

1 LATHAM & WATKINS LLP
 Marvin S. Putnam (SBN 212839)
 2 marvin.putnam@lw.com
 Amy C. Quartarolo (SBN 222144)
 3 amy.quartarolo@lw.com
 Adam S. Sieff (SBN 302030)
 4 adam.sieff@lw.com
 Harrison J. White (SBN 307790)
 5 harrison.white@lw.com
 355 South Grand Avenue, Suite 100
 6 Los Angeles, California 90071-1560
 Telephone: +1.213.485.1234
 7 Facsimile: +1.213.891.8763

8 National Center for Lesbian Rights
 Shannon P. Minter (SBN 168907)
 9 sminter@nclrights.org
 Amy Whelan (SBN 2155675)
 10 awhelan@nclrights.org
 870 Market Street, Suite 360
 11 San Francisco, CA 94102
 Telephone: +1.415.392.6257
 12 Facsimile: +1.415.392.8442

13 GLBTQ Legal Advocates & Defenders
 Jennifer Levi (*pro hac vice forthcoming*)
 14 jlevi@glad.org
 Mary L. Bonauto (*pro hac vice forthcoming*)
 15 mbonauto@glad.org
 30 Winter Street, Suite 800
 16 Boston, MA 02108
 Telephone: +1.617.426.1350
 Facsimile: +1.617.426.3594

17 *Attorneys for Plaintiffs*
 18 *Aiden Stockman, Nicolas Talbott,*
Tamasyn Reeves, Jaquice Tate, John Does 1-2,
 19 *Jane Doe, and Equality California*

20 UNITED STATES DISTRICT COURT
 21 CENTRAL DISTRICT OF CALIFORNIA

22 AIDEN STOCKMAN; NICOLAS
 23 TALBOTT; TAMASYN REEVES;
 JAQUICE TATE; JOHN DOES 1-2;
 24 JANE DOE; and EQUALITY
 CALIFORNIA,

25 Plaintiffs,

26 v.

27 DONALD J. TRUMP, et al.

28 Defendants.

CASE NO. 5:17-cv-01799-JGB-KKx

**DECLARATION OF MARGARET
 C. WILMOTH IN SUPPORT OF
 PLAINTIFFS' MOTION FOR
 PRELIMINARY INJUNCTION**

1 I, Margaret Chamberlain Wilmoth, declare as follows:

2 **Background and Experience**

3 1. I served as Deputy Surgeon General for Mobilization, Readiness and
4 Army Reserve Affairs in the Office of the Surgeon General of the United States
5 Army from July 2014 to May 1, 2017.

6 2. I received a Bachelor's degree in Nursing from the University of
7 Maryland in 1975, followed by a Master's Degree in Nursing from the University
8 of Maryland in 1979. I received a Ph.D. in Nursing from the University of
9 Pennsylvania in 1993. I received a Master's Degree in Strategic Studies from the
10 United States Army War College in 2001. I am a Registered Nurse.

11 3. My family's history of military service dates back to the
12 Revolutionary War. As a small child, I grew up hearing the stories of an aunt who
13 was a nurse and a neighbor who had served as an Army nurse during World War
14 II. From the time I was 6 or 7 years old, I knew I wanted to be an Army nurse.
15 When I graduated with my nursing degrees at the end of the Vietnam War, the
16 Army was drawing down, so I went into civilian practice. I spent the first seven
17 years of my nursing career as a teacher and researcher.

18 4. While I was teaching at the University of Delaware, my father, who
19 had joined the Air Force Reserve after serving as a pilot, encouraged me to pursue
20 my dream of serving as an Army nurse by joining the United States Army Reserve
21 (U.S.A.R.). I joined the U.S.A.R. in 1981 and served in various capacities during
22 over thirty-five years in service, achieving the ranks of Captain, Major, Lieutenant
23 Colonel, Colonel, Brigadier General, and Major General, before my retirement
24 from the military on May 1, 2017. When I was promoted to Brigadier General in
25 2005, I became the first nurse and first woman to command a medical brigade as a
26 general officer. When I was promoted to Major General, I became only the third
27 nurse from the Army Reserve ever to achieve that rank.

28 5. From July of 2008 through October 2011, I served as Assistant for

1 Mobilization and Reserve Affairs in the Office of the Secretary of Defense for
2 Health Affairs. From October 2011 through July of 2014, I served in the Control
3 Group. In July of 2014, I was appointed Deputy Surgeon General for Mobilization
4 and Reserve Affairs. When I received this appointment, I became the first nurse in
5 the more than 106-year history of the Army Reserve and the first woman to serve
6 in this position. I held this position until my retirement from the military on May
7 1, 2017.

8 6. In August of 2014, I was also appointed by the Secretary of the Army
9 to the Army Reserve Forces Policy Committee, where I most recently served as
10 Deputy Chair. This congressionally-mandated committee's role includes advising
11 the Secretary of the Army on major policy matters directly affecting the reserve
12 components and the mobilization preparedness of the Army. I held this position
13 until my retirement from the military on May 1, 2017.

14 7. In my more than three-and-a-half decades of service, I received many
15 decorations, including the Distinguished Service Medal, Defense Superior Service
16 Medal, the Legion of Merit Medal, the Meritorious Service Medal, the Army
17 Commendation Medal, and the Army Achievement Medal. I also hold the Expert
18 Field Medical Badge and was awarded the 9A proficiency designation in medical
19 surgical nursing by the Surgeon General, U.S. Army. I am a member of the Order
20 of Military Medical Merit.

21 8. My civilian professional experience includes academic appointments
22 at Central Missouri State University, University of Kansas, University of North
23 Carolina at Charlotte, and Georgia State University. At Georgia State, I served as
24 Dean of and Professor at the Byrdine F. Lewis School of Nursing and Health
25 Professions at Georgia State University. I also served as a Health Policy Fellow at
26 the Robert Wood Johnson Foundation. I am also a Fellow of the American
27 Academy of Nursing, where I have served as Co-Chair of the Military/Veterans
28 Expert Panel. In August of 2017, I joined the University of North Carolina School

1 of Nursing as the Executive Dean and Associate Dean for Academic Affairs.

2 9. Throughout my academic and research careers, my practice and
3 research focus has been in psychosocial oncology. My research led to the
4 development of a subspecialty in psychosexual oncology, which focuses on how
5 surgery, chemotherapy, radiation, and immunotherapy impact body image,
6 sexuality, and fertility. I have had more than sixty psychosexual oncology
7 academic papers published on topics such as comparing the effects of lumpectomy
8 vs. mastectomy on sexual behaviors; and strategies to help nurses become
9 comfortable with psychosexual assessments of patients.

10 **Formation of Working Group**

11 10. On July 28, 2015, Secretary of Defense Ashton Carter directed Brad
12 Carson, Acting Undersecretary of Defense for Personnel and Readiness, to
13 convene a working group (the “Working Group”) to study the policy and readiness
14 implications allowing transgender persons to serve openly in the Armed Forces.
15 The Working Group was asked to determine whether there were any objective,
16 evidence-based impediments to permitting transgender people to serve openly and,
17 if not, to develop an implementation plan for changing the policy to permit open
18 service with the goal of maximizing military readiness. A true and accurate copy
19 of this directive is attached hereto as Exhibit A.

20 11. When Secretary Carter directed the formation of the Working Group,
21 I was serving as Deputy Surgeon General for Mobilization, Readiness, and Army
22 Reserve Affairs. I was asked by Surgeon General, United States Army to serve as
23 that office’s representative to the Working Group. At the Working Group, I was
24 able to provide the benefit of my medical expertise, my academic research, and my
25 knowledge of the workings of the Military Health System and the Defense Health
26 Agency. I participated in the meetings of the Working Group from its initial
27 meeting in the summer of 2015 though the final meeting in late spring of 2016.

28

Working Group Process

12. The Working Group addressed many topics, one of which was determining how the medical needs of transgender service members could be met by the military. With respect to that topic, our process involved three steps: (1) Understanding the medical needs of transgender service members; (2) identifying how those needs could be met within the Military Health System; and (3) developing policies and protocols to ensure transgender service members could serve openly and have their medical needs met. The Working Group focused on ensuring that transgender service members' medical needs would be treated in the same manner and under the same framework as the medical needs of other service members, unless that proved unworkable.

13. Step 1: Understanding Medical Needs. The first step for the members of the Working Group was to establish a baseline level of knowledge among all Working Group members about the medical needs of transgender service members. We educated ourselves by meeting with experts from the civilian sector so we could begin to understand what being transgender means. We wanted to learn about the full range of medical treatment that might be required for a transgender service member. We sought to understand how an individual might go through a transition process and what the medical components of that process might be. We spoke to internal medicine experts, psychologists, endocrinologists, and surgeons who educated the Working Group regarding all aspects of transgender care including mental health treatment, pharmaceutical treatment, and surgical treatment.

14. Step 2: Identifying How Medical Needs Could Be Met Within the Military Health System. After we understood the universe of potential medical needs of transgender service members, we focused on how the Military Health System (MHS) could meet those needs. For the large majority of medical care needs, we found that MHS was already providing the same or substantially similar

1 services to other service members, and that there would be little, if any, additional
2 burden on MHS from the provision of the required medical services to transgender
3 service members.

4 15. With respect to hormonal therapy, we learned that MHS already
5 provides this service to service members. Women frequently receive hormonal
6 therapy, as do other service members who have adrenal or pituitary deficiencies
7 that require hormone replacement therapy. The Working Group concluded that
8 providing similar care for transgender individuals from a pharmaceutical
9 perspective would not be a complicating issue or an additional burden.

10 16. The Working Group also examined whether there were any
11 deployment-related obstacles to providing pharmaceutical care that requires
12 routine doses of medication. We learned that service members with chronic
13 conditions requiring routine medications regularly take with them enough
14 medication to last for at least the first ninety (90) days of their deployment.
15 Examples of such medications would include birth control, hormone replacement
16 therapy, and medications to address low testosterone, hypertension, and
17 osteoporosis, among other conditions. Each Combatant Command sets rules in the
18 form of Personnel Policy Guidance that specifies any special restrictions on
19 deployability of members to that Command, including medical restrictions. For
20 example, a theatre that has only intermittent access to a medical supply train might
21 require service members to bring extra medical supplies or restrict certain service
22 members from serving in particular locations. Such issues are readily addressed in
23 the field through the Personnel Policy Guidance, and no unique or different issues
24 would be raised by the pharmaceutical needs of transgender service members. The
25 Working Group concluded that no additional burden on deployability would be
26 created by transgender service members who required routine medication.

27 17. With respect to gynecological care, we learned that MHS already
28 routinely provides this care to its service members. With transgender service

1 members being permitted to serve openly, the concerns about confidentiality that
2 might previously have hindered transgender service members from seeking
3 gynecological care through MHS would no longer be an issue. Transgender
4 service members would now be able to receive all routine medical care including
5 gynecological services through MHS, allowing for more complete and coordinated
6 care for the service members. The Working Group concluded that no additional
7 burden on MHS would be created by the provision of gynecological care to
8 transgender service members.

9 18. With respect to mental health care, we learned that MHS already
10 routinely provides this care to its service members. With transgender service
11 members being permitted to serve openly, the concerns about confidentiality that
12 might previously have inhibited transgender service members from seeking mental
13 health care through MHS would no longer be an issue. Because transgender
14 service members would now be able to seek such care, if needed, openly through
15 MHS, the Working Group expected that the service members would benefit from
16 more complete and coordinated care. The Working Group concluded that no
17 additional burden on MHS would be created by the provision of mental health care
18 to transgender service members.

19 19. The Working Group also examined whether there were any
20 deployment or readiness related obstacles associated with addressing the mental
21 health needs of transgender service members. The Working Group educated itself
22 in part by consulting with our counterparts in Israel, the United Kingdom, and
23 Australia, where open service by transgender individuals is permitted. We learned
24 that those services have seen no reduced ability to serve from transgender service
25 members due to mental health or other gender identity related issues. The
26 Working Group also examined our own military's existing policies and learned
27 that there is a rigorous screening process for all individuals applying to join the
28 military that includes examination of mental health. The Military Entrance

1 Processing Stations (MEPS) (enlistment processing offices) evaluate psychological
2 stability as a component of fitness to serve. Additionally, once individuals are in
3 active or reserve service, mental health is evaluated on an annual basis as part of
4 the Periodic Health Assessment (PHA). The Working Group found that there was
5 no reason to think that these pre-existing military policies, when applied to
6 transgender service members serving openly, would not adequately protect the
7 services from any mental health issues interfering with deployment.

8 20. With respect to surgical therapy, the Working Group consulted with
9 surgical experts to determine whether there were any aspects of surgical therapy
10 for transgender service members in which MHS did not already have the requisite
11 expertise. We learned that MHS employs general surgeons, urologists who
12 perform urological surgeries, and obstetrician/gynecologists who perform
13 gynecological surgeries. Those skill sets are present in a substantial capacity
14 within MHS, and MHS is able to address most routine surgical needs at or near the
15 location of its service members. We learned, for instance, that surgeries for
16 transgender service members would be relatively rare and that many of those
17 surgeries are already routinely provided to non-transgender service members, such
18 as hysterectomies or chest surgeries. For surgeries requiring particular expertise,
19 MHS maintains major medical centers that are equipped to provide a broader array
20 of services. For surgeries requiring expertise outside of MHS's capacity, service
21 members are typically referred out to civilian providers. The non-routine surgical
22 needs of a transgender service member could be addressed either through training
23 or contracting with surgeons with the appropriate expertise to MHS, or through the
24 normal process for referring out of MHS to civilian providers. The Working
25 Group concluded that the surgical needs of transgender service members could be
26 addressed through either of these methods without creating additional burden on
27 MHS.

28 21. The Working Group also learned that the development of

1 gynecology/genitourinary (GYN/GU) surgical expertise within MHS could have
2 an added benefit for MHS beyond the provision of surgical care to transgender
3 service members. MHS struggles with ensuring that their medical providers
4 acquire and retain the skills they need to serve in a wartime scenario. Having
5 surgeons engage in training in the surgical techniques needed to perform sex-
6 reassignment surgery would provide analogous surgical skills required to address,
7 for instance, blast injuries in wartime scenarios. Having the expertise to address
8 genital mutilation from a blast would be a benefit for MHS and all service
9 members.

10 22. **Step 3: Policy Development.** Throughout this educational process,
11 the Working Group members developed a deep understanding of the medical needs
12 of transgender service members. Next, we turned our focus to developing a policy
13 that would address the psychological and physical needs of transgender individuals
14 and treat those individuals fairly while keeping readiness and deployability at the
15 forefront. Developing the protocol was an iterative process involving multiple
16 rounds of drafting, gathering input from the services, and redrafting.

17 23. The Working Group concluded that there were no barriers that should
18 prevent transgender service members from serving openly in the military. Open
19 service by transgender service members would not impose any significant burdens
20 on readiness, deployability, or unit cohesion. For those seeking to join the
21 military, the Working Group recommended that the medical standards for
22 accession into the Military Services by transgender persons be based upon the
23 same standards applied to persons with other medical conditions, which seek to
24 ensure that those entering service are free of medical conditions or physical defects
25 that may require excessive time lost from duty. Based upon that standard, the
26 Working Group recommended that the new accessions policy permit enlistment so
27 long as an applicant with a history of gender dysphoria or of treatment for gender
28 dysphoria has completed all medical treatment associated with the applicant's

1 medical condition and has been stable in the preferred gender for a sufficient
2 period of time.

3 24. The Working Group’s process for developing the protocol and
4 recommendations was deliberative and thoughtful, involved significant amounts of
5 research and education, and in the end resulted in a policy that all services
6 supported. We were very proud to have developed a policy that treats transgender
7 service members as the equal of their fellow service members, and as soldiers,
8 sailors, marines, cuttermen, and airmen first.

9

10 [REMAINDER OF PAGE INTENTIONALLY LEFT BLANK]

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

26

27

28

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28

I declare under the penalty of perjury that the foregoing is true and correct.

Dated: September 21, 2017

Margaret C. Wilmoth
Margaret C. Wilmoth

Exhibit A



SECRETARY OF DEFENSE
1000 DEFENSE PENTAGON
WASHINGTON, DC 20301-1000

MEMORANDUM FOR SECRETARIES OF THE MILITARY DEPARTMENTS

SUBJECT: Transgender Service Members

JUL 28 2015

Effective as of July 13, 2015, no Service member shall be involuntarily separated or denied reenlistment or continuation of active or reserve service on the basis of their gender identity, without the personal approval of the Under Secretary of Defense for Personnel and Readiness. This approval authority may not be further delegated.

The Under Secretary of Defense for Personnel and Readiness will chair a working group composed of senior representatives from each of the Military Departments, Joint Staff, and relevant components from the Office of the Secretary of Defense to formulate policy options for the DoD regarding the military service of transgender Service members. The working group will start with the presumption that transgender persons can serve openly without adverse impact on military effectiveness and readiness, unless and except where objective, practical impediments are identified, and shall present its recommendations to me within 180 days. Pending the issuance of DoD-wide policy following the submission of the working group's report, any interim guidance issued by the Military Departments will be coordinated with, and subject to the prior personal approval of, the Under Secretary of Defense for Personnel and Readiness. If questions relating to the service of transgender members arise, the Military Departments should address them to the Under Secretary of Defense for Personnel and Readiness.

A handwritten signature in black ink that reads "Ash Carter".

cc:
DepSecDef
CJCS
USDs
DoD, GC
ASD(LA)
ATSD(PA)