No. 18-35347

United States Court of Appeals for the Ninth Circuit

RYAN KARNOSKI, ET AL.,

Plaintiffs-Appellees,

STATE OF WASHINGTON,

Intervenor-Plaintiff-Appellee,

v.

DONALD J. TRUMP, PRESIDENT OF THE UNITED STATES, ET AL.,

Defendants-Appellants.

On Appeal from the United States District Court for the Western District of Washington
Case No. 2:17-cv-01297-MJP

PLAINTIFFS-APPELLEES' SUPPLEMENTAL ADDENDUM, PART 5

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May 14, 2018

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SUPPLEMENTAL ADDENDUM TABLE OF CONTENTS

District Court Orders and Opinions

Other[1]

[1] Declarations include all exhibits thereto, unless otherwise noted.

The Honorable Marsha J. Pechman

UNITED STATES DISTRICT COURT

WESTERN DISTRICT OF WASHINGTON AT SEATTLE

RYAN KARNOSKI, et al.,

Plaintiffs,

STATE OF WASHINGTON,

Plaintiff-Intervenor,

v.

DONALD J. TRUMP, et al.,

Defendants.

CASE No. 2:17-cv-01297-MJP

DECLARATION OF SAMANTHA EVERETT IN SUPPORT OF PLAINTIFFS' OPPOSITION TO DEFENDANTS' CROSS-MOTION FOR PARTIAL SUMMARY JUDGMENT

NOTE ON MOTION CALENDAR:
March 23, 2018

I, Samantha Everett, swear under penalty of perjury under the laws of the United States to the following:

1. I am counsel of record for Plaintiffs in this action, am over age 18, and competent to be a witness. I am making this Declaration based on facts within my own personal knowledge. I provide this Declaration in support of Plaintiffs' Opposition to Defendants' Cross-Motion for Partial Summary Judgment.

2. Attached hereto as **Exhibit 1** is a true and correct copy of documents bearing bates numbers USDOE00037688–USDOE0037696.

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

DATED: March 19, 2018

Samantha Everett

CERTIFICATE OF SERVICE

The undersigned certifies under penalty of perjury under the laws of the United States of America and the laws of the State of Washington that all participants in the case are registered CM/ECF users and that service of the foregoing documents will be accomplished by the CM/ECF system on March 19, 2018.

Samantha Everett, WSBA #47533
samantha@newmanlaw.com
Newman Du Wors LLP
2101 Fourth Ave., Ste. 1500
Seattle, WA 98121
(206) 274-2800

Exhibit 1

Neller Gen Robert B

From: Neller Gen Robert B
Sent: Sunday, August 06, 2017 15:23
To: Dunford Gen Joseph F
Cc: (b)(6) Walters Gen Glenn M
Subject: Re: Draft Transgender Memo (UNCLASSIFIED)

(b)(5)

V/R Neller

Sent from my BlackBerry 10 smartphone on the Verizon Wireless 4G LTE network.

Original Message
From: Dunford, Joseph F Jr Gen USMC JS (US)
Sent: Monday, August 7, 2017 6:06 AM
To: Neller Gen Robert B
Cc: (b)(6) Walters Gen Glenn M
Subject: RE: Draft Transgender Memo (UNCLASSIFIED)

CLASSIFICATION: UNCLASSIFIED

Commandant, ACMC--

(b)(5)

(b)(5) More to follow as this develops ... I saw it yesterday and immediately asked that it be forwarded to the Chiefs.

VR
Joe

-----Original Message-----
From: Neller Gen Robert B [mailto: (b)(6)
Sent: Saturday, August 5, 2017 9:50 PM
To: Dunford, Joseph F Jr Gen USMC JS (US)
< (b)(6) >

Neller Gen Robert B

From: Neller Gen Robert B
Sent: Saturday, August 05, 2017 21:50
To: Dunford, Joseph F Jr Gen USMC JS (US)
Cc: (b)(6) Walters LtGen Glenn M (b)(6)
Subject: FW: Draft Transgender Memo
Attachments: Draft PM -- Transgender in Military 4 Aug 2017.docx; Warning.txt; Warning.txt; Warning.txt

Chairman,
Read the statement. Have not discussed with the POTUS but only with the SECDEF.

(b)(5)

Getting ready to land on Guadalcanal.
Will check in later.
Understand min distribution/close hold.
V/R Neller

-----Original Message-----
From: (b)(6)
Sent: Sunday, August 06, 2017 8:04 AM
To: Neller Gen Robert B < (b)(6) >

Pages 3 through 4 redacted for the following reasons:

Not an Agency Record
Not an Agency Record

Subject: Fw: Draft Transgender Memo

Commandant
Attached is the draft PM to SD.

(b)(5)

CJCS requested min distro

Very Respectfully

(b)(6)
Headquarters, U.S. Marine Corps
Military Secretary to the Commandant of the Marine Corps
Office: (b)(6)
Cell: (b)(6)
Tanberg (b)(6)
NIPR: (b)(6)
SIPR: (b)(6)
From: (b)(6)
< (b)(6)
Sent: Saturday, August 5, 2017 9:42 AM
To: (b)(6)

(b)(6)

Cc: (b)(6)
Subject: Fwd: Draft Transgender Memo

Gentlemen,
Please see below for closehold information for your bosses'.
Likely this is a final draft and will be released soon.

Our legal team has had a chance to review but the Chairman wanted you all to have visibility.

Please protect with minimal distribution.
V/r

(b)(6)

(C)+ (b)(6)

-----Original Message-----
From: Dunford, Joseph F Jr Gen USMC JS (US)
Sent: Saturday, August 5, 2017 12:51 PM
To: Kremer, Kyle J Brig Gen USAF JS J1 (US)
< (b)(6)
<mailto: (b)(6) >
Cc: Selva, Paul J Gen USAF JS OCJCS (US)
< (b)(6)
>; (b)(6)
< (b)(6)
<mailto (b)(6)
(b)(6)
(b)(6) >; Crandall, Darse E
Jr RDML USN JS OCJCS (US) (b)(6)
(b)(6)
Subject: Re: Draft Transgender Memo (UNCLASSIFIED)

Kyle, All

I don't have additional changes to the memo beyond those from LC and I understand Del's assessment of paragraph 3.

I'll defer to OSD from here. Please make sure the Chiefs have an opportunity to review.

VR & Thanks
JFD
Begin forwarded message:

Resent-From: (b)(6)
(b)(6)

From: (b)(6)
(b)(6)
(b)(6)
Date: August 5, 2017 at 9:47:04 AM EDT
To: "Selva, Paul J Gen USAF JS OCJCS (US)"
(b)(6)
>, "Dunford, Joseph F Jr Gen USMC JS (US)"
(b)(6)
(b)(6)
Cc: (b)(6), (b)(7)(C)
(b)(6), (b)(7)(C) >, "Crandall, Darse E Jr RDML USN JS OCJCS (US)" (b)(6)
"Kremer, Kyle J Brig Gen USAF JS J1 (US)" (b)(6)
(b)(6)
Subject: Fwd: Draft Transgender Memo

Chairman, Vice Chairman,
Given the articulated timeline and high profile nature of this issue, I am flat tracking it to you directly and a slightly broader team to ensure full visibility.

Pending guidance,

V/r

(b)(6)

Begin forwarded message:

From: (b)(6)
(b)(6)
(b)(6)
Date: August 4, 2017 at 10:26:51 PM EDT

To: (b)(6)
(b)(6)
(b)(6)
(b)(6) Philip SD Raymond
(b)(6)
(b)(6)
(b)(6)
(b)(6)
(b)(6)
Cc: (b)(6)
< (b)(6)
(b)(6)
(b)(6)
(b)(6)
Subject: Draft Transgender Memo

DoD colleagues,

Attached, please find a close-hold draft of the POTUS memo on transgender. Per APNSA McMaster's promise to Secretary Mattis, we wanted to make sure you have seen it before going final.

I understand that OGC has already reviewed. We are waiting on DOJ review by noon tomorrow, before POTUS considers it. If you have any concerns, can you please let us know prior to noon tomorrow?

Again, I respectfully ask for your help in protecting this.

Many thanks
(b)(6)

From: Neller Gen Robert B
To: Dunford Gen Joseph F
Subject: RE: Transgender policy message (UNCLASSIFIED)
Date: Thursday, July 27, 2017 11:07:00 AM

Can you talk today?

-----Original Message-----
From: Dunford, Joseph F Jr Gen USMC JS (US) (b)(6)
Sent: Thursday, July 27, 2017 10:57 AM
To: Milley, Mark A GEN USARMY HQDA CSA (US); Richardson ADM John M; Neller Gen Robert B; Goldfein, David L Gen USAF AF-CC (US); Lengyel, Joseph L Gen USAF NG NGB (US)
Subject: RE: Transgender policy message (UNCLASSIFIED)

CLASSIFICATION: UNCLASSIFIED

P.S. When asked, I will state that I was not consulted ... expect that question will come NLT than my September hearing.

VR
Joe

-----Original Message-----
From: Dunford, Joseph F Jr Gen USMC JS (US)
Sent: Thursday, July 27, 2017 7:55 AM
To: Milley, Mark A GEN USARMY HQDA CSA (US) (b)(6) 'Richardson, John M ADM CNO' (b)(6) 'Neller Gen Robert B' (b)(6) Goldfein, David L Gen USAF AF-CC (US) (b)(6) Lengyel, Joseph L Gen USAF NG NGB (US) (b)(6)
Subject: Transgender policy message (UNCLASSIFIED)

CLASSIFICATION: UNCLASSIFIED

Chiefs,

I know yesterday's announcement was unexpected. The message below is provided in advance of an official letterhead memo from me. It's as much as we can say right now. I'd ask that you ensure widest dissemination ...

VR
Joe

From: CJCS
To: Service Chiefs, Commanders and Senior Enlisted Leaders

I know there are questions about yesterday's announcement on the transgender policy by the President. There will be no modifications to the current policy until the President's direction has been received by the Secretary of Defense and the Secretary has issued implementation guidance.

In the meantime, we will continue to treat all of our personnel with respect. As importantly, given the current fight and the challenges we face, we will all remain focused on accomplishing our assigned missions.

CLASSIFICATION: UNCLASSIFIED
CLASSIFICATION: UNCLASSIFIED

From: Neller Gen Robert B
To: Dunford, Joseph F Jr Gen USMC JS (US); Milley, Mark A GEN USARMY HQDA CSA (US); Richardson ADM John M; Goldfein, David L Gen USAF AF-CC (US); Lengyel, Joseph L Gen USAF NG NGB (US)
Cc: Walters LtGen Glenn M (b)(6) Laster LtGen James B; Brilakis LtGen Mark A; Ewers MajGen John R; Hogue SES Robert D (b)(6) Wissler LtGen John E; Berger LtGen David H (b)(6) McMillian LtGen Rex C (b)(6) Kennedy BGen Paul J (b)(6) Renforth BGen Austin E; Jurney BGen William M
Subject: RE: Transgender policy message (UNCLASSIFIED)
Date: Thursday, July 27, 2017 8:59:00 AM

Roger over.
V/R Neller

-----Original Message-----
From: Dunford, Joseph F Jr Gen USMC JS (US) (b)(6)
Sent: Thursday, July 27, 2017 7:55 AM
To: Milley, Mark A GEN USARMY HQDA CSA (US); Richardson ADM John M; Neller Gen Robert B; Goldfein, David L Gen USAF AF-CC (US); Lengyel, Joseph L Gen USAF NG NGB (US)
Subject: Transgender policy message (UNCLASSIFIED)

CLASSIFICATION: UNCLASSIFIED

Chiefs,

I know yesterday's announcement was unexpected. The message below is provided in advance of an official letterhead memo from me. It's as much as we can say right now. I'd ask that you ensure widest dissemination ...

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CLASSIFICATION: UNCLASSIFIED

The Honorable Marsha J. Pechman

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON AT SEATTLE

RYAN KARNOSKI, et al.,

Plaintiffs,

v.

DONALD J. TRUMP, et al.,

Defendants.

No. 2:17-cv-1297-MJP

DEFENDANTS' RESPONSE TO THE COURT'S MARCH 20, 2018 ORDER

U.S. DEPARTMENT OF JUSTICE
Civil Division, Federal Programs Branch
20 Massachusetts Ave., NW
Washington, DC 20530
Tel: (202) 514-4336

BACKGROUND

On March 19, 2018, Defendants filed a motion for clarification and, if necessary, reconsideration of the Court's order granting plaintiffs' motion to compel initial disclosures. Dkt. No. 205 at 1.[1] Defendants asked the Court to clarify whether it intended to order Defendants to disclose potentially privileged information about presidential deliberations, even though Defendants do not intend to rely on privileged information to support their defenses. Defendants further requested that, if the Court did intend to require such disclosures, the Court reconsider its decision. *Id.* Defendants also served Second Amended Initial Disclosures, which identified sixteen additional documents that they intend to rely on to support their defenses. Dkt. No. 206-1.

On March 20, 2018, the Court denied Defendants' motion for clarification and reconsideration. Dkt. No. 210. The Court stated that, "[w]hile Defendants claim they do not intend to rely on information concerning President Trump's deliberative process, their claim is belied by their ongoing defense of the current policy as one involving 'the complex, subtle, and professional decisions as to the composition . . . of a military force . . .' to which 'considerable deference' is owed." *Id.* at 3 (quoting Dkt. No. 194 at 16). The Court also noted that Defendants did not invoke Executive privilege in their Initial Disclosures, their Amended Initial Disclosures, or their Second Amended Initial Disclosures, or in their opposition to Plaintiffs' motion to compel, and that "[u]ntil now, Defendants have neither asserted Executive privilege nor provided a privilege log." Dkt. No. 210 at 2. The Court directed Defendants to comply with its order granting Plaintiffs' motion to compel "no later than 5:00 PM Pacific Daylight Time on March 22, 2018." *Id.*

[1] Additional background on the instant matter is set forth in the parties' prior submissions. *See* Dkt. Nos. 191-2, 191-3 (Defendants initial disclosures and amended initial disclosures); Dkt. No. 190 (Plaintiffs' motion to compel); Dkt. No. 199 (Defendants' opposition to motion to compel); Dkt. No. 203 (Plaintiffs' reply); and Dkt. No. 204 (order granting motion to compel).

U.S. DEPARTMENT OF JUSTICE
Civil Division, Federal Programs Branch
20 Massachusetts Ave., NW
Washington, DC 20530
Tel: (202) 514-4336

DISCUSSION

In compliance with Rule 26(a)(1) and the Court's order, Defendants Donald J. Trump, in his official capacity as President of the United States; the United States of America; James N. Mattis, in his official capacity as Secretary of Defense; and the United States Department of Defense state as follows:

Rule 26(a)(1) requires Defendants to identify "each individual likely to have discoverable information—along with the subjects of that information—that *the disclosing party may use* to support its claims or defenses" as well as "all documents, electronically stored information, and tangible things that *the disclosing party* has in its possession, custody, or control and *may use* to support its claims or defenses." Fed. R. Civ. P. 26(a)(1) (emphasis added). As this Court recognized, the rule requires Defendants to disclose "all information *Defendants may use* to support their claims or defense[s] with respect to the *current* policy prohibiting military service by openly transgender persons." Dkt No. 210 at 1 (emphasis added).

Defendants have determined that, in defending against Plaintiffs' challenge to the current policy, they do not intend to rely on information concerning the President's deliberative process that led to the policy that the Court has determined is currently at issue in this case (*i.e.* the policy announced on Twitter by President Trump on July 26, 2017 and formalized in an August 25, 2017 Presidential Memorandum, *see* ECF 210 at 1). Therefore, consistent with Federal Rule of Civil Procedure 26(a), Defendants have not identified such information in their initial disclosures. Defendants fully understand that, under Federal Rule of Civil Procedure 37(c)(1), they may be precluded in this case from using documents or witnesses not identified in Defendants' initial disclosures to defend the policy that is currently at issue, including at next week's hearing.

In its March 20, 2018 order, the Court appears to suggest that the President's policy decisions currently at issue in this case may not be entitled to judicial deference if the President is

U.S. DEPARTMENT OF JUSTICE
Civil Division, Federal Programs Branch
20 Massachusetts Ave., NW
Washington, DC 20530
Tel: (202) 514-4336

unwilling to identify the individuals with whom he consulted and the documents he reviewed before reaching the challenged decisions. Dkt. No. 210 at 3. Defendants respectfully disagree and adhere to their position that judicial deference to Executive decisions about the composition of the military is not dependent upon judicial review of the deliberative process that preceded the decisions at issue. In addition, Defendants do not waive any executive privileges simply by arguing for judicial deference to the President's military decisions.[2] Again, however, Defendants recognize the possibility that, based on its March 20, 2018 order, the Court will take into account Defendants' determination not to identify information about the President's deliberations in deciding and applying the level of deference that is due to the President's determinations with respect to military policy currently at issue in this case and in deciding Plaintiffs' and the State of Washington's pending motions for summary judgment.

In sum, Defendants have identified in their initial disclosures, as amended and supplemented, all of the individuals and documents that they expect to use to support their defense of the policy that the Court has determined is currently at issue in this litigation (*i.e.* the policy announced on Twitter by President Trump on July 26, 2017 and formalized in an August 25, 2017 Presidential Memorandum, *see* Dkt. 210 at 1). Defendants have determined not to use information that they have not identified in their initial disclosures in their defense of the current policy, including potentially privileged information about presidential deliberations. Given the Court's statements about Presidential deference, Defendants recognize that the Court may decide to take Defendants' decision into consideration in deciding the pending summary judgment motions.

---

[2] Defendants respectfully disagree that they were required to assert privilege in conjunction with their initial disclosures over information that they do not intend to use to support their defenses in this case. *See* Defendants' Motion to Clarify, Dkt. No. 205 at 6-7 (discussing *Cheney v. U.S. Dist. Ct.*, 542 U.S. 367 (2004)).

U.S. DEPARTMENT OF JUSTICE
Civil Division, Federal Programs Branch
20 Massachusetts Ave., NW
Washington, DC 20530
Tel: (202) 514-4336

Dated: March 22, 2018

Respectfully submitted,

CHAD A. READLER
Acting Assistant Attorney General
Civil Division

BRETT A. SHUMATE
Deputy Assistant Attorney General

JOHN R. GRIFFITHS
Branch Director

ANTHONY J. COPPOLINO
Deputy Director

/s/ Ryan B. Parker
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Civil Division, Federal Programs Branch
Telephone: (202) 514-4336
Email: ryan.parker@usdoj.gov

Counsel for Defendants

The Honorable Marsha J. Pechman

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON AT SEATTLE

RYAN KARNOSKI, et al.,

Plaintiffs,

v.

DONALD J. TRUMP, in his official capacity as President of the United States, et al.,

Defendants.

Case No. 2-17-cv-01297-MJP

DECLARATION OF BRAD R. CARSON IN SUPPORT OF PLAINTIFFS' OPPOSITION TO MOTION TO STAY PRELIMINARY INJUNCTION PENDING APPEAL

I, Brad R. Carson, declare as follows:

1. My professional background and qualifications are set forth in my previous declaration dated September 13, 2017. *See* Dkt. No. 46. A copy of that declaration is attached as Exhibit A.

2. As discussed in my previous declaration, I served as the Acting Under Secretary of Defense for Personnel and Readiness ("USD P&R") from April 2, 2015 to April 8, 2016. In that capacity, and at the direction of the Secretary of Defense, I led a group of senior personnel drawn from all of the armed services to develop, over many months of information collection and analysis, a Department- wide policy regarding service by transgender people (the "Open Service Policy").

3. The purpose of this supplemental declaration is to respond to the "Department of Defense Report and Recommendations of Military Service by Transgender Persons," which I

refer to in this declaration as the "Implementation Report." A copy of the Implementation Report is attached as Exhibit B.

4. I have knowledge of the matters stated in this declaration and have collected and cite to relevant literature concerning the issues that arise in this litigation.

THE WORKING GROUP'S MANDATE

5. As discussed in my previous declaration, on July 28, 2015, then-Secretary of Defense Ashton B. Carter ordered me, in my capacity as USD P&R, to convene a working group to formulate policy options for DoD regarding transgender service members (the "Working Group").

6. Secretary Carter's order directed the Working Group to "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." Memorandum from Ashton Carter, Secretary of Defense, "Transgender Service Members" (July 28, 2015). That mandate did not mean, as the Implementation Report insinuates, that "standards were adjusted or relaxed to accommodate service by transgender persons." Implementation Report at 19. Rather, instead of simply assuming that the medical needs of transgender service members were inconsistent with generally applicable standards for fitness or deployability, we conducted an evidence-based assessment to determine whether those prior assumptions were actually true.

7. We began our work based on reports from commanders that there were already transgender individuals serving in the field and performing their duties well, so the task before us was not merely an abstract exercise to establish a policy on military service by transgender persons. Rather, the question was whether there was any reason these existing service members should be deemed unfit for service and involuntarily separated due to their transgender status. We were receiving questions from the field about whether these individuals could continue serving, and we needed to develop a consistent policy rather than leaving the issue to ad hoc determinations by commanders.

8. Among other things, the Implementation Report ignores the significant contributions being made by transgender service members.

9. The Implementation Report is atypical of military assessments of policy because it does not account for the service level impacts where its conclusions may result in discharge of thousands of people currently in service.

10. The Implementation Report is also atypical of military assessment of policy because it does not consider the impacts of a reversal in policy with regard to the need to retrain command and troops. Nor does it account for the impacts a reversal of policy would have on non-transgender service members who may question whether other historically disadvantaged groups could be targeted for similar discriminatory treatment.

ADHERENCE TO MILITARY STANDARDS AND READINESS

11. A guiding principle for the Working Group whose work I led was that there would be no change in standards for fitness and deployability, and there would be no new standards or categories created only for transgender service members. Instead, the issue was how to apply the same standards equally to both transgender and non-transgender service members. After a lengthy process of review, our conclusion was that equal application of existing standards required transgender service members who complete gender transition as part of an approved medical treatment plan to meet the fitness standards of their gender following service members' gender transition.

12. In evaluating those standards, the Working Group examined the implications of ensuring equitable application of individual standards during the gender transition process, while also ensuring that commanders were able to maintain the highest standards of operational readiness for their units. The resulting regulations and military documentation released to support the Open Service Policy provide extensive guidance on the waivers and Exception to Policy (ETP) procedures that are available for service members and commanders to manage transitions. They recognize the reality that before a service member has completed gender transition, the service member will be treated as a member of the pre-transition gender. The rules

expressly address physical fitness tests, facilities, and grooming standards. They also make it clear that a service member is not necessarily entitled to any particular ETP, and emphasize that the process is tailored and individualized, taking into account the service member's needs and the readiness requirements of the command.

13. A change in gender marker in the DEERS system represents the end of the gender transition process, and requires a commander's approval, consistent with that commander's evaluation of "expected impacts on mission and readiness." DoDI 1300.28, "In-Service Transition for Transgender Service Members (June 30, 2016). What commanders may not consider in that evaluation, however, is "biases against transgender individuals." *Id*.

FITNESS AND DEPLOYABILITY

14. We also determined that service by transgender individuals would have no greater impact on deployability than service by individuals with many other medical conditions that are not disqualifying. Fitness and deployability are not measured in a vacuum. In our systematic review, we sought to ensure that any concerns about transgender service members' fitness or deployability were being treated consistently with the way service members with other conditions were being treated.

15. For example, with respect to deployment, the Working Group concluded that transgender service members could deploy while continuing to receive cross-sex hormone therapy without relaxing generally applicable standards. The Working Group determined that military policy and practice allows service members to use a range of medications, including hormones, while in such settings. The Military Health System ("MHS") has an effective system for distributing prescribed medications to deployed service members across the globe, including those in combat settings.

16. Avoiding an increase in the number of non-deployable service members was a priority for the Working Group. This led to the development of a policy on gender transition by existing service members that minimized any impact on deployability. Under the policy we developed, a service member could not begin a treatment plan for gender transition without prior

consultation with his or her commander. The service member was required to work with his or her commander and military medical provider to develop a transition plan that would not impact deployability. Depending on the individual's medical needs and the timing of any planned deployment, this might mean delaying the commencement of hormone replacement therapy or postponing planned surgeries.

17. Military and non-military medical experts confirmed that this approach was consistent with medical standards and satisfied military readiness concerns.

18. We also considered contingencies such as whether a transgender individual could safely experience periods of disruption in prescribed medications and found no significant issues that would impact deployability. We further considered whether transgender service members would need close medical monitoring during or after completing a treatment plan for gender transition, and after consulting with medical experts and considering all the available evidence, found that the recommended monitoring is for only a short period of time at the beginning of transition and could be safely adjusted or delayed to avoid any impact on readiness.

19. The Implementation Report does not provide any reason to think that the Working Group's conclusions were incorrect. Transgender people—like other service members who receive prescription medication on deployment—have been deploying across the globe for decades, and have been able to do so openly while receiving medical treatment for the past year and a half. The Implementation Report does not identify any instances in which a MHS was unable to provide transgender service members with access to cross-sex hormones the same way it provides medication to other service members.

20. In addition, the Working Group discussed that while some transgender service members might not be deployable for short periods of time due to their treatment, temporary periods of non-deployability are not unusual. It is common for service members to be non-deployable for periods of time due to medical conditions such as pregnancy, orthopedic injuries, obstructive sleep apnea, appendicitis, gall bladder disease, infectious disease, and myriad other

conditions. The Implementation Report does not provide any indication that the temporary non-deployability of some transgender service members raises unique logistical concerns.

COSTS

21. The Implementation Report does not provide any new information undermining the Working Group's predictions regarding the minimal costs of providing for the essential health care needs of transgender service members.

22. At the same time, the Implementation Report does not appear to take into account the substantial costs that would be incurred by reversing the Open Service Policy. For example, the implementation of the Open Service Policy was accompanied by extensive training for commanders, medical personnel, and service members. Not only would changing that policy result in waste of those sunk costs, it would entail significant training and other new costs without any meaningful reduction in medical or other costs.

PRIVACY AND UNIT COHESION

23. Although the Implementation Report states that its "analysis makes no assumptions" regarding transgender service members' ability to serve, a substantial portion of the Implementation Report consists of assumptions regarding transgender service members' impact on privacy and on good order and discipline. The Working Group addressed these questions, including privacy-related questions about showers and other sex-separated facilities. The evidence we considered, which included discussions with commanders and transgender service members who had been on deployment under spartan and austere conditions, was that transgender service members' use of shared facilities had not led to any significant issues or impacted morale or unit cohesion.

24. To begin with, for most service members, shower and toilet facilities are a secondary consideration at best compared to the other challenges and demands of military deployment. In addition, even in relatively harsh conditions, some privacy is usually available in showers and other facilities.

25. Finally, the policy developed by the Working Group gave discretion to commanders to deal with any privacy-related issues and make appropriate accommodations concerning facilities where necessary, such as scheduling the use of showers or offering alternate facilities. The need for such flexibility is not unusual on military deployments, nor is it limited to transgender service members. Combat service by female service members and local conditions in the place of deployment sometimes require such adjustments. For example, during my own military service in Iraq, it was necessary to deal with increased privacy needs for Iraqi women; commanders were able to accommodate these needs without disruption.

26. Similar concerns about privacy and unit cohesion were raised preceding policy changes permitting open service by gay and lesbian personnel and allowing women to serve in ground combat positions. In both cases, those concerns proved to be unfounded. The Implementation Report offers no evidence that such concerns are any more justified in the case of military service by transgender individuals.

27. The military's experience under "Don't Ask, Don't Tell" has shown that arbitrarily banning a group of people harms unit cohesion and military readiness.

28. Contrary to the conclusions of the Implementation Report, it is changing the Open Service policy, not maintaining it, that would likely have a negative impact on readiness, morale, and cohesion. Particularly after commanders and service members have received extensive training and begun implementation of the Open Service policy, an abrupt change in the policy would undermine the consistency and predictability on which morale and good order rely, increasing uncertainty and anxiety among those currently serving.

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

Executed on May 4, 2018.

Brad R. Carson

NEWMAN DU WORS LLP

2101 Fourth Avenue, Suite 1500
Seattle, Washington 98121
(206) 274-2800

CERTIFICATE OF SERVICE

The undersigned certifies under penalty of perjury under the laws of the United States of America and the laws of the State of Washington that all participants in the case are registered CM/ECF users and that service of the foregoing documents will be accomplished by the CM/ECF system on May 14, 2018.

Jason Sykes, WSBA #44369
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Exhibit A

The Honorable Marsha J. Pechman

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON AT SEATTLE

RYAN KARNOSKI, et al., *Plaintiffs*, v. DONALD J. TRUMP, in his official capacity as President of the United States, et al., *Defendants*.	Case No. 2:17-cv-01297-MJP **DECLARATION OF BRAD R. CARSON IN SUPPORT OF PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION** NOTE ON MOTION CALENDAR: October 6, 2017 ORAL ARGUMENT REQUESTED

I, Brad R. Carson, declare as follows:

1. I served as the Acting Under Secretary of Defense for Personnel and Readiness ("USD P&R") from April 2, 2015 to April 8, 2016. In that capacity, and at the direction of the Secretary of Defense, I led a group of senior personnel drawn from all of the armed services to develop, over many months of information collection and analysis, a Department-wide policy regarding service by transgender people, all as more fully described below.

PROFESSIONAL BACKGROUND

2. I attended Baylor University and obtained an undergraduate degree in history in 1989. After college, I attended Trinity College in Oxford, England on a Rhodes Scholarship and earned a Master's degree in Politics, Philosophy, and Economics. When I returned to the United States, I attended the University of Oklahoma College of Law, graduating with a law degree in

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1994.

3. After I graduated law school, I practiced as an attorney at the law firm Crowe & Dunlevy. From 1997 to 1998 I served as a White House Fellow, where I worked as a Special Assistant to the Secretary of Defense. From 2001 to 2005, I served in Congress as the Representative for the State of Oklahoma's 2nd District.

4. In addition to my civilian career, I am also a commissioned officer in the United States Navy Reserve. I currently serve in the Individual Ready Reserve. I deployed to Iraq in 2008 as Officer-in-Charge of intelligence teams embedded with the U.S. Army's 84th Explosive Ordnance Disposal Battalion. In Iraq, our teams were responsible for investigation of activities relating to improvised explosive devices and the smuggling of weapons and explosives. For my service in Iraq, I was awarded the Bronze Star Medal and other awards.

5. I have held several leadership positions within the Department of Defense ("DoD"). In 2011, I was nominated by the President to serve as General Counsel to the United States Army and unanimously confirmed by the U.S. Senate. As General Counsel, my duties included providing legal advice to the Secretary, Under Secretary, and Assistant Secretaries of the Army regarding the regulation and operation of the U.S. Army. I also assisted in the supervision of the Office of the Judge Advocate General. I served as General Counsel to the United States Army until March 2014.

6. In late 2013, while serving in that position, I was nominated by the President to serve as Under Secretary of the Army. I was unanimously confirmed by the U.S. Senate in February 2014 and sworn in on March 27, 2014. As Under Secretary of the Army, I was the second ranking civilian official in the Department of the Army. My responsibilities included the welfare of roughly 1.4 million active and reserve soldiers and other Army personnel, as well as a variety of matters relating to Army readiness, including oversight of installation management and weapons and equipment procurement. With the assistance of two Deputy Under Secretaries, I directly supervised the Assistant Secretaries of the Army for Manpower and Reserve Affairs; Acquisition, Logistics and Technology; Financial Management and Comptroller; Installations, Energy and Environment; and Civil Works. My responsibilities involved the management and

allocation of an annual budget amounting to almost $150 billion.

7. I was appointed by the President to serve as acting USD P&R in April 2015. In that capacity, I functioned as the principal staff assistant and advisor to the Secretary and Deputy Secretary of Defense for Total Force Management with respect to readiness; National Guard and Reserve component affairs; health affairs; training; and personnel requirements and management, including equal opportunity, morale, welfare, recreation, and quality of life matters. My responsibilities over these matters extended to more than 2.5 million military personnel.

DEVELOPMENT OF POLICY REGARDING TRANSGENDER SERVICE MEMBERS

8. On July 28, 2015, then-Secretary of Defense Ashton B. Carter ordered me, in my capacity as USD P&R, to convene a working group to formulate policy options for DoD regarding transgender service members (the "Working Group"). Secretary Carter ordered the Working Group to present its recommendations within 180 days. In the interim, transgender service members were not to be discharged or denied reenlistment or continuation of service on the basis of gender identity without my personal approval. A true and accurate copy of the July 28, 2015 order is attached hereto as Exhibit A.

9. The Working Group included roughly twenty-five members. Each branch of military service was represented by a senior uniformed officer (generally a three-star admiral or general), a senior civilian official, and various staff members. The Surgeons General and senior representatives of the Chaplains for each branch of service also attended the Working Group meetings.

10. The Working Group formulated its recommendations by collecting and considering evidence from a variety of sources, including a careful review of all available scholarly evidence and consultations with medical experts, personnel experts, readiness experts, health insurance companies, civilian employers, and commanders whose units included transgender service members.

THE FINDINGS OF THE RAND REPORT

11. On behalf of the Working Group, I requested that RAND, a nonprofit research

institution that provides research and analysis to the Armed Services, complete a comprehensive study of the health care needs of transgender people, including potential health care utilization and costs, and to assess whether allowing transgender service members to serve openly would affect readiness.

12. In 2016, RAND presented the results of its exhaustive study in a report entitled Assessing the Implications of Allowing Transgender Personnel to Serve Openly ("RAND Report"), a true and accurate copy of which is attached as Exhibit B.

13. The RAND Report explained that according to the American Psychiatric Association, the term transgender refers to "the broad spectrum of individuals who identify with a gender different from their natal sex." The RAND Report also explained that "transgender status alone does not constitute a medical condition," and that "only transgender individuals who experience significant related distress are considered to have a medical condition called gender dysphoria (GD)." For those individuals, the recognized standard of care includes some combination of psychosocial, pharmacological, and/or surgical care. "Not all patients seek all forms of care." "While one or more of these types of treatments may be medically necessary for some transgender individuals with GD, the course of treatment varies and must be determined on an individual basis by patients and clinicians."

14. The RAND Report evaluated the capacity of the military health system (MHS) to provide necessary care for transgender service members. The RAND Report determined that necessary psychotherapeutic and pharmacological care are available and regularly provided through the MHS, and that surgical procedures "quite similar to those used for gender transition are already performed within the MHS for other clinical indications." In particular, the MHS already performs reconstructive surgeries on patients who have been injured or wounded in combat. "The skills and competencies required to perform these procedures on transgender patients are often identical or overlapping." In addition, the RAND Report noted that "performing these surgeries on transgender patients may help maintain a vitally important skill required of military surgeons to effectively treat combat injuries."

15. The RAND Report also examined all available actuarial data to determine how

many transgender service members are likely to seek gender transition-related medical treatment. The RAND Report concluded that "we expect annual gender transition-related health care to be an extremely small part of overall health care provided to the AC [Active Component] population."

16. The RAND Report similarly concluded that the cost of extending health care coverage for gender transition-related treatments is expected to be "an exceedingly small proportion of DoD's overall health care expenditure."

17. The RAND Report found no evidence that allowing transgender people to serve openly would negatively impact unit cohesion, operational effectiveness, or readiness.

18. The RAND Report found that the estimated loss of days available for deployment due to transition-related treatments "is negligible." Based on estimates assuming the highest utilization rates, it concluded that the number of nondeployable man-years due to gender transition-related treatments would constitute 0.0015 percent of all available deployable labor-years across both the Active Component and Select Reserves.

19. The RAND Report also found no evidence that permitting openly transgender people to serve in the military would disrupt unit cohesion. The RAND Report noted that while similar concerns were raised preceding policy changes permitting open service by gay and lesbian personnel and allowing women to serve in ground combat positions, those concerns proved to be unfounded. The RAND Report found no evidence to expect a different outcome for open service by transgender persons.

20. The RAND Report examined the experience of eighteen other countries that permit open service by transgender personnel—including Israel, Australia, the United Kingdom, and Canada. The Report found that all of the available research revealed no negative effect on cohesion, operational effectiveness, or readiness. Some commanders reported that "increases in diversity led to increases in readiness and performance."

21. The Rand Report also identified significant costs associated with separation and a ban on open service, including "the discharge of personnel with valuable skills who are otherwise qualified."

ISSUES CONSIDERED BY THE WORKING GROUP

22. The Working Group sought to identify and address all relevant issues relating to service by openly transgender persons, including deployability. In addition to taking into consideration the conclusions of the RAND Report, the Working Group discussed that while some transgender service members might not be deployable for short periods of time due to their treatment, this is not unusual, as it is common for service members to be non-deployable for periods of time due to medical conditions such as pregnancy, orthopedic injuries, obstructive sleep apnea, appendicitis, gall bladder disease, infectious disease, and myriad other conditions. For example, the RAND Report estimated that at the time of the report, 14 percent of the active Army personnel—or 50,000 active duty soldiers—were ineligible to deploy for legal, medical, or administrative reasons.

23. The Working Group also addressed the psychological health and stability of transgender people. In addition to taking into account the conclusions of the RAND Report, the Working Group concluded, based on discussions with medical experts and others, that being transgender is not a psychological disorder. While some transgender people experience gender dysphoria, that condition is resolved with appropriate medical care. In addition, the Working Group noted the positive track record of transgender people in civilian employment, as well as the positive experiences of commanders with transgender service members in their units.

24. The Working Group also concluded that transgender service members would have ready access to any relevant necessary medication while deployed in combat settings. It determined that military policy and practice allows service members to use a range of medications, including hormones, while in such settings. The MHS has an effective system for distributing prescribed medications to deployed service members across the globe, including those in combat settings.

25. The Working Group also concluded that banning service by openly transgender persons would require the discharge of highly trained and experienced service members, leaving unexpected vacancies in operational units and requiring the expensive and time-consuming recruitment and training of replacement personnel.

26. The Working Group also concluded that banning service by openly transgender persons would harm the military by excluding qualified individuals based on a characteristic with no relevance to a person's fitness to serve.

27. I concluded my service as USD P&R on April 8, 2016. By that time, the Working Group was unanimously resolved that transgender personnel should be permitted to serve openly in the military.

RECENT REVERSAL OF POLICY

28. On July 26, 2017, President Donald Trump issued a statement that transgender individuals will not be permitted to serve in any capacity in the Armed Forces. On August 25, 2017, President Trump issued a memorandum to the Secretary of Defense and the Secretary of Homeland Security to reverse the policy adopted in June 2016 that permitted military service by openly transgender persons. That memorandum stated: "In my judgment, the previous Administration failed to identify a sufficient basis to conclude that terminating the Departments' longstanding policy and practice would not hinder military effectiveness and lethality, disrupt unit cohesion, or tax military resources, and there remain meaningful concerns that further study is needed to ensure that continued implementation of last year's policy change would not have those negative effects."

29. President Trump's stated rationale for a ban on military service by openly transgender service members is unfounded and refuted by the comprehensive investigation and review performed by the Working Group.

30. In addition to contravening the Working Group's conclusions and the exhaustive supporting evidence that was collected, I believe that prohibiting transgender individuals from serving openly in the military is harmful to the public interest for several reasons. My belief is based on my experience as USD P&R and in other leadership positions within DoD, and upon my active duty experience in Iraq.

31. First, a prohibition on service by openly transgender individuals would degrade military readiness and capabilities. Many military units include transgender service members who are highly trained and skilled and who perform outstanding work. Separating these service

members will deprive our military and our country of their skills and talents.

32. Second, banning military service by openly transgender persons would impose significant costs that far outweigh the minimal cost of permitting them to serve. A study authored in August 2017 by the Palm Center and professors associated with the Naval Postgraduate School estimated that separating transgender service members currently serving in the military would cost $960 million, based on the costs of recruiting and training replacements. A true and correct copy of the August 2017 Palm Center study is attached hereto at Exhibit C.

33. Third, the sudden and arbitrary reversal of the DoD policy allowing openly transgender personnel to serve will cause significant disruption and thereby undermine military readiness and lethality. This policy bait-and-switch, after many service members disclosed their transgender status in reliance on statements from the highest levels of the chain of command, conveys to service members that the military cannot be relied upon to follow its own rules or maintain consistent standards.

34. Fourth, in addition to the breach of transgender service members' trust resulting in the deprivation of their careers and livelihood, the President's policy reversal will cause other historically disadvantaged groups in the military, including women and gay and lesbian service members, to question whether their careers and ability to serve as equal members of the military may also be sacrificed.

35. Fifth, those serving in our Armed Forces are expected to perform difficult and dangerous work. The President's reversal of policy puts tremendous additional and unnecessary stress on transgender service members, their command leaders, and those with whom they serve.

36. In short, the President's reversal of the policy permitting military service by openly transgender individuals has had, and will continue to have, a deleterious effect on readiness, force morale, and trust in the chain of command in the Armed Services.

37. I have reviewed and am familiar with the declarations by my colleagues – Former Secretary of the Army Eric Fanning, Former Secretary of the Navy Raymond Mabus, Former Secretary of the Air Force Deborah Lee James, and Former Deputy Surgeon General Margaret Chamberlain Wilmoth – that were submitted in *Doe v. Trump*, Case Number 1:17-cv-01597

(District Court for the District of Columbia). I also submitted a declaration in that case. There is nothing in any of the declarations by my colleagues, filed in *Doe v. Trump*, with which I disagree.

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

DATED: September 13, 2017

Brad R. Carson

CERTIFICATE OF SERVICE

The undersigned certifies under penalty of perjury under the laws of the United States of America and the laws of the State of Washington that on September 14, 2017, I caused true and correct copies of the foregoing documents to be served by the method(s) listed below on the following interested parties:

By Hand Delivery:

US Attorney's Office
700 Stewart St., Suite 5220
Seattle, WA 98101-1271

By Registered or Certified Mail:

Attorney General of the United States
U.S. Department of Justice
950 Pennsylvania Avenue, NW
Washington, DC 20530-0001

Department of Defense
1400 Defense Pentagon
Washington, DC 20301-1400

Secretary of Defense James N. Mattis
1000 Defense Pentagon
Washington, DC 20301-1000

President Donald J. Trump
1600 Pennsylvania Ave. NW
Washington, DC 20500

I hereby certify under the penalty of perjury that the foregoing is true and correct. Executed on September 14, 2017 at Seattle, Washington.

s/Rachel Horvitz
Rachel Horvitz, *Paralegal*

Exhibit B

DEPARTMENT OF DEFENSE REPORT AND RECOMMENDATIONS ON MILITARY SERVICE BY TRANSGENDER PERSONS

FEBRUARY 2018

Table of Contents

Executive Summary

It is a bedrock principle of the Department of Defense that any eligible individual[1] who can meet the high standards for military service without special accommodations should be permitted to serve. This is no less true for transgender persons than for any other eligible individual. This report, and the recommendations contained herein, proceed from this fundamental premise.

The starting point for determining a person's qualifications for military duty is whether the person can meet the standards that govern the Armed Forces. Federal law requires that anyone entering into military service be "qualified, effective, and able-bodied."[2] Military standards are designed not only to ensure that this statutory requirement is satisfied but to ensure the overall military effectiveness and lethality of the Armed Forces.

The purpose of the Armed Forces is to fight and win the Nation's wars. No human endeavor is more physically, mentally, and emotionally demanding than the life and death struggle of battle. Because the stakes in war can be so high—both for the success and survival of individual units in the field and for the success and survival of the Nation—it is imperative that all Service members are physically and mentally able to execute their duties and responsibilities without fail, even while exposed to extreme danger, emotional stress, and harsh environments.

Although not all Service members will experience direct combat, standards that are applied universally across the Armed Forces must nevertheless account for the possibility that any Service member could be thrust into the crucible of battle at any time. As the Department has made clear to Congress, "[c]ore to maintaining a ready and capable military force is the understanding that each Service member is required to be available and qualified to perform assigned missions, including roles and functions outside of their occupation, in any setting."[3] Indeed, there are no occupations in the military that are exempt from deployment.[4] Moreover, while non-combat positions are vital to success in war, the physical and mental requirements for those positions should not be the barometer by which the physical and mental requirements for all positions, especially combat positions, are defined. Fitness for combat must be the metric against which all standards and requirements are judged. To give all Service members the best chance of success and survival in war, the Department must maintain the highest possible standards of physical and mental health and readiness across the force.

While individual health and readiness are critical to success in war, they are not the only measures of military effectiveness and lethality. A fighting unit is not a mere collection of individuals; it is a unique social organism that, when forged properly, can be far more powerful than the sum of its parts. Human experience over millennia—from the Spartans at Thermopylae to the band of brothers of the 101st Airborne Division in World War II, to Marine squads fighting building-to-building in Fallujah—teaches us this. Military effectiveness requires

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[1] 10 U.S.C. §§ 504, 505(a), 12102(b).
[2] 10 U.S.C. § 505(a).
[3] Under Secretary of Defense for Personnel and Readiness, "Fiscal Year 2016 Report to Congress on the Review of Enlistment of Individuals with Disabilities in the Armed Forces," pp. 8-9 (Apr. 2016).
[4] Id.

transforming a collection of individuals into a single fighting organism—merging multiple individual identities into one. This transformation requires many ingredients, including strong leadership, training, good order and discipline, and that most intangible, but vital, of ingredients—unit cohesion or, put another way, human bonding.

Because unit cohesion cannot be easily quantified, it is too often dismissed, especially by those who do not know what Justice Oliver Wendell Holmes called the "incommunicable experience of war."[5] But the experience of those who, as Holmes described, have been "touched with fire" in battle and the experience of those who have spent their lives studying it attest to the enduring, if indescribable, importance of this intangible ingredient. As Dr. Jonathan Shay articulated it in his study of combat trauma in Vietnam, "[s]urvival and success in combat often require soldiers to virtually read one another's minds, reflexively covering each other with as much care as they cover themselves, and going to one another's aid with little thought for safety."[6] Not only is unit cohesion essential to the health of the unit, Dr. Shay found that it was essential to the health of the individual soldier as well. "Destruction of unit cohesion," Dr. Shay concluded, "cannot be overemphasized as a reason why so many psychological injuries that might have healed spontaneously instead became chronic."[7]

Properly understood, therefore, military effectiveness and lethality are achieved through a combination of inputs that include individual health and readiness, strong leadership, effective training, good order and discipline, and unit cohesion. To achieve military effectiveness and lethality, properly designed military standards must foster these inputs. And, for the sake of efficiency, they should do so at the least possible cost to the taxpayer.

To the greatest extent possible, military standards—especially those relating to mental and physical health—should be based on scientifically valid and reliable evidence. Given the life-and-death consequences of warfare, the Department has historically taken a conservative and cautious approach in setting the mental and physical standards for the accession and retention of Service members.

Not all standards, however, are capable of scientific validation or quantification. Instead, they are the product of professional military judgment acquired from hard-earned experience leading Service members in peace and war or otherwise arising from expertise in military affairs. Although necessarily subjective, this judgment is the best, if not only, way to assess the impact of any given military standard on the intangible ingredients of military effectiveness mentioned above—leadership, training, good order and discipline, and unit cohesion.

For decades, military standards relating to mental health, physical health, and the physiological differences between men and women operated to preclude from military service transgender persons who desired to live and work as the opposite gender.

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[5] *The Essential Holmes: Selections from the Letters, Speeches, Judicial Opinions, and Other Writings of Oliver Wendell Holmes, Jr.*, p. 93 (Richard Posner, ed., University of Chicago Press 1992).
[6] Jonathan Shay, *Achilles in Vietnam*, p. 61 (Atheneum 1994).
[7] Id. at 198.

Relying on a report by an outside consultant, the RAND National Defense Research Institute, the Department, at the direction of Secretary Ashton Carter, reversed that longstanding policy in 2016. Although the new policy—the "Carter policy"—did not permit all transgender Service members to change their gender to align with their preferred gender identity, it did establish a process to do so for transgender Service members who were diagnosed with gender dysphoria—that is, the distress or impairment of functioning that is associated with incongruity between one's biological sex and gender identity. It also set in motion a new accession policy that would allow applicants who had a history of gender dysphoria, including those who had already transitioned genders, to enter into military service, provided that certain conditions were met. Once a change of gender is authorized, the person must be treated in all respects in accordance with the person's preferred gender, whether or not the person undergoes any hormone therapy or surgery, so long as a treatment plan has been approved by a military physician.

The new accession policy had not taken effect when the current administration came into office. Secretary James Mattis exercised his discretion and approved the recommendation of the Services to delay the Carter accession policy for an additional six months so that the Department could assess its impact on military effectiveness and lethality. While that review was ongoing, President Trump issued a memorandum to the Secretary of Defense and the Secretary of Homeland Security with respect to the U.S. Coast Guard expressing that further study was needed to examine the effects of the prior administration's policy change. The memorandum directed the Secretaries to reinstate the longstanding preexisting accession policy until such time that enough evidence existed to conclude that the Carter policy would not have negative effects on military effectiveness, lethality, unit cohesion, and military resources. The President also authorized the Secretary of Defense, in consultation with the Secretary of Homeland Security, to address the disposition of transgender individuals who were already serving in the military.

Secretary Mattis established a Panel of Experts that included senior uniformed and civilian leaders of the Department and U.S. Coast Guard, many with experience leading Service members in peace and war. The Panel made recommendations based on each Panel member's independent military judgment. Consistent with those recommendations, the Department, in consultation with the Department of Homeland Security, recommends the following policy to the President:

A. Transgender Persons Without a History or Diagnosis of Gender Dysphoria, Who Are Otherwise Qualified for Service, May Serve, Like All Other Service Members, in Their Biological Sex. Transgender persons who have not transitioned to another gender and do not have a history or current diagnosis of gender dysphoria—i.e., they identify as a gender other than their biological sex but do not currently experience distress or impairment of functioning in meeting the standards associated with their biological sex—are qualified for service, provided that they, like all other persons, satisfy all standards and are capable of adhering to the standards associated with their biological sex. This is consistent with the Carter policy, under which transgender persons without a history or diagnosis of gender dysphoria must serve, like everyone else, in their biological sex.

B. Transgender Persons Who Require or Have Undergone Gender Transition Are Disqualified. Except for those who are exempt under this policy, as described below, and except where waivers or exceptions to policy are otherwise authorized, transgender persons who are diagnosed with gender dysphoria, either before or after entry into service, and require transition-related treatment, or have already transitioned to their preferred gender, should be ineligible for service. For reasons discussed at length in this report, the Department concludes that accommodating gender transition could impair unit readiness; undermine unit cohesion, as well as good order and discipline, by blurring the clear lines that demarcate male and female standards and policies where they exist; and lead to disproportionate costs. Underlying these conclusions is the considerable scientific uncertainty and overall lack of high quality scientific evidence demonstrating the extent to which transition-related treatments, such as cross-sex hormone therapy and sex reassignment surgery—interventions which are unique in psychiatry and medicine—remedy the multifaceted mental health problems associated with gender dysphoria.

C. Transgender Persons With a History or Diagnosis of Gender Dysphoria Are Disqualified, Except Under Certain Limited Circumstances. Transgender persons who are diagnosed with, or have a history of, gender dysphoria are generally disqualified from accession or retention in the Armed Forces. The standards recommended here are subject to the same procedures for waiver or exception to policy as any other standards. This is consistent with the Department's handling of other mental conditions that require treatment. As a general matter, only in the limited circumstances described below should persons with a history or diagnosis of gender dysphoria be accessed or retained.

1. *Accession of Individuals Diagnosed with Gender Dysphoria.* Persons with a history of gender dysphoria may access into the Armed Forces, provided that they can demonstrate 36 consecutive months of stability (i.e., absence of gender dysphoria) immediately preceding their application; they have not transitioned to the opposite gender; and they are willing and able to adhere to all standards associated with their biological sex.

2. *Retention of Service Members Diagnosed with Gender Dysphoria.* Consistent with the Department's general approach of applying less stringent standards to retention than to accession in order to preserve the Department's substantial investment in trained personnel, Service members who are diagnosed with gender dysphoria after entering military service may be retained without waiver, provided that they are willing and able to adhere to all standards associated with their biological sex, the Service member does not require gender transition, and the Service member is not otherwise non-deployable for more than 12 months or for a period of time in excess of that established by Service policy (which may be less than 12 months).[8]

3. *Exempting Current Service Members Who Have Already Received a Diagnosis of Gender Dysphoria.* Transgender Service members who were diagnosed with gender dysphoria by a military medical provider after the effective date of the Carter policy, but before the effective date of any new policy, may continue to receive all medically necessary care,

[8] Under Secretary of Defense for Personnel and Readiness, "DoD Retention Policy for Non-Deployable Service Members" (Feb. 14, 2018).

to change their gender marker in the Defense Enrollment Eligibility Reporting System (DEERS), and to serve in their preferred gender, even after the new policy commences. This includes transgender Service members who entered into military service after January 1, 2018, when the Carter accession policy took effect by court order. The Service member must, however, adhere to the Carter policy procedures and may not be deemed to be non-deployable for more than 12 months or for a period of time in excess of that established by Service policy (which may be less than 12 months). While the Department believes that its solemn promise to these Service members, and the investment it has made in them, outweigh the risks identified in this report, should its decision to exempt these Service members be used by a court as a basis for invalidating the entire policy, this exemption is and should be deemed severable from the rest of the policy.

Although the precise number is unknown, the Department recognizes that many transgender persons who desire to serve in the military experience gender dysphoria and, as a result, could be disqualified under the recommended policy set forth in this report. Many transgender persons may also be unwilling to adhere to the standards associated with their biological sex as required by longstanding military policy. But others have served, and are serving, with distinction under the standards for their biological sex, like all other Service members. Nothing in this policy precludes service by transgender persons who do not have a history or diagnosis of gender dysphoria and are willing and able to meet all standards that apply to their biological sex.

Moreover, nothing in this policy should be viewed as reflecting poorly on transgender persons who suffer from gender dysphoria, or have had a history of gender dysphoria, and are accordingly disqualified from service. The vast majority of Americans from ages 17 to 24—that is, 71%—are ineligible to join the military without a waiver for mental, medical, or behavioral reasons.[9] Transgender persons with gender dysphoria are no less valued members of our Nation than all other categories of persons who are disqualified from military service. The Department honors all citizens who wish to dedicate, and perhaps even lay down, their lives in defense of the Nation, even when the Department, in the best interests of the military, must decline to grant their wish.

Military standards are high for a reason—the trauma of war, which all Service members must be prepared to face, demands physical, mental, and moral standards that will give all Service members the greatest chance to survive the ordeal with their bodies, minds, and moral character intact. The Department would be negligent to sacrifice those standards for any cause. There are serious differences of opinion on this issue, even among military professionals, but in the final analysis, given the uncertainty associated with the study and treatment of gender dysphoria, the competing interests involved, and the vital interests at stake—our Nation's defense and the success and survival of our Service members in war—the Department must proceed with caution.

[9] The Lewin Group, Inc., "Qualified Military Available (QMA) and Interested Youth: Final Technical Report," p. 26 (Sept. 2016).

History of Policies Concerning Transgender Persons

For decades, military standards have precluded the accession and retention of certain transgender persons.[10] Accession standards—i.e., standards that govern induction into the Armed Forces—have historically disqualified persons with a history of "transsexualism." Also disqualified were persons who had undergone genital surgery or who had a history of major abnormalities or defects of the genitalia. These standards prevented transgender persons, especially those who had undergone a medical or surgical gender transition, from accessing into the military, unless a waiver was granted.

Although retention standards—i.e., standards that govern the retention and separation of persons already serving in the Armed Forces—did not require the mandatory processing for separation of transgender persons, it was a permissible basis for separation processing as a physical or mental condition not amounting to a disability. More typically, however, such Service members were processed for separation because they suffered from other associated medical conditions or comorbidities, such as depression, which were also a basis for separation processing.

At the direction of Secretary Carter, the Department made significant changes to these standards. These changes—i.e., the "Carter policy"—prohibit the separation of Service members on the basis of their gender identity and allow Service members who are diagnosed with gender dysphoria to transition to their preferred gender.

Transition-related treatment is highly individualized and could involve what is known as a "medical transition," which includes cross-sex hormone therapy, or a "surgical transition,"

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[10] For purposes of this report, the Department uses the broad definition of "transgender" adopted by the RAND National Defense Institute in its study of transgender service: "an umbrella term used for individuals who have sexual identity or gender expression that differs from their assigned sex at birth." RAND National Defense Research Institute, *Assessing the Implications of Allowing Transgender Personnel to Serve Openly,* p.75 (RAND Corporation 2016), available at https://www.rand.org/content/dam/rand/pubs/research_reports/RR1500/RR1530/RAND_RR1530.pdf ("RAND Study"). According to the Human Rights Campaign, "[t]he transgender community is incredibly diverse. Some transgender people identify as male or female, and some identify as genderqueer, nonbinary, agender, or somewhere else on or outside of the spectrum of what we understand gender to be." Human Rights Campaign, "Understanding the Transgender Community," https://www.hrc.org/resources/understanding-the-transgender-community (last visited Feb. 14, 2018). A subset of transgender persons are those who have been diagnosed with gender dysphoria. According to the *Diagnostic and Statistical Manual of Mental Disorders* published by the American Psychiatric Association, "gender dysphoria" is a "marked incongruence between one's experienced/expressed gender and assigned gender" that "is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning." American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)*, pp. 452-53 (5th ed. 2013). Based on these definitions, a person can be transgender without necessarily having gender dysphoria (i.e., the transgender person does not suffer "clinically significant distress or impairment" on account of gender incongruity). A 2016 survey of active duty Service members estimated that approximately 1% of the force—8,980 Service members—identify as transgender. Office of People Analytics, Department of Defense, "2016 Workplace and Gender Relations Survey of Active Duty Members, Transgender Service Members," pp. 1-2. Currently, there are 937 active duty Service members who have been diagnosed with gender dysphoria since June 30, 2016. In addition, when using the term "biological sex" or "sex," this report is referring to the definition of "sex" in the RAND study: "a person's biological status as male or female based on chromosomes, gonads, hormones, and genitals (intersex is a rare exception)." RAND Study at 75.

which includes sex reassignment surgery. Service members could also forego medical transition treatment altogether, retain all of their biological anatomy, and live as the opposite gender—this is called a "social transition."

Once the Service member's transition is complete, as determined by the member's military physician and commander in accordance with his or her individualized treatment plan, and the Service member provides legal documentation of gender change, the Carter policy allows for the Service member's gender marker to be changed in the DEERS. Thereafter, the Service member must be treated in every respect—including with respect to physical fitness standards; berthing, bathroom, and shower facilities; and uniform and grooming standards—in accordance with the Service member's preferred gender. The Carter policy, however, still requires transgender Service members who have not changed their gender marker in DEERS, including persons who identify as other than male or female, to meet the standards associated with their biological sex.

The Carter policy also allows accession of persons with gender dysphoria who can demonstrate stability in their preferred gender for at least 18 months. The accession policy did not take effect until required by court order, effective January 1, 2018.

The following discussion describes in greater detail the evolution of accession and retention standards pertaining to transgender persons.

Transgender Policy Prior to the Carter Policy

A. Accession Medical Standards

DoD Instruction (DoDI) 6130.03, *Medical Standards for Appointment, Enlistment, or Induction in the Military Services*, establishes baseline accession medical standards used to determine an applicant's medical qualifications to enter military service. This instruction is reviewed every three to four years by the Accession Medical Standards Working Group (AMSWG), which includes medical and personnel subject matter experts from across the Department, its Military Services, and the U.S. Coast Guard. The AMSWG thoroughly reviews over 30 bodily systems and medical focus areas while carefully considering evidence-based clinical information, peer-reviewed scientific studies, scientific expert consensus, and the performance of existing standards in light of empirical data on attrition, deployment readiness, waivers, and disability rates. The AMSWG also considers inputs from non-government sources and evaluates the applicability of those inputs against the military's mission and operational environment, so that the Department and the Military Services can formally coordinate updates to these standards.

Accession medical standards are based on the operational needs of the Department and are designed to ensure that individuals are physically and psychologically "qualified, effective, and able-bodied persons"[11] capable of performing military duties. Military effectiveness requires that the Armed Forces manage an integrated set of unique medical standards and qualifications because all military personnel must be available for worldwide duty 24 hours a day without

[11] 10 U.S.C. § 505(a).

restriction or delay. Such duty may involve a wide range of demands, including exposure to danger or harsh environments, emotional stress, and the operation of dangerous, sensitive, or classified equipment. These duties are often in remote areas lacking immediate and comprehensive medical support. Such demands are not normally found in civilian occupations, and the military would be negligent in its responsibility if its military standards permitted admission of applicants with physical or emotional impairments that could cause harm to themselves or others, compromise the military mission, or aggravate any current physical or mental health conditions that they may have.

In sum, these standards exist to ensure that persons who are under consideration for induction into military service are:

- free of contagious diseases that probably will endanger the health of other personnel;
- free of medical conditions or physical defects that may require excessive time lost from duty for necessary treatment or hospitalization, or probably will result in separation from service for medical unfitness;
- medically capable of satisfactorily completing required training;
- medically adaptable to the military environment without the necessity of geographical area limitations; and
- medically capable of performing duties without aggravation of existing physical defects or medical conditions.[12]

Establishing or modifying an accession standard is a risk management process by which a health condition is evaluated in terms of the probability and effect on the five listed outcomes above. These standards protect the applicant from harm that could result from the rigors of military duty and help ensure unit readiness by minimizing the risk that an applicant, once inducted into military service, will be unavailable for duty because of illness, injury, disease, or bad health.

Unless otherwise expressly provided, a current diagnosis or verified past medical history of a condition listed in DoDI 6130.03 is presumptively disqualifying.[13] Accession standards reflect the considered opinion of the Department's medical and personnel experts that an applicant with an identified condition should only be able to serve if they can qualify for a waiver. Waivers are generally only granted when the condition will not impact the individual's assigned specialty or when the skills of the individual are unique enough to warrant the additional risk. Waivers are not generally granted when the conditions of military service may aggravate the existing condition. For some conditions, applicants with a past medical history may nevertheless be eligible for accession if they meet the requirements for a certain period of "stability"—that is, they can demonstrate that the condition has been absent for a defined period

[12] Department of Defense Instruction 6130.03, *Medical Standards for Appointment, Enlistment, or Induction in the Military Services* (Apr. 28, 2010), incorporating Change 1, p. 2 (Sept. 13, 2011) ("DoDI 6130.03").
[13] Id. at 10.

of time prior to accession.[14] With one exception,[15] each accession standard may be waived in the discretion of the accessing Service based on that Service's policies and practices, which are driven by the unique requirements of different Service missions, different Service occupations, different Service cultures, and at times, different Service recruiting missions.

Historically, mental health conditions have been a great concern because of the unique mental and emotional stresses of military service. Mental health conditions frequently result in attrition during initial entry training and the first term of service and are routinely considered by in-service medical boards as a basis for separation. Department mental health accession standards have typically aligned with the conditions identified in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM), which is published by the American Psychiatric Association (APA). The DSM sets forth the descriptions, symptoms, and other criteria for diagnosing mental disorders. Health care professionals in the United States and much of the world use the DSM as the authoritative guide to the diagnosis of mental disorders.

Prior to implementation of the Carter policy, the Department's accession standards barred persons with a "[h]istory of psychosexual conditions, including but not limited to transsexualism, exhibitionism, transvestism, voyeurism, and other paraphilias."[16] These standards were consistent with DSM-III, which in 1980, introduced the diagnosis of transsexualism.[17] In 1987, DSM-III-R added gender identity disorder, non-transsexual type.[18] DSM-IV, which was published in 1994, combined these two diagnoses and called the resulting condition "gender identity disorder."[19] Due to challenges associated with updating and publishing a new iteration of DoDI 6130.03, the DoDI's terminology has not changed to reflect the changes in the DSM, including further changes that will be discussed later.

DoDI 6130.03 also contains other disqualifying conditions that are associated with, but not unique to, transgender persons, especially those who have undertaken a medical or surgical transition to the opposite gender. These include:

- a history of chest surgery, including but not limited to the surgical removal of the breasts,[20] and genital surgery, including but not limited to the surgical removal of the testicles;[21]

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[14] See, e.g., id. at 47.
[15] The accession standards for applicants with HIV are not waivable absent a waiver from both the accessing Service and the Under Secretary of Defense for Personnel and Readiness. See Department of Defense Instruction 6485.01, *Human Immunodeficiency Virus (HIV) in Military Service Members* (Jun. 7, 2013).
[16] DoDI 6130.03 at 48.
[17] American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders (DSM-III)*, pp. 261-264 (3rd ed. 1980).
[18] American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders (DSM-III-R)*, pp. 76-77 (3rd ed. revised 1987).
[19] American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)*, pp. 532-538 (4th ed. 1994).
[20] DoDI 6130.03 at 18.
[21] Id. at 25-27.

- a history of major abnormalities or defects of the genitalia, including but not limited to change of sex, hermaphroditism, penis amputation, and pseudohermaphroditism;[22]
- mental health conditions such as suicidal ideation, depression, and anxiety disorder;[23] and
- the use of certain medications, or conditions requiring the use of medications, such as hormone therapies and anti-depressants.[24]

Together with a diagnosis of transsexualism, these conditions, which were repeatedly validated by the AMSWG, provided multiple grounds for the disqualification of transgender persons.

B. Retention Standards

The standards that govern the retention of Service members who are already serving in the military are generally less restrictive than the corresponding accession standards due to the investment the Department has made in the individual and their increased capability to contribute to mission accomplishment.

Also unlike the Department's accession standards, each Service develops and applies its own retention standards. With respect to the retention of transgender Service members, these Service-specific standards may have led to inconsistent outcomes across the Services, but as a practical matter, before the Carter policy, the Services generally separated Service members who desired to transition to another gender. During that time, there were no express policies allowing individuals to serve in their preferred gender rather than their biological sex.

Previous Department policy concerning the retention (administrative separation) of transgender persons was not clear or rigidly enforced. DoDI 1332.38, *Physical Disability Evaluation*, now cancelled, characterized "sexual gender and identity disorders" as a basis for allowing administrative separation for a condition not constituting a disability; it did not require mandatory processing for separation. A newer issuance, DoDI 1332.18, *Disability Evaluation System (DES)*, August 5, 2014, does not reference these disorders but instead reflects changes in how such medical conditions are characterized in contemporary medical practice.

Earlier versions of DoDI 1332.14, *Enlisted Administrative Separations*, contained a cross reference to the list of conditions not constituting a disability in former DoDI 1332.38. This was how "transsexualism," the older terminology, was used as a basis for administrative separation. Separation on this basis required formal counseling and an opportunity to address the issue, as well as a finding that the condition was interfering with the performance of duty. In practice, transgender persons were not usually processed for administrative separation on account of gender dysphoria or gender identity itself, but rather on account of medical comorbidities (e.g., depression or suicidal ideation) or misconduct due to cross dressing and related behavior.

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[22] Id.
[23] Id. at 47-48.
[24] Id. at 48.

The Carter Policy

At the direction of Secretary Carter, the Department began formally reconsidering its accession and retention standards as they applied to transgender persons with gender dysphoria in 2015. This reevaluation, which culminated with the release of the Carter policy in 2016, was prompted in part by amendments to the DSM that appeared to change the diagnosis for gender identity disorder from a disorder to a treatable condition called gender dysphoria. Starting from the assumption that transgender persons are qualified for military service, the Department sought to identify and remove the obstacles to such service. This effort resulted in substantial changes to the Department's accession and retention standards to accommodate transgender persons with gender dysphoria who require treatment for transitioning to their preferred gender.

A. Changes to the DSM

When the APA published the fifth edition of the DSM in May 2013, it changed "gender identity disorder" to "gender dysphoria" and designated it as a "condition"—a new diagnostic class applicable only to gender dysphoria—rather than a "disorder."[25] This change was intended to reflect the APA's conclusion that gender nonconformity alone—without accompanying distress or impairment of functioning—was not a mental disorder.[26] DSM-5 also decoupled the diagnosis for gender dysphoria from diagnoses for "sexual dysfunction and parphilic disorders, recognizing fundamental differences between these diagnoses."[27]

According to DSM-5, gender dysphoria in adolescents and adults is "[a] marked incongruence between one's experience/expressed gender and assigned gender, of at least 6 months' duration, as manifested by at least two of the following":

- A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics).
- A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender (or in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics).

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[25] See American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)*, pp. 451-459 (5th ed. 2013) ("DSM-5").

[26] RAND Study at 77; see also Hayes Directory, "Sex Reassignment Surgery for the Treatment of Gender Dysphoria" (May 15, 2014), p. 1 ("This change was intended to reflect a consensus that gender nonconformity is not a psychiatric disorder, as it was previously categorized. However, since the condition may cause clinically significant distress and since a diagnosis is necessary for access to medical treatment, the new term was proposed."); Irene Folaron & Monica Lovasz, "Military Considerations in Transsexual Care of the Active Duty Member," *Military Medicine*, Vol. 181, pp. 1182-83 (2016) ("In the DSM-5, [gender dysphoria] has replaced the diagnosis of 'gender identity disorder' in order to place the focus on the dysphoria and to diminish the pathology associated with identity incongruence.").

[27] Irene Folaron & Monica Lovasz, "Military Considerations in Transsexual Care of the Active Duty Member," *Military Medicine*, Vol. 181, p. 1183 (2016).

- A strong desire for the primary and/or secondary sex characteristics of the other gender.
- A strong desire to be of the other gender (or some alternative gender different from one's assigned gender).
- A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender).
- A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender).

Importantly, DSM-5 observed that gender dysphoria "is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning."[28]

B. The Department Begins Review of Transgender Policy

On July 28, 2015, then Secretary Carter issued a memorandum announcing that no Service members would be involuntarily separated or denied reenlistment or continuation of service based on gender identity or a diagnosis of gender dysphoria without the personal approval of the Under Secretary of Defense for Personnel and Readiness.[29] The memorandum also created the Transgender Service Review Working Group (TSRWG) "to study the policy and readiness implications of welcoming transgender persons to serve openly."[30] The memorandum specifically directed the working group to "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."[31]

As part of this review, the Department commissioned the RAND National Defense Research Institute to conduct a study to "(1) identify the health care needs of the transgender population, transgender Service members' potential health care utilization rates, and the costs associated with extending health care coverage for transition-related treatments; (2) assess the potential readiness impacts of allowing transgender Service members to serve openly; and (3) review the experiences of foreign militaries that permit transgender Service members to serve openly."[32] The resulting report, entitled *Assessing the Implications of Allowing Transgender Personnel to Serve Openly*, reached several conclusions. First, the report estimated that there are between 1,320 and 6,630 transgender Service members already serving in the active component of the Armed Forces and 830 to 4,160 in the Selected Reserve.[33] Second, the report predicted "annual gender transition-related health care to be an extremely small part of the overall health care provided to the [active component] population."[34] Third, the report estimated that active component "health care costs will increase by between $2.4 million and $8.4 million annually—an amount that will have little impact on and represents an exceedingly small proportion of

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[28] American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)*, p. 453 (5th ed. 2013).
[29] Memorandum from Ashton Carter, Secretary of Defense, "Transgender Service Members" (July 28, 2015).
[30] Id.
[31] Id.
[32] RAND Study at 1.
[33] Id. at x-xi.
[34] Id. at xi.

[active component] health care expenditures (approximately $6 billion in FY 2014)."[35] Fourth, the report "found that less than 0.0015 percent of the total available labor-years would be affected, based on estimated gender transition-related health care utilization rates."[36] Finally, the report concluded that "[e]xisting data suggest a minimal impact on unit cohesion as a result of allowing transgender personnel to serve openly."[37] "Overall," according to RAND, "our study found that the number of U.S. transgender Service members who are likely to seek transition-related care is so small that a change in policy will likely have a marginal impact on health care costs and the readiness of the force."[38]

The RAND report thus acknowledged that there will be an adverse impact on health care utilization and costs, readiness, and unit cohesion, but concluded nonetheless that the impact will be "negligible" and "marginal" because of the small estimated number of transgender Service members relative to the size of the active component of the Armed Forces. Because of the RAND report's macro focus, however, it failed to analyze the impact at the micro level of allowing gender transition by individuals with gender dysphoria. For example, as discussed in more detail later, the report did not examine the potential impact on unit readiness, perceptions of fairness and equity, personnel safety, and reasonable expectations of privacy at the unit and sub-unit levels, all of which are critical to unit cohesion. Nor did the report meaningfully address the significant mental health problems that accompany gender dysphoria—from high rates of comorbidities and psychiatric hospitalizations to high rates of suicide ideation and suicidality—and the scope of the scientific uncertainty regarding whether gender transition treatment fully remedies those problems.

C. New Standards for Transgender Persons

Based on the RAND report, the work of the TSRWG, and the advice of the Service Secretaries, Secretary Carter approved the publication of DoDI 1300.28, *In-service Transition for Service Members Identifying as Transgender*, and Directive-type Memorandum (DTM) 16-005, "Military Service of Transgender Service Members," on June 30, 2016. Although the new retention standards were effective immediately upon publication of the above memoranda, the accession standards were delayed until July 1, 2017, to allow time for training all Service members across the Armed Forces, including recruiters, Military Entrance Processing Station (MEPS) personnel, and basic training cadre, and to allow time for modifying facilities as necessary.

1. *Retention Standards*. DoDI 1300.28 establishes the procedures by which Service members who are diagnosed with gender dysphoria may administratively change their gender. Once a Service member receives a gender dysphoria diagnosis from a military physician, the physician, in consultation with the Service member, must establish a treatment plan. The treatment plan is highly individualized and may include cross-sex hormone therapy (i.e., medical transition), sex reassignment surgery (i.e., surgical transition), or simply living as the opposite gender but without any cross-sex hormone or surgical treatment (i.e., social

[35] Id. at xi-xii.
[36] Id. at xii.
[37] Id.
[38] Id. at 69.

transition). The nature of the treatment is left to the professional medical judgment of the treating physician and the individual situation of the transgender Service member. The Department does not require a Service member with gender dysphoria to undergo cross-sex hormone therapy, sex reassignment surgery, or any other physical changes to effectuate an administrative change of gender. During the course of treatment, commanders are authorized to grant exceptions from physical fitness, uniform and grooming, and other standards, as necessary and appropriate, to transitioning Service members. Once the treating physician determines that the treatment plan is complete, the Service member's commander approves, and the Service member produces legal documentation indicating change of gender (e.g., certified birth certificate, court order, or U.S. passport), the Service member may request a change of gender marker in DEERS. Once the DEERS gender marker is changed, the Service member is held to all standards associated with the member's transitioned gender, including uniform and grooming standards, body composition assessment, physical readiness testing, Military Personnel Drug Abuse Testing Program participation, and other military standards congruent to the member's gender. Indeed, the Service member must be treated in all respects in accordance with the member's transitioned gender, including with respect to berthing, bathroom, and shower facilities. Transgender Service members who do not meet the clinical criteria for gender dysphoria, by contrast, remain subject to the standards and requirements applicable to their biological sex.

2. *Accession Standards*. DTM 16-005 directed that the following medical standards for accession into the Military Services take effect on July 1, 2017:

(1) A history of gender dysphoria is disqualifying, unless, as certified by a licensed medical provider, the applicant has been stable without clinically significant distress or impairment in social, occupational, or other important areas of functioning for 18 months.

(2) A history of medical treatment associated with gender transition is disqualifying, unless, as certified by a licensed medical provider:

(a) the applicant has completed all medical treatment associated with the applicant's gender transition; and
(b) the applicant has been stable in the preferred gender for 18 months; and
(c) if the applicant is presently receiving cross-sex hormone therapy post-gender transition, the individual has been stable on such hormones for 18 months.

(3) A history of sex reassignment or genital reconstruction surgery is disqualifying, unless, as certified by a licensed medical provider:

(a) a period of 18 months has elapsed since the date of the most recent of any such surgery; and

(b) no functional limitations or complications persist, nor is any additional surgery required.[39]

[39] Memorandum from Ashton Carter, Secretary of Defense, "Directive-type Memorandum (DTM) 16-005, 'Military Service of Transgender Service Members,'" Attachment, pp. 1-2 (June 30, 2016).

Panel of Experts Recommendation

The Carter policy's accession standards for persons with a history of gender dysphoria were set to take effect on July 1, 2017, but on June 30, after consultation with the Secretaries and Chiefs of Staff of each Service, Secretary Mattis postponed the new standards for an additional six months "to evaluate more carefully the impact of such accessions on readiness and lethality."[40] Secretary Mattis specifically directed that the review would "include all relevant considerations" and would last for five months, with a due date of December 1, 2017.[41] The Secretary also expressed his desire to have "the benefit of the views of the military leadership and of the senior civilian officials who are now arriving in the Department."[42]

While Secretary Mattis's review was ongoing, President Trump issued a memorandum, on August 25, 2017, directing the Secretary of Defense, and the Secretary of Homeland Security with respect to the U.S. Coast Guard, to reinstate longstanding policy generally barring the accession of transgender individuals "until such time as a sufficient basis exists upon which to conclude that terminating that policy and practice" would not "hinder military effectiveness and lethality, disrupt unit cohesion, or tax military resources."[43] The President found that "further study is needed to ensure that continued implementation of last year's policy change would not have those negative effects."[44] Accordingly, the President directed both Secretaries to maintain the prohibition on accession of transgender individuals "until such time as the Secretary of Defense, after consulting with the Secretary of Homeland Security, provides a recommendation to the contrary" that is convincing.[45] The President made clear that the Secretaries may advise him "at any time, in writing, that a change to this policy is warranted."[46] In addition, the President gave both Secretaries discretion to "determine how to address transgender individuals currently serving" in the military and made clear that no action be taken against them until a determination was made.[47]

On September 14, 2017, Secretary Mattis established a Panel of Experts to study, in a "comprehensive, holistic, and objective" manner, "military service by transgender individuals, focusing on military readiness, lethality, and unit cohesion, with due regard for budgetary constraints and consistent with applicable law."[48] He directed the Panel to "conduct an independent multi-disciplinary review and study of relevant data and information pertaining to transgender Service members."[49]

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[40] Memorandum from James N. Mattis, Secretary of Defense, "Accession of Transgender Individuals into the Military Services" (June 30, 2017).
[41] Id.
[42] Id.
[43] Memorandum from Donald J. Trump, President of the United States, "Military Service by Transgender Individuals" (Aug. 25, 2017).
[44] Id. at 1.
[45] Id. at 2.
[46] Id.
[47] Id.
[48] Memorandum from James N. Mattis, Secretary of Defense, "Terms of Reference—Implementation of Presidential Memorandum on Military Service by Transgender Individuals," pp. 1-2 (Sept. 14, 2017).
[49] Id. at 2.

The Panel consisted of the Under Secretaries of the Military Departments (or officials performing their duties), the Armed Services' Vice Chiefs (including the Vice Commandant of the U.S. Coast Guard), and the Senior Enlisted Advisors, and was chaired by the Under Secretary of Defense for Personnel and Readiness or an official performing those duties. The Secretary of Defense selected these senior leaders because of their experience leading warfighters in war and peace or their expertise in military operational effectiveness. These senior leaders also have the statutory responsibility to organize, train, and equip military forces and are uniquely qualified to evaluate the impact of policy changes on the combat effectiveness and lethality of the force. The Panel met 13 times over a span of 90 days.

The Panel received support from medical and personnel experts from across the Departments of Defense and Homeland Security. The Transgender Service Policy Working Group, comprised of medical and personnel experts from across the Department, developed policy recommendations and a proposed implementation plan for the Panel's consideration. The Medical and Personnel Executive Steering Committee, a standing group of the Surgeons General and Service Personnel Chiefs, led by Personnel and Readiness, provided the Panel with an analysis of accession standards, a multi-disciplinary review of relevant data, and information about medical treatment for gender dysphoria and gender transition-related medical care. These groups reported regularly to the Panel and responded to numerous queries for additional information and analysis to support the Panel's review and deliberations. A separate working group tasked with enhancing the lethality of our Armed Forces also provided a briefing to the Panel on their work relating to retention standards.

The Panel met with and received input from transgender Service members, commanders of transgender Service members, military medical professionals, and civilian medical professionals with experience in the care and treatment of individuals with gender dysphoria. The Panel also reviewed information and analyses about gender dysphoria, the treatment of gender dysphoria, and the effects of currently serving individuals with gender dysphoria on military effectiveness, unit cohesion, and resources. Unlike past reviews, the Panel's analysis was informed by the Department's own data and experience obtained since the Carter policy took effect.

To fulfill its mandate, the Panel addressed three questions:

- Should the Department of Defense access transgender individuals?
- Should the Department allow transgender individuals to transition gender while serving, and if so, what treatment should be authorized?
- How should the Department address transgender individuals who are currently serving?

After extensive review and deliberation, which included evidence in support of and against the Panel's recommendations, the Panel exercised its professional military judgment and made recommendations. The Department considered those recommendations and the information underlying them, as well as additional information within the Department, and now proposes the following policy consistent with those recommendations.

Recommended Policy

To maximize military effectiveness and lethality, the Department, after consultation with and the concurrence of the Department of Homeland Security, recommends cancelling the Carter policy and, as explained below, adopting a new policy with respect to the accession and retention of transgender persons.

The Carter policy assumed that transgender persons were generally qualified for service and that their accession and retention would not negatively impact military effectiveness. As noted earlier, Secretary Carter directed the TSRWG, the group charged with evaluating, and making recommendations on, transgender service, to "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."[50] Where necessary, standards were adjusted or relaxed to accommodate service by transgender persons. The following analysis makes no assumptions but instead applies the relevant standards applicable to everyone to determine the extent to which transgender persons are qualified for military duty.

For the following reasons, the Department concludes that transgender persons should not be disqualified from service solely on account of their transgender status, provided that they, like all other Service members, are willing and able to adhere to all standards, including the standards associated with their biological sex. With respect to the subset of transgender persons who have been diagnosed with gender dysphoria, however, those persons are generally disqualified unless, depending on whether they are accessing or seeking retention, they can demonstrate stability for the prescribed period of time; they do not require, and have not undergone, a change of gender; and they are otherwise willing and able to meet all military standards, including those associated with their biological sex. In order to honor its commitment to current Service members diagnosed with gender dysphoria, those Service members who were diagnosed after the effective date of the Carter policy and before any new policy takes effect will not be subject to the policy recommended here.

Discussion of Standards

The standards most relevant to the issue of service by transgender persons fall into three categories: mental health standards, physical health standards, and sex-based standards. Based on these standards, the Department can assess the extent to which transgender persons are qualified for military service and, in light of that assessment, recommend appropriate policies.

A. Mental Health Standards

Given the extreme rigors of military service and combat, maintaining high standards of mental health is essential to military effectiveness and lethality. The immense toll that the burden and experience of combat can have on the human psyche cannot be overstated. Therefore, putting individuals into battle, who might be at increased risk of psychological injury, would be reckless, not only for those individuals, but for the Service members who serve beside them as well.

[50] Memorandum from Ashton Carter, Secretary of Defense, "Transgender Service Members" (July 28, 2015).

The Department's experience with the mental health issues arising from our wars in Afghanistan and Iraq, including post-traumatic stress disorder (PTSD), only underscores the importance of maintaining high levels of mental health across the force. PTSD has reached as high as 2.8% of all active duty Service members, and in 2016, the number of active duty Service members with PTSD stood at 1.5%.[51] Of all Service members in the active component, 7.5% have been diagnosed with a mental health condition of some type.[52] The Department is mindful of these existing challenges and must exercise caution when considering changes to its mental health standards.

Most mental health conditions and disorders are automatically disqualifying for accession absent a waiver. For example, persons with a history of bipolar disorder, personality disorder, obsessive-compulsive disorder, suicidal behavior, and even body dysmorphic disorder (to name a few) are barred from entering into military service, unless a waiver is granted.[53] For a few conditions, however, persons may enter into service without a waiver if they can demonstrate stability for 24 to 36 continuous months preceding accession. Historically, a person is deemed stable if they are without treatment, symptoms, or behavior of a repeated nature that impaired social, school, or work efficiency for an extended period of several months. Such conditions include depressive disorder (stable for 36 continuous months) and anxiety disorder (stable for 24 continuous months).[54] Requiring a period of stability reduces, but does not eliminate, the likelihood that the individual's depression or anxiety will return.

Historically, conditions associated with transgender individuals have been automatically disqualifying absent a waiver. Before the changes directed by Secretary Carter, military mental health standards barred persons with a "[h]istory of psychosexual conditions, including but not limited to transsexualism, exhibitionism, transvestism, voyeurism, and other paraphilias."[55] These standards, however, did not evolve with changing understanding of transgender mental health. Today, transsexualism is no longer considered by most mental health practitioners as a mental health condition. According to the APA, it is not a medical condition for persons to identify with a gender that is different from their biological sex.[56] Put simply, transgender status alone is not a condition.

Gender dysphoria, by contrast, is a mental health condition that can require substantial medical treatment. Many individuals who identify as transgender are diagnosed with gender dysphoria, but "[n]ot all transgender people suffer from gender dysphoria and that distinction," according to the APA, "is important to keep in mind."[57] The DSM-5 defines gender dysphoria as

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[51] Deployment Health Clinical Center, "Mental Health Disorder Prevalence among Active Duty Service Members in the Military Health System, Fiscal Years 2005-2016" (Jan. 2017).
[52] Id.
[53] DoDI 6130.03 at 47-48.
[54] Id.
[55] Id. at 48.
[56] DSM-5 at 452-53.
[57] American Psychiatric Association, "Expert Q & A: Gender Dysphoria," available at https://www.psychiatry.org/patients-families/gender-dysphoria/expert-qa (last visited Feb. 14, 2018). Conversely, not all persons with gender dysphoria are transgender. "For example, some men who are disabled in combat, especially if their injury includes genital wounds, may feel that they are no longer men because their bodies do not conform to their concept of manliness. Similarly, a woman who opposes plastic surgery, but who must undergo mastectomy because of breast

a "marked incongruence between one's experience/expressed gender and assigned gender, of at least 6 months duration," that is manifested in various specified ways.[58] According to the APA, the "condition is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning."[59]

Transgender persons with gender dysphoria suffer from high rates of mental health conditions such as anxiety, depression, and substance use disorders.[60] High rates of suicide ideation, attempts, and completion among people who are transgender are also well documented in the medical literature, with lifetime rates of suicide attempts reported to be as high as 41% (compared to 4.6% for the general population).[61] According to a 2015 survey, the rate skyrockets to 57% for transgender individuals without a supportive family.[62] The Department is concerned that the stresses of military life, including basic training, frequent moves, deployment to war zones and austere environments, and the relentless physical demands, will be additional contributors to suicide behavior in people with gender dysphoria. In fact, there is recent evidence that military service can be a contributor to suicidal thoughts.[63]

Preliminary data of Service members with gender dysphoria reflect similar trends. A review of the administrative data indicates that Service members with gender dysphoria are eight times more likely to attempt suicide than Service members as a whole (12% versus 1.5%).[64]

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cancer, may find that she requires reconstructive breast surgery in order to resolve gender dysphoria arising from the incongruence between her body without breasts and her sense of herself as a woman." M. Jocelyn Elders, George R. Brown, Eli Coleman, Thomas Kolditz & Alan Steinman, "Medical Aspects of Transgender Military Service," *Armed Forces & Society*, p. 5 n.22 (Mar. 2014).

[58] DSM-5 at 452.

[59] DSM-5 at 453.

[60] Cecilia Dhejne, Roy Van Vlerken, Gunter Heylens & Jon Arcelus, "Mental health and gender dysphoria: A review of the literature," *International Review of Psychiatry*, Vol. 28, pp. 44-57 (2016); George R. Brown & Kenneth T. Jones, "Mental Health and Medical Health Disparities in 5135 Transgender Veterans Receiving Healthcare in the Veterans Health Administration: A Case-Control Study," *LGBT Health*, Vol. 3, p. 128 (Apr. 2016).

[61] Ann P. Haas, Philip L. Rodgers & Jody L. Herman, *Suicide Attempts among Transgender and Gender Non-Conforming Adults: Findings of the National Transgender Discrimination Survey*, p. 2 (American Foundation for Suicide Prevention and The Williams Institute, University of California, Los Angeles, School of Law 2014), available at https://williamsinstitute.law.ucla.edu/wp-content/uploads/AFSP-Williams-Suicide-Report-Final.pdf; H.G. Virupaksha, Daliboyina Muralidhar & Jayashree Ramakrishna, "Suicide and Suicide Behavior among Transgender Persons," *Indian Journal of Psychological Medicine*, Vol.38, pp. 505-09 (2016); Claire M. Peterson, Abigail Matthews, Emily Copps-Smith & Lee Ann Conard, "Suicidality, Self-Harm, and Body Dissatisfaction in Transgender Adolescents and Emerging Adults with Gender Dysphoria," *Suicide and Life Threatening Behavior*, Vol. 47, pp. 475-482 (Aug. 2017).

[62] Ann P. Haas, Philip L. Rodgers & Jody L. Herman, *Suicide Attempts among Transgender and Gender Non-Conforming Adults: Findings of the National Transgender Discrimination Survey*, pp. 2, 12 (American Foundation for Suicide Prevention and The Williams Institute, University of California, Los Angeles, School of Law 2014), available at https://williamsinstitute.law.ucla.edu/wp-content/uploads/AFSP-Williams-Suicide-Report-Final.pdf.

[63] Raymond P. Tucker, Rylan J. Testa, Mark A.Reger, Tracy L. Simpson, Jillian C. Shipherd, & Keren Lehavot, "Current and Military-Specific Gender Minority Stress Factors and Their Relationship with Suicide Ideation in Transgender Veterans," *Suicide and Life Threatening Behavior* DOI: 10.1111/sltb.12432 (epub ahead of print), pp. 1-10 (2018); Craig J. Bryan, AnnaBelle O. Bryan, Bobbie N. Ray-Sannerud, Neysa Etienne & Chad E. Morrow, "Suicide attempts before joining the military increase risk for suicide attempts and severity of suicidal ideation among military personnel and veterans," *Comprehensive Psychiatry*, Vol. 55, pp. 534-541 (2014).

[64] Data retrieved from Military Health System data repository (Oct. 2017).

Service members with gender dysphoria are also nine times more likely to have mental health encounters than the Service member population as a whole (28.1 average encounters per Service member versus 2.7 average encounters per Service member).[65] From October 1, 2015 to October 3, 2017, the 994 active duty Service members diagnosed with gender dysphoria accounted for 30,000 mental health visits.[66]

It is widely believed by mental health practitioners that gender dysphoria can be treated. Under commonly accepted standards of care, treatment for gender dysphoria can include: psychotherapy; social transition—also known as "real life experience"—to allow patients to live and work in their preferred gender without any hormone treatment or surgery; medical transition to align secondary sex characteristics with patients' preferred gender using cross-sex hormone therapy and hair removal; and surgical transition—also known as sex reassignment surgery—to make the physical body—both primary and secondary sex characteristics—resemble as closely as possible patients' preferred gender.[67] The purpose of these treatment options is to alleviate the distress and impairment of gender dysphoria by seeking to bring patients' physical characteristics into alignment with their gender identity—that is, one's inner sense of one's own gender.[68]

Cross-sex hormone therapy is a common medical treatment associated with gender transition that may be commenced following a diagnosis of gender dysphoria.[69] Treatment for women transitioning to men involves the administration of testosterone, whereas treatment for men transitioning to women requires the blocking of testosterone and the administration of estrogens.[70] The Endocrine Society's clinical guidelines recommend laboratory bloodwork every 90 days for the first year of treatment to monitor hormone levels.[71]

As a treatment for gender dysphoria, sex reassignment surgery is "a unique intervention not only in psychiatry but in all of medicine."[72] Under existing Department guidelines

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[65] Data retrieved from Military Health System data repository (Oct. 2017). Study period was Oct. 1, 2015 to July 26, 2017.

[66] Data retrieved from Military Health System data repository (Oct. 2017).

[67] RAND Study at 5-7, Appendices A & C; see also Hayes Directory, "Sex Reassignment Surgery for the Treatment of Gender Dysphoria," p. 1 (May 15, 2014) ("The full therapeutic approach to [gender dysphoria] consists of 3 elements or phases, typically in the following order: (1) hormones of the desired gender; (2) real-life experience for 12 months in the desired role; and (3) surgery to change the genitalia and other sex characteristics (e.g., breast reconstruction or mastectomy). However, not everyone with [gender dysphoria] needs or wants all elements of this triadic approach."); Irene Folaron & Monica Lovasz, "Military Considerations in Transsexual Care of the Active Duty Member," *Military Medicine*, Vol. 181, p. 1183 (Oct. 2016) ("The Endocrine Society proposes a sequential approach in transsexual care to optimize mental health and physical outcomes. Generally, they recommend initiation of psychotherapy, followed by cross-sex hormone treatments, then [sex reassignment surgery].").

[68] RAND Study at 73.

[69] Wylie C. Hembree, Peggy Cohen-Kettenis, Lous Gooren, Sabine Hannema, Walter Meyer, M. Hassan Murad, Stephen Rosenthal, Joshua Safer, Vin Tangpricha, & Guy T'Sjoen, "Endocrine Treatment of Gender-Dysphoric/Gender Incongruent Persons: An Endocrine Society Clinical Practice Guideline," *The Journal of Clinical Endocrinology & Metabolism*, Vol. 102, pp. 3869-3903 (Nov. 2017).

[70] Id. at 3885-3888.

[71] Id.

[72] Ceclilia Dhejne, Paul Lichtenstein, Marcus Boman, Anna L. Johansson, Niklas Långström & Mikael Landén, "Long-Term Follow-Up of Transsexual Persons Undergoing Sex Reassignment Surgery: Cohort Study in Sweden," *PLoS One*, Vol. 6, pp. 1-8 (Feb. 2011); see also Hayes Directory, "Sex Reassignment Surgery for the Treatment of

implementing the Carter policy, men transitioning to women may obtain an orchiectomy (surgical removal of the testicles), a penectomy (surgical removal of the penis), a vaginoplasty (surgical creation of a vagina), a clitoroplasty (surgical creation of a clitoris), and a labiaplasty (surgical creation of the labia). Women transitioning to men may obtain a hysterectomy (surgical removal of the uterus), a mastectomy (surgical removal of the breasts), a metoidioplasty (surgical enlargement of the clitoris), a phalloplasty (surgical creation of a penis), a scrotoplasty (surgical creation of a scrotum) and placement of testicular prostheses, a urethroplasty (surgical enlargement of the urethra), and a vaginectomy (surgical removal of the vagina). In addition, the following cosmetic procedures may be provided at military treatment facilities as well: abdominoplasty, breast augmentation, blepharoplasty (eyelid lift), hair removal, face lift, facial bone reduction, hair transplantation, liposuction, reduction thyroid chondroplasty, rhinoplasty, and voice modification surgery.[73]

The estimated recovery time for each of the surgical procedures, even assuming no complications, can be substantial. For example, assuming no complications, the recovery time for a hysterectomy is up to eight weeks; a mastectomy is up to six weeks; a phalloplasty is up to three months; a metoidioplasty is up to eight weeks; an orchiectomy is up to six weeks; and a vaginoplasty is up to three months.[74] When combined with 12 continuous months of hormone therapy, which is required prior to genital surgery,[75] the total time necessary for surgical transition can exceed a year.

Although relatively few people who are transgender undergo genital reassignment surgeries (2% of transgender men and 10% of transgender women), we have to consider that the rate of complications for these surgeries is significant, which could increase a transitioning Service member's unavailability.[76] Even according to the RAND study, 6% to 20% of those receiving vaginoplasty surgery experience complications, meaning that "between three and 11 Service members per year would experience a long-term disability from gender reassignment

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Gender Dysphoria," p. 2 (May 15, 2014) (noting that gender dysphoria "does not readily fit traditional concepts of medical necessity since research to date has not established anatomical or physiological anomalies associated with [gender dysphoria]"); Hayes Annual Review, "Sex Reassignment Surgery for the Treatment of Gender Dysphoria" (Apr. 18, 2017).

[73] Memorandum from Defense Health Agency, "Information Memorandum: Interim Defense Health Agency Procedures for Reviewing Requests for Waivers to Allow Supplemental Health Care Program Coverage of Sex Reassignment Surgical Procedures" (Nov. 13, 2017); see also RAND Study at Appendix C.

[74] University of California, San Francisco, Center of Excellence for Transgender Health, "Guidelines for the Primary and Gender-Affirming Care of Transgender and Gender Nonbinary People," available at http://transhealth.ucsf.edu/trans?page=guidelines-home (last visited Feb. 16, 2018); Discussion with Dr. Loren Schechter, Visiting Clinical Professor of Surgery, University of Illinois at Chicago (Nov. 9, 2017).

[75] RAND Study at 80; see also Irene Folaron & Monica Lovasz, "Military Considerations in Transsexual Care of the Active Duty Member," *Military Medicine*, Vol. 181, p. 1184 (Oct. 2016) (noting that Endocrine Society criteria "require that the patient has been on continuous cross-sex hormones and has had continuous [real life experience] or psychotherapy for the past 12 months").

[76] Sandy E. James, Jody L. Herman, Susan Rankin, Mara Keisling, Lisa Mottet & Ma'ayan Anafi, *The Report of the 2015 U.S. Transgender Survey*, pp. 100-103 (National Center for Transgender Equality 2016) available at https://www.transequality.org/sites/default/files/docs/USTS-Full-Report-FINAL.PDF.

surgery."[77] The RAND study further notes that of those receiving phalloplasty surgery, as many as 25%—one in four—will have complications.[78]

The prevailing judgment of mental health practitioners is that gender dysphoria can be treated with the transition-related care described above. While there are numerous studies of varying quality showing that this treatment can improve health outcomes for individuals with gender dysphoria, the available scientific evidence on the extent to which such treatments fully remedy all of the issues associated with gender dysphoria is unclear. Nor do any of these studies account for the added stress of military life, deployments, and combat.

As recently as August 2016, the Centers for Medicare and Medicaid Services (CMS) conducted a comprehensive review of the relevant literature, over 500 articles, studies, and reports, to determine if there was "sufficient evidence to conclude that gender reassignment surgery improves health outcomes for Medicare beneficiaries with gender dysphoria."[79] After reviewing the universe of literature regarding sex reassignment surgery, CMS identified 33 studies sufficiently rigorous to merit further review, and of those, "some were positive; others were negative."[80] "Overall," according to CMS, "the quality and strength of evidence were low due to mostly observational study designs with no comparison groups, subjective endpoints, potential confounding . . . , small sample sizes, lack of validated assessment tools, and considerable [number of study subjects] lost to follow-up."[81] With respect to whether sex reassignment surgery was "reasonable and necessary" for the treatment of gender dysphoria, CMS concluded that there was "not enough high quality evidence to determine whether gender reassignment surgery improves health outcomes for Medicare beneficiaries with gender dysphoria and whether patients most likely to benefit from these types of surgical intervention can be identified prospectively."[82]

Importantly, CMS identified only six studies as potentially providing "useful information" on the effectiveness of sex reassignment surgery. According to CRS, "the four best designed and conducted studies that assessed the quality of life before and after surgery using validated (albeit, non-specific) psychometric studies did not demonstrate clinically significant changes or differences in psychometric test results after [sex reassignment surgery]."[83]

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[77] RAND Study at 40-41.
[78] Id. at 41.
[79] Tamara Jensen, Joseph Chin, James Rollins, Elizabeth Koller, Linda Gousis & Katherine Szarama, "Final Decision Memorandum on Gender Reassignment Surgery for Medicare Beneficiaries with Gender Dysphoria," Centers for Medicare & Medicaid Services, p. 9 (Aug. 30, 2016) ("CMS Report").
[80] Id. at 62.
[81] Id.
[82] Id. at 65. CMS did not conclude that gender reassignment surgery can never be necessary and reasonable to treat gender dysphoria. To the contrary, it made clear that Medicare insurers could make their own "determination of whether or not to cover gender reassignment surgery based on whether gender reassignment surgery is reasonable and necessary for the individual beneficiary after considering the individual's specific circumstances." Id. at 66. Nevertheless, CMS did decline to require all Medicare insurers to cover sex reassignment surgeries because it found insufficient scientific evidence to conclude that such surgeries improve health outcomes for persons with gender dysphoria.
[83] Id. at 62.

Additional studies found that the "cumulative rates of requests for surgical reassignment reversal or change in legal status" were between 2.2% and 3.3%.[84]

A sixth study, which came out of Sweden, is one of the most robust because it is a "nationwide population-based, long-term follow-up of sex-reassigned transsexual persons."[85] The study found increased mortality and psychiatric hospitalization for patients who had undergone sex reassignment surgery as compared to a healthy control group.[86] As described by CMS: "The mortality was primarily due to completed suicides (19.1-fold greater than in [the control group]), but death due to neoplasm and cardiovascular disease was increased 2 to 2.5 times as well. We note, mortality from this patient population did not become apparent until after 10 years. The risk for psychiatric hospitalization was 2.8 times greater than in controls even after adjustment for prior psychiatric disease (18%). The risk for attempted suicide was greater in male-to-female patients regardless of the gender of the control."[87]

According to the Hayes Directory, which conducted a review of 19 peer-reviewed studies on sex reassignment surgery, the "evidence suggests positive benefits," including "decreased [gender dysphoria], depression and anxiety, and increased [quality of life]," but "because of serious limitations," these findings "permit only weak conclusions."[88] It rated the quality of evidence as "very low" due to the numerous limitations in the studies and concluded that there is

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[84] Id.

[85] Ceclilia Dhejne, Paul Lichtenstein, Marcus Boman, Anna L. Johansson, Niklas Långström & Mikael Landén, "Long-Term Follow-Up of Transsexual Persons Undergoing Sex Reassignment Surgery: Cohort Study in Sweden," *PLoS One*, Vol. 6, p. 6 (Feb. 2011); see also id. ("Strengths of this study include nationwide representativity over more than 30 years, extensive follow-up time, and minimal loss to follow-up. . . . Finally, whereas previous studies either lack a control group or use standardised mortality rates or standarised incidence rates as comparisons, we selected random population controls matched by birth year, and either birth or final sex.").

[86] Id. at 7; see also at 6 ("Mortality from suicide was strikingly high among sex-reassigned persons, also after adjustment for prior psychiatric morbidity. In line with this, sex-reassigned persons were at increased risk for suicide attempts. Previous reports suggest that transsexualism is a strong risk factor for suicide, also after sex reassignment, and our long-term findings support the need for continued psychiatric follow-up for persons at risk to prevent this. Inpatient care for psychiatric disorders was significantly more common among sex-reassigned persons than among matched controls, both before and after sex reassignment. It is generally accepted that transsexuals have more psychiatric ill-health than the general population prior to the sex reassignment. It should therefore come as no surprise that studies have found high rates of depression, and low quality of life, also after sex reassignment. Notably, however, in this study the increased risk for psychiatric hospitalization persisted even after adjusting for psychiatric hospitalization prior to sex reassignment. This suggests that even though sex reassignment alleviates gender dysphoria, there is a need to identify and treat co-occurring psychiatric morbidity in transsexual persons not only before but also after sex reassignment.").

[87] CMS Report at 62. It bears noting that the outcomes for mortality and suicide attempts differed "depending on when sex reassignment was performed: during the period 1973-1988 or 1989-2003." Ceclilia Dhejne, Paul Lichtenstein, Marcus Boman, Anna L. Johansson, Niklas Långström & Mikael Landén, "Long-Term Follow-Up of Transsexual Persons Undergoing Sex Reassignment Surgery: Cohort Study in Sweden," *PLoS One*, Vol. 6, p. 5 (Feb. 2011). Even though both mortality and suicide attempts were greater for transsexual persons than the healthy control group across both time periods, this did not reach statistical significance during the 1989-2003 period. One possible explanation is that mortality rates for transsexual persons did not begin to diverge from the healthy control group until after 10 years of follow-up, in which case the expected increase in mortality would not have been observed for most of the persons receiving sex reassignment surgeries from 1989-2003. Another possible explanation is that treatment was of a higher quality from 1989-2003 than from 1973-1988.

[88] Hayes Directory, "Sex Reassignment Surgery for the Treatment of Gender Dysphoria," p. 4 (May 15, 2014).

not sufficient "evidence to establish patient selection criteria for [sex reassignment surgery] to treat [gender dysphoria]."[89]

With respect to hormone therapy, the Hayes Directory examined 10 peer-reviewed studies and concluded that a "substantial number of studies of cross-sex hormone therapy each show some positive findings suggesting improvement in well-being after cross-sex hormone therapy."[90] Yet again, it rated the quality of evidence as "very low" and found that the "evidence is insufficient to support patient selection criteria for hormone therapy to treat [gender dysphoria]."[91] Importantly, the Hayes Directory also found: "Hormone therapy and subsequent [sex reassignment surgery] failed to bring overall mortality, suicide rates, or death from illicit drug use in [male-to-female] patients close to rates observed in the general male population. It is possible that mortality is nevertheless reduced by these treatments, but that cannot be determined from the available evidence."[92]

In 2010, Mayo Clinic researchers conducted a comprehensive review of 28 studies on the use of cross-sex hormone therapy in sex reassignment and concluded that there was "very low quality evidence" showing that such therapy "likely improves gender dysphoria, psychological functioning and comorbidities, sexual function and overall quality of life."[93] Not all of the studies showed positive results, but overall, after pooling the data from all of the studies, the researchers showed that 80% of patients reported improvement in gender dysphoria, 78% reported improvement in psychological symptoms, and 80% reported improvement in quality of life, after receiving hormone therapy.[94] Importantly, however, "[s]uicide attempt rates decreased after sex reassignment but stayed higher than the normal population rate."[95]

The authors of the Swedish study discussed above reached similar conclusions: "This study found substantially higher rates of overall mortality, death from cardiovascular disease and suicide, suicide attempts, and psychiatric hospitali[z]ations in sex-reassigned transsexual individuals compared to a healthy control population. This highlights that post[-]surgical transsexuals are a risk group that need long-term psychiatric and somatic follow-up. Even though surgery and hormonal therapy alleviates gender dysphoria, it is apparently not sufficient to remedy the high rates of morbidity and mortality found among transsexual persons."[96]

Even the RAND study, which the Carter policy is based upon, confirmed that "[t]here have been no randomized controlled trials of the effectiveness of various forms of treatment, and

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[89] Id. at 3.
[90] Hayes Directory, "Hormone Therapy for the Treatment of Gender Dysphoria," pp. 2, 4 (May 19, 2014).
[91] Id. at 4.
[92] Id. at 3.
[93] Mohammad Hassan Murad, Mohamed B. Elamin, Magaly Zumaeta Garcia, Rebecca J. Mullan, Ayman Murad, Patricia J. Erwin & Victor M. Montori, "Hormonal therapy and sex reassignment: a systematic review and meta-analysis of qualify of life and psychosocial outcomes," *Clinical Endocrinology*, Vol. 72, p. 214 (2010).
[94] Id. at 216.
[95] Id.
[96] Ceclilia Dhejne, Paul Lichtenstein, Marcus Boman, Anna L. Johansson, Niklas Långström & Mikael Landén, "Long-Term Follow-Up of Transsexual Persons Undergoing Sex Reassignment Surgery: Cohort Study in Sweden," *PLoS One*, Vol. 6, pp. 1-8 (Feb. 2011).

most evidence comes from retrospective studies."[97] Although noting that "[m]ultiple observational studies have suggested significant and sometimes dramatic reductions in suicidality, suicide attempts, and suicides among transgender patients after receiving transition-related treatment," RAND made clear that "none of these studies were randomized controlled trials (the gold standard for determining treatment efficacy)."[98] "In the absence of quality randomized trial evidence," RAND concluded, "it is difficult to fully assess the outcomes of treatment for [gender dysphoria]."[99]

Given the scientific uncertainty surrounding the efficacy of transition-related treatments for gender dysphoria, it is imperative that the Department proceed cautiously in setting accession and retention standards for persons with a diagnosis or history of gender dysphoria.

B. Physical Health Standards

Not only is maintaining high standards of mental health critical to military effectiveness and lethality, maintaining high standards of physical health is as well. Although technology has done much to ease the physical demands of combat in some military specialties, war very much remains a physically demanding endeavor. Service members must therefore be physically prepared to endure the rigors and hardships of military service, including potentially combat. They must be able to carry heavy equipment sometimes over long distances; they must be able to handle heavy machinery; they must be able to traverse harsh terrain or survive in ocean waters; they must be able to withstand oppressive heat, bitter cold, rain, sleet, and snow; they must be able to endure in unsanitary conditions, coupled with lack of privacy for basic bodily functions, sometimes with little sleep and sustenance; they must be able to carry their wounded comrades to safety; and they must be able to defend themselves against those who wish to kill them.

Above all, whether they serve on the frontlines or in relative safety in non-combat positions, every Service member is important to mission accomplishment and must be available to perform their duties globally whenever called upon. The loss of personnel due to illness, disease, injury, or bad health diminishes military effectiveness and lethality. The Department's physical health standards are therefore designed to minimize the odds that any given Service member will be unable to perform his or her duties in the future because of illness, disease, or injury. As noted earlier, those who seek to enter military service must be free of contagious diseases; free of medical conditions or physical defects that could require treatment, hospitalization, or eventual separation from service for medical unfitness; medically capable of satisfactorily completing required training; medically adaptable to the military environment; and medically capable of performing duties without aggravation of existing physical defects or medical conditions.[100] To access recruits with higher rates of anticipated unavailability for deployment thrusts a heavier burden on those who would deploy more often.

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[97] RAND Study at 7.
[98] Id. at 10 (citing only to a California Department of Insurance report).
[99] Id.
[100] DoDI 6130.03 at 2.

Historically, absent a waiver, the Department has barred from accessing into the military anyone who had undergone chest or genital surgery (e.g., removal of the testicles or uterus) and anyone with a history of major abnormalities or defects of the chest or genitalia, including hermaphroditism and pseudohermaphroditism.[101] Persons with conditions requiring medications, such as anti-depressants and hormone treatment, were also disqualified from service, unless a waiver was granted.[102]

These standards have long applied uniformly to all persons, regardless of transgender status. The Carter policy, however, deviates from these uniform standards by exempting, under certain conditions, treatments associated with gender transition, such as sex reassignment surgery and cross-sex hormone therapy. For example, under the Carter policy, an applicant who has received genital reconstruction surgery may access without a waiver if a period of 18 months has elapsed since the date of the most recent surgery, no functional limitations or complications persist, and no additional surgery is required. In contrast, an applicant who received similar surgery following a traumatic injury is disqualified from military service without a waiver.[103] Similarly, under the Carter policy, an applicant who is presently receiving cross-sex hormone therapy post-gender transition may access without a waiver if the applicant has been stable on such hormones for 18 months. In contrast, an applicant taking synthetic hormones for the treatment of hypothyroidism is disqualified from military service without a waiver.[104]

C. Sex-Based Standards

Women have made invaluable contributions to the defense of the Nation throughout our history. These contributions have only grown more significant as the number of women in the Armed Forces has increased and as their roles have expanded. Today, women account for 17.6% of the force,[105] and now every position, including combat arms positions, is open to them.

The vast majority of military standards make no distinctions between men and women. Where biological differences between males and females are relevant, however, military standards do differentiate between them. The Supreme Court has acknowledged the lawfulness of sex-based standards that flow from legitimate biological differences between the sexes.[106] These sex-based standards ensure fairness, equity, and safety; satisfy reasonable expectations of privacy; reflect common practice in society; and promote core military values of dignity and respect between men and women—all of which promote good order, discipline, steady leadership, unit cohesion, and ultimately military effectiveness and lethality.

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[101] Id. at 25-27.
[102] Id. at 46-48.
[103] Id. at 26-27.
[104] Id. at 41.
[105] Defense Manpower Data Center, Active and Reserve Master Files (Dec. 2017).
[106] For example, in *United States v. Virginia*, the Court noted approvingly that "[a]dmitting women to [the Virginia Military Institute] would undoubtedly require alterations necessary to afford members of each sex privacy from the other sex in living arrangements, and to adjust aspects of the physical training programs." 518 U.S. 515, 550-51 n.19 (1996) (citing the statute that requires the same standards for women admitted to the service academies as for the men, "except for those minimum essential adjustments in such standards required because of physiological differences between male and female individuals").

For example, anatomical differences between males and females, and the reasonable expectations of privacy that flow from those differences, at least partly account for the laws and regulations that require separate berthing, bathroom, and shower facilities and different drug testing procedures for males and females.[107] To maintain good order and discipline, Congress has even required by statute that the sleeping and latrine areas provided for "male" recruits be physically separated from the sleeping and latrine areas provided for "female" recruits during basic training and that access by drill sergeants and training personnel "after the end of the training day" be limited to persons of the "same sex as the recruits" to ensure "after-hours privacy for recruits during basic training."[108]

In addition, physiological differences between males and females account for the different physical fitness and body fat standards that apply to men and women.[109] This ensures equity and fairness. Likewise, those same physiological differences also account for the policies that regulate competition between men and women in military training and sports, such as boxing and combatives.[110] This ensures protection from injury.

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[107] See, e.g., Department of the Army, Training and Doctrine Command, TRADOC Regulation 350-6, "Enlisted Initial Entry Training Policies and Administration," p. 56 (Mar. 20, 2017); Department of the Air Force, Air Force Instruction 32-6005, "Unaccompanied Housing Management," p. 35 (Jan 29., 2016); Department of the Army, Human Resources Command, AR 600-85, "Substance Abuse Program" (Dec. 28, 2012) ("Observers must . . . [b]e the same gender as the Soldier being observed.").

[108] See 10 U.S.C. § 4319 (Army), 10 U.S.C. § 6931 (Navy), and 10 U.S.C. § 9319 (Air Force) (requiring the sleeping and latrine areas provided for "male" recruits to be physically separated from the sleeping and latrine areas provided for "female" recruits during basic training); 10 U.S.C. § 4320 (Army), 10 U.S.C. § 6932 (Navy), and 10 U.S.C. § 9320 (Air Force) (requiring that access by drill sergeants and training personnel "after the end of the training day" be limited to persons of the "same sex as the recruits").

[109] See, e.g., Department of the Army, Army Regulation 600-9, "The Army Body Composition Program," pp. 21-31 (June 28, 2013); Department of the Navy, Office of the Chief of Naval Operations Instruction 6110.1J, "Physical Readiness Program," p. 7 (July 11, 2011); Department of the Air Force, Air Force Instruction 36-2905, "Fitness Program," pp. 86-95, 106-146 (Aug. 27, 2015); Department of the Navy, Marine Corps Order 6100.13, "Marine Corps Physical Fitness Program," (Aug. 1, 2008); Department of the Navy, Marine Corps Order 6110.3A, "Marine Corps Body Composition and Military Appearance Program," (Dec. 15, 2016); see also United States Military Academy, Office of the Commandant of Cadets, "Physical Program Whitebook AY 16-17," p. 13 (specifying that, to graduate, cadets must meet the minimum performance standard of 3:30 for men and 5:29 for women on the Indoor Obstacle Course Test); Department of the Army, Training and Doctrine Command, TRADOC Regulation 350-6, "Enlisted Initial Entry Training Policies and Administration," p. 56 (Mar. 20, 2017) ("Performance requirement differences, such as [Army Physical Fitness Test] scoring are based on physiological differences, and apply to the entire Army.").

[110] See, e.g., Headquarters, Department of the Army, TC 3-25.150, "Combatives," p. A-15 (Feb. 2017) ("Due to the physiological difference between the sexes and in order to treat all Soldiers fairly and conduct gender-neutral competitions, female competitors will be given a 15 percent overage at weigh-in."); id. ("In championships at battalion-level and above, competitors are divided into eight weight class brackets. . . . These classes take into account weight and gender."); Major Alex Bedard, Major Robert Peterson & Ray Barone, "Punching Through Barriers: Female Cadets Integrated into Mandatory Boxing at West Point," *Association of the United States Army* (Nov. 16, 2017), https://www.ausa.org/articles/punching-through-barriers-female-cadets-boxing-west-point (noting that "[m]atching men and women according to weight may not adequately account for gender differences regarding striking force" and that "[w]hile conducting free sparring, cadets must box someone of the same gender"); RAND Study at 57 (noting that, under British military policy, transgender persons "can be excluded from sports that organize around gender to ensure the safety of the individual or other participants"); see also International Olympic Committee Consensus Meeting on Sex Reassignment and Hyperandrogensim (Nov. 2015), https://stillmed.olympic.org/Documents/Commissions_PDFfiles/Medical_commission/2015-11_ioc_

Uniform and grooming standards, to a certain extent, are also based on anatomical differences between males and females. Even those uniform and grooming standards that are not, strictly speaking, based on physical biology nevertheless flow from longstanding societal expectations regarding differences in attire and grooming for men and women.[111]

Because these sex-based standards are based on legitimate biological differences between males and females, it follows that a person's physical biology should dictate which standards apply. Standards designed for biological males logically apply to biological males, not biological females, and vice versa. When relevant, military practice has long adhered to this straightforward and logical demarcation.

By contrast, the Carter policy deviates from this longstanding practice by making military sex-based standards contingent, not necessarily on the person's biological sex, but on the person's gender marker in DEERS, which can be changed to reflect the person's gender identity.[112] Thus, under the Carter policy, a biological male who identifies as a female (and changes his gender marker to reflect that gender) must be held to the standards and regulations for females, even though those standards and regulations are based on female physical biology, not female gender identity. The same goes for females who identify as males. Gender identity alone, however, is irrelevant to standards that are designed on the basis of biological differences.

Rather than apply only to those transgender individuals who have altered their external biological characteristics to fully match that of their preferred gender, under the Carter policy, persons need not undergo sex reassignment surgery, or even cross-sex hormone therapy, in order to be recognized as, and thus subject to the standards associated with, their preferred gender. A male who identifies as female could remain a biological male in every respect and still must be treated in all respects as a female, including with respect to physical fitness, facilities, and uniform and grooming. This scenario is not farfetched. According to the APA, not "all individuals with gender dysphoria desire a complete gender reassignment. . . . Some are satisfied with no medical or surgical treatment but prefer to dress as the felt gender in public."[113] Currently, of the 424 approved Service member treatment plans, at least 36 do not include cross-

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consensus_meeting_on_sex_reassignment_and_hyperandrogenism-en.pdf; NCAA Office of Inclusion; NCAA Inclusion of Transgender Student-Athletes (Aug. 2011), https://www.ncaa.org/sites/default/files/Transgender_Handbook_2011_Final.pdf.

[111] "The difference between men's and women's grooming policies recognizes the difference between the sexes; sideburns for men, different hairstyles and cosmetics for women. Establishing identical grooming and personal appearance standards for men and women would not be in the Navy's best interest and is not a factor in the assurance of equal opportunity." Department of the Navy, Navy Personnel Command, Navy Personnel Instruction 156651, "Uniform Regulations," Art. 2101.1 (July 7, 2017); see also Department of the Army, Army Regulation 670-1, "Wear and Appearance of Army Uniforms and Insignia," pp. 4-16 (Mar. 31, 2014); Department of the Air Force, Air Force Instruction 26-2903, "Dress and Personal Appearance of Air Force Personnel," pp. 17-27 (Feb. 9, 2017); Department of the Navy, Marine Corps Order P1020.34G, "Marine Corps Uniform Regulations," pp. 1-9 (Mar. 31, 2003).

[112] Department of Defense Instruction 1300.28, *In-service Transition for Service Members Identifying as Transgender*, pp. 3-4 (June 30, 2016).

[113] American Psychiatric Association, "Expert Q & A: Gender Dysphoria," available at https://www.psychiatry.org/patients-families/gender-dysphoria/expert-qa (last visited Feb. 14, 2018).

sex hormone therapy or sex reassignment surgery.[114] And it is questionable how many Service members will obtain any type of sex reassignment surgery. According to a survey of transgender persons, only 25% reported having had some form of transition-related surgery.[115]

The variability and fluidity of gender transition undermine the legitimate purposes that justify different biologically-based, male-female standards. For example, by allowing a biological male who retains male anatomy to use female berthing, bathroom, and shower facilities, it undermines the reasonable expectations of privacy and dignity of female Service members. By allowing a biological male to meet the female physical fitness and body fat standards and to compete against females in gender-specific physical training and athletic competition, it undermines fairness (or perceptions of fairness) because males competing as females will likely score higher on the female test than on the male test and possibly compromise safety. By allowing a biological male to adhere to female uniform and grooming standards, it creates unfairness for other males who would also like to be exempted from male uniform and grooming standards as a means of expressing their own sense of identity.

These problems could perhaps be alleviated if a person's preferred gender were recognized only after the person underwent a biological transition. The concept of gender transition is so nebulous, however, that drawing any line—except perhaps at a full sex reassignment surgery—would be arbitrary, not to mention at odds with current medical practice, which allows for a wide range of individualized treatment. In any event, rates for genital surgery are exceedingly low—2% of transgender men and 10% of transgender women.[116] Only up to 25% of surveyed transgender persons report having had some form of transition-related surgery.[117] The RAND study estimated that such rates "are typically only around 20 percent, with the exception of chest surgery among female-to-male transgender individuals."[118] Moreover, of the 424 approved Service member treatment plans available for study, 388 included cross-sex hormone treatment, but only 34 non-genital sex reassignment surgeries and one genital surgery have been completed thus far. Only 22 Service members have requested a waiver for a genital sex reassignment surgery.[119]

Low rates of full sex reassignment surgery and the otherwise wide variation of transition-related treatment, with all the challenges that entails for privacy, fairness, and safety, weigh in favor of maintaining a bright line based on biological sex—not gender identity or some variation thereof—in determining which sex-based standards apply to a given Service member. After all, a person's biological sex is generally ascertainable through objective means. Moreover, this approach will ensure that biologically-based standards will be applied uniformly to all Service members of the same biological sex. Standards that are clear, coherent, objective, consistent, predictable, and uniformly applied enhance good order, discipline, steady leadership, and unit cohesion, which in turn, ensure military effectiveness and lethality.

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[114] Data reported by the Departments of the Army, Navy, and Air Force (Oct. 2017).
[115] Id.
[116] Sandy E. James, Jody L. Herman, Susan Rankin, Mara Keisling, Lisa Mottet & Ma'ayan Anafi, *The Report of the 2015 U.S. Transgender Survey*, pp. 100-103 (National Center for Transgender Equality 2016) available at https://www.transequality.org/sites/default/files/docs/USTS-Full-Report-FINAL.PDF.
[117] Id. at 100.
[118] RAND Study at 21.
[119] Defense Health Agency, Supplemental Health Care Program Data (Feb. 2018).

New Transgender Policy

In light of the forgoing standards, all of which are necessary for military effectiveness and lethality, as well as the recommendations of the Panel of Experts, the Department, in consultation with the Department of Homeland Security, recommends the following policy:

A. Transgender Persons Without a History or Diagnosis of Gender Dysphoria, Who Are Otherwise Qualified for Service, May Serve, Like All Other Service Members, in Their Biological Sex.

Transgender persons who have not transitioned to another gender and do not have a history or current diagnosis of gender dysphoria—i.e., they identify as a gender other than their biological sex but do not currently experience distress or impairment of functioning in meeting the standards associated with their biological sex—are eligible for service, provided that they, like all other persons, satisfy all mental and physical health standards and are capable of adhering to the standards associated with their biological sex. This is consistent with the Carter policy, under which a transgender person's gender identity is recognized only if the person has a diagnosis or history of gender dysphoria.

Although the precise number is unknown, the Department recognizes that many transgender persons could be disqualified under this policy. And many transgender persons who would not be disqualified may nevertheless be unwilling to adhere to the standards associated with their biological sex. But many have served, and are serving, with great dedication under the standards for their biological sex. As noted earlier, 8,980 Service members reportedly identify as transgender, and yet there are currently only 937 active duty Service members who have been diagnosed with gender dysphoria since June 30, 2016.

B. Transgender Persons Who Require or Have Undergone Gender Transition Are Disqualified.

Except for those who are exempt under this policy, as described below in C.3, and except where waivers or exceptions to policy are otherwise authorized, persons who are diagnosed with gender dysphoria, either before or after entry into service, and require transition-related treatment, or have already transitioned to their preferred gender, should be disqualified from service. In the Department's military judgment, this is a necessary departure from the Carter policy for the following reasons:

1. *Undermines Readiness.* While transition-related treatments, including real life experience, cross-sex hormone therapy, and sex reassignment surgery, are widely accepted forms of treatment, there is considerable scientific uncertainty concerning whether these treatments fully remedy, even if they may reduce, the mental health problems associated with gender dysphoria. Despite whatever improvements in condition may result from these treatments, there is evidence that rates of psychiatric hospitalization and suicide behavior remain higher for persons with gender dysphoria, even after treatment, as compared to persons without gender dysphoria.[120] The persistence of these problems is a risk for readiness.

[120] See *supra* at pp. 24-26.

Another readiness risk is the time required for transition-related treatment and the impact on deployability. Although limited and incomplete because many transitioning Service members either began treatment before the Carter policy took effect or did not require sex reassignment surgery, currently available in-service data already show that, cumulatively, transitioning Service members in the Army and Air Force have averaged 167 and 159 days of limited duty, respectively, over a one-year period.[121]

Transition-related treatment that involves cross-sex hormone therapy or sex reassignment surgery could render Service members with gender dysphoria non-deployable for a significant period of time—perhaps even a year—if the theater of operations cannot support the treatment. For example, Endocrine Society guidelines for cross-sex hormone therapy recommend quarterly bloodwork and laboratory monitoring of hormone levels during the first year of treatment.[122] Of the 424 approved Service member treatment plans available for study, almost all of them—91.5%—include the prescription of cross-sex hormones.[123] The period of potential non-deployability increases for those who undergo sex reassignment surgery. As described earlier, the recovery time for the various sex reassignment procedures is substantial. For non-genital surgeries (assuming no complications), the range of recovery is between two and eight weeks depending on the type of surgery, and for genital surgeries (again assuming no complications), the range is between three and six months before the individual is able to return to full duty.[124] When combined with 12 continuous months of hormone therapy, which is recommended prior to genital surgery,[125] the total time necessary for sex reassignment surgery could exceed a year. If the operational environment does not permit access to a lab for monitoring hormones (and there is certainly debate over how common this would be), then the Service member must be prepared to forego treatment, monitoring, or the deployment. Either outcome carries risks for readiness.

Given the limited data, however, it is difficult to predict with any precision the impact on readiness of allowing gender transition. Moreover, the input received by the Panel of Experts varied considerably. On one hand, some commanders with transgender Service members

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[121] Data reported by the Departments of the Army and Air Force (Oct. 2017).

[122] Wylie C. Hembree, Peggy Cohen-Kettenis, Lous Gooren, Sabine Hannema, Walter Meyer, M. Hassan Murad, Stephen Rosenthal, Joshua Safer, Vin Tangpricha, & Guy T'Sjoen, "Endocrine Treatment of Gender-Dysphoric/Gender Incongruent Persons: An Endocrine Society Clinical Practice Guideline," *The Journal of Clinical Endocrinology & Metabolism*, Vol. 102, pp. 3869-3903 (Nov. 2017).

[123] Data reported by the Departments of the Army, Navy, and Air Force (Oct. 2017). Although the RAND study observed that British troops who are undergoing hormone therapy are generally able to deploy if the "hormone dose is steady and there are no major side effects," it nevertheless acknowledged that "deployment to all areas may not be possible, depending on the needs associated with any medication (e.g., refrigeration)." RAND Study at 59.

[124] For example, assuming no complications, the recovery time for a hysterectomy is up to eight weeks; a mastectomy is up to six weeks; a phalloplasty is up to three months; a metoidioplasty is up to 8 weeks; an orchiectomy is up to 6 weeks; and a vaginoplasty is up to three months. See University of California, San Francisco, Center of Excellence for Transgender Health, "Guidelines for the Primary and Gender-Affirming Care of Transgender and Gender Nonbinary People," available at http://transhealth.ucsf.edu/trans?page=guidelines-home (last visited Feb. 16, 2018); see also Discussion with Dr. Loren Schechter, Visiting Clinical Professor of Surgery, University of Illinois at Chicago (Nov. 9, 2017).

[125] RAND Study at 80; see also id. at 7; Irene Folaron & Monica Lovasz, "Military Considerations in Transsexual Care of the Active Duty Member," *Military Medicine*, Vol. 181, p. 1184 (Oct. 2016) (noting that Endocrine Society criteria "require that the patient has been on continuous cross-sex hormones and has had continuous [real life experience] or psychotherapy for the past 12 months").

reported that, from the time of diagnosis to the completion of a transition plan, the transitioning Service members would be non-deployable for two to two-and-a-half years.[126] On the other hand, some commanders, as well as transgender Service members themselves, reported that transition-related treatment is not a burden on unit readiness and could be managed to avoid interfering with deployments, with one commander even reporting that a transgender Service member with gender dysphoria under his command elected to postpone surgery in order to deploy.[127] This conclusion was echoed by some experts in endocrinology who found no harm in stopping or adjusting hormone therapy treatment to accommodate deployment during the first year of hormone use.[128] Of course, postponing treatment, especially during a combat deployment, has risks of its own insofar as the treatment is necessary to mitigate the clinically significant distress and impairment of functioning caused by gender dysphoria. After all, "when Service members deploy and then do not meet medical deployment fitness standards, there is risk for inadequate treatment within the operational theater, personal risk due to potential inability to perform combat required skills, and the potential to be sent home from the deployment and render the deployed unit with less manpower."[129] In short, the periods of transition-related non-availability and the risks of deploying untreated Service members with gender dysphoria are uncertain, and that alone merits caution.

Moreover, most mental health conditions, as well as the medication used to treat them, limit Service members' ability to deploy. Any DSM-5 psychiatric disorder with residual symptoms, or medication side effects, which impair social or occupational performance, require a waiver for the Service member to deploy.[130] The same is true for mental health conditions that pose a substantial risk for deterioration or recurrence in the deployed environment.[131] In managing mental health conditions while deployed, providers must consider the risk of exacerbation if the individual were exposed to trauma or severe operational stress. These determinations are difficult to make in the absence of evidence on the impact of deployment on individuals with gender dysphoria.[132]

The RAND study acknowledges that the inclusion of individuals with gender dysphoria in the force will have a negative impact on readiness. According to RAND, foreign militaries that allow service by personnel with gender dysphoria have found that it is sometimes necessary to restrict the deployment of transitioning individuals, including those receiving hormone therapy and surgery, to austere environments where their healthcare needs cannot be met.[133] Nevertheless, RAND concluded that the impact on readiness would be minimal—e.g., 0.0015% of available deployable labor-years across the active and reserve components—because of the

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[126] Minutes, Transgender Review Panel (Oct. 13, 2017).
[127] Id.
[128] Minutes, Transgender Review Panel (Nov. 9, 2017).
[129] Institute for Defense Analyses, "Force Impact of Expanding the Recruitment of Individuals with Auditory Impairment," pp. 60-61 (Apr. 2016).
[130] Modification Thirteen to U.S. Central Command Individual Protection and Individual, Unit Deployment Policy, Tab A, p. 8 (Mar. 2017).
[131] Id.
[132] See generally Memorandum from the Assistant Secretary of Defense for Health Affairs, "Clinical Practice Guidance for Deployment-Limiting Mental Disorders and Psychotropic Medications," pp. 2-4 (Oct. 7, 2013).
[133] RAND Study at 40.

exceedingly small number of transgender Service members who would seek transition-related treatment.[134] Even then, RAND admitted that the information it cited "must be interpreted with caution" because "much of the current research on transgender prevalence and medical treatment rates relies on self-reported, nonrepresentative samples."[135] Nevertheless, by RAND's standard, the readiness impact of many medical conditions that the Department has determined to be disqualifying—from bipolar disorder to schizophrenia—would be minimal because they, too, exist only in relatively small numbers.[136] And yet that is no reason to allow persons with those conditions to serve.

The issue is not whether the military can absorb periods of non-deployability in a small population; rather, it is whether an individual with a particular condition can meet the standards for military duty and, if not, whether the condition can be remedied through treatment that renders the person non-deployable for as little time as possible. As the Department has noted before: "[W]here the operational requirements are growing faster than available resources," it is imperative that the force "be manned with Service members capable of meeting all mission demands. The Services require that every Service member contribute to full mission readiness, regardless of occupation. In other words, the Services require all Service members to be able to engage in core military tasks, including the ability to deploy rapidly, without impediment or encumbrance."[137] Moreover, the Department must be mindful that "an increase in the number of non-deployable military personnel places undue risk and personal burden on Service members qualified and eligible to deploy, and negatively impacts mission readiness."[138] Further, the Department must be attuned to the impact that high numbers of non-deployable military personnel places on families whose Service members deploy more often to backfill or compensate for non-deployable persons.

In sum, the available information indicates that there is inconclusive scientific evidence that the serious problems associated with gender dysphoria can be fully remedied through transition-related treatment and that, even if it could, most persons requiring transition-related treatment could be non-deployable for a potentially significant amount of time. By this metric, Service members with gender dysphoria who need transition-related care present a significant challenge for unit readiness.

2. *Incompatible with Sex-Based Standards.* As discussed in detail earlier, military personnel policy and practice has long maintained a clear line between men and women where their biological differences are relevant with respect to physical fitness and body fat standards; berthing, bathroom, and shower facilities; and uniform and grooming standards. This line promotes good order and discipline, steady leadership, unit cohesion, and ultimately military

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[134] Id. at 42.
[135] Id. at 39.
[136] According to the National Institute of Mental Health, 2.8% of U.S. adults experienced bipolar disorder in the past year, and 4.4% have experienced the condition at some time in their lives. National Institute of Mental Health, "Bipolar Disorder" (Nov. 2017) https://www.nimh.nih.gov/health/statistics/bipolar-disorder.shtml. The prevalence of schizophrenia is less than 1%. National Institute of Mental Health, "Schizophrenia" (Nov. 2017) https://www.nimh.nih.gov/health/statistics/schizophrenia.shtml.
[137] Under Secretary of Defense for Personnel and Readiness, "Fiscal Year 2016 Report to Congress on the Review of Enlistment of Individuals with Disabilities in the Armed Forces," p. 9 (Apr. 2016).
[138] Id. at 10.

effectiveness and lethality because it ensures fairness, equity, and safety; satisfies reasonable expectations of privacy; reflects common practice in the society from which we recruit; and promotes core military values of dignity and respect between men and women. To exempt Service members from the uniform, biologically-based standards applicable to their biological sex on account of their gender identity would be incompatible with this line and undermine the objectives such standards are designed to serve.

First, a policy that permits a change of gender without requiring any biological changes risks creating unfairness, or perceptions thereof, that could adversely affect unit cohesion and good order and discipline. It could be perceived as discriminatory to apply different biologically-based standards to persons of the same biological sex based on gender identity, which is irrelevant to standards grounded in physical biology. For example, it unfairly discriminates against biological males who identify as male and are held to male standards to allow biological males who identify as female to be held to female standards, especially where the transgender female retains many of the biological characteristics and capabilities of a male. It is important to note here that the Carter policy does not require a transgender person to undergo any biological transition in order to be treated in all respects in accordance with the person's preferred gender. Therefore, a biological male who identifies as female could remain a biological male in every respect and still be governed by female standards. Not only would this result in perceived unfairness by biological males who identify as male, it would also result in perceived unfairness by biological females who identify as female. Biological females who may be required to compete against such transgender females in training and athletic competition would potentially be disadvantaged.[139] Even more importantly, in physically violent training and competition, such as boxing and combatives, pitting biological females against biological males who identify as female, and vice versa, could present a serious safety risk as well.[140]

This concern may seem trivial to those unfamiliar with military culture. But vigorous competition, especially physical competition, is central to the military life and is indispensable to the training and preparation of warriors. Nothing encapsulates this more poignantly than the words of General Douglas MacArthur when he was superintendent of the U.S. Military Academy and which are now engraved above the gymnasium at West Point: "Upon the fields of friendly

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[139] See *supra* note 109. Both the International Olympic Committee (IOC) and the National Collegiate Athletic Association (NCAA) have attempted to mitigate this problem in their policies regarding transgender athletes. For example, the IOC requires athletes who transition from male to female to demonstrate certain suppressed levels of testosterone to minimize any advantage in women's competition. Similarly, the NCAA prohibits an athlete who has transitioned from male to female from competing on a women's team without changing the team status to a mixed gender team. While similar policies could be employed by the Department, it is unrealistic to expect the Department to subject transgender Service members to routine hormone testing prior to biannual fitness testing, athletic competition, or training simply to mitigate real and perceived unfairness or potential safety concerns. See, e.g., International Olympic Committee Consensus Meeting on Sex Reassignment and Hyperandrogensim (Nov. 2015), https://stillmed.olympic.org/Documents/Commissions_PDFfiles/Medical_commission/2015-11_ioc_consensus_meeting_on_sex_reassignment_and_hyperandrogenism-en.pdf; NCAA Office of Inclusion, NCAA Inclusion of Transgender Student-Athletes (Aug. 2011), https://www.ncaa.org/sites/default/files/Transgender_Handbook_2011_Final.pdf.

[140] See *supra* note 109.

strife are sown the seeds that, upon other fields, on other days will bear the fruits of victory."[141] Especially in combat units and in training, including the Service academies, ROTC, and other commissioning sources, Service members are graded and judged in significant measure based upon their physical aptitude, which is only fitting given that combat remains a physical endeavor.

Second, a policy that accommodates gender transition without requiring full sex reassignment surgery could also erode reasonable expectations of privacy that are important in maintaining unit cohesion, as well as good order and discipline. Given the unique nature of military service, Service members of the same biological sex are often required to live in extremely close proximity to one another when sleeping, undressing, showering, and using the bathroom. Because of reasonable expectations of privacy, the military has long maintained separate berthing, bathroom, and shower facilities for men and women while in garrison. In the context of recruit training, this separation is even mandated by Congress.[142]

Allowing transgender persons who have not undergone a full sex reassignment, and thus retain at least some of the anatomy of their biological sex, to use the facilities of their identified gender would invade the expectations of privacy that the strict male-female demarcation in berthing, bathroom, and shower facilities is meant to serve. At the same time, requiring transgender persons who have developed, even if only partially, the anatomy of their identified gender to use the facilities of their biological sex could invade the privacy of the transgender person. Without separate facilities for transgender persons or other mitigating accommodations, which may be unpalatable to transgender individuals and logistically impracticable for the Department, the privacy interests of biological males and females and transgender persons could be anticipated to result in irreconcilable situations. Lieutenants, Sergeants, and Petty Officers charged with carrying out their units' assigned combat missions should not be burdened by a change in eligibility requirements disconnected from military life under austere conditions.

The best illustration of this irreconcilability is the report of one commander who was confronted with dueling equal opportunity complaints—one from a transgender female (i.e., a biological male with male genitalia who identified as female) and the other from biological females. The transgender female Service member was granted an exception to policy that allowed the Service member to live as a female, which included giving the Service member access to female shower facilities. This led to an equal opportunity complaint from biological females in the unit who believed that granting a biological male, even one who identified as a female, access to their showers violated their privacy. The transgender Service member responded with an equal opportunity complaint claiming that the command was not sufficiently supportive of the rights of transgender persons.[143]

The collision of interests discussed above are a direct threat to unit cohesion and will inevitably result in greater leadership challenges without clear solutions. Leaders at all levels

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[141] Douglas MacAruthur, *Respectfully Quoted: A Dictionary of Quotations* (1989), available at http://www.bartleby.com/73/1874.html.

[142] See *supra* note 108.

[143] Minutes, Transgender Review Panel (Oct. 13, 2017). Limited data exists regarding the performance of transgender Service members due to policy restrictions in Department of Defense 1300.28, *In-Service Transition for Transgender Service Members* (Oct. 1, 2016), that prevent the Department from tracking individuals who may identify as transgender as a potentially unwarranted invasion of personal privacy.

already face immense challenges in building cohesive military units. Blurring the line that differentiates the standards and policies applicable to men and women will only exacerbate those challenges and divert valuable time and energy from military tasks.

The unique leadership challenges arising from gender transition are evident in the Department's handbook implementing the Carter policy. The handbook provides guidance on various scenarios that commanders may face. One such scenario concerns the use of shower facilities: "A transgender Service member has expressed privacy concerns regarding the open bay shower configuration. Similarly, several other non-transgender Service members have expressed discomfort when showering in these facilities with individuals who have different genitalia." As possible solutions, the handbook offers that the commander could modify the shower facility to provide privacy or, if that is not feasible, adjust the timing of showers. Another scenario involves proper attire during a swim test: "It is the semi-annual swim test and a female to male transgender Service member who has fully transitioned, but did not undergo surgical change, would like to wear a male swimsuit for the test with no shirt or other top coverage." The extent of the handbook's guidance is to advise commanders that "[i]t is within [their] discretion to take measures ensuring good order and discipline," that they should "counsel the individual and address the unit, if additional options (e.g., requiring all personnel to wear shirts) are being considered," and that they should consult the Service Central Coordination Cell, a help line for commanders in need of advice.

These vignettes illustrate the significant effort required of commanders to solve challenging problems posed by the implementation of the current transgender service policies. The potential for discord in the unit during the routine execution of daily activities is substantial and highlights the fundamental incompatibility of the Department's legitimate military interest in uniformity, the privacy interests of all Service members, and the interest of transgender individuals in an appropriate accommodation. Faced with these conflicting interests, commanders are often forced to devote time and resources to resolve issues not present outside of military service. A failure to act quickly can degrade an otherwise highly functioning team, as will failing to seek appropriate counsel and implementing a faulty solution. The appearance of unsteady or seemingly unresponsive leadership to Service member concerns erodes the trust that is essential to unit cohesion and good order and discipline.

The RAND study does not meaningfully address how accommodations for gender transition would impact perceptions of fairness and equity, expectations of privacy, and safety during training and athletic competition and how these factors in turn affect unit cohesion. Instead, the RAND study largely dismisses concerns about the impact on unit cohesion by pointing to the experience of four countries that allow transgender service—Australia, Canada, Israel, and the United Kingdom.[144] Although the vast majority of armed forces around the world do not permit or have policies on transgender service, RAND noted that 18 militaries do, but only four have well-developed and publicly available policies.[145] RAND concluded that "the available research revealed no significant effect on cohesion, operational effectiveness, or

[144] RAND Study at 45.
[145] Id. at 50.

readiness."[146] It reached this conclusion, however, despite noting reports of resistance in the ranks, which is a strong indication of an adverse effect on unit cohesion.[147] Nevertheless, RAND acknowledged that the available data was "limited" and that the small number of transgender personnel may account for "the limited effect on operational readiness and cohesion."[148]

Perhaps more importantly, however, the RAND study mischaracterizes or overstates the reports upon which it rests its conclusions. For example, the RAND study cites *Gays in Foreign Militaries 2010: A Global Primer* by Nathaniel Frank as support for the conclusions that there is no evidence that transgender service has had an adverse effect on cohesion, operational effectiveness, or readiness in the militaries of Australia and the United Kingdom and that diversity has actually led to increases in readiness and performance.[149] But that particular study has nothing to do with examining the service of transgender persons; rather, it is about the integration of homosexual persons into the military.[150]

With respect to transgender service in the Israeli military, the RAND study points to an unpublished paper by Anne Speckhard and Reuven Paz entitled *Transgender Service in the Israeli Defense Forces: A Polar Opposite Stance to the U.S. Military Policy of Barring Transgender Soldiers from Service*. The RAND study cites this paper for the proposition that "there has been no reported effect on cohesion or readiness" in the Israeli military and "there is no evidence of any impact on operational effectiveness."[151] These sweeping and categorical claims, however, are based only on "six in-depth interviews of experts on the subject both inside and outside the [Israeli Defense Forces (IDF)]: two in the IDF leadership—including the spokesman's office; two transgender individuals who served in the IDF, and two professionals who serve transgender clientele—before, during and after their IDF service."[152] As the RAND report observed, however: "There do appear to be some limitations on the assignment of transgender personnel, particularly in combat units. Because of the austere living conditions in these types of units, necessary accommodations may not be available for Service members in the midst of a gender transition. As a result, transitioning individuals are typically not assigned to combat units."[153] In addition, as the RAND study notes, under the Israeli policy at the time, "assignment of housing, restrooms, and showers is typically linked to the birth gender, which does not change in the military system until after gender reassignment surgery."[154] Therefore, insofar as a Service member's change of gender is not recognized until after sex reassignment

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[146] Id. at 45.
[147] Id.
[148] Id.
[149] Id.
[150] Nathaniel Frank, "Gays in Foreign Militaries 2010: A Global Primer," p. 6 *The Palm Center* (Feb. 2010), https://www.palmcenter.org/wpcontent/uploads/2017/12/FOREIGNMILITARIESPRIMER2010FINAL.pdf ("This study seeks to answer some of the questions that have been, and will continue to be, raised surrounding the instructive lessons from other nations that have lifted their bans on openly gay service.").
[151] Rand Study at 45.
[152] Anne Speckhard & Reuven Paz, "Transgender Service in the Israeli Defense Forces: A Polar Opposite Stance to the U.S. Military Policy of Barring Transgender Soldiers from Service," p. 3 (2014), http://www.researchgate.net/publication/280093066.
[153] RAND Study at 56.
[154] Id. at 55.

surgery, the Israeli policy—and whatever claims about its impact on cohesion, readiness, and operational effectiveness—are distinguishable from the Carter policy.

Finally, the RAND study cites to a journal article on the Canadian military experience entitled *Gender Identity in the Canadian Forces: A Review of Possible Impacts on Operational Effectiveness* by Alan Okros and Denise Scott. According to RAND, the authors of this article "found no evidence of any effect on unit or overall cohesion."[155] But the article not only fails to support the RAND study's conclusions (not to mention the article's own conclusions), but it confirms the concerns that animate the Department's recommendations. The article acknowledges, for example, the difficulty commanders face in managing the competing interests at play:

> Commanders told us that the new policy fails to provide sufficient guidance as to how to weigh priorities among competing objectives during their subordinates' transition processes. Although they endorsed the need to consult transitioning Service members, they recognized that as commanding officers, they would be called on to balance competing requirements. They saw the primary challenge to involve meeting trans individual's expectations for reasonable accommodation and individual privacy while avoiding creating conditions that place extra burdens on others or undermined the overall team effectiveness. To do so, they said that they require additional guidance on a range of issues including clothing, communal showers, and shipboard bunking and messing arrangements.[156]

Notwithstanding its optimistic conclusions, the article also documents serious problems with unit cohesion. The authors observe, for instance, that the chain of command "has not fully earned the trust of the transgender personnel," and that even though some transgender Service members do trust the chain of command, others "expressed little confidence in the system," including one who said, "I just don't think it works that well."[157]

In sum, although the foregoing considerations are not susceptible to quantification, undermining the clear sex-differentiated lines with respect to physical fitness; berthing, bathroom, and shower facilities; and uniform and grooming standards, which have served all branches of Service well to date, risks unnecessarily adding to the challenges faced by leaders at all levels, potentially fraying unit cohesion, and threatening good order and discipline. The Department acknowledges that there are serious differences of opinion on this subject, even among military professionals, including among some who provided input to the Panel of Experts,[158] but given the vital interests at stake—the survivability of Service members, including

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[155] Id. at 45.

[156] Alan Okros & Denise Scott, "Gender Identity in the Canadian Forces," *Armed Forces and Society* Vol. 41, p. 8 (2014).

[157] Id. at 9.

[158] While differences of opinion do exist, it bears noting that, according to a Military Times/Syracuse University's Institute for Veterans and Military Families poll, 41% of active duty Service members polled thought that allowing gender transition would hurt their unit's readiness, and only 12% thought it would be beneficial. Overall, 57% had a negative opinion of the Carter policy. Leo Shane III, "Poll: Active-duty troops worry about military's transgender

transgender persons, in combat and the military effectiveness and lethality of our forces—it is prudent to proceed with caution, especially in light of the inconclusive scientific evidence that transition-related treatment restores persons with gender dysphoria to full mental health.

3. *Imposes Disproportionate Costs.* Transition-related treatment is also proving to be disproportionately costly on a per capita basis, especially in light of the absence of solid scientific support for the efficacy of such treatment. Since implementation of the Carter policy, the medical costs for Service members with gender dysphoria have increased nearly three times—or 300%—compared to Service members without gender dysphoria.[159] And this increase is despite the low number of costly sex reassignment surgeries that have been performed so far.[160] As noted earlier, only 34 non-genital sex reassignment surgeries and one genital surgery have been completed,[161] with an additional 22 Service members requesting a waiver for genital surgery.[162] We can expect the cost disparity to grow as more Service members diagnosed with gender dysphoria avail themselves of surgical treatment. As many as 77% of the 424 Service member treatment plans available for review include requests for transition-related surgery, although it remains to be seen how many will ultimately obtain surgeries.[163] In addition, several commanders reported to the Panel of Experts that transition-related treatment for Service members with gender dysphoria in their units had a negative budgetary impact because they had to use operations and maintenance funds to pay for the Service members' extensive travel throughout the United States to obtain specialized medical care.[164]

Taken together, the foregoing concerns demonstrate why recognizing and making accommodations for gender transition are not conducive to, and would likely undermine, the inputs—readiness, good order and discipline, sound leadership, and unit cohesion—that are essential to military effectiveness and lethality. Therefore, it is the Department's professional military judgment that persons who have been diagnosed with, or have a history of, gender dysphoria and require, or have already undergone, a gender transition generally should not be eligible for accession or retention in the Armed Forces absent a waiver.

C. Transgender Persons With a History or Diagnosis of Gender Dysphoria Are Disqualified, Except Under Certain Limited Circumstances.

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policies," *Military Times* (July 27, 2017) available at https://www.militarytimes.com/news/pentagon-congress/2017/07/27/poll-active-duty-troops-worry-about-militarys-transgender-policies/.

[159] Minutes, Transgender Review Panel (Nov. 2, 2017).

[160] Minutes, Transgender Review Panel (Nov. 2, 2017).

[161] Data retrieved from Military Health System Data Repository (Nov. 2017).

[162] Defense Health Agency Data (as of Feb. 2018).

[163] Data reported by the Departments of the Army, Navy, and Air Force (Oct. 2017).

[164] Minutes, Transgender Review Panel (Oct. 13, 2017); see also Irene Folaron & Monica Lovasz, "Military Considerations in Transsexual Care of the Active Duty Member," *Military Medicine*, Vol. 181, p. 1185 (Oct. 2016) ("As previously discussed, a new diagnosis of gender dysphoria and the decision to proceed with gender transition requires frequent evaluations by the [mental health professional] and endocrinologist. However, most [military treatment facilities] lack one or both of these specialty services. Members who are not in proximity to [military treatment facilities] may have significant commutes to reach their required specialty care. Members stationed in more remote locations face even greater challenges of gaining access to military or civilian specialists within a reasonable distance from their duty stations.").

As explained earlier in greater detail, persons with gender dysphoria experience significant distress and impairment in social, occupational, or other important areas of functioning. Gender dysphoria is also accompanied by extremely high rates of suicidal ideation and other comorbidities. Therefore, to ensure unit safety and mission readiness, which is essential to military effectiveness and lethality, persons who are diagnosed with, or have a history of, gender dysphoria are generally disqualified from accession or retention in the Armed Forces. The standards recommended here are subject to the same procedures for waiver as any other standards. This is consistent with the Department's handling of other mental conditions that require treatment. As a general matter, only in the limited circumstances described below should persons with a history or diagnosis of gender dysphoria be accessed or retained.

1. *Accession of Individuals Diagnosed with Gender Dysphoria.* Given the documented fluctuations in gender identity among children, a history of gender dysphoria should not alone disqualify an applicant seeking to access into the Armed Forces. According to the DSM-5, the persistence of gender dysphoria in biological male children "has ranged from 2.2% to 30%," and the persistence of gender dysphoria in biological female children "has ranged from 12% to 50%."[165] Accordingly, persons with a history of gender dysphoria may access into the Armed Forces, provided that they can demonstrate 36 consecutive months of stability—i.e., absence of gender dysphoria—immediately preceding their application; they have not transitioned to the opposite gender; and they are willing and able to adhere to all standards associated with their biological sex. The 36-month stability period is the same standard the Department currently applies to persons with a history of depressive disorder. The Carter policy's 18-month stability period for gender dysphoria, by contrast, has no analog with respect to any other mental condition listed in DoDI 6130.03.

2. *Retention of Service Members Diagnosed with Gender Dysphoria.* Retention standards are typically less stringent than accession standards due to training provided and on-the-job performance data. While accession standards endeavor to predict whether a given applicant will require treatment, hospitalization, or eventual separation from service for medical unfitness, and thus tend to be more cautious, retention standards focus squarely on whether the Service member, despite his or her condition, can continue to do the job. This reflects the Department's desire to retain, as far as possible, the Service members in which it has made substantial investments and to avoid the cost of finding and training a replacement. To use an example outside of the mental health context, high blood pressure does not meet accession standards, even if it can be managed with medication, but it can meet retention standards so long as it can be managed with medication. Regardless, however, once they have completed treatment, Service members must continue to meet the standards that apply to them in order to be retained. Therefore, Service members who are diagnosed with gender dysphoria after entering military service may be retained without waiver, provided that they are willing and able to adhere to all standards associated with their biological sex, the Service member does not require gender transition, and the Service member is not otherwise non-deployable for more than 12 months or for a period of time in excess of that established by Service policy (which may be less than 12 months).[166]

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[165] DSM-5 at 455.

[166] Under Secretary of Defense for Personnel and Readiness, "DoD Retention Policy for Non-Deployable Service Members" (Feb. 14, 2018).

3. *Exempting Current Service Members Who Have Already Received a Diagnosis of Gender Dysphoria.* The Department is mindful of the transgender Service members who were diagnosed with gender dysphoria and either entered or remained in service following the announcement of the Carter policy and the court orders requiring transgender accession and retention. The reasonable expectation of these Service members that the Department would honor their service on the terms that then existed cannot be dismissed. Therefore, transgender Service members who were diagnosed with gender dysphoria by a military medical provider after the effective date of the Carter policy, but before the effective date of any new policy, may continue to receive all medically necessary treatment, to change their gender marker in DEERS, and to serve in their preferred gender, even after the new policy commences. This includes transgender Service members who entered into military service after January 1, 2018, when the Carter accession policy took effect by court order. The Service member must, however, adhere to the procedures set forth in DoDI 1300.28, and may not be deemed to be non-deployable for more than 12 months or for a period of time in excess of that established by Service policy (which may be less than 12 months). While the Department believes that its commitment to these Service members, including the substantial investment it has made in them, outweigh the risks identified in this report, should its decision to exempt these Service members be used by a court as a basis for invalidating the entire policy, this exemption instead is and should be deemed severable from the rest of the policy.

Conclusion

In making these recommendations, the Department is well aware that military leadership from the prior administration, along with RAND, reached a different judgment on these issues. But as the forgoing analysis demonstrates, the realities associated with service by transgender individuals are more complicated than the prior administration or RAND had assumed. In fact, the RAND study itself repeatedly emphasized the lack of quality data on these issues and qualified its conclusions accordingly. In addition, that study concluded that allowing gender transition would impede readiness, limit deployability, and burden the military with additional costs. In its view, however, such harms were negligible in light of the small size of the transgender population. But especially in light of the various sources of uncertainty in this area, and informed by the data collected since the Carter policy took effect, the Department is not convinced that these risks could be responsibly dismissed or that even negligible harms should be incurred given the Department's grave responsibility to fight and win the Nation's wars in a manner that maximizes the effectiveness, lethality, and survivability of our most precious assets—our Soldiers, Sailors, Airmen, Marines, and Coast Guardsmen.

Accordingly, the Department weighed the risks associated with maintaining the Carter policy against the costs of adopting a new policy that was less risk-favoring in developing these recommendations. It is the Department's view that the various balances struck by the recommendations above provide the best solution currently available, especially in light of the significant uncertainty in this area. Although military leadership from the prior administration reached a different conclusion, the Department's professional military judgment is that the risks associated with maintaining the Carter policy—risks that are continuing to be better understood as new data become available—counsel in favor of the recommended approach.

The Honorable Marsha J. Pechman

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON AT SEATTLE

RYAN KARNOSKI, et al.,

Plaintiffs,

v.

DONALD J. TRUMP, in his official capacity as President of the United States, et al.,

Defendants.

Case No. 2-17-cv-01297-MJP

DECLARATION OF LINDSEY MULLER IN SUPPORT OF PLAINTIFFS' OPPOSITION TO MOTION TO STAY PRELIMINARY INJUNCTION PENDING APPEAL

I, Lindsey Muller, declare as follows:

1. My legal name is Lindsey Muller. I am a plaintiff in the above captioned action. I have actual knowledge of the matters stated in this declaration.

2. I am a Chief Warrant officer 3 (CW3) in the U.S. Army and am currently stationed at U.S. Army Garrison Humphreys Army Base in Pyeongtaek, South Korea.

3. The "Department of Defense Report and Recommendations of Military Service by Transgender Persons" states that "Transgender Service members who were diagnosed with gender dysphoria by a military medical provider after the effective date of the Carter policy . . . may continue to receive all medically necessary care, to change their gender marker in the Defense Enrollment Eligibility Reporting System (DEERS), and to serve in their preferred gender."

4. I was diagnosed with gender dysphoria by a military medical provider on October

21, 2014, before then Secretary of Defense Ash Carter announced a new military wide policy lifting the ban on transgender service members on June 30, 2016.

Pursuant to 28 U.S.C. S 1746, I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Executed on May 8, 2018.

Lindsey Muller

NEWMAN DU WORS LLP

2101 Fourth Avenue, Suite 1500
Seattle, Washington 98121
(206) 274-2800

CERTIFICATE OF SERVICE

The undersigned certifies under penalty of perjury under the laws of the United States of America and the laws of the State of Washington that all participants in the case are registered CM/ECF users and that service of the foregoing documents will be accomplished by the CM/ECF system on May 14, 2018.

Jason Sykes, WSBA #44369
jason@newmanlaw.com
Newman Du Wors LLP
2101 Fourth Ave., Ste. 1500
Seattle, WA 98121
(206) 274-2800

The Honorable Marsha J. Pechman

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON AT SEATTLE

RYAN KARNOSKI, et al.,

Plaintiffs,

v.

DONALD J. TRUMP, in his official capacity as President of the United States, et al.,

Defendants.

Case No. 2-17-cv-01297-MJP

DECLARATION OF CATHRINE SCHMID IN SUPPORT OF PLAINTIFFS' OPPOSITION TO MOTION TO STAY PRELIMINARY INJUNCTION PENDING APPEAL

I, Cathrine Schmid, declare as follows:

1. My legal name is Cathrine Schmid, although I often use the nickname "Katie." I am a plaintiff in the above captioned action. I have actual knowledge of the matters stated in this declaration.

2. I am a Staff Sergeant in the U.S. Army and am currently stationed at Joint Base Lewis McChord in Washington State.

3. The "Department of Defense Report and Recommendations of Military Service by Transgender Persons" states that "Transgender Service members who were diagnosed with gender dysphoria by a military medical provider after the effective date of the Carter policy . . . may continue to receive all medically necessary care, to change their gender marker in the Defense Enrollment Eligibility Reporting System (DEERS), and to serve in their preferred gender."

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2101 Fourth Avenue, Suite 1500
Seattle, Washington 98121
(206) 274-2800

4. I was diagnosed with gender dysphoria by a military medical provider on May 13, 2014, before then Secretary of Defense Ash Carter announced a new military wide policy lifting the ban on transgender service members on June 30, 2016.

Pursuant to 28 U.S.C. S 1746, I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Executed on May 11, 2018.

Cathrine Schmid

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Seattle, Washington 98121
(206) 274-2800

CERTIFICATE OF SERVICE

The undersigned certifies under penalty of perjury under the laws of the United States of America and the laws of the State of Washington that all participants in the case are registered CM/ECF users and that service of the foregoing documents will be accomplished by the CM/ECF system on May 14, 2018.

Jason Sykes, WSBA #44369
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The Honorable Marsha J. Pechman

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON AT SEATTLE

RYAN KARNOSKI, *et al.*,

Plaintiffs, and

STATE OF WASHINGTON,

Plaintiff-Intervenor,

v.

DONALD J. TRUMP, in his official capacity as President of the United States, *et al.*,

Defendants.

Case No. 2:17-cv-01297-MJP

DECLARATION OF DANIEL SIEGFRIED IN SUPPORT OF PLAINTIFFS' OPPOSITION TO DEFENDANTS' MOTION TO STAY PRELIMINARY INJUNCTION PENDING APPEAL

I, Daniel Siegfried, swear under penalty of perjury under the laws of the United States to the following:

1. I am counsel of record for Plaintiffs in this action, am over the age of 18, and am competent to be a witness. I make this declaration in support of Plaintiffs' opposition to Defendants' motion to stay preliminary injunction pending appeal based on facts within my own personal knowledge.

2. Attached hereto as **Exhibit 1** is a true and correct copy of an August 29, 2017 Statement by Secretary of Defense Jim Mattis on Military Service by Transgender Individuals, retrieved from https://www.defense.gov/News/News-Releases/News-Release-View/Article/1294351/statement-by-secretary-of-defense-jim-mattis-on-military-service-by-transgender/.

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3. Attached hereto as **Exhibit 2** is a true and correct copy of a September 14, 2017 memorandum titled, "Terms of Reference - Implementation of Presidential Memorandum on Military Service by Transgender Individuals" produced by Defendants bearing the Bates range USDOE00003230-31.

4. Attached hereto as **Exhibit 3** is a true and correct copy of Memorandum, DOD Retention Policy for Non-Deployable Service Members, Under Secretary of Defense, Personnel and Readiness (February 14, 2018), retrieved from https://www.defense.gov/Portals/1/Documents/pubs/DoD-Universal-Retention-Policy.PDF.

5. Attached hereto as **Exhibit 4** is a true and correct copy of a March 25, 2018 Think Progress article titled, "Pence secretly drafted Trump's latest transgender military ban," retrieved from https://thinkprogress.org/pence-responsible-for-trump-transgender-military-ban-f4d3b67bde47/.

6. Attached hereto as **Exhibit 5** is a true and correct copy of a March 27, 2018 Palm Center article titled, "26 Retired General and Flag Officers Oppose Trump Transgender Military Ban," retrieved from https://www.palmcenter.org/26-retired-general-and-flag-officers-oppose-trump-transgender-military-ban/.

7. Attached hereto as **Exhibit 6** is a true and correct copy of a statement released on March 28, 2018 by former U.S. Surgeons General Jocelyn Elders and David Satcher, retrieved from https://www.palmcenter.org/former-surgeons-general-debunk-pentagon-assertions-about-medical-fitness-of-transgender-troops/.

8. Attached hereto as **Exhibit 7** is a true and correct copy of a March 30, 2018 Washington Blade article titled, "Joint chiefs not briefed before Trump went public with trans military ban," retrieved from http://www.washingtonblade.com/2018/03/30/joint-chiefs-not-briefed-trump-went-public-trans-military-ban/.

9. Attached hereto as **Exhibit 8** is a true and correct copy of an April 2018 Palm Center report titled, DoD's Rationale for Reinstating the Transgender Ban Is Contradicted by Evidence, retrieved from https://www.palmcenter.org/wp-content/uploads/2018/04/Transgender-troops-are-medically-fit.pdf.

10. Attached hereto as **Exhibit 9** is a true and correct copy of an April 24, 2018 article titled, "All 4 service chiefs on record: No harm to units from transgender service," retrieved from https://www.militarytimes.com/news/your-military/2018/04/24/all-4-service-chiefs-on-record-no-harm-to-unit-from-transgender-service/.

11. Attached hereto as **Exhibit 10** is a true and correct copy of an amicus brief submitted by retired military officers and former national security officials in *Stone v. Trump*, No. 17-2459, Doc. No. 149-1 (D. Md.) on April 30, 2018, which is an updated version of the amicus brief submitted in this case at Doc. 152-2 on January 26, 2018.

12. Attached hereto as **Exhibit 11** is a true and correct copy of an August 23, 2017 Powerpoint titled, "All Things G-1 – Update to VCSA" produced by Defendants bearing the Bates range USDOE00124434-62.

13. Attached hereto as **Exhibit 12** is a true and correct copy of a document produced by Defendants bearing the Bates range USDOE00081113-16.

14. Attached hereto as **Exhibit 13** is a true and correct copy of a Powerpoint produced by Defendants bearing the Bates range USDOE00101839-45.

15. Attached hereto as **Exhibit 14** is a true and correct copy of an excerpt of the transcript of testimony before the Senate Committee on Armed Services, Hearing to Receive Testimony on the Posture of the Department of the Army in Review of the Defense Authorization Request for Fiscal Year 2019 and the Future Years Defense Program, April 12, 2018.

16. Attached hereto as **Exhibit 15** is a true and correct copy of an excerpt of the transcript of testimony before the Senate Committee on Armed Services, Hearing to Receive Testimony on the Posture of the Department of the Navy in Review of the Defense Authorization Request for Fiscal Year 2019 and the Future Years Defense Program, April 19, 2018.

17. Attached hereto as **Exhibit 16** is a true and correct copy of an excerpt of the transcript of testimony before the Senate Committee on Armed Services, Hearing to Receive Testimony on the Posture of the Department of the Air Force in Review of the Defense Authorization Request for Fiscal Year 2019 and the Future Years Defense Program, April 24,

2018.

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

DATED: May 14, 2018

s/Daniel Siegfried
Daniel Siegfried

NEWMAN DU WORS LLP

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Seattle, Washington 98121
(206) 274-2800

CERTIFICATE OF SERVICE

The undersigned certifies under penalty of perjury under the laws of the United States of America and the laws of the State of Washington that all participants in the case are registered CM/ECF users and that service of the foregoing documents will be accomplished by the CM/ECF system on May 14, 2018.

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Exhibit 1

IMMEDIATE RELEASE

Statement by Secretary of Defense Jim Mattis on Military Service by Transgender Individuals

Press Operations

Release No: NR-312-17
Aug. 29, 2017

The Department of Defense has received the Presidential Memorandum, dated August 25, 2017, entitled “Military Service by Transgender Individuals.” The department will carry out the president’s policy direction, in consultation with the Department of Homeland Security. As directed, we will develop a study and implementation plan, which will contain the steps that will promote military readiness, lethality, and unit cohesion, with due regard for budgetary constraints and consistent with applicable law. The soon arriving senior civilian leadership of DOD will play an important role in this effort. The implementation plan will address accessions of transgender individuals and transgender individuals currently serving in the United States military.

Our focus must always be on what is best for the military’s combat effectiveness leading to victory on the battlefield. To that end, I will establish a panel of experts serving within the Departments of Defense and Homeland Security to provide advice and recommendations on the implementation of the president’s direction. Panel members will bring mature experience, most notably in combat and deployed operations, and seasoned judgment to this task. The panel will assemble and thoroughly analyze all pertinent data, quantifiable and non-quantifiable. Further information on the panel will be forthcoming.

Once the panel reports its recommendations and following my consultation with the secretary of Homeland Security, I will provide my advice to the president concerning implementation of his policy direction. In the interim, current policy with respect to currently serving members will remain in place. I expect to issue interim guidance to the force concerning the president's direction, including any necessary interim adjustments to procedures, to ensure the continued combat readiness of the force until our final policy on this subject is issued.

- News
- Press Advisories
- News Releases
- Transcripts
- Speeches
- Publications

Exhibit 2

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

9/14/17

MEMORANDUM FOR SECRETARIES OF THE MILITARY DEPARTMENTS
CHAIRMAN OF THE JOINT CHIEFS OF STAFF
UNDER SECRETARIES OF DEFENSE
COMMANDANT, U.S. COAST GUARD
DEPUTY CHIEF MANAGEMENT OFFICER
CHIEF, NATIONAL GUARD BUREAU
GENERAL COUNSEL OF THE DEPARTMENT OF DEFENSE
DIRECTOR OF COST ASSESSMENT AND PROGRAM EVALUATION
INSPECTOR GENERAL OF THE DEPARTMENT OF DEFENSE
DIRECTOR OF OPERATIONAL TEST AND EVALUATION
CHIEF INFORMATION OFFICER OF THE DEPARTMENT OF DEFENSE
ASSISTANT SECRETARY OF DEFENSE FOR LEGISLATIVE AFFAIRS
ASSISTANT TO THE SECRETARY OF DEFENSE FOR PUBLIC AFFAIRS
DIRECTOR OF NET ASSESSMENT
DIRECTOR, STRATEGIC CAPABILITIES OFFICE
DIRECTORS OF DEFENSE AGENCIES
DIRECTORS OF DOD FIELD ACTIVITIES

SUBJECT: Terms of Reference - Implementation of Presidential Memorandum on Military Service by Transgender Individuals

Reference: Military Service by Transgender Individuals – Interim Guidance

I direct the Deputy Secretary of Defense and the Vice Chairman of the Joint Chiefs of Staff to lead the Department of Defense (DoD) in developing an Implementation Plan on military service by transgender individuals, to effect the policy and directives in Presidential Memorandum, *Military Service by Transgender Individuals*, dated August 25, 2017 ("Presidential Memorandum"). The implementation plan will establish the policy, standards and procedures for service by transgender individuals in the military, consistent with military readiness, lethality, deployability, budgetary constraints, and applicable law.

The Deputy Secretary and the Vice Chairman, supported by a panel of experts drawn from DoD and the Department of Homeland Security (DHS) ("Panel"), shall propose for my consideration recommendations supported by appropriate evidence and information, not later than January 15, 2018. The Deputy Secretary and the Vice Chairman will be supported by the Panel, which will be comprised of the Military Department Under Secretaries, Service Vice Chiefs, and Service Senior Enlisted Advisors. The Deputy Secretary and Vice Chairman shall

designate personnel to support the Panel's work to ensure Panel recommendations reflect senior civilian experience, combat experience, and expertise in military operational effectiveness. The Panel and designated support personnel shall bring a comprehensive, holistic, and objective approach to study military service by transgender individuals, focusing on military readiness, lethality, and unit cohesion, with due regard for budgetary constraints and consistent with applicable law. The Panel will be chaired by the Under Secretary of Defense for Personnel and Readiness and will report to the Deputy Secretary and the Vice Chairman at least every 30 days and address, at a minimum, the following three areas:

Accessions: The Presidential Memorandum directs DoD to maintain the policy currently in effect, which generally prohibits accession of transgender individuals into military service. The Panel will recommend updated accession policy guidelines to reflect currently accepted medical terminology.

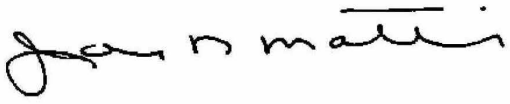
Medical Care: The Presidential Memorandum halts the use of DoD or DHS resources to fund sex-reassignment surgical procedures for military personnel, effective March 23, 2018, except to the extent necessary to protect the health of an individual who has already begun a course of treatment to reassign his or her sex. The implementation plan will enumerate the specific surgical procedures associated with sex reassignment treatment that shall be prohibited from DoD or DHS resourcing unless necessary to protect the health of the Service member.

Transgender Members Serving in the Armed Forces: The Presidential Memorandum directs that the Department return to the longstanding policy and practice on military service by transgender individuals that was in place prior to June 2016. The Presidential Memorandum also allows the Secretary to determine how to address transgender individuals currently serving in the Armed Forces. The Panel will set forth, in a single policy document, the standards and procedures applicable to military service by transgender persons, with specific attention to addressing transgender persons currently serving. The Panel will develop a universal retention standard that promotes military readiness, lethality, deployability, and unit cohesion.

To support its efforts, the Panel will conduct an independent multi-disciplinary review and study of relevant data and information pertaining to transgender Service members. The study will be planned and executed to inform the Implementation Plan. The independent multi-disciplinary review and study will address aspects of medical care and treatment, personnel management, general policies and practices, and other matters, including the effects of the service of transgender persons on military readiness, lethality, deployability, and unit cohesion.

The Panel may obtain advice from outside experts on an individual basis. The recommendations of the Deputy Secretary and the Vice Chairman will be coordinated with senior civilian officials, the Military Departments, and the Joint Staff.

All DoD Components will cooperate fully in, and will support the Deputy Secretary and the Vice Chairman in their efforts, by making personnel and resources available upon request in support of their efforts.



cc:
Secretary of Homeland Security

Exhibit 3

UNDER SECRETARY OF DEFENSE
4000 DEFENSE PENTAGON
WASHINGTON, D.C. 20301-4000

PERSONNEL AND READINESS

FEB 14 2018

MEMORANDUM FOR SECRETARIES OF THE MILITARY DEPARTMENTS
CHAIRMAN OF THE JOINT CHIEFS OF STAFF
UNDER SECRETARIES OF DEFENSE
DEPUTY CHIEF MANAGEMENT OFFICER
CHIEF, NATIONAL GUARD BUREAU
DIRECTOR OF COST ASSESSMENT AND PROGRAM EVALUATION

SUBJECT: DoD Retention Policy for Non-Deployable Service Members

In July, the Secretary of Defense directed the Office of the Under Secretary of Defense for Personnel and Readiness (OUSD(P&R)) to lead the Department's effort to identify changes to military personnel policies necessary to provide more ready and lethal forces. In his initial memorandum to the Department, Secretary Mattis emphasized, "[e]very action will be designed to ensure our military is ready to fight today and in the future." Given the Secretary's guidance, OUSD(P&R) moved forward from the underlying premise that all Service members are expected to be world-wide deployable. Based on the recommendations of the Military Personnel Policy Working Group, the Deputy Secretary of Defense determined that DoD requires a Department-wide policy establishing standardized criteria for retaining non-deployable Service members. The objective is to both reduce the number of non-deployable Service members and improve personnel readiness across the force.

The Deputy Secretary of Defense directed the following interim policy guidance, which will remain in effect until the Department issues a DoD Instruction on reporting and retention of non-deployable Service members:

- Service members who have been non-deployable for more than 12 consecutive months, for any reason, will be processed for administrative separation in accordance with Department of Defense Instruction (DoDI) 1332.14, *Enlisted Administrative Separations*, or DoD Instruction 1332.30, *Separation of Regular and Reserve Commissioned Officers*, or will be referred into the Disability Evaluation System in accordance with DoDI 1332.18, *Disability Evaluation System (DES)*. Pregnant and post-partum Service members are the only group automatically excepted from this policy.

- The Secretaries of the Military Departments are authorized to grant a waiver to retain in service a Service member whose period of non-deployability exceeds the 12 consecutive months limit. This waiver authority may be delegated in writing to an official at no lower than the Military Service headquarters level.

- The Military Services have until October 1, 2018, to begin mandatory processing of non-deployable Service members for administrative or disability separation under this policy, but they may begin such processing immediately.

- The Military Services may initiate administrative or disability separation upon determination that a Service member will remain non-deployable for more than 12 consecutive months; they are not required to wait until the Service member has been non-deployable for 12 consecutive months.

- The Military Services will continue to provide monthly non-deployable reports to OUSD(P&R) in the format established by the Military Personnel Policy Working Group.

My office will issue a DoDI to provide additional policy guidance and codify non-deployable reporting requirements. Publication of the DoDI will supersede and cancel this policy memorandum.

Robert L. Wilkie

cc:
Assistant Secretary of the Army
for Manpower and Reserve Affairs
Assistant Secretary of the Navy
for Manpower and Reserve Affairs
Assistant Secretary of the Air Force
for Manpower and Reserve Affairs
Senior Enlisted Advisor to the Chairman
of the Joint Chiefs of Staff
Deputy Chief of Staff, G-1, U.S. Army
Chief of Naval Personnel, U.S. Navy
Deputy Chief of Staff for Personnel and Services,
U.S. Air Force
Deputy Commandant for Manpower and Reserve
Affairs, U.S. Marine Corps
Director, Reserve and Military Personnel,
U.S. Coast Guard
Director, Manpower and Personnel, Joint Staff
National Guard Bureau, J-1

Exhibit 4

Pence secretly drafted Trump's latest transgender military ban

Junk science informed the new order, not military readiness.

ZACK FORD

MAR 25, 2018, 12:51 PM

CREDIT: MARK WILSON/GETTY IMAGES

When President Trump announced a new ban on transgender people serving in the military late Friday, it was somewhat of a surprise — Defense Secretary Jim Mattis had reportedly recommended in February that Trump allow transgender people to serve. It turns out that Vice President Pence and some of the country's most prominent anti-LGBTQ activists had a role in reversing the outcome, which explains why the report explaining the decision is rife with anti-trans junk science.

Slate's Mark Joseph Stern reported Friday night that, according to multiple sources, Pence played "a leading role" in creating the report, along with Ryan T.

Anderson of the Heritage Foundation, which has been dubbed "Trump's favorite think tank," and Tony Perkins of the Family Research Council (FRC), an anti-LGBTQ hate group. Both Heritage and FRC praised the report Friday. According to Stern's reporting, it was true that Mattis favored allowing transgender military service, but Pence "effectively overruled" him.

A separate source independently confirmed to ThinkProgress Saturday that Pence was involved, characterizing him as forming his own ad hoc "working group," including Anderson and Perkins, separate from the panel of experts Mattis had assembled. Though it bears Mattis' signature, the report released Friday appears to reflect the findings of Pence's working group and not the committee report that Mattis submitted to Trump last month. Mattis' original document was not currently publicly available at the time of the recommendation, but it was widely reported that Mattis favored an inclusive approach that resembled what had originally been proposed by Defense Secretary Ash Carter under President Obama in 2016. His February recommendation, also released Friday, jibes with the new report, contradicting reports at the time.

How exactly Pence overruled Mattis' recommendation over the past month the source did not know. But his working group's influence is apparent. In particular, the report features numerous anti-trans talking points that FRC and other anti-LGBTQ groups have used in various campaigns favoring discrimination against transgender people. It also attempts to distort the research on transgender health in ways that directly parallel Anderson's recently released book, *When Harry Became Sally: Responding to the Transgender Moment*. Anderson likewise argued

in his book against supporting trans people in their gender transitions, and the recommendations in the report rely on a strikingly similar framing.

Asked directly on Saturday whether he was involved in the report, Anderson cheekily responded in a series of tweets that "there's no evidence" he was involved in crafting the report, but he repeatedly refused to directly deny his participation.

"'Privacy" concerns and "unit cohesion"

One of the most obvious biases in the new report is an emphasis on concerns about how transgender people in the military might somehow infringe on the privacy of other soldiers — particularly women. These are the same arguments Perkins, Anderson, and others have made in justifying overturning LGBTQ protections in Houston or defending North Carolina's HB2, a law that mandated discrimination against transgender people.

According to the report, transgender people would violate other troops' privacy simply by sharing a space with them — to the detriment of unit cohesion:

> Allowing transgender persons who have not undergone a full sex reassignment [sic], and thus retain at least some of the anatomy of their biological sex, to use the facilities of their identified gender would invade the expectations of privacy that the strict male-female demarcation in berthing, bathroom, and shower facilities is meant to serve.

As examples of these burdens, it notes suggestions from the Carter policy about modifying shower facilities to provide more privacy or adjusting the timing of showers to accommodate service members who express "discomfort" sharing a facility with a transgender person. While these accommodations sound simple, the report instead characterizes them as requiring "significant effort… to solve challenging problems."

Borrowing a related argument opponents of trans equality frequently use (including Anderson in his book), the report also expresses concern that respecting transgender identities would be unfair and even dangerous to other service members when it comes to athletics and training. "Biological females who may be required to compete against such transgender females in training and athletic competition would potentially be disadvantaged," the report claims. This ignores that the NCAA and International Olympic Committee have both established clear standards for allowing transgender people to compete according to their gender identity, recognizing that transitioning mitigates gender-related advantages.

Not so subtly, the report concludes that unit cohesion will deteriorate if the anti-transgender prejudices of other service members are not catered to. "The potential for discord in the unit during the routine execution of daily activities is substantial," it argues. The RAND study that informed the Carter policy had dismissed concerns that lifting the ban would impact cohesion and readiness.

Experts on transgender military service have made clear that lifting the ban will not impact unit cohesion. Three former armed forces secretaries even testified in one of the lawsuits challenging the ban that it is unjustified.

Moreover, "unit cohesion" is the same hollow argument that was previously used to defend "Don't Ask, Don't Tell" (DADT), a law that prohibited lesbian, gay, and bisexual people from serving openly in the military. Such warnings even included near-identical concerns about shared shower use. Following DADT's repeal, a study showed that LGB inclusion had no negative impact on military morale, despite similar warnings.

"Considerable scientific uncertainty"

The report also contorts itself considerably to misrepresent both the experience of transitioning as well as the research about the health and well-being of transgender people. This is where the report most noticeably resembles Anderson's book, as it uses several of the exact same sources and distorts them in the exact same way.

One of the overarching themes in both the report and Anderson's book is that the "quality" of the research showing the benefits of transition is allegedly subpar. It's an attempt to claim that no matter how much research there is showing transition is an effective way to treat gender dysphoria, it simply isn't reliable for reasons like small sample sizes. Anderson has used this approach to justify his position that trans people should be discouraged from transitioning, while the report uses it to justify skepticism about whether people who have transitioned can be trusted to serve capably.

Two examples the new report use are a Centers for Medicare and Medicaid Services (CMS) review from August 2016 and a Hayes Directory review, both of which found that there were actually few studies of the same breadth and rigor

that is often used to assess coverage of other medical concerns. But the report relegates to a footnote that CMS still covers transition-related procedures on a case-by-case basis and likewise ignores entirely that, as ThinkProgress has previously pointed out, the Hayes Directory review is actually frequently cited by various health insurance policies to explain why it is the plans *will* cover transition-related procedures. In other words, these reviews of the research tend to support the exact opposite conclusion that the report (and likewise Anderson) draws from them.

The report expresses concern that there have been no "randomized controlled trials" on the effectiveness of hormone replacement therapy (HRT) or gender confirmation surgeries. Because of the nature of transgender identities, however, it would be difficult and likely unethical to take such an approach. That's because gender dysphoria is uniquely a mental health concern treated with physical changes to the body. An individual who was receiving a placebo instead of hormones would easily notice that their body was not undergoing the expected changes. Moreover, given the overwhelming evidence that transgender people do benefit from transitioning, a human subjects review board would likely consider it unethical to deny them medically necessary treatment as part of such a study. The small population of transgender people also limits the size and scope of such studies.

Nowhere does the report even mention that every major medical organization in the U.S. has arrived at a consensus that transgender people should be affirmed in their gender identities and supported in their transitions. The American Medical

Association has even explicitly expressed support for lifting the military's ban on transgender service. The report likewise makes no mention of the widely-used standards of care developed by the World Professional Association of Transgender Health (WPATH), which recognize the benefits of affirmative care.

As has become inevitable in just about every attempt to justify anti-trans discrimination (including Anderson's book), the study also wildly distorts studies about the suicidality of transgender people.

"High rates of suicide ideation, attempts, and completion among people who are transgender are also well documented in the medical literature," the report asserts. It cites an analysis of the National Transgender Discrimination Survey (NTDS), which found that 41 percent of trans people had attempted suicide at some point in their life. It also cites a Swedish study, which the report claims found mortality and psychiatric hospitalization for patients who had undergone sex reassignment surgery as compared to a healthy control group."

What the report downplays is the context of both studies. The NTDS study found significant connections between the high suicide rate and anti-trans discrimination, including factors such as racial stigma, poverty, unemployment, having less education, how easily they were perceived as trans, homelessness, bullying and violence, family rejection, and health care discrimination.

Likewise, the Swedish study did not find significantly higher suicide rates in transgender people who underwent surgery after 1989. Its author, Cecilia Dhejne, explained in an interview that the older group's experience "likely reflects a time when trans health and psychological care was less effective and social stigma was far worse," emphasizing that transition "won't resolve the effects of crushing social oppression." She has repeatedly rebuked those who use the study to justify rejecting the legitimacy of transgender identities. "I have said many times that the

study is not design to evaluate the outcome of medical transition," she said in a Reddit AMA last year. "[I]t does say that people who have transition[ed] are more vulnerable and that we need to improve care."

The report essentially manufactures doubt about the health outcomes of transgender people to justify the very kind of discrimination that is the most significant factor for trans people's negative experiences. This is most apparent when the report attempts to rationalize allowing current transgender service members to continue serving:

> While the Department believes that its commitment to these Service members, including the substantial investment it has made in them, outweigh the risks identified in this report, should its decision to exempt these Service members be used by a court as a basis for invalidating the entire policy, this exemption instead is and should be deemed severable from the rest of the policy.

In other words, if the courts conclude that the policy is blatantly hypocritical by allowing some trans people to continue to serve while banning others from joining, the military will responding by kicking them all out to achieve consistency.

The ex-trans framing

What is perhaps most bizarre about the report is its attempts to show how a transgender person could still serve under the new policy. Essentially, they have to be ex-trans.

The report states that a diagnosis of gender dysphoria is inherently disqualifying for service. This is despite the fact that the American Psychiatric Association does not recognize gender dysphoria as a disorder. It maintains diagnostic criteria for people who are distressed by their gender identity because such a diagnosis is often required for insurance companies to cover transition treatment.

Besides the exemption for current trans troops, the report offers only two ways that someone diagnosed with gender dysphoria could still serve:

> 1. If an individual is trying to join the military but has previously been diagnosed with gender dysphoria, they must show that they have gone three full years without symptoms and be "willing and able to adhere to all standards associated with their biological sex."
> 2. If a current service member is newly diagnosed with gender dysphoria, they may continue serving so long as they do not require gender transition and are "willing and able to adhere to all standards associated with their biological sex.

Given that transitioning is the best proven way to resolve the distress of gender dysphoria, it's unclear who would qualify to serve under these circumstances.

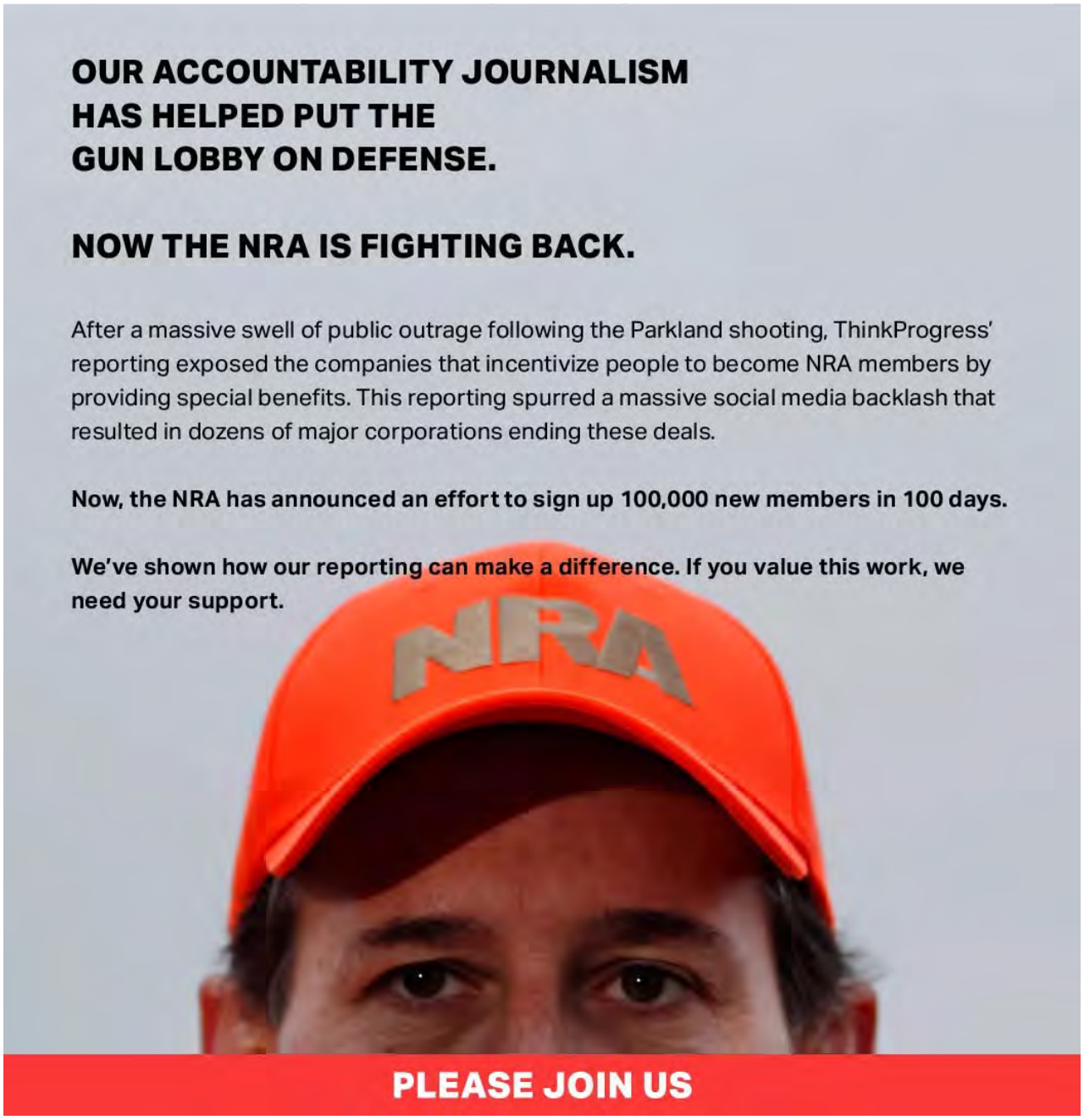
This approach, however, reflects prominent anti-trans views. FRC publicly advocates against affirming transgender people, insisting, "There is no rational or compassionate reason to affirm a distorted psychological self-concept that one's 'gender identity' is different from one's biological sex." Anderson's book likewise focuses on a few exceptional individuals who regretted steps they took to transition their gender, which he argues proves that transition is not helpful or necessary. Anderson, however, did not ask permission from these "detransitioners" to use their narratives and they subsequently objected to being used in a book that rejects transgender people.

The bottom line of the report is that the only good way to be trans in the military is to not be trans. This flies in the face of countless military experts and is easily disproven by the thousands of transgender people already capably serving in the

U.S. as well as in 19 other countries, including Australia, the United Kingdom, France, Germany, Spain, Canada, and Israel.

But as the report largely reflects the views of Pence, a longtime opponent of LGBTQ equality, and some of the top anti-LGBTQ activists in the country, it's easy to see how it arrived at such discriminatory conclusions.

UPDATE: This post has been updated to reflect the release of Mattis' February recommendation to Trump.



#DONALD TRUMP, #FAMILY RESEARCH COUNCIL, #HATE GROUPS, #LGBTQ, #MIKE PENCE, #MLITARY, #POLITICS, #RYAN T. ANDERSON, #TONY PERKINS, #TRANSGENDER

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Exhibit 5

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BLUEPRINTS FOR SOUND PUBLIC POLICY

MENU

MARCH 27, 2018

26 Retired General and Flag Officers Oppose Trump Transgender Military Ban

SAN FRANCISCO, CA – Following the American Psychological Association's statement yesterday, expressing alarm over the Trump Administration's "misuse of psychological science to stigmatize transgender Americans and justify limiting their ability to serve in uniform and

access medically necessary health care," the Palm Center today released the following statement by 26 retired General and Flag Officers:

> "The Administration's announcement on the treatment of transgender service members is a troubling move backward. Many of us personally experienced the belated removal of 'don't ask, don't tell' and faced firsthand how that mistaken policy set back our force and enabled discrimination against patriotic gay and lesbian Americans. We learned a clear lesson: the singling out of one group of service members for unequal treatment harms military readiness, while inclusion supports it. Under the newly announced policy, most transgender individuals either cannot serve or must serve under a false presumption of unsuitability, despite having already demonstrated that they can and do serve with distinction. They will now serve without the medical care every service member earns, and with the constant fear of being discharged simply for who they are. We should not return to the days of forcing men and women to hide in the shadows and serve their country without institutional support. This deprives the military of trained and skilled service members, which harms readiness and morale. There is simply no reason to single out brave transgender

Americans who can meet military standards and deny them the ability to serve."

Vice Admiral Donald Arthur, USN (Retired)
Vice Admiral Kevin P. Green, USN (Retired)
Lieutenant General Arlen D. Jameson, USAF (Retired)
Lieutenant General Claudia Kennedy, USA (Retired)
Major General Donna Barbisch, USA (Retired)
Major General J. Gary Cooper, USMC (Retired)
Rear Admiral F. Stephen Glass, USN (Retired)
Major General Irv Halter, USAF (Retired)
Rear Admiral Jan Hamby, USN (Retired)
Rear Admiral John Hutson, JAGC, USN (Retired)
Major General Dennis Laich, USA (Retired)
Major General Randy Manner, USA (Retired)
Major General Gale Pollock, CRNA, FACHE, FAAN, USA (Retired)
Major General Peggy Wilmoth, PhD, MSS, RN, FAAN, USA (Retired)
Rear Admiral Dick Young, USN (Retired)
Brigadier General Ricardo Aponte, USAF (Retired)
Rear Admiral Jamie Barnett, USN (Retired)
Brigadier General Julia Cleckley, USA (Retired)
Rear Admiral Jay DeLoach, USN (Retired)
Brigadier General John Douglass, USAF (Retired)
Brigadier General David R. Irvine, USA (Retired)
Brigadier General Carlos E. Martinez, USAF, (Retired)
Brigadier General John M. Schuster USA (Retired)
Rear Admiral Michael E. Smith, USN (Retired)
Brigadier General Paul Gregory Smith, USA (Retired)
Brigadier General Marianne Watson, USA (Retired)

###

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ABOUT THE PALM CENTER

The Palm Center is an independent research institute committed to sponsoring state-of-the-art scholarship to enhance the quality of public dialogue about critical and controversial issues of the day.

For the past decade, the Palm Center's research on sexual minorities in the military has been published in leading social scientific journals. The Palm Center seeks to be a resource for university-affiliated as well as independent scholars, students, journalists, opinion leaders, and members of the public. For more information, see palmcenter.org

IMPLEMENTATION

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Exhibit 6

PALM CENTER
BLUEPRINTS FOR SOUND PUBLIC POLICY

MENU

MARCH 28, 2018

Former Surgeons General Debunk Pentagon Assertions about Medical Fitness of Transgender Troops

SAN FRANCISCO, CA – Following this week's statement by the American Psychological Association expressing alarm over the Trump Administration's "misuse of psychological science to stigmatize transgender Americans and justify limiting their ability to serve in uniform and access medically necessary health care," the Palm Center today released the following statement by former U.S. Surgeons General M. Joycelyn Elders and David Satcher:

> "We are troubled that the Defense Department's report on transgender military service has mischaracterized the robust body of peer-reviewed research on the effectiveness of transgender medical care as demonstrating 'considerable scientific uncertainty.' In fact, there is a global medical consensus that such care is reliable, safe, and effective. An expectation of certainty is an unrealistic and counterproductive standard of evidence for health policy—whether civilian or military—because even the most well-established medical treatments could not satisfy that standard. Indeed, setting certainty as a standard suggests an inability to refute the research. A wide body of reputable, peer-reviewed research has demonstrated to psychological and health experts that treatments for gender dysphoria are effective. Research on the effectiveness of medical care for gender dysphoria was the basis of the American Medical Association's 2015 resolution that 'there is no medically valid reason to exclude transgender individuals from service in the U.S. military,' and we expressed our

support for the resolution at the time of its passage. In light of last week's announcement concerning military policy for transgender service members, we underscore that transgender troops are as medically fit as their non-transgender peers and that there is no medically valid reason—including a diagnosis of gender dysphoria—to exclude them from military service or to limit their access to medically necessary care."

M. Joycelyn Elders, M.D., M.S.

15th Surgeon General of the United States

David Satcher, M.D., Ph.D., FAAFP, FACPM, FACP

16th Surgeon General of the United States

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ABOUT THE PALM CENTER

The Palm Center is an independent research institute committed to sponsoring state-of-the-art scholarship to enhance the quality of public dialogue about critical and controversial issues of the day.

For the past decade, the Palm Center's research on sexual minorities in the military has been published in leading social scientific journals. The Palm Center seeks to be a resource for university-affiliated as well as independent scholars, students, journalists, opinion leaders, and members of the public. For more information, see palmcenter.org

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Exhibit 7

March 29, 2018 at 5:10 pm EDT | by Chris Johnson

DOD appears to contradict White House on process for trans military ban

The Pentagon has appeared to contradict the White House on drafting the trans military ban. (Public domain photo by Master Sgt. Ken Hammond).

A Defense Department spokesperson appeared Thursday to contradict the White House on the process for drafting the transgender military policy, asserting it was "a coordinated effort" with the White House and Justice Department as opposed to Defense Secretary James Mattis and his working group alone within the Pentagon.

Dana White, a Pentagon spokesperson, made the comments Thursday during a Pentagon news briefing in response to a question on timing for the release of the policy late Friday night and whether Mattis was "proud" of his recommendation against transgender military service.

"The secretary was asked for his thoughts, and he provided his recommendation," White said. "The way that this was done is that it was a coordinated effort with the White House as well as the Department of Justice, and because there were multiple filings done in different time zones, it drove the timing of the release."

White House Deputy Press Secretary Raj Shah, however, had a different take on the process when asked by the Washington Blade earlier this week whether President Trump, Vice

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President Mike Pence or anyone at the White House sought to influence the outcome of the recommendations.

"The Department of Defense's panel of experts was comprised of senior uniformed and civilian leaders who considered the issue based on data and their professional military judgment, without regard to any external factors," Shah said.

The comments from White lend credence to persistent rumors the policy wasn't driven by Mattis, but Vice President Mike Pence, who has an anti-LGBT history, even though his office denied he was involved. The comments also suggests U.S. Attorney General Jeff Sessions had a role in developing the policy at the Justice Department.

Neither the White House, nor the Pentagon responded to the Washington Blade's request to comment on Thursday to clarify the apparent contradiction between the two spokespersons.

White faced intense questioning during the news briefing on the transgender policy from reporters who demanded clarity and pointed out the policy bans transgender service members with limited exceptions, but is unclear and contradictory about those exceptions.

Throughout the briefing, White insisted the U.S. military despite the policy continues to allow, assess and retain transgender service members as a result of multiple court orders that have determined banning transgender service is unconstitutional.

"We will continue to comply with four court orders assessing transgender applicants for military service and retaining current transgender service members," White said. "Because there is ongoing litigation and to safeguard the integrity of the court process, I am unable to provide any further details at this time."

That didn't stop reporters from grilling White. One reporter said he thinks the Pentagon "owes the service members and the public at least some actual clarity about what the actual document says and what its intent was" because it was signed by Mattis.

> Pointing out the memo says transgender troops currently in service would be able to stay, but troops who require or undergo transition are disqualified without exception, the reporter asked whether transgender troops who had already transitioned would no longer be able to serve.
>
> White said in response she's "limited" in her ability to talk about the policy, deferring questions on the policy to the Justice Department, which said called "the lead" on the issue.

"One, we have to remember that what was posted was a recommendation," White said. "The department remains under four court orders, so we continue to assess transgender individuals as well as retain transgender service members, but beyond that, I have to respect the integrity of the litigation."

Throughout the briefing, White referred to the transgender military policy as a "recommendation." That supports a recent Buzzfeed report quoting legal experts as saying technically there's no actual policy on transgender service because the memo issued no new guidance even through the Trump administration continues to defend the ban on transgender service in court.

Asked whether what was posted is the Department's recommended policy, White replied: "What was posted was the recommendation. We remain, the Department of Defense remains under those four court orders. There is current litigation, and until any and all of that is resolved, I can't comment further."

In response to a question for another reporter who complained about the challenges in reporting on the confusing memo late Friday night and asked why the Justice Department should be the lead, White replied, "It's a recommendation."

"The Department of Justice is leading this," White said. "They will explain because there is a court — this is pending litigation, and as long as it's pending litigation, there is very limited amounts that we can talk about."

Recalling comments Mattis made earlier in the week in which he said the documents "stand on their own," White said, "We have to respect the integrity of the process. The documents

are there. They are free for you to read. We put them up as soon as we could. There are multiple filings that were done and this is pending litigation."

Asked for the individuals who comprised the panel of experts referenced in the Mattis memo, White said she doesn't have the information, but acknowledged multiple reporters are asking about it.

"We are working on what we can do, but again, the documents are there, the supporting documents are there, they stand for themselves," White said. "I understand there are questions, but, again, I have to respect that the fact that is pending litigation."

Another reporter asked why the Trump administration issued the policy now as opposed to waiting until is over. White pointed out the August memo issued by Trump in August called for recommendations from Mattis by February and implementation of a new policy by March 23.

"There was a memo, the secretary provided a recommendation, and that was very transparent," White said. "And so, now we are in this process, and we're going to see it through. We provided the documents, we provided the recommendation and we remain under the court orders."

On whether it was a White House or Pentagon decision to make public the recommendation from Mattis against transgender military service, White said the memo would have been public in any event because it was part of litigation.

"When it was filed, it became public, so by all means, we want to provide you — and we did as quickly as we could — when it was released, we provided it," White said.

Aaron Belkin, director of the San Francisco-based Palm Center, said in a statement after the briefing the Pentagon missed an opportunity to explain the transgender military ban.

"Dana White fielded nine questions about the transgender ban today, and declined to elaborate on the policy," Belkin said. "What's more important than whether or not the Pentagon opts to defend the ban is that the ban is based on scientific distortions that the American Psychological Association, American Psychiatric Association and former U.S. surgeons general immediately condemned. The Pentagon is distorting the science, and nothing that spokespersons say or don't say in the briefing room changes that."

AARON BELKIN DANA WHITE PALM CENTER RAJ SHAH WHITE HOUSE

Chris Johnson

Chris Johnson is Chief Political & White House Reporter for the Washington Blade. Johnson attends the daily White House press briefings and is a member of the White House Correspondents' Association. Follow Chris

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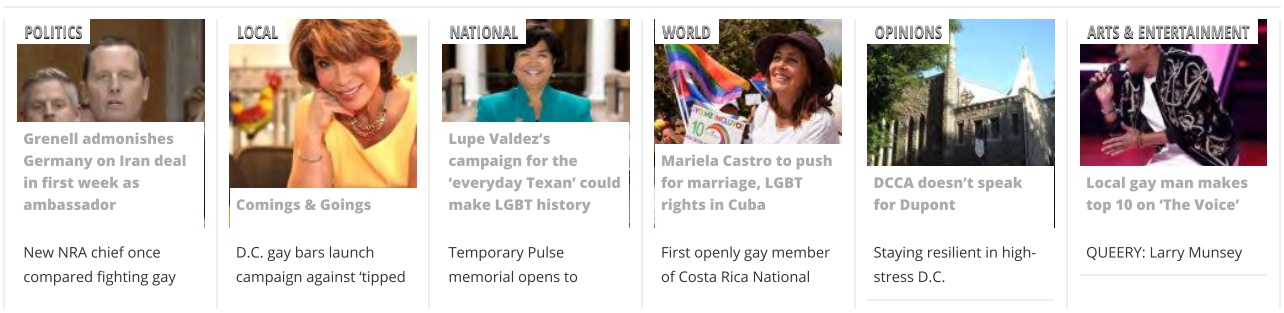

rights to fight against slavery

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Pelosi, speaking out

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Assembly takes office

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Exhibit 8

PALM CENTER

BLUEPRINTS FOR SOUND PUBLIC POLICY

DoD's Rationale for Reinstating the Transgender Ban Is Contradicted by Evidence

Vice Admiral Donald C. Arthur, USN (Ret.)
Former Surgeon General of the U.S. Navy

Major General Gale Pollock, USA (Ret.)
Former Acting Surgeon General of the U.S. Army

Rear Admiral Alan M. Steinman, USPHS/USCG (Ret.)
Former Director of Health and Safety (Surgeon General equivalent) of the U.S. Coast Guard

Nathaniel Frank, PhD
Director, What We Know Project, Cornell University

Professor Diane H. Mazur, JD
Legal Research Director, Palm Center

Professor Aaron Belkin, PhD
Director, Palm Center

April 2018

PALM CENTER

BLUEPRINTS FOR SOUND PUBLIC POLICY

Executive Summary

On March 23, 2018, the White House released a report, endorsed by Defense Secretary James Mattis, entitled, "Department of Defense Report and Recommendations on Military Service by Transgender Persons" ("Implementation Report"). The 44-page document contains recommendations that, if enacted into policy, would have the effect of banning many transgender individuals from military service. As of the writing of this study, inclusive policy for transgender individuals remains in effect because federal courts have enjoined the administration from reinstating the ban, and because the Report's recommendations have not yet been entered into the Federal Register or enacted into policy. The Justice Department, however, has asked the courts to allow the administration to reinstate the ban.

Given the possibility that the Implementation Report's recommendations could become policy, it is important to assess the plausibility of DoD's justification for reinstating the ban. This report undertakes that assessment and finds its rationale wholly unpersuasive.

The Implementation Report claims that inclusive policy would compromise medical fitness because there is "considerable scientific uncertainty" about the efficacy of medical care for gender dysphoria (incongruity between birth gender and gender identity), and because troops diagnosed with gender dysphoria are medically unfit and less available for deployment. Cohesion, privacy, fairness, and safety would be sacrificed because inclusive policy blurs the "clear lines that demarcate male and female standards and policies." Finally, according to the Report, financial costs would burden the military's health care system because the annual cost of medical care for service members diagnosed with gender dysphoria is three times higher than for other troops.

After carefully considering the recommendations and their justification in the Implementation Report, we have concluded that the case for reinstating the transgender ban is contradicted by ample evidence clearly demonstrating that transition-related care is effective, that transgender personnel diagnosed with gender dysphoria are deployable and medically fit, that inclusive policy has not compromised cohesion and instead promotes readiness, and that the financial costs of inclusion are not high. Specifically, we make the following eight findings:

1. **Scholars and experts agree that transition-related care is reliable, safe, and effective.** The Implementation Report makes a series of erroneous assertions and mischaracterizations about the scientific research on the mental health and fitness of individuals with gender dysphoria. Relying on a highly selective review of the evidence, and distorting the findings of the research it cites, the Report

inaccurately claims there is "considerable scientific uncertainty" about the efficacy of transition-related care, ignoring an international consensus among medical experts that transition-related care is effective and allows transgender individuals to function well.

2. **The proposed ban would impose double standards on transgender service members, applying medical rules and expectations to them that do not apply to any other members.** The Implementation Report's claim that individuals who transition gender are unfit for service only appears tenable when applying this double standard. When service members diagnosed with gender dysphoria are held to the same standards as all other personnel, they meet medical, fitness, and deployability standards.

3. **Scholarly research and DoD's own data confirm that transgender personnel, even those with diagnoses of gender dysphoria, are deployable and medically fit.** Research shows that individuals who are diagnosed with gender dysphoria and receive adequate medical care are no less deployable than their peers. DoD's own data show that 40 percent of service members diagnosed with gender dysphoria deployed to the Middle East and only one of those individuals could not complete deployment for mental health reasons.

4. **The Implementation Report offers no evidence that inclusive policy has compromised or could compromise cohesion, privacy, fairness, or safety**. Despite the lack of evidence, DoD advances these implausible claims anyway, citing only hypothetical scenarios and "professional military judgment." Yet the military's top Admirals and Generals have explicitly stated that, while the impact on cohesion is being "monitored very closely," they have received "precisely zero reports of issues of cohesion, discipline, morale," and related concerns after two years of inclusive service.

5. **The Report's contention that inclusive policy could compromise cohesion, privacy, fairness, and safety echoes discredited rationales for historical prohibitions against African Americans, women, and gays and lesbians**. In each of these historical cases, military leaders advanced unsupported arguments about cohesion, privacy, fairness, and safety. In each case, evidence showed that inclusive policies did not bring about the harmful consequences that were predicted, suggesting the fears were misplaced and unfounded.

6. **Research shows that inclusive policy promotes readiness, while exclusion harms it.** A more rigorous and comprehensive assessment of the implications of transgender service shows that a policy of equal treatment improves readiness by promoting integrity, reinforcing equal standards, increasing morale for minorities, and expanding the talent pool available to the military, while banning transgender service or access to health care harms readiness through forced dishonesty, double standards, wasted talent, and barriers to adequate care.

7. **The Implementation Report fails to consider the readiness benefits of inclusive policy or the costs to readiness of the proposed ban**. All policy changes involve costs and benefits, yet DoD's research focuses solely on the costs of inclusion, entirely ignoring the readiness benefits of inclusion and the costs of exclusion.

8. **The Implementation Report's presentation of financial cost data inaccurately suggests that transition-related care is expensive**. The Report states that medical costs for troops with gender dysphoria are higher than average, but isolating any population for the presence of a health condition will raise the average cost of care for that population. In truth, DoD's total cost for transition-related care in FY2017 was just $2.2 million, less than one tenth of one percent of its annual health care budget for the Active Component, amounting to just 9¢ (nine cents) per service member per month, or $12.47 per transgender service member per month.

Introduction[1]

On March 23, 2017, the White House released "Department of Defense Report and Recommendations on Military Service by Transgender Persons" ("Implementation Report"), a 44-page document whose recommendations would, if enacted into policy, have the effect of banning many transgender individuals from military service. Alongside the Implementation Report, the White House released a "Memorandum for the President" in which Defense Secretary James Mattis endorsed the Implementation Report's recommendations. As of the writing of this study, inclusive policy for transgender individuals remains in effect because federal courts have enjoined the administration from reinstating the ban, and because the Report's recommendations have not yet been entered into the Federal Register or enacted into policy. Although inclusive policy remains in effect at this time, the Justice Department has asked courts to dissolve the preliminary injunctions that prevent the administration from banning transgender service members. If courts grant the request, the administration will almost certainly reinstate the ban by implementing recommendations contained in the Implementation Report.

Given the possibility that the Implementation Report's recommendations could be enacted into policy, it is important to assess the plausibility of DoD's justification for the proposed reinstatement of the ban. According to DoD's Implementation Report, inclusive policy for transgender service members could compromise the medical fitness of the force; undermine unit cohesion, privacy, fairness, and safety; and impose burdensome financial costs. According to the Report, inclusive policy would compromise medical fitness because there is "considerable scientific uncertainty" about the efficacy of medical care for gender dysphoria (incongruity between birth gender and gender identity), and because troops diagnosed with gender dysphoria are medically unfit and less available for deployment. Cohesion, privacy, fairness, and safety would be sacrificed because inclusive policy "blur[s] the clear lines that demarcate male and female standards and policies."[2] Finally, according to the Report, financial costs would burden the military's health care system because the annual cost of medical care for service members diagnosed with gender dysphoria is three times higher than for other troops.

After carefully considering the recommendations and their justification in the Implementation Report, we have concluded that the case for reinstating the transgender ban is contradicted by the evidence: (1) Scholars and experts agree that transition-related care is, in fact, reliable, safe, and effective; (2) The proposed ban would impose double standards on transgender service members, in that DoD would apply medical rules and expectations to them that it does not apply to any other members; (3) Scholarly research as well as DoD's own data confirm that transgender personnel, even those with diagnoses of gender dysphoria, are deployable and medically fit; (4) The Report does not offer any evidence that inclusive policy has compromised or could compromise cohesion, privacy, fairness, and safety, and assertions and hypothetical scenarios offered in support of these concerns are implausible; (5) The Report's contention that inclusive policy could compromise cohesion, privacy, fairness, and safety echoes discredited rationales for historical prohibitions against African Americans, women, and gays and lesbians; (6) A more comprehensive assessment of costs and benefits indicates that inclusive policy

promotes readiness, while the proposed ban would compromise it; (7) The Report fails to consider the benefits of inclusive policy or the costs of the proposed ban; and (8) The Report's presentation of financial cost data inaccurately suggests that transition-related care is expensive.

Gender Transition Is Effective

The Implementation Report relies on a series of erroneous assertions and mischaracterizations about the substantial scientific research on the mental health and fitness of transgender individuals with gender dysphoria. As a result, it draws unfounded conclusions about the efficacy of gender transition and related care in successfully treating gender dysphoria and the health conditions that are sometimes associated with it. The Implementation Report argues that there is "considerable scientific uncertainty" about the efficacy of transition-related care, and that the military cannot be burdened with a group of service members for whom medical treatment may not restore medical fitness and "fully remedy" symptoms. This assertion, however, relies on a highly selective review of the relevant scientific evidence. In truth, the data in this field show a clear scholarly consensus, rooted in decades of robust research, that transgender individuals who have equal access to health care can and do function effectively.[3]

Consensus about the efficacy of care

An international consensus among medical experts affirms the efficacy of transition-related health care. The consensus does not reflect advocacy positions or simple value judgments but is based on tens of thousands of hours of clinical observations and on decades of peer-reviewed scholarly studies. This scholarship was conducted using multiple methodologies, study designs, outcome measures, and population pools widely accepted as standard in the disciplinary fields in which they were published. In many cases, the studies evaluated the complete universe of a country or region's medically transitioning population, not a selection or a sample.

The American Medical Association (AMA) has stated that "An established body of medical research demonstrates the effectiveness and medical necessity of mental health care, hormone therapy and sex reassignment surgery as forms of therapeutic treatment" for those with gender dysphoria. In response to the publication of DoD's Implementation Report, the AMA reiterated its view that "there is no medically valid reason—including a diagnosis of gender dysphoria—to exclude transgender individuals from military service." The AMA stated that the Pentagon's rationale for banning transgender service "mischaracterized and rejected the wide body of peer-reviewed research on the effectiveness of transgender medical care."[4]

The American Psychological Association responded to the publication of the Implementation Report by stating that "substantial psychological research shows that gender dysphoria is a treatable condition, and does not, by itself, limit the ability of individuals to function well and excel in their work, including in military service." A statement released by six former U.S. Surgeons General cited "a global medical

consensus" that transgender medical care "is reliable, safe, and effective." The American Psychiatric Association has recognized that "appropriately evaluated transgender and gender variant individuals can benefit greatly from medical and surgical gender transition treatments." The World Professional Association for Transgender Health has stated that gender transition, when "properly indicated and performed as provided by the Standards of Care, has proven to be beneficial and effective in the treatment of individuals with transsexualism, gender identity disorder, and/or gender dysphoria" and that "sex reassignment plays an undisputed role in contributing toward favorable outcomes" in transgender individuals.[5]

The global consensus reflected in this scholarship—that gender transition is an effective treatment for gender dysphoria—is made clear in numerous comprehensive literature reviews conducted across the last thirty years (which themselves confirm conclusions reached in earlier research). By conducting systematic, global literature searches and classifying the studies generated by the search, researchers and policymakers can avoid basing conclusions and policies on cherry-picked evidence that can distort the full range of what is known by scholars in the field.

Most recently, researchers at Cornell University's "What We Know Project" conducted a global search of peer-reviewed studies that addressed transgender health to assess the findings on the impact of transition-related care on the well-being of transgender people. The research team conducted a keyword search that returned 4,347 articles on transgender health published over the last 25 years. These were evaluated by reading titles, abstracts, and text to identify all those that directly address the impact of transition-related care on overall well-being of transgender individuals. Of the final 56 peer-reviewed studies that conducted primary research on outcomes of individuals who underwent gender transition, the team found that 52, or 93 percent, showed overall improvements, whereas only 4, or 7 percent, found mixed results or no change. No studies were found that showed harms. The research team concluded there was a "robust international consensus in the peer-reviewed literature that gender transition, including medical treatments such as hormone therapy and surgeries, improves the overall well-being of transgender individuals."[6]

The "What We Know" researchers assessed evidence from the last 25 years because it represents the most recent generation of scholarship. But the consensus dates to well before this period. In 1992, one of the first comprehensive literature reviews on transitioning outcomes was published in Germany. It examined 76 follow-up studies from 12 countries published between 1961 and 1991, covering more than 2,000 individuals. The review concluded that overall outcomes of gender transition were positive, stating that "sex reassignment, properly indicated and performed, has proven to be a valuable tool in the treatment of individuals with transgenderism."[7] A 1999 study notes that, throughout the 1990s, comparative research found uniformly positive outcomes from gender transition surgery, stating: "A review of postoperative cases [during this decade] concluded that transsexuals who underwent such surgery were many times more likely to have a satisfactory outcome than transsexuals who were denied this surgery."[8]

The positive results of research on transition-related care have only grown more robust with time. For more detailed information on the global consensus that transition-related care is effective, please see the Appendix.

DoD's critique of efficacy literature is contradicted by evidence

The Implementation Report claims that permitting service by transgender individuals treated for gender dysphoria poses an unacceptable risk to military effectiveness because "the available scientific evidence on the extent to which such treatments fully remedy all of the issues associated with gender dysphoria is unclear." The Report argues that the evidence that does exist is insufficient or of too poor quality to form a robust consensus. In support of that claim, the Implementation Report cites one government report by the U.S. Centers for Medicare and Medicaid Services (CMS) concluding that there is "not enough high quality evidence to determine whether gender reassignment surgery improves health outcomes" for individuals with gender dysphoria. In addition, the Implementation Report cites two literature reviews and one research study suggesting that the quality of efficacy evidence is low.

Yet DoD's findings rely on a selective reading of scholarship. Despite decades of peer-reviewed research, the Implementation Report could identify only four studies to sustain its conclusion. Critically, even these four studies, supposedly representing the best evidence documenting the uncertainty about transition-related care's efficacy, all conclude that such care mitigates symptoms of gender dysphoria. As we show below, these four studies do not sustain the Implementation Report's assertion about scientific uncertainty.

Before addressing each study that the Implementation Report relies on individually, several observations about standards of evidence require elaboration. To begin, the Implementation Report's critique that efficacy studies are not randomized controlled trials does not, in and of itself, impeach the quality or the force of the evidence. The Implementation Report places considerable weight on the absence of randomized controlled trials in the efficacy literature, but it fails to acknowledge that there are many criteria for assessing the quality of clinical research and many acceptable study designs. The CMS study that the Implementation Report relies on to indict the efficacy literature explains that while "randomized controlled studies have been typically assigned the greatest strength, . . . a well-designed and conducted observational study with a large sample size may provide stronger evidence than a poorly designed and conducted randomized controlled trial." CMS concludes that "Methodological strength is, therefore, a multidimensional concept that relates to the design, implementation, and analysis of a clinical study."[9]

Elsewhere, CMS explains that random trials are not the only preferred form of evidence, which can include "randomized clinical trials *or* other definitive studies."[10] CMS continues that other forms of evidence can support Medicare policy as well, including "scientific data or research studies published in peer-reviewed journals" and "Consensus of expert medical opinion."[11] Finally, there is a good reason why the efficacy literature

does not include randomized controlled trials of treatments for gender dysphoria: the condition is rare, and treatments need to be individually tailored. Given these circumstances, randomized controlled trials are unrealistic.[12]

The Implementation Report mentions four times that transition-related care does not "fully remedy" symptoms of gender dysphoria, but that is not a standard that the military or other public health entities apply to efficacy evaluation. Using this phrase falsely implies that the military enjoys a level of complete certainty about the medical evidence on which it relies in all other areas of health policy formulation. Yet as six former U.S. Surgeons General explain in a recent response to the Implementation Report, "An expectation of certainty is an unrealistic and counterproductive standard of evidence for health policy—whether civilian or military—because even the most well-established medical treatments could not satisfy that standard. Indeed, setting certainty as a standard suggests an inability to refute the research."[13] Many medical conditions are not categorically disqualifying for accession or retention, and none come with a guarantee that available treatments always "fully remedy" them, suggesting that a double standard is being applied to the transgender population. As documented above, decades of research confirm the efficacy of medical treatments for gender dysphoria, and recent research underscores that as treatments have improved and social stigma has decreased, transgender individuals who obtain the care that they need can achieve health parity with non-transgender individuals.

Parallel to its "fully remedy" double standard, the Implementation Report attempts to indict the efficacy literature because studies do not "account for the added stress of military life, deployments, and combat."[14] Given the historical transgender ban, it is unclear how efficacy literature could ever meet this standard, as DoD did not allow treatment for gender dysphoria while the ban was in effect, so service members could not have participated as subjects in efficacy studies. Generally, service members are not subjects in civilian research studies, and while service member medical and performance data, such as disability separation statistics, are studied to inform policy decisions about accession standards, civilian studies on the efficacy of medical treatments are not.[15]

CMS Study

The Implementation Report relies heavily on a 2016 CMS review of literature to sustain its claim about scientific uncertainty concerning the efficacy of gender transition surgery. According to the Implementation Report, CMS "conducted a comprehensive review of the relevant literature, [including] over 500 articles, studies, and reports, [and] identified 33 studies sufficiently rigorous to merit further review." It then cited CMS's conclusion that "the quality and strength of evidence were low."[16]

Yet the Implementation Report's interpretation and application of the CMS findings are highly misleading. By omitting a crucial point of context, the Implementation Report implies that CMS ultimately found insufficient evidence for the efficacy of gender reassignment surgery, when in fact it found the opposite. That point of context turns on the distinction between negative and affirmative National Coverage Determinations

(NCDs). Negative NCDs are blanket denials of coverage that prohibit Medicare from reimbursing for the cost of medical treatment. Prior to 2014, a negative NCD prohibited Medicare from covering the cost of gender reassignment surgery, but a Department of Health and Human Services Appeals Board ("Board") overturned the NCD after a comprehensive review of the efficacy literature determined surgery to be safe, effective, and medically necessary. As a result, under Medicare policy the need for gender reassignment surgery is determined on a case-by-case basis after consultation between doctor and patient, and there is no surgical procedure that is required in every case.

An affirmative NCD, by contrast, is a blanket entitlement mandating reimbursement of a treatment, the mirror opposite of a negative NCD. Affirmative NCDs are rare. The CMS review that the Implementation Report relies on did not contradict the Board's 2014 conclusion that there is "a consensus among researchers and mainstream medical organizations that transsexual surgery is an effective, safe and medically necessary treatment for transsexualism."[17] Nor did it contradict the Board's 2014 findings that "concern about an alleged lack of controlled, long-term studies is not reasonable in light of the new evidence"[18] and that "Nothing in the record puts into question the authoritativeness of the studies cited in new evidence based on methodology (or any other ground)." Rather, CMS concluded in 2016 that there was not enough evidence to sustain a blanket mandate that would automatically entitle *every* Medicare beneficiary diagnosed with gender dysphoria to surgery.

In addition, CMS only found that the evidence was "inconclusive *for the Medicare population*," not for all persons with gender dysphoria. CMS acknowledged that gender reassignment surgery "may be a reasonable and necessary service for certain beneficiaries with gender dysphoria," and confined its conclusions to the Medicare population, noting that "current scientific information is not complete for CMS to make a NCD that identifies *the precise patient population for whom the service would be reasonable and necessary*." CMS explained that the Medicare population "is different from the general population" and "due to the biology of aging, older adults may respond to health care treatments differently than younger adults. These differences can be due to, for example, multiple health conditions or co-morbidities, longer duration needed for healing, metabolic variances, and impact of reduced mobility. All of these factors can impact health outcomes."[19]

The Board's 2014 repeal of the negative NCD and CMS's 2016 decision not to establish an affirmative NCD means that, like most medical treatments, the need for gender reassignment surgery is determined on a case-by-case basis after consultation between doctor and patient under Medicare policy. The Implementation Report's depiction of the 2016 CMS review, however, obscures that point. In noting that CMS "decline[d] to require all Medicare insurers to cover sex reassignment surgeries," DoD mischaracterizes the CMS decision and erroneously states that its review "found insufficient scientific evidence to conclude that such surgeries improve health outcomes for persons with gender dysphoria." CMS did not bar transition-related coverage for the Medicare population, but determined that care should be offered on an individualized basis, which is the general standard applied to most medical care.

Perhaps the most misleading aspect of the Implementation Report's discussion is the suggestion that the 2016 CMS review undercuts the case for inclusive policy and the provision of medically necessary care. Quite to the contrary, both the 2014 Board review and the 2016 CMS review closely align Medicare policy with DoD's inclusive policy established by former Defense Secretary Ashton Carter. Under the Carter policy, treatment for gender dysphoria is determined on a case-by-case basis after consultation between doctor and patient, and there is no blanket entitlement to care for service members diagnosed with gender dysphoria. The 2016 CMS review may undercut the case for a blanket entitlement to gender reassignment surgery for Medicare beneficiaries. But it does not, as the Implementation Report insists, undercut the rationale for providing care to service members on an individualized basis as determined by doctor and patient.

According to Andrew M. Slavitt, Acting Administrator of CMS from March 2015 to January 2017, "It is dangerous and discriminatory to fire transgender service members and deny them the medical care they need. It is particularly disingenuous to justify it by a purposeful misreading of an unrelated 2016 CMS decision. Both the 2014 Board review and the 2016 CMS review closely align Medicare policy with DoD's inclusive policy established by former Secretary Carter. Under both Medicare and military policy, treatment for gender dysphoria is determined on a case-by-case basis after consultation between doctor and patient."[20]

Hayes Directory

DoD's Implementation Report cites the Hayes Directory in arguing that there is "considerable scientific uncertainty" about whether transition-related treatment fully remedies symptoms of gender dysphoria:

> According to the Hayes Directory, which conducted a review of 19 peer-reviewed studies on sex reassignment surgery, the "evidence suggests positive benefits," . . . but "because of serious limitations," these findings "permit only weak conclusions." It rated the quality of evidence as "very low" due to the numerous limitations in the studies . . . With respect to hormone therapy, the Hayes Directory examined 10 peer-reviewed studies and concluded that a "substantial number of studies of cross-sex hormone therapy each show some positive findings suggesting improvement in well-being after cross-sex hormone therapy." Yet again, it rated the quality of evidence as "very low" . . . Importantly, the Hayes Directory also found: "Hormone therapy and subsequent [gender transition surgery] failed to bring the overall mortality, suicide rates, or death from illicit drug use in [male-to-female] patients close to rates observed in the general male population."[21]

Hayes is not a scholarly organization and the Hayes Reports have not been published in a peer-reviewed journal, unlike the numerous literature reviews cited above. But Dr. Nick Gorton, a nationally recognized expert on transgender health, conducted a critical

analysis of the report cited by DoD as well as a 2004 Hayes Report addressing related research, and he shared his findings with us in a memo. "The Hayes Reports evaluating transition-related care," writes Dr. Gorton, "make repeated substantive errors, evidence poor systematic review technique, are inconsistent in applying their criteria to the evidence, make conclusions not supported by the evidence they present, misrepresent the statements made by professional organizations treating transgender patients, and have a strong systematic negative bias." He concludes that "these problems fatally damage the credibility of their analysis, casting substantial doubt on their conclusions. The reports cannot be relied upon as a valid systematic clinical review of the evidence on transition-related health care."[22]

For example, Hayes claims that its reports are comprehensive, but its 2004 report omitted dozens of relevant studies from its analysis. Dr. Gorton identified 31 applicable scholarly articles that Hayes failed to include in its review.[23] Hayes labels 13 studies it chose for one analysis as consisting only of "chart reviews or case series studies" and concludes that the "studies selected for detailed review were considered to be very poor." But Hayes does not explain why it selected what it considered to be poor quality studies when numerous high quality studies were available. Furthermore, the 13 studies Hayes did choose to review were not, in fact, only chart reviews and case series studies, but included cohort studies, which are considered higher quality evidence. "By mislabeling all the studies as 'chart reviews or case series,'" Dr. Gorton observed, Hayes is "saying they are lower level evidence than what is actually found in that group of studies."[24] Finally, Hayes erroneously states that none of the 13 studies "assessed subjective outcome measures before treatment." Dr. Gorton's review of the studies, however, shows that three of the studies included such baseline measures.

Hayes also asserts that a 2012 Task Force report of the American Psychiatric Association "concluded that the available evidence for treatment of gender dysphoria was low for all populations and treatments, and in some cases insufficient for support of evidence-based practice guidelines." Yet Hayes misrepresents the conclusion of the Task Force by taking quotes out of context and omitting mention of the higher quality evidence the APA also cites—*and uses as a basis for recommending consensus-based treatment options that include gender transition*. The "insufficient" evidence conclusion that Hayes cites applied only to studies of children and adolescents. What the Task Force concluded about adults with gender dysphoria was that there is sufficient evidence to recommend that treatment including gender transition be made available.[25]

Quoting the APA fully on this matter illustrates Hayes's misrepresentation: "The quality of evidence pertaining to most aspects of treatment in all subgroups was determined to be low; however, areas of broad clinical consensus were identified and were deemed sufficient to support recommendations for treatment in all subgroups. With subjective improvement as the primary outcome measure, current evidence was judged sufficient to support recommendations for adults in the form of an evidence-based APA Practice Guideline with gaps in the empirical data supplemented by clinical consensus."[26]

Finally, Dr. Gorton observes that, "Hayes writes reports that are aimed to please their customers who are all health care payers interested in being able to refuse to cover expensive or, in the case of transgender patients, politically controversial care. They obscure the nature of their systematically biased analysis by preventing scientists and clinicians from reading the reports and calling attention to their poor quality and systematic bias as would happen to any other evidence based review of health care treatments." Thus, clients of Hayes who may have paid for the meta-analyses could have a financial interest in declining to reimburse patients for transition-related care.[27]

Swedish research

Of the four studies that the Implementation Report cited to sustain its claim that there is scientific uncertainty about the efficacy of transition-related care, only one, a 2011 study from Sweden co-authored by Cecilia Dhejne, offers original research. According to the Swedish study, individuals receiving gender transition surgery had higher mortality rates than a healthy control group.

Yet much of the data on which the 2011 Swedish study relied in assessing outcomes was collected decades prior, when life for transgender individuals was more grim, with many subjects in the study undergoing gender transition as long ago as 1973. Importantly, the Swedish study, which assessed health data across three decades, compared outcomes from the first 15 years to those from the more recent 15 years and found that individuals who underwent transition since 1989 fared far better. This "improvement over time" is elaborated on in a more recent study co-authored by the same Swedish scholar in 2016 that states, "Rates of psychiatric disorders and suicide became more similar to controls over time; for the period 1989–2003, there was *no difference* in the number of suicide attempts compared to controls."[28]

Dhejne's 2016 study reviewed more than three dozen cross-sectional and longitudinal studies of prevalence rates of psychiatric conditions among people with gender dysphoria. The authors found, contrary to research cited in the Implementation Report, that transgender individuals who obtain adequate care can be just as healthy as their peers. Among its study sample, most diagnoses were of the common variety (general anxiety and depression) whereas "major psychiatric disorders, such as schizophrenia and bipolar disorder, were rare and were no more prevalent than in the general population." They concluded that, even when individuals start out with heightened anxiety or depression, they "improve following gender-confirming medical intervention, in many cases reaching *normative values*."[29]

In a 2015 interview, Dhejne explained that anti-transgender advocates consistently "misuse the study" she published in 2011 "to support ridiculous claims," including that transition-related care is not efficacious, which is not what her study found. She said that, "If we look at the literature, we find that several recent studies conclude that WPATH Standards of Care compliant treatment decrease[s] gender dysphoria and improves mental health."[30]

Mayo Clinic research

Similar to the CMS study, the Hayes Directory, and the Swedish research, the Mayo Clinic study actually concludes that transition-related care mitigates the symptoms of gender dysphoria, with 80 percent of subjects reporting "significant improvement" in gender dysphoria and quality of life, and 78 percent reporting "significant improvement" in psychological symptoms. Moreover, data cited in the Mayo Clinic report reach as far back as 1966, more than 50 years ago, covering a period when the social and medical climates for gender transition were far less evolved than they are today. As we show in this report, more recent research demonstrates even more positive results.[31]

As we note above, the AMA responded to the release of the Implementation Report by stating that DoD "mischaracterized and rejected the wide body of peer-reviewed research on the effectiveness of transgender medical care," and six former U.S. Surgeons General responded to DoD by citing "a global medical consensus" that transgender medical care "is reliable, safe, and effective." Similar to AMA, both APAs, WPATH, and the former Surgeons General, we are wholly unpersuaded by the Implementation Report's contention that there is "considerable scientific uncertainty" about the efficacy of transition-related care. Such a conclusion relies on a selective reading of a much larger body of evidence that flatly contradicts these claims.

Ban Would Create Separate Standards for Transgender Personnel

DoD's current, inclusive regulations hold transgender personnel to the same medical, fitness, and deployability standards as all other personnel. Contrary to the Implementation Report's assertion that former Defense Secretary Carter "relaxed" standards for transgender personnel,[32] the policy that he established requires transgender service members to meet all general medical, fitness, and deployability requirements. There are no exceptions for transgender personnel or for gender transition. The proposed ban, in contrast, would impose double standards on transgender troops, as DoD would apply unique rules and expectations to them that it does not apply to any other members. The Implementation Report's recommendations are not about requiring transgender personnel to meet military standards, because they already do. Under the guise of maintaining standards, the recommendations are about establishing separate standards that target transgender people alone. Separate standards, in other words, are bans in disguise.

The Implementation Report frequently emphasizes the importance of military standards and the necessity that all service members be required to meet them. It refers to "standards" well over one hundred times in the course of the Report. In endorsing the Implementation Report, the Secretary of Defense also pointed to the importance of standards, writing the following with respect to accession and retention of individuals with a history of gender dysphoria:

> Furthermore, the Department also finds that exempting such persons from well-established mental health, physical health, and sex-based standards,

> which apply to all Service members, including transgender Service members without gender dysphoria, could undermine readiness, disrupt unit cohesion, and impose an unreasonable burden on the military that is not conducive to military effectiveness and lethality.[33]

No one objects to the fundamental principle that a single standard should apply equitably to all service members. But the Implementation Report redefines the usual military understanding of a "standard" in order to create what are in fact two separate standards, one for transgender service members and one for everyone else.

DoD's regulation on disability evaluation offers a pertinent example of a true single standard, applicable to all. It states that service members will be referred for medical evaluation possibly leading to separation if they have a medical condition that may "prevent the Service member from reasonably performing the duties of their office, grade, rank, or rating . . . for more than 1 year after diagnosis"; or that "represents an obvious medical risk to the health of the member or to the health or safety of other members"; or that "imposes unreasonable requirements on the military to maintain or protect the Service member."[34]

A February 2018 memo from the Under Secretary of Defense, Personnel and Readiness, announced a stricter enforcement of this retention policy with respect to availability for deployment. It directed, consistent with the DoD regulation, that "Service members who have been non-deployable for more than 12 consecutive months, for any reason" will be processed for administrative or disability separation, absent a waiver at the service headquarters level.[35] Again, however, the standard that service members cannot remain non-deployable for more than 12 consecutive months is presumably a standard that applies across the board to all who are subject to the policy.

The Implementation Report on transgender policy turns the idea of a single standard on its head. Rather than determining whether transgender service members, who have been serving openly for almost two years now, have met this or other generally applicable standards, the Implementation Report recommends a behavior-based standard that only affects transgender personnel. Moreover, the only way to meet this targeted standard is to behave as if one is not transgender. The Implementation Report attempts to cast this as a single standard—that no one can behave as if they are transgender—but it obviously works as a ban targeted only at transgender personnel.

According to the Implementation Report, transgender individuals are eligible to serve if they can prove themselves indistinguishable from individuals who are not transgender. For example, at accession, transgender applicants with a history of gender dysphoria must submit medical documentation showing they are stable living in birth gender—not the gender in which they identify—for at least three years.[36] For transgender persons already in uniform (other than a specifically excepted registry of service members diagnosed with gender dysphoria prior to an effective date), retention is technically permitted but only if they serve in birth gender for the duration and receive no medical care in support of gender identity.[37]

In other words, transgender service members can be retained only if they suppress or conceal their identity as transgender. The Implementation Report characterized this as an equal treatment of, and a single standard for, all service members, whether transgender or not. Nominally, everyone must serve in birth gender, and no one can receive medical care in support of a gender identity that is inconsistent with birth gender:

> Service members who are diagnosed with gender dysphoria after entering military service may be retained without waiver, provided that they are *willing and able to adhere to all standards associated with their biological sex*, the Service member *does not require gender transition*, and the Service member is not otherwise non-deployable for more than 12 months or for a period of time in excess of that established by Service policy (which may be less than 12 months).[38]

This is the "standard" to which all service members will be held. According to the Implementation Report, this standard is necessary to maintain equity not only with colleagues who are not transgender, but also with transgender colleagues who, "like all other persons, satisfy all mental and physical health standards and are capable of adhering to the standards associated with their biological sex."[39] This incorrectly suggests that the problem with transgender personnel is that they cannot meet the standard, but the "standard" is drafted to target them by definition. The Implementation Report also casts those needing to transition gender as simply "unwilling" to meet standards, as in "unwilling to adhere to the standards associated with their biological sex."[40]

The Implementation Report carefully avoids any direct evaluation of transgender service members under a true single standard of fitness. It even misstates current accession standards in a way that makes it appear transgender individuals cannot meet them. For example, the Implementation Report incorrectly states that a history of chest surgery is disqualifying for enlistment.[41] The actual enlistment standard states that a history of chest surgery is only disqualifying for six months, assuming no persistent functional limitations.[42] The Implementation Report also incorrectly states that hormone therapy is specifically disqualifying.[43] It is not. The actual enlistment standard in fact permits enlistment by women who are prescribed hormones for medical management of gynecological conditions.[44]

The consistent theme of the Implementation Report is that transgender service members are so uniquely unfit and uniquely disruptive that they must be measured by unique and separate standards. But the strength of a traditional and single standard is that each service member is measured by the same expectation. Standards are no longer standards when they are not consistent across all members and are instead targeted narrowly to exclude or disqualify only one group.

This is why the current DoD regulation that governs gender transition in military service made clear that not only must transgender members be "subject to the same standards and procedures as other members with regard to their medical fitness," but also that command

decisions and policies should ensure individuals in comparable circumstances are treated comparably. For example, the primary regulation governing gender transition directs as follows:

> Any determination that a transgender Service member is non-deployable at any time will be consistent with established Military Department and Service standards, as applied to other Service members whose deployability is similarly affected in comparable circumstances unrelated to gender transition.[45]

The Implementation Report's recommendations are not about requiring transgender personnel to meet military standards because, as we show in the next section of this study, they already do. The recommendations are about establishing separate standards that target transgender people alone. Those separate standards are nothing less than bans in disguise.

Transgender Service Members Are Medically Fit

According to a statement by six former U.S. Surgeons General, "transgender troops are as medically fit as their non-transgender peers and there is no medically valid reason—including a diagnosis of gender dysphoria—to exclude them from military service or to limit their access to medically necessary care."[46] The Implementation Report concludes, however, that individuals who transition gender are uniquely unfit for service. As we demonstrate below, when service members diagnosed with gender dysphoria are held to the same standards as all other personnel, they meet medical, fitness, and deployability standards. The Implementation Report's characterization of unfitness depends on the application of standards that apply only to transgender service members, but not to anyone else.

DOD's claim: Medically unfit by definition

The Implementation Report contends that service members with gender dysphoria who need to transition gender are, *by definition*, medically unfit. According to the Report, transgender service members may or may not be medically fit. But any transgender service member with a medical need to transition gender is automatically unfit. The Report observes that, "Today, transsexualism is no longer considered by most mental health practitioners as a mental health condition . . . Gender dysphoria, by contrast, is a mental health condition that can require substantial medical treatment . . . According to the APA, the 'condition is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning.'"[47]

Although the Implementation Report is correct in noting that "clinically significant distress or impairment" is a criterion of the diagnosis, it failed to contextualize the observation in terms of the American Psychiatric Association's (APA) reasoning for defining gender dysphoria in this way. In creating the diagnosis, APA was well aware that many transgender individuals who need to transition are fully functional. In the

American medical system, however, patients cannot obtain treatment without a diagnosis code. Insurance companies tend not to reimburse care for mental health conditions that do not include the "clinically significant distress or impairment" language.

At the same time, APA was mindful that defining gender dysphoria in terms of clinically significant symptoms could risk stigmatizing transgender individuals as mentally ill. According to Dr. Jack Drescher, who helped create the gender dysphoria diagnosis during his service on the APA's DSM-5 Workgroup on Sexual and Gender Identity Disorders, "one challenge has been to find a balance between concerns related to the stigmatization of mental disorders and the need for diagnostic categories that facilitate access to healthcare."[48] Dr. Drescher explained to us in a personal communication why a diagnosis of gender dysphoria should not be conflated with unfitness:

> Many transgender individuals who receive gender dysphoria diagnoses are fully functional in all aspects of their lives. When APA revised the diagnosis, words were chosen carefully. Thus, making a diagnosis requires the presence of distress *or* impairment, not distress *and* impairment. One cannot and should not conflate "clinically significant distress" with impairment, as many recipients of the diagnosis experience no impairment whatsoever. In addition, "clinically significant distress" is a purely subjective measure that is difficult to objectively quantify. Many fully functional individuals may have clinically significant distress, such as a soldier separated from his family during deployment. However, being distressed does not mean the individual is impaired.[49]

The fact that DoD's own data reveal, as we discuss below, that 40 percent of service members diagnosed with gender dysphoria have deployed in support of Operations Enduring Freedom, Iraqi Freedom, or New Dawn, and that after the ban was lifted only one individual deploying with a diagnosis of gender dysphoria was unable to complete the deployment for mental health reasons, underscores the inaccuracy of conflating a diagnosis of gender dysphoria with unfitness. In response to DoD's release of the Implementation Report, the American Psychiatric Association's CEO and Medical Director Saul Levin stated that, "Transgender people do not have a mental disorder; thus, they suffer no impairment whatsoever in their judgment or ability to work."[50]

Artificial restrictions on deployment status

The Implementation Report's discussion of deployability illustrates how attributions of unfitness to transgender personnel depend on double standards. The Report overlooks that the small minority of transgender service members who are unfit, or who become unfit as a result of gender transition, can be managed under existing standards that apply to all service members. This includes the small minority of transgender personnel who, like other personnel, may be temporarily non-deployable. As with its recommendation for accession and retention policy, however, the Implementation Report avoids evaluating transgender members under existing deployability standards and instead assumes a separate standard that no one else will be required to meet. It assumes that transgender

members are uniquely at risk of becoming non-deployable and then concludes—contrary to policy—that therefore they must be measured by unique standards.

The Implementation Report makes the uncontroversial observation that deployment is a universal military obligation. No one disagrees that all must take their fair share of the burden:

> Above all, whether they serve on the frontlines or in relative safety in non-combat positions, every Service member is important to mission accomplishment and must be available to perform their duties globally whenever called upon . . . To access recruits with higher rates of anticipated unavailability for deployment thrusts a heavier burden on those who would deploy more often.[51]

Determination of medical eligibility for deployment, however, requires an individual assessment of fitness. Army deployment standards, as a representative example, state: "Because of certain medical conditions, some Soldiers may require administrative consideration when assignment to combat areas or certain geographical areas is contemplated."[52] The Army guidance goes on in greater detail to describe considerations that should be taken into account when evaluating certain conditions, including mental health conditions. For example, most psychiatric disorders are not disqualifying, provided the individual can "demonstrate a pattern of stability without significant symptoms for at least 3 months prior to deployment."[53] Medications are also generally not disqualifying for deployment, although the regulation includes a list of medications "most likely to be used for serious and/or complex medical conditions that could likely result in adverse health consequences," and these medications should be reviewed as part of a complete medical evaluation. Hormones, however, are not on this list of medications most likely to be used for serious or complex medical conditions.[54]

Given that medical deployment standards would not appear to be a significant obstacle for service members who are *not* transgender but have been diagnosed with a mental health condition or may be taking prescription medication, the Implementation Report's conclusion that gender transition makes someone uniquely unfit for deployment is difficult to understand. The Implementation Report does not rely on general standards that apply to service members across the board. Instead, the Report shifts focus to what "could" happen to "render Service members with gender dysphoria non-deployable for a significant period of time—perhaps even a year" or longer.[55]

Neither does the Implementation Report take into account the prior DoD professional judgment that gender transition can often be planned in ways that do not interfere with deployment or pose a risk to service member health. Instead, the Implementation Report sets up a false choice between assuming the risk of treatment and assuming the risk of complete denial of treatment.[56] In contrast, the Commander's Handbook—a DoD document containing military judgment on best practices for managing gender transition—relies on planning a schedule of transition care "that meets the individual's medical requirements and unit readiness requirements."[57] The policy explicitly authorizes

commanders to schedule gender transition so as not to interfere with deployment, and this balance is no different from the balance that commanders apply in managing deployment readiness for any other service member. Indeed, current military regulation requires that all service members be determined fit or unfit for deployment in accordance with established standards, "as applied to other Service members whose deployability is similarly affected in comparable circumstances unrelated to gender transition."[58]

The Implementation Report claims that "limited data" make it "difficult to predict with any precision the impact on readiness of allowing gender transition," but it cites the "potential" that individuals who transition gender will be "sent home from the deployment and render the deployed unit with less manpower."[59] But DoD's own data on deployment of service members diagnosed with gender dysphoria show these conclusions to be incorrect. Out of 994 service members diagnosed with gender dysphoria in FY2016 and the first half of 2017, 393 (40 percent) deployed in support of Operation Enduring Freedom, Operation Iraqi Freedom, or Operation New Dawn. *Exactly one* individual deploying with a diagnosis of gender dysphoria was unable to complete the deployment for mental health reasons since policy protecting transgender personnel from arbitrary dismissal was established in June 2016.[60] While the Implementation Report stated that "the Panel's analysis was informed by the Department's own data and experience obtained since the Carter policy took effect,"[61] the Panel's use of data is selective in nature. This information about actual deployment did not appear in the Implementation Report.

What did appear in the Implementation Report instead was a reference to service data showing that "cumulatively, transitioning Service members in the Army and Air Force have averaged 167 and 159 days of limited duty, respectively, over a one-year period."[62] This data was not connected to deployment and did not demonstrate any failure to meet a deployment obligation. What it did demonstrate, however, is the arbitrary way in which separate standards for fitness, targeted specifically against transgender personnel, can make them appear less medically fit and less deployable than their peers. Note that the Implementation Report's discussion of limited-duty status did not include the Navy. That is because, as the data source itself explains, the Navy does not automatically assign limited-duty status for gender transition without specific justification, which leads to a much smaller percentage of individuals on limited duty.[63] It stands to reason that average days of limited duty will be higher if the status is assigned arbitrarily without individual assessment, unlike the standard practice for personnel who are not transgender.

The Implementation Report cites the specific deployment guidelines[64] applicable to the U.S. Central Command (CENTCOM) combatant command in support of its contention that gender dysphoria limits ability to deploy and also presents risk to the service member and to others in a deployed environment.[65] First, as was the case with respect to accession standards, the Implementation Report mischaracterizes the content of CENTCOM deployment standards in order to buttress its case that service members who will transition gender cannot meet them. Second, the CENTCOM deployment standards supply another example of creating a separate standard that targets only transgender

service members, rather than applying a single standard that evaluates fitness in comparable fashion to personnel who are not transgender.

It is correct, as the Implementation Report states, that diagnosed psychiatric conditions can, in some circumstances, require individual waiver prior to deployment. However, it is not correct that "most mental health conditions, as well as the medication used to treat them, limit Service members' ability to deploy."[66] Waivers are normally required only if the condition presents special risk: residual impairment of social and/or occupational performance, substantial risk of deterioration, or need for periodic counseling.[67] A judgment based on these factors would necessarily be individual and case-by-case. All other psychiatric concerns in the CENTCOM standard are tied to the use of particular psychiatric medication such as benzodiazepines, recent hospitalization or suicide ideation/attempt, or recent treatment for substance abuse.[68]

Gender dysphoria, however, stands apart as the only condition requiring waiver regardless of lack of impairment, regardless of lack of risk of deterioration, and regardless of need for counseling. The CENTCOM standard automatically designates gender dysphoria as a condition with "complex needs" that must be treated differently. Not only does the standard require waiver in every instance regardless of mental fitness and stability, it specifically recommends that waiver should *not* be granted ("generally disqualified") for the duration of gender transition, "until the process, including all necessary follow-up and stabilization, is completed."[69]

Standards that designate anyone as automatically unfit for indefinite periods of time, without consideration of individual fitness, are extremely rare. In fact, the only mental health diagnoses that CENTCOM designates as a greater risk than gender dysphoria are psychotic and bipolar disorders, which are "strictly" disqualifying rather than "generally" disqualifying. This is clearly a circumstance in which gender dysphoria and gender transition are being evaluated under a standard that is unique to transgender service members. No other service members with mental health diagnoses are so completely restricted from deployment, with extremely rare and justified exception. This artificial restriction on deployment is then used to justify a ban on transgender service members and gender transition.

Service members routinely deploy with medication requirements, including hormones, but a transgender person's use of hormones is again assessed in unique fashion. The CENTCOM standard states that hormone therapies for endocrine conditions must be stable, require no laboratory monitoring or specialty consultation, and be administered by oral or transdermal means.[70] Part of the justification for the Implementation Report's conclusion that gender transition is inconsistent with deployment is the assumption that hormone therapy requires quarterly lab monitoring for the first year of treatment.[71] The Implementation Report cited civilian Endocrine Society guidelines in support of that monitoring requirement. According to the Implementation Report:

> Endocrine Society guidelines for cross-sex hormone therapy recommend quarterly bloodwork and laboratory monitoring of hormone levels during the

> first year of treatment . . . If the operational environment does not permit access to a lab for monitoring hormones (and there is certainly debate over how common this would be), then the Service member must be prepared to forego treatment, monitoring, or the deployment. Either outcome carries risks for readiness.[72]

While it is true that Endocrine Society standards of care recommend one year of monitoring after the commencement of hormone therapy, the Implementation Report did not disclose that the author of those guidelines communicated in writing to DoD to explain his medical judgment that monitoring hormone levels for three months prior to deployment, not twelve, was easily sufficient and that "there is no reason to designate individuals as non-deployable after the commencement of hormone replacement therapy."[73] Dr. Wylie C. Hembree, author of the Endocrine Society's standards of care, wrote the following in an October 2015 letter to the Pentagon's transgender policy group:

> (1) The recommendation for clinical monitoring was intended to cover a diverse, civilian population, including older, unreliable and/or unhealthy individuals who are not characteristic of the population of service members; (2) An initial monitoring at the 2–3 month mark is important to determine whether the initial prescribed hormone dose is appropriate for bringing an individual's hormone levels into the desired range. The initial dose will be accurate for approximately 80% of young, healthy individuals. Of the remaining 20% whose hormone levels will be discovered to be slightly too high or too low at the initial monitoring, adjusting the dose to bring levels into the desired clinical range is a simple matter; (3) Of the approximately 20% whose hormone levels will be discovered to be slightly too high or too low at initial monitoring, the health consequences of being slightly out of range are not significant; (4) The monitoring and, if necessary, re-adjustment of prescribed doses do not need to be performed by endocrinologists or specialists. Any physicians or nurses who have received a modest amount of training can perform these tasks; (5) Research is quite clear that hormone replacement therapy, especially for young, healthy individuals, is safe, with complication rates of less than 5%.

Hembree concluded that "There is no reason to designate individuals as non-deployable after the commencement of hormone replacement therapy. While individuals might be placed on limited duty (office work) until the initial monitoring at the 2–3 month mark, they can perform their jobs overseas in a wide range of deployed settings both before and after the initial monitoring."

The Hembree letter was provided directly to a Pentagon official who played a prominent role on the Transgender Service Review Working Group (TSRWG) that former Defense Secretary Carter created to study readiness implications of inclusive policy. The TSRWG, in turn, relied on the letter in determining how to implement inclusive policy without compromising readiness. That same official played a prominent role in Secretary Mattis's Panel of Experts, but the Implementation Report did not mention the Hembree

letter. Instead, it inaccurately claimed that a need for long-term monitoring would preclude deployment. The Report then established a false choice in claiming that service members commencing hormone therapy would have to "forego treatment, monitoring, or the deployment."[74] The Report added that "some experts in endocrinology . . . found no harm in stopping or adjusting hormone therapy treatment to accommodate deployment during the first year of hormone use."[75] As the author of the Endocrine Society's standards of care explained, however, there is no need to forego deployment after the initial 2–3 month period of monitoring.

Nor is refrigeration an obstacle to deployment. The Implementation Report cites a RAND study observation that British service members taking hormones serve in deployed settings, but that "deployment to all areas may not be possible, depending on the needs associated with any medication (e.g. refrigeration)."[76] However, hormone medications do not require refrigeration.

More broadly, singling out transgender service members as warranting a downgrade in medical fitness or deployment status is at odds with the way that the Defense Department treats hormone therapy for non-transgender troops. In 2014, former U.S. Surgeon General Joycelyn Elders co-directed a commission with a co-author of this study (Steinman), and the commission published a peer-reviewed study addressing hormones, gender identity, deployability, and fitness. While the commission's discussion of hormones is lengthy, we quote it in full because it underscores the contrast between the Implementation Report's treatment of hormone therapy for transgender personnel and the way that non-transgender service members requiring hormones are managed. The commission conducted its research before the implementation of inclusive policy, yet its observations about the double standards of the historical ban are fully applicable to the Implementation Report's proposed ban:

> [T]he military consistently retains non-transgender men and women who have conditions that may require hormone replacement. For example, the military lists several gynecological conditions (dysmenorrhea, endometriosis, menopausal syndrome, chronic pelvic pain, hysterectomy, or oophorectomy) as requiring referral for evaluation only when they affect duty performance. And the only male genitourinary conditions that require referral for evaluation involve renal or voiding dysfunctions. The need for cross-sex hormone treatment is not listed as a reason for referral for either men or women. The military also allows enlistment in some cases despite a need for hormone replacement. DoDI 6130.03, for example, does not disqualify all female applicants with hormonal imbalance. Polycystic ovarian syndrome is not disqualifying unless it causes metabolic complications of diabetes, obesity, hypertension, or hypercholesterolemia. Virilizing effects, which can be treated by hormone replacement, are expressly not disqualifying.
>
> Hormonal conditions whose remedies are biologically similar to cross-sex hormone treatment are grounds neither for discharge nor even for referral for medical evaluation, if service members develop them once they join the

> armed forces. Male hypogonadism, for example, is a disqualifying condition for enlistment, but does not require referral for medical evaluation if a service member develops it after enlisting. Similarly, DoDI 6130.03 lists "current or history of pituitary dysfunction" and various disorders of menstruation as disqualifying enlistment conditions, but personnel who develop these conditions once in service are not necessarily referred for evaluation. Conditions directly related to gender dysphoria are the only gender-related conditions that carry over from enlistment disqualification and continue to disqualify members during military service, and gender dysphoria appears to be the only gender-related condition of any kind that requires discharge irrespective of ability to perform duty.
>
> Military policy allows service members to take a range of medications, including hormones, while deployed in combat settings. According to a Defense Department study, 1.4 percent of all US service members (approximately 31,700 service members) reported prescription anabolic steroid use during the previous year, of whom 55.1 percent (approximately 17,500 service members) said that they obtained the medications from a military treatment facility. One percent of US service members exposed to high levels of combat reported using anabolic steroids during a deployment. According to Defense Department deployment policy, "There are few medications that are inherently disqualifying for deployment." And, Army deployment policy requires that "A minimum of a 180-day supply of medications for chronic conditions will be dispensed to all deploying Soldiers." A former primary behavioral health officer for brigade combat teams in Iraq and Afghanistan told Army Times that "Any soldier can deploy on anything." Although Tricare officials claimed not to have estimates of the amounts and types of medications distributed to combat personnel, Tricare data indicated that in 2008, "About 89,000 antipsychotic pills and 578,000 anti-convulsants [were] being issued to troops heading overseas." The Military Health Service maintains a sophisticated and effective system for distributing prescription medications to deployed service members worldwide.[77]

The Implementation Report's contention that transgender service members commencing hormone therapy must "forego treatment, monitoring, or the deployment" is inaccurate. Such therapy is not grounds for characterizing transgender service members as non-deployable or medically unfit beyond the initial 2–3 month monitoring period. Nor are such characterizations consistent with DoD's willingness to access, retain, and deploy tens of thousands of non-transgender service members who require hormones.

DoD's rationale for reinstating the ban cannot be about lost duty time during gender transition, because DoD's latest policy recommendation disqualifies from enlistment applicants who have already transitioned gender. The consistent theme across the Implementation Report is to create separate standards that target gender dysphoria and gender transition as uniquely disqualifying circumstances requiring uniquely

disqualifying measures, but to disregard generally applicable standards that transgender members would in fact meet. This allows the Implementation Report to suggest that transgender service members must be seeking "special accommodations,"[78] when the only accommodation they seek is the opportunity to meet general standards that apply to all.

Mental health encounters mandated by policy

The Implementation Report observes that "Service members with gender dysphoria are also nine times more likely to have mental health encounters than the Service member population as a whole (28.l average encounters per Service member versus 2.7 average encounters per Service member)."[79] [The encounters took place over 22 months, from October 2015 to July 2017.] However, the Implementation Report overlooked the main reason why service members diagnosed with gender dysphoria have high mental health utilization, leaving the incorrect impression that high usage is a reflection of medical unfitness or the difficulty of treating gender dysphoria.

In particular, the Implementation Report neglected to consider over-prescription of appointments for administrative rather than medical reasons. We determined in our research that service members with gender dysphoria diagnoses have high rates of utilization not because they are medically unfit, but because the military has over-prescribed visits as part of the process of providing transition-related care, requiring numerous medically unnecessary encounters for service members diagnosed with gender dysphoria, but not other medical conditions.

The over-prescription of appointments in the military has resulted from two distinct considerations, neither of which reflects medical unfitness. First, it has resulted from the medicalization of administrative matters, as aspects of care that would normally be handled administratively have been assigned to medical providers. As a result, the gender transition process can require a dozen or more mental health appointments regardless of the individual's actual mental health status and without regard to stability, fitness, or need for care. For example, a command decision to grant permission to wear a different uniform to work (exception to policy) requires a mental health workup and recommendation. Each step of the transition process, regardless of import or need, requires mental health workup and recommendation, and the medicalization of non-medical decisions inevitably increases usage.

The reason for the extra layer of administrative "ticket-punching" is not medical. It is the result, rather, of a military determination that it cannot allow transition-related medical care to occur without command supervision designed to ensure that changes in uniforms, grooming standards, facilities use, and the like do not undermine good order and discipline. And while these considerations are important and necessary to maintain operational readiness, they are not indicators of impaired mental health in the transgender member. The military, of course, follows standard professional guidelines for the diagnosis of gender dysphoria, the prescription of hormone therapy, and the authorization of surgery. The generation of unnecessary mental health visits comes not from these

decisions directly, but from the fact that, in the military, mental health providers serve as emissaries between the medical system and commanders. Mental health providers need to sign off on various administrative decisions along the way that have no counterpart in the civilian system, and no counterpart in the military's treatment of other mental health conditions. The military adds on an extra layer of medical approval to what otherwise would be purely administrative or workplace decisions, and this necessarily affects the degree to which medical providers are involved.

We reviewed a range of documents that mandate or guide the steps taken by military medical teams responsible for the care of transgender service members. For example, the principal DoD regulation governing gender transition[80] expands a medical provider's responsibility beyond making medical diagnoses and determining medically necessary treatment. In addition to those traditional and necessary aspects of health care, medical providers are responsible for justifying those medical judgments "for submission to the commander."[81] Medical providers must "advise the commander" on matters of gender transition, and in turn commanders must "coordinate with the military medical provider regarding any medical care or treatment provided to the Service member, and any medical issues that arise in the course of a Service member's gender transition."[82] The commander must approve every step along the path of gender transition, including the timing of any medical treatment and the timing of gender transition itself. Even with respect to military matters such as an exception to policy to wear a different-gender uniform, a military medical provider is responsible for consultation as part of requesting a commander's approval. These extra administrative consultations cannot help but increase medical utilization, even though they are not medically necessary in a traditional sense and do not reflect any lack of medical fitness.

The Commander's Handbook similarly emphasizes the unusual dual layer of justification and approval for decisions affecting transgender service members: "The oversight and management of the gender transition process is a team effort with the commander, the Service member, and the military medical provider." [83] Our observations are not intended to suggest there is anything inappropriate or militarily unnecessary about regulatory requirements that medical providers serve as emissaries between the medical system and the command structure. The point is simply that these dual layers of consultation and approval cannot help but drive up utilization of mental health care, but for reasons that are unrelated to mental health or fitness for duty.

Service-specific regulations produce over-prescriptions as well. According to interim guidance contained in a Navy Bureau of Medicine and Surgery document, a mental health diagnosis of gender dysphoria, coupled with a provider's determination that gender transition is medically necessary to relieve gender dysphoria, is only the first step in a series of requirements for approval of that medical care. Once a diagnosis and a recommendation for treatment is made, that diagnosis and recommendation must be referred for another layer of medical approval from the Transgender Care Team (TGCT). The TGCT will either validate or revise those medical decisions and forward the plan back to the originating provider. These decisions must then be documented once again as part of the package prepared to obtain a commander's approval: "Once the . . . medical

provider has received the validated medical treatment plan from the TGCT, the Service member and . . . medical provider should incorporate the validated medical treatment plan into the full gender transition plan for the Service member's commanding officer's review."[84]

Even at the end of the process of gender transition, the service member's "psychological stability" must be validated by a treating provider, validated a second time by the TGCT, and then validated a third time by a commander, all before an official gender marker change can occur. It might make sense to rely on a service member's duty performance as part of the judgment of whether he or she "consistently demonstrated psychological stability to transition to the preferred gender,"[85] but service-level procedures can instead substitute arbitrary numbers of mental-health visits over arbitrary minimums of time to satisfy a finding of "psychological stability." An "Individualized TGCT Care Plan" obtained from the Naval Medical Center in San Diego recommends that "At a minimum, the service member [undergoing transition] should follow up with a mental health provider or psychosocial support group on a monthly basis." These at-least-monthly visits are used to demonstrate a "6 month period of stability in real life experience documented by a mental health professional" and a "6 month period of emotional/psychosocial stability documented by a mental health professional."[86]

A senior military psychologist who has worked with transgender military members confirmed to us that in order to transition gender, a medical team must document several benchmarks of readiness for treatment and also for permission to change one's gender marker in the military identification system. As a result, he explained, many transgender service members may be required to attend multiple, inexpensive support group sessions that are essentially used as "ticket-punching" to verify administrative requirements. "It almost requires them to have those individual sessions on an ongoing basis," the psychologist said.[87] These requirements established by departments throughout the military health system are far more voluminous than anything required by the civilian medical system. Satisfying them necessitates extensive documentation, which creates incentives for over-prescribing health care appointments.

Lack of experience is the second reason for the over-prescribing of mental health visits, as well-intentioned medical providers inexperienced in transition-related care have been overly cautious in documenting gender stability. It is inevitable that an adjustment period would be needed for the military medical system, given how new it is to transgender health care. A survey of military medical providers found that even after the lifting of the ban, physicians were unprepared to treat transgender service members, as most respondents "did not receive any formal training on transgender care, most had not treated a patient with known gender dysphoria, and most had not received sufficient training" to oversee cross-hormone therapy.[88] This inevitable learning curve is closely connected to the over-prescribing of visits, in that overly cautious medical providers are requiring numerous, medically unnecessary appointments to document stability.

One social worker who is a clinical case manager for transgender service members explained that "The only way to verify that someone has been stable in their gender for

six months is if they communicate with someone showing that they're stable. So they must be checking in at least once per month," and sometimes more. As a result of that requirement, he said his department put recommendations in their transition treatment plans that service members check in with either a primary care provider or mental health provider regularly, or that they attend one of the transgender support groups. "Most of the naval hospitals within our region have a weekly trans support group," he said, "and that tends to be provided through the mental health department. People may be attending those meetings every week and that would show up in their notes as going to a mental health appointment every week." In short, to establish required stability, individuals "have to be reporting that to someone so it's documented so we can point to it and say, 'See? They're stable,' so we can draft a memo verifying it."[89]

A Veterans Affairs psychiatrist familiar with the military's management of transgender personnel told us that doctors "could be requiring the person to go to a mental health provider to check on their stability, and they *have* to go. These are situations that would be absent any specific need for mental health on the part of the service member. They're either explicitly required to go or implicitly required: you can't demonstrate stability if you're not seen by someone." He estimated that "people may have four to seven appointments, *absent any particular need*, just to demonstrate that they're stable in the course of their in-service transition." He added that most military clinicians "are unfamiliar with the process, and they don't yet have capacity. They're trying to learn this as they go along, and so they're being cautious. There's a kind of learning curve. As the system becomes more adept at working with this population, it could be that the number of visits goes down because the clinicians don't need the comfort of seeing the people as often as they do now."[90]

Transgender service members confirm that most of their mental health encounters are the result of over-prescribing visits, not medical need. We assessed the experiences of ten Active Duty transgender troops who transitioned or started to transition over the past two years. Out of 81 total mental health visits reported, 97.5 percent (79 visits) were classified as obligatory. A large number of these visits were mandated monthly counseling sessions that helped provide administrators with ways to document readiness and stability of transitioning service members. An Army First Lieutenant told us that upon beginning hormone therapy, he had "monthly checkups with my behavioral health clinical social worker, monthly checkups with my nurse case manager." A sailor reported that "I have to go for a five-minute consultation for them just to say, 'this is when your surgery is.'"[91]

An analysis by the Veterans Health Administration demonstrates that when a system is not characterized by over-prescribing, mental health care utilization among transgender individuals is far lower than the rate reported by DoD, and also that utilization among transgender and non-transgender individuals is roughly equivalent (as suggested below by the California Health Interview Survey). VHA data reveal that from FY2011 to FY2016, transgender patients averaged between 2.3 and 4.4 mental health encounters per year, as compared to slightly lower utilization among non-transgender patients diagnosed with depression.[92] These data suggest that DoD's finding that service members diagnosed

with gender dysphoria have an average of 15.3 mental health encounters per year is not a reflection of medical need.

Table 1. Incidence proportion of mental health utilization among VA patients by FY

	FY11	FY12	FY13	FY14	FY15	FY16
TRANSGENDER GROUP	**n**	**n**	**n**	**n**	**n**	**n**
Total unique patients	396	487	562	680	879	1089
Total # of mental health encounters	923	1454	1584	2653	2943	4806
Incidence of encounters/patient	2.3	3.0	2.8	3.9	3.3	4.4
SAMPLE OF NONTRANSGENDER PATIENTS						
Total unique patients	1188	1461	1686	2040	2637	3267
Total patients with depression diagnosis	173	201	230	276	338	446
Total # of mental health encounters	248	274	432	438	745	1381
Incidence of encounters/patient	1.4	1.4	1.9	1.6	2.2	3.1

Research indicates that when health care delivery is not over-prescribed, utilization among transgender and non-transgender adults is roughly equivalent. A 2018 study drew on California Health Interview Survey (CHIS) data to assess "utilization rates in access to primary and specialty care among a large cohort of insured transgender and cisgender [i.e., not transgender] patients." The authors calculated the "percentage of patients accessing primary care providers or specialty care providers among patients who reported having insurance coverage" and categorized patients as low, medium, or high utilizers. The results were that transgender patients "accessed both primary and specialty care services at a lower frequency than cisgender individuals and were more likely to fall into the low and medium utilizer groups." Fully 72.9 percent of transgender individuals were low utilizers (0–3 annual visits) compared to 70.9 percent of non-transgender individuals. Just 0.8 percent of transgender individuals were high utilizers (13–25 annual visits) compared to 4.6 percent of non-transgender people. The authors concluded that "transgender individuals are less likely to utilize healthcare services" than the overall population.[93]

Table 2: Frequency of Doctor Visits by Gender Identity

	GENDER IDENTITY					
NUMBER OF DOCTOR VISITS IN PAST YEAR	Not transgender (i.e., cisgender)		Transgender or gender non-conforming		All	
Low Utilizers (0–3 visits)	70.9%	15,117,000	72.9%	81,000	70.9%	15,197,000
Medium Utilizers (4–12 visits)	24.4%	5,203,000	26.3%	29,000	24.4%	5,232,000
High Utilizers (13–25 visits)	4.6%	990,000	0.8%	1,000	4.6%	991,000
Total	100%	21,310,000	100%	110,000	100%	21,421,000

High utilization is not evidence of unfitness, the burdensome needs of transgender troops, or the difficulty of treating gender dysphoria. To the extent that service members diagnosed with gender dysphoria log more mental health visits than average, it is because the system treats them differently and requires more engagement with mental health providers. It has little to do with need for care or fitness for duty. Military medical providers are taking extra steps, sometimes to comply with regulations, and other times out of excessive caution, to justify medical and administrative decisions during the transition process. DoD's failure to address this possibility in its research creates the misimpression that excessive utilization demonstrates the medical unfitness of transgender troops. But it is the military bureaucracy that creates elevated usage figures, not transgender service members.

Suicide is a military problem, not a transgender problem

Children of service members are more than 50 percent more likely to have attempted suicide than the general population, yet the military does not bar individuals in this high-risk group from entry.[94] The Implementation Report, however, attempts to invoke an analogous risk factor among transgender people in general as a basis for disqualification. The Implementation Report claims that "high rates of suicide ideation, attempts, and completion among people who are transgender are also well documented in the medical literature," and cites research indicating lifetime rates of suicide attempts among transgender civilians ranging from 41 percent to as high as 57 percent. But neither applicants for military service nor serving members in uniform are evaluated by characteristics of larger groups; they are measured by standards as individuals.

The Implementation Report also mischaracterizes and selectively cites DoD data on military personnel that, if accurately presented, would in fact demonstrate that rates of suicidal ideation among transgender and non-transgender service members are roughly equivalent. The Implementation Report claims that among military personnel, "Service members with gender dysphoria are eight times more likely to attempt suicide than Service members as a whole (12% versus 1.5%)" during a 22-month study window.[95] This is an inaccurate reading of DoD's own data as well as an inaccurate interpretation of what the data mean. First, the DoD data do not show that service members with gender dysphoria were eight times more likely to *attempt* suicide than other service members during the 22-month study period, but to *contemplate* suicide, a major distinction that the Implementation Report misconstrued.

Second, service members with gender dysphoria are not eight times more likely to contemplate suicide than other service members, because the data under-report the frequency of suicidal thoughts among service members as a whole. The reported 1.5 percent suicidal ideation rate among service members as a whole was based on a review of administrative records.[96] When DoD used more sophisticated methods to determine rates of suicidality among service members not being treated for behavioral health problems, military researchers determined that 14 percent of service members have had suicidal thoughts at some time in their lives, 11 percent had suicidal thoughts at some

point during their military careers, and 6 percent had suicidal thoughts during the past year.[97] Suicide is a military problem. It is not a transgender problem.

Finally, while DoD data indicate that service members diagnosed with gender dysphoria are slightly more prone to suicidal ideation than other service members, the Implementation Report did not take the historical legacy of the transgender ban into account. Extensive research has confirmed that both stigma and the denial of medically necessary care can lead to suicidality.[98] The historical transgender ban, in other words, contributed to stigma and deprivation of health care, which exacerbates the problems the Implementation Report has deemed disqualifying.

The reaction of professional mental health providers to this circular reasoning—denying necessary health care to transgender troops and then citing suboptimal health as the reason for exclusion—is summed up by statements recently released by two of the largest mental health associations in America. The CEO of the American Psychological Association recently stated that he was "alarmed by the administration's misuse of psychological science to stigmatize transgender Americans and justify limiting their ability to serve in uniform and access medically necessary health care."[99] And the American Psychiatric Association stated that the Pentagon's anti-transgender "discrimination has a negative impact on the mental health of those targeted."[100] If inclusive policy remains in effect, DoD will continue to provide medically necessary care to transgender service members. As a result, we would expect the slightly elevated ideation rate among service members diagnosed with gender dysphoria to disappear over time.

Unit Cohesion Has Not Been Compromised

The Implementation Report concludes that inclusive policy for transgender personnel could compromise unit cohesion, privacy, fairness, and safety by allowing transgender men who retain some physiological characteristics of their birth sex and transgender women who retain some physiological characteristics of their birth sex to serve in the military, thus blurring the line that distinguishes male and female bodies:

> [B]y allowing a biological male who retains male anatomy to use female berthing, bathroom, and shower facilities, it [inclusive policy] undermines the reasonable expectations of privacy and dignity of female Service members. By allowing a biological male to meet the female physical fitness and body fat standards and to compete against females in gender-specific physical training and athletic competition, it undermines fairness (or perceptions of fairness) because males competing as females will likely score higher on the female test than on the male test and possibly compromise safety.[101]

According to the Implementation Report, "sex-based standards ensure fairness, equity, and safety; satisfy reasonable expectations of privacy; reflect common practice in society; and promote core military values of dignity and respect between men and women—all of which promote good order, discipline, steady leadership, unit cohesion, and ultimately

military effectiveness and lethality."[102] Yet the Report does not include any evidence to support its contention that inclusive policy has had these effects. Three weeks after the Report's publication, Army Chief of Staff General Mark Milley responded to Senator Kirsten Gillibrand, who asked whether he had heard "anything about how transgender service members are harming unit cohesion," by testifying that "I have received precisely zero reports of issues of cohesion, discipline, morale and all those sorts of things."[103] Chief of Naval Operations Admiral John Richardson, Air Force Chief of Staff General David Goldfein, and Marine Corps Commandant General Robert Neller subsequently confirmed that inclusive policy has not compromised cohesion.[104]

The Implementation Report's explanation for failing to provide evidence is that cohesion "cannot be easily quantified" and that "Not all standards . . . are capable of scientific validation or quantification. Instead, they are the product of professional military judgment acquired from hard-earned experience leading Service members in peace and war or otherwise arising from expertise in military affairs. Although necessarily subjective, this judgment is the best, if not only, way to assess the impact of any given military standard on the intangible ingredients of military effectiveness mentioned above—leadership, training, good order and discipline, and unit cohesion."[105]

This contention, however, does not withstand scrutiny. In response to Senator Gillibrand's question about whether transgender troops have harmed unit cohesion, General Milley testified that "it is monitored very closely because I am concerned about that."[106] In addition, many military experts have quantified cohesion and other dimensions of readiness, and have assessed cause-and-effect claims about those phenomena in their research.[107] In 2011 and 2012, for example, a group of Service Academy professors used multiple methods including surveys, interviews, field observations, and longitudinal analysis to assess whether the repeal of "don't ask, don't tell" (DADT) had impacted readiness and its component dimensions, including unit cohesion and morale, and results were published in a leading peer-reviewed military studies journal.[108]

In the case at hand, DoD could have studied the validity of its contentions about cohesion, privacy, fairness, and safety without difficulty. For example, DoD could have (1) assessed readiness by comparing the performance of units that include a service member diagnosed with gender dysphoria with units that do not include anyone with a diagnosis; (2) measured cohesion via interviews, surveys, and/or field observations and then compared results from units that include a service member diagnosed with gender dysphoria with units that do not include anyone with a diagnosis; (3) assessed privacy and fairness via interviews, surveys, and/or field observations and then compared results from units that include a service member diagnosed with gender dysphoria with units that do not include anyone with a diagnosis; and (4) assessed safety by comparing disciplinary records of units that include a service member diagnosed with gender dysphoria with units that do not include anyone with a diagnosis.

Instead, and in lieu of evidence, the Implementation Report offers three scenarios, two of which are hypothetical, to sustain its assertions. The scenarios, however, do not sustain

the conclusion that inclusive policy has compromised or could compromise cohesion, privacy, fairness, or safety. Under the first hypothetical scenario, fairness and safety are compromised when transgender women compete with cisgender women in sporting events, for example boxing competitions.[109] The Report assumes incorrectly that "biologically-based standards will be applied uniformly to all Service members of the same biological sex," contrary to current practice in which gender-based presumptions are adjustable based on circumstances. At the U.S. Military Academy, for example, the Implementation Report observes that "Matching men and women according to weight may not adequately account for gender differences regarding striking force." But the Report ignores that Cadets' skill level and aggression, not just weight, are factored into safety decisions, and West Point allows men and women to box each other during training.[110]

While sex-based standards are used in concert with other factors to promote fairness and safety, male-female segregation is not absolute—and it is not sufficient. Ensuring fairness and safety in combative training is always a command concern because of the wide variation in body size and weight within gender even when gender is defined by birth. Commanders at all levels are able to make judgments about how to conduct training in ways that adequately protect the participants, and they are able to do the same thing for transgender service members when and if needed. This hypothetical scenario does not lend any credence to the contention that inclusive policy has compromised or could compromise cohesion, privacy, fairness, or safety.

Under the second hypothetical scenario, a transgender man who has not had chest-reduction surgery wants to perform a swim test with no shirt and breasts exposed. It is farfetched to imagine a transgender service member making such a request, and the Implementation Report does not offer any actual examples to buttress this hypothetical concern despite almost two years of inclusive policy. Despite the low likelihood of such a scenario, the Commander's Handbook guides commanders in what to do, and the guidance is sufficient. The Handbook holds the transgender service member responsible for maintaining decorum: "It is courteous and respectful to consider social norms and mandatory to adhere to military standards of conduct."[111] Then, the Handbook advises commanders that they may counsel the service member on this responsibility, but also may consider other options such as having everyone wear a shirt. Ultimately, according to the Handbook, the fundamental principle for commanders is that, "It is within your discretion to take measures ensuring good order and discipline."[112] Similar to the first hypothetical scenario, this scenario does not sustain a conclusion that inclusive policy has compromised or could compromise cohesion, privacy, fairness, or safety.

The third scenario, the only scenario that is not hypothetical, describes a cisgender female who claimed that the presence in shower facilities of a transgender female who retained some physiological characteristics of birth sex undermined her privacy, and the transgender service member claimed that her commander had not been supportive of her rights.[113] DoD guidance offers commanders tools that should have been sufficient for resolving the matter. The situation closely matches scenarios 11 and 15 in the Commander's Handbook, which emphasize that all members of the command should be

treated with dignity and respect: "In every case, you may employ reasonable accommodations to respect the privacy interests of Service members."[114] Commanders are given the following guidance on reasonable accommodations: "If concerns are raised by Service members about their privacy in showers, bathrooms, or other shared spaces, you may employ reasonable accommodations, such as installing shower curtains and placing towel and clothing hooks inside individual shower stalls, to respect the privacy interests of Service members. In cases where accommodations are not practicable, you may authorize alternative measures to respect personal privacy, such as adjustments to timing of the use of shower or changing facilities."[115]

The Commander's Handbook also makes clear that the transgender service member has responsibility: "Maintaining dignity and respect for all is important. You will need to consider both your own privacy needs and the privacy needs of others. This includes, but is not limited to, maintaining personal privacy in locker rooms, showers, and living quarters. One strategy might include adjusting personal hygiene hours."[116]

Inclusive policy cannot be blamed if commanders fail to follow the guidance or to implement it properly, and this scenario does not lend any credibility to the Implementation Report's contention that inclusive policy has compromised or could compromise cohesion, privacy, fairness, or safety. Army training materials are even more straightforward, essentially reminding Soldiers that military life involves a loss of privacy and instructing them that it is not the Army's job to protect tender sensibilities: "Understand that you may encounter individuals in barracks, bathrooms, or shower facilities with physical characteristics of the opposite sex despite having the same gender marker in DEERS."[117]

Cohesion and Related Concerns Have Historically Proven Unfounded

The Implementation Report's contention that inclusive policy could compromise cohesion, privacy, fairness, and safety echoes discredited rationales for historical prohibitions against African Americans, women, and gays and lesbians. In each case, military leaders made arguments about cohesion, privacy, fairness, and safety.[118] In the case of "don't ask, don't tell," for example, leaders insisted that because heterosexual service members did not like or trust gay and lesbian peers, lifting the ban would undermine unit cohesion. One of the principal architects of the policy, the late professor Charles Moskos, insisted that allowing gay men and lesbians to shower with heterosexuals would compromise privacy, and a judge advocate general argued that a "privacy injury" would take place every time an openly gay or lesbian service member witnessed the naked body of a heterosexual peer.[119] Others argued that the repeal of DADT would lead to an increase in male-male sexual assault.[120] One year after the ban's repeal, military professors published a study repudiating these predictions, and the New York Times editorialized that "politicians and others who warned of disastrous consequences if gay people were allowed to serve openly in the military are looking pretty foolish."[121]

Inclusive Policy Promotes Readiness

Scholarly research has shown that inclusive policy for transgender personnel promotes military readiness. According to a comprehensive implementation analysis by retired General Officers and scholars writing before the 2016 lifting of the ban, "when the US military allows transgender personnel to serve, commanders will be better equipped to take care of the service members under their charge."[122] While scholars have explored the relationship between readiness and inclusive policy for transgender personnel from a variety of angles including medical fitness, implementation, command climate, and deployability, all available research has reached the same conclusion: At worst, inclusive policy does not compromise readiness. At best, it enhances readiness by holding all service members to a single standard and promoting medical readiness.[123]

After a year of in-depth research, the Pentagon's Transgender Service Review Working Group (TSRWG) reached that very conclusion. Former Secretary of Defense Carter created the TSRWG on July 28, 2015, to study "the policy and readiness implications of welcoming transgender persons to serve openly."[124] The TSRWG included dozens of civilian and military policy analysts who engaged in extensive research, and who concluded that holding transgender service members "to the same standards and procedures as other members with regard to their medical fitness for duty, physical fitness, uniform and grooming, deployability, and retention, is consistent with military readiness."[125] DoD senior civilian leaders as well as the Service Chiefs signed off on the lifting of the transgender ban on June 30, 2016, because they concluded that inclusive policy would be "consistent with military readiness." The Office of the Secretary of Defense as well as the Services published 257 pages of implementing guidance spread across 14 documents and regulations.[126] These documents instruct commanders and service members how to implement inclusive policy without compromising readiness.

As part of the TSRWG's research, DoD commissioned the RAND Corporation to study whether inclusive policy for transgender personnel would compromise readiness. RAND studied the health care needs of transgender service members and estimated expected health care utilization rates as well as the expected financial cost of providing care following the lifting of the ban. In addition, RAND studied the impact of inclusive policy on unit cohesion and availability to deploy. Finally, RAND studied whether readiness had been compromised in foreign militaries that allow transgender personnel to serve openly. RAND published a 91-page study concluding that the impact of inclusive policy would be "negligible."[127]

Organizational experiences confirm the findings of the scholarly research. Eighteen foreign militaries allow transgender personnel to serve openly, and none has reported any compromise to readiness, cohesion, or any other indicator of military performance. A peer-reviewed study of 22 years of inclusive policy for transgender personnel in the Canadian Forces concluded that "allowing transgender personnel to serve openly has not harmed the CF's effectiveness."[128] According to RAND's analysis of foreign militaries that allow transgender personnel to serve openly, "In no case was there any evidence of

an effect on the operational effectiveness, operational readiness, or cohesion of the force."[129]

In the U.S., transgender service members have been serving openly for almost two years and have been widely praised by commanders. We interviewed four former senior DoD officials who oversaw personnel policy for more than 6 months of inclusive policy, as well as one current senior DoD official who oversaw personnel policy for more than 9 months of inclusive policy. During their combined 35 months of collective responsibility for personnel policy, none of these senior officials was aware of any evidence that inclusive policy compromised readiness. According to one of the former officials, "As of the time we left office, we had not seen any evidence that the Department's new transgender policy had resulted in a negative impact on readiness." When we asked former Navy Secretary Ray Mabus if inclusive policy for transgender personnel promoted readiness, he observed, "Absolutely . . . A more diverse force enhances readiness and combat effectiveness."[130]

DoD's critique of prior readiness research is unsupported by evidence

In recommending reinstatement of the ban, however, the Implementation Report takes aim at RAND's methodology as well as the validity of its conclusions. According to a memorandum from Secretary Mattis that accompanied the release of the Implementation Report, the RAND study "contained significant shortcomings. It referred to limited and heavily caveated data to support its conclusions, glossed over the impacts of healthcare costs, readiness, and unit cohesion, and erroneously relied on the selective experiences of foreign militaries with different operational requirements than our own."[131] The Implementation Report elaborated:

> The RAND report thus acknowledged that there will be an adverse impact on health care utilization, readiness, and unit cohesion, but concluded nonetheless that the impact will be "negligible" and "marginal" because of the small estimated number of transgender Service members . . . Because of the RAND report's macro focus, however, it failed to analyze the impact at the micro level of allowing gender transition by individuals with gender dysphoria. For example, . . . the report did not examine the potential impact on unit readiness, perceptions of fairness and equity, personnel safety, and reasonable expectations of privacy at the unit and sub-unit levels, all of which are critical to unit cohesion. Nor did the report meaningfully address the significant mental health problems that accompany gender dysphoria—from high rates of comorbidities and psychiatric hospitalizations to high rates of suicide ideation and suicidality—and the scope of the scientific uncertainty regarding whether gender transition treatment fully remedies those problems.[132]

Referring to both the TSRWG as well as the RAND study, the Implementation Report concludes that "the realities associated with service by transgender individuals are more complicated than the prior administration or RAND had assumed."[133]

The Implementation Report's critique of the RAND study is unsupported by evidence. Before addressing flaws in the critique, we underscore the depth of RAND's military expertise and trustworthiness. The RAND Corporation is perhaps the most distinguished and trusted research institute in the U.S. on matters of defense and national security, and RAND operates three federally funded research and development centers engaging in military research: RAND Arroyo Center, sponsored by the U.S. Army, RAND Project Air Force, sponsored by the U.S. Air Force, and RAND National Defense Research Institute, sponsored by the Office of the Secretary of Defense, the Joint Staff, the Unified Combatant Commands, the Department of the Navy, and other defense agencies.

While these centers are not government entities, they cooperate closely with their Defense Department sponsors. According to RAND Arroyo's 2015 annual report, for example, the Arroyo Center Policy Committee consisted of 17 General Officers (including the U.S. Army Vice Chief of Staff, the Chief of the National Guard Bureau, five Deputy Chiefs of Staff, and the Commanding General of U.S. Army Forces Command) and five Assistant Secretaries of the Army. RAND Arroyo's Director reported that "We collaborate closely with our Army sponsors not only as we develop our research agenda and design individual analysis, but also as we conduct our research."[134]

The Defense Department relies on RAND to provide nonpartisan, methodologically sophisticated research studies on strategy, doctrine, resources, personnel, training, health, logistics, weapons acquisition, intelligence, and other critically important topics. During the past several decades, RAND has published more than 2,500 military reports, and three of those reports concerned military service by LGBT individuals. In 1993, DoD commissioned RAND to do a $1.3 million study of whether allowing gays and lesbians to serve openly in the military would undermine readiness. RAND assembled a team of 53 researchers who studied foreign militaries, police and fire departments, prior experiences of minority integration into the military, and other aspects of the topic. RAND then published a 518-page report concluding that sexual orientation was "not germane" to military service and that lifting the ban would not undermine readiness. Military and political leaders disagreed with that conclusion, however, and the report was shelved. Seventeen years later, in 2010, DoD hired RAND to replicate its earlier study, and RAND again engaged in comprehensive research and again concluded that allowing gay men and lesbians to serve openly would not compromise readiness. DADT was repealed shortly after the publication of the second RAND study, and subsequent research confirmed the validity of RAND's 1993 and 2010 analyses, in that inclusion did not undermine any aspect of readiness including unit cohesion, morale, retention, and recruitment.[135]

The Implementation Report's critique of the 2016 RAND study on transgender military service is no more persuasive than earlier critiques of RAND's studies on gays and lesbians in the military. First, as argued throughout this study, and despite almost two years of inclusive policy, the Implementation Report has not produced any evidence showing that inclusive policy for transgender personnel has compromised any aspect of readiness, including medical fitness, unit cohesion, or good order and discipline. It is instructive that in its extensive analysis of the ways in which inclusive policy is expected

to undermine cohesion, privacy, fairness, and safety, the Implementation Report did not offer any supporting data. The Implementation Report critiques RAND for failing to assess unit cohesion "at the unit and sub-unit levels," but as noted above, three Service Chiefs confirmed after the Report's publication that inclusive policy has not compromised unit cohesion, including Army Chief of Staff Milley's testimony that cohesion "is monitored very closely because I am concerned about that and want to make sure that they [transgender Soldiers] are in fact treated with dignity and respect and no, I have received precisely zero reports of issues of cohesion, discipline, morale and all those sorts of things."

Second, DoD data validate most of RAND's statistical predictions. RAND estimated that between 1,320 and 6,630 transgender service members serve in the Active Component, and DoD data now show that there are 8,980 active duty transgender troops. RAND estimated that transgender service members in the Active Component would require an overall total of 45 surgeries per year, and DoD data indicate that the actual number was 34 surgeries during a 12-month window, from September 1, 2016, to August 31, 2017.[136] RAND estimated that transition-related health care would cost between $2.4 and $8.4 million per year, and DoD data indicate that the cost in FY2017 was $2.2 million.[137]

Third, the Implementation Report mischaracterized RAND's overall finding by drawing selectively from the study. According to the Implementation Report, RAND "acknowledged that there will be an adverse impact on health care utilization, readiness, and unit cohesion, but concluded nonetheless that the impact will be 'negligible' and 'marginal' because of the small estimated number of transgender Service members." But the Implementation Report misconstrues RAND's analysis. Any policy change yields some costs and some benefits, and RAND found that inclusive policy for transgender troops would have some negative effects, such as the financial cost of health care. But RAND found that inclusive policy would have some positive effects as well, and that continuing to ban transgender troops would entail some costs.[138] RAND did conclude that the effect of lifting the ban would be "negligible" because of the small number of transgender troops, but the Implementation Report fails to acknowledge the context of that conclusion, namely that RAND identified the benefits of inclusive policy and the costs of reinstating the ban, both of which would offset the minor downsides of the policy shift.

Fourth, while it is true that RAND did not address "perceptions of fairness and equity, personnel safety, and reasonable expectations of privacy at the unit and sub-unit levels, all of which are critical to unit cohesion," RAND had a good reason for restricting the scope of its analysis, in that available evidence indicated that cohesion was not compromised in any military force allowing transgender personnel to serve openly. Hence, there was no reason to focus on cohesion at a more granular level. Given that DoD has not offered any evidence to sustain any of its assertions about cohesion, privacy, fairness, and safety despite almost two years of inclusive policy, it seems unreasonable to critique RAND for neglecting to address a problem that does not exist.

Fifth and finally, the Implementation Report's critique of RAND's analysis of foreign militaries is unsupported by evidence. Neither RAND nor DoD has identified any evidence that any foreign military that allows transgender personnel to serve openly has experienced a decline in readiness or cohesion. But the Implementation Report mischaracterizes evidence in the RAND study to obscure that simple fact. An in-depth study of transgender military service in the Canadian Forces (CF) "found no evidence of any effect on unit or overall cohesion," but did find that the CF's failure to provide commanders with sufficient guidance and failure to train service members in inclusive policy led to implementation problems. But the CF's failure to provide implementation guidance does not mean that inclusive policy compromised readiness or cohesion. Rather, it means that the CF should have provided more guidance. Secretary Carter's TSRWG studied the Canadian example, learned from it, and issued extensive guidance and training materials, thus avoiding the CF's implementation challenges.

The Implementation Report claims that because the CF chain of command "has not fully earned the trust of the transgender personnel," there are "serious problems with unit cohesion." But according to the authors of the study, one of whom is a professor at the Canadian Forces College and one of the world's leading experts on personnel policy in the CF, the lack of trust is not evidence that inclusive policy has compromised unit cohesion. Rather, it is a reflection of the CF's failure to implement inclusive policy effectively, for the reasons discussed above.

The study of the CF that informed the RAND report was published in a leading, peer-reviewed military studies journal and was based on careful methodology, including an "extensive literature review, using 216 search permutations, to identity all relevant media stories, governmental reports, books, journal articles and chapters."[139] In addition, the authors received written, interview, and focus group data from 26 individuals, including 2 senior military leaders, 10 commanders, 2 non-transgender service members who served with transgender peers, 4 transgender service members and veterans, and 8 scholarly experts on readiness in the CF. By contrast, the Implementation Report presents exactly zero original research on the CF. If a professor in the Canadian Forces College concludes in a peer-reviewed study, and on the basis of extensive research, that inclusive policy, despite implementation problems, has not compromised readiness or cohesion, DoD cannot dismiss the weight of the conclusion by selectively relying on a handful of quotes.

The Implementation Report makes a similar attempt to dismiss RAND's conclusions about readiness and inclusive policy in the Israel Defense Forces (IDF). Available research on transgender service in the IDF is not as thorough as research on the CF, but RAND nonetheless analyzed a study that was based on several interviews, including interviews with two senior IDF leaders who confirmed that inclusive policy had not compromised readiness or cohesion. The Implementation Report dismisses these "sweeping and categorical claims," but offers no evidence to the contrary. If two senior leaders in a military organization confirm that a policy has a certain effect, that counts as data, especially absent contradictory evidence, and especially when the data line up with evidence from other military forces.

The Implementation Report is correct that operational and other differences distinguish the U.S. armed forces from other militaries. That does not detract, however, from the fact that RAND was unable to find any evidence that readiness or cohesion had declined as a result of inclusive policy in any of the 18 nations that allow transgender personnel to serve openly.

DoD Does Not Consider Benefits of Inclusive Policy or Costs of Ban

Every change of policy involves costs and benefits, and when analysts study whether or not to abandon the status quo in favor of an alternative policy option, typically they address the costs and benefits of both the status quo as well as the contemplated policy modification. DoD's research, however, was artificially narrowed at the outset to focus exclusively on the costs of inclusion, and the Implementation Report did not include any assessment of the benefits of inclusive policy or the costs of the proposed ban. DoD could have framed its research question broadly by asking, "What impact has inclusive policy for transgender troops had on military readiness?" Instead, the Implementation Report addressed only the costs of inclusive policy and failed to consider overall readiness implications. A more rigorous and comprehensive assessment of readiness indicates that inclusive policy for transgender personnel promotes readiness, while banning transgender personnel and denying them medically necessary care compromises it.

Failure to consider benefits of inclusive policy

If DoD researchers had studied benefits as well as costs, they could have assessed promotion rates, time-in-service, and commendations to determine whether transgender personnel have served successfully. They could have conducted case studies of transgender personnel who have completed gender transition to determine whether transitions have been effective. DoD researchers could have studied the experience of Lieutenant Colonel Bryan (Bree) Fram, an astronautical engineer currently serving as the Air Force's Iraq Country Director at the Pentagon, overseeing all Air Force security cooperation and assistance activity for operations in Iraq. They could have evaluated the experience of Air Force Staff Sergeant Logan Ireland, who deployed to Afghanistan after transitioning gender and was named "NCO of the Quarter." DoD could have studied the experience of Staff Sergeant Ashleigh Buch, whose commander said that "She means the world to this unit. She makes us better. And we would have done that [supported gender transition] for any airman but it made it really easy for one of your best." Or DoD could have assessed the experience of Lance Corporal Aaron Wixson, whose commander reported that "We are lucky to have such talent in our ranks and will benefit from his retention if he decides to undertake a subsequent tour of duty . . . Enabling LCpl Wixson to openly serve as a transgender Marine necessarily increases readiness and broadens the overall talent of the organization."[140]

The Implementation Report's explanation for failing to study the performance of transgender troops is that "Limited data exists regarding the performance of transgender Service members due to policy restrictions . . . that prevent the Department from tracking individuals who may identify as transgender as a potentially unwarranted invasion of

personal privacy."[141] But this excuse in unpersuasive, as DoD researchers could have asked data analysts to match medical records of service members diagnosed with gender dysphoria with administrative records concerning promotion rates, time-in-service, commendations, and other indicators of performance without revealing names or identifying details. Instead, DoD failed to consider any benefits of inclusive policy, and it focused exclusively on costs.

By omitting any analysis of benefits, the Implementation Report failed to address critical ways in which the accession and retention of transgender personnel promote readiness. To begin, inclusive policy for transgender service members promotes medical readiness by ensuring adequate health care to a population that would otherwise serve "underground." As we mention in our discussion of efficacy, a robust body of scholarly research shows that transgender people who receive the care they need are better off and function well at work and beyond.[142]

After the repeal of "don't ask, don't tell," gay and lesbian service members experienced a decline in harassment, because they could approach offending colleagues and politely point out that unprofessional behavior was no longer acceptable in the workplace, or could safely report inappropriate behavior if it persisted.[143] Inclusive policy for transgender personnel is expected to produce a similar effect, but the Implementation Report does not address this possibility.

Finally, the Implementation Report ignores the financial gains of retaining transgender personnel. DoD data indicate that the per-person cost of care in FY2017 was $18,000 for each service member diagnosed with gender dysphoria, but the Report does not mention that by DoD's own estimate, recruiting and training one service member costs $75,000.[144] It is much cheaper to provide medical care than to replace service members who need it.

Failure to consider costs of the ban

In response to DoD's release of the Implementation Report, the American Psychiatric Association's CEO and Medical Director Saul Levin stated that the proposed transgender ban "not only harms those who have chosen to serve our country, but it also casts a pall over all transgender Americans. This discrimination has a negative impact on the mental health of those targeted." The Implementation Report, however, seems premised on the notion that the proposed ban would incur no costs. In addition to evidence that enables us to assess costs directly, scholars and experts have produced a great deal of evidence concerning the costs of "don't ask, don't tell," and it is not unreasonable to expect that some of the burdens associated with that failed policy could recur if the transgender ban were reinstated.

Research on transgender military service as well as DADT suggests that reinstating the ban could (1) undermine medical readiness by depriving 14,700 transgender service members of medically necessary care should they require it;[145] (2) increase harassment of transgender personnel, just as DADT promoted harassment of gay men and lesbians;[146] and (3) drain financial resources due to the cost of replacing transgender personnel and

the cost of litigation.[147] In addition, the ban could (4) compromise unit cohesion by introducing divisiveness in the ranks; (5) discourage enlistment and re-enlistment by lesbians, gays, and bisexuals, who would be wary of serving in an anti-LGBT atmosphere; (6) discourage enlistment and re-enlistment by women, because this ban is based on discomfort with people who cross gender lines or otherwise violate traditional gender roles; and (7) promote policy instability. The ban would constitute the fifth policy on transgender military service over the past two years. As former U.S. Navy Judge Advocate General Admiral John D. Hutson observed, "Whatever one thinks about transgender service . . . , there is no question that careening personnel policy from one pole to the other is bad for the armed forces."[148]

Similar to DADT, the reinstatement of the ban would (8) force many transgender service members to hide their gender identity, given the stigma that the Implementation Report implicitly authorizes. Scholars have demonstrated that the requirement to serve in silence effectively forces troops to lie about their identity, leading to elevated incidence of depression and anxiety.[149] (9) When service members lie about their identity, peers suspect that they are not being forthcoming, and both social isolation and general distrust can result.[150] In turn, (10) forcing service members to lie about their identity compromises military integrity. Prior to the repeal of DADT, former Chairman of the Joint Chiefs of Staff Admiral Mike Mullen said that, "I cannot escape being troubled by the fact that we have in place a policy which forces young men and women to lie about who they are in order to defend their fellow citizens. For me, personally, it comes down to integrity—theirs as individuals and ours as an institution."[151]

Finally, (11) the ban would signal to the youth of America that the military is not a modern institution. Scholarly research established that DADT was an ongoing public relations embarrassment for the Pentagon and that ripple effects impacted recruitment. Every major editorial page in the U.S. opposed DADT, and anti-military activists used the policy to rally opposition.[152] Approximately three-quarters of the public opposed DADT.[153] According to one report, high schools denied military recruiters access to their campuses on 19,228 separate occasions in 1999 alone, in part as an effort "to challenge the Pentagon's policy on homosexuals in the military."[154] In the case of military service by transgender personnel, the Implementation Report cites one poll suggesting that service members oppose inclusive policy. Other polling, however, indicates that service members, veterans, retirees, and military family members favor inclusion, as does the public at large.[155] There is every reason to believe that the transgender ban would be just as unpopular as was DADT.

DoD Cites Misleading Figures on Financial Costs of Inclusion

The Implementation Report observed that "Since the implementation of the Carter policy, the medical costs for Service members with gender dysphoria have increased nearly three times—or 300 percent—compared to Service members without gender dysphoria."[156] While the Implementation Report's claim is correct, the cost data are taken out of context and reported in a misleading way. DoD data indicate that the average annual per-person cost for service members diagnosed with gender dysphoria is approximately $18,000, as

opposed to the $6,000 annual cost of care for other service members.[157] But the higher average per-person cost would appear any time a population is selected *for the presence of a specific health condition* and then compared to an average cohort of all other service members.

The Report's claim that medical costs for service members diagnosed with gender dysphoria are three times, or 300 percent, higher than for other troops implies that medical care for transgender personnel is expensive. But the Report does not mention that DoD's total cost for transition-related care in FY2017 was only $2.2 million, which is less than one tenth of one percent of DoD's annual health care budget for the Active Component.

Insurance actuaries sometimes calculate costs in terms of the cost of care per plan member per month of coverage. With financial costs of transition-related care distributed force-wide, the cost of providing transition-related care is 9¢ (nine cents) per service member per month.[158] Even if the per-member/per-month cost estimate were restricted to the cohort of transgender service members, the financial impact of providing care would be low, because very few of the currently serving 14,700 transgender troops required *any* transition-related care during FY2017: $2.2 million / 14,700 = $149.66 per transgender service member per year; $149.66 / 12 = $12.47 per transgender service member per month.

Higher average per-person costs would appear any time a population is selected for the presence of a specific condition and then compared to an average cohort of other service members. Even setting this qualification aside, reporting the cost of care for service members with gender dysphoria as 300 percent higher than the cost of care for other troops, without contextualizing the observation in terms of the low overall cost, could mislead readers into believing that transition-related care is expensive, which it is not.

Conclusion

Scholars and experts agree that transition-related care is reliable, safe, and effective, and medical research as well as DoD's own data confirm that transgender personnel, even those with diagnoses of gender dysphoria, are deployable and medically fit. In advancing its case for the reinstatement of the transgender ban, however, the Implementation Report mischaracterized the medical research that sustains these conclusions. The proposed transgender ban is based on double standards consisting of rules and expectations that DoD would apply only to transgender service members, but to no one else. The Report did not present any evidence showing that inclusive policy has compromised or could compromise cohesion, privacy, fairness, or safety. Finally, the Implementation Report's justification depends on partial and misleading assessments of costs and benefits, as DoD neglected to assess the benefits of inclusive policy or the costs of the ban.

The RAND study was correct in concluding that inclusive policy was unlikely to pose a meaningful risk to the readiness of the armed forces. If anything, the evidence suggests that inclusive policy for transgender service members has promoted readiness. Just like

justifications for prohibitions against women and African Americans in the military as well as the failed DADT policy, the case for banning transgender individuals from the armed forces is not supported by evidence and is unpersuasive.

Appendix

Efficacy of transition-related care

As we described earlier, an international consensus among medical experts affirms the efficacy of transition-related health care. This Appendix details that scholarship, showing that the DoD Report selected only a small slice of available evidence to reach its conclusions about the efficacy of transition-related care.

A large Dutch study published in 2007 reported follow-up data of 807 individuals who underwent surgical gender transition. Summarizing their results, the authors reaffirmed the conclusion of a much-cited 1990 study that gender transition dramatically reduces the symptoms of gender dysphoria, and hence "is the most appropriate treatment to alleviate the suffering of extremely gender dysphoric individuals." They found that, across 18 outcome studies published over two decades, 96 percent of subjects were satisfied with transitioning, and "regret was rare." The authors wrote that, even though there were "methodological shortcomings" to many of the studies they reviewed (lacking controls or randomized samples), "we conclude that SRS [sex reassignment surgery] is an effective treatment for transsexualism and the only treatment that has been evaluated empirically with large clinical case series." Gender transition, they stated, "is not strongly theory driven, but a pragmatic and effective way to strongly diminish the suffering of persons with gender dysphoria." It must be noted that not all studies of the efficacy of gender transition lack controls. The Dutch authors cite a controlled study from 1990 that compared a waiting-list condition with a treatment condition and found "strong evidence for the effectiveness" of surgical gender transition.[159]

In a 2010 meta-analysis noted by the Implementation Report, researchers at the Mayo Clinic conducted a systematic review of 28 scholarly studies enrolling 1,833 participants who underwent hormone therapy as part of gender transition. The reviewed studies were published between 1966 and February 2008. Results indicated that 80 percent of individuals reported "significant improvement" in gender dysphoria and in quality of life, and 78 percent reported "significant improvement" in psychological symptoms. The authors concluded that "sex reassignment that includes hormonal interventions… likely improves gender dysphoria, psychological functioning and comorbidities, sexual function and overall quality of life."[160]

A 2015 Harvard and University of Houston longitudinal study of testosterone treatment also reviewed prior literature and found that numerous recent cross-sectional studies "suggest that testosterone treatment among transgender men is associated with improved mental health and well-being," including improved quality of life, less anxiety, depression and social distress, and a reduction in overall mental stress.[161]

A 2016 literature review screened 647 studies to identify eleven longitudinal studies providing data on transgender individuals. Ten of them found "an improvement of psychiatric morbidity and psycho-pathology following" medical intervention (hormone therapy and/or gender-confirming surgery). Sizing up the overall research body on

transgender psychiatric outcomes, Cecilia Dhejne and her co-authors wrote: "This review found that longitudinal studies investigating the same cohort of trans people pre- and post-interventions showed an overall improvement in psychopathology and psychiatric disorders post-treatment. In fact, the findings from *most studies showed that the scores of trans people following GCMI were similar to those of the general population*."[162] Another 2016 study, a systematic review of literature, identified numerous longitudinal studies finding that "depression, global psychopathology, and psychosocial functioning difficulties appear to reduce" in transgender individuals who get treatment for gender dysphoria, leading to "improved mental health."[163]

Copious studies reflecting a wide range of methodologies, population samples, and nationalities reached similarly positive conclusions to what was found by the researchers mentioned above, namely that individuals who obtain the care they need achieve health parity with non-transgender individuals. A 2009 study using a probability sample of 50 transgender Belgian women found "no significant differences" in overall health between subjects and the general population, which the study noted was "in accordance with a previous study in which no differences in psychological and physical complaints between transsexuals and the general Belgian population were found."[164] A 2012 study reported that "Most transsexual patients attending a gender identity unit reported subclinical levels of social distress, anxiety, and depression" and did "not appear to notably differ from the normative sample in terms of mean levels of social distress, anxiety, and depression." Patients who were not yet treated for gender dysphoria had "marginally higher distress scores than average, and treated subjects [were] *in the normal range*."[165] An Italian study that assessed the impact of hormonal treatment on the mental health of transgender patients found that "the majority of transsexual patients have no psychiatric comorbidity, suggesting that transsexualism is not necessarily associated with severe comorbid psychiatric findings."[166] A Croatian study from the same year concluded that, "Despite the unfavorable circumstances in Croatian society, participants demonstrated stable mental, social, and professional functioning, as well as a relative resilience to minority stress."[167]

Efficacy of hormone therapy

Studies show clearly that hormone treatment is effective at treating gender dysphoria and improving well-being. In 2015, Harvard and University of Houston researchers published the first controlled longitudinal follow-up study to examine the immediate effects of testosterone treatment on the psychological functioning of transgender men. The study used the Minnesota Multiphasic Personality Inventory test (2nd ed.) to take an empirical measure of psychological well-being after hormone treatment, assessing outcomes before and after treatment. (The MMPI-2 is one of the oldest, most commonly used psychological tests and is considered so rigorous that it typically requires many years of intensive psychotherapy to generate notable improvements in outcomes.) The results showed marked change in just three months: Transgender subjects who presented with clinical distress and demonstrated "poorer psychological functioning than nontransgender males" prior to treatment functioned "as well as male and female controls and demonstrated positive gains in multiple clinical domains" after just three months of

testosterone. "There were no longer statistically significant differences between transgender men and male controls" on a range of symptoms including hypochondria, hysteria, paranoia, and others after three months of treatment, the study concluded. "Overall findings here," concluded the study, "suggest significant, rapid, and positive effects of initiating testosterone treatment on the psychological functioning in transgender men."[168]

These findings echoed earlier research on the efficacy of hormone therapy for treating gender dysphoria. A 2006 U.S. study of 446 female-to-male (FTM) subjects found improvements when comparing those who had and had not received hormone treatment: "FTM transgender participants who received testosterone (67 percent) reported statistically significant higher quality of life scores ($p<0.01$) than those who had not received hormone therapy." The study concluded that providing transgender individuals "with the hormonal care they request is associated with improved quality of life."[169] A 2012 study assessed outcome differences between transgender patients who obtained hormone treatment and those who did not among 187 subjects. It found that "patients who have not yet initiated cross-sex hormonal treatment showed significantly higher levels of social distress and emotional disturbances than patients under this treatment."[170]

An Italian study published in 2014 that assessed hormone therapy found that "when treated, transsexual patients reported less anxiety, depression, psychological symptoms and functional impairment" with the improvements between baseline and one-year follow-up being "statistically significant." The study stated that "psychiatric distress and functional impairment were present in a significantly higher percentage of patients before starting the hormonal treatment than after 12 months."[171] Another study published in 2014 found that "participants who were receiving testosterone endorsed fewer symptoms of anxiety and depression as well as less anger than the untreated group."[172]

Efficacy of surgery

A wide body of scholarly literature also demonstrates the effectiveness of gender-transition surgery. A 1999 follow-up study using multi-point questionnaires and rigorous qualitative methods including in-depth, blind follow-up interviews evaluated 28 MTF subjects who underwent transition surgery at Albert Einstein College of Medicine. The study was authored by four physicians who conducted transition surgeries at university centers in New York and Israel. *All* their subjects reported satisfaction in having transitioned, and they responded positively when asked if their lives were "becoming easier and more comfortable" following transition. Large majorities said that reassignment surgery "solved most of their emotional problems," adding in follow-up assessments comments such as: "I am now a complete person in every way," "I feel more self-confident and more socially adapted," "I am more confident and feel better about myself," and "I am happier." Summarizing their conclusions, the authors noted "a marked decrease of suicide attempts, criminal activity, and drug use in our postoperative population. This might indicate that there is a marked improvement in antisocial and self-destructive behavior, that was evident prior to sex reassignment surgery. Most patients

were able to maintain their standard of living and to continue working, usually at the same jobs."[173]

A 2010 study of thirty patients found that "gender reassignment surgery improves the QoL [quality of life] for transsexuals in several different important areas: most are satisfied of their sexual reassignment (28/30), their social (21/30) and sexual QoL (25/30) are improved."[174] A long-term follow-up study of 62 Belgian patients who underwent gender transition surgery, published in 2006, found that, while transgender subjects remain a vulnerable population "in some respects" following treatment, the vast majority "proclaimed an overall positive change in their family and social life." The authors concluded that "SRS proves to be an effective therapy for transsexuals even after a longer period, mainly because of its positive effect on the gender dysphoria."[175]

Efficacy of the combination of hormone therapy and surgery

Some studies assessed global outcomes from a combination of hormone treatment and transition surgery, or they did not isolate one form of treatment from the other in reporting their overall results. They consistently found improved outcomes when transgender individuals obtained the specific care recommended by their doctor.

A 2011 Canadian study found that "the odds of depression were 2.8 times greater for FTMs not currently using hormones compared with current users" and that FTM subjects "who were planning to medically transition (hormones and/or surgery) but had not begun were five times more likely to be depressed than FTMs who had medically transitioned." The finding shows that gender transition is strongly correlated with improved well-being for transgender individuals.[176] An Australian study found that "the combination of current hormone use and having had some form of gender affirmative surgery provided a significant contribution to lower depressive symptoms over and above control variables."[177]

A 2015 study conducted in Germany with follow-up periods up to 24 years, with a mean of 13.8 years, tracked 71 transgender participants using a combination of quantitative and qualitative outcome measures that included structured interviews, standardized questionnaires, and validated psychological assessment tools. It found that "positive and desired changes were determined by all of the instruments." The improvements included that "participants showed significantly fewer psychological problems and interpersonal difficulties as well as a strongly increased life satisfaction at follow-up than at the time of the initial consultation." The authors cautioned that, notwithstanding the positive results, "the treatment of transsexualism is far from being perfect," but noted that, in addition to the positive result they found in the current study, "numerous studies with shorter follow-up times have already demonstrated positive outcomes after sex reassignment" and that this study added to that body of research the finding that "these positive outcomes persist even 10 or more years" beyond their legal gender transition.[178]

Regrets low

A strong indicator of the efficacy of gender transition is the extremely low rate of regrets that studies have found across the board. A recent focus in popular culture on anecdotes by individuals who regretted their gender transition has served to obscure the overall statistics on regret rates. A 2014 study co-authored by Cecilia Dhejne evaluated the entirety of individuals who were granted a legal gender change in Sweden across the 50-year period from 1960 through 2010. Of the total number of 681 individuals, the number who sought a reversal was 15, a regret rate of 2.2 percent. The study also found a "significant decline of regrets over the time period." For the most recent decade covered by Dhejne's data, 2000 to 2010, the regret rate was just three tenths of one percent. Researchers attribute the improvements over time to advances in surgical technique and in social support for gender minorities, suggesting that today's transgender population is the most treatable in history, while also sounding a caution that institutional stigma and discrimination can themselves become barriers to adequate care.[179]

The low regret rate is consistent in the scholarly literature, and it is confirmed by qualitative studies and quantitative assessments. A 1992 study authored by one of the world's leading researchers on transgender health put the average regret rate at between 1 and 1.5 percent. This figure was based on cumulative numbers from 74 different follow-up studies conducted over three decades, as well as a separate clinical follow-up sample of more than 600 patients.[180] A 2002 literature review also put the figure at 1 percent.[181] A 1998 study put the figure as high as 3.8 percent, but attributed most regret to family rejection of the subjects' transgender identity.[182] The 1999 study of transition surgery outcomes at Albert Einstein College of Medicine found that "None of the patients regretted or had doubts about having undergone sex-reassignment surgery."[183] The 2006 Belgian study mentioned elsewhere followed 62 subjects who underwent transition surgery and "none of them showed any regrets" about their transition. "Even after several years, they feel happy, adapt well socially and feel no regrets," the authors concluded.[184] And the 2015 German follow-up study of adults with gender dysphoria found that none of its 71 participants expressed a wish to reverse their transition.[185]

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[121] "A Military Success Story," *New York Times* (editorial), September 15, 2012.
[122] Gale S. Pollock and Shannon Minter (2014), "Report of the Planning Commission on Transgender Military Service," Palm Center, 21.
[123] Schaefer et al., "Assessing the Implications"; M. Joycelyn Elders, George R. Brown, Eli Coleman, Thomas A. Kolditz, and Alan M. Steinman (2014), "Medical Aspects of Transgender Military Service," *Armed Forces and Society*, 41(2): 199–220; Pollock and Minter, "Report of the Planning Commission"; Alan Okros and Denise Scott (2014), "Gender Identity in the Canadian Forces: A Review of Possible Impacts on Operational Effectiveness," *Armed Forces and Society,* 41(2): 243–56.
[124] Department of Defense, "Statement by Secretary of Defense Ash Carter on DoD Transgender Policy," (press release), July 13, 2015, Memorandum from Ashton Carter, Secretary of Defense, "Transgender Service Members" (July 28, 2015).
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AMEDD Guidance for Transgender Medical Care (August 3, 2016); SECNAV Instruction 1000.11, Service of Transgender Sailors and Marines (November 4, 2016); U.S. Navy, Transgender and Gender Transition: Commanding Officer's Toolkit (2016); Department of the Navy, BUMED Notice 6000, Medical Treatment of Transgender Service Members–Interim Guidance (September 27, 2016); AFPM 2016-36-01, Air Force Policy Memorandum for In-Service Transition for Airmen Identifying as Transgender (October 6, 2016); Marine Corps Bulletin 1121, Transgender Service (November 22, 2016); U.S. Coast Guard, COMDTINST M1000.13, Military Transgender Service (December 22, 2016).

[127] Schaefer et al., "Assessing the Implications," 70.

[128] Okros and Scott, "Gender Identity in the Canadian Forces," 243.

[129] Schaefer et al., "Assessing the Implications," xiii.

[130] Correspondence with senior civilian DoD official, April 21, 2017; Telephone interview with former Navy Secretary Ray Mabus, April 20, 2017; Correspondence with former Air Force Secretary Deborah James, April 20, 2017; Correspondence with former Army Secretary Eric Fanning, April 24, 2017; Correspondence with former senior civilian DoD official, April 19, 2017.

[131] Memorandum, Secretary of Defense, Military Service by Transgender Individuals (February 22, 2018), 2.

[132] DoD Report, 14.

[133] Ibid., 44.

[134] Rand Arroyo Center Annual Report 2015, 1.

[135] Belkin et al., "Readiness and DADT Repeal."

[136] Department of Defense, Health Data on Active Duty Service Members with Gender Dysphoria, 21.

[137] Ibid., 31.

[138] For various benefits of inclusive policy and costs of the ban, see Schaefer et al., "Assessing the Implications," 8 (surgical skills); 45, 60–61 (diversity and readiness); and 10 (denial of care).

[139] Okros and Scott, "Gender Identity in the Canadian Forces," 246.

[140] John D. Hutson, "An Unwarranted Attack on Transgender Service," *Stars and Stripes*, February 6, 2018; Steve Liewer, "Transgender Offutt Airman – Finally 'Able to Live as My True Self' – Finds Support, Acceptance during Transition," *Omaha World-Herald*, April 22, 2017; Emanuella Grinberg, "A transgender Marine Comes Out, Tests Military's New Policy," *CNN*.com, November 19, 2016.

[141] DoD Report, 37, Note 143.

[142] Dhejne et. al, "Mental Health and Gender Dysphoria."

[143] Gay and lesbian service members reported an increase in morale after DADT repeal. See Belkin et al., "Readiness and DADT Repeal."

[144] According to a 2015 estimate by Accession Medical Standards Analysis and Research Activity (AMSARA), "Recruiting, screening and training costs are approximately $75,000 per enlistee." Accession Medical Standards Analysis & Research Activity, http://www.amsara.amedd.army.mil/Default.aspx, last modified date April 1, 2015, accessed August 3, 2017.

[145] See Schaefer et al., "Assessing the Implications," 9–10. For the estimate that 14,700 transgender personnel serve currently in the Active Component and Selected Reserve, see Palm Center, "Breaking Down the March 23, 2018 Transgender Military Ban," March 27, 2018.

[146] For extensive evidence on this point, see the ten annual reports of the Servicemembers Legal Defense Network that are posted at http://dont.law.stanford.edu/commentary/, accessed April 23, 2018. Sharon Terman argues that harassment cannot be regulated in institutions that allow formal discrimination. See Sharon Terman, "The Practical and Conceptual Problems with Regulating Harassment in a Discriminatory Institution," Center for the Study of Sexual Minorities in the Military, 2004.

[147] Aaron Belkin, Frank J. Barrett, Mark J. Eitelberg, and Marc J. Ventresca (2017), "Discharging Transgender Troops Would Cost $960 Million," Palm Center.

[148] Hutson, "An Unwarranted Attack."

[149] Tobias Barrington Wolff (1997), "Compelled Affirmations, Free Speech, and the U.S. Military's Don't Ask, Don't Tell Policy," Brooklyn Law Review, 63: 1141–1211.

[150] Frank, *Unfriendly Fire*, xix.

[151] "Top Military Officer: Gays Should Serve," *NBC News*, February 2, 2010.

[152] Aaron Belkin (2008), "'Don't Ask, Don't Tell': Does the Gay Ban Undermine the Military's Reputation?" *Armed Forces and Society*, 34(2): 276–91.

[153] Belkin, "'Don't Ask, Don't Tell.'"

[154] "Easier Access for Military Recruiters," *Tampa Tribune*, July 6, 2000, as cited in Belkin, "'Don't Ask, Don't Tell,'" 283, and David F. Burrelli and Jody Feder (2009), "Homosexuals in the U.S. Military: Current Issues," Congressional Research Service, 24.
[155] According to a poll that was administered to 5,650 service members, retirees, veterans, and their family members in October and November 2017, "twice as many respondents support transgender individuals serving in the military as those who don't." See "Survey 2017 Results," Military Family Advisory Network, 31. According to an August 2017 Quinnipiac poll, 68 percent of voters support allowing transgender individuals to serve in the military, with 27 percent opposing. See Quinnipiac University, "U.S. Voters Say 68–27% Let Transgender People Serve," (press release), August 3, 2017.
[156] DoD Report, 41.
[157] Department of Defense, Health Data on Active Duty Service Members with Gender Dysphoria, 31-32.
[158] $2.2 million / 2.1 million service members / 12 months = 9 cents per member per month.
[159] Luk Gijs and Anne Brewaeys (2007), "Surgical Treatment of Gender Dysphoria in Adults and Adolescents: Recent Developments, Effectiveness, and Challenges," *Annual Review of Sex Research*, 18(1): 178–224. The 1990 study was Charles Mate-Kole, Maurizio Freschi, and Ashley Robin (1990), "A Controlled Study of Psychological and Social Change after Surgical Gender Reassignment in Selected Male Transsexuals," *The British Journal of Psychiatry,* 157(2): 261–64.
[160] Murad et al., "Hormonal Therapy." The DoD Report notes that the Murad study found the quality of most evidence to be "low," a claim we address elsewhere in this report.
[161] Colton Keo-Meier, Levi Herman, Sari Reisner, Seth Pardo, Carla Sharp, and Julia Babcock (2015), "Testosterone Treatment and MMPI-2 Improvement in Transgender Men: A Prospective Controlled Study," *Journal of Consulting and Clinical Psychology,* 83(1): 143–56.
[162] Dhejne et. al, "Mental Health and Gender Dysphoria."
[163] Rosalià Costa and Marco Colizzi (2016), "The Effect of Cross-Sex Hormonal Treatment on Gender Dysphoria Individuals' Mental Health: A Systematic Review," *Neuropsychiatric Disease and Treatment* 12: 1953–66.
[164] Steven Weyers et al. (2009), "Long-Term Assessment of the Physical, Mental, and Sexual Health among Transsexual Women," *The Journal of Sexual Medicine*, 6(3): 752–60.
[165] Ester Gomez-Gil et al. (2012), "Hormone-Treated Transsexuals Report Less Social Distress, Anxiety and Depression," *Psychoneuroendocrinology*, 37(5): 662–70.
[166] Marco Colizzi, Rosalià Costa, and Orlando Todarello (2014), "Transsexual Patients' Psychiatric Comorbidity and Positive Effect of Cross-Sex Hormonal Treatment on Mental Health: Results from a Longitudinal Study," *Psychoneuroendocrinology*, 39: 65–73.
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[168] Keo-Meier et al., "Testosterone Treatment."
[169] Emily Newfield, Stacey Hart, Suzanne Dibble, and Lori Kohler (2006), "Female-to-Male Transgender Quality of Life," *Quality of Life Research*, 15(9): 1447–57.
[170] Gomez-Gil et al., "Hormone-Treated Transsexuals."
[171] Colizzi, Costa, and Todarello, "Transsexual Patients' Psychiatric Comorbidity."
[172] Samuel Davis and S. Colton Meier, (2014), "Effects of Testosterone Treatment and Chest Reconstruction Surgery on Mental Health and Sexuality in Female-to-Male Transgender People," *International Journal of Sexual Health*, 26(2): 113–28.
[173] Rehman et al., "The Reported Sex and Surgery Satisfactions."
[174] Nathalie Parola et al. (2010), "Study of Quality of Life for Transsexuals after Hormonal and Surgical Reassignment," *Sexologies*, 19(1): 24–28.
[175] Griet De Cuypere et al. (2006), "Long-Term Follow-up: Psychosocial Outcome of Belgian Transsexuals after Sex Reassignment Surgery," *Sexologies*, 15(2): 126–33.
[176] Nooshin Khobzi Rotondi et al. (2011), "Prevalence of and Risk and Protective Factors for Depression in Female-to-Male Transgender Ontarians: Trans PULSE Project," *Canadian Journal of Community Mental Health*, 30(2): 135–55.
[177] Crystal Boza and Kathryn Nicholson Perry (2014), "Gender-Related Victimization, Perceived Social Support, and Predictors of Depression among Transgender Australians," *International Journal of Transgenderism*, 15(1): 35–52.

[178] Ulrike Ruppin, and Freidemann Pfäfflin (2015), "Long-Term Follow-up of Adults with Gender Identity Disorder," *Archives of Sexual Behavior*, 44(5): 1321–29.
[179] Cecilia Dhejne, Katarina Öberg, Stefan Arver, and Mikael Landén (2014), "An Analysis of All Applications for Sex Reassignment Surgery in Sweden, 1960-2010: Prevalence, Incidence, and Regrets," *Archives of Sexual Behavior*, 43(8): 1535–45.
[180] Freidemann Pfäfflin (1992; sometimes listed as 1993), "Regrets after Sex Reassignment Surgery," *Journal of Psychology and Human Sexuality*, 5(4): 69–85.
[181] Aude Michel, Marc Ansseau, Jean-Jacques Legros, William Pitchot, and Christian Mormont (2002), "The Transsexual: What about the Future?" *European Psychiatry*, 17(6): 353–62.
[182] Mikael Landén, Jan Wålinder, Gunnar Hambert, and Bengt Lundström (1998), "Factors Predictive of Regret in Sex Reassignment," *Acta Psychiatrica Scandinavica*, 97(4): 284–89.
[183] Rehman et al., "The Reported Sex and Surgery Satisfactions."
[184] De Cuypere et al., "Long-Term Follow-up."
[185] Ruppin and Pfäfflin, "Long-Term Follow-up."

Exhibit 9

Your Military

(/news/your-military/)

All 4 service chiefs on record: No harm to units from transgender service

By: Tara Copp (/author/tara-copp) April 24

3K

Air Force Chief of Staff Gen. Dave Goldfein told Congress Tuesday he was not aware of any negative effects from transgender personnel serving (https://www.militarytimes.com/news/your-military/2018/03/26/mattis-pentagon-quiet-on-new-transgender-policy/), joining all three other service chiefs in a rare public split with President Donald Trump (https://www.militarytimes.com/news/your-military/2018/03/24/here-is-the-mattis-guidance-and-pentagon-study-behind-trump-transgender-decision/) over the issue.

Sen. Kristen Gillibrand, D-N.Y., as she had with the top military leaders of the Army, Navy and Marine Corps when they appeared before the Senate Armed Services Committee for their budget hearings, used the opportunity to question Goldfein as to whether he was aware of any "issues of unit cohesion, disciplinary problems or issues of morale resulting from open transgender service."

"In the last two weeks Gen. [Mark] Milley, Gen. [Robert] Neller, and Adm. [John] Richardson have told me that they have seen zero reports of issues of cohesion, discipline, morale as a result of open transgender service in their respective service branches," Gillibrand said, referring to the chiefs of staff of the Army, Marine Corps and Navy, respectively.

Goldfein said he was not aware of any issues with transgender service members, but emphasized that each case is unique. Goldfein said among the transgender service members he had talked to, he had found a "commitment to serve by each of them."

(/news/your-military/2018/03/24/here-is-the-mattis-guidance-and-pentagon-study-behind-trump-transgender-decision/)

Here is the Mattis guidance and Pentagon study behind the Trump transgender decision (/news/your-military/2018/03/24/here-is-the-mattis-guidance-and-pentagon-study-behind-trump-transgender-decision/)

The White House's late Friday announcement was influenced by the these documents.

By: Tara Copp

Likewise, in earlier testimonies, when the three other service secretaries were asked if they had heard of any harm to unit cohesion or other problems, they responded:

Navy: "By virtue of being a Navy sailor, we treat every one of those Navy sailors, regardless, with dignity and respect," said Chief of Naval Operations Adm. John Richardson (https://www.militarytimes.com/news/your-navy/2018/04/19/no-reports-of-transgender-troops-affecting-unit-cohesion-marine-corps-and-navy-leaders-say/). "That is warranted by wearing the uniform of the United States Navy. By virtue of that approach, I am not aware of any issues."

Marine Corps: "By reporting those Marines that have come forward, there's 27 Marines that have identified as transgender, one sailor serving. I am not aware of any issues in those areas," said Marine Commandant Gen. Robert Neller.

Army: "We have a finite number. We know who they are, and it is monitored very closely, because, you know, I'm concerned about that, and want to make sure that they are, in fact, treated with dignity and respect. And no, I have received precisely zero reports," said Army Chief of Staff Gen. Mark Milley.

Last month the White House announced that it would leave the decision to the service secretaries on whether or not to allow transgender personnel to serve; but also directed that a subset of transgender personnel — those with a diagnosis of gender dysphoria — would be prohibited from serving. Gender dysphoria is a condition where a person experiences discomfort with their biological sex.

In his February guidance to President Trump (https://www.militarytimes.com/news/your-army/2018/03/24/trump-order-would-ban-most-transgender-troops-from-serving/), Mattis also listed several other limitations on transgender service, including an extension of the amount of time someone would need to be stable in their preferred sex to 36 months and a prohibition on service members who have undergone corrective surgery.

Critics have said the gender dysphoria argument is an attempt to keep all transgender personnel from serving, because "gender dysphoria" is a broadly used diagnosis used by the medical community for transgender persons and not indicative of a more serious issue.

The four service chiefs, along with the chief of the National Guard Bureau and Chairman of the Joint Chiefs of Staff Gen. Joseph Dunford, comprise the president's top circle of military advisers. Each service chief's testimony marked an unusual split with the president and Defense Secretary Jim Mattis, who have advised that allowing personnel with gender dysphoria to serve would harm unit cohesion and present an "unreasonable burden on the military."

The administration's prohibitions on transgender service are still being challenged in the courts; four federal courts have already overturned Trump's previous ban on new accessions by transgender personnel and the other aspects of the administration's transgender policy are now part of ongoing lawsuits.

3K

Exhibit 10

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MARYLAND

BROCK STONE, et al., *Plaintiffs*, v. DONALD J. TRUMP, et al., *Defendants*.	Case No. 1:17-cv-02459-MJG Date: April 30, 2018

BRIEF OF RETIRED MILITARY OFFICERS AND FORMER NATIONAL SECURITY OFFICIALS AS AMICI CURIAE IN SUPPORT OF PLAINTIFFS' OPPOSITION TO DEFENDANTS' MOTION TO DISSOLVE THE PRELIMINARY INJUNCTION

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INTEREST OF AMICI CURIAE

Amici are retired military officers and former national security officials who have collectively devoted countless decades to safeguarding the security of the United States. They have been responsible for the readiness of the service members under their command in times of hostilities and peace, and they have led and participated in policy-making processes regarding military personnel at the senior-most levels of the U.S. government. They greatly appreciate and value military expertise, and the importance of the judiciary deferring to that expertise in appropriate cases. They submit this brief to explain why this is not such a case. The President's actions here continue to reflect a sharp departure from decades of military practice across multiple administrations regarding considered policy-making on major questions of military readiness. Excluding transgender individuals from patriotic service that they are trained and qualified to give based on group characteristics, rather than individual fitness to serve, undermines rather than promotes the national security interests of the United States.

ARGUMENT

On the morning of July 26, 2017, President Donald Trump issued three tweets that announced a ban on transgender service members serving in the military. The tweets did not emerge from a policy review of any kind, and his Joint Chiefs of Staff were unaware that he planned to make this decision at all. Less than a month later, on August 25, 2017, President Trump issued a Presidential Memorandum that formalized the tweets. But that document again did not identify any policy-making process or consultations with senior military officials.[1] Nor

[1] Mem. from the President of the United States to Sec'y of Def. & Sec'y of Homeland Sec., 82 Fed. Reg. 41,319 (Aug. 25, 2017) [hereinafter Presidential Mem.].

did it point to a single piece of evidence demonstrating that the ban was necessary for reasons of military necessity, national security, or any other legitimate national interest.

Last month, the Secretary of Defense sent a memorandum to the President implementing the August 2017 Presidential Memorandum.[2] The DOD memorandum was unambiguously meant to be an *implementation memorandum*, executing the previously made presidential decision; the Presidential memorandum called for such an implementation of its directives, and multiple internal documents make clear that that this is precisely what this memorandum and the study it adopted were intended to be. Even so, Defendants try to shield this execution of the President's directives from judicial review, asserting throughout their motion that the President is owed the "great deference" that is due "the professional judgment of military authorities."[3] But these actions are as far removed as one can imagine from those cases where courts have deferred to the genuine "considered" or "professional judgment" of military officials.[4] In fact, the President's tweets and Memorandum did not involve the professional judgment of military authorities at all. He did not seek their judgment then, and cannot hide behind it now. And convening a military group to implement his order after the fact cannot erase the original sin. A predetermined, constitutionally defective order that is based on no evidence or consultations cannot be saved by process that is designed only to implement that order.

Defendants cannot point to a single case where a court has afforded deference to a President regarding military affairs when that President ordered the abrogation of an existing

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[2] Dep't of Def., Report and Recommendations on Military Service by Transgender Persons (Feb. 2018) [hereinafter Report and Recommendations].
[3] Mem. of Points and Authorities in Supp. of Defs.' Mot. to Dissolve the Prelim. Inj. [hereinafter Defs.' Mem.] at 18 (quoting *Winter v. Nat. Res. Def. Council*, 555 U.S. 7, 24 (2008)) (citations omitted); *see also, e.g.*, *id.* at 12-17, 26-27.
[4] *Winter*, 555 U.S. at 24 (quotations and citations omitted); *Goldman v. Weinberger*, 475 U.S. 503, 508-09 (1986).

policy based on no considered review, no consultations with military officials, and no evidence to support his decision. The President's actions here reflect a remarkable departure from decades of practice across multiple administrations regarding the proper approach to major policy changes regarding personnel issues within the U.S. military. Consequently, the policies that emerged from such a process will do serious harm to our military's readiness and unit cohesion.

Although the President's policies in this case *affect* national security, they did not emerge from the sort of national security *judgment* that deserves—much less compels—judicial deference. Amici well understand the critical importance of considered military expertise to the security of our nation, and the need for the judiciary to defer to that expertise in the appropriate circumstances. But the President should not be allowed to hide behind a cloak of deference a capricious and discriminatory order that will grievously harm not only the service members immediately affected, but also the national security and foreign policy of the United States.

I. The President's actions departed sharply from decades of practice involving similar military policy changes.

Throughout its history, the U.S. military has exercised great care in the selection, training, and retention of qualified personnel as an integral aspect of military readiness. Significant changes to its personnel policies—particularly those involving the exclusion of entire groups of individuals from military service—have been subjected time and again to a process that includes: 1) a searching policy review, 2) involving senior military officials, 3) that thoroughly examines the best available evidence regarding the impact and consequences of the change. This practice reflects an appreciation for the gravity of such decisions and the ways in which even incremental changes in military policy can dramatically affect our Armed Forces' overall readiness to protect our country.

The paradigmatic case of a major personnel change in the U.S. military is President Truman's decision seven decades ago to integrate African Americans into the Armed Forces. Although African Americans had served in the United States military since the Revolutionary War,[5] many had served in segregated units due to perceived concerns about unit cohesion and morale.[6] Prompted by growing concern about racial inequality and unrest in the United States, on December 5, 1946 President Truman issued an Executive Order appointing the President's Committee on Civil Rights, a presidential commission comprised of senior defense officials, religious leaders, and civil rights activists to study, *inter alia*, the question of whether to desegregate the military.[7] Over nearly a year, the Committee deliberated across ten meetings, undertook multiple studies, heard from numerous witnesses in public and private hearings, received hundreds of communications from private organizations and individuals, and was assisted in its work by twenty-five agencies across the federal government.[8]

In December 1947, the Committee issued its final report. The report found that the practices of the military services in excluding African-Americans was "indefensible," concluding that that practice had "cost[] lives and money in the inefficient use of human resources," "weaken[ed] our defense" by "preventing entire groups from making their maximum contribution to the national defense," and "impose[d] heavier burdens on the remainder of the population."[9] As a result, the Committee called for an immediate end to discrimination and

[5] *See* Michael Lee Lanning, *African Americans in the Revolutionary War* 73 (2000).
[6] *See* Martin Binkin & Mark J. Eitelberg, *Blacks and the Military* 25-26 (1982).
[7] Exec. Order No. 9,808, 11 Fed. Reg. 14,153 (Dec. 5, 1946); Harry S. Truman Library and Museum, *Records of the President's Committee on Civil Rights* (2000).
[8] President's Comm. on Civil Rights, *To Secure These Rights: The Report of the President's Committee on Civil Rights* XI (1947) [hereinafter *To Secure These Rights*]; Harry S. Truman Library and Museum, *Records of the President's Committee on Civil Rights*, *supra* note 7.
[9] *To Secure These Rights*, *supra* note 8, at 46-47, 162-63.

segregation based on "race, color, creed, or national origin, in the organization and activities of all branches of the Armed Services."[10] Several months later, President Truman issued an executive order declaring that it would be the policy of the United States to require equality of treatment and opportunity for all persons in the U.S. Armed Services without regard to race.[11]

The Obama Administration's repeal of the Don't Ask, Don't Tell directive, which allowed gay, lesbian or bisexual people to serve openly in the military, followed a similarly searching process. In March 2010, Secretary of Defense Robert Gates convened a working group co-chaired by General Counsel Jeh Johnson of the Department of Defense and General Carter F. Ham of the U.S. Army, and comprised of senior civilian and military leaders from across the Armed Services, to undertake a comprehensive review of the impacts of any repeal.[12] For nine months, members of the working group conducted 95 "information exchange forums" at 51 bases and installations around the world, conducted 140 focus groups, solicited input from nearly 400,000 active duty and reserve service members, engaged the RAND Corporation to update an earlier 1993 study on the topic, studied foreign militaries' integration of gays and lesbians, and conducted a thorough legal review.[13]

On November 30, 2010, the working group issued a 256-page report rejecting the contention that allowing gays to serve openly in the military would result in long-lasting and detrimental effects on unit cohesion or the ability of units to conduct military missions.[14] Shortly

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[10] *Id.* at 163.
[11] Harry S. Truman Library and Museum, *Records of the President's Committee on Equality of Treatment and Opportunity in the Armed Services*; Exec. Order No. 9981, 13 Fed. Reg. 4313 (July 28, 1948).
[12] U.S. Dep't of Def., *Report of the Comprehensive Review of the Issues Associated with a Repeal of "Don't Ask, Don't Tell,"* Nov. 30, 2010.
[13] *Id.* at 33-39.
[14] *Id.* at 119.

thereafter, Secretary Gates and Chairman of the Joint Chiefs Admiral Michael Mullen called on Congress to immediately repeal the Don't Ask, Don't Tell law. Congress passed just such a bill, which President Obama signed into law. Seven months later, President Obama, newly confirmed Secretary of Defense Leon Panetta, and Admiral Mullen formally certified under the new statute that the American military was ready to repeal the old policy.[15]

The decision to include female service members in combat roles likewise emerged from a careful, evidence-based process—this time, a congressionally mandated policy and legal review undertaken by the Secretary of Defense, in consultation with the Military Department Secretaries, of the policies and regulations that had officially barred women from serving in combat positions. The process involved an extensive review of the policies and laws governing the assignment of women in the Armed Forces, and the feasibility of opening to women military occupational specialties that were then closed to them. Following that review, the Department of Defense wrote a February 2012 report concluding that, given the "dynamics of the modern-day battlefield . . . there is no compelling reason" to preclude female service members from being assigned to . . . direct ground combat units," and declaring its intent to rescind the "co-location rule" that had prevented female Service members from being assigned to units that were doctrinally required to physically co-locate with direct ground combat units.[16]

Following nine months of additional study, the Joint Chiefs of Staff unanimously recommended to Secretary Panetta that he also do away with the remaining barriers to service for women. On January 24, 2013, Secretary Panetta announced that the Department would rescind

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[15] Jody Feder, *"Don't Ask, Don't Tell": A Legal Analysis,* CRS Rep. R40795, Aug. 6, 2013.
[16] U.S. Dep't of Def., *Report to Congress on the Review of Laws, Policies, and Regulations Restricting the Service of Female Members in the U.S. Armed Forces*, Feb. 2012; Fact Sheet: Women in Service Review (WISR) Implementation [hereinafter "Fact Sheet"].

the Direct Combat Exclusion Rule on women serving in previously restricted occupations.[17] He also called on each of the services to undertake their own separate "women in the service" reviews of how to move forward with the integration of women into previously closed positions, and identify any recommended exemptions for particular positions.[18] This process led to more than thirty additional studies over the next three years.[19] After the Secretaries of each of the services completed their reviews and submitted their final recommendations, Secretary of Defense Ashton Carter ordered the military to open all combat jobs to women who meet the validated occupational standards.[20]

Finally, the very opening of military service to transgender personnel that President Trump now is seeking summarily to reverse emerged from a rigorous, now-truncated policymaking process. In July 2015, Secretary Carter created a formal working group to explore the "policy and readiness implications of welcoming transgender persons to serve openly" in the military.[21] Over the following year, the working group engaged in what one senior member would describe as a "detailed, deliberative, [and] carefully run process."[22] Each military service was represented in the working group by a senior uniformed officer, a senior civilian official, and various staff members.[23] The working group created sub-groups to investigate specific

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[17] Kristy N. Kamarck, *Women in Combat: Issues for Congress*, Cong. Res. Serv. R42075, Dec. 13, 2016.
[18] U.S. Dep't of Def., *Statement from Pentagon Press Secretary Peter Cook on Secretary Carter's Approval of Women in Service Review Implementation Plans*, March 10, 2016.
[19] Fact Sheet, *supra* note 16.
[20] U.S. Sec'y of Def., *Remarks on the Women-in-Service Review*, Dec. 3, 2015; Kamarck, *supra* note 17.
[21] U.S. Dep't of Def., *Statement by Secretary of Defense Ash Carter on DOD Transgender Policy,* Release No: NR-272-15, July 13, 2015.
[22] Decl. of Raymond Edwin Mabus, Jr. in Support of Plaintiffs' Motion for Preliminary Injunction at 3, *Karnoski v. Trump*, No. 2:17-cv-1297 (W.D. Wash. 28 Aug. 2017).
[23] Decl. of Brad R. Carson in Support of Plaintiffs' Motion for Preliminary Injunction at 3, *Karnoski v. Trump*, No. 2:17-cv-1297 (W.D. Wash. 28 Aug. 2017).

issues, consulted with medical, personnel, and readiness experts, and spoke with health insurance companies and commanders of transgender service members. At the end of this process, the working group unanimously concluded that transgender individuals should be permitted to serve openly.[24]

Meanwhile, the Department had commissioned a parallel, independent study from the RAND Corporation. This study focused on seven broad research questions, among them the cost of providing medical coverage to transgender individuals, the readiness implications of the proposed policy, and any applicable lessons from the eighteen foreign militaries that already allowed open transgender service.[25] RAND laid out its findings in a 71-page report, which found that allowing transgender people to serve openly would place an "exceedingly small" burden on health care expenditures and have a "minimal impact" on readiness.[26] Based on the review carried out by these two independent and thorough processes, Secretary Carter announced the policy change in June 2016.

For more than a year after that change, transgender individuals currently in the military were able to serve openly alongside their fellow service members. The Department released a 71-page handbook specifying implementation strategies,[27] and issued guidelines for both in-service medical transition procedures and treatment of gender dysphoria.[28] But for President

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[24] *Id*. at 3, 7.
[25] RAND Corp., *Assessing the Implications of Allowing Transgender Personnel to Serve Openly* ix (2016).
[26] *Id*. at xi and 47.
[27] U.S. Dep't of Def., *Transgender Service in the U.S. Military: An Implementation Handbook* (2016).
[28] U.S. Dep't of Def., *Instr. 1300.28, In-Service Transition for Transgender Service Members* (Oct. 1, 2016); Mem. from Assistant Sec'y of Def. for Health Affairs to Assistant Sec'y of the Army et al., *Guidance for Treatment of Gender Dysphoria for Active and Reserve Component Service Members*, July 29, 2016.

Trump's abrupt about-face, this studied, measured, and incremental process would have concluded on January 1, 2018 with the accession of openly transgender individuals into the U.S. military.

Each of the above personnel decisions was the product of a rigorous policy review involving senior military officials and an evidence-based examination of the likely impact of the proposed change. The results were neither pre-cooked nor based on presumptions about the capabilities of the groups under study. In sharp contrast, on the morning of July 26, 2017, President Trump suddenly announced a ban on transgender persons serving in the military. In a series of three tweets, the President (speaking as @realDonaldTrump) declared,

> "The United States Government will not accept or allow . . . [t]ransgender individuals to serve in any capacity in the U.S. Military. Our military must be focused on decisive and overwhelming . . . victory and cannot be burdened with the tremendous medical costs and disruption that transgender [sic] in the military would entail. Thank you[.]"

No effort was made—nor evidence presented—to show that this pronouncement resulted from any analysis of the cost or disruption allegedly caused by allowing transgender individuals to serve openly in the military. According to reports, the Joint Chiefs of Staff were not consulted at all on the decision before the President issued the tweet.[29] Secretary of Defense James N. Mattis, who was on vacation at the time, was given only a single day's notice that the decision was coming.[30] The announcement came so abruptly that White House and Pentagon officials were unable to explain even the most basic details about how it would be carried out.[31]

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[29] Barbara Starr et al., *US Joint Chiefs blindsided by Trump's transgender ban*, CNN (July 27, 2017).
[30] Julie Hirschfeld Davis & Helene Cooper, *Trump Says Transgender People Will Not Be Allowed in the Military*, N.Y. Times (July 26, 2017).
[31] *Id.*

About four weeks later, on August 25, 2017, President Trump followed the tweets with a Presidential Memorandum entitled "Military Service by Transgender Individuals," directed to the Secretary of Defense and the Secretary of Homeland Security.[32] This Memorandum instructed the Secretaries to return to the earlier policy of discrimination against transgender service members (in section 1(b)), and to maintain the bar on accession of transgender individuals into the military and halt the use of all resources to fund new sex reassignment surgical procedures (in section 2). Again, this Memorandum pointed to no policy process that led to the decision, did not cite any consultations with any military officers, and did not identify a single piece of evidence to support its change in policy.

The Presidential Memorandum also instructed the Secretary of Defense, in consultation with the Secretary of Homeland Security, to "submit to me a plan for *implementing* both the general policy set forth in section 1(b) of this memorandum and the specific directives set forth in section 2 of this memorandum" by February 21, 2018.[33] On September 14, 2017, the Secretary of Defense wrote a memorandum to senior Pentagon officials explaining that he had received the Presidential Memorandum and would "present the President with a plan to *implement* the policy and directives in the Presidential Memorandum."[34] The Secretary nowhere suggested that he had any discretion or intention to promote reconsideration of the original policy decision made by presidential tweet.

In a separate memorandum issued the same day, the Secretary of Defense "direct[ed] the Deputy Secretary of Defense and the Vice Chairman of the Joint Chiefs of Staff to lead the

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[32] Presidential Mem., *supra* note 1.
[33] *Id.* § 3 (emphasis added). The Presidential Memorandum twice more referred to this undertaking as an "implementation plan." *Id.*
[34] Mem. from Sec'y of Def., *Military Service by Transgender Individuals – Interim Guidance*, Sept. 14, 2017.

Department of Defense (DOD) in developing an Implementation Plan on military service by transgender individuals, to effect the policy and directives in Presidential Memorandum, Military Service by Transgender Individuals, dated August 25, 2017."[35] The memorandum ordered the creation of a panel of civilian and uniformed military leaders and combat veterans, and instructed that their work would be "planned and executed to inform the Implementation Plan."[36] The memorandum went on to observe, with regard to accessions, that the "Presidential Memorandum directs DoD to maintain the policy currently in effect, which prohibits accession of transgender individuals into military service," and instruct that the role of the Panel would be not to consider the merits of this policy, but instead to recommend updates to the "guidelines to reflect currently accepted medical terminology."[37] In February 2018, the Secretary of Defense, with the agreement of the Secretary of Homeland Security, sent the President a memorandum adopting the results of the panel, and a 44-page report reflecting the panel's work.[38] The President adopted this implementation plan in a March 23, 2018 Presidential Memorandum.[39]

The President now seeks to shield this sequence of events from judicial scrutiny by invoking "the highly deferential review" that the Constitution has historically afforded national security and military judgments.[40] He claims that such deference is appropriate here because the lawsuit is challenging "independent military judgment."[41] In fact, the Supreme Court has only

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[35] Mem. from Sec'y of Def., *Terms of Reference – Implementation of Presidential Memorandum on Military Service by Transgender Individuals*, Sept. 14, 2017.
[36] *Id.*
[37] *Id.*
[38] Mem. from Sec'y of Def., Mem. for the President, *Military Service by Transgender Individuals*, Feb. 22, 2018.
[39] Mem. for Sec'y of Def. & Sec'y of Homeland Sec., *Military Service by Transgender Individuals*, March 23, 2018.
[40] Defs.' Mem. at 3.
[41] *Id.*

given "great deference to the *professional judgment of military authorities* concerning the relative importance of a particular military interest," *Winter*, 555 U.S. at 7 (emphasis added) (citations omitted), and the "*considered professional judgment*" of "appropriate military officials," *Weinberger*, 475 U.S. at 508-09 (emphasis added). Here, the President issued the order to ban transgender individuals from the military entirely on his own, without even seeking the judgment of his senior military officials, then looked to those officials only to "implement" his decision. The President cannot bypass the judgment of his military advisers, and then invoke deference expressly based on that judgment.

A review of earlier cases illustrates the sort of judgment that courts look for before affording special deference to the coordinate branches on issues of military personnel policy-making. For example, in *Rostker v. Goldman*, 453 U.S. 57 (1981), the Supreme Court upheld the constitutionality of provisions that authorized the President to require men, but not women, to register for the draft. The Court deferred to "Congress' evaluation of th[e] evidence," noting that "[t]his case is quite different from several of the gender-based discrimination cases we have considered in that . . . Congress did not act 'unthinkingly' or 'reflexively and not for any considered reason.'" *Id.* at 72, 83 (quoting Br. for Appellees) (emphasis omitted). The Court pointed to the fact that the issue was "extensively considered by Congress in hearings, floor debate, and in committee" before a decision was reached. *Id.* at 72; *see also, e.g.*, *id.* at 63, 79.

By contrast, the U.S. District Court for the District of Columbia found unconstitutional a statutory provision barring the assignment of female personnel to duty on Navy vessels other than hospital ships and transports. *Owens v. Brown*, 455 F. Supp. 291 (D.D.C. 1978). The court acknowledged that "a high degree of deference is owed to the political branches of government in the area of military affairs," in part because "oversight of military operations typically

involves complex, subtle, and professional judgments that are best left to those steeped in the pertinent learning." *Id.* at 299 (quotations and citations omitted). But the court noted that the language in that case had been "added casually, over the military's objections and without significant deliberation," and the court found compelling "the results of the experiment conducted by the Navy on the USS Sanctuary . . . that assigning women to noncombat duty on vessels will pose no insurmountable obstacles." *Id.* at 305, 309.

The Fourth Circuit itself has afforded deference to a military personnel decision where it has reflected a considered policy making process, and withheld deference where it has not. In *Thomasson v. Perry*, the court premised its decision upholding the constitutionality of the Don't Ask, Don't Tell policy on a lengthy discussion of the policy deliberations that took place before the enactment of the directive. 80 F.3d 915, 921-23 (4th Cir. 1996). Emphasizing that the directive emerged from an "exhaustive review" and "extensive deliberation" by the executive branch and Congress, the court only then went on to defer to what it described as the "considered judgment" of those coordinate branches of government. *Id.* at 922-27.

In *Int'l Refugee Assistance Project ("IRAP") v. Trump*, by contrast, the Fourth Circuit sitting en banc held that a challenge to President Trump's Proclamation restricting the entry of individuals from predominantly Muslim-majority countries was likely succeed on its merits, over the President's attempt to invoke deference on national security grounds. 883 F.3d 233 (4th Cir. 2018) (en banc). The court underscored at the outset of its opinion that the "President's national security officials were taken by surprise" by the initial executive order in the case, and that the executive order "did not undergo the usual deliberative process." *Id.* at 250 (citations omitted).[42]

[42] *See also Int'l Refugee Assistance Project v. Trump*, 857 F.3d 554, 592 (4th Cir. 2017), *vacated as moot sub nom.*, *Trump v. Int'l Refugee Assistance Project*, __ S.Ct. __, 2017 WL 4518553 (relying, in an earlier iteration of the same case, on "the exclusion of national security agencies

President Trump's tweets and August 2017 Memorandum ordering a ban on transgender individuals in the military show no signs of the considered judgment that traditionally has given rise to deference in the military sphere. These initial orders were not driven by the "professional judgment" of "appropriate military officials," as there is no indication that military officials were involved in the tweets and Memorandum at all. *Weinberger*, 475 U.S. at 508-09. Nor did these actions also result from an "exhaustive review", as in fact there was no review to speak of. *Thomasson*, 80 F.3d at 927. The President's actions here far more closely resemble those cases where the decision was made "casually," *Owens,* 455 F. Supp. at 305, or "reflexively and not for any considered reason," *Rostker*, 453 U.S. at 72, or where it "did not undergo the usual deliberative process." *IRAP*, 857 F.3d at 596.

It is no answer for Defendants to suggest that the recent Pentagon review belatedly introduced military judgment into the process. As the President plainly directed – and as the Secretary of Defense acknowledged – this review was meant only to "implement[]" the President's order in his August 2017 Memorandum.[43] The military's role here was only to follow orders, not to revisit the initial presidential judgment. Predictably, the policy that resulted – a sequence of rules that collectively bar transgender individuals from serving consistent with their gender identity – achieves precisely what the President's tweets and August 2017 Memorandum commanded.

Even if the Department of Defense and Homeland Security review did not merely implement existing orders, process after-the-fact process still would not cure the illegality of the

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from the decision-making process" to conclude that the Order's "stated national security interest was provided in bad faith, as a pretext for its religious purpose.").

[43] *See supra* at pages 14-16; *see also Stone v. Trump*, 280 F.Supp.3d 747, 763 (D.Md. 2017) (holding that the President's instruction in the Memorandum to complete an implementation plan was "not a request for a study but an order to implement the Directives contained therein").

President's tweets and Memorandum. The law is clear that an initial order that is tainted by an unconstitutional purpose cannot be cured by a later review that preserves the essence of the original. *See McCreary County* v. *ACLU of Kentucky,* 545 U.S. 844, 866 (2005) (holding that sectarian purpose had persisted in later iterations of a public display; the suggestion that "purpose in a case like this one should be inferred . . . only from the latest news about the last in a series of governmental actions . . . just bucks common sense"); *United States* v. *Fordice*, 505 U.S. 717, 730 (1992) (invalidating Mississippi's re-classification of its state colleges and universities because "[i]f policies traceable to the *de jure* system are still in force and have discriminatory effects, those policies too must be reformed to the extent practicable"); *IRAP*, 883 F.3d at 268 (rejecting argument that a later-in-time "months-long multi-agency review" cured the impermissible purpose reflected in an initial executive order) (quotations omitted).

Here, the process that led to the decision was not just deficient, but sharply departed from precedent. The Supreme Court has emphasized that "[d]epartures from the normal procedural sequence . . . might afford evidence that improper purposes are playing a role" in government action. *Vill. of Arlington Heights v. Metro. Hous. Dev. Corp.*, 429 U.S. 252, 267 (1977). The President's failure to consult military experts in his initial tweet and August 2017 Presidential Memorandum, his failure to ground his decision in any evidence or facts, and his failure to undertake any considered review apart from implementing a major personnel decision he had already made, represents such a dramatic break from precedent that it can only call the true basis for that decision into question.

II. The President's actions will harm the national security and foreign policy interests of the United States.

The implementation plan imposes three principal restrictions on transgender individuals. First, transgender individuals who "require or have undergone gender transition" are disqualified

from military service. Second, transgender individuals with a "history or diagnosis of gender dysphoria are disqualified from military service" except "under limited circumstances." Third, all other transgender individuals are permitted to serve only "in their biological sex."[44] Together, these rules effectively bar transgender individuals from serving consistent with their gender identity. This exclusion of transgender individuals based on group characteristics rather than individual fitness will gravely harm the effectiveness of our military and the national security and foreign policy interests of the United States.

On its face, this policy harms military readiness by categorically excluding individuals on the basis of their gender identity, rather than their fitness to serve. The U.S. military has in place objective physical and psychological standards tied to individual performance and competency that all members must meet. There is every indication that these standards can effectively screen transgender individuals who are unable to serve without the need for a categorical ban. By the Department of Defense review's own admission, under the Open Policy, particular transgender individuals were disqualified on the basis of these standards, for reasons such as depression, just as other service members were.[45] President Trump has proposed expanding the number of active duty Army and Marine Corps service members by almost 70,000 personnel—but to accomplish such an ambitious goal without degrading the effectiveness of our troops, the U.S. military will need to recruit all qualified individuals, not exclude entire groups from military service based on sweeping generalizations and prejudice, without regard for individuals' capacity to serve.[46]

Next, these prohibitions will negatively affect unit cohesion. The policy forces transgender service members to live a lie, authorizes discriminatory behavior among fellow

[44] Mem. from Sec'y of Def., *supra* note 38.
[45] Report and Recommendations, *supra* note 3, at 7.
[46] K.K. Rebecca Lai et al., *Is America's Military Big Enough?*, N.Y. Times, Mar. 22, 2017.

service members, and places troops in the unconscionable position of having "to choose between reporting their comrades or disobeying policy."[47] The policy turns in part on the presence of a history or diagnosis of gender dysphoria – that is, "distress or impairment of functioning in meeting the standards associated with their biological sex."[48] In the same way as the Don't Ask, Don't Tell policy encouraged service members to hide their LGBT status, the new policy encourages transgender troops to hide any distress they may experience from their gender identity and discourages them from seeking access to counseling and other mental health services. Transgender service members have long been allowed to serve openly in the militaries of such close United States allies as Israel and the United Kingdom without any evidence of harm to unit cohesion, and these transgender service members have already served alongside U.S. troops in NATO units without any demonstrated adverse effect on unit cohesion. Notably, a number of current, high-ranking military leaders have confirmed publicly in congressional testimony in the last two weeks that they see no evidence that transgender troops serving openly have presented a problem for unit cohesion or military readiness.[49]

Finally, such a transparently discriminatory set of restrictions will send a troubling signal to those abroad, showing both allies and adversaries that the United States military is willing to distort its justly admired personnel polices to serve prejudice and political expediency. The President's tweets and Memorandum convey to the world that able and patriotic Americans, eager and qualified to serve their country's military, can nevertheless be denied equal rights and opportunity based on illusory arguments. That message undermines our government's efforts to

[47] Palm Center, *Fifty-Six Retired Generals and Admirals Warn That President Trump's Anti-Transgender Tweets, If Implemented, Would Degrade Military Readiness* 1 (Aug. 1, 2017).
[48] Report and Recommendations, *supra* note 3, at 32.
[49] *See* Richard Sisk, *Top Military Brass at Odds with Mattis on Transgender Issues*, Military Times (Apr. 20, 2018).

advance human rights and principles of non-discrimination and equality throughout the world, as a longstanding central tenet of our foreign policy, and a critical means of promoting peace and security and avoiding humanitarian crises around the globe.

As public servants, amici took as an article of faith that our government will only judge individuals based on the content of their character, not on group characteristics unrelated to their ability to do their jobs. To abandon that principle based on a transparently discriminatory façade is unworthy of the deference that the Constitution and the courts have historically afforded to genuine national security and military judgment.

CONCLUSION

For the foregoing reasons, Defendants' motion to dissolve the preliminary injunction should be denied.

Dated April 30, 2018

Respectfully submitted,

_____/s/_____

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APPENDIX

LIST OF AMICI

1. Brigadier General Ricardo Aponte, USAF (Ret.)

2. Vice Admiral Donald Arthur, USN (Ret.)

3. Michael R. Carpenter served as Deputy Assistant Secretary of Defense for Russia, Ukraine, Eurasia from 2015 to 2017.

4. Brigadier General Stephen A. Cheney, USMC (Ret.)

5. Derek Chollet served as Assistant Secretary of Defense for International Security Affairs from 2012 to 2015.

6. Rudy DeLeon served as Deputy Secretary of Defense from 2000 to 2001. Previously, he served as Under Secretary of Defense for Personnel and Readiness from 1997 to 2000.

7. Rear Admiral Jay A. DeLoach, USN (Ret.)

8. Major General (Ret.) Paul D. Eaton, USA

9. Brigadier General (Ret.) Evelyn "Pat" Foote, USA

10. Vice Admiral Kevin P. Green, USN (Ret.)

11. General Michael Hayden, USAF (Ret.), served as Director of the Central Intelligence Agency from 2006 to 2009, and Director of the National Security Agency from 1995 to 2005.

12. Chuck Hagel served as Secretary of Defense from 2013 to 2015. From 1997 to 2009, he served as U.S. Senator for Nebraska.

13. Kathleen Hicks served as Principal Deputy Under Secretary of Policy from 2012 to 2013.

14. Brigadier General (Ret.) David R. Irvine, USA

15. Lieutenant General Arlen D. Jameson (USAF) (Ret.), served as the Deputy Commander of U.S. Strategic Command.

16. Brigadier General (Ret.) John H. Johns, USA

17. Colin H. Kahl served as Deputy Assistant to the President and National Security Advisor to the Vice President. Previously, he served as Deputy Assistant Secretary of Defense for the Middle East from 2009 to 2011.

18. Lieutenant General (Ret.) Claudia Kennedy, USA

19. Major General (Ret.) Dennis Laich, USA

20. Major General (Ret.) Randy Manner, USA

21. Brigadier General (Ret.) Carlos E. Martinez, USAF (Ret.)

22. General (Ret.) Stanley A. McChrystal, USA, served as Commander of Joint Special Operations Command from 2003 to 2008, and Commander of the International Security Assistance Force and Commander, U.S. Forces Afghanistan from 2009 to 2010.

23. Kelly E. Magsamen served as Principal Deputy Assistant Secretary of Defense for Asian and Pacific Security Affairs from 2014 to 2017.

24. Leon E. Panetta served as Secretary of Defense from 2011 to 2013. From 2009 to 2011, he served as Director of the Central Intelligence Agency.

25. Major General (Ret.) Gale S. Pollock, CRNA, FACHE, FAAN.

26. Rear Admiral Harold Robinson, USN (Ret.)

27. Brigadier General (Ret.) John M. Schuster, USA

28. Rear Admiral Michael E. Smith, USN (Ret.)

29. Brigadier General (Ret.) Paul Gregory Smith, USA

30. Julianne Smith served as Deputy National Security Advisor to the Vice President of the United States from 2012 to 2013. Previously, she served as the Principal Director for European and NATO Policy in the Office of the Secretary of Defense in the Pentagon.

31. Admiral James Stavridis, USN (Ret.), served as the 16th Supreme Allied Commander at NATO.

32. Brigadier General (Ret.) Marianne Watson, USA

33. William Wechsler served as Deputy Assistant Secretary for Special Operations and Combating Terrorism at the U.S. Department of Defense from 2012 to 2015.

34. Christine E. Wormuth served as Under Secretary of Defense for Policy from 2014 to 2016.

CERTIFICATE OF SERVICE

I, Phillip Spector, hereby certify that on April 30, 2018, the foregoing document was filed and served through the CM/ECF system.

Respectfully Submitted,

/s/

Phillip Spector (Bar No. 20147)
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Exhibit 11

All Things G-1

Update to VCSA

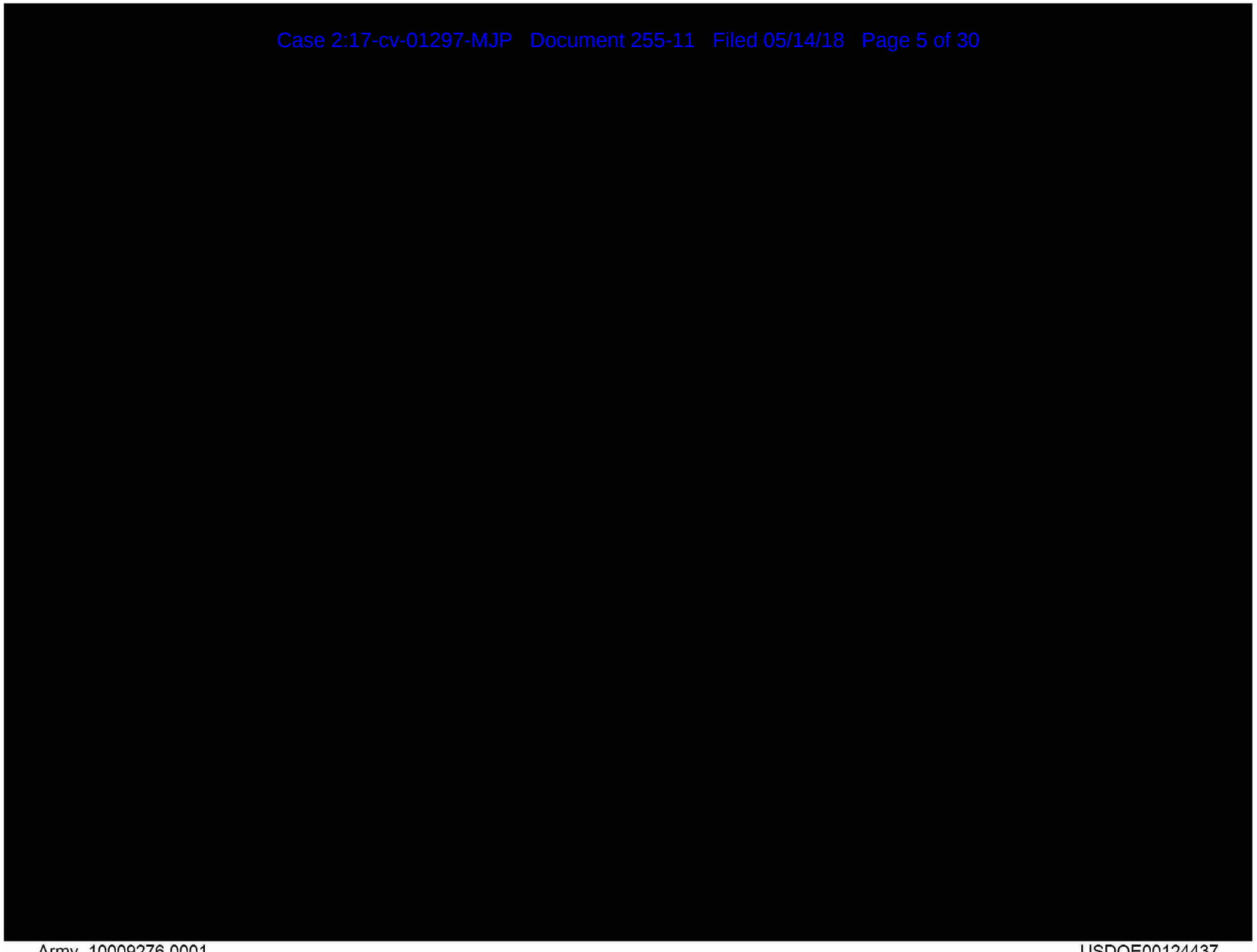
23 August 2017

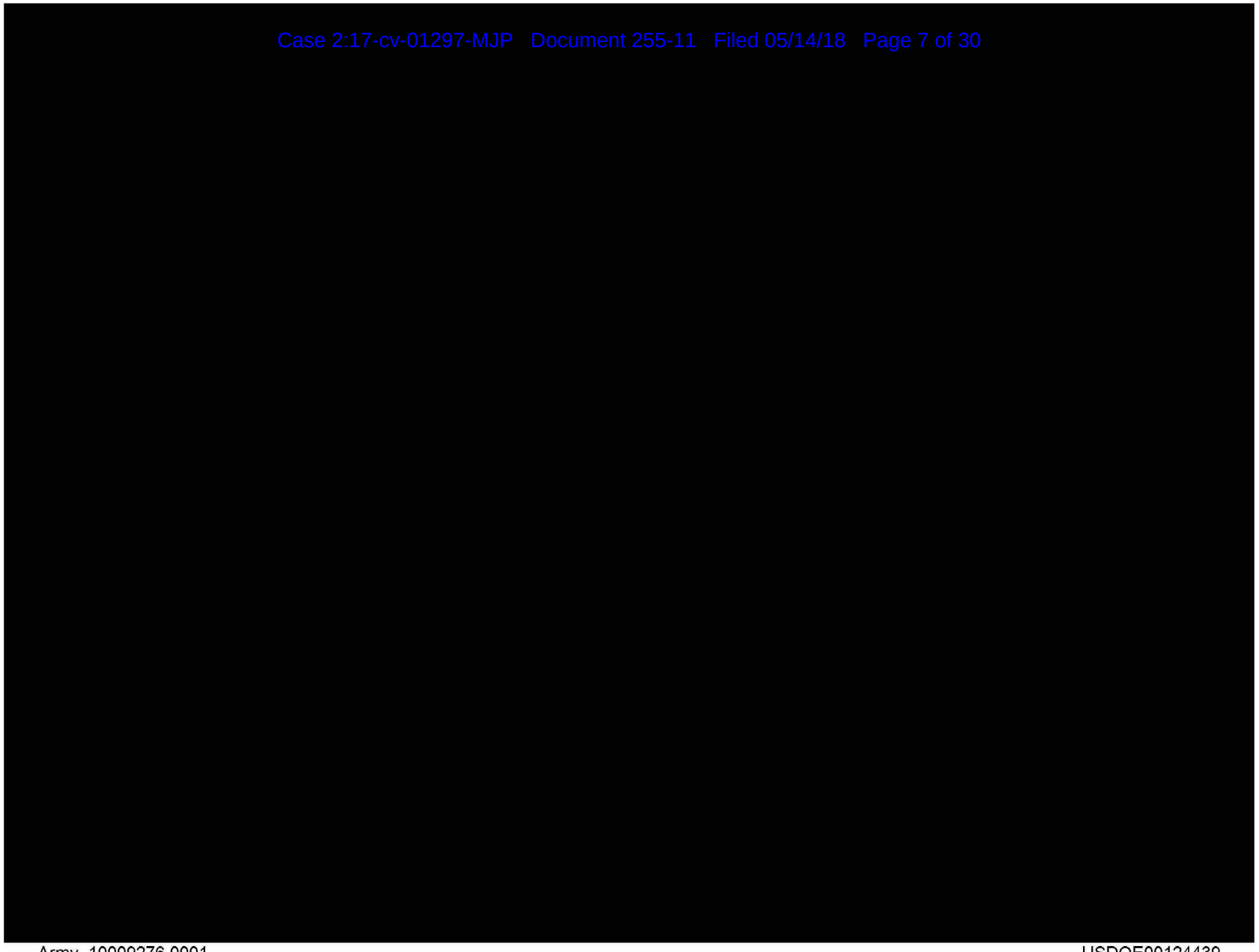
Agenda

- DMPM (Briefers: BG Calloway/COL Turner)
  - **Update:** Increase Total Army Endstrength
  - **Information:** Military Accessions Vital to the National Interest (MAVNI)
  - **Information:** Transgender (TG) Personnel
- TBAI (Briefer: COL Johnson)
  - **Update:** IPPS-A
- ARD (Briefer: Mr. Lane)
  - **Update:** Commander's Risk Reduction Dashboard
- PR (Briefer: Mr. Lock)
  - **Update:** Blended Retirement – How do we Educate 100% of the Force?
- HSI Exposition
  - **Information:** Invitation to attend

DMPM Topics - Agenda

- Increase Total Army End Strength (IES) – FY17 Status & FY18 Planning
- Military Accessions Vital to the National Interest (MAVNI) – Current Status
- Transgender Personnel (TG) – Policy Status & Attrition





Transgender Personnel

Policy & Attrition Status

Transgender Personnel – as of 7 August 2017

- **Total Personnel (108):** 77 RA, 13 USAR, & 18 ARNG
- **Enlisted (88):** 91% attrite by end of FY21 (80 of 88)
- **Officer/WO (20):** no clear end dates; separations occur due to promotion non-selection, attrition, elimination, and retirement

•108 Total Transgender Personnel:

	Trans-Female	Trans-Male	Total	COMPO		
				RA	AR	NG
OFF	9	8	17	12	2	3
WO	1	2	3	2	0	1
ENL	44	44	88	63	11	14
TOT	**54**	**54**	**108**	**77**	**13**	**18**

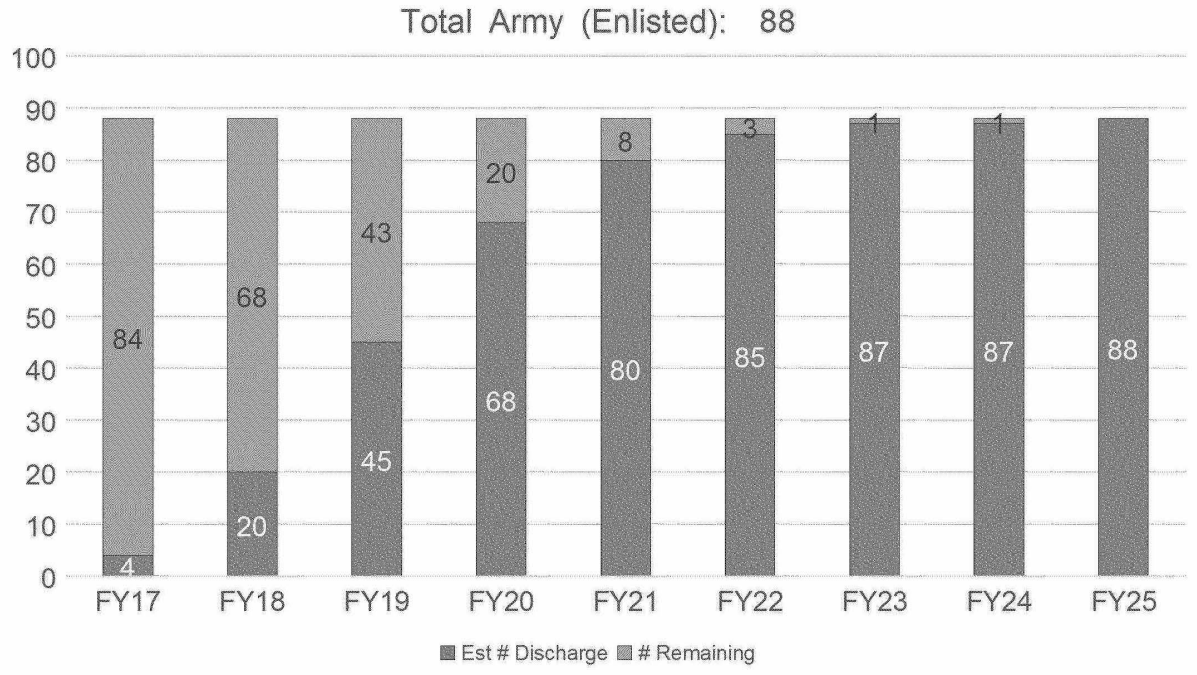
•50 with Gender Marker Changes:

	Trans-Female	Trans-Male	Total	COMPO		
				RA	AR	NG
OFF	5	4	9	5	1	3
WO	1	2	3	2	0	1
ENL	25	13	38	23	6	9
TOT	**31**	**19**	**50**	**30**	**7**	**13**

•58 pending Gender Marker Changes:

	Trans-Female	Trans-Male	Total	COMPO		
				RA	AR	NG
OFF	4	4	8	7	1	0
WO	0	0	0	0	0	0
ENL	19	31	50	40	5	5
TOT	**23**	**35**	**58**	**47**	**6**	**5**

Transgender Attrition - Status Each FY – Total Army ENL: 88



Reenlistment Category	AC	AR	NG	Total	%
Initial Term	30	5	2	37	42%
Mid Career	18	5	6	29	33%
Careerist	15	1	6	22	25%
Total	63	11	14	88	100%

- 88 Transgender RA Enlisted Soldiers
- 45 in Reenlistment window thru FY19
- Majority (80 of 88) attrite by end of FY21

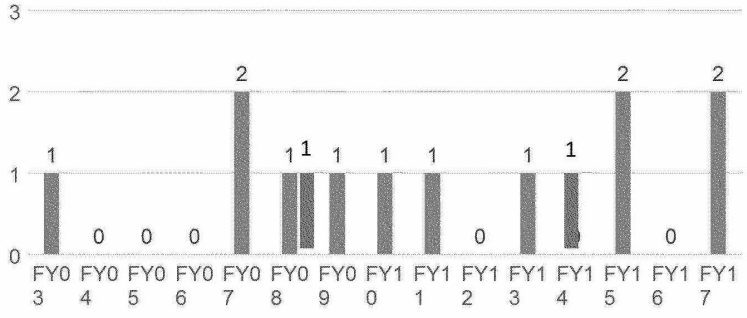
Transgender Officers / Warrant Officers (WO): 20

- **Failure to advance and natural attrition are the primary force shaping tools**
- **Officers may be eliminated for:**
  - **Substandard duty performance or derogatory information**
  - **Misconduct, moral/professional dereliction, interests of national security**
- **Probationary Officers may be separated without a Board of Inquiry**

RA	Trans-Female	Trans-Male	Total	Probationary?	
				Yes	No
OFF	5	7	12	4	8
WO	1	1	2	1	1
TOT	6	8	14	5	9

RC	Trans-Female	Trans-Male	Total	Probationary?	
				Yes	No
OFF	3	2	5	2	3
WO	0	1	1	0	1
TOT	3	3	6	2	4

RA Officer (12) & WO (2) Year Groups: 14



Officer (5) and WO (1) MRDs: 6

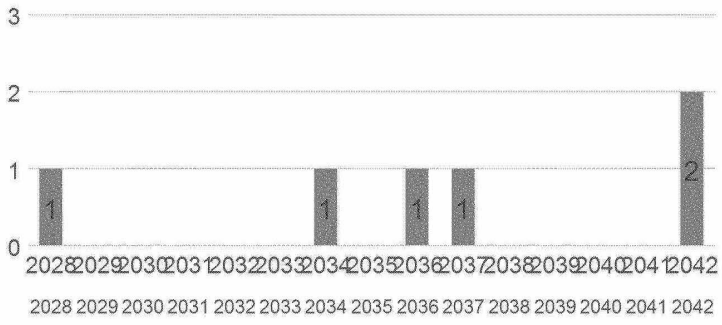


Exhibit 12

Thomas P. Dee
SES
703-819-1314
December 14, 2017

MEMORANDUM FOR THE RECORD

Subj: Dissenting Opinion from the Majority Recommendations of the "Military Service by Transgender Individuals - Panel of Experts"

This memorandum records my dissent from the majority opinion of the DoD "Military Service by Transgender Individuals - Panel of Experts" which has recommended the following policy be adopted concerning the military service of transgender individuals:

Redacted

Redacted The recommendations are

Redacted

Redacted are not supported by the data provided to the panel in terms of military effectiveness, lethality, or budget constraints, and are likely not consistent with applicable law.

Recommendation 1.

Redacted

During the course of our panel, neither the transgender service members, the military doctors, nor the civilian doctors suggested that a person serving outside of their birth

gender would necessarily be unable to meet medical or physical standards, nor did any of our briefers suggest that those standards should be loosened or waived to allow transgender service. Redacted

Redacted

DODI 6130.03 governs the physical standards for the appointment, enlistment, or induction of Service personnel. Those standards should apply to everyone regardless of gender identity. The instruction states that individuals under consideration for appointment, enlistment, or induction into the Military Services should be:

1. Free of contagious diseases that probably will endanger the health of other personnel.
2. Free of medical conditions or physical defects that may require excessive time lost from duty for necessary treatment or hospitalization, or probably will result in separation from the Service for medical unfitness.
3. Medically capable of satisfactorily completing required training.
4. Medically adaptable to the military environment without the necessity of geographical area limitations.
5. Medically capable of performing duties without aggravation of existing physical defects or medical conditions.

Enclosure (4) of that instruction provides the specific medical conditions that are disqualifying for service. Redacted The instruction makes no mention of transgenderism or gender dysphoria, but enclosure (4) paragraph 29.r. states that a "current or history of psychosexual conditions including but not limited to transsexualism… tranvestism… and other paraphilias" is disqualifying. The language in that section is no longer consistent with current medical guidelines, the DSM V, which distinguishes gender dysphoria (identity disorder) from psychosexual conditions and paraphilia's (sexual attraction or behaviorial disorder). Redacted

Redacted

Redacted Of note, the FAA allows persons with a history of gender dysphoria to serve as commercial pilots or air traffic controllers after a stability period of five years.

DODI 1304.26, "Qualification Standards for Enlistment, Appointment, and Induction", states that waivers for otherwise disqualifying current or past medical conditions may be considered based on a "whole person" review of the applicant. Redacted

Redacted

Redacted

y

Redacted No data was presented during the course of the panel to conclude that such separate accommodation would be required Redacted As the total cost of all medical treatment of the entire DoD transgender population over the past few years is $3.3M (exclusive of unit incurred costs) i Redacted

Redacted

Recommendation 2.

Redacted

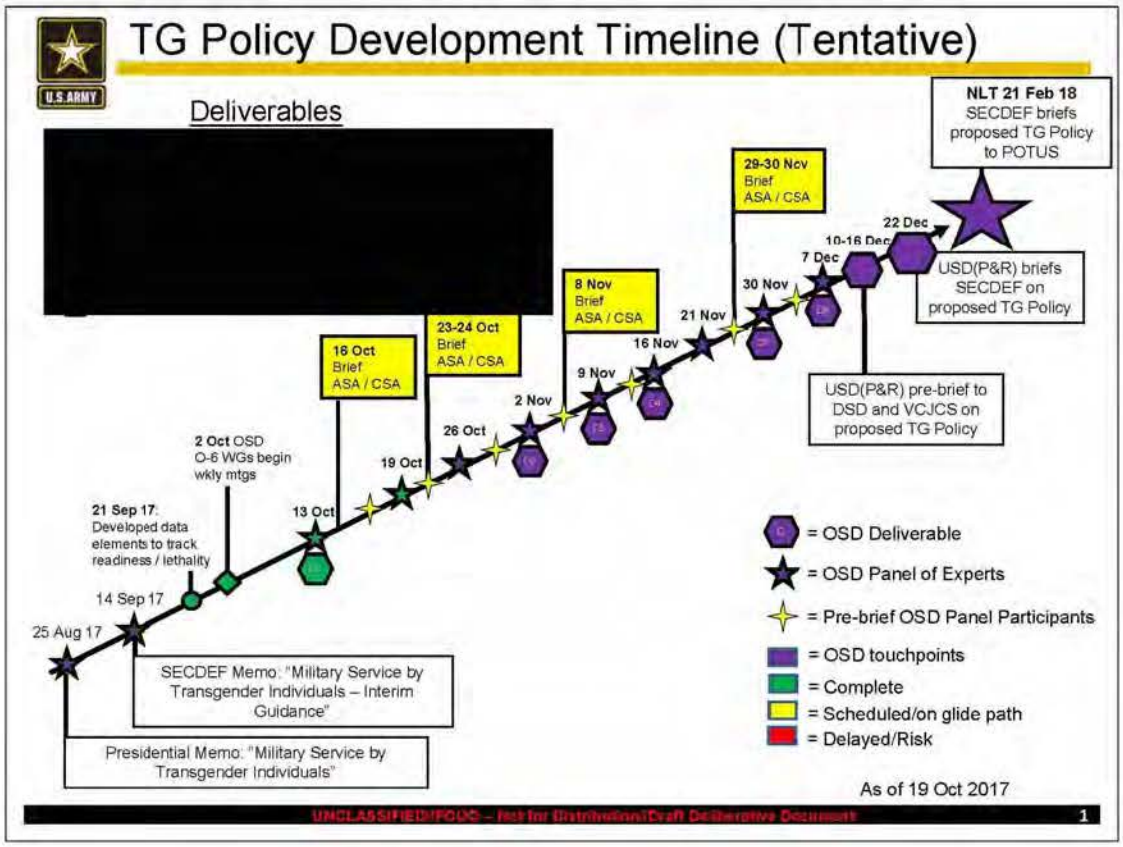
Redacted

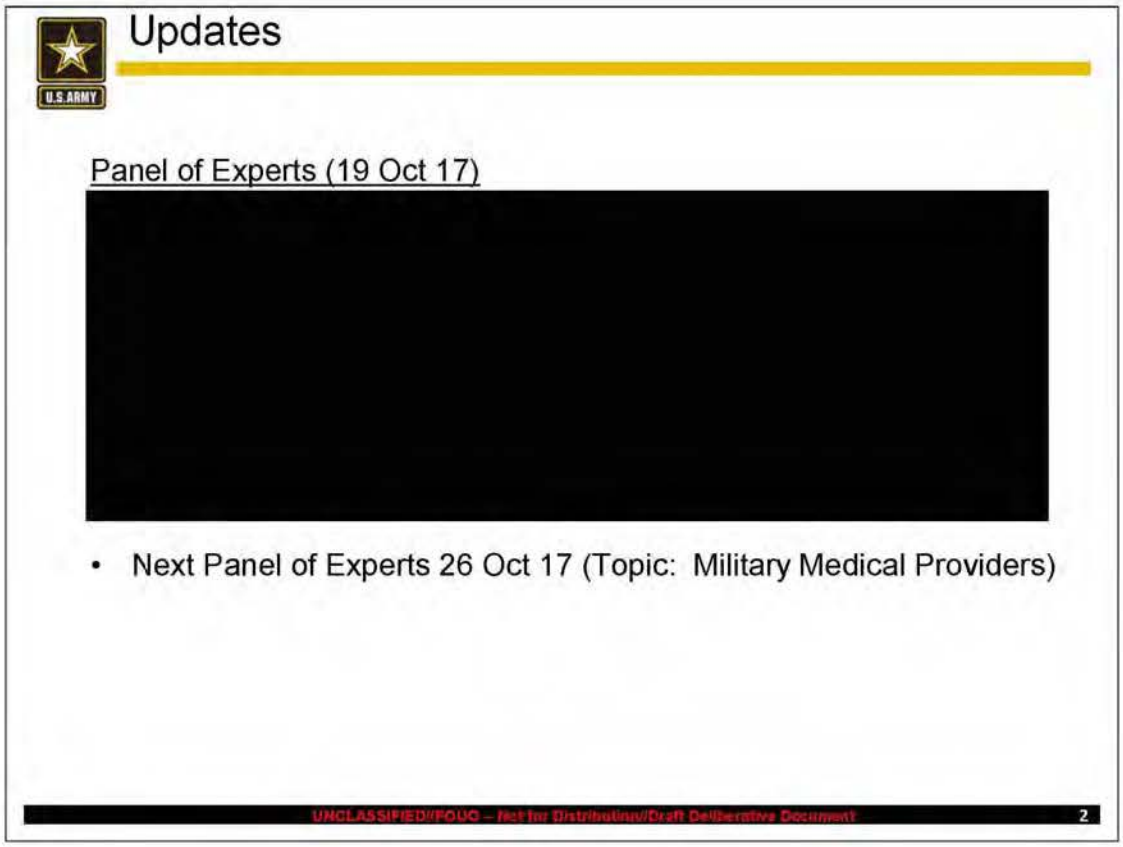
Recommendation.

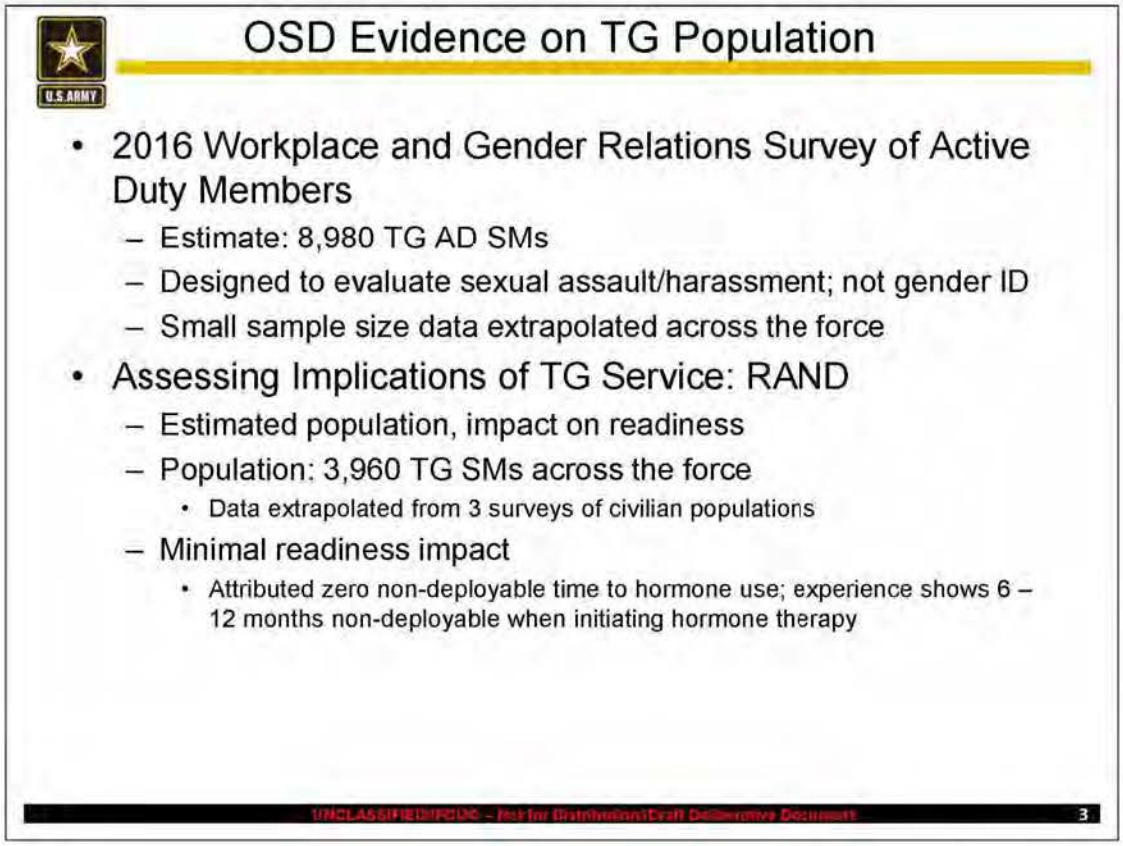
Redacted

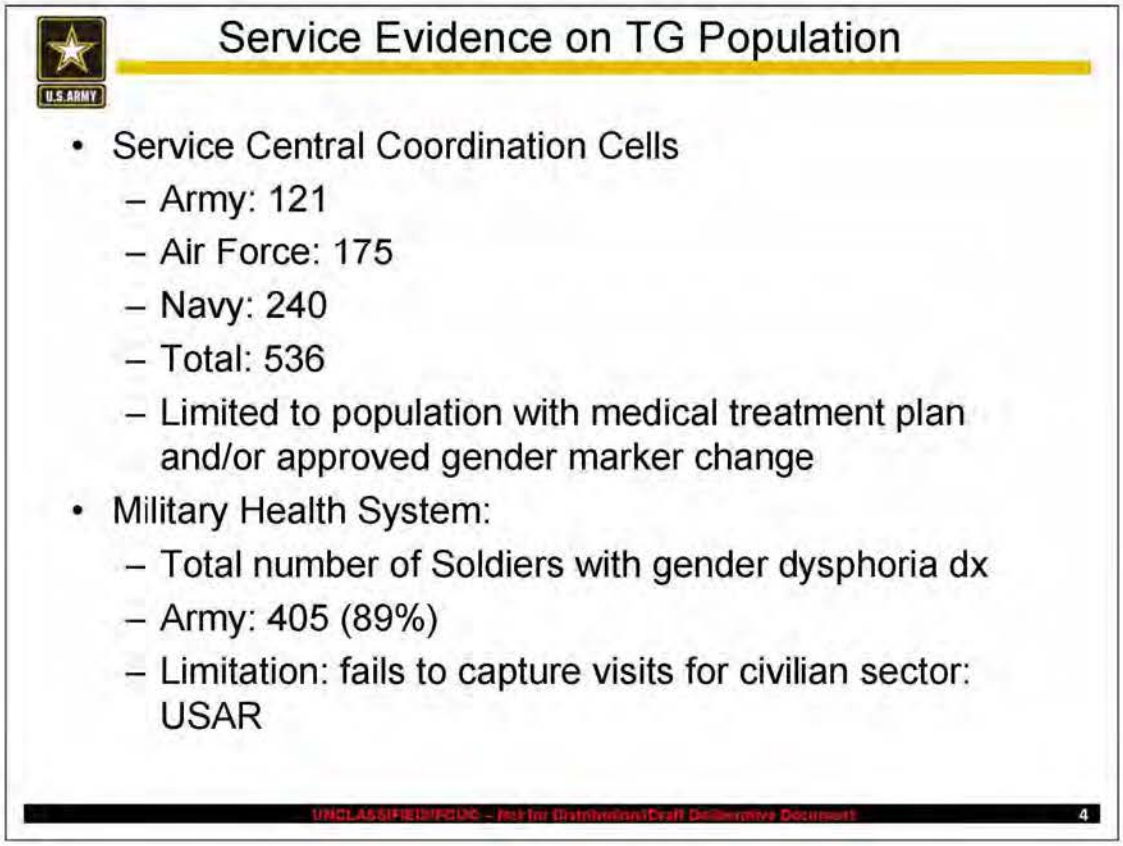
//S//
Thomas P. Dee

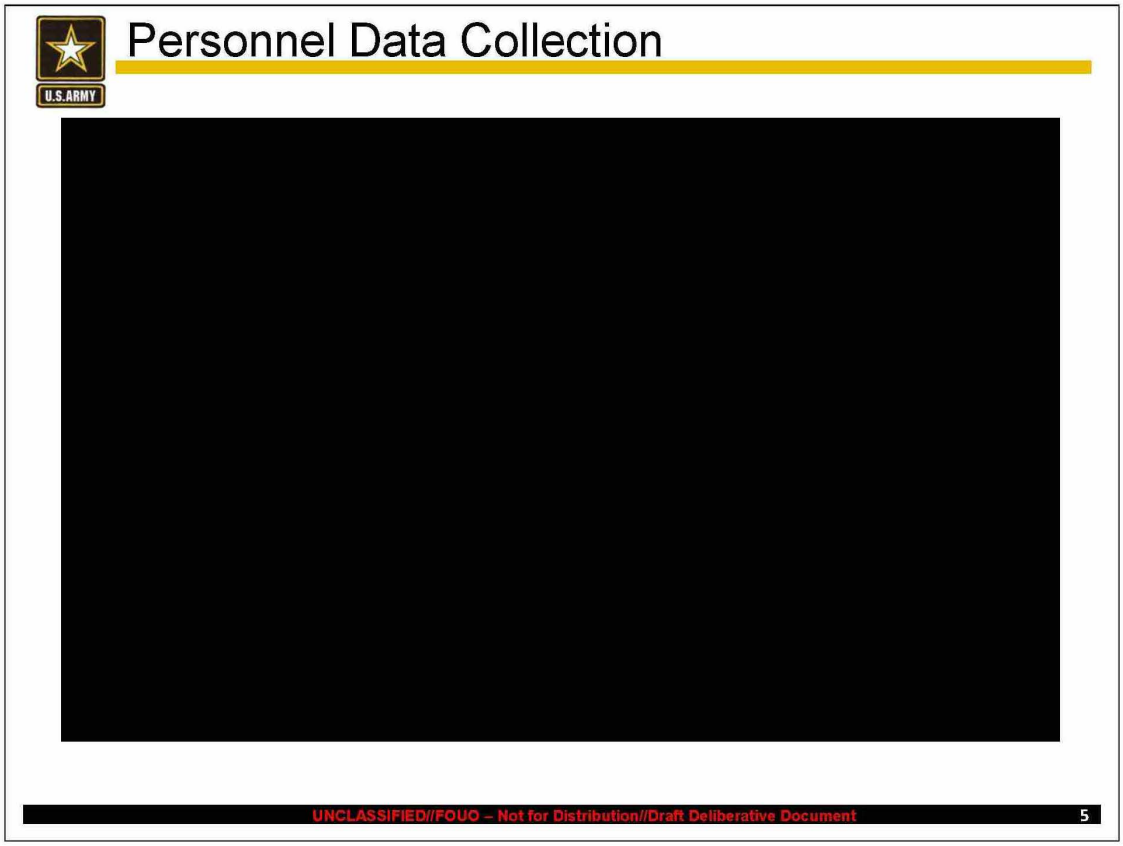
Exhibit 13


TG Policy Development Timeline (Tentative)
U.S.ARMY
Deliverables
[redacted]
NLT 21 Feb 18
SECDEF briefs proposed TG Policy to POTUS
29-30 Nov
Brief
ASA / CSA
22 Dec
10-16 Dec
7 Dec
30 Nov
21 Nov
16 Nov
9 Nov
8 Nov
Brief
ASA / CSA
2 Nov
26 Oct
23-24 Oct
Brief
ASA / CSA
19 Oct
16 Oct
Brief
ASA / CSA
13 Oct
2 Oct OSD
O-6 WGs begin
wkly mtgs
21 Sep 17:
Developed data
elements to track
readiness / lethality
14 Sep 17
25 Aug 17
USD(P&R) briefs SECDEF on proposed TG Policy
USD(P&R) pre-brief to DSD and VCJCS on proposed TG Policy
= OSD Deliverable
= OSD Panel of Experts
= Pre-brief OSD Panel Participants
= OSD touchpoints
= Complete
= Scheduled/on glide path
= Delayed/Risk
SECDEF Memo: "Military Service by Transgender Individuals – Interim Guidance"
Presidential Memo: "Military Service by Transgender Individuals"
As of 19 Oct 2017
UNCLASSIFIED//FOUO – Not for Distribution/Draft Deliberative Document
1


Updates
Panel of Experts (19 Oct 17)
[redacted]
• Next Panel of Experts 26 Oct 17 (Topic: Military Medical Providers)
UNCLASSIFIED//FOUO – Not for Distribution//Draft Deliberative Document
2


OSD Evidence on TG Population
• 2016 Workplace and Gender Relations Survey of Active Duty Members
– Estimate: 8,980 TG AD SMs
– Designed to evaluate sexual assault/harassment; not gender ID
– Small sample size data extrapolated across the force
• Assessing Implications of TG Service: RAND
– Estimated population, impact on readiness
– Population: 3,960 TG SMs across the force
• Data extrapolated from 3 surveys of civilian populations
– Minimal readiness impact
• Attributed zero non-deployable time to hormone use; experience shows 6 – 12 months non-deployable when initiating hormone therapy
3


Service Evidence on TG Population
U.S.ARMY
• Service Central Coordination Cells
– Army: 121
– Air Force: 175
– Navy: 240
– Total: 536
– Limited to population with medical treatment plan and/or approved gender marker change
• Military Health System:
– Total number of Soldiers with gender dysphoria dx
– Army: 405 (89%)
– Limitation: fails to capture visits for civilian sector: USAR
4


Personnel Data Collection
U.S.ARMY
[redacted]
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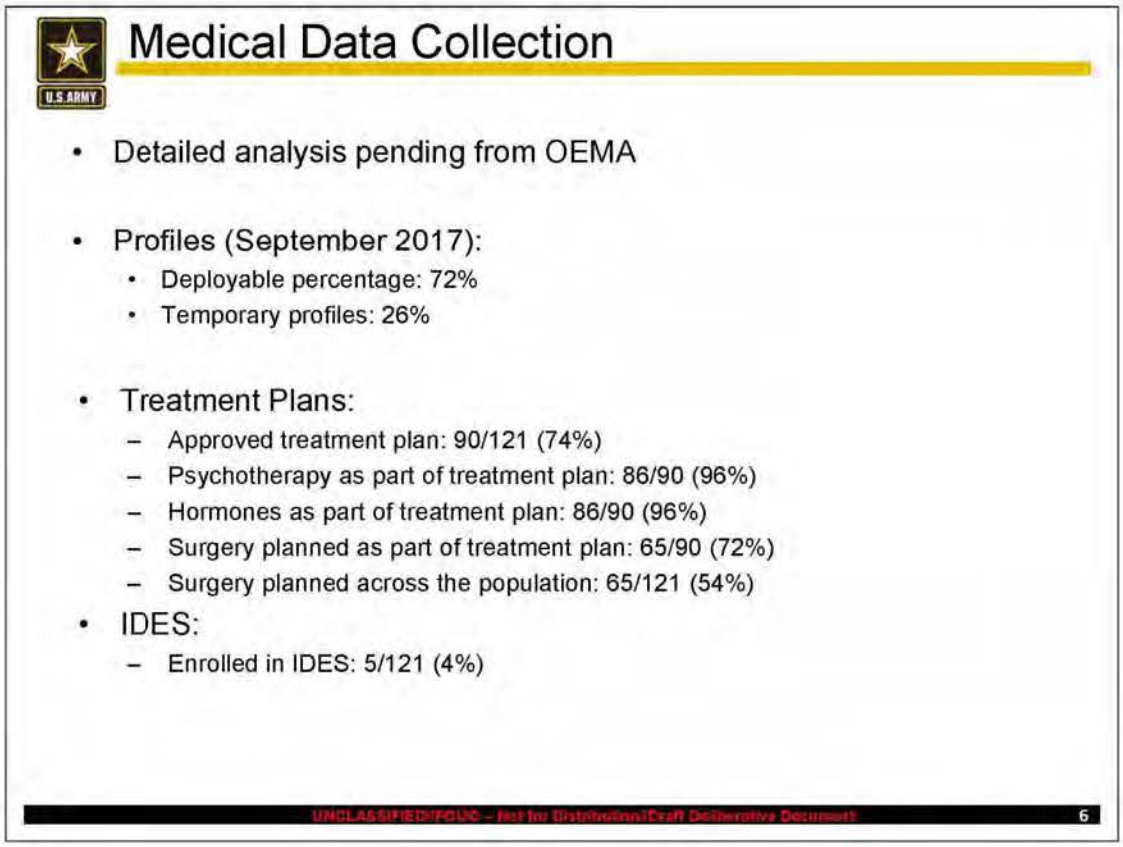
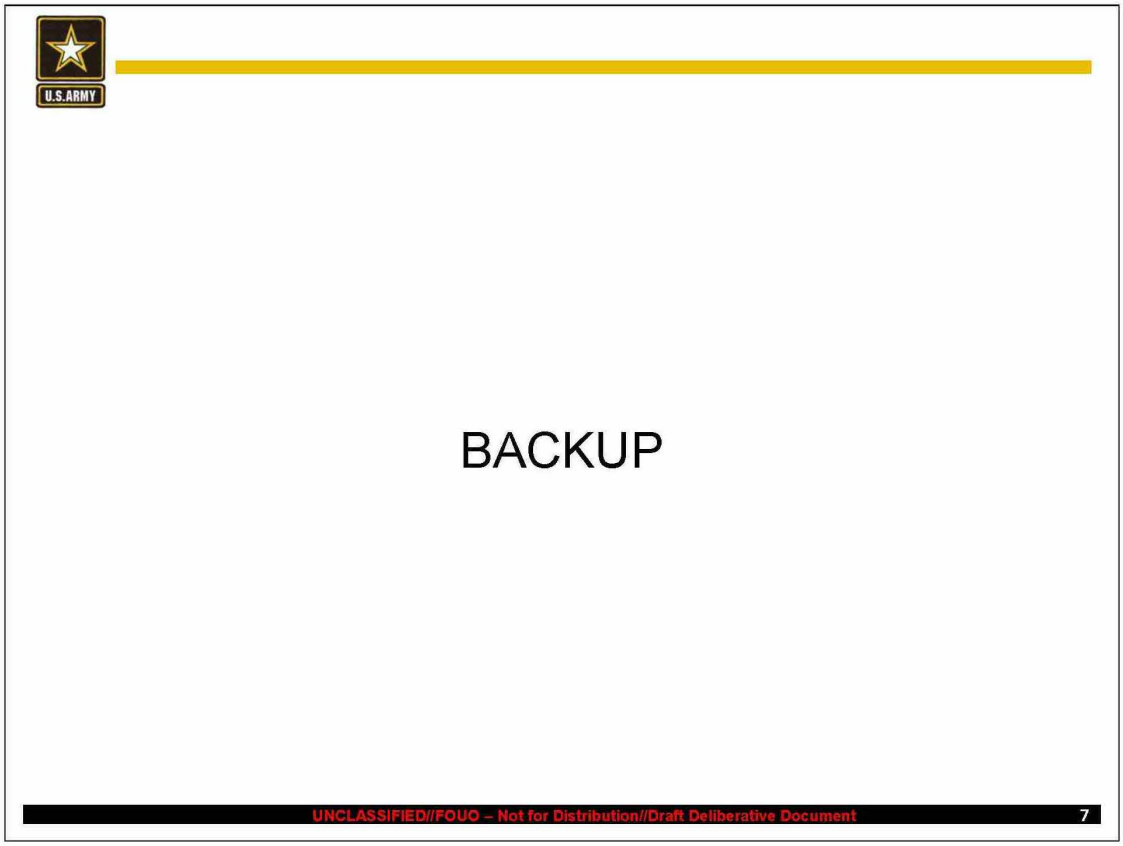
5


Medical Data Collection
U.S.ARMY
• Detailed analysis pending from OEMA
• Profiles (September 2017):
• Deployable percentage: 72%
• Temporary profiles: 26%
• Treatment Plans:
– Approved treatment plan: 90/121 (74%)
– Psychotherapy as part of treatment plan: 86/90 (96%)
– Hormones as part of treatment plan: 86/90 (96%)
– Surgery planned as part of treatment plan: 65/90 (72%)
– Surgery planned across the population: 65/121 (54%)
• IDES:
– Enrolled in IDES: 5/121 (4%)
6


U.S.ARMY
BACKUP
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7

Exhibit 14

Stenographic Transcript
Before the

COMMITTEE ON
ARMED SERVICES

UNITED STATES SENATE

HEARING TO RECEIVE TESTIMONY ON THE POSTURE OF THE DEPARTMENT OF THE ARMY IN REVIEW OF THE DEFENSE AUTHORIZATION REQUEST FOR FISCAL YEAR 2019 AND THE FUTURE YEARS DEFENSE PROGRAM

Thursday, April 12, 2018

Washington, D.C.

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(202) 289-2260
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HEARING TO RECEIVE TESTIMONY ON THE
POSTURE OF THE DEPARTMENT OF THE ARMY IN REVIEW OF THE
DEFENSE AUTHORIZATION REQUEST FOR FISCAL YEAR 2019 AND THE
FUTURE YEARS DEFENSE PROGRAM

Thursday, April 12, 2018

U.S. Senate
Committee on Armed Services
Washington, D.C.

The committee met, pursuant to notice, at 9:37 a.m. in Room SD-G50, Dirksen Senate Office Building, Hon. James M. Inhofe, presiding.

Committee Members Present: Senators Inhofe [presiding], Inhofe, Wicker, Fischer, Cotton, Rounds, Ernst, Tillis, Sullivan, Perdue, Cruz, Graham, Reed, Nelson, McCaskill, Shaheen, Gillibrand, Blumenthal, Donnelly, Hirono, Kaine, King, Heinrich, Warren, and Peters.

General Milley: Sure.

Senator Gillibrand: Dr. Esper and General Milley, in light of the existing injunctions, DOD is currently operating under the previous transgender open service policy put in place by the last administration, yet transgender soldiers have now seen the Department's recommendations and are on notice that, if the policy is implemented, they will get kicked out for seeking care or treatment for their gender dysphoria. I'm worried that this uncertainty will get -- will have a negative impact on these individuals, but also on their units, and that fear of these recommendations will stop these soldiers from seeking care. What are you doing to ensure readiness in light of the pall that has been cast on the future of transgender soldiers?

Dr. Esper: Senator, we continue to treat every soldier, transgender or not, with dignity and respect, ensure that they're well trained and well equipped for whatever future fights. With regard to accessions, our accessions folks understand that we are operating under the Carter policy, if you will. We've had some persons already join, transgender persons join, and we will continue to access them and train them and treat them well, in accordance with that policy.

Senator Gillibrand: Well, I'm concerned, because the report that was included with the memo claimed that

transgender persons serving in our military might hurt unit cohesion. So, that is different than treating everyone with dignity and respect. When asked by reporters, in February, whether soldiers have concerns about serving beside openly transgender individuals, you said it really hasn't come up. Are you aware of any problems with unit cohesion arising since you made that comment? And, if so, can you tell us how they were handled by the unit leadership involved?

Dr. Esper: Senator, nothing has percolated up to my level. When I made that comment, I was -- it was a question about, you know, have I met with soldiers and talked about these issues? What do they raise? And, as I said then, the soldiers tend to -- you know, young kids tend to raise the issue in front of them at the day. It could be that they're performing all-night duty or didn't get their paycheck, and this was just not an issue that came up at that moment in time. And, beyond that --

Senator Gillibrand: Have you since heard anything, how transgender servicemembers are harming unit cohesion?

Dr. Esper: Again, nothing has percolated up to me.

Senator Gillibrand: General Milley, have you heard that?

General Milley: No, not at all. The -- and we have a finite number. We know who they are, and it is monitored very closely, because, you know, I'm concerned about that,

and want to make sure that they are, in fact, treated with dignity and respect. And no, I have received precisely zero reports --

Senator Gillibrand: Okay.

General Milley: -- of issues of cohesion, discipline, morale, and all those sorts of things. No.

Senator Gillibrand: That's good news.

I know that the Secretary spoke with transgender soldiers recently. Of all the ones that you have personally spoke with of the Active Duty transgender soldiers, were you concerned by any of them continuing to serve?

Dr. Esper: Well, I actually met with them in the first 30 days on the job, Senator. And no, nothing came up that would cause me concern. I was, you know, impressed by what I heard.

Senator Gillibrand: And have either of you spoken to any transgender servicemembers since this set of recommendations was released by the administration in March? And, if you have, what did you hear?

Dr. Esper: No, ma'am.

General Milley: I have not. I did before. I have not. But, let -- you know, the case, as you are well aware, is in litigation. It's in four different courts. So, the -- we're limited in, actually, what we should or could say right this minute, because it could, either one way or the

Exhibit 15

Stenographic Transcript
Before the

COMMITTEE ON
ARMED SERVICES

UNITED STATES SENATE

HEARING TO
RECEIVE TESTIMONY ON THE POSTURE OF THE DEPARTMENT OF THE NAVY IN REVIEW OF THE DEFENSE AUTHORIZATION REQUEST FOR FISCAL YEAR 2019 AND THE FUTURE YEARS DEFENSE PROGRAM

Thursday, April 19, 2018

Washington, D.C.

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HEARING TO RECEIVE TESTIMONY ON THE
POSTURE OF THE DEPARTMENT OF THE NAVY IN REVIEW OF THE
DEFENSE AUTHORIZATION REQUEST FOR FISCAL YEAR 2019 AND THE
FUTURE YEARS DEFENSE PROGRAM

Thursday, April 19, 2018

U.S. Senate
Committee on Armed Services
Washington, D.C.

The committee met, pursuant to notice, at 9:31 a.m. in Room SD-G50, Dirksen Senate Office Building, Hon. James M. Inhofe, presiding.

Committee Members Present: Senators Inhofe [presiding], Wicker, Fischer, Cotton, Ernst, Tillis, Sullivan, Perdue, Graham, Scott, Reed, Nelson, McCaskill, Shaheen, Gillibrand, Blumenthal, Donnelly, Hirono, Kaine, King, Warren, and Peters.

with our terrific allies in Norway who are just doing yeoman's work monitoring the gap. But, they opened my eyes as to what's going on in the Arctic. I had read about it, but, when you see what's going on there, what Russia is doing, repaving 12,000-foot runways, 10,000 spetznaz up there in Barracks 4, search and rescue, we need to have presence up there.

The complication, as you well know, because we've talked about this, is -- icebreaking is one of the complications. It's not a mission of the Navy. We are working hand in hand with the Coast Guard. In fact, we have just finished helping them design in requirements for the next class of icebreaker. But, that is their mission.

That being said, we do not have ice-hardened ships. There is a new terminology up there, called the Blue Water Arctic, that there now is open blue waters up there. The CNO and I have talked about, How do we have presence up there? We're working on that. And when we see our strategy roll out, you will see more this summer.

Senator Sullivan: Great. I appreciate it.

Thank you, gentlemen.

Senator Inhofe: Thank you, Senator Sullivan.

Senator Gillibrand.

Senator Gillibrand: Thank you, Mr. Chairman.

Admiral Richardson and General Neller, General Milley

told me, last week, that there were, quote, "precisely zero reports of issues of cohesion, discipline, morale, and all sorts of things in the Army as a result of open transgender service." Are you aware of any issue of unit cohesion, disciplinary problems, or issues with morale resulting from open transgender service?

Admiral Richardson: Senator, I'll go first on that. You know, by virtue of being a Navy sailor, we treat every one of those sailors, regardless, with dignity and respect that is warranted by wearing the uniform of the United States Navy. By virtue of that approach, I am not aware of any issues.

Senator Gillibrand: General Neller?

General Neller: Senator, by reporting, those marines that have come forward -- there's 27 marines that have identified as transgender, one sailor serving -- I am not aware of any issues in those areas. The only issues I have heard of is, in some cases, because of the medical requirements of some of these individuals, that there is a burden on the commands to handle all their medical stuff. But, discipline, cohesion of the force, no.

Senator Gillibrand: Can you amplify what burdens on the command are related to medical issues?

General Neller: Some of these individuals -- and, you know, they've resolved whatever it was that -- as they went

through the process of identifying other than their birth sex, and so they're going forward. And I think those that came forward, we have a -- we have to honor the fact that they came out and they trusted us to say that, and that we need to make sure that we help them get through that process. Some of them are in a different place than others. And so, there is -- part of it's an education, but part of it is that there are some medical things that have to be involved as they go through the process of transitioning and real-life experience and whatever their level of dysphoria is. So, for commanders, some of them have said, "No, it's not a problem at all." Others have said that there is a lot of time where this individual is -- may or may not be available.

So, we're all about readiness. We're looking for deployability. But, in the areas that you talked about, no, I have not -- I have not heard of or have reported to me any issues.

Senator Gillibrand: Have you had the opportunity, General Neller, to meet with any of your transgender troops?

General Neller: Yes.

Senator Gillibrand: And what did you learn from those meetings?

General Neller: I learned that -- I learned a lot about the experience that they had. I learned that -- I met

with four -- actually, one was a naval officer, one was an Army staff sergeant, one was a marine officer, and one was a Navy corpsman -- and I learned about their desire to serve. I learned about, you know, where their recognition of their identification opposite their birth sex. We had a very candid, frank conversation. And I respect -- as CNO said -- respect their desire to serve. And all of them, to the best of my knowledge, were ready and prepared to deploy, and they-- as long as they can meet the standard of what their particular occupation was, then I think we'll move forward.

Senator Gillibrand: Thank you, General Neller.

Admiral Richardson, what are you doing to ensure readiness at the personnel and unit level, in light of this new policy that's come forward from the White House, in terms of a new burden placed on transgender sailors and marines?

Admiral Richardson: Ma'am, I will tell you that we're-- it's steady as she goes. We have a worldwide deployable Navy. All of our sailors, or the vast, vast majority of our sailors, are worldwide deployable. We're taking lessons from when we integrated women into the submarine force. And one of the pillars of that was to make sure that there were really no differences highlighted in our approach to training those sailors. That program has gone very well. And so, maintaining that level playing field of a standards-

based approach seems to be the key to -- a key to success, and that's the approach we're taking.

Senator Gillibrand: Thank you, Admiral.

You and I had a long conversation about military justice. And we talked about some of the sexual harassment and assault issues that are within the Navy. We had a issue with regard to "Bad Santa," as you know, where your public affairs officer was allowed to stay in his position for several months despite his clearly inappropriate behavior. Do you have a sense of what message members serving under you received from him being allowed to stay in that position? And have you changed your approach because of that incident?

Admiral Richardson: The beginning of that approach was really defined by making sure that we got a thorough investigation into a complicated scenario there with allegations and counter-allegations. So, that -- the investigation took some of the time.

Having said all that, I've become acutely aware that that may have sent a bad message, particularly to the survivors of the behavior. And so, that -- you know, my radar has been completely retuned, in terms of sensitivity to that message. And I hope that we've arrived at a good place at the end of the -- at the end of this event. It took longer, in hindsight, than it should have. If I was

Exhibit 16

Stenographic Transcript
Before the

COMMITTEE ON
ARMED SERVICES

UNITED STATES SENATE

HEARING TO RECEIVE TESTIMONY ON
THE POSTURE OF
THE DEPARTMENT OF THE AIR FORCE
IN REVIEW OF THE DEFENSE AUTHORIZATION REQUEST
FOR FISCAL YEAR 2019 AND
THE FUTURE YEARS DEFENSE PROGRAM

Tuesday, April 24, 2018

Washington, D.C.

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HEARING TO RECEIVE TESTIMONY ON

THE POSTURE OF

THE DEPARTMENT OF THE AIR FORCE

IN REVIEW OF THE DEFENSE AUTHORIZATION REQUEST

FOR FISCAL YEAR 2019 AND

THE FUTURE YEARS DEFENSE PROGRAM

Tuesday, April 24, 2018

U.S. Senate

Committee on Armed Services

Washington, D.C.

The committee met, pursuant to notice, at 9:30 a.m. in Room SD-G50, Dirksen Senate Office Building, Hon. James M. Inhofe, presiding.

Committee Members Present: Senators Inhofe [presiding], Wicker, Fischer, Cotton, Rounds, Ernst, Tillis, Sullivan, Cruz, Scott, Reed, Nelson, McCaskill, Shaheen, Gillibrand, Blumenthal, Donnelly, Hirono, Kaine, King, Heinrich, Warren, and Peters.

Senator Sullivan: So you think the Army is capable to provide you the Air Force and the bases that you are in charge of globally with sufficient short-range air defense systems to defend overseas air bases?

General Goldfein: I believe the Army has -- and I cannot speak for my fellow joint chief, General Milley, in terms of what is in his budget submission, but I will tell you that I know the Army is invested and committed to their responsibility for base defense.

Senator Sullivan: But not just ballistic missile. I am talking cruise missile.

General Goldfein: Right.

Senator Sullivan: Madam Secretary, do you have a view on that?

Dr. Wilson: Senator, I do think that when it comes to air base defense, that is an area where we probably need to look really carefully. It is one that long term I think all of us as airmen have concerns about. Are we going to be able to defend the bases from which we fight?

Senator Sullivan: Thank you, Mr. Chairman.

Senator Inhofe: Thank you, Senator Sullivan.

Senator Gillibrand?

Senator Gillibrand: Hi, General Goldfein. Hi, Madam Secretary. Thank you so much for being here.

General Goldfein, in the last 2 weeks, General Milley,

General Neller, and Admiral Richardson have told me that they have seen zero reports of issues of cohesion, discipline, and morale, as a result of open transgender service in their respective service branches. Are you aware of any specific issues of unit cohesion, disciplinary problems, or issues of morale resulting from open transgender service members in the Air Force?

General Goldfein: Not the way you have presented the question, ma'am, I am not. I will tell you that I have talked commanders in the field, first sergeants, senior NCOs, and I am committed to ensure that they have the right levels of guidance to understand these very personal issues that they are dealing with. And so we continue to move forward to ensure that we understand the issues.

Senator Gillibrand: And have you personally met with transgender service members?

General Goldfein: Yes, ma'am, I have.

Senator Gillibrand: And what did you learn from those meetings?

General Goldfein: A combination of, one, commitment to serve by each of them, and then number two, how individual each particular case is. It is not a one-size-fits-all approach. It is very personal to each individual. And that is why I go back to we have an obligation to ensure that we understand this medically and that we can provide our

commanders and supervisors the guidance they need to be able to deal with this so we do not have issues.

Senator Gillibrand: Thank you.

Secretary Wilson, on April 3rd, 2018, the American Medical Association wrote a letter to Secretary decrying the recent policy released by the White House. Echoing concerns raised by the American Psychological Association and two former Surgeon Generals, the American Medical Association said, quote, we believe there is no medically valid reason, including a diagnosis of gender dysphoria, to exclude transgender individuals from military service. The memo mischaracterized and rejected the wide body of peer-reviewed research on the effectiveness of transgender medical care. Yet, this DOD panel of experts came to a drastically different conclusion from the preeminent medical organizations in America about gender dysphoria, the effectiveness and impact of gender transition on medical and psychological health, and the ability of transgender service members to meet standards of accession and retention.

Do you know who represented the Air Force on this panel?

Dr. Wilson: On the advisory panel to the Secretary of Defense?

Senator Gillibrand: Yes.

Dr. Wilson: Yes, ma'am, I do.

CERTIFICATE OF SERVICE

I hereby certify that I electronically filed the foregoing with the Clerk of the Court for the United States Court of Appeals for the Ninth Circuit by using the appellate CM/ECF system on May 14, 2018. I certify that all participants in the case are registered CM/ECF users and that service will be accomplished by the appellate CM/ECF system.

s/ Daniel Siegfried
Daniel Siegfried