans-related care medically necessary have relied on GID diagnoses. When courts find trans-related care medically necessary based on evidence that trans identity is a pathology, they produce concrete gains for trans people whose identities are well explained by the medical

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serious medical need when they failed to provide him with the second step of treatment from the Standards of Care, the real-life experience, in the face of his repeated self-mutilations and suicide attempts."). *But see* Kosilek v. Maloney, 221 F. Supp. 2d 156, 158, 194–95 (D. Mass. 2002) (finding inmate failed to prove that the denial of adequate care was a result of deliberate indifference where prisoner had attempted self-castration and suicide following denial of hormones and commissioner had policy of maintaining hormone treatments at pre-incarceration levels).

[92] *See* Philips v. Mich. Dep't of Corr., 731 F. Supp. 792, 800 (W.D. Mich. 1990), *aff'd*, 932 F.2d 969 (6th Cir. 1991) (reinstating hormone treatment for trans prisoner who received treatment prior to incarceration, distinguishing failure "to provide an inmate with care that would improve his or her medical state, such as refusing to provide sex reassignment surgery" from "[t]aking measures which actually reverse the effects of years of healing medical treatment").

[93] *See* Praylor v. Tex. Dep't of Criminal Justice, 430 F.3d 1208, 1209 (5th Cir. 2005) ("Assuming, without deciding, that transsexualism does present a serious medical need, we hold that, on this record, the refusal to provide hormone therapy did not constitute the requisite deliberate indifference."); Fields v. Smith, 712 F. Supp. 2d 830, 855–67 (E.D. Wis. 2010) (striking down a law banning gender-confirming medical care for prisoners, finding that it constituted deliberate indifference to the plaintiff's serious medical needs in violation of the Eighth Amendment by denying hormone therapy without regard for individuals' medical needs and the judgment of their health care providers); Brooks v. Berg, 270 F. Supp. 2d 302, 312 (N.D.N.Y. 2003), *vacated in part for procedural reasons*, 289 F. Supp. 2d 286 (N.D.N.Y. 2003) ("Prison officials are . . . obliged to determine whether [a transsexual prisoner] has a serious medical need and, if so, to provide him with at least some treatment.").

[94] *See supra* notes 92–93.

[95] *See* O'Donnabhain v. Comm'r, 134 T.C. 34, 70–71 (2010).

[96] *See* Maggert v. Hanks, 131 F.3d 670, 672 (7th Cir. 1997) (affirming trial court's dismissal of prisoner's Eighth Amendment claim for denial of gender-confirming care in the absence of "special circumstances" and stating that, given the cost of surgery, "[w]e do not want transsexuals committing crimes because it is the only route to obtaining a cure"); Kosilek v. Maloney, 221 F. Supp. 2d 156, 194–95 (D. Mass. 2002).

[97] *See* Mariah L. v. Admin. for Children's Servs., 859 N.Y.S.2d 8, 19–20 (N.Y. App. Div. 2008).

model, such as Jesse, *the trapped man*. However, for trans people who do not have a GID diagnosis, either because they are opposed to the pathologization of their identity or because they do not meet the "criteria," these cases do not produce gains.

Legal arguments for medical necessity without a GID diagnosis are unprecedented, but they should be considered as the option of obtaining hormones based on informed consent, without a diagnosis, becomes more common. Such arguments may be barred under existing case law that only understands trans rights when associated with medical diagnoses. Yet arguments for medical necessity without a GID diagnosis could undermine current recognition of the medical necessity by exposing a lack of consensus in the scientific community regarding the basis for providing such care.

For those who conform to the medical model, the recognition of the medical necessity of care can have positive spillover effects by increasing the recognition of the medical model in other areas of law.[98] At the same time, for those opposed to the medicalization of trans identities, or those who do not seek medical intervention—such as Jesse, *the gender chameleon* and Jesse, *the muted man*—the entrenchment of the notion that trans people suffer so much psychologically that without medical intervention they may die,[99] produces an inaccurate and incomplete framing.

B. Identity Documents

i. Doctrine

In order to modify gender markers on identity documents, trans people must navigate the policies of multiple agencies that administer these documents, including departments of health and human services, the Social Security Administration, and departments of motor vehicles. In response to society's growing awareness of the trans population, many agencies have adopted policies that allow individuals to change gender markers.[100] State agencies that allow changes require varying degrees of evidence of trans-related care, from vague doctor's notes to completion of specific surgeries.[101] The Social Security Administration requires a letter from a surgeon stating that "sex reassignment surgery" has been completed, although the term is

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[98] *See, e.g.*, *O'Donnabhain*, 134 T.C. at 62 (relying on several prison care cases in determining that GID is a disease for purposes of a tax deduction).

[99] *Id.* at 43, 58–59 (finding gender-confirming care medically necessary by relying on a medical expert's opinion that failure to treat GID with gender-confirming care may result in suicide).

[100] *See* Spade, *supra* note 10, at 733–34.

[101] For a discussion of these requirements and a list of all state requirements, see *id.* at 734–36, 822–32 apps. 1–3.

not defined.[102] The State Department requires a letter from a licensed physician for gender change on a passport.[103] Forty-nine states allow gender change on a birth certificate, and each requires proof of surgery.[104] DMV requirements for gender reclassification vary by state, with the most lenient requiring only a doctor's letter that need not specify completion of surgery, and others requiring proof of surgery, an amended birth certificate, a court order, or some combination thereof.[105]

Although a name change does not adjudicate one's gender, courts have relied on medical evidence when ruling on name changes of trans people. In the past, courts denied name changes where the petitioner failed to introduce medical evidence of transition, fearing that the person may "defraud" the public.[106] More recently, courts have shifted away from requirements of medical evidence, and have granted name change requests without medical evidence, recognizing the right to change one's name absent fraud.[107] When courts do rely on medical evidence, it is not as evidence of an essential gender change, but to determine whether the applicant is "committed" to her gender.[108] Although a name change does not determine gender, some courts go out of their way to clarify that they are not adjudicating gender.[109]

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[102] *See* SOC. SEC. ADMIN., PROGRAM OPERATIONS MANUAL SYSTEM § RM 10212.200, CHANGING NUMIDENT DATA FOR REASONS OTHER THAN NAME CHANGE (2011), *available at* http://policy.ssa.gov/poms.nsf/lnx/0110212200.

[103] U.S. DEP'T OF STATE, FOREIGN AFFAIRS MANUAL, 7 FAM. 1300 APP'X M (2011), *available at* http://www.state.gov/documents/organization/143160.pdf.

[104] Spade, *supra* note 10, at 768, 832 app. 3 (listing state requirements for gender classification on birth certificates). Tennessee is the only state that forbids changing gender on birth certificate. *See* TENN. CODE ANN. § 68-3-203(d) (2006).

[105] Spade, *supra* note 10, at 822–31 apps. 1–2 (listing the requirements of each state's DMV for changing gender).

[106] *See, e.g.*, In re Anonymous, 155 Misc. 2d 241, 241–42 (N.Y. Civ. Ct. 1992) (denying trans woman's application for name change where she did not introduce evidence that she had completed "a sex change operation").

[107] *See, e.g.*, In re McIntyre, 715 A.2d 400, 403 (Pa. 1998) (granting name change request and overturning lower court's denial of name change request pending petitioner's completion of sex reassignment surgery); Matter of Winn-Ritzenberg, 891 N.Y.S.2d 220, 220–21 (N.Y. App. Term 2009) ("There is no sound basis in law or policy to engraft upon the statutory provisions an additional requirement that a transgendered-petitioner present medical substantiation for the desired name change."); Matter of Eck, 584 A.2d 859, 860–61 (N.J. Super. Ct. App. Div. 1991) (reversing court below and ordering name change for trans woman, citing medical expert testimony that she was a "true transsexual," but stating that has no bearing on name change).

[108] *In re* Harris, 707 A.2d 225, 227–28 (Pa. Super. Ct. 1997) (granting name change where trans woman had lived as a women for over twenty years, and "gone to . . . great[] lengths" to "permanently alter" her gender including hormone therapy and reconstructive surgeries but not bottom surgery).

[109] *In re* Guido, 1 Misc. 3d 825, 826, 828 (N.Y. Civ. Ct. 2003) (citing trans woman's GID diagnosis and medical care when granting name change, but stating that order could not serve as evidence of a court acknowledgment of a change in gender); *In re* Rivera, 165 Misc. 2d 307, 311–12 (N.Y. Civ. Ct. 1995) (granting name change subject to the condition that the applicant could not use the grant of name change as any evidence whatsoever or as a judicial determination that the sex of the applicant had in fact been changed anatomically).

ii. Distributive Effects

Identity documents that accurately reflect one's gender identity are important to navigating daily life. When gender markers on identity documents do not conform to gender expression, trans people often face acute social and economic consequences.[110] Whenever a trans person's gender identity is challenged—for example in a bathroom or other sex-segregated space—identity documents serve as a proof of gender with the potential to keep the person safe from violence and harassment, or expose her to it. Failure to produce identity documents that match one's gender identity is a substantial driver of employment discrimination and unemployment among trans people.[111] Given the unclear status of anti-discrimination protection for trans people, employers often deny jobs to trans applicants once aware of their gender history.[112]

Requirements to change gender have income-based effects. Because a letter from a doctor is required to change gender markers on ID, those without access to a doctor will be left with IDs that do not reflect their gender. When states require evidence of surgery—as required for changing gender on their birth certificates in any state—the income-based impact is even greater. Thus, even for those who experience their identity in a manner consistent with the medical model, stringent requirements have distributive effects. Jesse, *the trapped man*, fit the medical model's pathologized notion of a trans person, but he has not completed gender-confirming surgery, and is therefore denied recognition of his gender on identity documents.[113]

The requirement of evidence of medical intervention also has distributive effects for those who do not conform to the medical model. Jesse, *the muted man*, who has undergone no medical intervention, will be unable to modify his birth certificate, passport, and Social Security Administration records. For a change of DMV ID, even in the most lenient states which do not require evidence of surgery or hormones, a physician or psychologist must certify an applicant's gender identification.[114] Those savvy enough to navigate the DMV bureaucracies, however, such as Jesse, *the gender chameleon*, can exploit the system by convincing bureaucrats to make the change based on the trans person's appearance and common notions of gender.

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[110] *See* Spade, *supra* note 10, at 751.

[111] *Id.*; GRANT ET AL., *supra* note 11, at 53.

[112] *See* Glenn v. Brumby, 724 F. Supp. 2d 1284, 1291 (N.D. Ga. 2010) ("Before terminating Glenn, Brumby conducted legal research to determine the legality of firing her based upon her gender transition . . . . [S]ome authority indicated that terminating an employee for undergoing gender transition was illegal, but some authority indicated that such firings are permissible."); *see also* Spade, *supra* note 10, at 752.

[113] The WPATH Standards of Care for GID treatment do not recommend surgery for all trans people. *See* STANDARDS OF CARE, *supra* note 28.

[114] *See, e.g.*, CAL. DEP'T OF MOTOR VEHICLES, MEDICAL CERTIFICATION AND AUTHORIZATION (GENDER CHANGE) (2008), *available at* http://www.dmv.ca.gov/forms/dl/dl329.pdf.

Identity requirements in and of themselves present a problem for those who seek to challenge the gender binary. This constituency wants to move away from gender as a basis of categorizing people. The stability of the binary categories is undermined, however, by the ability to move between them. Thus, a change in rules that allows more trans people to modify gender markers on identification can also serve the goals of this constituency, albeit indirectly.

C. Education

i. Doctrine

Because of the policing of gender norms in schools, by both students and administrators, many trans people are denied access to an education. Schools often place trans students in gender-segregated spaces that conflict with their gender identities, refer to them with the incorrect pronouns or names, and force them to wear gender-specific clothing.[115] Trans students often face bullying and harassment by teachers, administrators, and students.[116]

While many issues are dealt with among schools, students, and families, some trans students have sought redress in court. In one case, a trans student filed a claim against a school for constructively expelling her by refusing to allow her to attend in girls clothing.[117] The court relied on the medical model in denying the school's motion to dismiss, finding that the student's GID diagnosis could justify a disability claim and that requiring her to attend school in men's clothing could endanger her "psychiatric health," thus serving as a constructive expulsion.[118]

ii. Distributive Effects

Recognition of GID as a basis upon which a student can deviate from the norms of the gender assigned to her at birth could produce concrete gains for those youth who fit the criteria for a diagnosis. As reflected in Jesse, *the spurned youth*'s experience, however, many youth—including those who come from low-income families, are in foster care, or have hostile parents—who fit the criteria are still unable to obtain a diagnosis because they lack access to care.[119]

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[115] GAY, LESBIAN, & STRAIGHT EDUC. NETWORK, NATIONAL SCHOOL CLIMATE SURVEY 67, 88 (2009), *available at* http://www.glsen.org/binary-data/GLSEN_ATTACHMENTS/file/000/001/1675-1.pdf.

[116] *Id.*

[117] Doe v. Yunits, 15 Mass. L. Rep. 278 (Mass. Super. Ct. 2001) (unpublished).

[118] *Id.*

[119] *See* Spade, *supra* note 16, at 33–35.

Gender-non-conforming youth who do not identify as trans or do not meet the criteria for a GID diagnosis do not benefit directly from these victories.[120] When courts recognize GID as a proper basis for deviating from norms of the gender assigned at birth, but do not recognize gender non-conformity, the norms remain unchallenged. These victories entrench the idea that only gender non-conformity that is essential to a student's identity should be protected, thus forcing those such as Jesse, *the gender chameleon*, to state insincere legal claims, consequently invalidating the experiences of those like Jesse, *the muted man* who do not adhere to the script of identity categories.[121]

D. Family

i. Doctrine

The state scrutinizes trans people's gender in the context of the family. While trans people are often able to obtain a heterosexual-marriage license with the proper showing of identity documents that match their gender, the status of these marriages remains uncertain if later challenged in court, as most states have not ruled on whether such marriages are valid.[122]

In determining the validity of a marriage, courts make findings of trans persons' gender as a matter of law. Such courts usually decline to adopt the medical model's view that gender identity coupled with medical operations can transform a person's gender. Instead courts invoke "common sense" notions of sex, describing it as fixed or immutable from birth, or noting that chromosomes cannot be changed.[123] In declining to defer to medical evi-

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[120] Paisley Currah compares the outcome in *Yunits* with a case in which a non-trans-identified student challenged a school's policy requiring females to wear specific attire for a yearbook photo. Paisley Currah, *Gender Pluralisms*, *in* TRANSGENDER RIGHTS, *supra* note 38, at 3, 7–13 (discussing Youngblood v. Sch. Bd. of Hillsborough County, No. 02-15924-CC (11th Cir. May 5, 2003)). Her gender identity comported with the gender assigned to her at birth, so she could not claim to suffer from a mental illness, and her challenge was unsuccessful. *Id.*

[121] *See* Gilden, *supra* note 46, at 113–15.

[122] The issue has been adjudicated, with varying results, in New Jersey, Florida, Kansas, Texas, Ohio, New York, and California. *See infra* note 123.

[123] *See* Kantaras v. Kantaras, 884 So. 2d 155, 161 (Fla. Dist. Ct. App. 2004) (finding a trans man's marriage invalid, despite medical evidence of his change of sex, stating "the common meaning of male and female, as those terms are used statutorily, . . . refer to immutable traits determined at birth"), *review denied*, 898 So. 2d 80 (Fla. 2005); *In re* Estate of Gardiner, 42 P.3d 120, 137 (Kan. 2002) (holding that a trans woman was male for the purposes of marriage even after she had completed numerous gender-confirming surgeries, hormone therapy, and counseling), *cert. denied sub nom* Gardiner v. Gardiner, 537 U.S. 825 (2002); B v. B, 355 N.Y.S.2d 712, 717 (N.Y. Sup. Ct. 1974) ("Assuming, as urged, that defendant was a male entrapped in the body of a female, the record does not show that the entrapped male successfully escaped to enable defendant to perform male functions in a marriage."); In re Ladrach, 32 Ohio Misc. 2d 6, 10 (Ohio Prob. Ct. 1987) (denying trans woman's application for marriage license to marry a man stating that nothing can change the "true sex" assigned at birth); Littleton v. Prange, 9 S.W.3d 223, 224, 231 (Tex. App. 1999) (rejecting the notion that "a physician [can] change the gender of a person with a scalpel, drugs and counseling" and

dence of change of sex, these courts often state that the question of whether one can marry as a member of a sex other than the one assigned at birth is an issue of "public policy" to be resolved by the legislature.[124] In the two states that have recognized trans people's heterosexual marriages, the courts relied on medical evidence, including completed surgery, in affirming trans persons' gender.[125]

Trans parents create legally recognized relationships with children through a biological connection, presumed parenthood through marriage or domestic partnership, or adoption. Yet when adjudicating custody disputes in the "best interests of the child," some courts look to the trans parent's gender identity's effect on the child.[126] Because courts routinely rely on a parent's mental health as a factor in determining the best interests of the child, a GID diagnosis may be detrimental to the case of a parent seeking visitation or custody.[127] In addition, courts have denied custody to parents who facilitate their child's transition.[128]

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holding that a trans woman was male for the purposes of marriage). *But see* Vecchione v. Vecchione, No. 96D003769 (Cal. Super. Ct. Nov. 26, 1997) (finding trans man's marriage valid); M.T. v. J.T., 355 A.2d 204, 210–11 (N.J. Super. Ct. App. Div. 1976) (upholding a trans woman's marriage finding her to be legally female).

[124] *Kantaras*, 884 So. 2d at 161 ("Whether advances in medical science support a change in the meaning commonly attributed to the terms male and female as they are used in the Florida marriage statutes is a question that raises issues of public policy that should be addressed by the legislature."); *In re* Estate of Gardiner, 42 P.3d at 137 ("[T]he validity of [the] marriage is a question of public policy to be addressed by the legislature and not by this court."); *In re* Nash, Nos. 2002-T-0149, 2002-T-0179, 2003 WL 23097095 (Ohio Ct. App. Dec. 31, 2003) (holding a marriage between a trans man and his wife void as against public policy).

[125] *See Vecchione*, No. 96D003769 (Cal. Super. Ct. Nov. 26, 1997) (finding that a trans man who had undergone multiple surgeries and hormone therapy was considered a man for the purposes of marriage); *M.T. v. J.T.*, 355 A.2d at 210–11 ("If . . . sex reassignment surgery is successful and the postoperative transsexual is, by virtue of medical treatment, thereby possessed of the full capacity to function sexually as a male or female, as the case may be, we perceive no legal barrier, cognizable social taboo, or reason grounded in public policy to prevent that person's identification at least for purposes of marriage to the sex finally indicated."); *see also In re* Estate of Gardiner, 22 P.3d 1086 (Kan. Ct. App. 2001) (relying on evidence of GID in holding that sex is determined by considering multiple factors including gender identity), *rev'd*, *In re* Estate of Gardiner, 42 P.3d at 120.

[126] *In re* Marriage of Magnuson, 170 P.3d 65, 67 (Wash. Ct. App. 2007) (holding that lower court did not impermissibly consider the effect of father's transition on the children in granting residential placement to the mother); J.L.S. v. D.K.S., 943 S.W.2d 766, 774 (Mo. Ct. App. 1997) (reversing the trial court's award of joint custody basing its decision in part on the parent's trans identity and recent sex reassignment surgery).

[127] *See, e.g.*, Sinsabaugh v. Heinerscheid, 428 N.W.2d 476, 479–80 (Minn. Ct. App. 1988) (relying on the mother's mental health diagnosis of depression and anxiety as a factor in awarding custody to the father); *see also J.L.S.*, 943 S.W.2d at 770–73 (discussing expert evidence of trans parent's GID and its effect on children noting that the parent's gender identity could cause emotional problems for the children and remanding to the trial court to "determine the mental and emotional status of the parents and children to determine what is in the best interests of the children").

[128] *See, e.g.*, Smith v. Smith, No. 05 JE 42, 2007 WL 901599 (Ohio Ct. App. Mar. 23, 2007).

ii. Distributive Effects

Because sex categorization for the purposes of marriage is heavily based on medical evidence, it disadvantages those who do not conform to the medical model. For example, many trans people are unable to obtain a heterosexual-marriage license in the first instance, as it is based on the ability to provide evidence of one's gender in identity documents. In addition, where courts adopt the medical model in order to recognize gender identity for marriage, by relying on evidence like surgery, the success is limited to those who conform to the model.[129]

On the other hand, when courts decline to recognize a trans person's gender based on medical evidence, they set a precedent that allows trans people to marry another person of the same gender. Thus, Jesse, *the gender chameleon*, can marry another man in a state where same-sex marriage is prohibited.

In the area of custody, the medical model actually has negative distributive consequences for those who conform to it, as both the pathologization of the parent's identity and the desire to subject one's child to the model provide a basis for challenging custodial rights.

E. Employment

i. Doctrine

Many trans people face employment discrimination due to their gender identity.[130] For most, stating a claim of discrimination is unrealistic due to inherent problems of proof of discrimination, and the particular difficulty trans people face in finding legal advocates.[131] This is one area of law that has been welcoming to arguments outside of the medical model—although some successes have come at the cost of disavowing self-identified gender, and initial victories often prove pyrrhic as courts are persuaded that adverse employment actions are justified by countervailing interests to exclude trans people from bathrooms based on genitalia.

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[129] *See Vecchione*, No. 96D003769 (Cal. Super. Ct. Nov. 26, 1997); *M.T.*, 355 A.2d at 210–11; *see also* Nat'l Ctr. for Lesbian Rights, Press Release, Florida Court of Appeal Invalidates Marriage But Rejects Mother's Request to Deprive Transgender Father of Parental Rights (July 23, 2004), *available at* http://www.transgenderlaw.org/kantarasjuly04.pdf (discussing Kantaras v. Kantaras, No. 98-5375CA (Fla. 6th Cir. Ct. Feb. 21, 2003) *rev'd*, 884 So. 2d 155 (Fla. Cir. Ct. 2004), *review denied*, 898 So. 2d 80 (Fla. 2005)) (ruling that trans man was male for purposes of marriage in an over eight-hundred-page decision reviewing medical history of transsexualism)).

[130] GRANT ET AL., *supra* note 11, at 50–70.

[131] DEAN SPADE, *Compliance is Gendered: Struggling for Gender Self-Determination in a Hostile Economy*, in TRANSGENDER RIGHTS, *supra* note 38, at 217, 228 (discussing the difficulty that trans people face in accessing legal services).

Some state laws[132] and local ordinances[133] prohibit discrimination on the basis of gender identity, leaving the framing of the identity less complex. Where this protection is unavailable, however, trans plaintiffs have brought actions under Title VII's prohibition against discrimination "because of sex." When pleading an antidiscrimination claim under Title VII, a trans person can characterize her gender in a number of ways. Trans plaintiffs have claimed discrimination based on their sex assigned at birth,[134] as their self-identified sex,[135] or both.[136] In the past, courts commonly rejected trans people's discrimination claims on the ground that transsexuals are not a protected class,[137] but more recently courts have held that trans identity is not fatal to a claim of employment discrimination under Title VII.[138]

When pleading a sex-stereotyping claim based on the sex assigned at birth, a trans litigant does not challenge the supposedly fixed nature of that sex. It is noteworthy that this characterization of identity requires a trans litigant to disavow her self-identified gender for the purpose of pleading the claim. In such cases, the court need not rely on the medical model to find that discrimination occurred.[139] Nevertheless, courts often discuss the plain-

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[132] *See* CAL. GOV'T CODE §§ 12926(p), 12940 (West 2005); CAL. PENAL CODE § 422.56(c) (West 2005); COLO. REV. STAT. ANN. §§ 2-4-401(13.5), 24-34-402 (West 2009); D.C. CODE §§ 2-1401.02 (12A), 2-1402.11 (2010); 775 ILL. COMP. STAT. 5/1-103 (O-1),(Q), 5/2-102(A) (2010); IOWA CODE ANN. §§ 216.2(10), 216.6 (West 2009); ME. REV. STAT. ANN. tit. 5, §§ 4553(9-C), 4572 (2007); MINN. STAT. ANN. §§ 363A.03(44), 363A.08 (West 2010); N.J. STAT. ANN. §§ 10:5-4, 10:5-5 (rr) (West 2010); N.M. STAT. ANN. §§ 28-1-2 (q), 28-1-7 (West 2007); OR. REV. STAT. ANN. §§ 174.100(6), 659A.030(1) (West 2008); R.I. GEN. LAWS §§ 28-5-6 (10), 28-5-7 (2009); VT. STAT. ANN. tit. 1 § 144 (2007); VT. STAT. ANN. tit. 21 § 495(a) (2007); WASH. REV. CODE ANN. §§ 49.60.030(1)(a), 49.60.040(26) (2009).

[133] *See, e.g.*, BOS., MASS., MUN. CODE § 12-9.1 (2010); NORTHAMPTON, MASS., MUN. CODE § 22-104 (2005); N.Y.C., N.Y., ADMIN. CODE §§ 8-102(23), 8-107(A) (2009); PORTLAND, OR., CODE § 23.01.010 (2010); SEATTLE, WASH., MUN. CODE § 14.04.040 (2008).

[134] *See, e.g.*, Barnes v. Cincinnati, 401 F.3d 729, 733, 737 (6th Cir. 2005); Smith v. Salem, 378 F.3d 566, 571–72 (6th Cir. 2004).

[135] *See, e.g.*, Ulane v. E. Airlines, Inc., 742 F.2d 1081, 1082 (7th Cir. 1984); Kastl v. Maricopa Cnty. Cmty. Coll. Dist., No. CV-02-1531-PHX-SRB, 2006 WL 2460636, at *1–2 (D. Ariz. Aug. 22, 2006), *aff'd*, 325 Fed. App'x 492 (9th Cir. 2009).

[136] *See, e.g.*, Amended Complaint at ¶¶ 56–58, Schroer v. Billington, 577 F. Supp. 2d 293 (D.D.C. 2008).

[137] *See, e.g.*, *Ulane*, 742 F.2d at 1087; Sommers v. Budget Mktg., Inc., 667 F.2d 748, 750 (8th Cir. 1982) (per curiam); Holloway v. Arthur Andersen & Co., 566 F.2d 659, 664 (9th Cir. 1977).

[138] *See, e.g.*, *Smith*, 378 F.3d at 575 ("Sex stereotyping based on a person's gender non-conforming behavior is impermissible discrimination, irrespective of the cause of that behavior; a label, such as 'transsexual,' is not fatal to a sex discrimination claim where the victim has suffered discrimination because of his or her gender non-conformity."); *Barnes*, 401 F.3d at 737 (similar); *see also Schroer*, 577 F. Supp. 2d at 307 (holding that trans plaintiff stated a claim under Title VII and reasoning that it applies in ways Congress could not have contemplated) (citing Oncale v. Sundowner Offshore Servs., Inc., 523 U.S. 75, 79 (1998) (holding male on male sexual harassment violated Title VII reasoning that the Act is not limited in application to principal intent of legislators)).

[139] *Barnes*, 401 F.3d at 733 (affirming judgment in favor of trans woman's sex stereotyping claim pled as a gender-non-conforming man without citing the medical model).

tiff's medical diagnosis at length.[140] Although this discussion is not central to the ruling in these cases, it justifies the litigants' extreme departure from the gender assigned at birth, labeling it as a core part of their identity, and distinguishing it from volitional gendered behavior.[141]

More recently, trans litigants have pled claims as the self-identified sex, relying on the medical model as a basis for arguing that gender identity is one component of a person's sex.[142] For example, in *Schroer v. Billington*, a trans woman pled her discrimination claim as a woman, not a gender-non-conforming man.[143] The plaintiff provided extensive evidence of the medical model, including briefing requested by the court on the etiology of trans identity. The court ultimately declined to categorize the plaintiff as a gender-non-conforming man, a gender-non-conforming woman, or a transsexual, finding that the discrimination occurred based on sex stereotyping of the plaintiff as a member of either one of those protected classes, and based on the plain meaning of sex in the statute.[144] The court analogized to religion, reasoning that if an employer terminated a convert for changing religions, a court would certainly consider it discrimination "because of religion." Thus, when an employer terminates a trans person for changing her sex, the adverse action is similarly discrimination "because of sex."[145] Advocates in *Schroer* were prepared to use the medical model as a core component of their argument, but the court conferred a legal benefit on the plaintiff without adhering to the strict confines of the medical model or demanding a showing of trans-related surgery. The court's holding in *Schroer* demonstrates that successful arguments need not be based on the medical model.

But such victories may often prove pyrrhic. Even after trans people state a prima facie case of discrimination, many employers have defeated these claims by arguing that the adverse employment action was based on a legitimate non-discriminatory reason, namely the concern that if a trans employee used a bathroom with genitalia not traditionally associated with the gender assigned to that bathroom, she would violate the trust, privacy, or

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[140] Etsitty v. Utah Transit Auth., 502 F.3d 1215, 1218–19 (10th Cir. 2007) (citing the plaintiff's GID diagnosis, mental health treatment, hormone therapy, and transition plan); *Smith*, 378 F.3d at 568 (noting the plaintiff's GID diagnosis and the DSM); Glenn v. Brumby, 724 F. Supp 2d. 1284, 1289–90 (N.D. Ga. 2010) (citing the criteria for GID in the DSM, the WPATH Standards of Care, and the plaintiff's gender identification during puberty).

[141] An example of disregard for seemingly volitional gendered conduct can be seen in *Jespersen v. Harrah's Operating Co.*, 444 F.3d 1104, 1106 (9th Cir. 2006) (en banc), in which the court rejected plaintiff's sex-stereotyping claim for being fired after refusing to wear make-up.

[142] *See* Kastl v. Maricopa Cnty. Cmty. Coll. Dist., No. CV-02-1531-PHX-SRB, 2006 WL 2460636, at *2 (D. Ariz. Aug. 22, 2006), *aff'd*, 325 Fed. App'x 492 (9th Cir. 2009) ("Plaintiff alleged that she is 'biologically female, determined in accordance with the portion of her brain that determines gender identity, her overall physiology, and as confirmed by two (2) PhD psychologists and at least one medical doctor.' ").

[143] Amended Complaint, *supra* note 136, at ¶ 52 ("Plaintiff is a female.").

[144] Schroer v. Billington, 577 F. Supp. 2d 293, 305 (D.D.C. 2008).

[145] *Id.* at 306, 308.

safety of others.[146] Courts that find the bathroom defense persuasive thereby predicate successful sex-stereotyping claims on completion of genital surgery, which many trans people do not undergo.

ii. Distributive Effects

The role of the medical model in employment discrimination is muted, as courts have not explicitly relied on the medical model to categorize litigants according to their genders for the purposes of stating a claim, or to defeat a bathroom defense. Nevertheless, advocates' attempts to integrate the model into this body of law have distributive consequences.

While courts have not relied on the medical model in their holdings, a medical model history has existed in the factual background of almost all of these cases. Thus, if Jesse, *the muted man*, were to bring a case as his male self-identified gender, it is not clear that even a court as sympathetic as the *Schroer* court would consider him a "convert" without any medical evidence of transition. Under existing law, he would be able to state a claim of sex stereotyping in many jurisdictions, but this would require him to disavow his gender identity and plead the case as a woman.

Title VII gender-stereotyping cases have provided concrete gains for trans litigants but misrecognize trans people's gender identity. Because the sex-stereotyping claim requires trans people to disavow their self-identified gender, it is available only to those trans people who will deploy their gender opportunistically. Further, entrenching this misrecognition in an influential body of law sets a negative precedent that courts may rely on in other areas of law to deny recognition of trans people's self-identified gender.

The shortcomings of sex-stereotyping claims, and the success of the bathroom defense, were catalysts for advancing the argument that gender identity has a biological etiology and is therefore a part of sex in the narrow (biological) sense of the word.[147] If gender identity determines sex as a matter of medical fact—as this argument proposes—a rule preventing anyone other than a biological woman from using the women's bathroom would not be legitimate grounds for terminating a trans woman. Although this argument has yet to be embraced by a court in the United States, it is relevant here because it appears to be the next wave in trans Title VII litigation strat-

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[146] This defense has been successful in cases brought under state and local ordinances prohibiting discrimination based on gender identity as well as under Title VII. *See Kastl*, 325 Fed. App'x at 493 (affirming summary judgment for defendant on plaintiff's Title VII claim where employer banned her from using restroom until she completed "sex reassignment surgery," and finding plaintiff failed to show employer's actions were motivated by gender, not safety reasons); Goins v. West Grp., 635 N.W.2d 717, 723 (Minn. 2001). *But see* Glenn v. Brumby, 724 F. Supp. 2d 1284, 1302–03 (N.D. Ga. 2010) (finding the employer's bathroom concern did not withstand intermediate scrutiny).

[147] *See* McGowan, *supra* note 47, at 240–41. A similar shift to a reliance on a biological etiology occurred in the context of gay rights in the 1990s; for a critique of this move, see Janet E. Halley, *Sexual Orientation and the Politics of Biology: A Critique of the Argument From Immutability*, 46 STAN. L. REV. 503 (1994).

egy.[148] For those who do not conform to the medical model, however, this argument is problematic. Any future successful argument on this ground will likely exclude a large subset of the trans population who cannot, or choose not to, certify their gender with a GID diagnosis. This approach also fails to challenge the binary nature of sex, because it simply provides additional criteria on which to base sex categorization, but leaves the validity of the categories of male and female unchallenged.[149]

A softer distributive effect is driven by the selection of plaintiffs that conform to the medical model when advancing these cases in impact litigation. The medical model produces trans identity as immutable and does not challenge gender norms, thus making these plaintiffs more palatable to courts. At the same time, many trans people do not view their identity as immutable and explicitly seek to challenge gender norms. So while impact litigation serves the role of advancing novel legal arguments, the decision not to advance arguments that are more encompassing of diverse trans identities is telling, as it has profound effects for framing the identity in law. These choices produce negative distributive effects, even if they do not strictly prohibit a discrimination claim. In fact, the ability to frame one's identity may be worth more than the ability to successfully state a Title VII claim.

Conclusion

When legal advocates rely on the medical model in an attempt to lay ground rules for the treatment of trans people in law, they cannot determine a priori that these rules will be "good" for trans people. The outcomes are complex, and the desired results often conflict, which makes the determination of an ideal method of collective action a thorny issue. While the distributive analysis does not identify one correct approach, it does provide the following insights: favorable rulings need not be based on medical evidence such as a GID diagnosis, hormone therapy, or completion of gender-confirming surgeries, unless directly relevant to the claim;[150] outcomes of advocacy based on the medical model are indeterminate, even for those who conform to the model; advancing arguments from outside of the medical model can avoid the intellectual hurdles required to essentialize trans identity within existing understandings of sex; and the use of the medical model as a frame limits the ability to claim legal and social authority for alternate

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[148] *See* McGowan, *supra* note 47, at 240–42. Indeed, such litigation is already making waves abroad. *See, e.g.*, *Kevin v Att'y Gen.* (2001) 165 F.L.R. 404, 472 (Austl.) ("I have found on the balance of probabilities that Kevin's sense of being a man is based on some biological characteristics of his brain.").

[149] *See* Gilden, *supra* note 46, at 86.

[150] For example, in the context of health-care related claims, reliance on the medical model may remain necessary for the foreseeable future. Even here, however, advocates must consider how to advance arguments of medical necessity as the medical community shifts to providing care based on informed consent in lieu of a GID diagnosis.

understandings of trans identity. Thus, reliance on the medical model should be limitedly employed with these consequences in mind, and advocates should utilize more encompassing arguments when attempting to shape the law governing trans persons' lives.