

[NOT YET SCHEDULED FOR ORAL ARGUMENT]

No. 18-5257

IN THE UNITED STATES COURT OF APPEALS
FOR THE DISTRICT OF COLUMBIA CIRCUIT

JANE DOE 2, et al.,
Plaintiffs-Appellees,

v.

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

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

JOINT APPENDIX, VOLUME II (pp. 580-1093)
Public Appendix—Material Under Seal in Separate Supplement

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HEALTH AFFAIRS

THE ASSISTANT SECRETARY OF DEFENSE

1200 DEFENSE PENTAGON
WASHINGTON, DC 20301-1200

JUL 29 2016

MEMORANDUM FOR ASSISTANT SECRETARY OF THE ARMY (MANPOWER AND
RESERVE AFFAIRS)
ASSISTANT SECRETARY OF THE NAVY (MANPOWER AND
RESERVE AFFAIRS)
ASSISTANT SECRETARY OF THE AIR FORCE (MANPOWER
AND RESERVE AFFAIRS)
DIRECTOR, DEFENSE HEALTH AGENCY
DIRECTOR, HEALTH, SAFETY AND WORK LIFE, U.S. COAST
GUARD

SUBJECT: Guidance for Treatment of Gender Dysphoria for Active and Reserve
Component Service Members

In accordance with Department of Defense Instruction (DoDI) 1300.28, "In-Service Transition for Transgender Service Members," June 30, 2016, and Directive-Type Memorandum (DTM)16-005, "Military Service of Transgender Service Members," June 30, 2016, this memorandum provides guidance for the medical care of transgender Service members. This memorandum supplements requirements in those issuances; it does not supersede any such requirements.

General Provisions:

The Military Health System (MHS) will either provide or arrange consultation for medically necessary care for members on active duty for a period of more than 30 days (referred to as Active Duty Service members (ADSMs) throughout the remainder of this document). Such care is based upon the individual's unique health care needs and, following initial evaluation, may include counseling and behavioral health services, medical support, and assistance with establishing a treatment plan for the Service member's submission to the unit commander, followed by any medically necessary treatment.

Until the DoD is able to promulgate specific clinical practice guidelines for the care of transgender personnel, the MHS will adhere to the attached 2009 version of the Endocrine Society's Standards of Care, "Endocrine Treatment of Transsexual Persons: An Endocrine Society Clinical Practice Guideline," as the primary guideline to provide consistent, evidence based care to transitioning patients. Explanation of any clinically indicated deviation from the guideline should be documented in the patient's health record. Clinical Practice Guidelines from other professional societies may also help inform clinical decision making (e.g., the 2015 American Psychological Association Guidelines for Psychological Practice with Transgender and Gender Nonconforming People and the World Professional Association for Transgender Health Standards of Care). Key components of medical care for the purpose of treating gender dysphoria include initial assessment and, based upon that assessment of the individual's needs,

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the establishment of a treatment plan which may include real life experience (RLE) that is provided in a manner consistent with the requirements of DoDI 1300.28 and DTM 16-005 regarding RLE, cross-sex hormone therapy, and surgical transition. Treatment plans must be individualized and approved by a military medical provider. The following guidance addresses various stages of treatment:

1. For Active Duty Service members (ADSMs) seeking initial treatment for gender dysphoria, a diagnosis of gender dysphoria must be established by a privileged behavioral health provider (or similarly qualified civilian provider if unavailable in a military facility), with appropriate referral to other types of providers as indicated or required. The assessment should be comprehensive in nature, including exclusion of other causes for dysphoria, and lead to formulation of an initial treatment plan.
2. For ADSMs who have already received a diagnosis of gender dysphoria and established a treatment plan approved by a military medical provider, and who desire to proceed to or continue cross-sex hormone therapy, an endocrinologist or other physician with appropriate professional expertise should exclude medical conditions making hormone therapy unsafe, may initiate or continue hormone therapy if indicated as medically necessary, and monitor response to hormones in accordance with the Endocrine Society's Standards of Care guidelines, to include periodic screening for hormone associated adverse outcomes.
3. ADSMs with an established treatment plan desiring surgical treatment following a period of RLE and who are compliant with all facets of an approved treatment plan should be referred to an appropriately qualified surgeon for evaluation. The surgeon should fully discuss all surgical options and potential complications in order to provide informed consent before surgery is proposed. Consistent with current DoD policies, purely cosmetic or other non-medically necessary surgery is not authorized.
4. Any Service member for whom the Defense Enrollment Eligibility Reporting System has recorded a gender change, or who is in the process of obtaining such a change, must have an ongoing plan to address needed medical care, including follow up of hormone treatment and any appropriate health screening.
5. Unless and until adequate surgical capabilities have been established in DoD Military Treatment Facilities (MTFs), medically necessary surgical treatment will be evaluated using the existing MHS waiver process for private sector care for Active Duty members under the Supplemental Health Care Program (SHCP). This standardized process requires referral through the Service chain of command and review and approval by the Director, Defense Health Agency (DHA).
6. The expectation is for the MHS to provide an interdisciplinary team approach to transition care in accordance with evidence based guidelines and practices, reinforcing at all times the transgender Service member's right to receive all medical care with dignity and respect. Provision of care may involve multiple facilities and require appropriate care coordination between providers. In no circumstance will a provider be required to

deliver care that he or she feels unprepared to provide either by lack of clinical skill or due to ethical, moral or religious beliefs. However, referral to an appropriate provider or level of care is required under such circumstances.

7. As with all other medical conditions, in the first 180 days of service in the military, all personnel must continue to meet the medical standards associated with accession (DoDI 6130.03, "Medical Standards for Appointment, Enlistment, or Induction in the Military Services"). Ongoing fitness for duty and deployment screening after 180 days shall be assessed in accordance with current Service practices and policies applied to other medical conditions.

Central Coordination:

1. Service Central Coordination Cells (SCCC) established under DoDI 1300.28 shall provide multi-disciplinary (e.g., medical, legal, military personnel management) expert advice and assistance to commanders with regard to service by transgender Service members and gender transition in the military to assist commanders in the execution of DoD, Military Department, and Service policies and procedures.
2. The Under Secretary of Defense for Personnel and Readiness (USD(P&R)) has established a Central Coordination Cell with Office of the Secretary of Defense, DHA, and Service representatives to oversee consistent and uniform implementation of DoDI 1300.28, provide consultation to SCCC's, and receive and analyze data reported by the Services. The Central Coordination Cell is not a substitute for SCCC's, but provides information and advice on policy matters, and assistance with identification and coordination of needed treatment resources, when necessary. DHA has provided a senior representative to facilitate coordination of care and services delivered by the managed care support contractors and the DHA Waiver Authority process.
3. To assist Commanders and Service members until each Service establishes its own SCCC, the DoD Central Coordination Cell has established the following website: <https://prext.osd.mil/DoDCCC>. This is a Common Access Card-enabled website for secure questions by all Service members. Policy documents and Frequently Asked Questions reside on this website and questions will be answered by policy, legal and medical experts.

Service and DHA Requirements and Responsibilities:

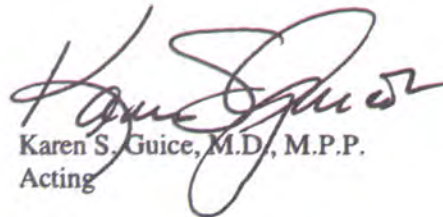
1. Each Service and DHA shall develop and submit an assessment of current Service medical capacity and expertise in providing medical and surgical support for treating gender dysphoria to the USD(P&R) no later than August 31, 2016. This assessment should include a listing of MTFs at which interdisciplinary care and treatment are available or under development for this purpose, and use the attached data reporting template.

2. Each Service and DHA shall develop an education and training plan for both privileged and non-privileged medical personnel no later than November 1, 2016. This plan should detail how the Service will ensure familiarity with applicable Department policies and requirements, evidence-based practice guidelines and standards of care, and any Service-specific policies. To the extent practicable, training plans and requirements, and additional procedural guidance for care and services will be consistent across the MHS, and will be published as DHA procedural guidance.
3. Each Service and DHA shall be prepared to begin supporting transition medical care to transgender ADSMs no later than October 1, 2016. At a minimum, Services will be expected to provide, by referral if necessary, initial assessment, psychological and pharmaceutical support. As directed by the Secretary of Defense, in the period prior to October 1, 2016, the Military Departments and Services will address requests for gender transition from serving transgender Service members on a case-by-case basis, following the spirit and intent of DTM 16-005 and DoDI 1300.28. Until the capability of MHS MTFs to provide surgical transition services has been documented, any proposed genital surgical transition procedures within MTFs shall be prospectively reviewed by the appropriate Surgeon General or, in the case of the National Capital Region facilities, the Director, DHA. Approvals will be reported to the Assistant Secretary of Defense for Health Affairs (ASD(HA)) monthly.
4. The Director, DHA, will ensure that the Managed Care Support Contractors identify appropriate referral resources with providers experienced in care and treatment of transgender persons to ensure availability of care to complement MTF capabilities. An inventory of such resources shall be provided to the ASD(HA) not later than August 31, 2016.
5. The Director, DHA, will evaluate proposed referrals to the TRICARE network for surgical treatment in accordance with the Supplemental Health Care Program (SHCP). MHS care for ADSMs from non-DoD providers is governed by section 1074(c)(2) of title 10, U.S. Code, and section 199.16 of title 32, Code of Federal Regulations. Under these provisions, the SHCP normally follows TRICARE rules, which disallow surgical treatment of gender dysphoria, but the prohibition is subject to waiver for medically necessary care for ADSMs. The Director, DHA, is authorized to grant waivers on a case-by-case basis. Waiver requests will follow existing processes. Each waiver request, with appropriate clinical documentation, should be submitted through the Surgeon General concerned, to the Director, DHA.
6. To the extent a SHCP waiver would be needed to authorize non-surgical care for an ADSM, this memorandum approves such a waiver on a blanket basis if such care is recommended by a military health care provider in accordance with established SHCP procedures and this memorandum.

7. With respect to Reserve Component Service members not on active duty for a period of more than 30 days who initiate or are involved in a gender transition process, the Services shall establish procedures to ensure that a medical diagnosis and treatment plan (or significant revisions to a treatment plan) or a recommendation for a change in a member's gender marker made by a civilian medical provider is reviewed and approved by an appropriate military medical provider and communicated in a timely and efficient manner with the Reserve Component command involved.

ASD(HA) Responsibilities:

1. The ASD(HA) shall establish collaboration with the Veterans Health Administration and academic medical centers to support Service training plans and specialty consultations, including via telemedicine, where necessary and appropriate.
2. The ASD(HA) shall monitor compliance with this memorandum, which may include assessing Service and DHA performance on all provisions contained within this memorandum.



Karen S. Guice, M.D., M.P.P.
Acting

Attachments:
As stated

cc:
Under Secretary of Defense for Personnel and Readiness
Assistant Secretary of Defense (Manpower and Reserve Affairs)
Surgeon General of the Army
Surgeon General of the Navy
Surgeon General of the Air Force
Joint Staff Surgeon
Medical Office of the Marine Corps



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

JUN 30 2016

MEMORANDUM FOR SECRETARIES OF THE MILITARY DEPARTMENTS
CHAIRMAN OF THE JOINT CHIEFS OF STAFF
UNDER SECRETARIES OF DEFENSE
DEPUTY CHIEF MANAGEMENT OFFICER
CHIEF OF THE NATIONAL GUARD BUREAU
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ASSISTANT TO THE SECRETARY OF DEFENSE FOR PUBLIC
AFFAIRS
DIRECTOR, NET ASSESSMENT
DIRECTORS OF THE DEFENSE AGENCIES
DIRECTORS OF THE DOD FIELD ACTIVITIES

SUBJECT: Directive-type Memorandum (DTM) 16-005, "Military Service of Transgender Service Members"

References: DoD Directive 1020.02E, "Diversity Management and Equal Opportunity in the DoD," June 8, 2015
DoD Directive 1350.2, "Department of Defense Military Equal Opportunity (MEO) Program," August 18, 1995
DoD Instruction 6130.03, "Medical Standards for Appointment, Enlistment, or Induction in the Military Services," April 28, 2010, as amended

Purpose. This DTM:

- Establishes policy, assigns responsibilities, and prescribes procedures for the standards for retention, accession, separation, in-service transition, and medical coverage for transgender personnel serving in the Military Services.
- Except as otherwise noted, this DTM will take effect immediately. It will be converted to a new DoDI. This DTM will expire effective June 30, 2017.

Applicability. This DTM applies to OSD, the Military Departments (including the Coast Guard at all times, including when it is a Service in the Department of Homeland Security by agreement with that Department), the Office of the Chairman of the Joint Chiefs of Staff and the

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Joint Staff, the Combatant Commands, the Office of the Inspector General of the Department of Defense, the Defense Agencies, the DoD Field Activities, and all other organizational entities within the DoD.

Policy.

- The defense of the Nation requires a well-trained, all-volunteer force comprised of Active and Reserve Component Service members ready to deploy worldwide on combat and operational missions.
- The policy of the Department of Defense is that service in the United States military should be open to all who can meet the rigorous standards for military service and readiness. Consistent with the policies and procedures set forth in this memorandum, transgender individuals shall be allowed to serve in the military.
- These policies and procedures are premised on my conclusion that open service by transgender Service members while being subject 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 and with strength through diversity.

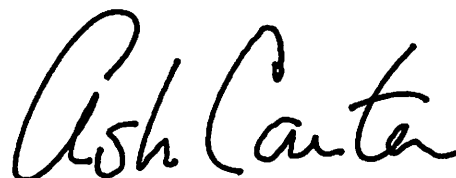
Responsibilities

- The Secretaries of the Military Departments will:
 - Take immediate action to identify all DoD, Military Department, and Service issuances, the content of which relate to, or may be affected by, the open service of transgender Service members.
 - Draft revisions to the issuances identified, and, as necessary and appropriate, draft new issuances, consistent with the policies and procedures in this memorandum.
 - Submit to the Under Secretary of Defense for Personnel and Readiness (USD(P&R)) the text of any proposed revisions to existing Military Department and Service regulations, policies, and guidance, and of any proposed new issuance, no later than 30 days in advance of the proposed publication date of each.
- The USD(P&R) will:
 - Take immediate action to identify all DoD, Military Department, and Service issuances, the content of which relate to, or may be affected by, the open service of transgender Service members.

- Draft revisions to the issuances identified in this memorandum and, as necessary and appropriate, draft new issuances consistent with the policies and procedures in this memorandum.

Procedures. See Attachment.

Releasability. **Cleared for public release.** This DTM is available on the DoD Issuances Website at <http://www.dtic.mil/whs/directives>.

A handwritten signature in black ink that reads "Ash Carter". The signature is written in a cursive, flowing style.

Attachment:

As stated

cc:

Secretary of Homeland Security
Commandant, United States Coast Guard

ATTACHMENT

PROCEDURES

1. SEPARATION AND RETENTION

a. Effective immediately, no otherwise qualified Service member may be involuntarily separated, discharged or denied reenlistment or continuation of service, solely on the basis of their gender identity.

b. Transgender Service members will be subject to the same standards as any other Service member of the same gender; they may be separated, discharged, or denied reenlistment or continuation of service under existing processes and basis, but not due solely to their gender identity or an expressed intent to transition genders.

c. A Service member whose ability to serve is adversely affected by a medical condition or medical treatment related to their gender identity should be treated, for purposes of separation and retention, in a manner consistent with a Service member whose ability to serve is similarly affected for reasons unrelated to gender identity or gender transition.

2. ACCESSIONS

a. Medical standards for accession into the Military Services help to ensure that those entering service are free of medical conditions or physical defects that may require excessive time lost from duty. Not later than July 1, 2017, the USD(P&R) will update DoD Instruction 6130.03 to reflect the following policies and procedures:

(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.

b. The Secretaries of the Military Departments and the Commandant, United States Coast Guard, may waive or reduce the 18-month periods, in whole or in part, in individual cases for applicable reasons.

c. The standards for accession described in this memorandum will be reviewed no later than 24 months from the effective date of this memorandum and may be maintained or changed, as appropriate, to reflect applicable medical standards and clinical practice guidelines, ensure consistency with military readiness, and promote effectiveness in the recruiting and retention policies and procedures of the Armed Forces.

3. IN-SERVICE TRANSITION

a. Effective October 1, 2016, DoD will implement a construct by which transgender Service members may transition gender while serving, in accordance with DoDI 1300.28, which I signed today.

b. Gender transition while serving in the military presents unique challenges associated with addressing the needs of the Service member in a manner consistent with military mission and readiness needs.

4. MEDICAL POLICY. Not later than October 1, 2016, the USD(P&R) will issue further guidance on the provision of necessary medical care and treatment to transgender Service members. Until the issuance of such guidance, the Military Departments and Services will handle requests from transgender Service members for particular medical care or to transition on a case-by-case basis, following the spirit and intent of this memorandum and DoDI 1300.28.

5. EQUAL OPPORTUNITY

a. All Service members are entitled to equal opportunity in an environment free from sexual harassment and unlawful discrimination on the basis of race, color, national origin, religion, sex, or sexual orientation. It is the Department's position, consistent with the U.S. Attorney General's opinion, that discrimination based on gender identity is a form of sex discrimination.

b. The USD(P&R) will revise DoD Directives (DoDDs) 1020.02E, "Diversity Management and Equal Opportunity in the DoD," and 1350.2, "Department of Defense Military Equal Opportunity (MEO) Program," to prohibit discrimination on the basis of gender identity and to incorporate such prohibitions in all aspects of the DoD MEO program. The USD(P&R) will prescribe the period of time within which Military Department and Service issuances implementing the MEO program must be conformed accordingly.

6. EDUCATION AND TRAINING

a. The USD(P&R) will expeditiously develop and promulgate education and training materials to provide relevant, useful information for transgender Service members, commanders, the force, and medical professionals regarding DoD policies and procedures on transgender service. The USD(P&R) will disseminate these training materials to all Military Departments and the Coast Guard not later than October 1, 2016.

b. Not later than November 1, 2016, each Military Department will issue implementing guidance and a written force training and education plan. Such plan will detail the Military Department's plan and program for training and educating its assigned force (to include medical professionals), including the standards to which such education and training will be conducted, and the period of time within which it will be completed.

7. IMPLEMENTATION AND TIMELINE

a. Not later than October 1, 2016, the USD(P&R) will issue a Commander's Training Handbook, medical guidance, and guidance establishing procedures for changing a Service member's gender marker in DEERS.

b. In the period between the date of this memorandum and October 1, 2016, the Military Departments and Services will address requests for gender transition from serving transgender Service members on a case-by-case basis, following the spirit and intent of this memorandum and DoDI 1300.28.

Remarks on Ending the Ban on Transgender Service in the U.S. Military

As Delivered by Secretary of Defense Ash Carter, Pentagon Briefing Room, June 30, 2016

Good afternoon. Thanks for being here. I'm here today to announce some changes in the Defense Department's policies regarding transgender servicemembers.

Before I announce what changes we're making, I want to explain why. And there are three main reasons – having to do with our future force, our current force, and matters of principle.

The first and fundamental reason is that the Defense Department and the military need to avail ourselves of all talent possible in order to remain what we are now – the finest fighting force the world has ever known.

Our mission is to defend this country, and we don't want barriers unrelated to a person's qualification to serve preventing us from recruiting or retaining the soldier, sailor, airman, or Marine who can best accomplish the mission. We have to have access to 100 percent of America's population for our all-volunteer force to be able to recruit from among them the most highly qualified – and to retain them.

Now, while there isn't definitive data on the number of transgender servicemembers, RAND looked at the existing studies out there and their best estimate was that about 2,500 people out of approximately 1.3 million active-duty servicemembers and about 1,500 out of approximately 825,000 reserve servicemembers are transgender, with the upper end of their range of estimates of around 7,000 in the active component and 4,000 in the reserves.

Although relatively few in number, we're talking about talented and trained Americans who are serving their country with honor and distinction. We invest hundreds of thousands of dollars to train and develop each individual, and we want to take the opportunity to retain people whose talent we've invested in and who have proven themselves.

And this brings me to the second reason, which is that the reality is that we have transgender servicemembers serving in uniform today, and I have a responsibility to them and to their commanders to provide them both with clearer and more consistent guidance than is provided by current policies.

We owe commanders better guidance on how to handle questions such as deployment, medical treatment and other matters. And this is particularly true for

Also, right now, most of our transgender servicemembers must go outside the military medical system in order to obtain medical care that is judged by doctors to be necessary, and they have to pay for it out of their own pockets. This is inconsistent with our promise to all our troops that we will take care of them and pay for necessary medical treatment.

I and the Defense Department's other senior leaders who have been studying this issue over the past year have met with some of these transgender servicemembers – they've deployed all over the world, serving on aircraft, submarines, forward operating bases, and right here in the Pentagon. And while I learned that in most cases their peers and local commanders have recognized the value of retaining high-quality people, I also learned that the lack of clear guidelines for how to handle this issue puts the commanders and the servicemembers in a difficult and unfair position. One servicemember I met with described how some people had urged him to leave the military because of the challenges he was facing with our policies, and he said he just wouldn't quit. He was too committed to the mission and this was where he wanted to be. These are the kind of people we want serving in our military.

The third and final reason, also important, is a matter of principle. Americans who want to serve and can meet our standards should be afforded the opportunity to compete to do so. After all, our all-volunteer force is built upon having the most qualified Americans. And the profession of arms is based on honor and trust.

Army Chief of Staff General Milley recently reminded us of this, when he said, and I quote him, "The United States Army is open to all Americans who meet the standard, regardless of who they are. Embedded within our Constitution is that very principle, that all Americans are free and equal. And we as an Army are sworn to protect and defend that very principle. And we are sworn to even die for that principle. So if we in uniform are willing to die for that principle, then we in uniform should be willing to live by that principle." That's General Milley.

In view of these three reasons to change our policy, last July I directed the commencement of a study to identify the practical issues related to transgender Americans serving openly, and to develop an implementation plan that addresses those issues consistent with military readiness – because our mission, which is defending this country, has to come first.

I 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.

It's been an educational process for a lot of people here in the Department, including me. We had to look carefully and deliberately at medical, legal, and policy

considerations that have been evolving very rapidly in recent years, and we had to take into account the unique nature of military readiness and make sure we got it right. I'm proud of the thoughtful and deliberate manner in which the Department's leadership has pursued this review. I've been guided throughout by one central question: is someone the best qualified servicemember to accomplish our mission?

Let me now describe the process we used to study this over the last year.

The leadership of the armed services – the Joint Chiefs of Staff, the Service Secretaries, myself, together with personnel, training, readiness, and medical specialists from across the Department of Defense – studied the available data. We also had the RAND Corporation analyze relevant data and studies to help us with our review. And we got input from transgender servicemembers, from outside expert groups, and from medical professionals outside of the Department.

We looked carefully at what lessons could be learned from the outside, including from allied militaries that already allow transgender servicemembers to serve openly, and from the private sector also – because even though we're not a business, and are different from a company in important ways, their experience and practices are still relevant.

It's worth noting, for example, that at least 18 countries already allow transgender personnel to serve openly in their militaries. These include close allies such as the UK, Israel, and Australia, and we were able to study how they dealt with this issue.

We also saw that among doctors, employers, and insurance companies today, providing medical care for transgender individuals is becoming common and normalized – in both public and private sectors alike. Today, over a third of Fortune 500 companies – including companies like Boeing, CVS, and Ford – offer employee health insurance plans with transgender-inclusive coverage. That's up from zero such companies in 2002. Similarly, non-discrimination policies at two-thirds of Fortune 500 companies now cover gender identity, up from just 3 percent in 2002. And for the public sector, all civilian federal employees have access today to a health insurance plan that provides comprehensive coverage for transgender-related care and medical treatment. All this represents a sea change from even just a decade ago.

Based on its analysis of allied militaries, and the expected rate at which American transgender servicemembers would require medical treatment that would impact their fitness for duty and deployability, RAND's analysis concluded that there would be "minimal readiness impacts from allowing transgender servicemembers to serve openly."

And in terms of cost, RAND concluded the health care costs would represent, again, their words, "an exceedingly small proportion" of DOD's overall health care

Now, as a result of this year-long study, I'm announcing today that we are ending the ban on transgender Americans in the United States military. Effective immediately, transgender Americans may serve openly, and they can no longer be discharged or otherwise separated from the military just for being transgender.

Additionally, I have directed that the gender identity of an otherwise qualified individual will not bar them from military service, or from any accession program.

In taking these steps, we're eliminating policies that can result in transgender servicemembers being treated differently from their peers based solely upon their gender identity rather than their ability to serve. And we're confirming that, going forward, we will apply the same general principles, standards, and procedures to transgender servicemembers as we do to all servicemembers. What I heard from the transgender servicemembers I met with, overwhelmingly, was that they don't want special treatment, they want to be held to the same standards and be treated like everyone else.

As I directed, the study identified practical issues that arise with respect to transgender service. And it developed an implementation plan to address those issues. Let me briefly describe that implementation plan to address those issues.

I want to emphasize that in this case, as in the Department's decisions on "Don't Ask, Don't Tell" and Women-in-Service, simply declaring a change in policy is not effective implementation. That's why we have worked hard on the implementation plan and must continue to do so.

These policies will be implemented in stages over the next 12 months – starting most immediately with guidance for current servicemembers and their commanders, followed by training for the entire force, and then beginning to access new military servicemembers who are transgender. Implementation will begin today.

Starting today: Otherwise qualified servicemembers can no longer be involuntarily separated, discharged, or denied reenlistment or continuation of service just for being transgender.

Then, no later than 90 days from today: The Department will complete and issue both a commanders' guidebook for leading currently-serving transgender servicemembers, and medical guidance to doctors for providing transition-related care if required to currently-serving transgender servicemembers. Our military treatment facilities will begin providing transgender servicemembers with all medically necessary care based on that medical guidance. Also starting on that date, servicemembers will be able to initiate the process to officially change their gender in our personnel management systems.

that will be prepared, the services will conduct training of the force – from commanders, to medical personnel, to the operating force and recruiters.

When the training is complete, no later than one year from today, the military services will begin accessing transgender individuals who meet all standards – holding them to the same physical and mental fitness standards as everyone else who wants to join the military.

Our initial accession policy will require an individual to have completed any medical treatment that their doctor has determined is necessary in connection with their gender transition and to have been stable in their identified gender for 18 months, as certified by their doctor, before they can enter the military. I've directed that this accession standard be reviewed no later than 24 months from today to ensure it reflects what more we learn over the next two years as this is implemented as well as the most up to date medical knowledge.

I've discussed the implementation plan with our senior military leaders, including Chairman Dunford. The chiefs had specific recommendations about the timeline, and I made adjustments to the implementation plan timeline to incorporate those recommendations. The Chairman has indicated that the Services support the final implementation timeline that I've laid out today.

Overall, the policies we're issuing today will allow us to access talent of transgender servicemembers to strengthen accomplishment of our mission, clarify guidance for commanders and military medical providers, and reflect better the Department's and our nation's principles.

I want to close by emphasizing that deliberate and thoughtful implementation will be key. I and the senior leaders of the Department will therefore be ensuring that all issues identified in the study are addressed in implementation. I'm confident they can and will be addressed in implementation. That's why we're taking the step-by-step approach I described.

I'm 100 percent confident in the ability of our military leaders and all our men and women in uniform to implement these changes in a manner that both protects the readiness of the force and also upholds values cherished by the military – honor, trust, and judging every individual on their merits.

I'm also confident that we have reason to be proud today of what this will mean for our military – because it's the right thing to do, and it's another step in ensuring that we continue to recruit and retain the most qualified people – and good people are the key to the best military in the world. Our military, and the nation it defends, will be stronger.



Assessing the Implications of Allowing Transgender Personnel to Serve Openly

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Preface

U.S. Department of Defense (DoD) policies have rendered both the physical and psychological aspects of “transgender conditions” as disqualifying conditions for accession and allow for the administrative discharge of service members who fall into these categories. However, in July 2015, Secretary of Defense Ashton Carter announced that DoD would “create a working group to study the policy and readiness implications of welcoming transgender persons to serve openly.” In addition, he directed that “decision authority in all administrative discharges for those diagnosed with gender dysphoria¹ or who identify themselves as transgender be elevated to the Under Secretary of Defense (Personnel and Readiness), who will make determinations on all potential separations” (DoD, 2015b).

It is against this backdrop that DoD is considering allowing transgender personnel to serve openly. To assist in identifying the potential implications of such a change in policy, the Office of the Under Secretary of Defense for Personnel and Readiness asked 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 implications of allowing transgender service members to serve openly; and (3) review the experiences of foreign militaries that permit transgender service members to serve openly. This report documents the findings from that study. This research should be of interest to DoD and military service leadership, members of Congress, and others who are interested in the potential implications of allowing transgender personnel to serve openly in the U.S. armed forces.

This research was sponsored by the Office of the Under Secretary of Defense for Personnel and Readiness and conducted within the Forces and Resources Policy Center of the RAND National Defense Research Institute, a federally funded research and development center sponsored by the Office of the Secretary of Defense, the Joint

¹ *Gender dysphoria* is “discomfort or distress that is caused by a discrepancy between a person’s gender identity and that person’s sex assigned at birth” (World Professional Association for Transgender Health, 2011, p. 2).

Staff, the Unified Combatant Commands, the Navy, the Marine Corps, the defense agencies, and the defense Intelligence Community.

For more information on the RAND Forces and Resources Policy Center, see www.rand.org/nsrd/ndri/centers/frp or contact the director (contact information is provided on the web page).

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Summary

The U.S. Department of Defense (DoD) is reviewing its policy on transgender personnel serving openly and receiving gender transition–related treatment during military service. The prospect of transgender personnel serving openly raises a number of policy questions, including those regarding access to gender transition–related health care, the range of transition-related treatments to be provided, the potential costs associated with these treatments, and the impact of gender transition–related health care needs (i.e., surgical, pharmacologic, and psychosocial) on military readiness—specifically, in terms of the deployability of transgender service members. The Office of the Under Secretary of Defense for Personnel and Readiness asked 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 implications of allowing transgender service members to serve openly; and (3) review the experiences of foreign militaries that permit transgender service members to serve openly. This report presents the study findings centered around the following research questions:

- What are the health care needs of the transgender population?
- What is the estimated transgender population in the U.S. military?
- How many transgender service members are likely to seek gender transition–related medical treatment?
- What are the costs associated with extending health care coverage for gender transition–related treatments?
- What are the potential readiness implications of allowing transgender service members to serve openly?
- What lessons can be learned from foreign militaries that permit transgender personnel to serve openly?
- Which DoD policies would need to be changed if transgender service members are allowed to serve openly?

In the following sections, we summarize the findings associated with each research question.

What Are the Health Care Needs of the Transgender Population?

For the purposes of this analysis, we use *transgender* as an umbrella term to refer to individuals who identify with a gender different from the sex they were assigned at birth. Under the recently established criteria and terminology in the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5), the American Psychiatric Association (APA) publication that provides standard language and criteria for classifying mental health conditions, transgender status alone does not constitute a medical condition (APA, 2013). Instead, under the revised diagnostic guidelines, only transgender individuals who experience significant related distress are considered to have a medical condition called *gender dysphoria* (GD). Some combination of psychosocial, pharmacologic (mainly but not exclusively hormonal), or surgical care may be medically necessary for these individuals. Psychotherapy to confirm a diagnosis of GD is a common first step in the process, often followed by hormone therapy and, perhaps, gender reassignment surgery involving secondary or primary sex characteristics. Not all individuals seek all forms of care.

A subset of transgender individuals may choose to *transition*, the term we use to refer to the act of living and working as a gender different from that assigned at birth. For some, the transition may be primarily social, with no accompanying medical treatment; we refer to this as *social transition*. For others, medical treatments, such as hormone therapy and hair removal, are important steps to align their physical body with their target gender. We refer to this as *medical transition*. A subset of those who medically transition may choose to undergo gender reassignment surgery to make their body as congruent as possible with their gender identity. This process of surgical transition is also often referred to as *sex* or *gender reassignment* or *gender confirmation*.

What Is the Estimated Transgender Population in the U.S. Military?

Estimates of the transgender population in the U.S. military and the analyses presented in this report should be interpreted with caution, as there have been no rigorous epidemiological studies of the size or health care needs of either the transgender population in the United States or the transgender population serving in the military. As a result, much existing research relies on self-reported, nonrepresentative survey samples. We applied a range of prevalence estimates from published research to fiscal year (FY) 2014 personnel numbers to estimate the number of transgender individuals serving in the U.S. military. We estimate that there are between 1,320 and

6,630 transgender personnel serving in the active component (AC) and 830–4,160 in the Selected Reserve (SR). Combining survey evidence from multiple states and adjusting for the male/female distribution in the military gave us a midrange estimate of around 2,450 transgender personnel in the AC and 1,510 in the SR.

How Many Transgender Service Members Are Likely to Seek Gender Transition–Related Medical Treatment?

We developed two estimates of demand for gender transition–related medical treatments based on private health insurance data and self-reported data from the National Transgender Discrimination Survey (NTDS). Based on our analyses of available private health insurance data on transition-related health care utilization, we expect only a small number of AC service members to access transition-related health care each year. Our estimates based on private health insurance data ranged from 0.022 to 0.0396 annual claimants per 1,000 individuals. Applied to the AC population, these estimates led to a lower-bound estimate of 29 AC service members and an upper-bound estimate of 129 AC service members annually utilizing transition-related health care, out of a total AC force of 1,326,273 in FY 2014.

We also projected health care utilization using the estimated prevalence of transgender service members and self-reported survey data from the NTDS describing the proportion of the transgender population seeking transition-related treatments by age group. Based on these calculations, we estimated, as an upper-bound, 130 total gender transition–related surgeries and 140 service members initiating transition-related hormone therapy (out of a total AC force of 1,326,273 in FY 2014). To put these numbers in perspective, an estimated 278,517 AC service members accessed mental health services in FY 2014. Hence, we expect annual gender transition–related health care to be an extremely small part of the overall health care provided to the AC population.

What Are the Costs Associated with Extending Health Care Coverage for Gender Transition–Related Treatments?

To determine the budgetary implications of gender transition–related treatment for Military Health System (MHS) health care costs, we again used data from the private health insurance system on the cost of extending coverage for this care to the transgender personnel population. We estimate that AC MHS 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 AC health care expendi-

tures (approximately \$6 billion in FY 2014)¹ and overall DoD health care expenditures (\$49.3 billion actual expenditures for the FY 2014 Unified Medical Program; Defense Health Agency, 2015, p. 22). These estimates imply small increases in annual health care costs; results that are consistent with the low prevalence of transgender personnel and the low annual utilization estimates that we identified.

What Are the Potential Readiness Implications of Allowing Transgender Service Members to Serve Openly?

Similarly, when assessing the readiness impact of a policy change, we 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.² This is because even at upper-bound estimates, less than 0.1 percent of the total force would seek transition-related care that could disrupt their ability to deploy.³ Existing data also suggest a minimal impact on unit cohesion as a result of allowing transgender personnel to serve openly. However, we caution that these results rely on data from the general civilian population and foreign militaries, as well as previous integration experiences in the military (e.g., gays, lesbians, women), which may not hold for transgender service members.

What Lessons Can Be Learned from Foreign Militaries That Permit Transgender Personnel to Serve Openly?

There are 18 countries that allow transgender personnel to serve openly in their militaries: Australia, Austria, Belgium, Bolivia, Canada, Czech Republic, Denmark, Estonia, Finland, France, Germany, Israel, Netherlands, New Zealand, Norway, Spain, Sweden, and the United Kingdom (Polchar et al., 2014). Our analysis focused on the policies of the four countries—Australia, Canada, Israel, and the United Kingdom—with the most well-developed and publicly available policies on transgender military personnel. Several common themes emerged from our analysis of their experiences:

- The service member's gender is usually considered to have shifted to the target gender in areas such as housing, uniforms, identification cards, showers, and restrooms when a service member publicly discloses an intention to live as the target

¹ AC beneficiaries make up less than 15 percent of TRICARE beneficiaries (Defense Health Agency, 2015).

² We define a labor-year as the amount of work done by an individual in a year.

³ We note that the ability to deploy is not exactly equivalent to readiness. A service member's readiness could be measured by the ability to participate in required training and exercises, which could be affected by treatments as well. Our estimates include days of inactivity due to medical treatments, which could also apply in these settings.

gender and receives a diagnosis of gender incongruence. However, physical fitness standards typically do not fully shift until the medical transition is complete. In many cases, personnel are considered exempt from physical fitness tests during transition.

- Because the gender transition process is unique for each individual, issues related to physical standards and medical readiness are typically addressed on a case-by-case basis. This flexibility has been important in addressing the needs of transgender personnel.
- The foreign militaries we analyzed permit the use of sick leave for gender transition–related medical issues and cover some, if not all, medical or surgical treatments related to a service member’s gender transition.
- In no case was there any evidence of an effect on the operational effectiveness, operational readiness, or cohesion of the force.

The case studies also suggested a number of key best practices:

- Ensure strong leadership support.
- Develop an explicit written policy on all aspects of the gender transition process.
- Provide education and training to the entire force on transgender personnel policy, but integrate this training with other diversity-related training and education.
- Develop and enforce a clear anti-harassment policy that addresses harassment aimed at transgender personnel alongside other forms of harassment.
- Make subject-matter experts and gender advisers serving within military units available to commanders seeking guidance or advice on gender identity issues.
- Identify and communicate the benefits of an inclusive and diverse workforce.

Which DoD Policies Would Need to Be Changed if Transgender Service Members Are Allowed to Serve Openly?

We reviewed 20 current accession, retention, separation, and deployment regulations across the services and the Office of the Secretary of Defense to assess the impact of changes that may be required to allow transgender individuals to serve openly. We also reviewed 16 other regulations that have been replaced by more recent regulations or that did not mention transgender personnel.⁴ Based on the experiences of foreign militaries, we recommend that DoD issue clear and comprehensive policies.

⁴ These additional policies can be listed in Appendix D of this report.

Accession Policy

We recommend that DoD review and revise the language in accession instructions to match the DSM-5 for conditions related to mental fitness, ensuring the alignment of mental health–related language and facilitating appropriate screening and review processes for disorders that may affect fitness for duty. Similarly, physical fitness standards should specify physical requirements (rather than physical conditions). Finally, physical fitness policies should clarify when the service member’s target gender requirements will begin to apply.

Retention Policy

We recommend that DoD expand and enhance its guidance and directives to clarify retention standards for review during and after medical transition. For example, evidence from Canada and Australia suggests that transgender personnel may need to be held medically exempt from physical fitness testing and requirements (Canadian Armed Forces, 2012; Royal Australian Air Force, 2015). However, after completing medical transition, the service member could be required to meet the standards of the acquired gender.

Separation Policy

DoD may wish to revise the current separation process based on lessons learned from the repeal of Don’t Ask, Don’t Tell. The current process relies on administrative decisions outside the purview of the standard medical and physical review process. This limits the documentation and review of discharges, and it could prove burdensome if transgender-related discharges become subject to re-review and redetermination. When medically appropriate, DoD may wish to establish guidance on when such discharge reviews should be handled through the existing medical fitness processes. We also recommend that DoD develop and disseminate clear criteria for assessing whether and how transgender-related conditions may interfere with duty performance.

Deployment Policy

The degree of austerity will differ across deployment environments, and some locations may be able to meet the health care needs of some transgender individuals. Moreover, recent advancements can minimize the invasiveness of treatments and allow for telemedicine or other forms of remote medical care.

Given this, DoD may wish to adjust some of its processes and deployment restrictions in the context of medical and technological advancements (e.g., minimally invasive treatments, telemedicine). Such reforms could minimize the readiness impact of medical procedures that are common among the transgender population. For example, current regulations specifying that conditions requiring regular laboratory visits that cannot be accommodated in a deployed environment can leave service members ineligible for deployment and would affect all individuals receiving hormone treatments

(Office of the Assistant Secretary of Defense for Health Affairs, 2013, p. 3). These treatments require laboratory monitoring every three months for the first year as hormone levels stabilize (Hembree et al., 2009; Elders et al., 2014). To avoid this cost, DoD would need to either permit more flexible monitoring strategies⁵ or provide training to deployed medical personnel.⁶

⁵ Some experts suggest that alternatives, such as telehealth reviews, would address this issue for rural populations with limited access to medical care (see, for example, World Professional Association for Transgender Health, 2011).

⁶ “Independent duty corpsmen, physician assistants, and nurses can supervise hormone treatment initiated by a physician” (Elders et al., 2014).

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Abbreviations

AC	active component
APA	American Psychiatric Association
DoD	U.S. Department of Defense
DoDI	U.S. Department of Defense instruction
DSM-5	<i>Diagnostic and Statistical Manual of Mental Disorders</i> , fifth ed.
FY	fiscal year
GD	gender dysphoria
IDF	Israel Defense Forces
LGBT	lesbian, gay, bisexual, and transgender
MHS	Military Health System
MTF	military treatment facility
NTDS	National Transgender Discrimination Survey
SR	Selected Reserve
VHA	Veterans Health Administration
WPATH	World Professional Association for Transgender Health

CHAPTER ONE

Introduction

U.S. Department of Defense (DoD) policies have rendered both the physical and psychological aspects of “transgender conditions” disqualifying conditions for accession and allowed for the administrative discharge of service members who fall into these categories. However, in July 2015, Secretary of Defense Ashton Carter announced that DoD would “create a working group to study the policy and readiness implications of welcoming transgender persons to serve openly.” In addition, he directed that “decision authority in all administrative discharges for those diagnosed with gender dysphoria¹ or who identify themselves as transgender be elevated to the Under Secretary of Defense (Personnel and Readiness), who will make determinations on all potential separations” (DoD, 2015b). It is against this backdrop that DoD is considering allowing transgender service members to serve openly. To assist in identifying the potential implications of such a policy change, the Office of the Under Secretary of Defense for Personnel and Readiness asked 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.

Study Approach

Our study approach centered around the following research questions:

- What are the health care needs of the transgender population?
- What is the estimated transgender population in the U.S. military?

¹ *Gender dysphoria*, or GD, is “discomfort or distress that is caused by a discrepancy between a person’s gender identity and that person’s sex assigned at birth” (World Professional Association for Transgender Health [WPATH], 2011, p. 2).

- How many transgender service members are likely to seek gender transition–related medical treatment?
- What are the costs associated with extending health care coverage for gender transition–related treatments?
- What are the potential readiness implications of allowing transgender service members to serve openly?
- What lessons can be learned from foreign militaries that permit transgender personnel to serve openly?
- Which DoD policies would need to be changed if transgender service members are allowed to serve openly?

We explain our methodological approaches in detail in each chapter of this report, but, here, we present overviews of the various methodologies that we employed. We began our analysis by defining the term *transgender* and then identifying the health care needs of the transgender population. This entailed an extensive literature review of these health care needs, along with treatment standards and medical options—particularly for those who have been diagnosed with gender dysphoria (GD).

We then undertook a review of existing data to estimate the prevalence and likely utilization rates of the transgender population in the U.S. military. Based on our estimates of the potential utilization of gender transition–related health care services, we estimated the Military Health System (MHS) costs for transgender active-component (AC) service members and reviewed the potential effects on force readiness from allowing these service members to serve openly.

We adopted two distinct but related approaches to estimating health care utilization and readiness impact. The first is what we label the *prevalence-based approach*, in which we estimated the prevalence of transgender personnel in the military and applied information on rates of gender transition and reported preferences for different medical treatments to measure utilization and the implied cost and readiness impact. This approach has the benefit of including those who may seek other forms of accommodation, even if they do not seek medical care. It also provides detailed information on the types of medical treatments likely to be sought, which can improve the accuracy of cost and readiness estimates. However, this approach suffers from a lack of rigorous evidence in terms of the rates at which transgender individuals seek treatment and instead relies on the nonscientific National Transgender Discrimination Survey (NTDS). This approach also relies on prevalence measures from only two states, Massachusetts and California, which may not be directly applicable to military populations.

Using our second approach, which we label the *utilization-based approach*, we estimated the rates of utilization of gender transition–related medical treatment. This approach has the benefit of providing real-world measures of utilization, which may be more accurate and more rigorously collected than survey information. However, it suffers from a lack of large-scale evidence and instead relies on several case studies

that may not be directly applicable to the U.S. military. Given the caveats described, these approaches provide the best available estimate of the potential number of transgender service members likely to seek medical treatment or require readiness-related accommodations.² In both cases, we applied measures of population prevalence and utilization to fiscal year (FY) 2014 DoD force size estimates to provide estimates of prevalence within the U.S. military.

We also reviewed the policies of foreign militaries that allow transgender service members to serve openly. Our primary method supporting the observations presented in this report was an extensive document review that included primarily publicly available policy documents, research articles, and news sources that discussed policies on transgender personnel in these countries. The information about the transgender personnel policies of foreign militaries came directly from the policies of these countries, as well as from research articles describing the policies and their implementation. Findings on the effects of open transgender service on cohesion and readiness drew largely from research articles that specifically examined this question using interviews and an analysis of studies completed by the foreign militaries themselves. Finally, insights on best practices and lessons learned emerged both directly from research articles describing the evolution of policy and experience and indirectly from commonalities in the policies and experiences of our four in-depth case studies. Recommendations provided in this report are based on these best practices and lessons learned, as well as a consideration of the unique characteristics of the U.S. military.

Finally, for our analysis of DoD policies, we reviewed 20 current accession, retention, separation, and deployment regulations across the services and the Office of the Secretary of Defense. We also reviewed 16 other regulations that have been replaced by more recent regulations or that did not mention transgender personnel.³ Our review focused on transgender-specific DoD instructions (DoDIs) that may contain unnecessarily restrictive conditions and reflect outdated terminology and assessment processes. However, in simply removing these restrictions, DoD could inadvertently affect standards overall. While we focused on reforms to specific instructions and directives, we note that DoD may wish to conduct a more expansive review of personnel policies to ensure that individuals who join and remain in service can perform at the desired level, regardless of gender identity.

Limitations and Caveats

A critical limitation of such a comprehensive assessment is the lack of rigorous epidemiological studies of the size or health care needs of either the U.S. transgender population or the transgender population serving in the military. Indeed, much of the

² We define *accommodations* as adjustments in military rules and policies to allow individuals to live and work in their target gender.

³ These additional policies are listed in Appendix D of this report.

existing research on the transgender population relies on self-reported, nonrepresentative survey data, along with unstandardized calculations using results from available studies. Because there are no definitive data on this topic, the information presented here should be interpreted with caution and, therefore, we present the full range of estimates.

Organization of This Report

The report is organized around our seven research questions. Chapter Two defines what is meant by the term *transgender*, identifies the health care needs of the transgender population, explains the various treatment options for those diagnosed with GD, and examines the capacity of the MHS to provide treatment options to service members diagnosed with GD. Chapter Three estimates the number of transgender service members in the AC and Selected Reserve (SR). Chapter Four estimates how many transgender service members are likely to seek medical treatment. Chapter Five estimates the costs associated with extending health care coverage for gender transition–related treatments. Chapter Six assesses the potential readiness implications of allowing transgender service members to serve openly. Chapter Seven identifies lessons learned from foreign militaries that allow transgender personnel to serve openly. Chapter Eight offers recommendations regarding which DoD accession, retention, separation, and deployment policies would need to be changed if a decision is made to allow transgender service members to serve openly. Chapter Nine summarizes key findings presented in the report and suggests best practices for implementing policy changes.

Appendix A presents definitions of common terms related to gender transition and transgender identity. Appendix B provides a history of the historical nomenclature associated with transgender identity. Appendix C provides details on the psychosocial, pharmacologic, surgical, and other treatments for GD. Appendix D lists the DoD accession, retention, separation, and deployment policies that we reviewed.

CHAPTER TWO

What Are the Health Care Needs of the Transgender Population?

This report begins by describing the health care needs of the U.S. transgender population overall. To discern the potential impact of changing DoD policies to allow transgender military personnel to serve openly and to ensure appropriate health care for those who seek gender transition–related treatment, it is also important to consider whether the MHS has the capacity to provide this care.

Definitions of Key Terms and Concepts

A challenge to our efforts to understand the health care needs of the transgender population in general, as well as in the military, is the varied and shifting terminology used in the clinical literature. Consequently, here, we define a range of terms that we will use throughout this review.¹ Consistent with the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5), the American Psychiatric Association (APA) publication that provides standard language and criteria for classifying mental health conditions, we use the term *transgender* to refer to “the broad spectrum of individuals who . . . identify with a gender different from their natal gender” (APA, 2013).² *Natal gender* or *birth sex*, which is the sex that an individual was assigned at birth and typically correlates with primary sex characteristics (e.g., genitalia).

We refer to the subset of the population whose gender identity does not conform with the expressions and behaviors typically associated with the sex to which they were assigned at birth as *transgender* or *gender nonconforming*. Many identities fall under these umbrella terms, including individuals who identify as androgynous, multigendered, third gender, and two-spirit people. The *gender nonconforming* category also includes individuals who *cross-dress*, which means they wear clothing that is traditionally worn by a gender different from that of their birth sex. The exact definitions of each of these identities vary under the term *gender nonconforming*, and individuals may

¹ A comprehensive list of terms and definitions is provided in Appendix A.

² A brief history of the DSM language and diagnostic criteria for related conditions is presented in Appendix B.

fluidly change, blend, or alter their gender identity over time. For the purposes of this analysis, we use *transgender* as an umbrella term that refers to individuals who identify with a gender different from the sex they were assigned at birth.

Importantly, under the recently established criteria and terminology outlined in DSM-5, transgender status alone does not constitute a medical condition (APA, 2013). Instead, under the revised diagnostic guidelines, only transgender individuals who experience significant related distress are considered to have a medical condition called *gender dysphoria* (GD). Some combination of psychosocial, pharmacologic (mainly but not exclusively hormonal), or surgical care may be medically necessary for these individuals. Psychotherapy to confirm a diagnosis of GD is a common first step in the process, often followed by hormone therapy and, perhaps, by gender reassignment surgery involving secondary or primary sex characteristics. Not all patients seek all forms of care. However, recognized standards of care require documentation of 12 continuous months of hormone therapy and living in the target gender role consistently and in all aspects of life. Unfortunately, the diagnosis is newly established, and data from which to estimate the size of these subgroups are lacking. In the future, however, transgender individuals seeking gender transition–related treatment are likely to require a GD diagnosis as the clinical justification.

Among transgender individuals, a subset may choose to *transition*, the term used to refer to the act of living and working in a gender different from one’s sex assigned at birth. For some individuals, this may involve primarily social change but no medical treatment; this is referred to as *social transition*. For others, medical treatments, such as hormone therapy and hair removal, are important steps to align their physical body with their target gender. This is referred to as *medical transition*. A subset of those who medically transition may choose to undergo *gender reassignment surgery* to make their physical body as congruent as possible with their gender identity. This process of *surgical transition* is also often referred to as *sex* or *gender reassignment* or *gender confirmation*.

Health Care Needs of the Transgender Population

The main types of gender transition–related treatments are psychosocial, pharmacologic (primarily but not exclusively hormonal), and surgical. While one or more of these types of treatments may be necessary for some transgender individuals with GD, the course of treatments varies and must be determined on an individual basis by patients and clinicians. Since little is known about currently serving transgender service members, the following discussion draws primarily from available research on nonmilitary transgender populations.³

³ The 2015 DoD Health Related Behavior Survey of active-duty service members was being fielded concurrently to this research. It marked the first time a U.S. military survey asked questions relating to gender identity

Diagnosis and Treatments for Gender Dysphoria

Treatments deemed necessary for transgender populations have shifted over time based on research advancements and the accumulation of clinical knowledge. The World Professional Association for Transgender Health (WPATH) regularly publishes revised versions of its *Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People*; the most current at the time of our research was version 7. The standards are designed to guide the treatment of patients experiencing GD while recognizing that not all expressions of gender nonconformity require treatment (WPATH, 2011, p. 2). Some transgender individuals (again, the proportion is largely unknown) experience significant dysphoria (distress) with the sex and gender they were assigned at birth, and they meet formal DSM-5 diagnostic criteria for GD, as described in Appendix B of this report. For those diagnosed with GD, treatment options include psychotherapy, hormone therapy, surgery, and changes to gender expression and role (i.e., how people present themselves to the world; WPATH, 2011, pp. 9–10). We discuss these treatment options in detail in Appendix C.

Not all patients will prefer or need all or any of these options; however, when clinically indicated, appropriate care can “alleviate gender dysphoria by bringing one’s physical characteristics into alignment with one’s internal sense of gender” (Herman, 2013b, p. 4). There have been no randomized controlled trials of the effectiveness of various forms of treatment, and most evidence comes from retrospective studies. The widely endorsed consensus-based practice guidelines outlined in the WPATH *Standards of Care* suggest that transition-related mental health care, hormone therapy, and surgery are generally effective and constitute necessary health care for many individuals with GD.⁴ The appropriate treatment plan is best determined collaboratively by patients and their health care providers. Optimally, specialized transgender health care will be provided by an interdisciplinary team (WPATH, 2011, p. 26).

Military Health System Capacity and Gender Transition–Related Treatment

To discern the potential impact of changing DoD policies to allow transgender military personnel to serve openly and to ensure appropriate health care for GD, it is also important to consider whether the MHS has the capacity to provide this care.

We anticipate that these survey results will provide additional information regarding how many transgender personnel currently serve in the U.S. military and their health behaviors.

⁴ These standards are endorsed by the American Medical Association, American Psychological Association, American Academy of Family Physicians, National Association of Social Workers, World Professional Association for Transgender Health, and American College of Obstetricians and Gynecologists (see Lambda Legal, 2012). Major insurers, including Aetna and UnitedHealthcare, have incorporated many of these standards of care into their policies (see, for example UnitedHealthcare, 2015).

Psychotherapy, Hormone Therapies, and Gender Transition–Related Surgery

Both psychotherapy and hormone therapies are available and regularly provided through the military's direct care system, though providers would need some additional continuing education to develop clinical and cultural competence for the proper care of transgender patients. Surgical procedures quite similar to those used for gender transition are already performed within the MHS for other clinical indications.

Reconstructive Surgery

Reconstructive breast/chest and genital surgeries are currently performed on patients who have had cancer, been in vehicular and other accidents, or been wounded in combat. The skills and competencies required to perform these procedures on transgender patients are often identical or overlapping. For instance, mastectomies are the same for breast cancer patients and female-to-male transgender patients. Perhaps most importantly, the surgical skills and competencies for some gender transition surgeries also overlap with skills required for the repair of genital injuries sustained in combat, which have increased dramatically among troops deployed to Afghanistan. From 2009 to 2010, the percentage of wounded troops with genitourinary injuries transiting through Landstuhl Regional Medical Center in Germany nearly doubled from 4.8 percent to 9.1 percent—a dramatic increase that led some health providers to call this the “new ‘signature wound’” of Operation Enduring Freedom (D. Brown, 2011).⁵ There are particular similarities to the procedures recommended to treat those experiencing dismounted complex blast injuries, which typically involve multiple amputations with other injuries, often to the genitals (Wallace, 2012). Providing high-quality surgery to treat the 5 percent of combat wounds that require penile reconstruction requires extensive knowledge and practice in reconstructive techniques (Williams and Jezior, 2013). Assuming the MHS continues to directly provide health services as it has in the past, there are at least two potential implications: First, military surgeons may currently have the competencies required to surgically treat patients with GD, and, second, performing these surgeries on transgender patients may help maintain a vitally important skill required of military surgeons to effectively treat combat injuries during a period in which fewer combat injuries are sustained.

Cosmetic Surgery

Recognition of the requirement for reconstructive plastic surgery as a result of the war-time mission drives the existing DoD policy for cosmetic surgery procedures in the MHS; the services have requirements and manpower authorizations for specialists who can perform reconstructive plastic surgery (Office of the Assistant Secretary of Defense

⁵ Experimental penis transplants, expected to be performed for the first time within the next year at Johns Hopkins School of Medicine, are being developed in the United States specifically for combat-wounded veterans; however, there may be benefits for transgender patients as well (Welsh, 2015).

for Health Affairs, 2005, p. 1). Cosmetic/reconstructive surgery skills need to be maintained with practice, and surgeons must also “meet board certification, recertification, and graduate medical education program requirements” (Office of the Assistant Secretary of Defense for Health Affairs, 2005, p. 1).

Current DoD policy draws a distinction between elective cosmetic plastic surgery performed “to improve the patient’s appearance or self-esteem” and reconstructive plastic surgery performed on bodily structures that are abnormal due to health conditions to improve function or approximate a normal appearance (Office of the Assistant Secretary of Defense for Health Affairs, 2005, p. 3). While reconstructive surgeries constitute necessary treatment, access to elective cosmetic surgical procedures is subject to added constraints. For example, cosmetic procedures are performed on a space-available basis and restricted to those who will be TRICARE-eligible for at least six months. These procedures also require written permission from the commander of the service member’s active-duty unit, and the patient must pay surgical, institutional, and anesthesia fees (Office of the Assistant Secretary of Defense for Health Affairs, 2005, p. 3).⁶ DoD recognizes the need for these reconstructive surgery competencies and has crafted a policy to cover plastic surgeries to maintain providers’ surgical skills and certification requirements.

Potential Consequences of Not Providing Necessary Gender Transition–Related Care

The discussion of the health care needs of transgender military personnel is incomplete without considering the potential unintended effects of constraining or limiting gender transition–related treatment. Little question remains that there are transgender personnel currently serving in the AC. Adverse consequences of not providing transition-related health care to transgender personnel could include avoidance of other necessary health care, such as important preventive services, as well as increased rates of mental and substance use disorders, suicide, and reduced productivity.

Research indicates that, “due to discrimination and problematic interactions with health care providers, transgender individuals frequently do not access health care, resulting in short and long-term adverse health outcomes” (Roller, Sedlak, and Draucker, 2015, p. 418).⁷ Further, patients denied appropriate health care may turn to other solutions, such as injecting construction-grade silicone into their bodies to alter

⁶ Interestingly, according to Elders et al. (2014, p. 19), there is no difference in leave policies related to recovery time between the two.

⁷ For example, among NTDS respondents, 28 percent reported postponing or avoiding treatment when sick or injured, and 33 percent delayed or skipped preventive care due to discrimination or disrespect from health care providers (Grant et al., 2011, p. 76). In one study, transgender respondents had fewer self-reports of good health and were more likely to report limitations on daily activities due to health issues (Kates et al., 2015, p. 5).

their shape (State of California, 2012, p. 12). There are also potential costs related to mental health care services for individuals who do not receive such care (Herman, 2013b, p. 20). Multiple observational studies have suggested significant and sometimes dramatic reductions in suicidality, suicide attempts, and suicides among transgender patients after receiving transition-related treatment (State of California, 2012, p. 10). A study by Padula, Heru, and Campbell (2015) found that removing exclusions on transgender care “could change the trajectory of health for all transgender persons” at a minimal cost per member per month.⁸

However, we caution that it is not known how well these findings generalize to military personnel. Moreover, while the existing data offer some indication of the needs for and costs of gender transition–related health care, it is important to note that none of these studies were randomized controlled trials (the gold standard for determining treatment efficacy). In the absence of quality randomized trial evidence, it is difficult to fully assess the outcomes of treatment for GD.

⁸ Specifically, they found that insurance provider coverage for transgender-related services resulted in “greater effectiveness, and was cost-effective relative to no health benefits at 5 and 10 years from a willingness-to-pay threshold of \$100,000/[quality-adjusted life year].”

CHAPTER THREE

What Is the Estimated Transgender Population in the U.S. Military?

This chapter provides several estimates of the number of transgender service members in the U.S. military. To date, there have been no systematic studies of the number of transgender individuals in the U.S. general population or in the U.S. military. Current studies rely on clinical samples of health care service utilizers, nonrepresentative samples assembled in ways that are difficult to replicate, and self-reported survey data from a small number of states.

General Population Estimates of Transgender Prevalence

The transgender prevalence in the U.S. general population is thought to be significantly less than 1 percent (Gates, 2011, p. 6; APA, 2013, p. 454). However, there have been no rigorous epidemiological studies in the general U.S. population that confirm this estimate. Our subsequent estimates must be qualified, therefore, as somewhat speculative; they are based on numerous sources, including health services claims data, representative state-level health surveillance survey data, a convenience (i.e., non-representative) sample recruited by an advocacy network, the experiences of foreign militaries, and selected other data sources.

The Williams Institute at the University of California, Los Angeles, School of Law, calculated that, based on estimates from Massachusetts and California, 0.3 percent of the U.S. population is transgender (Gates, 2011, p. 6). The Massachusetts data were collected between 2007 and 2009 as part of the Massachusetts Behavioral Risk Factor Surveillance System initiative. The survey suggests that 0.5 percent of the population in Massachusetts identifies as “transgender” (95-percent confidence interval: 0.3 to 0.6 percent; Conron et al., 2012). The California data combine information on the percentage of individuals who are transgender from the California Lesbian, Gay, Bisexual, and Transgender (LGBT) Tobacco Survey and the percentage of the overall population that is LGBT from the 2009 California Health Interview Survey. Gates

multiplies these values together to estimate that 0.1 percent of the population of California is transgender.¹

To develop an estimate of transgender prevalence for the entire United States, Gates (2011) simply averages the Massachusetts and California values, yielding 0.25 percent, then rounds that up to 0.3 percent. This measure is very problematic, however. While survey-based estimates of transgender prevalence are likely to be accurate measures of true state-level transgender prevalence, it is not clear that taking an unweighted average from states with vastly different population sizes is appropriate for estimating national prevalence. For example, a weighted average calculation using the 2009 census population estimates for California and Massachusetts implies a 0.16 percent “national” prevalence estimate, as opposed to the 0.3 percent estimate calculated by Gates (2011)—a nearly 50-percent difference. We used this 0.16 percent weighted average as our combined, national estimate using the California and Massachusetts studies. This estimate was our midrange starting point, though we included both the 0.1 percent (from California) and 0.5 percent (from Massachusetts) as comparison points.

We note that there have been and continue to be other efforts to measure the prevalence of transgender identity in the general population. The two most prominent examples are the meta-analysis conducted by WPATH and a recent effort from the U.S. census. We did not use these estimates due to concerns that they systematically undercounted the prevalence of transgender identity for a variety of reasons detailed in the discussions that follow.

Separately, in 2007, the WPATH reviewed ten studies of prevalence with estimates for transgender individuals presenting for gender transition–related care, ranging from 1:11,900 to 1:45,000 for male-to-female transitions and 1:30,400 to 1:200,000 for female-to-male transitions (WPATH, 2011).² The studies cited were largely based on clinical usage. The WPATH authors note that these numbers should be considered “minimum estimates at best”:

The published figures are mostly derived from clinics where patients met criteria for severe gender dysphoria and had access to health care at those clinics. These estimates do not take into account that treatments offered in a particular clinic setting might not be perceived as affordable, useful, or acceptable by all self-identified gender dysphoric individuals in a given area. By counting only those people who

¹ Although Gates (2011) states that 3.2 percent of the LGBT population is transgender, we note that an earlier document (California Department of Health Services, 2004) reporting analyses from the same survey states that 2 percent of this population is transgender. We were not able to obtain the raw data and could not verify which of the two values is correct. We used the 3.2-percent estimate to calculate the California transgender prevalence estimate.

² The studies were Wälinder, 1968; Wälinder, 1971; Hoenig and Kenna, 1974; Eklund, Gooren, and Bezemer, 1988; Tsoi, 1988; Bakker et al., 1993; van Kesteren, Gooren, and Megens, 1996; Weitze and Osburg, 1996; De Cuypere et al., 2007; and Zucker and Lawrence, 2009.

present at clinics for a specific type of treatment, an unspecified number of gender dysphoric individuals are overlooked. (WPATH, 2011, p. 7)

Additionally, the information is based on utilization rates from the ten studies, mostly conducted in European countries, such as the United Kingdom, the Netherlands, Sweden, Germany, and Belgium. One study was conducted in Singapore. This raises concerns about the applicability of these estimates to the U.S. population due to differences in costs and social tolerance, both of which would likely make health utilization behavior in Europe significantly different from that in the United States. Moreover, the studies were conducted over a 30-year period in which utilization was dramatically increasing, suggesting that the estimates were not stable. This concern is reported in the WPATH report, with the authors noting that the trend (over time) was due to higher rates of individuals seeking care. In one example, the estimated transgender population doubled in just five years in the United Kingdom. If the numbers are increasing over time based on the use of clinics, then an estimate from ten to 15 years ago would likely be very low relative to utilization in those same places today, and again not representative of likely utilization in the United States.³

Harris (2015) used information on name and sex changes in Social Security Administration data files to estimate the number of transgender individuals in the U.S. population. Using information on male-to-female and female-to-male name changes, he estimates that there were 89,667 transgender individuals in the United States in 2010. Of this group, 21,833 (24 percent) also changed their sex, according to Social Security records; during some periods in U.S. history, this required documented proof of either initiation or completion of medical transition. Since name changes are not required, prevalence estimated in this manner is likely to be a lower-bound estimate of the true transgender prevalence rate in the United States. Using the 2010 population of adults age 18 and over as the denominator (234,564,071), 89,667 transgender cases implies a lower-bound transgender prevalence rate of 0.038 percent in the United States.

³ According to the WPATH authors,

The trend appears to be towards higher prevalence rates in the more recent studies, possibly indicating increasing numbers of people seeking clinical care. Support for this interpretation comes from research by Reed and colleagues (2009), who reported a doubling of the numbers of people accessing care at gender clinics in the United Kingdom every five or six years. Similarly, Zucker and colleagues (2008) reported a four- to five-fold increase in child and adolescent referrals to their Toronto, Canada clinic over a 30-year period. (WPATH, 2011, p. 7)

Prevalence-Based Approach to Estimating the Number of Transgender Service Members in the U.S. Military

Before discussing estimates of prevalence of transgender individuals in the U.S. military, it is important to note that, to our knowledge, no studies have directly measured the prevalence or incidence of transgender individuals currently serving in the active or reserve component.⁴ To estimate prevalence in the military, we have constructed estimates using a combination of data sources.⁵ One of those sources, the NTDS, provides detailed information on the choices and preferences of transgender individuals but it is not a randomized, representative sample of the military and thus is not generalizable.

We applied measures of population prevalence to DoD force size estimates to estimate prevalence in the U.S. military. We measured force size using information from DoD's 2014 demographics report (DoD, 2014; see Table 3.1). The demographics are separated into AC and SR. For much of the discussion of our medical care analysis, we focus on the AC. We did not include reserve-component service members, retirees, or dependents in the cost analyses because we did not have information on age and sex distribution within these beneficiary categories. Some of these beneficiary categories also have limited eligibility for health care provided through military treatment facilities (MTFs) and may receive their health care through TRICARE coverage in the purchased care setting or through other health insurance plans. For our readiness analysis, we included both the AC and SR because both components may be used for deployments. Although there are ongoing discussions regarding the feasibility of activating the Individual Ready Reserve, we excluded this population because we lacked the detailed information on gender and age needed to conduct our analysis.

Table 3.2 contains estimates of the number of transgender personnel in the AC and SR using the baseline prevalence from existing studies and shows the results of several tests that provide a range of estimates based on different assumptions in the literature. To estimate prevalence in the military, we conducted analyses using five values: (1) a lower-bound estimate of 0.1 percent based on a study in California

⁴ G. Brown (1988) found that eight out of 11 evaluated natal males with severe GD had a military background; he explains his findings by positing a "hypermasculine" phase among transgender individuals that coincides with the age of enlistment. Since the sample size in that study was extremely small, we do not consider this good evidence for this theory. Gates and Herman (2014) used estimates from the NTDS, combined with estimates of transgender prevalence (0.3 percent) from Gates (2011) and history of military service in the U.S. population from the American Community Survey, to estimate transgender prevalence in the military. Data from the National College of Health Administration showed that military experience was significantly higher among transgender individuals than among those who did not identify as transgender (9.4 percent versus 2.1 percent; Blossnich, Gordon, and Fine, 2015). However, these data were collected from only 51 institutions, and the response rate for the survey was only 20 percent, which again raises questions regarding the validity of the estimates.

⁵ Our estimates were constructed using Gates (2011), which combined estimates from the Massachusetts Behavioral Risk Factor Social Surveys with the California LGBT Tobacco Survey, and Gates and Herman (2014), which used data from the NTDS, Gates (2011), and the American Community Survey.

Table 3.1
DoD Military Force Demographics

Category	Number	%
Active Component		
Sex		
Female	200,692	15
Male	1,125,581	85
Age		
<25	572,293	43
26–30	293,698	22
31–35	201,137	15
36–40	137,653	11
41+	121,492	9
Total	1,326,273	—
Selected Reserve		
Sex		
Female	149,759	18
Male	682,233	82
Age		
<25	285,494	34
26–30	156,983	19
31–35	124,179	15
36–40	86,151	10
41+	179,185	22
Total	831,992	—

SOURCE: DoD, 2014.

(Conron, 2012); (2) an upper-bound estimate of 0.5 percent based on a study in Massachusetts (Gates, 2011); (3) a population-weighted average of the California and Massachusetts studies, yielding a prevalence estimate of 0.16 percent; (4) an adjustment of this population-weighted approach based on the natal male/female distribution in the military, yielding a prevalence estimate of 0.19 percent; and (5) a doubling of the population-weighted, gender-adjusted value, yielding a prevalence estimate of 0.37 percent.

Table 3.2
Prevalence-Based Estimates of the Number of Transgender Active-Component and Selected Reserve Service Members

Component	Total Force Size (FY 2014)	0.1% ^a (CA study)	0.16% ^b (combined, population-weighted CA + MA studies)	0.19% ^c (gender-adjusted rate)	0.37% ^d (twice gender-adjusted rate)	0.5% ^e (MA study)
Active	1,326,273	1,320	2,120	2,450	4,900	6,630
Selected Reserve	831,992	830	1,330	1,510	2,930	4,160

SOURCES: Estimates for force size are based on RAND calculations using FY 2014 data from DoD, 2014.

^a Based on estimates of prevalence from a California study (Conron, 2012).

^b Based on weighted average of studies from California and Massachusetts, weighted by relative population sizes in each state.

^c Based on weighted average of studies from California and Massachusetts, weighted by relative population sizes in each state and applied specifically to the male/female distribution in the military components.

^d Based on estimates of prevalence from NTDS, Gates (2011), and the American Community Survey (Gates and Herman, 2014) and applied specifically to the male/female distribution in the military.

^e Based on estimates of prevalence from a Massachusetts study (Gates, 2011).

Based on the 0.1 percent lower bound, we estimate that there are approximately 1,320 transgender individuals in the AC and approximately 830 in the SR. Using the Massachusetts study (0.5 percent) as an upper bound, we estimate that there are approximately 6,630 transgender service members in the AC and 4,160 in the SR. Because these estimates are based on selected populations in the state and the variation in these populations is significant, we were concerned that they were not representative of broader national numbers, especially as they pertain to the gender mix of the military. Therefore, we adjusted the population-weighted combination of these estimates to account for the male/female distribution in the U.S. military populations. This gender adjustment is critical, as most research indicates that male-to-female transitions are two to three times more common than female-to-male transitions (APA, 2013; Horton, 2008; Gates, 2011; Grant et al., 2011). This assumption of a two to one difference in underlying prevalence across genders applied to the 0.16 percent aggregate estimate implies a natal male-specific prevalence of 0.2 percent and a natal female-specific prevalence of 0.1 percent. Assigning these values to the male/female AC distributions increases the military prevalence estimate from 0.16 percent to 0.19 percent, which implies that there are 2,450 transgender individuals in the AC and 1,510 in the SR.

The estimate of 0.37 percent doubles the gender-adjusted rate based on information provided by the NTDS that 20 percent of the transgender population in its sample reported a history of military service, which is twice the rate of the general population,

as reported in the American Community Survey (Grant et al., 2011). We note that this is likely to be an overestimate of the overall transgender population for two reasons. First, given the highly tolerant environment in Massachusetts and California, the prevalence estimates in those two states are likely to overstate the nationwide prevalence.⁶ Second, the evidence that transgender individuals are twice as likely to serve in the military is based on extrapolations from a nonrepresentative sample of individuals and not on direct, rigorous study of the transgender military population.

⁶ For example, both California and Massachusetts are rated as “top places for LGBT rights” (Keen, 2015).

CHAPTER FOUR

How Many Transgender Service Members Are Likely to Seek Gender Transition–Related Medical Treatment?

We adopted two distinct but related approaches to estimate the health care utilization and impact on readiness of allowing transgender personnel to serve openly in the U.S. military. The first is what we label the *prevalence-based approach*, in which we estimated the prevalence of transgender individuals in the military and applied information on rates of gender transition and reported preferences for different medical treatments to measure utilization and the implied cost and readiness impact. This approach has the benefit of including those who may seek other forms of accommodation, even if they do not seek medical care. It also provides detailed information on the types of medical treatments likely to be sought, which can improve the accuracy of cost and readiness estimates. However, this approach suffers from a lack of rigorous evidence in terms of the rates at which transgender individuals seek treatment and instead relies on the nonscientific NTDS. It also relies on prevalence measures from only two states—Massachusetts and California—that may not be directly applicable to military populations.

We refer to our second approach as the *utilization-based approach*, which we used to estimate the rates of utilization of medical treatment. This approach has the benefit of providing real-world measures of utilization based on health insurance claims, which may be more accurate and more rigorously collected than survey information. However, this approach suffers from a lack of large-scale evidence and instead relies on several case studies that may not be directly applicable to the U.S. military. Despite these caveats, these approaches provide the best available estimate of the range in the potential number of transgender service members likely to seek medical treatment or require readiness-related accommodations.¹

In both cases, we applied measures of population prevalence and utilization to DoD force size demographics to provide estimates of prevalence within the U.S. military. As indicated in the previous chapter, our calculations of population prevalence and health care utilization used FY 2014 data from DoD’s 2014 demographics report (DoD, 2014; see Table 3.1 in Chapter Three).

¹ Again, we define *accommodations* as adjustments in military rules and policies to allow individuals to live and work in their target gender.

Prevalence-Based Approach to Estimating the Number of Gender Transition–Related Treatments in the U.S. Military

To estimate the utilization of gender transition–related health care treatments, we scaled the prevalence of transgender service members identified in Chapter Three by the rates of transition and reported take-up of medical treatments. We based our transition rates on self-reported transitions in the NTDS data. According to the NTDS, 55 percent of transgender individuals reported living and working as their target gender; we refer to this as *social transition*.² For others, medical treatments, such as hormone therapy and hair removal, are important steps to align their physical body with their target gender. We refer to this as *medical or surgical transition*.³

Using the prevalence estimates from Table 3.2 in Chapter Three, we used information from the NTDS on the age of transition for individuals under 25, 26–30, 31–35, 36–40, and over 40 and calibrated our estimates with the age distribution in the military. Fifty-five percent of NTDS respondents reported that they had socially transitioned over their lifetime, and the data indicate that male-to-female transition ages differ from female-to-male transition ages. Nearly 54 percent of female-to-male transitions occurred before the age of 25, compared with only 23 percent of male-to-female transitions.

We focus on social transition because we assess this as most relevant for individuals who may need accommodations as they live and work in a different gender. This was also used as the basis in some foreign militaries, as discussed in Chapter Seven. Table 4.1 presents the estimated number of individuals who may seek to transition each year under each of our prevalence assumptions. We found that a lower bound of 40 AC and 20 SR service members and an upper bound of 190 AC and 110 SR service members will seek to transition each year and may need some sort of accommodations. The population-weighted, gender-adjusted estimate implies a middle range of 65 AC and 40 SR service members who will seek to transition each year.

Next, we combine the estimates of the number of transgender service members with information on the proportion undergoing transition and the age-specific proportion undergoing gender transition–related treatment to generate the number of annual treatments. Surgical preference rates vary by transition type (male-to-female versus female-to-male transition; see Table 4.2). Surgeries are distributed evenly across

² We note that an additional 27 percent of those who had not yet socially transitioned wished to transition at some point in the future. Because the timeline and desire for transition are difficult to translate to concrete numbers, we used the estimate of 55 percent of transgender individuals living and working full-time as their target gender as our planning parameter for readiness accommodations.

³ In the NTDS sample, 65 percent of transgender individuals had medically transitioned, and 33 percent had surgically transitioned. Note that the rate of medical transitions is higher than the rate of social transitions because some individuals receive hormone treatments but do not live full-time as their target gender.

Table 4.1
Estimated Number of Transgender Service Members Who May Seek to Transition per Year

Estimate Source	Active Component (total force: 1,326,273)	Selected Reserve (total force: 831,992)
0.1% (CA study) ^a	40	20
0.16% (combined, population-weighted CA + MA studies) ^b	60	30
0.19% (gender-adjusted rate) ^c	65	40
0.37% (twice gender-adjusted rate) ^d	130	80
0.5% (MA study) ^e	190	110

SOURCES: Estimated proportions of subgroups based on Grant et al., 2011, p. 25. Estimates for the AC and SR are based on RAND calculations using FY 2014 data from DoD, 2014.

^a Based on estimates of prevalence from a California study (Conron, 2012).

^b Based on weighted average of studies from California and Massachusetts, weighted by relative population sizes in each state.

^c Based on weighted average of studies from California and Massachusetts, weighted by relative population sizes in each state and applied specifically to the male/female distribution in the military components.

^d Based on estimates of prevalence from NTDS, Gates (2011), and the American Community Survey (Gates and Herman, 2014) and applied specifically to the male/female distribution in the military.

^e Based on estimates of prevalence from a Massachusetts study (Gates, 2011).

NOTE: The table excludes Individual and Inactive Ready Reserve members because comparable information on their demographics was not available for analysis.

four procedures for male-to-female transitions and primarily over two procedures for female-to-male transitions.

Recall, not all of the individuals seeking to transition would meet the diagnostic criteria for GD, which is a requirement for these surgeries. Moreover, even among individuals who transition in some manner, surgical treatment rates are typically only around 20 percent, with the exception of chest surgery among female-to-male transgender individuals (see Table 4.2).

Table 4.3 shows the estimated annual number of hormone therapy treatments and surgeries in the AC and SR calculated using the same prevalence assumptions described in Chapter Three (see Table 3.2). The surgeries included in the calculations are vaginoplasty, chest surgeries, orchiectomy, hysterectomy, metoidioplasty, and phalloplasty. Note that these estimates constitute the number of treatments, not necessarily the number of individuals. For hormone therapy recipients, the number of treatments and recipients is the same, and these estimates can be treated as counts of individuals. However, the number of individuals is likely smaller for surgical counts because the

Table 4.2
Lifetime Surgery Preferences Among NTDS Survey Respondents

Procedure	Have Had (%)	Want Someday (%)	Do Not Want (%)
Male-to-female			
Augmentation mammoplasty	21	53	26
Orchiectomy	25	61	14
Vaginoplasty	23	64	14
Facial surgery	17	Not reported	Not reported
Female-to-male			
Chest surgery	43	50	7
Hysterectomy	21	58	21
Metoidioplasty	4	53	44
Phalloplasty	2	27	72

SOURCE: NTDS data (Grant et al., 2011).

NOTE: These estimates are from cross-sectional data; individuals likely received each treatment only once and varied in the age at treatment initiation.

same individual may receive more than one type of surgical treatment.⁴ Using the lower-bound estimate from the California study and the upper-bound estimate from the Massachusetts study (see Table 4.3), we estimated that there will be between 45 and 220 hormone treatments and between 40 and 200 transition-related surgeries annually in the AC and SR. The combined population-weighted and gender-adjusted estimate indicates a midrange of 80 hormone treatments and 70 transition-related surgical treatments annually. Although surgical procedures are most likely to be one-time events, hormone therapy treatment rates are likely to be used indefinitely, and the cost and manpower effects will apply until individuals leave the MHS. We did not have information on the length of service conditional on age and therefore could not calculate the total number of service members who would be receiving hormone therapy at any given point in time. We recommend that this line of analysis be explored in the future.

Utilization-Based Approach to Estimating the Number of Gender Transition-Related Treatments in the U.S. Military

While the prevalence-based approach provides a tractable means to estimate potential utilization of gender transition-related care, there are a number of concerns regard-

⁴ For example, a female-to-male transition might include both chest surgery and phalloplasty.

Table 4.3
Estimated Annual Number of Surgeries and Hormone Therapy Users

Assumption Regarding Underlying Prevalence	Active Component		Selected Reserve	
	Annual Major Surgeries	Annual Hormone Therapy	Annual Major Surgeries	Annual Hormone Therapy
0.1% (CA study) ^a	25	30	15	15
0.16% (combined, population-weighted CA + MA studies) ^b	40	45	20	25
0.19% (gender-adjusted) ^c	45	50	25	30
0.37% (twice gender-adjusted rate) ^d	90	100	50	55
0.5% (MA study) ^e	130	140	70	80

SOURCE: RAND analysis.

^a Based on estimates of prevalence from a California study (Conron, 2012).

^b Based on weighted average of studies from California and Massachusetts, weighted by relative population sizes in each state.

^c Based on weighted average of studies from California and Massachusetts, weighted by relative population sizes in each state and applied specifically to the male/female distribution in the military components.

^d Based on estimates of prevalence from NTDS, Gates (2011), and the American Community Survey (Gates and Herman, 2014) and applied specifically to the male/female distribution in the military.

^e Based on estimates of prevalence from a Massachusetts study (Gates, 2011).

NOTE: Hormone therapy is person-level; surgery statistics are counts of surgeries, and one person may have multiple surgeries.

ing the information on which these estimates rely. As stated previously, these concerns include both a reliance on prevalence estimates from just two states and a reliance on data from the NTDS, which were not collected from a random sample. Our utilization estimates were taken primarily from three sources:

- private health insurance utilization data on annual rates of enrollee transgender-related health care utilization in health insurance plans that cover transition-related health care, as reported by Herman (2013b)
- private health clinic data showing estimates of the rates of penectomies and bilateral mastectomies in the U.S. population in 2001, as reported by Horton (2008)⁵

⁵ A penectomy is the surgical removal of the penis. A bilateral mastectomy is the surgical removal of both breasts.

- Veterans Health Administration (VHA) claims data, which were used to calculate prevalence and incidence rates of gender identity disorder (now referred to as GD in DSM-5) from 2006 to 2013, as reported by Kauth et al. (2014).

Each of these data sources provides information on a different outcome, which makes understanding the results more complicated. However, collectively, the information taken from these three studies provides a broad, useful picture regarding potential gender transition–related health care utilization in the AC population. In the following sections, we review each of these studies in detail, identify key estimates from each, and apply the estimates to the AC population identified in Table 3.2 in Chapter Three.

Private Health Insurance Utilization Estimates

Herman (2013b) reports on the experiences of 34 employers that provided gender transition–related health care benefits to their employees and dependents via their health insurance plans. This study specifically reports on the annual number of enrollees who accessed “transition-related care.” This information is derived from health insurance claims data and thus is dependent on the treatments that were covered by the health insurance companies.⁶ The firms surveyed typically covered major gender transition–related surgeries and hormone therapy, but they varied in their coverage of other transition-related treatments, such as vocal cord surgery.⁷

Firms reviewed by Herman (2013b) also typically did not report information on the number of dependents covered but included dependents in their utilization estimates. Data from several sources (e.g., Sonier et al., 2013; Gould, 2012) imply an approximate average one-to-one ratio of employees to dependents in privately insured firms in the United States. Thus, not accounting for the role of dependents in these utilization estimates would overstate utilization by approximately 100 percent.⁸ For

⁶ If firms do not cover particular treatments, it is not possible to file a claim for reimbursement. If individuals in these firms utilized services that were not covered, thus paying for treatments out of pocket or through some other form of health insurance, these utilization estimates will be biased downward.

⁷ One hundred percent of firms covered major gender transition–related surgeries, including hysterectomy, oophorectomy, metoidioplasty, phalloplasty, urethroplasty, vaginectomy, orchiectomy, vaginoplasty, labiaplasty, and clitoroplasty. Ninety-two percent of firms covered bilateral mastectomy for female-to-male patients, but only 59 percent covered female-to-male chest reconstruction, and only 59 percent covered male-to-female augmentation mammoplasty (breast augmentation). All firms covered hormone therapies, specifically estrogen, progesterone, spironolactone, and testosterone.

⁸ We used two different data sources to determine the typical number of dependents covered by the main policyholder in private health insurance firms in the United States. First, we used information from the Robert Wood Johnson Foundation on the number of people who are covered by employer-sponsored health insurance and are the main policyholders and on the number of people who are covered by employer-sponsored health insurance and are dependents. Using these figures, we estimated a 1-to-0.99 policyholder-to-dependent ratio in employer-sponsored private health insurance. The Economic Policy Institute also reports information on this question using data from the U.S. census Current Population Survey. Using this information, we calculated a policyholder-to-dependent ratio of 1 to 0.94.

firms that did not provide information on dependents, we imputed a one-to-one ratio of employees to dependents to identify the total number of enrolled individuals in a given health plan.

Table 4.4 presents the information from Herman (2013b) on the utilization of gender transition–related care in private health insurance firms. The first column shows available information on the identity of the firm. The second describes the number of firms in each category for which we had utilization estimates. The third contains our estimates regarding the total number of enrollees and dependents from all firms in that category. For confidentiality reasons, some surveyed data sources report only ranges for the number of employees in a firm. Therefore, we used the midpoint of the range to impute the number of employees in a particular firm, then assigned the total number of dependents based on this employee value. For example, we had utilization data from two firms in the “private 1,000–9,999 employees” category. Since we assume the midpoint value for firm size, this implies that there are 5,000 employees in each firm, or 10,000 total employees across the two firms. Assuming a one-to-one employee-to-dependent ratio implies an additional 10,000 covered individuals, resulting in a combined total of 20,000 enrollees.

The estimates presented in Table 4.4 indicate that utilization rates range from an annual low of zero individuals per 1,000 enrollees to an annual high of 0.064 individuals per 1,000 enrollees. To obtain a combined estimate of the different values, we constructed a weighted average using the existing utilization estimates, weighting by the number of covered individuals that generated each of the estimates in Table 4.4. A weighted average of all the estimates results in an overall utilization estimate of 0.0396 individuals per 1,000 enrollees.

Table 4.4
Enrollee Utilization of Gender Transition–Related Benefits in Private Health Insurance Firms

Private and Public Firms	Number of Firms	Total Contribution (enrollees + dependents)	Individual Claimants per 1,000 Enrollees
Private, fewer than 1,000 employees	1	1,000	0.0000
Private, 1,000–9,999 employees	2	20,000	0.0540
Private, 10,000–49,000 employees	5	250,000	0.0220
City and County of San Francisco	NA	80,000	0.0640
University of California	NA	100,000	0.0620
Weighted average per 1,000 enrollees			0.0396

SOURCE: Data from Herman, 2013b.

We conducted two sets of calculations using these estimates. First, we used the lowest non-zero utilization figure (0.022 claimants per 1,000 enrollees);⁹ then, we used the weighted average calculation of 0.0396 per 1,000 enrollees. Applying the 0.022 claimants per 1,000 figure to the AC population of 1,326,273 implies that 29 AC service members would receive gender transition–related care annually. Applying the weighted average estimate of 0.0396 per 1,000 enrollees to the AC population implies that 53 service members would receive gender transition–related care annually.

Sensitivity Analyses

We also conducted two additional sensitivity analyses to determine the full potential scope of gender transition–related health care utilization in the AC. A key consideration when applying estimates from civilian populations to the military is that the underlying male/female distribution in the AC is different, with 85 percent of the AC population being male (versus approximately 50 percent in the civilian population). Studies suggest that the prevalence of transgender individuals is higher in the male population than in the female population (APA, 2013; Horton, 2008; Gates, 2011; Grant et al., 2011), so applying civilian estimates directly to the AC would underestimate the true utilization rates.

Accurately accounting for this issue required sex-specific utilization estimates that we could then multiply with the male/female AC distribution (85 percent male, 15 percent female). Unfortunately, we could not identify any sex-specific utilization estimates in the available private health insurance data; the aggregate cost and utilization estimates that we were able to identify already included underlying prevalence differences between the sexes. We posited that utilization would be twice as large for male-to-female transitions than for female-to-male transitions based on an assumption of linearity between transgender prevalence, for which we have sex-specific estimates, and total utilization (Horton, 2008).

Combining this assumption about differing utilization rates with the fact that the male/female labor force participation in the civilian population is close to 50 percent male and 50 percent female, we were able to solve for the sex-specific utilization estimates implied by the aggregate lower-bound (0.022) and weighted average (0.0396) values. Solving for the sex-specific utilization estimates in this manner, for the 0.022 aggregate estimate, we estimated a utilization rate of 0.0293 per 1,000 natal male enrollees and a utilization rate of 0.0146 per 1,000 natal female enrollees.¹⁰ Similarly, for the 0.0396 weighted average figure, solving for the natal sex–specific utiliza-

⁹ The unadjusted version of this figure (0.0044 percent) was also used in Belkin (2015) to estimate health care utilization in the military.

¹⁰ The equation we solved to calculate the natal male–specific and natal female–specific utilization rates is as follows: $0.5(x) + 0.5(2x) = 0.022$. In this equation, the variable x is the natal female–specific utilization rate, and solving for x results in a value of 0.0146. Since the natal male–specific utilization rate is assumed to be twice the natal female rate, it equals 0.0293.

tion estimates, we identified a utilization rate of 0.0528 per 1,000 natal male enrollees and a utilization rate of 0.0264 per 1,000 natal female enrollees.

Applying these solved sex-specific estimates to the AC male/female distribution (1,125,581, or 85 percent male, versus 200,692, or 15 percent female) increased our initial lower-bound estimate of claimants from 29 to 36 and increased our estimate from applying the weighted average from 53 to 65.

Finally, the sociology and psychology literature speculates that there is a higher transgender prevalence in the military compared with the civilian population (G. Brown, 1988). Gates and Herman (2014) also calculated that transgender prevalence in the military is approximately twice the civilian prevalence (Gates, 2011; Gates and Herman, 2014).¹¹ Although we believe that the current body of empirical evidence validating this theory is weak, we take it seriously and consider the possible implications for transition-related health care utilization in the military. Assuming that transgender prevalence in the military is twice the transgender prevalence in the civilian population, and, again, assuming a direct relationship between prevalence and utilization, this would inflate our male/female distribution-adjusted estimates of individuals receiving transition-related care annually from 36 to 72, and from 65 to 129 in the AC. Table 4.5, which summarizes the results from applying the private health insurance estimates to the AC population, allows for a comparison of the different estimates.

Private Health Clinic Estimates

A second source of information regarding gender transition-related health care utilization comes from a survey of surgical clinics conducted by Horton (2008). In 2001, Horton surveyed all major clinics in the United States known to provide transition-related care to determine the number of penectomies and bilateral mastectomies performed on transgender patients. Table 4.6 reports surgery incidence estimates broken out by male-to-female transitions and female-to-male transitions. The third column shows estimates using clinic-reported data only. Horton also developed lower- and upper-bound estimates via assumptions regarding treatment counts for clinics with missing data, and these numbers are reported in the second and fourth columns of Table 4.6.¹² These data were collected in 2001 and coverage of gender transition-related benefits have increased over time, so it is also reasonable to assume that surgical tran-

¹¹ As stated previously, Gates and Herman (2014) used estimates from the NTDS and Gates (2011) for a transgender prevalence of 0.3 percent. That study also used data on history of military service in the U.S. population from the American Community Survey to estimate transgender prevalence in the military. Data from the National College of Health Administration show that military experience was significantly higher among transgender individuals than among those who did not identify as transgender (9.4 percent versus 2.1 percent; Blossnich, Gordon and Fine, 2015). However, data were collected from only 51 institutions, and the response rate for the survey was only 20 percent, which again raises questions regarding the validity of the estimates.

¹² Horton generated upper- and lower-bound estimates by assigning the largest and smallest surgical counts in the data to the clinics with missing values.

Table 4.5
Utilization Estimates from Applying Private Health Insurance Parameters

Annual Individual Claimants	Estimate from the Literature	Estimates Using Private Employer Data		
		Baseline	Sensitivity Analysis 1 ^a	Sensitivity Analysis 2 ^b
Active component, lower-bound estimate	0.022 claimants per 1,000 individuals	29	36	72
Active component, weighted average estimate	0.0396 claimants per 1,000 individuals	53	65	129

NOTES: Each cell in the “Estimates Using Private Employer Data” columns represents a unique prediction for utilization in the AC population. In the second column of the table, we describe the estimate from the literature that is applied to the AC population. See the text for details on each of the calculations.

^a Sensitivity Analysis 1: We calculated a set of estimates that accounted for differences in the male/female distribution between the civilian and AC populations.

^b Sensitivity Analysis 2: We calculated a set of estimates that accounted for differences in the male/female distribution between the civilian and AC populations and the possibility that transgender prevalence is twice as high in the military population as in the civilian population.

Table 4.6
Incidence of Penectomies and Bilateral Mastectomies Performed on Transgender Individuals

Transition Type	Incidence Estimates (%)		
	Low	Clinic-Reported Data	High
Male-to-female	0.00048	0.00053	0.00103
Female-to-male	0.00020	0.00030	0.00084

SOURCE: 2001 data from Horton, 2008.

NOTE: The table includes data on penectomies and bilateral mastectomies only.

sitions have also increased over time. Thus, these utilization rates of penectomies and bilateral mastectomies should be considered lower-bound estimates.

Applying these estimates to the AC male/female distribution results in low, medium, and high annual estimates of 5.8, 6.6, and 13.2 AC service members receiving these two surgeries, respectively. We reiterate here that these estimates are not directly comparable to the private health insurance estimates presented in the previous section because these estimates apply to only two specific procedures, while the private health insurance estimates include any gender transition–related procedures that private health insurance firms cover. One would expect estimates for two specific surgeries from 2001 to be lower than estimates generated from the private health insurance system in the later 2000s. Indeed, they are, but it is more difficult to make other direct

comparisons between these two estimates, given the private health insurance utilization data presented in Herman (2013b).

Veterans Health Administration Estimates

In this analysis, we used VHA data to calculate the expected annual incidence of gender identity disorder (the condition now known as GD in the DSM-5) in the AC population. As described previously, those with a gender identity disorder diagnosis are a subset of transgender individuals. Kauth et al. (2014) used VHA health claims data to identify incidence rates of new diagnoses. They also calculated prevalence rates of gender identity disorder in each year using previous yearly incidence rates. Because 2006 was the first year in their data set, the prevalence rate in the first year of their data is equivalent to the incidence rate. In the years after 2006, the prevalence rate is essentially a running total of the incidence rates in the previous years added to the most recent incidence rates.

The data in Table 4.7 imply that the incidence of gender identity disorder increased from 3.5 of 100,000 enrollees in FY 2006 to 6.7 of 100,000 enrollees in FY 2013 among veterans who use VHA health care (Kauth et al., 2014). Before applying these estimates to the AC population, we note two important points with respect to the analyses in Kauth et al. (2014). First, because the prevalence rate is simply a running total of new cases diagnosed since the first year of the study’s data (2006), adding years of data prior to 2006 would mechanically increase the prevalence estimates. Thus, Kauth et al.’s prevalence calculations are a lower-bound for the total gender

Table 4.7
Prevalence and Incidence of Gender Identity Disorder
Diagnoses in VHA Claims Data

Fiscal Year	New Diagnosis Rate (%)	Prevalence (%)
2006	0.0035	0.0035
2007	0.0034	0.0068
2008	0.0034	0.0098
2009	0.0038	0.0131
2010	0.0046	0.0172
2011	0.0051	0.0217
2012	0.0060	0.0270
2013	0.0067	0.0329

SOURCE: Kauth et al., 2014.

NOTE: The authors calculated new cases diagnosed and total existing cases in a given year based on the entirety of the data since 2006.

identity disorder prevalence rate in this population. Second, estimates based on claims data will likely be lower-bound estimates of incidence and prevalence, since individuals are identified only if they interact with the health care system for reasons related to gender identity disorder. These two caveats should be kept in mind when interpreting the extrapolations here.

Applying estimates from the 2013 data in Table 4.7 to the AC population, one would expect approximately 90 new cases of gender identity disorder each year and that approximately 440 AC service members would be diagnosed with this condition. Although the male/female distribution in the VHA system mirrors that of the AC, veterans who use VHA health care services may have lower socioeconomic and health status than veterans who do not use VHA health care, other military retirees, and AC service members. The VHA population also differs by age and, potentially, by other unmeasured characteristics related to underlying health status. For these varied reasons, these estimates may not be generalizable to the military population overall.

Summarizing the Estimates

Table 4.8 summarizes the key results after applying the estimates from the various data sets to the AC and SR populations. The largest estimate—270 treatments (surgeries and hormone therapies)—was calculated by combining the upper-bound population-level transgender prevalence estimate from Massachusetts with information from the NTDS data on the age of those receiving common transition-related treatments. When applied to the AC population, estimates from VHA and the private health insurance literature imply that only 30–90 AC service members will receive some type of gender transition–related treatment annually.

To understand the full implications of our estimates regarding the expected annual number of AC service members likely to obtain gender transition–related care, in Figure 4.1 we compare the above utilization estimates with the number of AC service members who self-reported visiting a mental health care provider in a given year (21 percent) and the number of AC service members who visited a mental health care specialist in a given year (7 percent; Hoge et al., 2006; McKibben et al., 2013). We chose this outcome because mental health care among military populations is an important, well-studied topic, and data were readily accessible for us to conduct the comparison. The mental health care utilization estimates represent unique service members accessing health care; thus, they compare most directly to the estimates using the private health insurance data and the NTDS hormone therapy estimates. For clarity's sake, we do not present all of the private health insurance and NTDS hormone therapy estimates in Figure 4.1. We do include the smallest, middle, and largest estimates using the private health insurance data and the largest hormone therapy estimate drawn from the NTDS data.

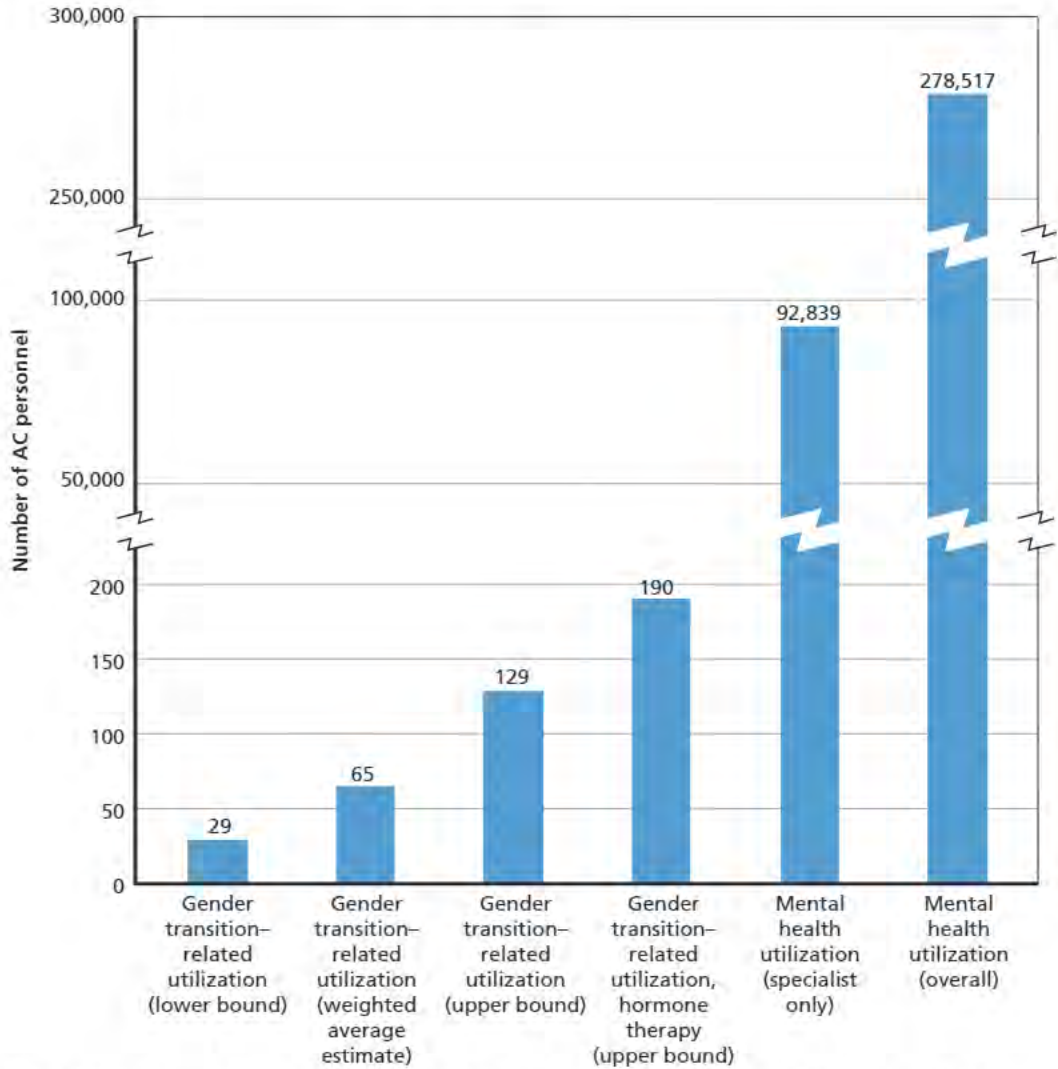
Table 4.8
Annual Gender Transition–Related Treatment Estimates from All Data Sources

Estimate Type	Active Component			Selected Reserve		
	Hormone Treatment	Surgical Treatments	All Treatments	Hormone Treatment	Surgical Treatments	All Treatments
Prevalence-based estimates (using NTDS data)						
Annual treatments based on CA study estimate (0.1%)	30	25	55	15	15	30
Annual treatments based on combined, population-weighted, gender-adjusted rate (0.19%)	50	45	95	25	30	55
Annual treatments based on MA study estimate (0.5%)	140	130	270	70	80	150
Utilization-based estimates						
Private health insurance annual individual claimants (0.022 per 1,000)	NA	NA	29	NA	NA	20
Private health insurance annual individual claimants (0.0396 per 1,000)	NA	NA	53	NA	NA	30
VHA-based annual new diagnoses (0.0067%)	90	NA	NA	60	NA	NA
Clinical utilization of penectomies and bilateral chest surgeries (0.0005%)	NA	10	NA	NA	5	NA

SOURCE: RAND analysis.

As Figure 4.1 shows, our estimates of the number of AC personnel who will use the gender transition–related health care benefits are overwhelmingly small compared with the number of AC personnel who access mental health treatment. Overall, based on our calculations, we expect annual gender transition–related health care to be an extremely small part of overall health care provided to the AC population.

Figure 4.1
Comparison of Annual Estimated Gender Transition–Related Health Care Utilization and Mental Health Care Utilization, Active Component



SOURCE: RAND analysis. Utilization rates in the figure are derived from both the prevalence-based and utilization-based approaches presented in Table 4.8.

NOTES: The non-hormone therapy transgender utilization estimates are from the application of estimates from the private health insurance data. The hormone therapy upper-bound transgender utilization estimate is from calculations using the NTDS data.

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CHAPTER FIVE

What Are the Costs Associated with Extending Health Care Coverage for Gender Transition–Related Treatments?

In this chapter, we provide estimates for the costs associated with extending health care coverage for gender transition–related treatments. We focused on transgender service members in the AC because they have uniform MHS access. We did not include reserve-component service members in our analyses, but their MHS utilization and the associated cost will be negligible, given their highly limited military health care eligibility. Likewise, we did not include retirees or dependents in the cost analyses because we did not have information on age and sex distribution within these beneficiary categories. Some of these beneficiary categories also have limited eligibility for health care provided through MTFs and may receive their health care through TRICARE coverage in the purchased care setting or through other health insurance plans. Given these unknowns, it was only feasible to estimate the costs of gender transition–related care for AC service members; however, we recommend expanding these analyses in the future to include reserve-component members, as well as all individuals eligible for treatment under TRICARE. For the following analyses, we used demographic characteristics of the 2014 AC population to estimate the cost of providing such services.

Private Health Insurance Cost Estimates

To determine the potential costs of covering gender transition–related health care for transgender service members, we collected information on private health insurers' experiences with covering this care from two sources (Herman, 2013b; State of California, 2012). These actuarial estimates represent the expected increase in health care costs from covering a new set of treatments or a new group of beneficiaries. If employers decide to provide coverage for a particular treatment, these actuarial estimates are translated into premium increases for covered employees. These estimates should be thought of as the expected costs of extending coverage for gender transition–related care to transgender AC service members. Moreover, we note that the military may already be incurring the cost of some transgender treatments, as some patients and their providers use "omissions and ambiguities" to acquire needed care (Roller, Sedlak, and Draucker, 2015, p. 420). For example, a currently serving female-to-male patient

who had undergone a hysterectomy reported taking only the testosterone and not the estrogen prescribed as part of hormone therapy with his endocrinologist’s knowledge and tacit support, while another was trying to get breast reduction surgery due to back pain rather than GD (Parco, Levy, and Spears, 2015, pp. 235–236).

Table 5.1 presents available data from public employers and private firms on the actuarial costs of covering gender transition–related care. It identifies the particular institution, the number of employees and dependents covered, and the identified premium increases due to expanding benefits.

Data from Table 5.1 show, generally, that the actuarial estimates of providing benefits for gender transition–related care increased total premiums (employee + employer share) by only a small fraction of a percent—and, in the most extreme cases, by only approximately 1 percent. Taking a weighted average of most of the information,¹ we estimated that extending insurance coverage to transgender individuals would increase health care spending by 0.038 percent. Applying this figure to total AC health care spending of \$6.27 billion,² we find that covering gender transition–related care will increase AC health care spending by approximately \$2.4 million (see Table 5.2).

The data in Table 5.1 suggest that the University of California, with 100,000 enrollees in its health plan, is one of the key drivers of the 0.038-percent weighted

Table 5.1
Actuarial Estimated Costs of Gender Transition–Related Health Care Coverage from the Literature

Public Employer Data	Actuarially Calculated Premium Increase	Total Contribution (employees + dependents)
City of Seattle	0.19% increase in health care budget	23,090
City of Portland	0.08% increase in health care budget	18,000
City of San Francisco	0% increase in health care budget	100,000
University of California	0% increase in health care budget	100,000
Private Employer Data	Estimate	Total Contribution (employees + dependents)
22 firms	Many employers reported no actuarial costs to adding benefit; estimates range from 0 to 0.2%	Mix of firm sizes
2 firms	Approximately 1% increase in premiums	5,800
1 firm	Much less than 1% increase in premium	77,000

SOURCE: Estimates are from Herman, 2013b, and State of California, 2012.

¹ We did not use information about the firm with 77,000 enrollees because it is not clear what “much less than 1 percent” implies with respect to the premium increase.

² Pharmaceutical and direct and purchased care inpatient and outpatient data calculated from TRICARE costs in Defense Health Agency, 2015.

average result. In addition to the actuarial increases, the University of California also reported a realized increase in health care spending of 0.05 percent, so we recalculated the weighted average figure by replacing the 0-percent estimate with the 0.05 percent estimate. This new calculation raised the overall cost estimate from 0.038 percent to 0.054 percent, or from \$2.4 million to \$3.4 million when applied to the AC. To summarize, our baseline estimates regarding expected gender transition–related health care costs in the AC are between \$2.4 million and \$3.4 million.

Sensitivity Analyses

To understand the potential full range of cost effects in the AC population, we conducted two additional sensitivity analyses similar to those described for our utilization ranges in Chapter Four. We used these sensitivity analyses to account for the skewed male/female distribution in the military population and for the possibility that transgender prevalence is higher in the military population. As in the utilization case, we were not able to identify any sex-specific effects on the premium increases. Thus, as in our utilization analysis, we assume that cost estimates are linearly related to prevalence,³ and cost estimates for male-to-female transitions are twice the cost estimates for female-to-male transitions. Using this relationship, we again calculated natal male– and natal female–specific estimates from the aggregate estimates.

Given the assumption about differing cost effects, we calculated a natal male–specific cost estimate of 0.05 percent and a natal female–specific cost estimate of 0.025 percent for the aggregate premium estimate of 0.038 percent. Applying these sex-specific estimates to the AC male/female distribution increased our initial premium estimate from 0.038 percent to 0.047 percent. A similar calculation can be performed for our realized cost estimate of 0.054 percent. Assuming that gender transition–related health care costs are twice as large for male-to-female transitions as for female-to-male transitions, we calculated a natal male–specific cost effect of 0.072 percent and a natal female–specific cost effect of 0.036 percent. Applying these sex-specific estimates to the AC male/female distribution increased our initial premium estimate from 0.054 percent to 0.067 percent. Applying these newly calculated health care costs to the 2014 AC health care expenditures (\$6.27 billion) increased our estimate of costs from the initial range of \$2.4–3.4 million to a range of \$2.9–4.2 million.

Finally, as noted previously, Gates (2011) and Gates and Herman (2014) calculated that transgender prevalence in the military is approximately twice that in civilian

³ We also note that built into this linearity assumption and how it is applied in the two sensitivity analyses is the assumption that the cost of male-to-female transitions is the same as the cost of female-to-male transitions. Since there is no sex-specific information in the private health insurance cost data, the validity of the cost per case being equivalent is unknown. Padula, Heru, and Campbell (2015) estimated that a male-to-female surgical case is 33 percent more expensive than a female-to-male surgical case, but these estimates were not based on private employer data, so we did not directly incorporate this result into our calculations.

populations. Assuming that this estimate is valid, and, again, assuming that health care costs are linearly related to underlying prevalence, this would increase the above calculated value of \$2.9 million to \$5.8 million and the calculated value of \$4.2 million to \$8.4 million. Table 5.2 summarizes the results from the calculations described in this section.

To better understand the relative importance of our estimates regarding expected AC annual gender transition–related health care spending, we compared our cost estimates to the MHS spending on mental health in 2012 and to total AC health care spending in FY 2014. As Figure 5.1 shows, gender transition–related health care spending is expected to be extremely small compared with MHS spending on mental health (Blakely and Jansen, 2013) and overall AC health care expenditures (Defense Health Agency, 2015).

Summarizing the Estimates

A direct application of estimates from the private health insurance system implies a baseline spending range between \$2.4 million and \$3.4 million for AC gender transition–related health care. Sensitivity analyses that attempt to account for the fact that the male/female distribution in the AC population skews more heavily male than the civilian population and that transgender prevalence might be higher in the military increase this initial range to \$5.8 million to \$8.4 million. The implication is that even in the most extreme scenario that we were able to identify using the private health insurance data, we expect only a 0.13-percent (\$8.4 million out of \$6.2 billion) increase in AC health care spending.⁴

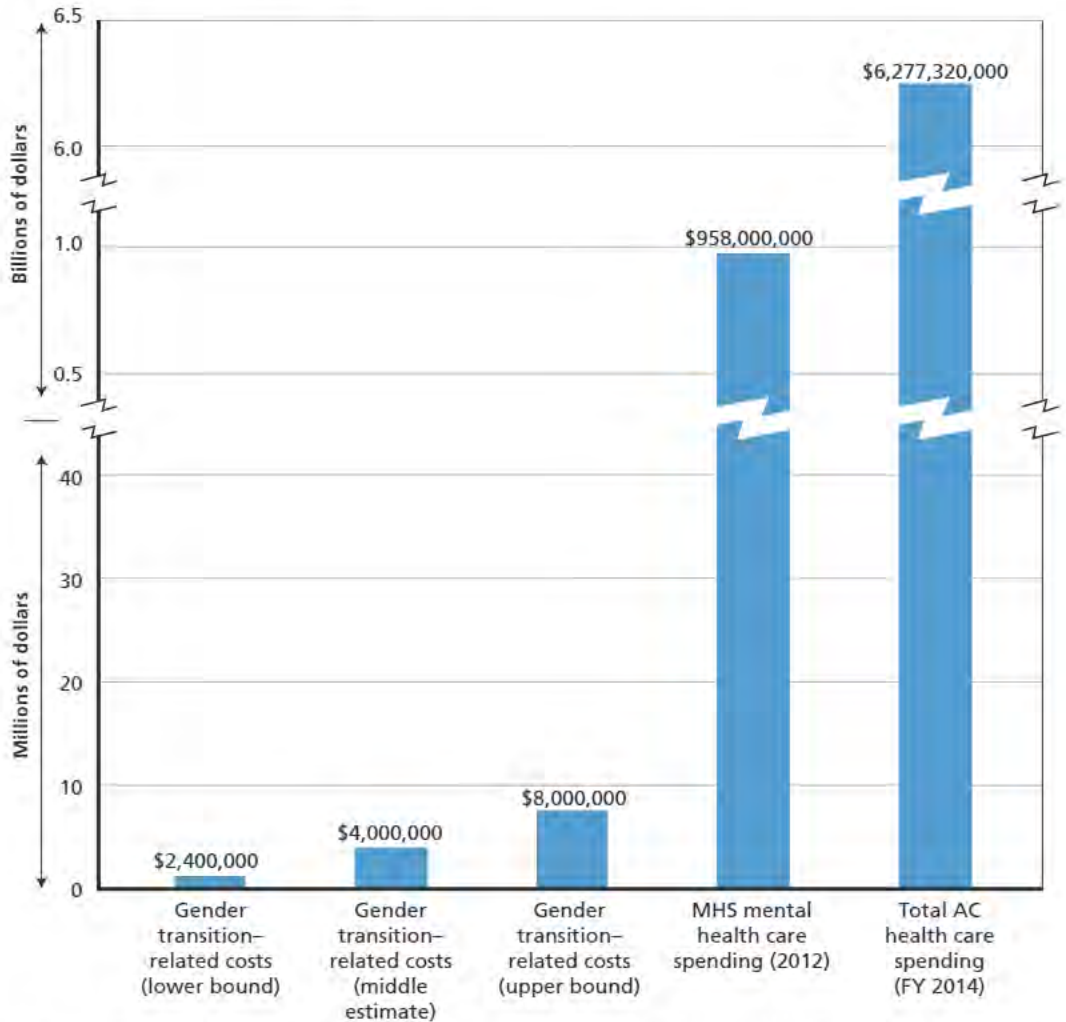
Table 5.2
Estimated Annual MHS Costs of Gender Transition–Related Health Care, Active Component

Analysis Type	Calculations Using Only Actuarial Premium Estimates 0.038% (actuarial)	Calculations Using Actuarial Premiums and Realized Values 0.054% (actuarial + realized)
Baseline	\$2.4 million	\$3.4 million
Sensitivity analysis 1: Adjusts for the male/female distribution in the AC population	\$2.9 million	\$4.2 million
Sensitivity analysis 2: Adjusts for the male/female distribution in the AC population and the assumption that transgender prevalence is twice as high in the military compared to the civilian population	\$5.8 million	\$8.4 million

SOURCE: RAND analysis.

⁴ AC beneficiaries make up less than 15 percent of total TRICARE beneficiaries (Defense Health Agency, 2015).

Figure 5.1
 Gender Transition–Related Health Care Cost Estimates Compared with Total Health Spending, Active Component



SOURCES: RAND analysis; Blakely and Jansen, 2013; Defense Health Agency, 2015. Estimates of premium increased and realized costs are reported in Table 5.1.

NOTES: The lower-bound estimate refers to premium increases only. The middle estimate includes premium increases and realized costs after adjusting for male/female distribution in the military. The upper-bound estimate includes premium increases and realized costs after adjusting for male/female distribution in the military and assuming the prevalence rate of transgender individuals in the military is twice that of civilian populations.

RAND RR1350-5.1

CHAPTER SIX

What Are the Potential Readiness Implications of Allowing Transgender Service Members to Serve Openly?

As DoD considers whether to allow transgender personnel to serve openly and to receive transition-related treatment during the course of their military service, it must consider the implications of such a policy change on the service members' ability to deploy and potential reductions in unit cohesion. In prior legal challenges to the transgender military discharge policy, DoD has expressed concern that the medical needs of these service members would affect military readiness and deployability. To address these concerns, this chapter provides estimates of the potential effects on force readiness from a policy change allowing these service members to serve openly.

A critical limitation of such an assessment is that much of the current research on transgender prevalence and medical treatment rates relies on self-reported, nonrepresentative samples. Thus, the information cited here must be interpreted with caution because it may have varying degrees of reliability. In addition, to estimate effects on readiness, we focused on transgender personnel in the AC and SR only. We did not include the Individual Ready Reserve because of the lack of publicly available, detailed demographic information. We used the same approach that applied to our analysis of health care utilization, applying both the prevalence-based and utilization-based approaches to force size. We note that the prevalence-based approach was the only approach that allowed us to estimate the number of transgender service members who may seek to live and work as their target gender. Transition does not necessarily imply the use of medical treatments, and we emphasize that some of these service members may still require accommodations in terms of housing and administrative functions (e.g., military identification cards, restrooms).

Impact on Ability to Deploy

The most salient and complex issue in allowing transgender personnel to serve openly is how DoD should regulate and manage operational deployment requirements for these personnel in the context of their transition to their target gender.

Pre-Transition

If transgender personnel are allowed to serve openly prior to transition, DoD will need to establish policies on when individuals may use the uniforms, physical standards, and facilities (e.g., barracks, restrooms) of their target gender. Additionally, DoD will need to clarify policies related to qualifications for deployment. Current deployment rules suggest that to qualify for deployment, individuals with diagnosed mental health disorders must show a “pattern of stability without significant symptoms or impairment for at least three months prior to deployment.”¹ Ensuring appropriate screening will be critical to minimizing any mental health–related readiness issues. Secondary prevention measures prior to deployment, such as screening for GD, may be needed to ensure a pattern of stability and readiness for deployment.

During Transition

DoD would also need to determine when transitioning service members would be able to change uniforms and adhere to the physical standards of their target gender, as well as which facilities and identification cards they will use. Other countries have found that, in some cases, it may be necessary to restrict deployment of transitioning individuals to austere environments where their health care needs cannot be met. Deployment restrictions may also be required for individuals seeking medical treatment, including those seeking hormone therapy and surgical treatments.

We detail the constraints associated with transition-related medical treatments in Table 6.1. These constraints typically include a postoperative recovery period that would prevent any work and a period of restricted physical activity that would prevent deployment. The rightmost column of Table 6.1 presents the estimated number of non-deployable days we used to estimate the readiness impact. We note that these estimates do not account for any additional time required to determine medical fitness to deploy. Army guidelines, for example, do not permit deployment within six weeks of surgery. Nevertheless, there may be a significant difference between the estimated availability to deploy and the actual impact on deployability, as it is possible that transgender service members would time their medical treatments to minimize the effect on their eligibility to deploy.²

In addition to an expected, short-term inability to deploy during standard postoperative recovery time, some individuals experience postoperative complications that would render them unfit for duty. For instance, among those receiving vagino-

¹ Detailed guidance is provided in a memorandum from the Office of the Assistant Secretary of Defense for Health Affairs, 2013, p. 2.

² See for example, Personnel Policy Guidance Tab A (known as PPG-TAB A) that accompanies the medical guidelines document MOD TWELVE, Section 15.C, which articulates the minimal standards of fitness for deployment to the U.S. Central Command area of responsibility (U.S. Central Command, 2013).

plasty surgery, 6–20 percent have complications.³ This implies that between three and 11 service members per year would experience a long-term disability from gender reassignment surgery. Among those receiving phalloplasty surgery, as many as 25 percent experience some medical complications (Elders et al., 2014).

Table 6.1
Gender Transition–Related Readiness Constraints

Transition Type and Treatment	Recovery Time	Leave and Deployment Implications	Estimated Nondeployable Days
Male-to-Female			
Hormone therapy only	Long-term, no recovery required	None (pending accommodations)	N/A
Augmentation mammoplasty	1 week no work, 4–6 weeks restricted physical activity	Up to 14 days medical leave, up to 60 days medical disability	75
Genital surgery (orchiectomy, vaginoplasty)	4–6 weeks no work, 8+ weeks restricted physical activity	Up to 45 days medical leave, up to 90 days medical disability	135
Female-to-Male			
Hormone therapy only	Long-term, no recovery required	None (pending accommodations)	N/A
Chest surgery	1 week no work, 4–6 weeks restricted physical activity	Up to 14 days medical leave, up to 60 days medical disability	75
Hysterectomy	2 weeks no work, 4–8 weeks restricted physical activity	Up to 21 days medical leave, up to 90 days medical disability	111
Genital surgery (metoidioplasty, phalloplasty)	2–4 weeks no work, 4–6 weeks restricted physical activity	Up to 21 days medical leave, up to 60 days medical disability	81

SOURCES: Treatment times based on RAND research compiled for this study. Estimates of numbers of treatments based on rates in Gates, 2011. Estimated nondeployable days based on RAND calculations using FY 2014 data from DoD, 2014.

NOTES: The total population in the table includes AC and SR personnel. Estimates of treatments are non-unique per person. Individuals may (and likely will) seek multiple treatments simultaneously. As such, deployment days are measured per treatment, not per individual. Estimates of nondeployable days do not include estimated delays generated by Medical Evaluation Board/Physical Evaluation Board review, which may be required depending on service rules.

³ According to Elders et al. (2014, p. 15), summarizing findings from 15 studies, “2.1 percent of patients had rectal-vaginal fistula, 6.2 percent with vaginal stenosis, 5.3 percent had urethral stenosis, 1.9 percent with clitoral necrosis, and 2.7 percent with vaginal prolapse,” and approximately 2.3 percent of patients experienced complications after vaginoplasty.

Taking the estimates for treatment and recovery time, we then applied the standards for leave and restricted physical activity.⁴ We applied the recovery times and translated those into nondeployable days separated into medical leave, in which the service member is off the job, and medical disability, in which the service member can be at work but is subject to restricted physical requirements (e.g., no physical training, no heavy lifting). This provided us with the total number of nondeployable days per treatment type. We scaled this estimate by the number of days an individual can be deployed per year. For the AC, we assumed this to be 330 days per year (allowing 30 days of leave plus five days of processing time).⁵ For the SR, we assumed 270 days per year (which allows nine months of deployment time). We counted each treatment separately and applied the number of treatments by treatment type shown in Table 6.1.

Note that because individuals may seek multiple treatments, sometimes at the same time, this number is not the same as the total number of individuals who will be nondeployable. Therefore, the estimates presented in Table 6.2 should be considered an upper bound in each category. Moreover, the prevalence-based estimates are significantly larger than the utilization-based estimates as shown in Table 4.8. Using the prevalence-based approach, we found that between eight and 43 of the available 1.2 million labor-years in the AC may be unavailable for deployment.⁶ The combined, population-weighted, and gender-adjusted estimate implies that about 16 labor-years from the AC and about 11 labor-years from the SR may be nondeployable. This represents 0.0015 percent of available deployable labor-years across the AC and SR.

These estimates are based on surgical take-up rates ranging from 25 to 130 per year in the AC, with 55–270 total treatments, including hormone treatments. Similarly, the prevalence-based estimates imply 15–80 surgical treatments per year in the SR, with between 30 and 150 total treatments, including hormone therapy.

The utilization-based approach implies many fewer treatments. Although we could not estimate the impact on labor-years because we did not have information on specific treatments, based on usage rates in California, the utilization-based approach implies 30–50 total treatments, including surgeries and hormone therapy. Evidence from the VHA suggests that 90 service members in the AC and 50 in SR are diagnosed with GD in any given year. Such a diagnosis would be a prerequisite for any surgical treatments, suggesting that true utilization rates in the military may be significantly lower than suggested by the prevalence-based approach.

We caution that our labor-year estimates also likely overcount actual nondeployable time because our estimate captures “availability to deploy,” rather than the deploy-

⁴ For reference, we used the Army Regulation 40-501 (revised 2011), which governs leave and disability, and the Navy Medical Policy 07-009 (2007), which provides guidance on pre-clearance, accommodations for deployment readiness, and additional requirements in the U.S. Central Command area of operations.

⁵ We based this estimate on Army Regulation 600-8-101 (2015).

⁶ We define a labor-year as the amount of work done by an individual in a year.

Table 6.2
Estimated Number of Nondeployable Man-Years Due to Gender Transition-Related Treatments

Component	Total Labor-Years Available (FY 2014)	Estimated Number of Nondeployable Labor-Years				
		0.1% ^a (CA study)	0.16% ^b (combined, population-weighted CA + MA studies)	0.19% ^c (gender-adjusted rate)	0.37% ^d (twice gender-adjusted rate)	0.5% ^e (MA study)
Active	1,199,096	8.2	13.7	16.2	32.3	42.8
Selected Reserve	615,446	5.9	9.9	10.7	21.3	29.9

SOURCES: Estimates for nondeployable labor-years are based on RAND calculations using FY 2014 data from DoD, 2014.

^a Based on estimates of prevalence from a California study (Conron, 2012).

^b Based on weighted average of studies from California and Massachusetts, weighted by relative population sizes in each state.

^c Based on weighted average of studies from California and Massachusetts, weighted by relative population sizes in each state and applied specifically to the male/female distribution in the military components.

^d Based on estimates of prevalence from NTDS, Gates (2011), and the American Community Survey (Gates and Herman, 2014) and applied specifically to the male/female distribution in the military.

^e Based on estimates of prevalence from a Massachusetts study (Gates, 2011).

ment impact itself. This difference comes from three key assumptions that we make to calculate these estimates: (1) service members who are seeking treatment will also be deployed; (2) service members who are seeking treatment cannot time those treatments to avoid affecting their deployment eligibility; and (3) service members seek only one treatment at a time rather than having multiple treatments at the same time, which would allow concurrent (rather than sequential) recovery times. Thus, it is likely that a service member's care would have a substantial overall impact on readiness only if that service member worked in an especially unique military occupation, if that occupation was in demand at the time of transition, and if the service member needed to be available for frequent, unpredicted mobilizations.

Post-Transition

Having completed medical transition, a service member could resume activity in an operational unit if otherwise qualified. As in other cases in which a service member receives a significant medical treatment, DoD should review and ensure that any longer-term medical care or other accommodations relevant to the transgender service member's specific medical needs are addressed.

Impact on Unit Cohesion

A key concern in allowing transgender personnel to serve openly is how this may affect unit cohesion—a critical input for unit readiness. The underlying assumption is that if service members discover that a member of their unit is transgender, this could inhibit bonding within the unit, which, in turn, would reduce operational readiness. Similar concerns were raised in debates over whether to allow gay and lesbian personnel to serve openly (Rostker et al., 1993; RAND National Defense Research Institute, 2010), as well as whether to allow women to serve in ground combat positions (Schaefer et al., 2015; Szayna et al., 2015). Evidence from foreign militaries and surveys of the attitudes of service members have indicated that this was not the case for women or for lesbian and gay personnel (Schaefer et al., 2015; Harrell et al., 2007; RAND National Defense Research Institute, 2010). In examining the experiences of foreign militaries, the limited publicly available data we found indicated that there has been no significant effect of openly serving transgender service members on cohesion, operational effectiveness, or readiness. (For a more in-depth discussion of this topic, see Chapter Seven.) However, we do not have direct survey evidence or other data to directly assess the impact on the U.S. military.

Evidence from the General U.S. Population

According to recent research on the U.S. general population, attitudes toward transgender individuals are significantly more negative than attitudes toward other sexual minorities (Norton and Herek, 2013). However, heterosexual adults' positive attitudes toward and acceptance of transgender individuals are strongly correlated with their attitudes and acceptance of gay, lesbian, and bisexual individuals (Flores, 2015). As such, similar to changes seen in public attitudes toward homosexuality, tolerance and acceptance toward the transgender population could change over time. Additionally, evidence does indicate that direct interactions with transgender individuals significantly reduce negative perceptions and increase acceptance (Flores, 2015), which would suggest that those who have previously interacted with transgender individuals would be more likely to be tolerant and accepting of them in the future. Similar findings have arisen from surveys and focus groups with service members regarding attitudes toward the integration of women into direct combat positions (Szayna et al., 2015) and attitudes toward allowing gay and lesbian service members to serve openly in the U.S. military (RAND National Defense Research Institute, 2010).⁷

⁷ A recent article examined the attitudes of military academy, Reserve Officers' Training Corps, and civilian undergraduates in the United States toward transgender people in general, in the workplace, and in the military (see Ender, Rohall, and Matthews, 2016).

Evidence from Foreign Militaries

While there are limited data on the effects of transgender personnel serving openly in foreign militaries, the available research revealed no significant effect on cohesion, operational effectiveness, or readiness. In the case of Australia, there is no evidence and there have been no reports of any effect on cohesion, operational effectiveness, or readiness (Frank, 2010). In the case of Israel, there has also been no reported effect on cohesion or readiness (Speckhard and Paz, 2014). Transgender personnel in these militaries have reported feeling supported and accommodated throughout their gender transition, and there is no evidence of any impact on operational effectiveness (Speckhard and Paz, 2014). In fact, commanders have reported that transgender personnel perform their military duties and contribute effectively to their units (Speckhard and Paz, 2014). Interviews with commanders in the United Kingdom also found no effect on operational effectiveness or readiness (Frank, 2010). Some commanders reported that increases in diversity had led to increases in readiness and performance. Interviews with these same commanders also found no effect on cohesion, though there were some reports of resistance to the policy change within the general military population, which led to a less-than-welcoming environment for transgender personnel. However, this resistance was apparently short-lived (Frank, 2010).

The most extensive research on the potential effects of openly serving transgender personnel on readiness and cohesion has been conducted in Canada. This research involved an extensive review of internal defense reports and memos, an analysis of existing literature, and interviews with military commanders. It found no evidence of any effect on operational effectiveness or readiness. In fact, the researchers heard from commanders that the increased diversity improved readiness by giving units the tools to address a wider variety of situations and challenges (Okros and Scott, 2015). They also found no evidence of any effect on unit or overall cohesion. However, there have been reports of bullying and hostility toward transgender personnel, and some sources have described the environment as somewhat hostile for transgender personnel (Okros and Scott, 2015).

To summarize, our review of the limited available research found no evidence from Australia, Canada, Israel, or the United Kingdom that allowing transgender personnel to serve openly has had any negative effect on operational effectiveness, cohesion, or readiness. However, it is worth noting that the four militaries considered here have had fairly low numbers of openly serving transgender personnel, and this may be a factor in the limited effect on operational readiness and cohesion.

Costs of Separation Requirements Related to Transgender Service Members

We considered the costs and benefits of providing appropriate care to transgender service members, the requirements for those who would serve openly if the current policy changed, and the costs of continuing the current administrative separation process. We analyzed the costs of separation under several assumptions: (1) some transgender personnel are currently serving but are not able to reveal their transgender status, (2) some individuals who would be desirable recruits could be excluded for reasons only related to their gender identity, and (3) some individuals who are transgender are or have been separated for reasons only related to their gender identity, which imposes separation costs.

Separation and a continued ban on open service (i.e., manpower losses) are the alternatives to meeting the medical needs of transgender individuals. As detailed in Chapter Two, the continued ban on open service may result in worsening mental health status, declining productivity, and other negative outcomes due to lack of treatment for gender identity–related issues. In addition, if DoD actively pursues separation, the process can be tedious, especially now that it requires the approval of the Under Secretary of Defense for Personnel and Readiness. Under current DoD regulations, transgender personnel can be declared administratively unfit for service if their gender identity affects their ability to meet operational or duty requirements. A June 2015 revision to DoD policy requires that a discharge justification be based on inability to meet duty requirements. However, any “administratively unfit” finding prohibits the individual from being medically evaluated for continued service.⁸ Absent this process, transgender service members do not have recourse to allow mental health experts or medical professionals to review their case concurrently. This can result in unnecessary and inconsistent approaches to discharging transgender service members. As was the case in enforcing the policy on homosexual conduct, this can involve costly administrative processes and result in the discharge of personnel with valuable skills who are otherwise qualified (U.S. Government Accountability Office, 2011).

Moreover, the total cost in lost days available for deployment is negligible and significantly smaller than the lack of availability due to medical conditions. For example, in 2015 in the Army alone, there were 102,500 nondeployable soldiers, 50,000 of whom were in the AC (Tan, 2015). This accounted for about 14 percent of the AC—personnel who were ineligible to deploy for legal, medical, or administrative reasons.

⁸ These boards provide an established process and mechanism for evaluating whether a service member with an ailment or diagnosis, such as a mental health diagnosis, could continue military service. The services use the Medical Evaluation Board and Physical Evaluation Board systems to determine whether personnel “with an ailment or diagnosis, such as a mental health diagnosis, can continue . . . military service,” based on a thorough review of fitness to serve (DoDI 1332.38, 1996).

Of those, 37,000 could not deploy due to medical conditions.⁹ Excluding those who were severely injured and required longer-term care, there were 28,490 service members who had either category 1 (up to 30 days) or category 2 (more than 30 days) restrictions. Assuming those in category 1 cannot deploy for 30 days and those in category 2 cannot deploy for 90 days, we estimate there are currently 5,300 nondeployable labor-years in the Army alone. Thus, we anticipate a minimal impact on readiness from allowing transgender personnel to serve openly.

⁹ Rates of injury and nondeployability time as reported in Cox (2015).

CHAPTER SEVEN

What Lessons Can Be Learned from Foreign Militaries That Permit Transgender Personnel to Serve Openly?

As the U.S. military considers changes to its transgender personnel policy, revisions to several other policies may be necessary. Policies in need of change would cover a range of personnel, medical, and operational issues affecting individuals and units, including some policies that currently vary by gender. Examples of the latter would include housing assignments, restrooms, uniforms, and physical standards. While these are new questions for the U.S. military, there are other countries that already allow transgender personnel to serve openly in their militaries and have already addressed these policy issues.

We reviewed policies in foreign militaries that allow transgender service members to serve openly. Our primary source for the observations presented in this report was an extensive document review that included primarily publicly available policy documents, research articles, and news sources that discussed policies on transgender personnel in these countries. The information about the policies of foreign militaries came directly from the policies of these countries as well as from research articles describing the policies and their implementation. Our findings on the effects of policy changes on readiness draw largely from research articles that have specifically examined this question using interviews and analyses of studies completed by the militaries themselves. Finally, our insights on best practices and lessons learned emerged both directly from research articles describing the evolution of policy and the experiences of foreign militaries and indirectly from commonalities in the policies and experiences across our four case studies. Recommendations provided in this report are based on these best practices and lessons learned, as well as a consideration of unique characteristics of the U.S. military.

This review and analysis of the policies in foreign militaries can serve as a reference for U.S. decisionmakers as they consider possible policy revisions to support the integration of openly transgender personnel into the U.S. military. We include information on how, when, and why each country changed its policy. We also detail the policies of each country, covering such issues as the medical and administrative

requirements before gender transition can begin, housing assignments, uniform wear, and physical fitness standards.

Policies on Transgender Personnel in Foreign Militaries

According to a report by the Hague Center for Security Studies, there are 18 countries that allow transgender personnel to serve openly in their militaries: Australia, Austria, Belgium, Bolivia, Canada, Czech Republic, Denmark, Estonia, Finland, France, Germany, Israel, Netherlands, New Zealand, Norway, Spain, Sweden, and the United Kingdom (Polchar et al., 2014). This chapter describes the policies of the four countries—Australia, Canada, Israel, and the United Kingdom—with the most well-developed and publicly available policies on transgender military personnel. It focuses explicitly on policies that describe how these foreign militaries treat transgender personnel and how they address this population's gender transition needs. While the focus of the chapter is on the specific policies integrating openly transgender military personnel in these four foreign militaries, we also provide some information about what happened after the policy change, including bullying and harassment, and summarize best practices and challenges that emerged from our four case studies.¹

The formal policies on transgender personnel in the four countries address a number of aspects of the gender transition process.² Generally, these policies do not explicitly address such issues as the recruitment or retention of transgender personnel, though we provide information on the qualification of transgender personnel to serve when it is available. They do generally address such issues as the requirements for transitioning, housing assignments, restroom use, uniforms, identity cards, and physical standards. They also address whether the transitioning personnel remain with their old units or shift to new ones and how other members of a unit should be informed. Finally, the policies address access to medical care and what is or is not covered by the military health care system.

In addition to addressing these crucial issues, foreign military policies on transgender personnel typically lay out a gender transition plan, which describes the timeline or steps in the transition process. However, it is worth noting that each individual's

¹ We looked for information on the policies of the other 14 countries but were unable to find any publicly available documents in English.

² We note a few interesting points about other countries that we investigated but for which we were unable to find sufficient publicly available information to construct a complete case. The Netherlands was the first country to allow transgender personnel to serve openly in its military, opening its ranks in 1974. New Zealand opened its military to transgender personnel in 1993; although we could not find a written policy, a 2014 report by Hague Center for Strategic Studies referred to New Zealand's as the most friendly military to transgender personnel. The New Zealand Defence Force also has an advocacy group, OverWatch, that provides support to lesbian, gay, bisexual, and transgender personnel (see Polchar et al., 2014).

gender transition is unique. While some choose to undergo hormone therapy or gender reassignment surgery, this is not required for gender transition. As a result, the timelines outlined in the policies are intended to be examples only.

Australia

In 2010, the Australian Defence Force revoked the defense instruction that prohibited transgender individuals from serving openly, stating that excluding transgender personnel from service was discrimination that could no longer be tolerated (Ross, 2014). The Australian Department of Defence, with the advocacy group Defence Lesbian, Gay, Bisexual, Transgender, and Intersex Information Service, has produced guides to support commanders, transitioning service members, and the units in which transitioning members are serving (Royal Australian Air Force, 2015). The guide outlines five stages in the gender transition process: diagnosis, commencement of treatment, disclosure to commanders and colleagues, the post-transition experience, and, if applicable, gender reassignment surgery (Royal Australian Air Force, 2015). There is no public information on the number of transgender personnel in the Australian military or the costs associated with covering gender transition–related medical care.

A service member's gender transition begins after receiving a medical diagnosis of gender incongruence from a doctor approved by the Australian Defence Force. According to Australian Defence Force policy, once service members receive this diagnosis and present a medical certification form to their commanders, they can begin the "social transition," which policy defines as the time when an individual begins living publicly as the target gender. Under the current policy, after this point, the service member's administrative record is updated to indicate the target gender for the purposes of uniforms, housing, name, identification cards, showers, and restrooms (Royal Australian Air Force, 2015). This means that, after this point, the service member is assigned to housing of the target gender, may use the restrooms of the target gender, has an identification card with the target gender and new name, and can wear the uniform of the target gender.

During the social transition, the service member may undergo hormone therapy. However, neither hormone therapy nor gender reassignment surgery is required for the administrative changes to occur. Importantly, this shift in gender for military administrative purposes may not always match the legal transition (with respect to the Australian government) to the target gender (Royal Australian Air Force, 2015). Finally, when transgender service members choose to transition, they may choose whether to stay with their current unit or transfer to a different one. They may also choose how colleagues are informed of the gender transition—that is, whether they wish to tell colleagues themselves or have a senior leader do so.

Australia's policy also addresses matters related to physical standards and medical readiness. During the transition period, a service member may be downgraded in terms of physical readiness or declared unable to deploy for some time. However, this

determination is decided on a person-by-person basis and is only temporary. According to the guide provided to service members and commanders, most individuals are placed on “MEC [Medical Employment Classification] 3—Rehabilitation” status during their medical transition or if they require four consecutive weeks of sick leave. Others may be able to remain “MEC 2—Employable and Deployable with Restrictions” for the majority of the gender transition period. In most cases, this determination is made by a certification board, though commanders are also given discretion to downgrade transitioning service members or declare them unfit to deploy, contingent on a stated inability to accommodate the service member’s needs or a determination that the transitioning service member’s presence would undermine the unit’s performance. However, there is no public information available on the types of justifications a commander might give in making such a determination.

The deployment status of each individual will vary during the gender transition based on the transition path chosen (for example, whether hormone therapy or surgery is undertaken). Some of these treatments are covered by military health care. In Australia, medical treatments associated with gender transition, including both hormone therapy and gender reassignment surgery, are covered, but treatments considered “cosmetic” might not be (Royal Australian Air Force, 2015). However, it is not clear what is classified as cosmetic or what might be considered medically necessary. Importantly, gender transition–related medical procedures are provided only at certain facilities, so service members who wish to receive these treatments may need to make special requests for specific assignments where their needs can be met. In general, personnel are permitted to take sick leave to facilitate their medical transition (Royal Australian Air Force, 2015).

Transitioning service members’ deployment status will also depend on their ability to meet physical fitness standards. During the transition period, a service member may be considered medically exempt from meeting physical fitness standards, with a coinciding readiness classification of nondeployable. Once deemed medically able to complete the test by a medical professional, the service member may be asked to meet the standards of the target gender. However, which gender standards the individual is required to meet and when is determined by the medical officer overseeing the gender transition (Royal Australian Air Force, 2015). Thus, the point at which each transitioning service member is required to meet the target-gender standards varies.

Canada

In Canada, a 1992 lawsuit from a member of the armed forces resulted in the repeal of a regulation banning gay, lesbian, and transgender individuals from serving openly in the military (Okros and Scott, 2015). In 1998, the Canadian military explicitly recognized gender identity disorder and agreed to cover gender reassignment surgery. In 2010, Canadian military policy was revised to clarify transgender personnel issues, such as name changes, uniforms, fitness standards, identity cards, and records (Okros

and Scott, 2015). An updated policy, Military Personnel Instruction 01/11, “Management of Transsexual Members,” was released in 2012 (Canadian Armed Forces, 2012). It stated, “The CF [Canadian Forces] shall accommodate the needs of CF transsexual members except where the accommodation would: constitute undue hardship; or cause the CF member to not meet, or to not be capable of meeting. . . . Minimum Operational Standards Relating to Universality of Service” (Canadian Armed Forces, 2012, p. 5). Other considerations that can be used to determine whether an accommodation is reasonable include cost and the safety of other service members and the public (Canadian Armed Forces, 2012, p. 5). Data suggest that there are approximately 265 transgender personnel serving openly and that the Canadian military pays for about one gender reassignment surgery per year (Okros and Scott, 2015).

Canada’s policy on transgender personnel covers such issues as housing, identification cards, restrooms, physical standards, deployment, medical treatment, and uniforms. The process is similar in most ways to that in Australia, described earlier. In Canada, one of the first steps in the gender transition process is a medical assessment in which the individual is given a diagnosis of gender incongruence and assigned a temporary medical category that defines both employment limitations and accommodations that will be needed to support the service member during gender transition. After receiving this diagnosis, service members are responsible for informing their commanders and are asked to give commanders as much notice as possible before beginning their gender transition. After that, the service member, the service member’s manager, and the unit’s commanding officer are expected to meet to discuss the service member’s gender transition plan and to address any necessary accommodations. The policy recommends frequent meetings between the service member and relevant leaders and medical professionals to ensure that the transitioning service member’s needs are met. The policy also identifies subject-matter experts, such as chaplains and mental health professionals, who might be available to provide advice (Canadian Armed Forces, 2012).

The policy states that the gender transition plan should address housing, uniforms, deployments, and other administrative considerations. While the timeline will vary for each individual, in most cases, after receiving the diagnosis and informing the commander, the service member is able to begin living openly as the target gender. At this point, the service member is assigned to housing of the target gender, given ID cards with the target gender and new name, given uniforms of the target gender, and permitted to use restrooms of the target gender. However, while the individual is considered a member of the target gender for all administrative purposes within the military at this point, an official name and gender change in the military personnel system requires both medical certificates and legal documentation (Canadian Armed Forces,

2012).³ Finally, medals and awards earned by the service member prior to transitioning cannot be transferred to the new name when the service member transitions to the target gender (Okros and Scott, 2015).

While the policy expects accommodations to be made to meet the needs of transgender personnel, it also notes that commanders must strike a balance between meeting the needs and legal rights of transgender personnel and the privacy needs of other service members in restrooms, showers, and housing. It does not, however, provide guidance on how this should be accomplished (Canadian Armed Forces, 2012). The policy also makes clear that incidents of harassment must be dealt with according to the Canadian military's discrimination and harassment policy. Finally, if the transgender service member is assigned to a new unit permanently or temporarily, any required accommodations are to be communicated to the new commanding officer prior to the service member's arrival (Canadian Armed Forces, 2012).

The medical assessment and gender transition plan developed at the start of transition are also used to determine a service member's readiness status and deployability. The policy states that service members can be downgraded temporarily in terms of their readiness, ability to deploy, and eligibility for remote assignments until gender transition is complete (Canadian Armed Forces, 2012). This determination is made primarily by the medical professionals overseeing the service member's gender transition. After the gender transition is complete, the continued need for a reduced medical standard is decided on a case-by-case basis based on the service member's overall health, chronic conditions, and need for access to medical care. After beginning the gender transition, and based on the medical assessment, the service member is considered medically exempt from physical fitness testing and requirements until legally assuming the acquired or target gender (which, as noted earlier, requires provincial recognition). At that point, the fitness standards for the acquired or target gender apply. More specifically, once personnel are removed from the medical exemption list, they have 90 days to meet the new standards (Canadian Armed Forces, 2012).

A reduced medical readiness determination during gender transition is intended primarily to ensure that the service member has uninterrupted access to medical care. Once gender transition is complete, transgender service members and their commanders are responsible for identifying the service member's specific needs and how they will be addressed (Canadian Armed Forces, 2012). Gender reassignment surgery will not, however, automatically result in permanent deployment restrictions. As in Australia, gender reassignment surgery and hormone therapy are covered by military health care. The Canadian military paid for one gender reassignment surgery in 1998 and has paid for one or two surgeries per year since then (Canadian Armed Forces, 2012).

³ Also note that the requirements for the legal change vary by province but typically involve only a statement that the individual has assumed the target gender and a medical certification from a doctor of a diagnosis of gender incongruence.

Israel

The Israel Defense Forces (IDF) have allowed transgender personnel to serve openly since 1998 (Speckhard and Paz, 2014).⁴ The IDF experience with transgender personnel is somewhat unique because Israel's military is composed largely of conscripts who serve two or three years and then serve in the reserves with extended periods of active service. As a result, a very high percentage of the population spends extended periods of time mixing military and civilian life. From the perspective of this report, this blending of civilian and military life creates unique challenges for transgender personnel, as they cannot be one person in their civilian life and then a different person in their military life. Some transgender individuals receive a discharge or exemption from their military service based on their gender incongruence, but this decision is currently at the discretion of the commander. There is no official IDF policy on transgender personnel, but according to one report, senior members of the IDF are working to draft one (Speckhard and Paz, 2014). In 2014, the IDF announced that it would support transgender individuals throughout the transition process. Under this new policy, transgender teens who have not yet begun to transition to another gender will be enlisted according to their birth sex, but after enlistment, they will be given support and assistance with the gender transition process (Zitun, 2014). As a result, Speckhard and Paz (2014) noted, experiences vary for transgender personnel in the IDF. Some individuals report that once they ask to transition, they are allowed to dress and serve as their target gender. However, it is unclear how generalizable this is.

Typically, IDF administrative records use the gender at that time of enlistment. Since conscription occurs at age 18, and because hormone treatment for gender incongruence cannot legally begin until age 18, the administrative records of most personnel show their birth gender. Under a newly announced policy, personnel enlisted using their birth gender who identify as transgender can immediately receive support and treatment to begin the gender transition (Zitun, 2014). Importantly, however, as of 2014, the military identification card carries the birth gender until a service member undergoes gender reassignment surgery, even if the service member is living publicly as the target gender (Speckhard and Paz, 2014). It should be noted that, in Israel, only one hospital can perform gender reassignment surgery, and this surgery cannot be performed until age 21, though some people go abroad for it (Speckhard and Paz, 2014). This creates some complications for housing and other matters, discussed in more detail later. The new policy will also allow transgender recruits to receive support for gender transition after enlistment.

Available evidence suggests that, in the IDF, 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. Service members who are undergo-

⁴ We do not know the exact date for this change because there was never a formal policy allowing or prohibiting transgender personnel from serving. It was in 1998 that the first openly transgender individual served in the IDF.

ing gender transition are accommodated, however, through the use of ad hoc solutions, including giving transitioning personnel their own showers, housing, or restrooms (Speckhard and Paz, 2014). Once transitioning personnel have completed gender reassignment surgery, they can be assigned to the housing, restrooms, and showers of their acquired gender. It is also worth noting that the majority of noncombat personnel are able to live at home, off base. As a result, the housing issue does not affect a large number of transitioning personnel (Speckhard and Paz, 2014). The issue of uniforms is usually easier to address, and service members are able to wear the uniform of the target gender once they begin their gender transition.

In addition to addressing housing and other administrative matters for conscripts and career soldiers, the IDF must address transitioning reservists. The limited information available suggests that the approach to addressing the needs of this group also varies from person to person. Usually, if reserve members are in the process of transitioning or have transitioned when called to active duty, they are permitted to return to service as their target or acquired gender (following the same administrative policies described earlier). For example, a service member who served in an all-male combat unit and is transitioning to female may be moved to another position. Again, many reservists serve their duty while living at home, so housing is not usually an issue. Restroom and shower assignments are addressed on an ad hoc basis (Speckhard and Paz, 2014). Finally, some personnel who have transitioned or are in the process of transitioning are exempted from their reserve duty. However, this is becoming less common as the IDF strives to accommodate the needs of these personnel rather than exempting them from service (Speckhard and Paz, 2014).

The IDF does not have a formal policy on physical standards for transgender individuals serving their conscription duty, reserve duty, or as professional soldiers. Available information suggests only that transgender personnel can serve in any unit or occupation for which they meet the requirements, with the exception of a few male-only combat units and certain security-related positions (Speckhard and Paz, 2014). Personnel transitioning from female to male are able to serve in male-only combat units only if they can meet the requirements set for other men. Personnel transitioning from male to female cannot serve in male-only combat units once they begin hormone treatment (Speckhard and Paz, 2014).

There do appear to be some limitations on the assignment of transgender personnel, particularly in combat units. Because of 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 (Speckhard and Paz, 2014). Transgender personnel are also limited from assignment to certain security-related positions due to concerns about blackmail, based on the assumption that these service members might be open about their gender identity in the military but might not have told others, including family members. Keeping

these types of secrets might make an individual susceptible to blackmail or extortion (Speckhard and Paz, 2014).

In the IDF, medical issues and matters related to the readiness of transgender personnel are addressed on a case-by-case basis, though a more formal policy is being developed. For conscripts, the only treatment that can be provided by the military is hormone therapy because gender reassignment surgery is possible in Israel only after age 21, by which point the conscription duty is usually completed (Speckhard and Paz, 2014). Those who choose to stay in the military full-time after the age of 21, as well as those in the reserve called to back to active service, may receive both hormone therapy and gender reassignment surgery. Those who choose to undergo surgery are permitted to take a period of sick leave for the surgery and recovery, as they can for any other medical treatment or surgery (Speckhard and Paz, 2014). Israel has nationalized health care that typically covers all treatments associated with gender transition, ranging from psychiatric care to pre- and postoperative care, hormone treatment, breast augmentation, and facial feminization. Apart from the approaches used to address physical standards for transitioning individuals (discussed earlier), there are no specific policies governing the readiness classification of transitioning IDF personnel, though some are in development (Zitun, 2014).

United Kingdom

The United Kingdom lifted the ban on transgender personnel in 2000 following a European Court of Human Rights ruling that the country's policy violated the right to privacy under the European Convention on Human Rights (Frank, 2010). The policy change was implemented with guidance to commanders, as well as a code of social conduct that allowed commanders to address inappropriate behavior toward transgender personnel by appealing to broader principles of tolerance and diversity and to guard operational effectiveness (Yerke and Mitchell, 2013). In 2009, the British Armed Forces released the "Policy for Recruitment and Management of Transsexual Personnel in the Armed Forces" to offer clearer guidance to commanders on how gender transition-related issues should be addressed (Yerke and Mitchell, 2013). While transgender personnel are able to serve openly, under the current policy, they can be excluded from sports that organize around gender to ensure the safety of the individual or other participants. The British Army also provides its official policy on transgender personnel on its website:

The Army welcomes transgender personnel and ensures that all who apply to join are considered for service subject to meeting the same mental and physical entry standard as any other candidate. If you have completed transition you will be treated as an individual of your acquired gender. Transgender soldiers serve throughout the Army playing their part in the country's security. There is a formal network that operates in the Army to ensure that transgender soldiers can find advice and support with issues that affect their daily lives. (British Army, undated)

However, the military encourages those who have not yet started their gender transition to complete their transition before joining (UK Ministry of Defence, 2009).

The 2009 UK policy is similar to those in Canada and Australia in terms of the areas covered and approaches to addressing key issues, though the UK policy provides some additional room for individual differences. The policy also includes an extensive discussion of the legal and privacy protections afforded to transgender personnel. These protections are important because they also apply to administrative and medical records in the military system.

The UK policy defines five stages of gender transition: diagnosis, social transition (the individual begins living openly as the target gender), medical treatment/hormone therapy, surgical reassignment, and postoperative transition. However, it also recognizes that the process of gender transition may be different for each person. The policy suggests that each individual work with commanders and service authorities to develop a plan that includes a timeline for transition. The gender transition plan agreed to by the service member and commanders should specify the timing of changes, such as to housing assignments and uniforms. The specific point at which a service member transitions for the purposes of name, uniform, housing, restrooms, and ID cards may vary from person to person. Typically, when service members begin living publicly as the target gender (the social transition) they are reassigned to housing of the target gender, use the restrooms and uniforms of the target gender, and are given an ID card indicating that they are a member of the target gender. Importantly, this shift in gender for administrative purposes does not have to correspond to the point at which an individual transitions gender within the UK legal system, a process that involves a diagnosis of gender incongruence and two years of living as the acquired gender (UK Ministry of Defence, 2009). The policy also notes that it is unlawful to force transgender personnel to use separate toilet or shower facilities or occupy separate housing accommodations from the rest of the force.

The gender transition plan addresses other logistics of the transition. For example, it should specify scheduled time off required for medical procedures, including gender reassignment surgery. In general, medical treatment associated with gender transition is treated like any other medical issue experienced by a service member. However, while hormone replacement therapy is covered by military health care, gender reassignment surgery is not (UK Ministry of Defence, 2009). The policy notes that the timeline and timing of the transition must take into consideration the needs of the service. As a result, at least four weeks notice is typically needed prior to the start of a service member's gender transition. The gender transition plan should also specify whether service members wish to transition in their current post or transfer to a new position and whether they want to tell their colleagues about the gender transition themselves or would like someone else to do this. This decision may depend on the size of the unit. In a small unit, it may be easy to inform fellow service members personally. In a larger organization, it may not be necessary to tell every individual. Commanders of units

with transgender personnel are encouraged to consult members of the Service Equality and Diversity staff about how to approach education and management in matters associated with transgender service members.

The UK policy also addresses medical readiness and physical standards. Transgender personnel are evaluated for medical readiness and deployability on a case-by-case basis following a medical evaluation. During the transition period, specifically during hormone treatment and immediately before and after surgery, service members may receive a reduced Medical Employment Standard, which restricts deployability and sea service (UK Ministry of Defence, 2009). Transitioning service members who continue to meet physical standards throughout this period and are able to perform their jobs may retain normal readiness standards. Usually, those who do not undergo hormone therapy or gender reassignment surgery are able to maintain a fully deployable status throughout their gender transition (UK Ministry of Defence, 2009). Service members who are undergoing hormone therapy are able to deploy, as long as the hormone dose is steady and there are no major side effects. However, deployment to all areas may not be possible, depending on the needs associated with any medication (e.g., refrigeration). Some service members may also be required to have a psychiatric evaluation, but only if they show signs of mental health distress (UK Ministry of Defence, 2009). Individuals who have finished their gender transition and can meet the requirements of their legal gender are considered fully deployable. However, those who remain in a state of reduced readiness for an extended period may have to be discharged (UK Ministry of Defence, 2009). Importantly, the British military encourages individuals who are in the midst of their gender transition and are considering joining the military to wait until the gender transition is complete before joining, as the military may not always be able to provide the support the individual needs during gender transition.

The specific physical standards a transitioning individual must meet during and after the gender transition period are determined on a case-by-case basis. The policy allows that there may be a period of time—especially for individuals transitioning from female to male—during which a service member is not yet able to meet the standards of the target gender. In these cases, medical staff and commanders may assess the individual and determine the appropriate interim standards (UK Ministry of Defence, 2009). Once the gender transition is considered “complete,” personnel are required to meet the standards of the target gender (UK Ministry of Defence, 2009). However, the policy recognizes that the point at which the gender transition is complete may vary: It may be complete after hormone therapy or after surgery, or simply after the individual begins living as the target gender. Therefore, the policy continues to allow for some flexibility in physical standards, even for members at the end of their gender transition process (UK Ministry of Defence, 2009). Modified standards may be set by medical staff and commanders, if necessary. Continued failure to meet whatever physical stan-

dards are determined to be appropriate (modified or otherwise) can lead to administrative discharge (UK Ministry of Defence, 2009).

The policy also addresses positions that are “gender-restricted” or have unique standards. The United Kingdom still has a number of combat occupations closed to women. Personnel who are transitioning from male to female may not serve in male-only occupations as long as this policy remains in place. Those transitioning from female to male may hold these jobs, assuming that they are able to meet the physical standards (UK Ministry of Defence, 2009). Transgender personnel may hold positions that have unique standards related to the occupation, as long as they can meet the physical and other requirements for the specific position. Finally, according to the policy, service members may request that their medals be transferred to a new name by submitting the request in writing. They are allowed to continue wearing qualifications earned while serving as their birth gender. However, this may indicate their transgender status to others (UK Ministry of Defence, 2009).

Effects on Cohesion and Readiness

As indicated in Chapter Six, while there is limited research on the effects of transgender personnel serving openly in foreign militaries, the available evidence indicated no significant effect on cohesion, operational effectiveness, or readiness. In the Australian case, there is no evidence and there have been no reports of any effect on cohesion, operational effectiveness, or readiness (Frank, 2010). In the Israeli case, there has also been no reported effect on cohesion or readiness (Speckhard and Paz, 2014). Transgender personnel in these militaries report feeling supported and accommodated throughout their gender transition, and there has been no evidence of any effect on operational effectiveness (Speckhard and Paz, 2014). As noted earlier, commanders report that transgender personnel perform their military duties and contribute to their units effectively (Speckhard and Paz, 2014). Interviews with commanders in the United Kingdom also found no effect on operational effectiveness or readiness (Frank, 2010). Some commanders reported that increases in diversity had led to increases in readiness and performance. Interviews with these same commanders also found no effect on cohesion, though there were some reports of resistance to the policy change within the general military population, which led to a less-than-welcoming environment for transgender personnel. However, this resistance was apparently short-lived (Frank, 2010).

The most extensive research on the potential effects of openly serving transgender personnel on readiness and cohesion has been conducted in Canada. This research involved an extensive review of internal defense reports and memos, an analysis of existing literature, and interviews with military commanders. It found no evidence of any effect on operational effectiveness or readiness. In fact, the researchers

heard from commanders that the increased diversity improved readiness by giving units the tools to address a wider variety of situations and challenges (Okros and Scott, 2015). They also found no evidence of any effect on unit or overall cohesion. However, there have been reports of bullying and hostility toward transgender personnel, and some sources have described the environment as somewhat hostile for transgender personnel (Okros and Scott, 2015).

To summarize, our review of the limited available research found no evidence from Australia, Canada, Israel, or the United Kingdom that allowing transgender personnel to serve openly has had any negative effect on operational effectiveness, cohesion, or readiness. However, it is worth noting that the four militaries considered here have had fairly low numbers of openly serving transgender personnel, and this may be a factor in the limited effect on operational readiness and cohesion.

Best Practices from Foreign Militaries

Several best practices and lessons learned emerged both directly from research articles describing the evolution of policy and the experiences of foreign militaries and indirectly from commonalities in the policies and experiences across our four case studies. The best practices that extended across all cases include the following:

The Importance of Leadership

Sources from each of our case-study countries stressed that leadership support was important to executing the policy change. Leaders provided the impetus to draft and implement new policies and were integral to communicating a message of inclusion to the entire force. Supportive leaders were also important in holding accountable those personnel who participated in discrimination (Okros and Scott, 2015; Speckhard and Paz, 2014). Each of the cases underscores the importance of having strong leadership support to back and enforce the policy change, along with clearly written policies that are linked to national policy wherever possible (Frank, 2010). The militaries found that presenting a “business case” for diversity and emphasizing the advantages of an inclusive military, including better retention and recruiting, can help reduce resistance to a policy change (Frank, 2010).

Awareness Through Broad Diversity Training

The most effective way to educate the force on matters related to transgender personnel is to integrate training on these matters into the diversity and harassment training already given to the entire force. This training addresses all forms of harassment and bullying, including that based on religion, race, and ethnicity (Frank, 2010; Okros and Scott, 2015; Belkin and McNichol, 2000–2001).

In the four cases we reviewed in-depth, we found that targeting only commanders with training and information on what it means to be transgender is not as effective in fostering an inclusive and supportive environment as training that targets the entire force and is integrated into broader forcewide diversity training. The foreign militaries that we examined train not only units with transitioning individuals but also the entire force by including gender identity alongside sexual orientation, religion, ethnicity, and other markers of difference in diversity training and education. However, efforts must be made simultaneously to protect the privacy of transitioning service members. In some cases, telling a unit that a transgender member is arriving before that individual arrives can be counterproductive (Frank, 2010).

The Importance of an Inclusive Environment

An all-inclusive military environment—not just as it pertains to transgender personnel, sexual orientation, or gender identity, but a culture that embraces diversity—can support the integration of openly serving transgender personnel. In this context, gender identity is just one marker of diversity.⁵

Ensuring Availability of Subject-Matter Experts to Advise Commanders

Most of the four countries we examined in-depth also make subject-matter experts (e.g., chaplains, psychiatrists) and gender advisers (individuals who have special training in gender awareness and gender mainstreaming in the military context) available to commanders tasked with the integration of transgender personnel. Gender advisers were originally intended to deal primarily with issues associated with integrating women into male-dominated military environments, but they could also help with other gender-related matters, including transgender personnel policy. They serve directly within military units and are a readily available resource to commanders. Adopting a similar practice of integrating advisers with expertise in the area of transgender personnel policy and gender transition-related matters might also support the integration of transgender service members in the U.S. military.

Lessons Learned and Issues to Consider for U.S. Military Policy

Based on these best practices and the broader experiences of four foreign militaries, there are some key lessons to be learned and possible issues to consider when crafting U.S. military transgender personnel policy. First, in each of the four foreign militaries, there were some reports of resistance, bullying, and harassment of transgender personnel who made their gender transition public. This harassment ranged from exclusion to more aggressive behavior. In most cases, this behavior was relatively limited; however,

⁵ Remarks by a Canadian subject-matter expert in a phone discussion with RAND researchers, November 2015.

in some cases, it did contribute to a hostile work environment for transgender personnel and had the effect of discouraging these personnel from being open about their gender transition or gender identity (Okros and Scott, 2015; Frank, 2010). Although the foreign militaries we examined tended to adopt a policy of no tolerance for this type of harassment, some bullying behavior may have gone unreported (Okros and Scott, 2015; Frank, 2010). In the case of Canada, the issue of restrooms for transgender personnel is an ongoing topic of discussion, and restrooms have been a common site of harassment and discrimination (Okros and Scott, 2015).

A second lesson learned is related to problems caused by the lack of an explicit, clearly written policy. For instance, in the IDF, without a clear policy, some transitioning individuals are placed in difficult and uncomfortable situations. For example, in some cases, personnel who have been permitted to begin hormone therapy cannot be housed with members of their target gender or grow their hair and fingernails (in the case of individuals transitioning from male to female). Others have been isolated, assigned to separate housing, or asked to use separate restrooms (Speckhard and Paz, 2014). Recognizing these challenges, IDF leadership is working to design a clear and explicit policy. In the Israeli case, transgender individuals were allowed to serve openly before a formal policy was written. Only when it was faced with questions about the integration of transgender personnel did the IDF begin to create a formal policy.⁶ In Canada, a similar policy gap arose when transgender personnel were allowed to serve openly following a national policy revision that ended discrimination based on sexual orientation or gender. However, the focus at that point was on gay and lesbian service members, and no formal policy was created to address transgender personnel explicitly. When matters related to the medical care of transgender personnel arose, Canadian defense leaders developed a policy that just addressed this narrow, pressing issue, and did not develop policies to address the other matters (e.g., housing, restrooms, name changes). Commanders complained that the original policy was too vague and lacked sufficient details. A new, revised policy was written in 2012, and commanders have responded with positive feedback.⁷ The lack of a clear, written policy has also been an issue in Australia.

A third and final issue that has come up in at least two of the countries we surveyed is that of awards and medals. In the UK case, medals and awards received prior to gender transition can be transferred to the service member's post-transition name (UK Ministry of Defence, 2009). In the Canadian case, this is not possible, and the awards remain associated only with the original name. This is a cause for concern among transgender personnel in the Canadian military, but Canadian officials have responded that they cannot rewrite history (Okros and Scott, 2015). This is a policy area that the United States should consider alongside other administrative policies.

⁶ Remarks by a Canadian subject-matter expert in a phone discussion with RAND researchers, November 2015.

⁷ Remarks by a Canadian subject-matter expert in a phone discussion with RAND researchers, November 2015.

CHAPTER EIGHT

Which DoD Policies Would Need to Be Changed if Transgender Service Members Are Allowed to Serve Openly?

This chapter reviews DoD accession, retention, separation, and deployment policies and provides an assessment of the impact of changes required to allow transgender personnel to serve openly. For our analysis of DoD policies, we reviewed 20 current accession, retention, separation, and deployment regulations across the services and the Office of the Secretary of Defense. We also reviewed 16 other regulations that have been replaced by more recent regulations or did not mention transgender policies.¹ DoDI 6130.03 establishes medical standards for entry into military service, including a list of disqualifying physical and mental conditions, some of which are transgender-related.² Current DoD policy also authorizes, but no longer requires, the discharge of transgender personnel for reasons related to both medical conditions that generate disabilities, as well as mental health concerns.³ However, a July 2015 directive from the Office of the Secretary of Defense elevated decisions to administratively separate transgender service members to the Office of the Under Secretary of Defense for Personnel and Readiness (DoD, 2015b).

Note that our review focused on transgender-specific DoD instructions that may contain unnecessarily restrictive conditions and reflect outdated terminology and assessment processes. However, in simply removing these restrictions, DoD could inadvertently affect overall standards. While we focus on reforms to specific instruc-

¹ These additional policies are listed in Appendix D.

² The instruction specifies conditions that disqualify accessions, including “current or history of psychosexual conditions, including but not limited to transsexualism, exhibitionism, transvestism, voyeurism, and other paraphilias”; “history of major abnormalities or defects of the genitalia including but not limited to change of sex, hermaphroditism, pseudohermaphroditism, or pure gonadal dysgenesis”; and “history of major abnormalities or defects of the genitalia such as change of sex, hermaphroditism, pseudohermaphroditism, or pure gonadal dysgenesis” (DoDI 6130.03, 2011, enclosure 4).

³ “Sexual gender and identity disorders” are specified as medical conditions that may generate disabilities under DoDI 1332.38, enclosure 5 (2006). Mental health conditions are specified in DoDI 1332.14 (2014) and DoDI 1332.30 (2013) for enlisted and officers, respectively. DoDI 1332.18, issued on August 5, 2014, updated these guidelines and established general criteria for referral for disability evaluation and defers to service-specific standards for retention. However, a recent review of this revision suggests that service-specific regulations may still disqualify transgender personnel, and the new guidance may not overrule those service policies (Pollock and Minter, 2014).

tions and directives, we note that DoD may wish to conduct a more expansive review of personnel policies to ensure that individuals who join and remain in service can perform at the desired level, regardless of gender identity.

Accession Policy

The language pertaining to transgender individuals in accession instructions does not match that used in DSM-5.⁴ This results in restrictions in DoD policy that do not match current medical understanding of gender identity issues and thus may be misapplied or difficult to interpret in the context of current medical treatments and diagnoses. Under current guidelines, otherwise qualified individuals could be excluded for conditions that are unlikely to affect their military service, and individuals with true restrictions may be more difficult to screen for and identify. Modernizing the terminology to match current psychological and medical understanding of gender identity would help ensure that existing procedures do not inadvertently exclude otherwise qualified individuals who might want to join the military. We recommend that DoD review and revise the language to match the DSM-5 for conditions related to mental fitness so that mental health screening language matches current disorders and facilitates appropriate screening and review processes for disorders that may affect fitness for duty. Similarly, physical fitness standards should specify physical requirements, rather than physical conditions. Finally, the physical fitness language should clarify when in the transition process the service member's target gender requirements will begin to apply.

Retention Policy

We recommend that DoD expand and enhance its guidance and directives to clarify and adjust, where necessary, standards for retention of service members during and after gender transition. Evidence from Canada and Australia suggests that transgender personnel may need to be held medically exempt from physical fitness testing and requirements during transition (Canadian Armed Forces, 2012; Royal Australian Air Force, 2015). However, after completing transition, the service member could be required to meet the standards of the acquired gender. The determination of when the service member is "medically ready" to complete the physical fitness test occurs on a case-by-case basis and is typically made by the unit commander.

⁴ Two key changes are that the term *transsexualism* has been replaced, and *gender dysphoria* is no longer in the chapter "Sexual Desire Disorders, Sexual Dysfunctions, and Paraphilias" but, rather, has its own chapter (Mishler, 2014).

Separation Policy

DoD may wish to revise the current separation process based on lessons learned from the repeal of Don't Ask, Don't Tell. The current process relies on administrative decisions outside the purview of the standard medical and physical review process. This limits the available documentation and opportunities for review, and it could prove burdensome if transgender-related discharges become subject to re-review. When medically appropriate, DoD may wish to establish guidance on when and how such discharge reviews should be handled. We also recommend that DoD develop and disseminate clear criteria for assessing whether transgender-related conditions may interfere with duty performance.

Deployment Policy

Deployment conditions vary significantly based on the unique environment of each deployment, with some deployed environments able to accommodate transgender individuals, even those who are undergoing medical treatments. Moreover, recent medical advancements can minimize the invasiveness of treatments and allow for telemedicine or other forms of remote medical care. Given medical and technological advances, DoD may wish to adjust some of its processes and deployment restrictions to minimize the impact on readiness. For example, current regulations specify that conditions requiring regular laboratory visits make service members ineligible for deployment, including all service members who are receiving hormone treatments,⁵ since such treatments require laboratory monitoring every three months for the first year as hormone levels stabilize (Hembree et al., 2009; Elders et al., 2014). Such a change would require DoD to either permit more flexible monitoring strategies⁶ or provide training to deployed medical personnel.⁷ Similarly, the use of refrigerated medications is a disqualifying condition for deployment,⁸ even though nearly all hormone therapies are available in other formats that do not require refrigeration.

⁵ Current regulations state that "medications that require laboratory monitoring or special assessment of a type or frequency that is not available or feasible in a deployed environment" disqualify an individual from deployment (Office of the Assistant Secretary of Defense for Health Affairs, 2013, p. 3).

⁶ Some experts suggest that alternatives, such as telehealth reviews, would address this issue for rural populations with limited access to medical care (see, for example, WPATH, 2011).

⁷ "Independent duty corpsmen, physician assistants, and nurses can supervise hormone treatment initiated by a physician" (Elders et al., 2014).

⁸ The memo issued by the Office of the Assistant Secretary of Defense for Health Affairs states, "Medications that disqualify an individual for deployment include . . . [m]edications that have special storage considerations, such as refrigeration (does not include those medications maintained at medical facilities for inpatient or emergency use)" (Office of the Assistant Secretary of Defense for Health Affairs 2013, p. 3).

CHAPTER NINE

Conclusion

By many measures, there are currently serving U.S. military personnel who are transgender. Overall, 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. We estimate, based on state-level surveys of transgender prevalence, that between 1,320 and 6,630 transgender personnel may be serving in the AC, and 830–4,160 may be serving in the SR. Estimates based on studies from multiple states, weighted for population and the gender distribution in the military, imply that there are around 2,450 transgender service members in the AC and 1,510 in the SR.¹

However, only a small proportion of these service members will seek gender transition–related treatment each year. Employing utilization and cost data from the private health insurance system, we estimated the potential impact of providing this care to openly serving transgender personnel on AC health care utilization and costs. Directly applying private health insurance utilization rates to the AC military population indicated that a very small number of service members will access gender transition–related care annually. Our estimates based on private health insurance data ranged from a lower-bound estimate of 29 AC service members to an upper-bound estimate of 129 annually using care, including those seeking both surgical and other medical treatments.

Using estimates from two states and adjusting for the male/female AC distribution, we also estimate a total of 45 gender transition–related surgeries, with 50 service members initiating transition-related hormone therapy annually in the AC.² We estimate 30 gender transition-related surgeries and 25 service members initiating hormone therapy treatments in the SR. These are likely to be upper-bound estimates, given the nonrepresentative sample selection procedures used in the NTDS. Furthermore, the best prevalence estimates that we were able to identify were from two of the more transgender-tolerant states in the country, and the empirical evidence that trans-

¹ Estimates are based on FY 2014 AC and SR personnel numbers.

² For hormone therapy recipients, the number of treatments and recipients is the same, and these estimates can be treated as counts of individuals.

gender prevalence is higher in the military than in the general population is weak. As a point of comparison, we also compared these estimated values to mental health utilization in the AC population overall. Using data from McKibben et al. (2013), we calculated that approximately 278,517 AC service members accessed mental health care treatment in 2014, the implication being that health care for the transgender population will be a very small part of the total health care provided to AC service members across the MHS.

With respect to health care costs, actuarial estimates from the private health insurance sector indicate that covering gender transition–related care for transgender employees increased premiums by less than 1 percent. Taking a weighted average of the identified firm-level data, we estimate that covering transgender-related care for service members will increase the U.S. military’s AC health care spending by only 0.038–0.054 percent. Using these baseline estimates, we estimate that MHS health care costs will increase by between \$2.4 million and \$8.4 million. These numbers represent only a small proportion of FY 2014 AC health care expenditures (\$6.27 billion) and the FY 2014 Unified Medical Program budget (\$49.3 billion). This is consistent with our estimate of relatively low AC rates of gender transition–related health care utilization in the MHS.

Similarly, when considering the impact on readiness, we found that using either the prevalence-based approach or the utilization-based approach yielded an estimate of less than 0.0015 percent of total labor-years likely to be affected by a change in policy. This is much smaller than the current lost labor-years due to medical care in the Army alone.

Even if transgender personnel serve in the military at twice the rate of their prevalence in the general population and we use the upper-bound rates of health care utilization, the total proportion of the force that is transgender and would seek treatment would be less than 0.1 percent, with fewer than 130 AC surgical cases per year even at the highest utilization rates. Given this, true usage rates from civilian case studies imply only 30 treatments in the AC, suggesting that the total number of individuals seeking treatment may be substantially smaller than 0.1 percent of the total force. Thus, we estimate the impact on readiness to be negligible.

We conclude with some general recommendations and insights based on the experiences of foreign militaries that permit transgender individuals to serve openly—specifically, Australia, Canada, Israel, and the United Kingdom. Our case studies provide some guidance that policymakers should consider as they develop policies to govern the employment of transgender personnel in the U.S. military. These cases also suggested a number of key implementation practices if a decision is made to allow transgender service members to serve openly:

- Ensure strong leadership support.
- Develop an explicit written policy on all aspects of the gender transition process.

- Provide education and training to the rest of the force on transgender personnel policy, but integrate this training with other diversity-related training and education.
- Develop and enforce a clear anti-harassment policy that addresses harassment aimed at transgender personnel alongside other forces of harassment.
- Make subject-matter experts and gender advisers serving within military units available to commanders seeking guidance or advice on gender transition-related issues.
- Identify and communicate the benefits of an inclusive and diverse workforce.

APPENDIX A

Terminology

Augmentation mammoplasty: breast augmentation involving implants or lipofilling

Buccal administration: placement of medication between the gums and cheek

Chest surgery: surgery to create a contoured, male-looking chest

Clitoroplasty: surgical creation/restoration of a clitoris

Cross-dresser: someone who dresses in the clothes of the other gender, not always on a full-time basis

Female-to-male: those assigned female sex at birth who identify as male; transgender men; transmen

Gender: an individual's gender identity, which is influenced by societal norms and expectations; public, lived role as male or female

Gender assignment: initial assignment at birth as male or female; yields "natal gender" (APA, 2013, p. 451)

Gender atypical: behaviors not typical for one's gender "in a given society and historical era" (APA, 2013, p. 451)

Gender identity: "one's inner sense of one's own gender, which may or may not match the sex assigned at birth" (Office of Personnel Management, 2015, p. 2)

Gender dysphoria: "discomfort or distress that is caused by a discrepancy between a person's gender identity and that person's sex assigned at birth (and the associated gender role and/or primary and secondary sex characteristics)" (WPATH, 2011, p. 2).

Gender nonconformity: "the extent to which a person's gender identity, role, or expression differs from the cultural norms prescribed for people of a particular sex" (WPATH, 2011, p. 5, citing Institute of Medicine definition)

Gender transition–related surgery/gender-confirming surgery/sex reassignment surgery: surgery to mitigate distress associated with gender dysphoria by aligning sex characteristics with gender identity

Genderqueer: those who “define their gender outside the construct of male or female, such as having no gender, being androgynous, or having elements of multiple genders” (Roller, Sedlak, and Draucker, 2015, p. 417)

Gluteal augmentation: buttocks augmentation involving implants or lipofilling

Hormone therapy: “the administration of exogenous endocrine agents to induce feminizing or masculinizing changes” (WPATH, 2011, p. 33)

Hysterectomy: surgery to remove the uterus

Intersex: “a general term used for a variety of conditions in which a person is born with a reproductive or sexual anatomy that doesn’t seem to fit the typical definitions of female or male” (Intersex Society of North America, undated)

Labiaplasty: plastic surgery for altering or creating the labia

Lipofilling: injection of fat rather than artificial implants

Male-to-female: those assigned male sex at birth who identify as female; transgender females; transwomen

Mastectomy: surgical removal of one or both breasts

Metoidioplasty: surgically relocating a clitoris that has been enlarged by hormone therapy to a more forward position that more closely resembles that of a penis; average length is 1.5–2 inches

Oophorectomy: surgical removal of one or both ovaries

Orchiectomy: surgical removal of one or both testicles

Ovariectomy: surgical removal of one or both ovaries

Parenteral administration: intravenous injection (into a vein) or intramuscular infusion (into muscle) of medication

Penectomy: surgical removal of the penis

Phalloplasty: surgical creation/reconstruction of a penis using one of a variety of techniques including free or pedicled (attached) flap (see Rashid and Tamimy, 2013)

Primary sex characteristics: physical characteristics/sex organs directly involved in reproduction

Salpingo-oophorectomy: removal of the ovaries and fallopian tubes

Scrotoplasty: surgical creation/reconstruction of testicles; in transmen, native labia tissue is used; testicular implants can be used

Secondary sex characteristics: physical characteristics that appear at puberty and vary by sex but are not directly involved in reproduction (e.g., breasts)

Sex: a person's biological status as male or female based on chromosomes, gonads, hormones, and genitals (intersex is a rare exception)

Sexual orientation: sexual identity in relation to the gender to which someone is attracted: heterosexual, homosexual, or bisexual

Thyroid chondroplasty: removal or reduction of the Adam's apple

Transdermal administration: delivery of medication across the skin with patches

Transgender: "an umbrella term used for individuals who have sexual identity or gender expression that differs from their assigned sex at birth" (Roller, Sedlak, and Draucker, 2015, p. 417)

Transsexual: someone whose gender identity is inconsistent with their assigned sex and who desires to permanently transition their physical characteristics to match their inner sense of their own gender

Urethroplasty: surgical reconstruction or fabrication of the urethra.

Vaginectomy (colpectomy): surgical removal of all or part of the vagina

Vaginoplasty: surgical creation/reconstruction of a vagina

Vulvoplasty: surgical creation/reconstruction of the vulva

APPENDIX B

History of DSM Terminology and Diagnoses

A brief historical understanding of the evolving diagnostic nomenclature pertaining to transgender status is important to discussions of related health care. DSM-III (APA, 1980) first contained the diagnosis of transsexualism. DSM-III-R (APA, 1987) introduced gender identity disorder, non-transsexual type. In DSM-IV (APA, 1994), these two diagnoses were merged and called *gender identity disorder*. Gender identity disorder, together with the paraphilias (disorders of extreme, dangerous, or abnormal sexual desire, including transvestic fetishism, sometimes referred to as cross-dressing), constituted the DSM-IV section “Sexual and Gender Identity Disorders.”

With DSM-5 (APA, 2013) came the migration from *gender identity disorder* to *gender dysphoria*. The clinical significance of the shift in DSM-5 was great: For the first time, without accompanying symptoms of distress, transgender individuals were no longer considered to have a diagnosable mental disorder. The historical parallel with homosexuality is hard to miss: In 1980, DSM-III similarly normalized the DSM-II diagnosis of homosexuality, moving instead to ego-dystonic homosexuality, a diagnosis reserved only for gay persons who felt related distress. In the next DSM iteration, DSM-III-R, all reference to homosexuality as a diagnostic term was removed. In the aftermath of depathologizing gender nonconformity, a similar move relating to transgender status appears to be underway.

As noted in this report, there is a consensus among clinicians and their professional organizations that transition-related treatment with hormones or surgery constitutes necessary health care, though there is a divide over whether it serves as “a strategy to diminish the serious suffering” of the patient or “a method to assist people in finding self-actualization” (Gijs and Brewaeys, 2007, p. 184). The conclusion that transition-related surgery “is an effective treatment for gender identity disorder in adults” is based primarily on retrospective studies of satisfaction rather than randomized controlled trials or prospective studies (Gijs and Brewaeys, 2007, p. 199). The prevalence of post-operative regret is very low, though “little empirical research has been done” on related risk and protective factors (Gijs and Brewaeys, 2007, pp. 201, 204). Overall, surgery is considered “the most appropriate treatment to alleviate the suffering of extremely gender dysphoric individuals,” but rigorous controlled-outcome studies evaluating its

effectiveness should be conducted despite feasibility and ethical challenges (Gijs and Brewaeys, 2007, pp. 215–216; Buchholz, 2015, p. 1786).

DSM-5 Diagnostic Criteria: Gender Dysphoria in Adolescents and Adults 302.85 (F64.1)

- A. A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months' duration, as manifested by at least two of the following:
 - 1. 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).
 - 2. 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).
 - 3. A strong desire for the primary and/or secondary sex characteristics of the other gender.
 - 4. A strong desire to be of the other gender (or some alternative gender different from one's assigned gender).
 - 5. A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender).
 - 6. 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).
- B. The condition is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning.

APPENDIX C

Treatments for Gender Dysphoria

In this appendix, we provide additional details about psychosocial, pharmacologic, surgical, and other treatments for gender dysphoria (GD).

Psychotherapy

The emphasis of psychotherapy for this population today is on “affirming a unique transgender identity,” rather than focusing on gender transition (Institute of Medicine, 2011, p. 52). Mental health professionals can also help patients presenting with GD navigate the process of coming out to family, friends, and peers; treat comorbid mental health conditions;¹ weigh options related to gender identity, gender expression, and transition-related treatment interventions; and conduct assessments, make referrals, and guide preparation for and provide support through the transition-related treatment process (WPATH, 2011, pp. 22–26). Referral from a mental health professional is necessary under the standards of care for those seeking breast/chest or genital surgeries, and the latter also requires confirmation from an independent mental health provider (WPATH, 2011, p. 27). Mental health providers may also serve an important role on behalf of their patients by providing education and advocacy within the community and supporting changes to identity documents (WPATH, 2011, p. 31).

Of note, treatment aimed at changing one’s gender identity to align with the sex assigned at birth has proven unsuccessful and is no longer considered ethical care; mental health providers who are unwilling or unable to provide appropriate care should refer patients to a provider who is (WPATH, 2011, p. 32).

Hormone Therapy

Hormone therapy is necessary for many individuals with GD (WPATH, 2011, p. 33). It has two major goals: (1) reduce naturally occurring hormones to minimize secondary sex characteristics and (2) maximize desired feminization/masculinization using the principles and medications used for hormone replacement in non-transgender patients who do not produce enough hormones, such as women who have had hyster-

¹ Co-occurring mental health conditions could range from anxiety and depression, which are common among the transgender population, to more severe and rare illnesses, such as schizophrenia or bipolar disorder.

ectomies or men with low testosterone (WPATH, 2011, p. 33; Hembree et al., 2009). As with most medications, there are risks, which may increase in the presence of some health conditions or behaviors (such as smoking); these should be evaluated and managed (Hembree et al., 2009).

For those transitioning from female to male, hormone therapy should lead to “deepened voice, clitoral enlargement (variable, 3–8 cm), growth in facial and body hair, cessation of menses, atrophy of breast tissue, increased libido, and increased percentage of body fat.” For those transitioning from male to female, hormone therapy should lead to “breast growth (variable), decreased libido and erections, decreased testicular size, and increased percentage of body fat” (WPATH, 2011, p. 36). The timeline for these and other physical changes varies by individual; expected onset is within months, and maximum expected effect (such as body fat and muscle mass changes) is generally achieved in three or more years. Feminizing hormone therapy typically involves both estrogen and antiandrogens.² Masculinizing hormone therapy consists primarily of testosterone, which is available in oral, transdermal, parenteral (intravenous/intramuscular), buccal (cheek), and implantable administrations; brief use of progestin can help stop menstrual periods early in treatment (WPATH, 2011, p. 49). Detailed clinical practice guidelines are available from the Endocrine Society (Hembree et al., 2009).

Gender Transition–Related Surgery

As noted, gender transition–related surgery (also called sex reassignment surgery or gender-confirming surgery) is necessary for some transgender patients. Under the standards of care, mental health professionals must refer patients for surgery; in addition, criteria for both breast/chest and genital surgery include persistent and well-documented GD, the capacity to make informed decisions and to consent, and for other mental or general health concerns to be reasonably well controlled if present (WPATH, 2011, p. 59). Hormone therapy is not a prerequisite for breast/chest (also called “top”) surgery, though it is recommended for 12–24 months for male-to-female patients to achieve optimal results (Hembree et al., 2009).

For genital (also called “bottom”) surgery, 12 continuous months of hormone therapy are required prior to oophorectomy or orchiectomy (surgical removal of ovaries or testicles), unless contraindicated; health record documentation of “12 continuous months of living in a gender role that is congruent with their gender identity . . . consistently, on a day-to-day basis and across all settings of life” is also required for metoidioplasty (surgical relocation of an enlarged clitoris), phalloplasty (surgical creation of a penis), or vaginoplasty (surgical creation of a vagina; WPATH, 2011,

² Transdermal rather than oral estrogen is recommended. Common antiandrogens include spironolactone (an antihypertensive agent that requires electrolyte monitoring); cyproterone acetate (not approved in the United States); GnRH agonists, such as goserelin, buserelin, or triptorelin (available as injectables or implants); and 5-alpha reductase inhibitors, such as finasteride and dutasteride (WPATH, 2011, p. 48).

pp. 60–61). Mastectomy is often the only surgery undertaken by the female-to-male population; for those who do undergo genital surgery, phalloplasty is relatively uncommon, as it often requires multiple procedures and has frequent complications (WPATH, 2011, pp. 63–64). Surgeons should work closely with patients and other care providers, if needed, to ensure that the advantages, disadvantages, and risks of various treatments and procedures are well understood.

Other Treatments

Aside from breast/chest and genital surgery, other surgical interventions may include liposuction, lipofilling, and various aesthetic procedures. For male-to-female patients, these may include “facial feminization surgery, voice surgery, thyroid cartilage reduction, gluteal augmentation (implants/lipofilling), [and] hair reconstruction”; female-to-male patients may seek pectoral implants (WPATH, 2011, pp. 57–58). There is ongoing debate regarding whether these and other transition-related treatments are “medically necessary” (and therefore covered by insurance). For example, in some circumstances, facial hair removal for male-to-female patients may constitute necessary transition-related treatment: One study found that those who have undergone the procedure were “less likely to experience harassment in public spaces,” and harassment can “have a negative impact on the success of a person’s treatment for gender dysphoria” (Herman, 2013b, p. 19). In addition, voice and communication therapy to develop vocal characteristics and nonverbal communication patterns congruent with gender identity may prevent “vocal misuse and long-term vocal damage” (WPATH, 2011, pp. 52–54).

APPENDIX D

Review of Accession, Retention, and Separation Regulations

Directive	Date	Department
Air Force Instruction 36-2002, <i>Regular Air Force and Special Category Accessions</i>	4/7/1999, revised 6/2/2014	Air Force
Air Force Instruction Guidance Memorandum AFI48-123_AFGM2015-01, "Guidance Memorandum: AFI 48-123, <i>Medical Examinations and Standards</i> "	8/27/2015	Air Force
Air Force Instruction Guidance Memorandum 48-123_AFGM4, "Air Force Guidance Memorandum to AFI 48-123, <i>Medical Examinations and Standards</i> "	1/29/2013	Air Force
Air Force Recruiting Service Instruction 36-2001, <i>Recruiting Procedures for the Air Force</i>	8/1/2012	Air Force
Air Force Instruction 41-210, <i>TRICARE Operations and Patient Administration Functions</i>	6/6/2012	Air Force
U.S. Army Recruiting Command, <i>Pocket Recruiter Guide</i>	7/1/2013	Army
Army Regulation 635-40, <i>Physical Evaluation for Retention, Retirement, or Separation</i>	3/20/2012	Army
Army Regulation 601-280, <i>Army Retention Program</i>	9/15/2011	Army
Army Regulation 40-501, <i>Standards of Medical Fitness</i>	8/4/2011	Army
Army Regulation 40-66, <i>Medical Record Administration and Healthcare Documentation</i>	1/4/2010	Army
Army Regulation 635-200, <i>Active Duty Enlisted Administrative Separations</i>	9/6/2011	Army
Army Regulation 601-210, <i>Active and Reserve Components Enlistment Program</i>	3/12/2013	Army
DoDI 6130.03, <i>Medical Standards for Appointment, Enlistment, or Induction in the Military Services</i>	4/28/2010, revised 9/13/11	DoD
DoDI 1332.18, <i>Disability Evaluation System (DES)</i>	8/5/2014	DoD
Office of the Under Secretary of Defense for Personnel and Readiness, <i>Disability Evaluation System (DES) Pilot Operations Manual</i>	12/2008	DoD

Directive	Date	Department
Marine Corps Order 1040.31, <i>Enlisted Retention and Career Development Program</i>	9/8/2010	Marine Corps
Marine Corps Order 6110.3, <i>Marine Corps Body Composition and Military Appearance Program</i>	8/8/2008	Marine Corps
Marine Administrative Message 064/11, "Amplification to Testing Accession Standards for the Purpose of Application to Marine Office Commissioning Programs"	1/26/2011	Marine Corps
Navy Military Personnel Manual 1306-964, "Recruiting Duty"	5/9/2014	Navy
Navy Medicine Manual P-117, <i>Manual of the Medical Department</i> , Chapter 15, Article 15-31, "Waivers of Physical Standards"	5/3/2012	Navy and Marine Corps

References

- American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders (DSM-III)*, 3rd ed., Arlington, Va., 1980.
- , *Diagnostic and Statistical Manual of Mental Disorders (DSM-III-R)*, 3rd ed., revised, Arlington, Va., 1987.
- , *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)*, 4th ed., revised, Arlington, Va., 1994.
- , *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)*, 5th ed., Arlington, Va., 2013a.
- , “Gender Dysphoria,” fact sheet, 2013b. As of January 5, 2016:
<http://www.dsm5.org/documents/gender%20dysphoria%20fact%20sheet.pdf>
- APA—See American Psychiatric Association.
- Army Regulation 40-501, *Standards of Medical Fitness*, December 14, 2007, revised August 4, 2011.
- Army Regulation 600-8-101, *Personnel Processing (In-, Out-, Soldier Readiness, and Deployment Cycle)*, February 19, 2015.
- Bakker, A., P. J. van Kesteren, L. J. Gooren, and P. D. Bezemer, “The Prevalence of Transsexualism in the Netherlands,” *Acta Psychiatrica Scandinavica*, Vol. 87, No. 4, April 1993, pp. 237–238.
- Belkin, Aaron, “Caring for Our Transgender Troops—The Negligible Cost of Transition-Related Care,” *New England Journal of Medicine*, Vol. 373, No. 12, September 17, 2015, pp. 1089–1092.
- Belkin, Aaron, and Jason McNichol, “Homosexual Personnel Policy in the Canadian Forces: Did Lifting the Gay Ban Undermine Military Performance?” *International Journal*, Vol. 56, No. 1, Winter 2000–2001, pp. 73–88.
- Blakely, Katherine, and Don J. Jansen, *Post-Traumatic Stress Disorder and Other Mental Health Problems in the Military: Oversight Issues for Congress*, Washington, D.C.: Congressional Research Service, August 8, 2013.
- Blosnich, John R., Adam J. Gordon, and Michael J. Fine, “Associations of Sexual and Gender Minority Status with Health Indicators, Health Risk Factors, and Social Stressors in a National Sample of Young Adults with Military Experience,” *Annals of Epidemiology*, Vol. 25, No. 9, September 2015, pp. 661–667.
- British Army, “Diversity,” web page, undated. As of January 4, 2016:
<http://www.army.mod.UK/join/38473.aspx>

Brown, David, "Amputations and Genital Injuries Increase Sharply Among Soldiers in Afghanistan," *Washington Post*, May 4, 2011. As of January 5, 2016:

https://www.washingtonpost.com/national/amputations-and-genital-injuries-increase-sharply-among-soldiers-in-afghanistan/2011/02/25/ABX0TqN_story.html

Brown, George R., "Transsexuals in the Military: Flight into Hypermasculinity," *Archives of Sexual Behavior*, Vol. 17, No. 6, December 1988, pp. 527–537.

Buchholz, Laura, "Transgender Care Moves into the Mainstream," *Journal of the American Medical Association*, Vol. 314, No. 17, November 3, 2015, pp. 1785–1787.

California Department of Health Services, *California Lesbian, Gay, Bisexual, and Transgender Tobacco Survey 2004*, San Francisco, Calif., 2004.

Canadian Armed Forces, Military Personnel Instruction 01/11, "Management of Transsexual Members," 2012.

Conron, Kerith, Gunner Scott, Grace Sterling Stowell, and Stewart J. Landers, "Transgender Health in Massachusetts: Results from a Household Probability Sample of Results," *American Journal of Public Health*, Vol. 102, No. 1, January 2012, pp. 118–122.

Cox, Matthew, "Army Has 50,000 Active Soldiers Who Can't Deploy, Top NCO Says," *Military.com*, November 25, 2015. As of March 16, 2016:

<http://www.military.com/daily-news/2015/11/25/army-has-50000-active-soldiers-who-cant-deploy-top-nco-says.html>

De Cuyper, G., M. Van Hemelrijck, A. Michel, B. Carael, G. Heylens, R. Rubens, P. Hoebeke, and S. Monstrey, "Prevalence and Demography of Transsexualism in Belgium," *European Psychiatry*, Vol. 22, No. 3, 2007, pp. 137–141.

Defense Health Agency, TRICARE Management Activity, *Evaluation of the TRICARE Program: Access, Cost, and Quality, Fiscal Year 2015*, 2015. As of January 5, 2016:

<http://www.health.mil/Military-Health-Topics/Access-Cost-Quality-and-Safety/Health-Care-Program-Evaluation/Annual-Evaluation-of-the-TRICARE-Program>

DoD—See U.S. Department of Defense.

Eklund, P. L., L. J. Gooren, and P. D. Bezemer, "Prevalence of Transsexualism in the Netherlands," *British Journal of Psychiatry*, Vol. 152, No. 5, May 1988, pp. 638–640.

Elders, Joycelyn, Alan M. Steinman, George R. Brown, Eli Coleman, and Thomas A. Kolditz, *Report of the Transgender Military Service Commission*, Santa Barbara, Calif.: Palm Center, March 2014.

Ender, Morten G., David E. Rohall, and Michael D. Matthews, "Cadet and Civilian Undergraduate Attitudes Toward Transgender People: A Research Note," *Armed Forces and Society*, Vol. 42, No. 2, April 2016, pp. 427–435.

Flores, Andrew R., "Attitudes Toward Transgender Rights: Perceived Knowledge and Secondary Interpersonal Contact," *Politics, Groups, and Identities*, Vol. 3, No. 3, 2015.

Frank, Nathaniel, *Gays in Foreign Militaries 2010: A Global Primer*, Santa Barbara, Calif.: Palm Center, 2010.

Gates, Gary J., *How Many People Are Lesbian, Gay, Bisexual, and Transgender?* Los Angeles, Calif.: Williams Institute, University of California, Los Angeles, School of Law, April 2011.

Gates, Gary J., and Jody L. Herman, "Transgender Military Service in the United States," Los Angeles, Calif.: Williams Institute, University of California, Los Angeles, School of Law, May 2014.

Gijs, Luk, and Anne Brewaeys, "Surgical Treatment of Gender Dysphoria in Adults and Adolescents: Recent Developments, Effectiveness, and Challenges," *Annual Review of Sex Research*, Vol. 18, No. 1, 2007, pp. 178–224.

Gould, Elise, *A Decade of Declines in Employer-Sponsored Health Insurance Coverage*, Washington, D.C.: Economic Policy Institute, February 2012. As of January 5, 2016:

<http://www.epi.org/publication/bp337-employer-sponsored-health-insurance>

Grant, Jaime M., Lisa A. Mottet, and Justin Tanis, with Jack Harrison, Jody L. Herman, and Mara Keisling, *Injustice at Every Turn: A Report of the National Transgender Discrimination Survey*, Washington, D.C.: National Center for Transgender Equality and National Gay and Lesbian Task Force, 2011.

Harrell, Margaret C., Laura Werber, Peter Schirmer, Bryan W. Hallmark, Jennifer Kavanagh, Daniel Gershwin, and Paul S. Steinberg, *Assessing the Assignment Policy for Army Women*, Santa Monica, Calif.: RAND Corporation, MG-590-1-OSD, 2007. As of March 17, 2016:

<http://www.rand.org/pubs/monographs/MG590-1.html>

Harris, Benjamin Cerf, *Likely Transgender Individuals in the U.S. Federal Administrative Records and the 2010 Census*, Washington, D.C.: U.S. Census Bureau, May 4, 2015.

Hembree, Wylie C., Peggy Cohen-Kettenis, Henriette A. Delemarre-van de Waal, Louis J. Gooren, Walter J. Meyer III, Norman P. Spack, Vin Tangpricha, and Victor M. Montori, "Endocrine Treatment of Transsexual Persons: An Endocrine Society Clinical Practice Guideline," *Journal of Clinical Endocrinology and Metabolism*, Vol. 94, No. 9, September 2009, pp. 3132–3154.

Herman, Jody L., *The Cost of Employment and Housing Discrimination Against Transgender Residents of New York*, Los Angeles, Calif.: Williams Institute, University of California, Los Angeles, School of Law, April 2013a.

———, *Costs and Benefits of Providing Transition-Related Health Care Coverage in Employee Health Benefits Plans: Findings from a Survey of Employers*, Los Angeles, Calif.: Williams Institute, University of California, Los Angeles, School of Law, September 2013b.

Hoening, J., and J. C. Kenna, "The Prevalence of Transsexualism in England and Wales," *British Journal of Psychiatry*, Vol. 124, No. 579, 1974, pp. 181–190.

Hoge, Charles W., Jennifer Auchterlonie, and Charles S. Millike, "Mental Health Problems, Use of Mental Health Services, and Attrition from Military Service After Returning from Deployment to Iraq or Afghanistan," *Journal of the American Medical Association*, Vol. 295, No. 9, March 1, 2006, pp. 1023–1032.

Horton, Mary Ann, "The Incidence and Prevalence of SRS Among US Residents," paper presented at the Out and Equal Workplace Summit, September 12, 2008. As of January 5, 2016:

<http://www.tgender.net/taw/thb/THBPrevalence-OE2008.pdf>

Institute of Medicine, *The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding*, Washington, D.C.: National Academies Press, 2011.

Intersex Society of North America, "What Is Intersex?" web page, undated. As of January 5, 2016: http://www.isna.org/faq/what_is_intersex

Kates, Jen, Usha Ranji, Adara Beamesderfer, Alina Salganicoff, and Lindsey Dawson, *Health and Access to Care and Coverage for Lesbian, Gay, Bisexual, and Transgender Individuals in the U.S.*, Menlo Park, Calif.: Henry J. Kaiser Family Foundation, July 2015.

Kauth, Michael R., Jillian C. Shipherd, Jan Lindsay, John R. Blosnich, George R. Brown, and Kenneth T. Jones, "Access to Care for Transgender Veterans in the Veterans Health Administration: 2006–2013," *American Journal of Public Health*. Vol. 104, No. S4, September 2014, pp. S532–S534.

Keen, Lisa, "Mass. Ranks Sixth for LGBT-Friendly Laws, Study Says," *Boston Globe*, May 28, 2015. As of March 17, 2016:

<https://www.bostonglobe.com/news/politics/2015/05/27/mass-ranks-sixth-for-lgbt-friendly-laws-study-says/sBX5TpZdNeusUo7Iuqs2qN/story.html>

Lambda Legal, "Professional Organization Statements Supporting Transgender People in Health Care," last updated June 8, 2012. As of January 4, 2016:

http://www.lambdalegal.org/sites/default/files/publications/downloads/fs_professional-org-statements-supporting-trans-health_1.pdf

McKibben, Jodi B. A., Carol S. Fullerton, Christine L. Gray, Ronald C. Kessler, Murray B. Stein, and Robert J. Ursano, "Mental Health Service Utilization in the U.S. Army," *Psychiatric Services*, Vol. 64, No. 4, April 2013, pp. 347–353.

Milhiser, Mark R., "Transgender Service: The Next Social Domino for the Army," *Military Law Review*, Vol. 220, Summer 2014, pp. 191–217.

Navy Medical Policy 07-009, *Deployment Medical Readiness*, April 6, 2007.

Norton, Aaron T., and Gregory M. Herek, "Heterosexuals' Attitudes Toward Transgender People: Findings from a National Probability Sample of U.S. Adults," *Sex Roles*, Vol. 68, No. 11, June 2013, pp. 738–753.

Office of the Assistant Secretary of Defense for Health Affairs, "Policy for Cosmetic Surgery Procedures in the Military Health System," Health Affairs Policy 05-020, October 25, 2005.

———, "Clinical Practice Guidance for Deployment-Limiting Mental Disorders and Psychotropic Medications," memorandum, October 7, 2013.

Office of Personnel Management, *Addressing Sexual Orientation and Gender Identity Discrimination in Federal Civilian Employment*, Washington, D.C., June 2015.

Okros, Alan, and Denise Scott, "Gender Identity in the Canadian Forces," *Armed Forces and Society*, Vol. 41, No. 2, April 2015, pp. 243–256.

Padula, William V., Shiona Heru, and Jonathan D. Campbell, "Societal Implications of Health Insurance Coverage for Medically Necessary Services in the U.S. Transgender Population: A Cost-Effectiveness Analysis," *Journal of General Internal Medicine*, October 19, 2015.

Parco, James E., David A. Levy, and Sarah R. Spears, "Transgender Military Personnel in the Post-DADT Repeal Era: A Phenomenological Study," *Armed Forces and Society*, Vol. 41, No. 2, 2015, pp. 221–242.

Polchar, Joshua, Tim Sweijs, Phillip Marten, and Jan Gladega, *LGBT Military Personnel: A Strategic Vision for Inclusion*, The Hague, Netherlands: The Hague Centre for Strategic Studies, 2014.

Pollock, Gale S., and Shannon Minter, *Report of the Planning Commission on Transgender Military Service*, Santa Barbara, Calif.: Palm Center, August 2014.

RAND National Defense Research Institute, *Sexual Orientation and U.S. Military Personnel Policy: An Update of RAND's 1993 Study*, Santa Monica, Calif.: RAND Corporation, MG-1056-OSD, 2010. As of March 17, 2016:

<http://www.rand.org/pubs/monographs/MG1056.html>

Rashid, Mamoon, and Muhammad Sarmad Tamimy, "Phalloplasty: The Dream and the Reality," *Indian Journal of Plastic Surgery*, Vol. 46, No. 2, May 2013, pp. 283–293.

Reed, Bernard, Stephenne Rhodes, Pietà Schofield, and Kevan Wylie, *Gender Variance in the UK: Prevalence, Incidence, Growth and Geographic Distribution*, Surrey, UK: Gender Identity Research and Education Society, June 2009.

Roller, Cyndi Gale, Carol Sedlak, and Claire Burke Draucker, "Navigating the System: How Transgender Individuals Engage in Health Care Services," *Journal of Nursing Scholarship*, Vol. 47, No. 5, September 2015, pp. 417–424.

Ross, Allison, "The Invisible Army: Why the Military Needs to Rescind its Ban on Transgender Service Members," *Southern California Interdisciplinary Law Journal*, Vol. 23, No. 1, 2014, pp. 185–216.

Rostker, Bernard D., Scott A. Harris, James P. Kahan, Erik J. Frinking, C. Neil Fulcher, Lawrence M. Hanser, Paul Koegel, John D. Winkler, Brent A. Boultinghouse, Joanna Heilbrunn, Janet Lever, Robert J. MacCoun, Peter Tiemeyer, Gail L. Zellman, Sandra H. Berry, Jennifer Hawes-Dawson, Samantha Ravich, Steven L. Schlossman, Timothy Haggarty, Tanjam Jacobson, Ancella Livers, Sherie Mershon, Andrew Cornell, Mark A. Schuster, David E. Kanouse, Raynard Kington, Mark Litwin, Conrad Peter Schmidt, Carl H. Builder, Peter Jacobson, Stephen A. Saltzburg, Roger Allen Brown, William Fedorochko, Marilyn Fisher Freemon, John F. Peterson, and James A. Dewar, *Sexual Orientation and U.S. Military Personnel Policy: Options and Assessment*, Santa Monica, Calif.: RAND Corporation, MR-323-OSD, 1993. As of March 17, 2016: http://www.rand.org/pubs/monograph_reports/MR323.html

Royal Australian Air Force, *Air Force Diversity Handbook: Transitioning Gender in Air Force*, July 2015.

Schaefer, Agnes Gereben, Jennie W. Wenger, Jennifer Kavanagh, Jonathan P. Wong, Gillian S. Oak, Thomas E. Trail, and Todd Nichols, *Implications of Integrating Women into the Marine Corps Infantry*, Santa Monica, Calif.: RAND Corporation, RR-1103-USMC, 2015. As of March 17, 2016: http://www.rand.org/pubs/research_reports/RR1103.html

Sonier, Julie, Brett Fried, Caroline Au-Yeung, and Breanna Auringer, *State-Level Trends in Employer-Sponsored Health Insurance, A State-by-State Analysis*, Minneapolis, Minn.: State Health Access Data Center and Robert Wood Johnson Foundation, April 2013.

Speckhard, Anne, and 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," unpublished research paper, 2014. As of January 4, 2016: <http://www.researchgate.net/publication/280093066>

State of California, Department of Insurance, "Economic Impact Assessment: Gender Nondiscrimination in Health Insurance," Regulation File Number: REG-2011-00023, April 13, 2012. As of January 5, 2016: <http://transgenderlawcenter.org/wp-content/uploads/2013/04/Economic-Impact-Assessment-Gender-Nondiscrimination-In-Health-Insurance.pdf>

Szayna, Thomas S., Eric V. Larson, Angela O'Mahony, Sean Robson, Agnes Gereben Schaefer, Miriam Matthews, J. Michael Polich, Lynsay Ayer, Derek Eaton, William Marcellino, Lisa Miyashiro, Marek Posard, James Syme, Zev Winkelman, Cameron Wright, Megan Zander-Cotugno, and William Welsler, *Considerations for Integrating Women into Closed Occupations in the U.S. Special Operations Forces*, Santa Monica, Calif.: RAND Corporation, RR-1058-USSOCOM, 2015. As of March 17, 2016: http://www.rand.org/pubs/research_reports/RR1058.html

Tan, Michelle, "SMA Calls for Bonus Money for Soldiers on Deployment, at NTC," *Army Times*, November 1, 2015. As of March 16, 2016: <http://www.armytimes.com/story/military/benefits/pay/allowances/2015/11/01/sma-calls-bonus-money-soldiers-deployment-ntc/74821828>

Tsoi, W. F., "The Prevalence of Transsexualism in Singapore," *Acta Psychiatrica Scandinavica*, Vol. 78, No. 4, 1988, pp. 501–504.

UK Ministry of Defence, “Policy for the Recruitment and Management of Transsexual Personnel in the Armed Forces,” January 2009.

UnitedHealthcare, “Gender Dysphoria (Gender Identity Disorder) Treatment,” Coverage Determination Guideline CDG.011.05, effective October 1, 2015. As of January 5, 2016: https://www.unitedhealthcareonline.com/ccmcontent/ProviderII/UHC/en-US/Assets/ProviderStaticFiles/ProviderStaticFilesPdf/Tools%20and%20Resources/Policies%20and%20Protocols/Medical%20Policies/Medical%20Policies/Gender_Identity_Disorder_CD.pdf

U.S. Central Command, “PPG-TAB A: Amplification of the Minimal Standards of Fitness for Deployment to the CENTCOM AOR; to Accompany MOD ELEVEN to USCENTCOM Individual Protection and Individual/Unit Deployment Policy,” December 2, 2013. As of March 17, 2016: <http://www.tam.usace.army.mil/Portals/53/docs/UDC/medical-disqualifiers.pdf>

U.S. Department of Defense, *2014 Demographics: Profile of the Military Community*, Washington, D.C., 2014. As of January 5, 2016: <http://download.militaryonesource.mil/12038/MOS/Reports/2014-Demographics-Report.pdf>

———, “DoD Announces Recruiting and Retention Numbers for Fiscal 2015, Through November 2014,” press release, No. NR-001-15, January 6, 2015a. As of January 4, 2016: <http://www.defense.gov/News/News-Releases/News-Release-View/Article/605335>

———, “Statement by Secretary of Defense Ash Carter on DoD Transgender Policy,” press release, No. NR-272-15, July 15, 2015b. As of March 16, 2016: <http://www.defense.gov/News/News-Releases/News-Release-View/Article/612778>

U.S. Department of Defense Instruction 1332.14, *Enlisted Administrative Separations*, January 27, 2014, incorporating change 1, December 4, 2014.

U.S. Department of Defense Instruction 1332.18, *Disability Evaluation System (DES)*, August 5, 2014.

U.S. Department of Defense Instruction 1332.30, *Separation of Regular and Reserve Commissioned Officers*, November 25, 2013.

U.S. Department of Defense Instruction 1332.38, *Physical Disability Evaluation*, November 14, 1996, incorporating change 1, July 10, 2006.

U.S. Department of Defense Instruction 6130.03, *Medical Standards for Appointment, Enlistment, or Induction in the Military Services*, April 28, 2010, incorporating change 1, September 13, 2011.

U.S. Government Accountability Office, *Personnel and Cost Data Associated with Implementing DOD’s Homosexual Conduct Policy*, Washington, D.C., GAO-11-170. January 2011.

Van Kesteren, Paul J., Louis J. Gooren, and Jos A. Megens, “An Epidemiological and Demographic Study of Transsexuals in the Netherlands,” *Archives of Sexual Behavior*, Vol. 25, No. 6, 1996, pp. 589–600.

Wälinder, Jan, “Transsexualism: Definition, Prevalence and Sex Distribution,” *Acta Psychiatrica Scandinavica*, Vol. 43, No. S203, August 1968, pp. 255–257.

———, “Incidence and Sex Ratio of Transsexualism in Sweden,” *British Journal of Psychiatry*, Vol. 119, No. 549, 1971, pp. 195–196.

Wallace, Duncan, “Trends in Traumatic Limb Amputation in Allied Forces in Iraq and Afghanistan,” *Journal of Military and Veterans’ Health*, Vol. 20, No. 2, April 2012.

Weitze, Cordula, and Susanne Osburg, "Transsexualism in Germany: Empirical Data on Epidemiology and Application of the German Transsexuals' Act During Its First Ten Years," *Archives of Sexual Behavior*, Vol. 25, No. 4, 1996, pp. 409–425.

Welsh, Ashley, "First U.S. Penis Transplants Planned to Help Wounded Vets," CBS News, December 7, 2015. As of January 5, 2016:

<http://www.cbsnews.com/news/first-penis-transplants-planned-in-u-s-to-help-wounded-vets>

Williams, Molly, and James Jezior, "Management of Combat-Related Urological Trauma in the Modern Era," *Nature Reviews Urology*, Vol. 10, No. 9, September 2013, pp. 504–512.

World Professional Association for Transgender Health, *Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People*, version 7, Elgin, Ill., 2011.

WPATH—See World Professional Association for Transgender Health.

Yerke, Adam F., and Valory Mitchell, "Transgender People in the Military: Don't Ask? Don't Tell? Don't Enlist!" *Journal of Homosexuality*, Vol. 60, Nos. 2–3, 2013, pp. 436–457.

Zitun, Yoav, "IDF to Support Transgender Recruits Throughout the Sex Change Process,"

YNET News, December 26, 2014. As of January 4, 2016:

<http://www.ynetnews.com/articles/0,7340,L-4608141,00.html>

Zucker, Kenneth J., Susan J. Bradley, Allison Owen-Anderson, Sarah J. Kibblewhite, and James M. Cantor, "Is Gender Identity Disorder in Adolescents Coming out of the Closet?" *Journal of Sex and Marital Therapy*, Vol. 34, No. 4, June 2008, pp. 287–290.

Zucker, Kenneth J., and Anne A. Lawrence, "Epidemiology of Gender Identity Disorder: Recommendations for the Standards of Care of the World Professional Association for Transgender Health," *International Journal of Transgenderism*, Vol. 11, No. 1, 2009, pp. 8–18.

Current U.S. Department of Defense (DoD) policy bans transgender personnel from serving openly in the military. DoD has begun considering changes to this policy, but the prospect raises questions regarding access to gender transition-related health care, the range of transition-related treatments that DoD will need to provide, the potential costs associated with these treatments, and the impact of these health care needs on force readiness and the deployability of transgender service members. A RAND study identified the health care needs of the transgender population and transgender service members in particular. It also examined the costs of covering transition-related treatments, assessed the potential readiness implications of a policy change, and reviewed the experiences of foreign militaries that permit transgender service members to serve openly.



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

MEMORANDUM FOR SECRETARIES OF THE MILITARY DEPARTMENTS

SUBJECT: Transgender Service Members

JUL 28 2015

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

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

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

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

JA709

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IMMEDIATE RELEASE

Statement by Secretary of Defense Ash Carter on DOD Transgender Policy

Press Operations

Release No: NR-272-15

July 13, 2015

Over the last fourteen years of conflict, the Department of Defense has proven itself to be a learning organization. This is true in war, where we have adapted to counterinsurgency, unmanned systems, and new battlefield requirements such as MRAPs. It is also true with respect to institutional activities, where we have learned from how we repealed "Don't Ask, Don't Tell," from our efforts to eliminate sexual assault in the military, and from our work to open up ground combat positions to women. Throughout this time, transgender men and women in uniform have been there with us, even as they often had to serve in silence alongside their fellow comrades in arms.

The Defense Department's current regulations regarding transgender service members are outdated and are causing uncertainty that distracts commanders from our core missions. At a time when our troops have learned from experience that the most important qualification for service members should be whether they're able and willing to do their job, our officers and enlisted personnel are faced with certain rules that tell them the opposite. Moreover, we have transgender soldiers, sailors, airmen, and Marines - real, patriotic Americans - who I know are being hurt by an outdated, confusing, inconsistent approach that's contrary to our value of service and individual merit.

Today, I am issuing two directives to deal with this matter. First, DoD will create a working group to study over the next six months the policy and readiness implications of welcoming transgender persons to serve openly. Led by (Acting) Under Secretary of Defense for Personnel and Readiness Brad Carson, and composed of military and civilian personnel representing all the

JA710

military services and the Joint Staff, this working group will report to Deputy Secretary of Defense Bob Work. At my direction, the working group will start with the presumption that transgender persons can serve openly without adverse impact on military effectiveness and readiness, unless and except where objective, practical impediments are identified. Second, I am directing that decision authority in all administrative discharges for those diagnosed with gender dysphoria or who identify themselves as transgender be elevated to Under Secretary Carson, who will make determinations on all potential separations.

As I've said before, we must ensure that everyone who's able and willing to serve has the full and equal opportunity to do so, and we must treat all our people with the dignity and respect they deserve. Going forward, the Department of Defense must and will continue to improve how we do both. Our military's future strength depends on it.

Medical Services

Standards of Medical Fitness

Headquarters
Department of the Army
Washington, DC
29 August 2003

UNCLASSIFIED

JA712

SUMMARY of CHANGE

AR 40-501

Standards of Medical Fitness

This revision, dated 29 August 2003--

- o Clarifies the medical examination requirements for Army aviation (chaps 4 and 6).
- o Deletes flying duty Class 2S (chaps 4 and 6).
- o Expands the physical profiling authority for podiatrists (para 7-6a(5)).
- o Adds requirements for the medical examinations for Ranger School applicants (para 8-12k).
- o Changes the requirements for age specific periodic medical examinations to an every 5 year schedule (para 8-19c(3)).
- o Deletes the requirement to have a duplicate medical examination recorded on DD Form 2808 (Report of Medical Exam) if a separation medical examination has already been completed by the Department of Veterans Affairs (para 8-23e).
- o Rescinds DA Form 5675 (Health Risk Appraisal).

This administrative revision dated 30 September 2002--

- o Corrects an error in the conditions of the lower extremities that are causes for rejection for appointment, enlistment, and induction (para 2-10c(2)).
- o Corrects an error in a paragraph reference for certain physical exams (para 10-23d).
- o Includes correction of publication titles and sources in appendix A.

This revision (dated 28 March 2002)--

- o Revises the list of authorities who approve waivers for the medical fitness standards contained in chapters 2, 3, 4, or 5 (para 1-6).
- o Revises the medical accession standards in compliance with DOD Directive 6130.3, "Physical Standards for Appointment, Enlistment, or Induction," 15 December 2000, and DOD Instruction 6130.4, "Criteria and Procedure Requirements for Physical Standards for Appointment, Enlistment, or Induction in the Armed Forces," 14 December 2000 (chap 2).
- o Adds the International Classification of Disease codes for medical conditions causing rejection for appointment, enlistment, and induction (chap 2).

- o Revises the medical retention standards, including new standards on asthma (chap 3).
- o Adds metabolic equivalent testing to functional classifications of patients with cardiovascular disease (table 3-1).
- o Revises the aviation chapters (chap 4 and chap 6).
- o Reduces the number of physician signatures on permanent 3 or 4 profiles (chap 7) and updates the description of profile codes (table 7-1).
- o Adds occupational history requirements to the pregnancy profile (chap 7).
- o Replaces SF 93 (Report of Medical History) and SF 88 (Report of Medical Examination) with two new forms, DD Form 2807-1 (Report of Medical History) and DD Form 2808 (Report of Medical Examination) (chap 8 and table 8-1).
- o Revises the Cardiovascular Screening program requirements (chap 8).
- o Adds policies for medical examinations and physical standards for the Army National Guard (chap 10).
- o Rescinds DA Form 4970 and DA Form 4970-E (Medical Screening Summary--Over 40 Physical Fitness Program).

Headquarters
Department of the Army
Washington, DC
29 August 2003

***Army Regulation 40–501**

Effective 29 September 2003

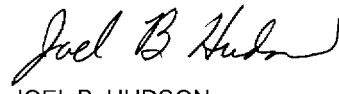
Medical Services

Standards of Medical Fitness

By order of the Secretary of the Army:

PETER J. SCHOOMAKER
General, United States Army
Chief of Staff

Official:



JOEL B. HUDSON
Administrative Assistant to the
Secretary of the Army

History. This publication is a rapid action revision. The portions affected by this revision are listed in the summary of change.

Summary. This regulation provides information on medical fitness standards for induction, enlistment, appointment, retention, and related policies and procedures. This publication implements DOD Directive 6130.3, Physical Standards for Appointment, Enlistment, and Induction, December 15, 2000, and DOD Instruction

6130.4, Criteria and Procedure Requirements for Physical Standards for Appointment, Enlistment, or Induction in the Armed Forces, December 14, 2000.

Applicability. This regulation applies to candidates for military service and to Active Army personnel. It also applies to the Army National Guard of the United States and the U.S. Army Reserve. This publication is applicable during mobilization.

Proponent and exception authority. The proponent of this regulation is the Office of the Surgeon General. The proponent has the authority to approve exceptions to this regulation that are consistent with controlling law and regulation. Proponents may delegate the approval authority, in writing, to a division chief within the proponent agency in the grade of colonel or the civilian equivalent.

Army management control process. This regulation contains management control provisions, but it does not identify key management controls that must be evaluated.

Supplementation. Supplementation of

this regulation and establishment of command or local forms are prohibited without prior approval from HQDA (DASG–HS–AS), 5109 Leesburg Pike, Falls Church, VA 22041–3258.

Suggested improvements. Users are invited to send comments and suggested improvements on DA Form 2028 (Recommended Changes to Publications and Blank Forms) directly to HQDA (DASG–HS–AS), 5109 Leesburg Pike, Falls Church, VA 22041–3258.

Distribution. This publication is available in electronic media only (EMO), and is intended for command levels A, B, C, D, and E for medical activities only of the Active Army, the Army National Guard of the United States, and the U.S. Army Reserve.

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*This regulation supersedes Army Regulation 40–501, dated 30 September 2002, and rescinds DA Form 5675, February 1992.

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Military acceptable weight (in pounds) as related to age and height for females—Initial Army procurement¹, ²—Continued

Height (inches)	Minimum weight any age	Maximum weight by years of age			
		17–20	21–27	28–39	40 and over
73	128	177	182	188	193
74	130	183	189	194	198
75	133	188	194	200	204
76	136	194	200	206	209
77	139	199	205	211	215
78	141	204	210	216	220
79	144	209	215	222	226
80	147	214	220	227	232

	Maximum body fat by years of age			
	17–20	21–27	28–39	40 and over
	30%	32%	34%	36%

Notes:

¹ If a female exceeds these weights, percent body fat will be measured by the method described in AR 600–9.

² If a female also exceeds this body fat, she will be rejected for service.

Chapter 3
Medical Fitness Standards for Retention and Separation, Including Retirement

3–1. General

This chapter gives the various medical conditions and physical defects which may render a soldier unfit for further military service and which fall below the standards required for the individuals in paragraph 3–2 below.

3–2. Application

These standards apply to the following individuals (see chaps 4 and 5 for other standards that apply to specific specialties):

- a. All commissioned and warrant officers of the Active Army, ARNGUS, and USAR.
- b. All enlisted soldiers of the Active Army, ARNGUS, and USAR.
- c. Students already enrolled in the HPSP and USUHS programs.
- d. Enlisted soldiers of the ARNGUS or USAR who apply for enlistment in the regular Army.
- e. Commissioned and warrant officers of the ARNGUS or USAR who apply for appointment in the Active Army.
- f. Soldiers of the ARNGUS or USAR who re-enter active duty under the “split-training option.” (However, the weight standards of tables 2–1 and 2–2 apply to split option trainees.)
- g. Retired soldiers recalled to active duty.

3–3. Disposition

Soldiers with conditions listed in this chapter who do not meet the required medical standards will be evaluated by an MEB as defined in AR 40–400 and will be referred to a PEB as defined in AR 635–40 with the following caveats:

- a. USAR or ARNGUS soldiers not on active duty, whose medical condition was not incurred or aggravated during an active duty period, will be processed in accordance with chapter 9 and chapter 10 of this regulation.
- b. Soldiers pending separation in accordance with provisions of AR 635–200 or AR 600–8–24 authorizing separation under other than honorable conditions who do not meet medical retention standards will be referred to an MEB. In the case of enlisted soldiers, the physical disability processing and the administrative separation processing will be conducted in accordance with the provisions of AR 635–200 and AR 635–40. In the case of commissioned or warrant officers, the physical disability processing and the administrative separation processing will be conducted in accordance with the provisions of AR 600–8–24 and AR 635–40.
- c. A soldier will not be referred to an MEB or a PEB because of impairments that were known to exist at the time of acceptance in the Army and that have remained essentially the same in degree of severity and have not interfered with successful performance of duty.
- d. Physicians who identify soldiers with medical conditions listed in this chapter should initiate an MEB at the time of identification. Physicians should not defer initiating the MEB until the soldier is being processed for nondisability.

retirement. Many of the conditions listed in this chapter (for example, arthritis in para 3–14*b*) fall below retention standards only if the condition has precluded or prevented successful performance of duty. In those cases when it is clear the condition is long standing and has not prevented the soldier from reaching retirement, then the soldier meets the standard and an MEB is not required.

e. Soldiers who have previously been found unfit for duty by a PEB, but were continued on active duty (COAD) under the provisions of AR 635–40, chapter 6, will be referred to a PEB prior to retirement or separation processing.

f. If the Secretary of Defense prescribes less stringent standards during partial or full mobilization, individuals who meet the less stringent standards but do not meet the standards of this chapter will not be referred for an MEB or a PEB, until the termination of the mobilization or as directed by the Secretary of the Army.

3–4. General policy

Possession of one or more of the conditions listed in this chapter does not mean automatic retirement or separation from the Service. Physicians are responsible for referring soldiers with conditions listed below to an MEB. It is critical that MEBs are complete and reflect all of the soldier’s medical problems and physical limitations. The PEB will make the determination of fitness or unfitness. The PEB, under the authority of the U.S. Army Physical Disability Agency, will consider the results of the MEB, as well as the requirements of the soldier’s MOS, in determining fitness. (See chapter 9 and chapter 10 of this regulation for processing of RC soldiers.)

3–5. Abdominal and gastrointestinal defects and diseases

The causes for referral to an MEB are as follows:

a. Achalasia (cardiospasm) with dysphagia not controlled by dilatation or surgery, continuous discomfort, or inability to maintain weight.

b. Amoebic abscess with persistent abnormal liver function tests and failure to maintain weight and vigor after appropriate treatment.

c. Biliary dyskinesia with frequent abdominal pain not relieved by simple medication, or with periodic jaundice.

d. Cirrhosis of the liver with recurrent jaundice, ascites, or demonstrable esophageal varices or history of bleeding therefrom.

e. Gastritis, if severe, chronic hypertrophic gastritis with repeated symptomatology and hospitalization, confirmed by gastroscopic examination.

f. Hepatitis, chronic, when, after a reasonable time (1 or 2 years) following the acute stage, symptoms persist, and there is objective evidence of impairment of liver function.

g. Hernia, including inguinal, and other abdominal, except for small asymptomatic umbilical, with severe symptoms not relieved by dietary or medical therapy, or recurrent bleeding in spite of prescribed treatment or other hernias if symptomatic and if operative repair is contraindicated for medical reasons or when not amenable to surgical repair.

h. Crohn’s Disease/Ileitis, regional, except when responding well to treatment.

i. Pancreatitis, chronic, with frequent abdominal pain of a severe nature; steatorrhea or disturbance of glucose metabolism requiring hypoglycemic agents.

j. Peritoneal adhesions with recurring episodes of intestinal obstruction characterized by abdominal colicky pain, vomiting, and intractable constipation requiring frequent admissions to the hospital.

k. Proctitis, chronic, with moderate to severe symptoms of bleeding, painful defecation, tenesmus, and diarrhea, and repeated admissions to the hospital.

l. Ulcer, duodenal, or gastric with repeated hospitalization, or “sick in quarters” because of frequent recurrence of symptoms (pain, vomiting, or bleeding) in spite of good medical management and supported by endoscopic evidence of activity.

m. Ulcerative colitis, except when responding well to treatment.

n. Rectum, stricture of with severe symptoms of obstruction characterized by intractable constipation, pain on defecation, or difficult bowel movements, requiring the regular use of laxatives or enemas, or requiring repeated hospitalization.

3–6. Gastrointestinal and abdominal surgery

The causes for referral to an MEB are as follows:

a. Colectomy, partial, when more than mild symptoms of diarrhea remain or if complicated by colostomy.

b. Colostomy, when permanent.

c. Enterostomy, when permanent.

d. Gastrectomy, total.

e. Gastrectomy, subtotal, with or without vagotomy, or gastrojejunostomy, with or without vagotomy, when, in spite of good medical management, the individual develops “dumping syndrome” which persists for 6 months postoperatively; or develops frequent episodes of epigastric distress with characteristic circulatory symptoms or diarrhea persisting 6 months postoperatively; or continues to demonstrate appreciable weight loss 6 months postoperatively.

- f.* Gastrostomy, when permanent.
- g.* Ileostomy, when permanent.
- h.* Pancreatectomy.
- i.* Pancreaticoduodenostomy, pancreaticogastrostomy, or pancreaticojejunostomy, followed by more than mild symptoms of digestive disturbance, or requiring insulin.
- j.* Proctectomy.
- k.* Proctopexy, proctoplasty, proctorrhaphy, or proctotomy, if fecal incontinence remains after an appropriate treatment period.

3-7. Blood and blood-forming tissue diseases

The causes for referral to an MEB are as follows:

- a.* Anemia, hereditary, acquired, aplastic, or unspecified, when response to therapy is unsatisfactory, or when therapy is such as to require prolonged, intensive medical supervision.
- b.* Hemolytic crisis, chronic and symptomatic.
- c.* Leukopenia, chronic, when response to therapy is unsatisfactory, or when therapy is such as to require prolonged, intensive medical supervision.
- d.* Hypogammaglobulinemia with objective evidence of function deficiency and severe symptoms not controlled with treatment.
- e.* Purpura and other bleeding diseases, when response to therapy is unsatisfactory, or when therapy is such as to require prolonged, intensive medical supervision.
- f.* Thromboembolic disease when response to therapy is unsatisfactory, or when therapy is such as to require prolonged, intensive medical supervision.
- g.* Splenomegaly, chronic.
- h.* HIV confirmed antibody positivity, with the presence of progressive clinical illness or immunological deficiency.

For regular Army soldiers and RC soldiers on active duty for more than 30 days (except for evaluation under the Walter Reed Staging System or for training under 10 USC 10148), an MEB must be accomplished and, if appropriate, the soldier must be referred to a PEB under AR 635-40. For RC soldiers not on active duty for more than 30 days or on ADT under 10 USC 10148, referral to a PEB will be determined under AR 635-40. Records of official diagnoses provided by private physicians (that is, civilian doctors providing evaluations under contract with Department of the Army (DA) or DOD, or civilian public health officials) concerning the presence of progressive clinical illness or immunological deficiency in RC soldiers may be used as a basis for administrative action under, for example, AR 135-133, AR 135-175, AR 135-178, or AR 140-10, as appropriate. (See AR 600-110 for HIV policies, including testing requirements.)

3-8. Dental diseases and abnormalities of the jaws

The causes for referral to an MEB are diseases of the jaws, periodontium, or associated tissues when, following restorative surgery, there are residuals that are incapacitating or interfere with the individual's satisfactory performance of military duty.

3-9. Ears

The causes for referral to an MEB are as follows:

- a.* Infections of the external auditory canal when chronic and severe, resulting in thickening and excoriation of the canal or chronic secondary infection requiring frequent and prolonged medical treatment and hospitalization.
- b.* Malfunction of the acoustic nerve. (Evaluate functional impairment of hearing under para 3-10.)
- c.* Mastoiditis, chronic, with constant drainage from the mastoid cavity, requiring frequent and prolonged medical care.
- d.* Mastoiditis, chronic, following mastoidectomy, with constant drainage from the mastoid cavity, requiring frequent and prolonged medical care or hospitalization.
- e.* Meniere's syndrome or any peripheral imbalance, syndrome or labyrinthine disorder with recurrent attacks of sufficient frequency and severity as to interfere with the satisfactory performance of duty or requiring frequent or prolonged medical care or hospitalization.
- f.* Otitis media, moderate, chronic, suppurative, resistant to treatment, and necessitating frequent and prolonged medical care or hospitalization.

3-10. Hearing

Trained and experienced personnel will not be categorically disqualified if they are capable of effective performance of duty with a hearing aid. Most soldiers having a hearing defect can be returned to duty with appropriate assignment limitations. Soldiers incapable of performing duty with a hearing aid will be referred for MEB/PEB processing. (See paragraph 8-26.)

3-11. Endocrine and metabolic disorders

The causes for referral to an MEB are as follows:

- a. Acromegaly with severe function impairment.
- b. Adrenal dysfunction that does not respond to therapy satisfactorily or where replacement therapy presents serious problems in management.
- c. Diabetes insipidus unless mild and the patient shows good response to treatment.
- d. Diabetes mellitus when proven to require insulin or oral medications for control.
- e. Goiter causing breathing obstruction.
- f. Gout in advanced cases with frequent acute exacerbations and severe bone, joint, or kidney damage.
- g. Hyperinsulinism when caused by a tumor or when the condition is not readily controlled.
- h. Hyperparathyroidism when residuals or complications of surgical correction such as renal disease or bony deformities preclude the reasonable performance of military duty.
- i. Hypofunction, adrenal cortex requiring medication for control.
- j. Osteomalacia with residuals after therapy of such nature or degree as to preclude the satisfactory performance of duty.

3-12. Upper extremities

The causes for referral to an MEB are as follows (see also para 3-14):

- a. Amputation of part or parts of an upper extremity equal to or greater than—
 - (1) A thumb proximal to the interphalangeal joint.
 - (2) Two fingers of one hand, other than the little finger, at the proximal interphalangeal joints.
 - (3) One finger, other than the little finger, at the metacarpophalangeal joint and the thumb of the same hand at the interphalangeal joint.
- b. Joint ranges of motion which do not equal or exceed the measurements listed below. Measurements must be made with a goniometer and conform to the methods illustrated and described in TC 8-640.
 - (1) Shoulder—forward elevation to 90 degrees, or abduction to 90 degrees.
 - (2) Elbow—flexion to 100 degrees, or extension to 60 degrees.
 - (3) Wrist—a total range extension plus flexion of 15 degrees.
 - (4) Hand (for this purpose, combined joint motion is the arithmetic sum of the motion at each of the three finger joints (TC 8-640))—an active flexor value of combined joint motions of 135 degrees in each of two or more fingers of the same hand, or an active extensor value of combined joint motions of 75 degrees in each of the same two or more fingers, or limitation of motion of the thumb that precludes opposition to at least two finger tips.
- c. Recurrent dislocations of the shoulder, when not repairable or surgery is contraindicated.

3-13. Lower extremities

The causes for referral to an MEB are as follows (see also para 3-14):

- a. Amputations.
 - (1) Loss of toes that precludes the abilities to run or walk without a perceptible limp and to engage in fairly strenuous jobs.
 - (2) Any loss greater than that specified above to include foot, ankle, below the knee, above the knee, femur, hip.
- b. Feet.
 - (1) Hallux valgus when moderately severe, with exostosis or rigidity and pronounced symptoms; or severe with arthritic changes.
 - (2) Pes planus, when symptomatic, more than moderate, with pronation on weight bearing which prevents the wearing of military footwear, or when associated with vascular changes.
 - (3) Pes cavus when moderately severe, with moderate discomfort on prolonged standing and walking, metatarsalgia, and which prevents the wearing of military footwear.
 - (4) Neuroma that is refractory to medical treatment, refractory to surgical treatment, and interferes with the satisfactory performance of military duties.
 - (5) Plantar fasciitis or heel spur syndrome that is refractory to medical or surgical treatment, interferes with the satisfactory performance of military duties, or prevents the wearing of military footwear.
 - (6) Hammertoes, severe, that precludes the wearing of appropriate military footwear, refractory to surgery, or interferes with satisfactory performance of duty.
 - (7) Hallux limitus, hallux rigidus.
- c. Internal derangement of the knee.
 - (1) Residual instability following remedial measures, if more than moderate in degree.
 - (2) If complicated by arthritis, see paragraph 3-14a.

d. Joint ranges of motion. Motion that does not equal or exceed the measurements listed below. Measurements must be made with a goniometer and conform to the methods illustrated and described in TC 8–640.

- (1) Hip—flexion to 90 degrees or extension to 0 degree.
 - (2) Knee—flexion to 90 degrees or extension to 15 degrees.
 - (3) Ankle—dorsiflexion to 10 degrees or planter flexion to 10 degrees.
- e.* Shortening of an extremity that exceeds 2 inches.
- f.* Recurrent dislocations of the patella.

3–14. Miscellaneous conditions of the extremities

The causes for referral to an MEB are as follows (see also paras 3–12 and 3–13):

a. Arthritis due to infection, associated with persistent pain and marked loss of function with objective x-ray evidence and documented history of recurrent incapacity for prolonged periods. For arthritis due to gonococcal or tuberculous infection, see paragraphs 3–40 and 3–45*b*.

b. Arthritis due to trauma, when surgical treatment fails or is contraindicated and there is functional impairment of the involved joints so as to preclude the satisfactory performance of duty.

c. Osteoarthritis, with severe symptoms associated with impairment of function, supported by x-ray evidence and documented history of recurrent incapacity for prolonged periods.

d. Avascular necrosis of bone when severe enough to prevent successful performance of duty.

e. Chondromalacia or osteochondritis dissecans, severe, manifested by frequent joint effusion, more than moderate interference with function, or with severe residuals from surgery.

f. Fractures.

(1) Malunion of fractures, when, after appropriate treatment, there is more than moderate malunion with marked deformity and more than moderate loss of function.

(2) Nonunion of fractures, when, after an appropriate healing period, the nonunion precludes satisfactory performance of duty.

(3) Bone fusion defect, when manifested by more than moderate pain and loss of function.

(4) Callus, excessive, following fracture, when functional impairment precludes satisfactory performance of duty and the callus does not respond to adequate treatment.

g. Joints.

(1) Arthroplasty with severe pain, limitation of motion, and of function.

(2) Bony or fibrous ankylosis, with severe pain involving major joints or spinal segments in an unfavorable position, and with marked loss of function.

(3) Contracture of joint, with marked loss of function and the condition is not remediable by surgery.

(4) Loose bodies within a joint, with marked functional impairment and complicated by arthritis to such a degree as to preclude favorable results of treatment or not remediable by surgery.

(5) Prosthetic replacement of major joints if there is resultant loss of function or pain that precludes satisfactory performance of duty.

h. Muscles.

(1) Flaccid paralysis of one or more muscles with loss of function that precludes satisfactory performance of duty following surgical correction or if not remediable by surgery.

(2) Spastic paralysis of one or more muscles with loss of function that precludes the satisfactory performance of military duty.

i. Myotonia congenita.

j. Osteitis deformans (Paget's disease) with involvement of single or multiple bones with resultant deformities or symptoms severely interfering with function.

k. Osteoarthropathy, hypertrophic, secondary with moderately severe to severe pain present, with joint effusion occurring intermittently in one or multiple joints, and with at least moderate loss of function.

l. Osteomyelitis, chronic, with recurrent episodes not responsive to treatment and involving the bone to a degree that interferes with stability and function.

m. Tendon transplant with fair or poor restoration of function with weakness that seriously interferes with the function of the affected part.

3–15. Eyes

The causes for referral to an MEB are as follows:

a. Active eye disease or any progressive organic disease or degeneration, regardless of the stage of activity, that is resistant to treatment and affects the distant visual acuity or visual fields so that distant visual acuity does not meet the standard stated in paragraph 3–16*e* or the diameter of the field of vision in the better eye is less than 20 degrees.

b. Aphakia, bilateral.

- c. Atrophy of the optic nerve due to disease.
- d. Glaucoma, if resistant to treatment or affecting visual fields as in a above, or if side effects of required medication are functionally incapacitating.
- e. Degenerations, when vision does not meet the standards of paragraph 3–16e, or when vision is correctable only by the use of contact lenses or other special corrective devices (telescopic lenses, etc.).
- f. Diseases and infections of the eye, when chronic, more than mildly symptomatic, progressive, and resistant to treatment after a reasonable period. This includes intractable allergic conjunctivitis inadequately controlled by medications and immunotherapy.
- g. Residuals or complications of injury or disease, when progressive or when reduced visual acuity does not meet the criteria stated in paragraph 3–16e.
- h. Unilateral detachment of retina if any of the following exists:
 - (1) Visual acuity does not meet the standard stated in paragraph 3–16e.
 - (2) The visual field in the better eye is constricted to less than 20 degrees.
 - (3) Uncorrectable diplopia exists.
 - (4) Detachment results from organic progressive disease or new growth, regardless of the condition of the better eye.
- i. Bilateral detachment of retina, regardless of etiology or results of corrective surgery.

3–16. Vision

The causes for referral to an MEB are as follows:

- a. Aniseikonia, with subjective eye discomfort, neurologic symptoms, sensations of motion sickness and other gastrointestinal disturbances, functional disturbances and difficulties in form sense, and not corrected by iseikonica lenses.
- b. Binocular diplopia, not correctable by surgery, that is severe, constant, and in a zone less than 20 degrees from the primary position.
- c. Hemianopsia, of any type if bilateral, permanent, and based on an organic defect. Those due to a functional neurosis and those due to transitory conditions, such as periodic migraine, are not considered to fall below required standards.
- d. Night blindness, of such a degree that the soldier requires assistance in any travel at night.
- e. Visual acuity.
 - (1) Vision that cannot be corrected with ordinary spectacle lenses (contact lenses or other special corrective devices (telescopic lenses, etc.) are unacceptable) to at least: 20/60 in one eye and 20/60 in the other eye, or 20/50 in one eye and 20/80 in the other eye, or 20/40 in one eye and 20/100 in the other eye, or 20/20 in one eye and 20/800 in the other eye; or
 - (2) An eye has been enucleated.
- f. Visual field with bilateral concentric constriction to less than 20 degrees.

3–17. Genitourinary system

The causes for referral to an MEB are as follows:

- a. Cystitis, when complications or residuals of treatment themselves preclude satisfactory performance of duty.
- b. Dysmenorrhea, when symptomatic, irregular cycle, not amenable to treatment, and of such severity as to necessitate recurrent absences of more than 1 day.
- c. Endometriosis, symptomatic and incapacitating to a degree that necessitates recurrent absences of more than 1 day.
- d. Hypospadias, when accompanied by evidence of chronic infection of the genitourinary tract or instances where the urine is voided in such a manner as to soil clothes or surroundings and the condition is not amenable to treatment.
- e. Incontinence of urine, due to disease or defect not amenable to treatment and of such severity as to necessitate recurrent absence from duty.
- f. Kidney.
 - (1) Calculus in kidney, when bilateral, resulting in frequent or recurring infections, or when there is evidence of obstructive uropathy not responding to medical or surgical treatment.
 - (2) Congenital anomaly, when bilateral, resulting in frequent or recurring infections, or when there is evidence of obstructive uropathy not responding to medical or surgical treatment.
 - (3) Cystic kidney (polycystic kidney), when symptomatic and renal function is impaired or is the focus of frequent infection.
 - (4) Glomerulonephritis, when chronic.
 - (5) Hydronephrosis, when more than mild, bilateral, and causing continuous or frequent symptoms.
 - (6) Hypoplasia of the kidney, when symptomatic and associated with elevated blood pressure or frequent infections and not controlled by surgery.

- (7) Nephritis, when chronic.
- (8) Nephrosis.
- (9) Perirenal abscess, with residuals of a degree that precludes the satisfactory performance of duty.
- (10) Pyelonephritis or pyelitis, when chronic, that has not responded to medical or surgical treatment, with evidence of hypertension, eye-ground changes, cardiac abnormalities.
- (11) Pyonephrosis, when not responding to treatment.
 - g. Menopausal syndrome, physiologic or artificial, when symptoms are not amenable to treatment and preclude successful performance of duty.
 - h. Chronic pelvic pain with or without demonstrative pathology that has not responded to medical or surgical treatment and of such severity to necessitate recurrent absence from duty.
 - i. Strictures of the urethra or ureter, when severe and not amenable to treatment.
 - j. Urethritis, chronic, when not responsive to treatment and necessitating frequent absences from duty.

3-18. Genitourinary and gynecological surgery

The causes for referral to an MEB are as follows:

- a. Cystectomy.
 - b. Cystoplasty, if reconstruction is unsatisfactory or if residual urine persists in excess of 50 cubic centimeters (cc) or if refractory symptomatic infection persists.
 - c. Hysterectomy, when residual symptoms or complications preclude the satisfactory performance of duty.
 - d. Nephrectomy, when after treatment, there is infection or pathology in the remaining kidney.
 - e. Nephrostomy, if drainage persists.
 - f. Oophorectomy, when complications or residual symptoms are not amenable to treatment and preclude successful performance of duty.
 - g. Pyelostomy, if drainage persists.
 - h. Ureterocolostomy.
 - i. Ureterocystostomy, when both ureters are markedly dilated with irreversible changes.
 - j. Ureteroileostomy cutaneous.
 - k. Ureteroplasty.
- (1) When unilateral procedure is unsuccessful and nephrectomy is necessary, consider it on the basis of the standard for a nephrectomy; or
- (2) When bilateral, evaluate residual obstruction or hydronephrosis and consider it on the basis of the residuals involved.
- l. Uretersigmoidostomy.
 - m. Ureterostomy, external or cutaneous.
 - n. Urethrostomy, if there is complete amputation of the penis or when a satisfactory urethra cannot be restored.
 - o. Kidney transplant recipient.

3-19. Head

The causes for referral to an MEB are loss of substance of the skull with or without prosthetic replacement when accompanied by moderate residual signs and symptoms such as described in paragraph 3-30. (See also para 3-29.) A skull defect that poses a danger to the soldier or interferes with the wearing of protective headgear is cause for referral to an MEB/PEB.

3-20. Neck

The causes for referral to an MEB are torticollis (wry neck); severe fixed deformity with cervical scoliosis, flattening of the head and face, and loss of cervical mobility. (See also para 3-11.)

3-21. Heart

The causes for referral to an MEB are as follows (see table 3-1 for functional classifications and for metabolic equivalents (METs) ratings to be included in the MEB):

- a. Coronary heart disease associated with—
 - (1) Myocardial infarction, angina pectoris, or congestive heart failure due to fixed obstructive coronary artery disease or coronary artery spasm. The policies for trial of duty, profiling, and referral to an MEB and a PEB (as outlined in para 3-25) apply. The trial of duty will be for 120 days.
 - (2) Myocardial infarction with normal coronary artery anatomy. The policies for trial of duty, profiling, and referral to an MEB and a PEB (as outlined in para 3-25) apply. The trial of duty will be for 120 days.
 - (3) Angina pectoris in association with objective evidence of myocardial ischemia in the presence of normal coronary artery anatomy.
 - (4) Fixed obstructive coronary artery disease, asymptomatic but with objective evidence of myocardial ischemia.

The policies for trial of duty, profiling, and referral to an MEB and a PEB (as outlined in para 3–25) apply. The trial of duty will be for 120 days.

b. Supraventricular tachyarrhythmias, when life threatening or symptomatic enough to interfere with performance of duty and when not adequately controlled. This includes atrial fibrillation, atrial flutter, paroxysmal supraventricular tachycardia, and others.

c. Endocarditis with any residual abnormality or if associated with valvular, congenital, or hypertrophic myocardial disease.

d. Heart block (second degree or third degree AV block) and symptomatic bradyarrhythmias, even in the absence of organic heart disease or syncope. Wenckebach second degree heart block occurring in healthy asymptomatic individuals without evidence of organic heart disease is not a cause for referral to a PEB. None of these conditions is cause for MEB/PEB when associated with recognizable temporary precipitating conditions: for example, perioperative period, hypoxia, electrolyte disturbance, drug toxicity, acute illness.

e. Myocardial disease, New York Heart Association or Canadian Cardiovascular Society Functional Class II or worse. (See table 3–1.)

f. Ventricular flutter and fibrillation, ventricular tachycardia when potentially life threatening (for example, when associated with forms of heart disease that are recognized to predispose to increased risk of death and when there is no definitive therapy available to reduce this risk) or when symptomatic enough to interfere with the performance of duty. None of these ventricular arrhythmias are a cause for medical board referral to a PEB when associated with recognizable temporary precipitating conditions: for example, perioperative period, hypoxia, electrolyte disturbance, drug toxicity, or acute illness.

g. Sudden cardiac death, when an individual survives sudden cardiac death that is not associated with a temporary or treatable cause, and when there is no definitive therapy available to reduce the risk of recurrent sudden cardiac death.

h. Hypertrophic cardiomyopathy when of sufficient degree to restrict activity.

i. Pericarditis as follows:

(1) Chronic constrictive pericarditis unless successful remedial surgery has been performed.

(2) Chronic serous pericarditis.

j. Valvular heart disease with cardiac insufficiency at functional capacity of Class II or worse as defined by the New York Heart Association. (See table 3–1.)

k. Ventricular premature contractions with frequent or continuous attacks, whether or not associated with organic heart disease, accompanied by discomfort or fear of such a degree as to interfere with the satisfactory performance of duty.

l. Recurrent syncope or near syncope of cardiovascular etiology that is not controlled or when it interferes with the performance of duty, even if the etiology is unknown.

m. Any cardiovascular disorder requiring chronic drug therapy in order to prevent the occurrence of potentially fatal or severely symptomatic events that would interfere with duty performance.

3–22. Vascular system

The causes for referral to an MEB are as follows:

a. Arteriosclerosis obliterans when any of the following pertain:

(1) Intermittent claudication of sufficient severity to produce discomfort and inability to complete a walk of 200 yards or less on level ground at 112 steps per minute without a rest.

(2) Objective evidence of arterial disease with symptoms of claudication, ischemic rest pain, or with gangrenous or ulcerative skin changes of a permanent degree in the distal extremity.

(3) Involvement of more than one organ, system, or anatomic region (the lower extremities comprise one region for this purpose) with symptoms of arterial insufficiency.

b. Major cardiovascular anomalies including coarctation of the aorta, unless satisfactorily treated by surgical correction or other newly developed techniques, and without any residual abnormalities or complications.

c. Aneurysm of any vessel not correctable by surgery and aneurysm corrected by surgery after a period of up to 90 days trial of duty that results in the individual's inability to perform satisfactory duty. The policies for trial of duty, profiling, and referral to an MEB and a PEB (as outlined in para 3–25) apply.

d. Periarteritis nodosa with definite evidence of functional impairment.

e. Chronic venous insufficiency (postphlebotic syndrome) when more than mild and symptomatic despite elastic support.

f. Raynaud's phenomenon manifested by trophic changes of the involved parts characterized by scarring of the skin or ulceration.

g. Thromboangiitis obliterans with intermittent claudication of sufficient severity to produce discomfort and inability to complete a walk of 200 yards or less on level ground at 112 steps per minute without rest, or other complications.

h. Thrombophlebitis when repeated attacks requiring treatment are of such frequency as to interfere with the satisfactory performance of duty.

- i.* Varicose veins that are severe and symptomatic despite therapy.
- j.* Cold injury. (See paragraph 3–46).

3–23. Miscellaneous cardiovascular conditions

The causes for referral to an MEB are as follows:

- a.* Hypertensive cardiovascular disease and hypertensive vascular disease. Diastolic pressure consistently more than 110 mmHg following an adequate period of therapy in an ambulatory status.
- b.* Rheumatic fever, active, with heart damage. Recurrent attacks.

3–24. Surgery and other invasive procedures involving the heart, pericardium, or vascular system

These procedures include newly developed techniques or prostheses not otherwise covered in this paragraph. The causes for referral to an MEB are as follows:

- a.* Permanent prosthetic valve implantation.
- b.* Implantation of permanent pacemakers, antitachycardia and defibrillator devices, and similar newly developed devices.
- c.* Reconstructive cardiovascular surgery employing exogenous grafting material.
- d.* Vascular reconstruction, after a period of 90 days trial of duty when medically advisable, that results in the individual's inability to perform satisfactory duty. The policies for trial of duty, profiling, and referral to an MEB and a PEB (as outlined in para 3–25) apply.
- e.* Coronary artery revascularization, with the option of a 120-day trial of duty based upon physician recommendation when the individual is asymptomatic, without objective evidence of myocardial ischemia, and when other functional assessment (such as exercise testing and newly developed techniques) indicates that it is medically advisable. Any individual undergoing median sternotomy for surgery will be restricted from lifting 25 pounds or more, performing pullups and pushups, or as otherwise prescribed by a physician for a period of 90 days from the date of surgery on DA Form 3349 (Physical Profile). The policies for trial of duty, profiling, and referral to an MEB and a PEB (as outlined in para 3–25) apply.
- f.* Heart or heart-lung transplantation.
- g.* Coronary or valvular angioplasty procedures, with the option of a 180-day trial of duty based upon physician recommendation when the individual is asymptomatic, without objective evidence of myocardial ischemia, and when other functional assessment (such as cardiac catheterization, exercise testing, and newly developed techniques) indicates that it is medically advisable. The policies for trial of duty, profiling, and referral to an MEB and a PEB (as outlined in para 3–25) apply.
- h.* Cardiac arrhythmia ablation procedures, with the option of a 180-day trial of duty based upon physician recommendation when asymptomatic, and no evidence of any unfitting arrhythmia as noted in paragraph 3–21. The policies for trial of duty, MEB, and physical profile (as outlined in para 3–25) apply.

3–25. Trial of duty and profiling for cardiovascular conditions

a. Trial of duty will be based upon physician recommendation when the individual is asymptomatic without objective evidence of myocardial ischemia, and when other functional assessment (such as coronary angiography, exercise testing, and newly developed techniques) indicates it is medically advisable.

b. Prior to commencing the trial of duty period, an MEB will be accomplished in all cases (including evaluation by a cardiologist or internist) and a physical activity prescription on DA Form 3349 will be provided by a physician. Upon completion of the trial of duty period, the results will be incorporated into the MEB. The results of the trial of duty will include the individual's interim history, present condition, prognosis, and the final recommendations. A detailed report from the commander or supervisor clearly describing the individual's ability to accomplish assigned duties and to perform physical activity will be incorporated into the MEB record. The results of the MEB and an updated DA Form 3349 will then be forwarded to a PEB in all cases except for the following: If the soldier successfully completes the trial of duty, is considered a New York Heart Association Functional Class I, AND there are no physical or assignments restrictions, the soldier may be returned to duty without referral to a PEB. If the soldier's condition becomes worse at a later date, a new MEB will be accomplished and the soldier will be referred to a PEB. For RC soldiers not on active duty, the trial of duty may consider performance in the soldier's civilian position, as well as any military duty that may have been performed in the interim.

c. The following profile guidelines supplement chapter 7. Individuals returning to a trial of duty will be given a temporary P–3 profile with specific written limitations and instructions for physical and cardiovascular rehabilitation on DA Form 3349. The completed MEB will include a permanent numerical designator in the "P" factor of the physical profile that is based on functional assessment as follows:

(1) Numerical designator "1." Individuals who are asymptomatic, without objective evidence of myocardial ischemia or other cardiovascular functional abnormality (New York Heart Association Functional Class I).

(2) Numerical designator "2." Individuals with minor physical activity limitations or who require frequent medical follow-up.

(3) Numerical Designator “3.” Individuals who are asymptomatic but with objective evidence of myocardial ischemia or other cardiovascular functional abnormality. Those requiring assignment limitations.

(4) Numerical designator “4.” Individuals who are symptomatic (New York Heart Association Functional Class II or worse).

3–26. Tuberculosis, pulmonary

The cause for referral to an MEB for pulmonary tuberculosis—

a. If an expiration of service will occur before completion of the period of hospitalization. (Career soldiers who express a desire to reenlist after treatment may extend their enlistment to cover the period of hospitalization.)

b. When a member of the USAR or ARNGUS not on active duty has active disease that will probably require treatment for more than 12 to 15 months including an appropriate period of convalescence before he or she can perform full-time military duty. Individuals who are retained in the USAR or ARNGUS while undergoing treatment may not be called or ordered to active duty (including mobilization), ADT, or inactive duty training (IDT) during the period of treatment and convalescence.

3–27. Miscellaneous respiratory disorders

The causes for referral to an MEB are as follows:

a. Asthma. This includes reactive airway disease, exercise-induced bronchospasm, asthmatic bronchospasm, or asthmatic bronchitis within the criteria outlined in paragraphs (1) through (4) below.

(1) Definitions/diagnostic criteria are as follows.

(a) Asthma is a clinical syndrome characterized by cough, wheeze, or dyspnea and physiologic evidence of reversible airflow obstruction or airway hyperactivity that persists over a prolonged period of time (generally more than 6 to 12 months).

(b) Reversible airflow obstruction is defined as more than 15 percent increase in FEV1 following the administration of an inhaled bronchodilator or prolonged corticosteroid therapy.

(c) Increased bronchial responsiveness is the presence of an exaggerated decrease in airflow induced by a standard bronchoprovocation challenge such as methacholine inhalation (PD20 FEV1 less than or equal to 4mg/ml). Demonstration of exercise induced bronchospasm (15 percent decline in FEV1) is also diagnostic of increased bronchial responsiveness; however, failure to induce bronchospasm with exercise does not rule out the diagnosis of asthma. Bronchoprovocation or exercise testing should be performed by a credentialed provider privileged to perform the procedures.

(d) Soldiers who are diagnosed as having asthma may be placed on a temporary profile under the “P” factor of the physical profile for up to 12 months trial of duty, when medically advisable. If at the end of that period, the soldier is unable to perform all military training and duty as cited below, the soldier will be referred to MEB/PEB.

(e) Acute, self limited, reversible airflow obstruction and airway hyperactivity can be caused by upper respiratory infections and inhalation of irritant gases or pollutants. This should not be permanently diagnosed as asthma unless significant symptoms or airflow abnormalities persist for more than 12 months.

(2) Chronic asthma is cause for a permanent P–3 or P–4 profile and MEB/PEB referral if it—

(a) Results in repetitive hospitalizations, repetitive emergency room visits or excessive time lost from duty.

(b) Requires repetitive use of oral corticosteroids to enable the soldier to perform all military training and duties.

(c) Results in inability to run outdoors at a pace that meets the standards for the timed 2-mile run despite medications. (The P–3 for the inability to perform the run refers to the inability due to asthma and should not be confused with giving an L2 or L3 based on an underlying orthopedic condition that requires an alternate Army Physical Fitness Test (APFT).)

(d) Prevents the soldier from wearing a protective mask.

(3) All soldiers meeting an MEB for asthma should receive a consultation from an internist, pulmonologist, or allergist.

(4) Chronic asthma meets retention standards, but is a cause for a permanent P–2 profile if it—

(a) Requires regular medications including low dose inhaled corticosteroids and/or oral or inhaled bronchodilators; but

(b) Does not prevent the soldier from otherwise performing all military training and duties including the 2 mile run within time standards.

(5) Soldiers with a diagnosis of asthma who require no medications or activity limitations require no profiling action.

b. Atelectasis, or massive collapse of the lung. Moderately symptomatic with paroxysmal cough at frequent intervals throughout the day or with moderate emphysema or with residuals or complications that require repeated hospitalization.

c. Bronchiectasis or bronchiolectasis. Cylindrical or saccular type that is moderately symptomatic, with paroxysmal

cough at frequent intervals throughout the day or with moderate emphysema with a moderate amount of bronchiectatic sputum or with recurrent pneumonia or with residuals or complications that require repeated hospitalization.

d. Bronchitis. Chronic, severe, persistent cough, with considerable expectoration or with dyspnea at rest or on slight exertion or with residuals or complications that require repeated hospitalization.

e. Cystic disease of the lung, congenital disease involving more than one lobe of a lung.

f. Diaphragm, congenital defect. Symptomatic.

g. Hemopneumothorax, hemothorax, or pyopneumothorax. More than moderate pleuritic residuals with persistent underweight or marked restriction of respiratory excursions and chest deformity or marked weakness and fatigue on slight exertion.

h. Histoplasmosis. Chronic and not responding to treatment.

i. Pleurisy, chronic, or pleural adhesions. Severe dyspnea or pain on mild exertion associated with definite evidence of pleural adhesions and demonstrable moderate reduction of pulmonary function.

j. Pneumothorax, spontaneous. Recurrent episodes of pneumothorax not corrected by surgery or pleural sclerosis.

k. Pneumoconiosis. Severe, with dyspnea on mild exertion.

l. Pulmonary calcification. Multiple calcifications associated with significant respiratory embarrassment or active disease not responsive to treatment.

m. Pulmonary emphysema. Marked emphysema with dyspnea on mild exertion and demonstrable moderate reduction in pulmonary function.

n. Pulmonary fibrosis. Linear fibrosis or fibrocalcific residuals of such a degree as to cause dyspnea on mild exertion and demonstrable moderate reduction in pulmonary function.

o. Pulmonary sarcoidosis. If not responding to therapy and complicated by demonstrable moderate reduction in pulmonary function.

p. Stenosis, bronchus. Severe stenosis associated with repeated attacks of bronchopulmonary infections requiring hospitalization of such frequency as to interfere with the satisfactory performance of duty.

3-28. Surgery of the lungs

The cause for referral to an MEB is a complete lobectomy, if pulmonary function (ventilatory tests) is impaired to a moderate degree or more.

3-29. Mouth, esophagus, nose, pharynx, larynx, and trachea

The causes for referral to an MEB are as follows:

a. Esophagus.

(1) Achalasia, unless controlled by medical therapy.

(2) Esophagitis, persistent and severe.

(3) Diverticulum of the esophagus of such a degree as to cause frequent regurgitation, obstruction, and weight loss that does not respond to treatment.

(4) Stricture of the esophagus of such a degree as to almost restrict diet to liquids, require frequent dilatation and hospitalization, and cause difficulty in maintaining weight and nutrition.

b. Larynx.

(1) Paralysis of the larynx characterized by bilateral vocal cord paralysis seriously interfering with speech and adequate airway.

(2) Stenosis of the larynx of a degree causing respiratory embarrassment upon more than minimal exertion.

c. Obstructive edema of glottis. If chronic, not amenable to treatment, and requires a tracheotomy.

d. Rhinitis. Atrophic rhinitis characterized by bilateral atrophy of nasal mucous membrane with severe crusting, concomitant severe headaches, and foul, fetid odor.

e. Sinusitis. Severe, chronic sinusitis that is suppurative, complicated by chronic or recurrent polyps, and that does not respond to treatment.

f. Trachea. Stenosis of trachea.

3-30. Neurological disorders

The causes for referral to an MEB are as follows:

a. Amyotrophic lateral sclerosis and all other forms of progressive neurogenic muscular atrophy.

b. All primary muscle disorders including facioscapulohumeral dystrophy, limb girdle atrophy, and myotonia dystrophy characterized by progressive weakness and atrophy.

c. Myasthenia gravis unless clinically restricted to the extraocular muscles.

d. Progressive degenerative disorders of the basal ganglia and cerebellum including Parkinson's disease, Huntington's chorea, hepatolenticular degeneration, and variants of Friedreich's ataxia.

e. Multiple sclerosis, optic neuritis, transverse myelitis, and similar demyelinating disorders.

- f. Stroke, including both the effects of ischemia and hemorrhage, when residuals affect performance.
- g. Migraine, tension, or cluster headaches, when manifested by frequent incapacitating attacks.
- h. Narcolepsy, sleep apnea syndrome, or similar disorders. (See para 3–41.)
- i. Seizure disorders and epilepsy. Seizures by themselves are not disqualifying unless they are manifestations of epilepsy. However, they may be considered along with other disabilities in judging fitness. In general, epilepsy is disqualifying unless the soldier can be maintained free of clinical seizures of all types by nontoxic doses of medications. The following guidance applies when determining whether a soldier will be referred to an MEB/PEB.
 - (1) All active duty soldiers with suspected epilepsy must be evaluated by a neurologist who will determine whether epilepsy exists and whether the soldier should be given a trial of therapy on active duty or referred directly to an MEB for referral to a PEB. In making the determination, the neurologist may consider the underlying cause, EEG findings, type of seizure, duration of epilepsy, family history, soldier's likelihood of compliance with therapeutic program, absence of substance abuse, or any other clinical factor influencing the probability of control or the soldier's ability to perform duty during the trial of treatment.
 - (2) If a trial of duty on treatment is elected by the neurologist, the soldier will be given a temporary P–3 profile with as few restrictions as possible.
 - (3) Once the soldier has been seizure free for 1 year, the profile may be reduced to a P–2 profile with restrictions specifying no assignment to an area where medical treatment is not available.
 - (4) If seizures recur beyond 6 months after the initiation of treatment, the soldier will be referred to an MEB.
 - (5) Should seizures recur during a later attempt to withdraw medications or during transient illness, referral to a PEB is at the discretion of the physician or MEB.
 - (6) If the soldier has remained seizure free for 36 months, he or she may be removed from profile restrictions.
 - (7) Recurrent pseudoseizures are disqualifying under the same rules as epilepsy.
- j. Any other neurologic conditions, regardless of etiology, when after adequate treatment there remains residual symptoms and impairments such as persistent severe headaches, uncontrolled seizures, weakness, paralysis, or atrophy of important muscle groups, deformity, uncoordination, tremor, pain, or sensory disturbance, alteration of consciousness, speech, personality, or mental function of such a degree as to significantly interfere with performance of duty.

Note. Diagnostic concepts and terms used in paragraphs 3–31 through 3–37 are in consonance with the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM–IV). The minimum psychiatric evaluation will include Axis I, II, and III.

3–31. Disorders with psychotic features

The causes for referral to an MEB are mental disorders not secondary to intoxication, infectious, toxic, or other organic causes, with gross impairment in reality testing, resulting in interference with duty or social adjustment.

3–32. Mood disorders

The causes for referral to an MEB are as follows:

- a. Persistence or recurrence of symptoms sufficient to require extended or recurrent hospitalization; or
- b. Persistence or recurrence of symptoms necessitating limitations of duty or duty in protected environment; or
- c. Persistence or recurrence of symptoms resulting in interference with effective military performance.

3–33. Anxiety, somatoform, or dissociative disorders

The causes for referral to an MEB are as follows:

- a. Persistence or recurrence of symptoms sufficient to require extended or recurrent hospitalization; or
- b. Persistence or recurrence of symptoms necessitating limitations of duty or duty in protected environment; or
- c. Persistence or recurrence of symptoms resulting in interference with effective military performance.

3–34. Dementia and other cognitive disorders due to general medical condition

The causes for referral to an MEB include persistence of symptoms or associated personality change sufficient to interfere with the performance of duty or social adjustment.

3–35. Personality, sexual and gender identity, or factitious disorders; disorders of impulse control not elsewhere classified; substance-related disorders

The conditions may render an individual administratively unfit rather than unfit because of physical disability. Interference with performance of effective duty in association with these conditions will be dealt with through administrative channels.

3–36. Adjustment disorders

Situational maladjustments due to acute or chronic situational stress do not render an individual unfit because of physical disability, but may be the basis for administrative separation if recurrent and causing interference with military duty.

3-37. Eating disorders

The causes for referral to an MEB are eating disorders that are unresponsive to treatment or that interfere with the satisfactory performance of duty.

3-38. Skin and cellular tissues

The causes for referral to an MEB are as follows:

- a. Acne. Severe, unresponsive to treatment, and interfering with the satisfactory performance of duty or wearing of the uniform or other military equipment.
- b. Atopic dermatitis. More than moderate and after hospitalization interfering with performance of duty.
- c. Amyloidosis. Generalized.
- d. Cysts and tumors. (See paras 3-42 and 3-43.)
- e. Dermatitis herpetiformis. Not responsive to therapy.
- f. Dermatomyositis.
- g. Dermographism. Interfering with the performance of duty.
- h. Eczema, chronic. Regardless of type, when there is more than minimal involvement and the condition is unresponsive to treatment and interferes with the satisfactory performance of duty.
- i. Elephantiasis or chronic lymphedema. Not responsive to treatment.
- j. Epidermolysis bullosa.
- k. Erythema multiforme. More than moderate and recurrent or chronic.
- l. Exfoliative dermatitis. Chronic.
- m. Fungus infections, superficial or systemic types. If not responsive to therapy and interfering with the satisfactory performance of duty.
- n. Hidradenitis suppurative and/or folliculitis decalvans (dissecting cellulitis of the scalp).
- o. Hyperhidrosis. On the hands or feet, when severe or complicated by a dermatitis or infection, either fungal or bacterial and not amenable to treatment.
- p. Leukemia cutis or mycosis fungoides or cutaneous T-Cell lymphoma. (See also para 3-42.)
- q. Lichen planus. Generalized and not responsive to treatment.
- r. Lupus erythematosus. Cutaneous or mucous membranes involvement that is unresponsive to therapy and interferes with the satisfactory performance of duty.
- s. Neurofibromatosis. When interfering with the satisfactory performance of duty.
- t. Panniculitis. Relapsing, febrile, nodular.
- u. Parapsoriasis. Extensive and not controlled by treatment.
- v. Pemphigus. Not responsive to treatment and with moderate constitutional or systemic symptoms, or interfering with the satisfactory performance of duty.
- w. Psoriasis. Extensive and not controllable by treatment.
- x. Radiodermatitis. If resulting in malignant degeneration at a site not amenable to treatment.
- y. Scars and keloids. So extensive or adherent that they seriously interfere with the function of an extremity or interfere with the performance of duty.
- z. Scleroderma. Generalized or of the linear type that seriously interferes with the function of an extremity.
- aa. Tuberculosis of the skin. (See paragraph 3-40.)
- ab. Ulcers of the skin. Not responsive to treatment after an appropriate period of time if interfering with the satisfactory performance of duty.
- ac. Urticaria/Angioedema. Chronic, severe, and not responsive to treatment.
- ad. Xanthoma. Regardless of type, but only when interfering with the satisfactory performance of duty.
- ae. Intractable plantar keratosis, chronic. Requires frequent medical/surgical care or that interferes with the satisfactory performance of duty.
- af. Other skin disorders. If chronic or of a nature that requires frequent medical care, or interferes with the satisfactory performance of military duty.

3-39. Spine, scapulae, ribs, and sacroiliac joints

The causes for referral to an MEB are as follows (see also para 3-14):

- a. Dislocation. Congenital, of hip.
- b. Spina bifida. Demonstrable signs and moderate symptoms of root or cord involvement.
- c. Spondylolysis or spondylolisthesis. More than mild symptoms resulting in repeated outpatient visits, or repeated hospitalization or limitations effecting performance of duty.
- d. Coxa vara. More than moderate with pain, deformity, and arthritic changes.
- e. Herniation of nucleus pulposus. More than mild symptoms following appropriate treatment or remedial measures, with sufficient objective findings to demonstrate interference with the satisfactory performance of duty.

- f.* Kyphosis. More than moderate, interfering with military duties.
- g.* Scoliosis. Severe deformity with over 2 inches deviation of tips of spinous process from the midline, or of lesser degree if recurrently symptomatic and interfering with military duties.
- h.* Nonradicular pain involving the cervical, thoracic, lumbosacral, or coccygeal spine, whether idiopathic or secondary to degenerative disc or joint disease, that fails to respond to adequate conservative treatment and necessitates significant limitation of physical activity.

3–40. Systemic diseases

The causes for referral to an MEB are as follows:

- a.* Amyloidosis.
- b.* Blastomycosis.
- c.* Brucellosis. Chronic with substantiated, recurring febrile episodes, severe fatigue, lassitude, depression, or general malaise.
- d.* Leprosy. Any type that seriously interferes with performance of duty or is not completely responsive to appropriate treatment.
- e.* Myasthenia gravis.
- f.* Mycosis. Active, not responsive to therapy or requiring prolonged treatment, or when complicated by residuals that themselves are unfitting.
- g.* Panniculitis. Relapsing, febrile, nodular.
- h.* Porphyria, cutanea tarda.
- i.* Sarcoidosis. Progressive with severe or multiple organ involvement and not responsive to therapy.
- j.* Tuberculosis.
 - (1) Meningitis, tuberculous.
 - (2) Pulmonary tuberculosis (see para 3–26), tuberculous empyema, and tuberculous pleurisy.
 - (3) Tuberculosis of the male genitalia. Involvement of the prostate or seminal vesicles and other instances not corrected by surgical excision, or when residuals are more than minimal, or are symptomatic.
 - (4) Tuberculosis of the female genitalia.
 - (5) Tuberculosis of the kidney.
 - (6) Tuberculosis of the larynx.
 - (7) Tuberculosis of the lymph nodes, skin, bone, joints, eyes, intestines, and peritoneum or mesentery. These will be evaluated on an individual basis, considering the associated involvement, residuals, and complications.
- k.* Rheumatoid arthritis that interferes with successful performance of duty or requires geographic assignment limitations or requires medication for control that requires frequent monitoring by a physician due to debilitating or serious side effects.
- l.* Spondyloarthropathies. Chronic or recurring episodes of arthritis causing functional impairment interfering with successful performance of duty supported by objective, subjective, and radiographic findings, or requires medication for control that requires frequent monitoring by a physician due to debilitating or serious side effects.
 - (1) Ankylosingpondylitis.
 - (2) Reiter's syndrome.
 - (3) Psoriatic arthritis.
 - (4) Arthritis associated with inflammatory bowel disease.
 - (5) Whipple's disease.
- m.* Systemic lupus erythematosus that interferes with successful performance of duty or requires geographic assignment limitations or requires medication for control that requires frequent monitoring by a physician due to debilitating or serious side effects.
- n.* Sjogren's syndrome. When chronic, more than mildly symptomatic and resistant to treatment after a reasonable period of time.
- o.* Progressive systemic sclerosis, diffuse and limited disease that interferes with successful performance of duty or requires geographic assignment limitations or requires medication for control that requires frequent monitoring by a physician due to debilitating or serious side effects.
- p.* Myopathy, to include inflammatory, metabolic or inherited, that interferes with successful performance of duty or requires geographic assignment limitations or requires medication for control that requires frequent monitoring by a physician due to debilitating or serious side effects.
- q.* Systemic vasculitis involving major organ systems, chronic, that interferes with successful performance of duty or requires geographic assignment limitations or requires medication for control that requires frequent monitoring by a physician due to debilitating or serious side effects.
- r.* Hypersensitivity angitis when chronic or having recurring episodes that are more than mildly symptomatic or show definite evidence of functional impairment which is resistant to treatment after a reasonable period of time.

s. Behcet's syndrome that interferes with successful performance of duty or requires geographic assignment limitations or requires medication for control that requires frequent monitoring by a physician due to debilitating or serious side effects.

t. Adult onset Still's disease that interferes with successful performance of duty or requires geographic assignment limitations or requires medication for control that requires frequent monitoring by a physician due to debilitating or serious side effects.

u. Mixed connective tissue disease and other overlap syndromes that interfere with successful performance of duty or require geographic assignment limitations or require medication for control that requires frequent monitoring by a physician due to debilitating or serious side effects.

v. Any chronic or recurrent systemic inflammatory disease or arthritis not listed above that interferes with successful performance of duty or requires geographic assignment limitations, or requires medication for control that requires frequent monitoring by a physician due to debilitating or serious side effects.

3-41. General and miscellaneous conditions and defects

The causes for referral to an MEB are as follows:

a. Allergic manifestations.

(1) Allergic rhinitis, chronic, severe, and not responsive to treatment. (See also paras 3-29d and 3-29e.)

(2) Asthma. (See para 3-27a.)

(3) Allergic dermatoses. (See para 3-38.)

b. Cold injury/heat injury. (See paras 3-45 and 3-46.)

c. Sleep apnea. Obstructive sleep apnea or sleep-disordered breathing that causes daytime hypersomnolence or snoring that interferes with the sleep of others and that cannot be corrected with medical therapy, surgery, or oral prosthesis. The diagnosis must be based upon a nocturnal polysomnogram and the evaluation of a pulmonologist, neurologist, or a provider with expertise in sleep medicine. A 12-month trial of therapy with nasal continuous positive air pressure may be attempted to assist in weight reduction or other interventions, during which time the individual will be profiled as T3. Long-term therapy with nasal continuous positive air pressure requires referral to an MEB.

d. Fibromyalgia, when severe enough to prevent successful performance of duty. Diagnosis will include evaluation by a rheumatologist.

e. Miscellaneous conditions and defects. Conditions and defects not mentioned elsewhere in this chapter are causes for referral to an MEB, if—

(1) The conditions (individually or in combination) result in interference with satisfactory performance of duty as substantiated by the individual's commander or supervisor.

(2) The individual's health or well-being would be compromised if he or she were to remain in the military service.

(3) In view of the soldier's condition, his or her retention in the military service would prejudice the best interests of the Government (for example, a carrier of communicable disease who poses a health threat to others). Questionable cases, including those involving latent impairment, will be referred to PEBs.

3-42. Malignant neoplasms

The causes for referral to an MEB are as follows:

a. Malignant neoplasms that are unresponsive to therapy, or when the residuals of treatment are in themselves unfitting under other provisions of this chapter.

b. Neoplastic conditions of the lymphoid and blood-forming tissues that are unresponsive to therapy, or when the residuals of treatment are in themselves unfitting under other provisions of this chapter.

c. Malignant neoplasms, when on evaluation for administrative separation or retirement, the observation period subsequent to treatment is deemed inadequate in accordance with accepted medical principles.

d. The above definitions of malignancy or malignant disease exclude basal cell carcinoma of the skin.

3-43. Benign neoplasms

The causes for referral to an MEB are as follows:

a. Benign tumors if their condition precludes the satisfactory performance of military duty.

b. Ganglioneuroma.

c. Meningeal fibroblastoma, when the brain is involved.

d. Pigmented villonodular synovitis when severe enough to prevent successful performance of duty.

3-44. Sexually transmitted diseases

The causes for referral to an MEB are as follows:

a. Symptomatic neurosyphilis in any form.

b. Complications or residuals of a sexually transmitted disease of such chronicity or degree that the individual is incapable of performing useful duty.

3-45. Heat illness and injury

The causes for referral to an MEB are as follows:

a. Heat exhaustion.

(1) Heat exhaustion is defined as collapse, including syncope, occurring during or immediately following exercise-heat stress without evidence of organ damage or systemic inflammatory activation.

(2) Individual episodes of heat exhaustion are not cause for MEB referral. However, soldiers suffering from recurrent episodes of heat exhaustion (three or more in less than 24 months) should be referred for complete medical evaluation for contributing factors.

(3) If no remediable factor causing recurrent heat exhaustion is identified, then the soldier will be referred to an MEB.

b. Heat stroke.

(1) The definitions of heat stroke are as follows.

(a) Heat stroke: A syndrome of hyperpyrexia, collapse, and encephalopathy with evidence of organ damage and/or systemic inflammatory activation occurring in the setting of environmental heat stress.

(b) Exertional rhabdomyolysis: Rhabdomyolysis with myoglobinuria occurring with exercise-heat stress but without the encephalopathy of heat stroke.

(2) Soldiers will be referred to an MEB after an episode of heat stroke or exertional rhabdomyolysis. If the soldier has had full clinical recovery, and particularly if a circumstantial contributing factor to the episode can be identified, the MEB may recommend a trial of duty with a P-3 (T) profile. The profile will restrict the soldier from performing vigorous physical exercise for periods longer than 15 minutes. Maximal efforts, such as the APFT 2-mile run are not permitted. If, after 3 months, the soldier has not manifested any heat intolerance, the profile may be modified to P-2 (T) and normal unrestricted work permitted. Maximal exertion and significant heat exposure (such as wearing Mission Oriented Protective Posture (MOPP) IV) are still restricted. If the soldier manifests no heat intolerance, including a season of significant environmental heat stress, normal activities can be resumed and the soldier may be returned to duty without a PEB. Any evidence of significant heat intolerance, either during the period of the profile or subsequently, requires a referral to a PEB. (A description of the heat intolerance should be included in the MEB narrative summary.)

3-46. Cold injury

The causes for referral to an MEB are as follows:

a. Frostbite (freezing cold injury).

(1) The definition of frostbite is the consequence of freezing of tissue. First degree frostbite is manifested by superficial injury without blistering. Second degree frostbite is manifested by superficial injury with clear blisters with only epidermal tissue loss. Third degree and fourth degree frostbite are manifested by significant subepidermal tissue loss.

(2) Soldiers with first degree frostbite after clinical healing will be given a permanent P-2 profile permitting the use of extra cold weather protective clothing, including nonregulation items, to be worn under authorized outer garments.

(3) Soldiers with frostbite more than first degree will be given a P-3 profile, renewed as appropriate, for the duration of the cold season restricting them from any exposure to temperatures below 0 degrees C (32 degrees F) and from any activities limited by the remainder of the season. After the cold season, soldiers will be reevaluated and, if appropriate, given the P-2 profile described in (2) above.

(4) Soldiers will be referred to an MEB for recurrent cold injury, recurrent or persistent cold sensitivity despite the P-2 profile, vascular or neuropathic symptoms, or disability due to tissue lost from cold injury.

b. Trench foot (nonfreezing cold injury).

(1) The definition of trench foot is the consequence of prolonged cold immersion of an extremity. It is manifested by maceration of tissue and neurovascular injury.

(2) Soldiers with residual symptoms or significant tissue loss after healing will be referred to an MEB.

c. Accidental hypothermia.

(1) The definition of accidental hypothermia is clinically significant depression of body temperature due to environmental cold exposure.

(2) Soldiers with significant symptoms of cold intolerance or a recurrence of hypothermia after an episode of accidental hypothermia will be referred to an MEB.

Table 3-1
Methods of assessing cardiovascular disability

Class	New York Heart Association Functional Classification	Canadian Cardiovascular Society Functional Classification	Specific activity scale (Goldstein et al: Circulation 64:1227, 1981)	New York Heart Association Functional Classification (Revised)
I.	Patient with cardiac disease but without resulting limitations of physical activity. Ordinary physical activity does not cause undue fatigue, palpitations, dyspnea, or anginal pain.	Ordinary physical activity, such as walking and climbing, stairs, does not cause angina. Angina with strenuous or rapid or prolonged exertion at work or recreation.	Patients can perform to completion any activity requiring 7 metabolic equivalents: for example, can carry 24 lbs up eight steps, carry objects that weigh 80 lbs, do outdoor work. (shovel snow, spade soil), do recreational activities (skiing, basketball, handball, jog, and walk 5 mph).	Cardiac status uncompromised.
II.	Patients with cardiac disease resulting in slight limitation of physical activity. They are comfortable at rest. Ordinary physical activity results in fatigue, palpitation, dyspnea, or anginal pain	Slight limitations of ordinary activity. Walking or climbing stairs rapidly, walking uphill, walking or stair climbing after meals, in cold, in wind, or when under emotional stress, or only during the few hours after awakening. Walking more than 2 blocks on the level and climbing more than one flight of ordinary stairs at a normal pace and in normal conditions.	Patient can perform to completion any activity requiring ≥ 5 metabolic equivalents, but cannot and does not perform to completion activities requiring metabolic equivalents: for example, have sexual intercourse without stopping, garden, rake, weed, roller skate, dance fox trot, walk at 4 mph on level ground.	Slightly compromised.
III.	Patients with cardiac disease resulting in marked limitation of physical activity. They are comfortable at rest. Less than ordinary physical activity causes fatigue, palpitation, dyspnea, or anginal pain.	Marked limitation of ordinary physical activity. Walking one to two blocks on the level and climbing more than one flight in normal conditions.	Patient can perform to completion any activity requiring ≥ 2 metabolic equivalents but cannot and does not perform to completion activities requiring ≥ 5 metabolic equivalents: for example, shower without stopping, strip and make bed, clean windows, walk 2.5 mph, bowl, play golf, dress without stopping.	Moderately compromised.
IV.	Patient with cardiac disease resulting in inability to carry on any physical activity without discomfort. Symptoms of cardiac insufficiency or of the anginal syndrome may be present even at rest. If any physical activity is undertaken, discomfort is increased.	Inability to carry on any physical activity without discomfort—anginal syndrome may be present at rest.	Patient cannot or does not perform to completion activities requiring ≥ 2 metabolic equivalents. Cannot carry activities listed above (specify activity scale, Class III).	Severely compromised.

New York Heart Association Therapeutic Classification

Therapeutic Classification		Revised classification (prognosis)
Class A-	Patients with cardiac disease whose physical activity need not be restricted	Class I—Good.
Class B-	Patients with cardiac disease whose ordinary activity need not be restricted, but who should be advised against severe or competitive physical efforts.	Class II—Good with therapy.
Class C-	Patients with cardiac disease whose ordinary physical activity should be moderately restricted, and whose more strenuous efforts should be discontinued.	Class III—Fair with therapy.
Class D-	Patients with cardiac disease who should be at complete rest, confined to bed or chair.	Class IV—Guarded despite therapy.

METS Equivalents (Required for PEB adjudication)

Table 3-1
Methods of assessing cardiovascular disability—Continued

Class	New York Heart Association Functional Classification	Canadian Cardiovascular Society Functional Classification	Specific activity scale (Goldstein et al: Circulation 64:1227, 1981)	New York Heart Association Functional Classification (Revised)
Class I=8 METS or greater				
Class II=5–8 METS				
Class III=3–5 METS				
Class IV=Less than 3 METS				

Chapter 4
Medical Fitness Standards For Flying Duty

4-1. General

a. In this regulation, the term “flying duty” is synonymous with “flight status” and “aviation service.” The term “aircrew” or “aircrew member” applies to rated and non-rated personnel in aviation service and air traffic control. All provisions apply to the USAR and the ARNGUS.

b. The Aviation Medicine Consultant (AMC) to TSG will recommend to TSG a senior specialist in aerospace medicine to be placed on orders for designation as the Aeromedical Review Authority. Responsibilities will include all administrative actions and medical fitness standards for flying duty for all active and RC Army aviators. The Aeromedical Review Authority is located at Building 301, Dustoff Avenue, Fort Rucker, AL 36362-5333.

c. Provisions in this chapter are subject to NATO Standardization Agreement (STANAG) 3526, which applies to allied nation aircrews serving with U.S. Forces or attending U.S. Army training programs, and to U.S. aircrews serving with foreign forces.

d. This chapter lists medical conditions and physical defects that are causes for rejection in selection, training, and retention of—

- (1) Army aviators.
- (2) DA civilian (DAC) pilots and contract civilian pilots who are employed by firms under contract to DA.
- (3) Flight surgeons (FSs) (MOS 61N) and aeromedical physician assistants (APAs).
- (4) Military, DAC, and DA contract air traffic controllers (ATCs).
- (5) Individuals ordered by competent authority to participate in regular flights as nonrated aircrew.
- (6) Applicants for special flight training programs directed by DA or National Guard Bureau (NGB), such as Army ROTC or USMA flight training programs.
- (7) Aircrew of allied host nations or U.S. Government agencies other than DA who are flying Army aircraft, unless superseded by agreements with that nation or agency.

e. A failure to meet medical standards for flying duties remains disqualifying for flying duties until reviewed by the Aeromedical Review Authority. The Aeromedical Review Authority may recommend qualified, qualified with waiver, or medical suspension from aviation service. The Aeromedical Review Authority issues Aeromedical Policy Letters (APLs) and Aeromedical Technical Bulletins (ATBs) that provide detailed recommendations for specific, common disqualifications. Refer all questionable cases to the Aeromedical Review Authority, Fort Rucker, AL 36362-5333.

4-2. Classes of medical standards for flying and applicability

The classes of medical fitness standards for flying duties are as follows:

- a. Class 1 (warrant officer candidate) or Class 1A (commissioned officer or cadet) standards apply to—
 - (1) Applicants for aviator training. (See also AR 611-85 and AR 611-110.)
 - (2) Applicants for special flight training programs directed by DA or NGB, such as Army ROTC or USMA flight training programs.
 - (3) Other non-U.S. Army personnel selected for training until the beginning of training at aircraft controls, or as determined by Chief, Army Aviation Branch.
- b. Class 2 standards apply to—
 - (1) Student aviators after beginning training at aircraft controls or as determined by Chief, Army Aviation Branch.
 - (2) Rated Army aviators (AR 600-105).
 - (3) DAC pilots and contract civilian pilots who are employed by firms under contract to the DA that conduct flight operations or training, utilizing Army aircraft or aircraft leased by the Army. (See para 4-31.)
 - (4) Army aviators considered for return to aviation service.
 - (5) Senior career officers. When directed by DA or NGB under special procurement programs for initial Army aviation flight training, selected senior officers of the Army may be medically qualified under Army Class 2 medical standards.



AMERICAN PSYCHOLOGICAL ASSOCIATION

March 26, 2018

APA Statement Regarding Transgender Individuals Serving in Military

WASHINGTON — Following is a statement by Arthur C. Evans Jr., PhD, regarding President Trump's placing new limits on transgender individuals serving in the military:

"The American Psychological Association is 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."

"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. The science is clear that individuals who are adequately treated for gender dysphoria should not be considered mentally unstable. Additionally, the incidence of gender dysphoria is extremely low."

"No scientific evidence has shown that allowing transgender people to serve in the armed forces has an adverse impact on readiness or unit cohesion. What research does show is that discrimination and stigma undermine morale and readiness by creating a significant source of stress for sexual minorities that can harm their health and well-being."

APA's governing Council of Representatives adopted a resolution (<http://www.apa.org/about/policy/chapter-12b.aspx#transgender>) in 2008 supporting full equality for transgender and gender-variant people and calling for legal and social recognition of transgender individuals.

The American Psychological Association, in Washington, D.C., is the largest scientific and professional organization representing psychology in the United States. APA's membership includes nearly 115,700 researchers, educators, clinicians, consultants and students. Through its divisions in 54 subfields of psychology and affiliations with 60 state, territorial and Canadian provincial associations, APA works to advance the creation, communication and application of psychological knowledge to benefit society and improve people's lives.

Find this article at:

<http://www.apa.org/news/press/releases/2018/03/transgender-military.aspx>



JAMES L. MADARA, MD
EXECUTIVE VICE PRESIDENT, CEO

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April 3, 2018

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

Dear Secretary Mattis:

On behalf of the physician and medical student members of the American Medical Association (AMA), I am writing to express our concern about the new policy recently approved by President Trump imposing limits on transgender individuals serving in the military. This new policy, based on recommendations you made in February to President Trump, states that “transgender persons with a history or diagnosis of gender dysphoria—individuals who the policies state may require substantial medical treatment, including medications and surgery—are disqualified from military service except under certain limited circumstances” (Presidential Memorandum for the Secretary of Defense and the Secretary of Homeland Security Regarding Military Service by Transgender Individuals, May 23, 2018).

We believe there is no medically valid reason—including a diagnosis of gender dysphoria—to exclude transgender individuals from military service. Transgender individuals have served, and continue to serve, our country with honor, and we believe they should be allowed to continue doing so. We share [the concerns recently expressed by former Surgeons General M. Joycelyn Elders and David Satcher](#) that the Defense Department’s February 22, 2018, Memorandum for the President mischaracterized and rejected the wide body of peer-reviewed research on the effectiveness of transgender medical care. This research, demonstrating that medical care for gender dysphoria is effective, was the rationale for the AMA’s adoption of policy by our House of Delegates in 2015, that there is no medically valid reason to exclude transgender individuals from military service.

The AMA also supports public and private health insurance coverage for treatment of gender dysphoria as recommended by the patient’s physician. We support the finding of the RAND study conducted for the Department of Defense on the impact of transgender individuals in the military that the financial cost is negligible and a rounding error in the defense budget. It should not be used as a reason to deny patriotic Americans an opportunity to serve their country. We should be honoring their service.

Sincerely,

A handwritten signature in black ink that reads "James L. Madara". The signature is written in a cursive, flowing style.

James L. Madara, MD



OBJECTIVE ANALYSIS.
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by [Agnes Gereben Schaefer](#)



Agnes Gereben Schaefer
Senior Political Scientist

In September 2015, the Department of Defense (DoD) asked the RAND Corporation's National Defense Research Institute (NDRI), a federally funded research and development center sponsored by the Office of the Secretary of Defense, to initiate a study on the implications of allowing transgender personnel to serve openly. RAND NDRI is regularly called on by DoD to undertake analysis on sensitive policy issues when independence and objectivity are required.

The results of the study were briefed to the Under Secretary of Defense for Personnel and Readiness, as well as to the DoD Transgender Service Review Working Group, which was composed of military and civilian personnel representing all the military services and the Joint Staff. This DoD Working Group was charged by Secretary of Defense Ashton Carter to study the

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JA743

policy and readiness implications of allowing transgender persons to serve openly in the military. The findings from the RAND study and the DoD Working Group's research, as well as the advice of the Service Chiefs, were forwarded to Secretary Carter, and in July 2016 he decided to lift the ban on transgender personnel.

Since its publication, the research has been widely viewed as the most comprehensive and authoritative analysis on this topic.

RAND stands by the study's research approach, analysis, and findings. In light of recent references to our research, we offer the following points of clarification.

First, it is important to clarify that DoD did not ask RAND to recommend whether or not the ban on transgender personnel should be lifted. Instead, the Office of the Under Secretary of Defense for Personnel and Readiness asked RAND to conduct research on seven questions: What are the health care needs of the transgender population? What is the estimated transgender population in the U.S. military? How many transgender service members are likely to seek gender transition-related treatments? What are the costs associated with extending health care coverage for gender transition-related treatments? What are the potential readiness implications of allowing transgender service members to serve openly? What lessons can be learned from foreign militaries that permit transgender personnel to serve openly? Which DoD policies would need to be changed if transgender service members were allowed to serve openly?

Given the complexity of these multi-faceted research questions, RAND assembled a multidisciplinary research team composed of experts in areas including military personnel policy, psychiatry, the military health system, health economics, military readiness, unit cohesion, and lessons learned from previous integration efforts in the military. Most of the members of the team had M.D.s or Ph.D.s, and two members of the research team were combat veterans.

Second, while there was limited data available related to some of the research questions DoD asked us to answer, and we aimed to provide DoD with a thorough analysis of the available data, we highlighted and caveated those limitations throughout the report so that DoD could understand the limitations and factor them into its decisionmaking process.

Third, our study reported on the health care needs, medical standards, and treatment options for gender dysphoria that were current and endorsed by professional medical associations

including the American Medical Association, American Psychological Association, and American Association of Family Physicians at the time. The study notes that under the recently established criteria and terminology outlined in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, transgender status alone does not constitute a medical condition. Under these guidelines, only transgender individuals who experience clinically significant distress are considered to have a medical condition called gender dysphoria. It is unknown what proportion of transgender individuals experience dysphoria.

Fourth, regarding our analysis of the potential readiness implications of allowing transgender service members to serve openly, DoD specifically asked us to provide a detailed analysis of the potential implications that a decision to allow transgender personnel to serve openly would have on nondeployability rates. This was a particularly salient concern for DoD because constraints associated with transition-related medical treatments typically include a postoperative recovery period that would prevent any work and a period of restricted physical activity that would prevent deployment. Our analysis estimated that the readiness impact of transition-related treatment would lead to a loss of less than 0.0015 percent of total available labor-years in the active component.

Fifth, when written, our study provided the most comprehensive analysis of the policies, best practices, and lessons learned from all 18 foreign militaries that allowed transgender service members to serve openly. We found little publicly available data on most countries; therefore, the study provided an in-depth analysis of the policies of the four countries (Australia, Canada, Israel, and the United Kingdom) with the most well-developed and publicly available policies on transgender military personnel. The data indicated that there has been no significant effect of openly serving transgender service members on cohesion, operational effectiveness, or readiness. Findings on the effects of open transgender service on cohesion and readiness drew largely from research articles that specifically examined this question using interviews and an analysis of studies completed by the foreign militaries themselves. We did note that the militaries that are examined in-depth have had fairly low numbers of openly serving transgender personnel, and this may be a factor in the limited effect on operational readiness and cohesion.

Lastly, our analysis of the potential impacts on unit cohesion includes evidence from the available research on foreign militaries. However, the study does note that we do not have

direct survey evidence or other data to directly assess the impacts on the U.S. military. The study also presents findings related to unit cohesion from previous DoD efforts to integrate gays and lesbians, and women into combat positions.

Our study also cites previous research that has found that while *task cohesion* (the shared commitment among members to achieving a goal that requires the collective efforts of the group) has long been recognized as a key contributor to unit effectiveness, evidence that social cohesion (the nature and quality of the emotional bonds of friendship, liking, caring, and closeness among group members) directly affects unit performance is mixed. In other words, unit members' ability to contribute effectively to the efforts of the group matters more for unit performance than unit member similarity or liking for one another.

Agnes Schaefer is a senior political scientist at the nonprofit, nonpartisan RAND Corporation.

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REPORT OF THE TRANSGENDER MILITARY SERVICE COMMISSION

March, 2014

JA748



Report of the Transgender Military Service Commission

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A nonpartisan national commission, comprised of medical and psychological experts, to consider whether Pentagon policies that exclude transgender service members are based on medically sound reasons.

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EXECUTIVE SUMMARY

- 1) This commission has been convened to determine whether US military policies that ban transgender service members are based on medically sound reasons. We find that there is no compelling medical rationale for banning transgender military service, and that eliminating the ban would advance a number of military interests, including enabling commanders to better care for their service members.
- 2) Medical regulations requiring the discharge of all transgender personnel are inconsistent with how the military regulates medical and psychological conditions, and arbitrary in that medical conditions related to transgender identity appear to be the only gender-related conditions requiring discharge irrespective of fitness for duty.
- 3) The American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders 5th ed. (DSM-5)* no longer classifies gender non-conformity as a mental illness. While military regulations are updated to reflect revisions of DSM for non-transgender-related conditions, regulations have not been amended to reflect scientific consensus about gender non-conformity.
- 4) The prohibition on medically necessary cross-sex hormone treatment is inconsistent with the fact that many non-transgender military personnel rely on prescribed medications, including anabolic steroids, even while deployed in combat zones, and is based on inaccurate understandings of the complexity, risks and efficacy of such treatments.
- 5) Regulations that prohibit transgender service members from obtaining medically necessary gender-confirming surgery are harmful to the service members and inconsistent with policy concerning other reconstructive surgeries that service members are allowed to have.
- 6) The ban on transgender military service compromises continuity of care between the Military Health Service and Veterans Health Administration, undermining an important goal that officials from both systems have endorsed.
- 7) Military regulations should be stripped of enlistment disqualifications for transgender conditions, whether defined physically or mentally, as well as retention provisions that specify gender identity disorder as grounds for administrative separation. Transgender personnel should be treated in accordance with established medical standards of care, as is done with all other medical conditions.
- 8) Senior leaders should rely on the experiences and standards of other militaries and US federal agencies in formulating administrative policy to address fitness testing, records and identification, uniforms, housing and privacy.

1) OVERVIEW

This Commission came together with the modest goal of assessing whether US military policies that ban transgender service members are based on medically sound rationales.¹ In the process of answering this question, we came to have a deeper appreciation for the consequences of these policies, and we were troubled by what we learned. We determined not only that there is no compelling medical reason for the ban, but also that the ban itself is an expensive, damaging and unfair barrier to health care access for the approximately 15,450 transgender personnel who serve currently in the active, Guard and reserve components.² Medical regulations requiring the discharge of transgender personnel are inconsistent with how the military regulates all other medical and psychological conditions, and transgender-related conditions appear to be the only gender-related conditions that require discharge irrespective of fitness for duty.

Medical standards for enlistment are generally designed to ensure that applicants are free of conditions that would interfere with duty performance, endanger oneself or others, or impose undue burdens for medical care. The regulations, however, bar the enlistment of transgender individuals regardless of ability to perform or degree of medical risk. Unlike other medical disqualifications, which are based on modern medical expertise and military experience, the transgender enlistment bar is based on standards that are decades out of date.

Medical standards for retention are generally designed to identify permanent medical conditions that cannot be corrected and are likely to affect, or have already affected, performance of duty. Existing regulations, however, give commanders complete discretion to separate transgender individuals without medical review (“for the convenience of the government”), regardless of ability to perform or degree of medical risk. As with the enlistment regulations, the retention regulations are inconsistent with modern medical understanding. They include transgender conditions on a list of disqualifying, maladaptive traits assumed to be resistant to treatment and inconsistent with either fitness for duty or good order and discipline. By regulation, service members are simultaneously barred from treatment and also presumed to be unfit, despite the lack of medical evidence to support the policy.

Research shows that depriving transgender service members of medically necessary health care poses significant obstacles to their well-being.³ According to one recent study, “Mental health, medical and substance abuse services obtained outside of the military are supposed to be communicated back to the military, so transgender people who seek these services elsewhere still risk exposure... This leads individuals to go without treatment, allowing symptoms to exacerbate, and causing some to treat symptoms with alcohol or drugs, which could lead to substance abuse or dependence.”⁴ Research has confirmed, as well, that policies that force individuals to conceal their identities can have significant mental health consequences.⁵

Transgender medical care should be managed in terms of the same standards that apply to all medical care, and there is no medical reason to presume transgender individuals are unfit for duty. Their medical care is no more specialized or difficult than other sophisticated medical care the military system routinely provides. Transgender service members should not be required to meet a higher standard of medical self-sufficiency than the military requires of anyone

else. Existing policies and practices are adequate for identifying rare and extreme circumstances that may affect duty performance.

Removal of the military's blanket ban on transgender service members would improve health outcomes, enable commanders to better care for their troops, and reflect the federal government's commitment to reducing disparities in health care access for transgender people. According to a 2013 resolution introduced by the United States and passed unanimously by delegates to the Pan American Health Organization, member states agree to "work to promote the delivery of health services to all people...taking into account the diversity of gender expression and gender identity" and to "give priority to promoting equal access to health services in national policies."⁶

In 2012, a federal appellate court affirmed that denying prisoners medically necessary health care for transgender-related conditions violates the 8th Amendment's prohibition against cruel treatment.⁷ While acknowledging significant differences that distinguish military and prison environments, when it comes to accessing health care, US service members' dependence on the Military Health System resembles prisoners' reliance on prison medical facilities. The ban on transgender military service should be eliminated, and the health care needs of transgender personnel should be addressed in the same way that medical needs of non-transgender personnel are managed.

2) DEMOGRAPHICS

The term *transgender* is a broad, umbrella term that refers to individuals who do not identify with the physical gender that they were assigned at birth. Being transgender does not mean that one has already transitioned to a different gender, or that such a transition will occur in the future. It means recognizing that the gender one has always had does not match the physical gender that was assigned at birth. The transgender community includes people who have already transitioned to the other gender, those who have not yet transitioned but who plan to do so, those who identify with the other gender but do not wish to transition, and others.⁸ Individuals assigned female at birth who identify as male are referred to as female-to-male (FTM), while individuals assigned male at birth who identify as female are referred to as male-to-female (MTF).⁹ There is no single medical treatment for transgender individuals who undergo gender transition. Surgical transition refers to the use of gender-confirming surgery to change one's gender, while medical transition refers to the use of surgery and/or cross-sex hormone treatment (CSH) to do so.

Social scientists estimate that there are 700,000 transgender American adults, representing .3 percent of the nation's adult population. In addition, Dr. Gary Gates and Dr. Jody Herman estimate that 15,450 transgender service members serve currently in the US armed forces, including 8,800 in the active component and 6,650 in the National Guard and reserve components, and that 134,350 veterans are transgender. Transgender adult citizens are more than twice as likely as non-transgender Americans (2.2 percent transgender vs .9 percent non-transgender) to serve currently in the military.¹⁰ Survey data suggest that approximately 90 percent of transgender service members are MTF transgender women.¹¹

Despite their service in the armed forces, little is known about transgender service members. Almost no scholarly research has been published on transgender military service, and the available body of literature includes just seven peer-reviewed and three non-peer-reviewed studies.¹² Of those ten studies, seven offer original empirical research, including five that include data on active-duty service members and veterans and two that focus exclusively on veterans.

3) REGULATIONS

3.a) Rationale for Regulations that Ban Transgender Service Members

Four themes characterize regulations banning transgender service members. In particular, the rules are (1) binding, in that there is no option or procedure for commanders or doctors to waive rules that disqualify transgender individuals for military service, either for accession or retention; (2) decentralized, in that they are articulated in different provisions of various Department of Defense Instructions; (3) unclear, in that regulatory terminology that references transgender identity is inconsistent; and (4) regulatory, not statutory. Because policies that prohibit transgender service are spelled out in Defense Department as well as service-specific regulations, but not in congressional statute, the Commander in Chief could change policy without obtaining congressional approval. That said, provisions of the Uniform Code of Military Justice that are not specific to transgender service members, such as conduct unbecoming, have been used as the basis for discharging these service members.

US military policies that ban transgender service members do not include rationales that explain why the armed forces prohibit them from serving, although the policies are embedded in comprehensive medical and other regulations that are designed, broadly speaking, to preserve health and good order. While regulations do not offer reasons for banning transgender service members, several transgender individuals have challenged the ban's lawfulness in court, and military representatives have presented rationales via testimony and affidavit. In *Doe v. Alexander* (1981), a federal district court noted "evidence that transsexuals would require medical maintenance to ensure their correct hormonal balances and continued psychological treatment and that the army would have to acquire the facilities and expertise to treat the endocrinological complications which may stem from the hormone therapy. The army might well conclude that those factors could cause plaintiff to lose excessive duty time and impair her ability to serve in all corners of the globe."¹³ In testimony for *Leyland v. Orr* (1987), an Air Force consulting physician testified that assigning individuals who had undergone a sex change operation to remote geographic areas, "would be equivalent to placing an individual with known coronary artery disease in a remote location without readily available coronary care."¹⁴

Finally, in *DeGroat v. Townsend* (2007), an Air Force consulting physician stated that,

The known and potential complications of sex change operations are many and varied and can affect the long term health and duty performance of the individual. Additionally, many of these patients are maintained on hormone therapy which independently has potential side effects. Further, individuals undergoing male to female gender conversions may encounter prostatic diseases which are more difficult to diagnose and to manage. Air Force duties require individuals from all

career fields to serve in a variety of locations around the globe, often changing assignments on short-term notice. Military medical providers in the field are not familiar with the problems these patients may encounter. Individuals who have undergone sex change procedures would not be qualified for world-wide service and if the Air Force assigned them even to remote domestic locations they would be without access to potentially acute specialized tertiary medical care, which would only be available at major medical centers. Overall, it is neither in the best interest of the individual patient to have their access to necessary health care limited during potential Air Force duties, nor is it in the best interest of the Air Force to have to provide the medical care that these individuals may require.¹⁵

Scholars have been unable to uncover any documentation on the history of the rules or the reasons why they were enacted. Hence, the trial records discussed above offer the only available official rationales for US military policies banning transgender service members.

3.b) Regulations Banning Transgender Service Members

Policies governing transgender service can be broken down into two categories: accession disqualifications and retention disqualifications.

Accession disqualification: Department of Defense Instruction (DODI) 6130.03 establishes medical standards for entry into military service.¹⁶ The purpose of the Instruction, as explained in an introductory section, is to ensure that individuals under consideration are free of contagious diseases that could endanger the health of other personnel, free of conditions or defects that may require excessive time lost from duty or that probably would result in separation, and medically capable of completing required training, adapting to military environments without geographic limitations, and performing duties without aggravating existing conditions.¹⁷

Enclosure 4 of DODI 6130.03 contains a list of disqualifying physical and mental conditions that preclude applicants from joining the military, and the list includes the following conditions, some of which are transgender-related: 14f. Female genitalia: History of major abnormalities or defects of the genitalia including but not limited to change of sex, hermaphroditism, pseudohermaphroditism, or pure gonadal dysgenesis...15r. Male genitalia: History of major abnormalities or defects of the genitalia such as change of sex, hermaphroditism, pseudohermaphroditism, or pure gonadal dysgenesis...25l. Endocrine and metabolic: Male hypogonadism...29r. Learning, psychiatric and behavioral: Current or history of psychosexual conditions, including but not limited to transsexualism, exhibitionism, transvestism, voyeurism, and other paraphilias.¹⁸

Medical regulations generally allow for waivers of accession standards under some circumstances. Under DODI 6130.03, the services shall "Authorize the waiver of the standards [for entry] in individual cases for applicable reasons and ensure uniform waiver determinations."¹⁹ Service-specific implementing rules affirm the possibility of accession waivers. By Army rules, for example, "Examinees initially reported as medically unacceptable by reason of medical unfitness...may request a waiver of the medical fitness standards in accordance with the basic administrative directive governing the personnel action."²⁰

While accession standards allow for the possibility of waivers, they also specify that accession waivers will not be granted for conditions that would disqualify an individual for the possibility of retention: "Waivers for initial enlistment or appointment, including entrance and retention in officer procurement programs, will not be granted if the applicant does not meet the retention standards."²¹ As discussed below, because some conditions related to transgender identity are grounds for discharge, and because recruiters cannot waive a condition upon enlistment that would be disqualifying for retention, transgender individuals cannot obtain medical waivers for entrance into the military. In response to a 2013 Freedom of Information Act (FOIA) request, the Pentagon disclosed that between 2008 and 2012, three individuals had been denied entry into the military for transgender-related conditions. We are unaware of any instances in which transgender-related conditions have been waived for accession.

Retention disqualification: Medical standards that apply to the retention of individuals already in military service generally are more accommodating and flexible than accession standards, due to the investment that the military makes in training. DODI 1332.38 contains rules for retiring or separating service members because of physical disability, and includes an Enclosure 4 (similar to the Enclosure 4 of DODI 6130.03 discussed above) listing medical conditions and physical and psychiatric diagnoses that require referral for physical disability evaluation.²²

Not all medical conditions, however, are eligible for physical disability evaluation. Unlike regulations governing entry, regulations governing retention divide potentially disqualifying conditions into two tracks. Individuals with conditions deemed "physical disabilities" (Enclosure 4 conditions) are tracked into a medical system of physical disability evaluation, leading to a determination of fitness for duty or entitlement to benefits for medical separation or retirement. However, service members with conditions "not constituting a physical disability" (Enclosure 5 conditions) can be separated administratively from military service at a commander's discretion, without the same opportunity to demonstrate medical fitness for duty or eligibility for disability compensation. Enclosure 5 of DODI 1332.38 diverts service members out of the medicine-based physical disability system and into the commander-based system for administrative separation, and renders them ineligible for physical disability evaluation. Enclosure 5 lists more than twenty conditions and circumstances defined by the regulation as "not constituting a physical disability," including "Sexual Gender and Identity Disorders, including Sexual Dysfunctions and Paraphilias."²³

DODI 1332.14 controls administrative separations for enlisted persons (DODI 1332.30 controls for officers), and the policies behind administrative separation emphasize conduct and discipline, not medical fitness.²⁴ A service member may be separated for the convenience of the government and at the discretion of a commander for "other designated physical or mental conditions," a category defined to include "sexual gender and identity disorders."²⁵ However, the regulation contains no specific guidance for determining whether, or under what circumstances, "sexual gender and identity disorders" interfere with assignment or performance of duty. The regulation appears to conclude that any of the conditions listed in DODI 1332.38 Enclosure 5 automatically meet that standard, giving commanders unguided discretion to proceed. Unlike the regulation governing physical disability evaluation, DODI 1332.14 does not offer service members the

opportunity to concede that a condition exists and then to demonstrate that it does not affect their fitness for duty.

Commanders do not of course seek out every individual with an Enclosure 5 condition and discharge them, and whether a "convenience of the government" separation will be initiated, or not, is at the discretion of the commander. But when Enclosure 5 of DODI 1332.38 lists "sexual gender and identity disorders" as conditions that are inherently maladaptive in military service, that is a strong statement about disqualification, and there is no suggestion in any of the regulations that transgender-related conditions may under some circumstances be consistent with military service. To the contrary, the regulations suggest that separations for transgender-related conditions would always be appropriate.

Some commanders do appear to believe that they have the discretion to retain transgender service members in the same way that they may retain people with other Enclosure 5 conditions if they are performing well enough. But that is not a distinction written into the regulations. In response to a recent FOIA request for discharge data, a Pentagon spokesperson said that the military does not track the number of service members who have been separated for transgender-related reasons. We are aware, however, of approximately two dozen service members who have been discharged because of their transgender identity in recent years.

In addition to the accession and retention regulations discussed above, some aspects of transgender military service are governed by other rules. For example, transgender service members may violate orders for receiving undisclosed or prohibited medical treatment if they obtain health care from non-military doctors without receiving permission from commanders.²⁶

4) MEDICAL ASPECTS OF TRANSGENDER SERVICE

4.a) Mental Health

As discussed above, some regulatory provisions that prohibit transgender service emphasize psychological factors. In turn, scholars have found that some transgender service members report poor mental health. One recent study concluded that the transgender community faces, "elevated rates of suicide, risk for HIV infection, exposure to trauma, and other health challenges."²⁷ In a sample of 1,261 transgender respondents with prior military service, 40 percent had attempted suicide.²⁸ Among 70 veterans evaluated for gender identity disorder between 1987 and 2007, 4 percent "had actively harmed their genitals," 61 percent "revealed a history of serious suicidal thoughts," and 43 percent "had additional psychiatric diagnoses exclusive of [gender identity disorder]."²⁹

Despite such data, arguments based on mental health are not convincing rationales for prohibiting transgender military service, and DODI 6130.03 is not consistent with modern medical understanding.³⁰ Indeed, scientists have abandoned psychopathological understandings of transgender identity, and no longer classify gender non-conformity as a mental illness.

"Transsexualism" was eliminated as a diagnosis by the *DSM-IV* in 1994 and replaced by gender identity disorder. Yet *DSM-IV* did not classify gender identity disorder as a paraphilia. In the

newest edition of the *Diagnostic and Statistical Manual (DSM-5)*, gender identity disorder has been replaced with gender dysphoria, a diagnostic term that refers to an incongruence between a person's gender identity and the physical gender that they were assigned at birth, and to clinically significant distress that may follow from that incongruence.³¹ While gender identity disorder was pathologized as an all-encompassing mental illness, gender dysphoria is understood as a condition that is amenable to treatment.³² And, mental health professionals agree that not all transgender individuals suffer from dysphoria.

The World Health Organization's Working Group on the Classification of Sexual Disorders and Sexual Health (WGCSDSH) has recommended that the forthcoming version of the *International Statistical Classification of Diseases and Related Health Problems (ICD-11)*, due for publication in 2015, "abandon the psychopathological model of transgender people based on 1940's conceptualizations of sexual deviance."³³ According to a recent publication by WGCSDSH members, "once-prevailing views that reject the aim of supporting transition are no longer part of the mainstream of either psychiatric or general medical thought and practice...[and] the continued linkage of gender identity diagnoses with paraphilias and diagnoses of sexual dysfunction in the classification system appears to be both outdated and inappropriate."³⁴

The reclassification of transgender identity in both DSM and ICD is based, in part, on the understanding among scientists and medical practitioners that distress can be the result of prejudice and stigmatization, not mental illness, and that many individuals who do not identify with the physical gender that they were assigned at birth do not suffer from clinically significant distress, and therefore do not have a medical or psychological condition.³⁵ WGCSDSH members wrote recently that, "there are individuals who today present for gender reassignment who may be neither distressed nor impaired."³⁶ The high reported rates of distress among transgender veterans and service members have been based on clinical samples that over-represented patients requiring psychological care. And, a significant body of evidence shows that treatment can alleviate symptoms among those who do experience distress. A meta-analysis of more than 2,000 patients in 79 studies published between 1961 and 1991 found "Favorable effects of therapies that included both hormones and surgery...Most patients reported improved psychosocial outcomes, ranging between 87% for MTF patients and 97% for FTM patients."³⁷ Satisfaction rates have increased over time: "studies have been reporting a steady improvement in outcomes as the field becomes more advanced."³⁸

Defense Department rules concerning mental health, deployment and fitness for duty do not regulate gender identity in a manner that is consistent with the management of other psychological conditions, and have the effect of singling out transgender personnel for punishment even when they are mentally healthy. For example, DODI 6130.03 prohibits individuals suffering from serious mental illnesses such as autistic, schizophrenic and delusional disorders from enlisting in the armed forces. Yet for less serious disorders, regulations strike a careful balance between admitting those whose conditions can be managed without imposing undue burdens on commanders or doctors while excluding those whose conditions would impair their service. Thus, individuals with Attention Deficit Hyperactivity Disorder are prohibited from enlisting unless they meet five criteria including documenting that they maintained a 2.0 grade point average after the age of 14. Similarly, individuals with simple phobias are banned from

enlisting unless they meet three criteria including documenting that they have not required medication for the past 24 continuous months.

Retention regulations strike a balance as well. For those who develop mood or anxiety disorders while in the military, regulations require a referral for physical disability evaluation only if their condition requires extended or recurrent hospitalization or interferes with duty performance. And, service members requiring medication for mood and anxiety disorders are not categorically barred from deployment. The determination depends on the seriousness and stability of the condition, logistical difficulties in providing medication, and the need for clinical monitoring.

Finally, empirical data suggest that many non-transgender service members continue to serve despite psychological conditions that may not be as amenable to treatment as gender dysphoria. A 2012 meta-analysis of available scholarship estimated that 5.7 percent of active-duty service members who had never been deployed suffered from major depressive disorder, and that the prevalence rate among deployed service members was approximately 12 percent.³⁹ In 2009, at least 15,328 service members were hospitalized for mental health disorders, and the *Los Angeles Times* reported in 2012 that, “110,000 active-duty Army troops last year were taking prescribed antidepressants, narcotics, sedatives, antipsychotics and anti-anxiety drugs.”⁴⁰ According to the Congressional Research Service, “Between 2001 and 2011...[a] total of 936,283 servicemembers, or former servicemembers during their period of service, have been diagnosed with at least one mental disorder over this time period...Nearly 49% of these servicemembers were diagnosed with more than one mental disorder.”⁴¹ During manpower shortages, non-transgender individuals whose psychological well-being has not met entrance standards outlined in DODI 6130.03 have been able to obtain waivers allowing them to enlist in the military. According to the National Academy of Sciences, 1,468 of the 4,303 applicants (34 percent) who failed to meet psychiatric entrance standards from May 1, 2003, thru April 30, 2005, received waivers.⁴²

Despite its legitimate need to screen out individuals suffering from mental illnesses that would impair their service, the Defense Department allows those with manageable conditions to enlist and serve. For psychological conditions that fall short of schizophrenia, autism, and other serious illnesses, military regulations strike a thoughtful balance between these two goals. In contrast, Defense Department regulations that govern service by transgender personnel, who frequently do not suffer from distress, make no such distinction, banning all transgender individuals who seek entrance into the military and requiring the automatic discharge of all transgender personnel. And, military regulations conflate transgender identity with mental illness, even though APA and WHO have abandoned psychopathological models, and even though scientists have concluded that transgender and transsexual identity do not always entail distress and that treatments are effective for alleviating symptoms among those who do experience distress.

The British regulatory provision on mental health and transgender military service may warrant consideration at this point: “Although transsexual people generally may have an increased risk of suicide, depression and self-harm, transsexual applicants should not automatically be referred to a Service Psychiatrist. Transsexual applicants with no history of mental health problems or deliberate self-harm who meet other fitness standards should be passed as being fit to join the Armed Forces.”⁴³

4.b) Cross-Sex Hormone Treatment

Although regulations prohibit service members from intervening surgically to modify their genitals, they are not prohibited explicitly from obtaining cross-sex hormone treatment. That said, the use of hormones to modify primary or secondary sex characteristics would almost certainly constitute evidence of having a transgender identity, which is grounds for discharge.

Many, but not all, transgender people wish to take cross-sex hormones in order to achieve feminization or masculinization of their hair and fat distribution, genitalia, and musculature, and to achieve and maintain a gender presentation consistent with their gender identity. Hormonal therapy for male-to-female (MTF) reassignment involves medications that block the production and effects of testosterone (anti-androgen therapy) and simultaneously produce feminizing effects (estrogen therapy). Several classes of medications decrease testosterone level. Spironolactone is generally safe and inexpensive and is most commonly used. Most primary care providers are familiar with its use, as it is commonly prescribed for other conditions. Spironolactone decreases libido, prostate size, erections and the growth of hair on the face and body, and causes some breast growth.

Estrogens that augment breast size and redistribute body fat are the main medications that promote feminization. Generally, feminizing effects are first noticeable in three to six months with an expected maximum effect after two to three years of treatment. That said, the degree and timing of the changes can differ from person to person. For female-to-male (FTM) patients, the main treatment for hormonal reassignment is testosterone, which can be administered through patches, gels, or injection and which usually produces satisfactory results. Masculinizing hormone therapy tends to lower the voice, produce body and facial hair, enhance upper body musculature and strength, and it also ends menses. Most effects take place beginning at eight weeks and maximize at about two years and vary depending on age and genetic make-up.

Cross-sex hormone administration is currently an off-label use of both estrogens and androgens, and entails some degree of risk, dependent on the type of medication, dose, route of administration, and patient's age, health, family history and health habits.⁴⁴ Feminizing hormones are associated with increased risk of weight gain, hypertriglyceridemia, gallstones and elevated liver enzymes. Oral estrogen may increase risk for venous thromboembolic disease and Type 2 diabetes, though this effect is attenuated for transdermal estrogen. The most serious risks of masculinizing hormones are weight gain, acne, sleep apnea, balding, and polycythemia (increased production of red blood cells).⁴⁵ For these reasons, laboratory monitoring is recommended before starting any hormone regimen. Clinical monitoring for effect is not complicated, and involves simple clinical exams and assessments of patient satisfaction. With appropriate training and/or access to expert consultation, independent duty corpsmen, physician assistants, and nurses can supervise hormone treatment initiated by a physician.

Despite the risks associated with hormone replacement, over 50 years of clinical experience have demonstrated that hormones are an effective treatment for gender dysphoria, that psychological benefits follow from cross-sex hormone administration, and that the incidence of complications is quite low.⁴⁶ Studies looking at the risk of blood clots from estrogen found an occurrence of anywhere from 0 to 142 blood clots per 10,000 people per year, with much lower rates in more

recent studies with newer estrogens and non-oral administration.⁴⁷ Clinics with a high volume of transgender patients on estrogen therapy report having “rarely seen adverse effects.”⁴⁸

While the use of hormones may entail some risk, the military consistently retains non-transgender men and women who have conditions that may require hormone replacement. For example, gynecological conditions listed in DODI 1332.38 Enclosure 4 (dysmenorrhea, endometriosis, menopausal syndrome, chronic pelvic pain, hysterectomy, or oophorectomy) require 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 comprehensive 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% (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.⁴⁹ According to Defense Department deployment policy, “There are few medications that are inherently disqualifying for deployment.”⁵⁰ 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.”⁵¹ 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.”⁵² The Military Health Service maintains a sophisticated and effective system for distributing prescription medications to deployed service members worldwide.⁵³

Our nearest allies, Canada, the United Kingdom and Australia, have determined that the risk of deploying transgender service members on cross-sex hormone treatment is low, and post-

transition individuals from Canada and the United Kingdom have completed tours in Afghanistan. The US has deployed a post-operative transgender member of the Military Sealift Command repeatedly on Navy ships.⁵⁴

4.c) Gender-Confirming Surgery

The consensus of the medical profession, as reflected in official policies of the American Medical Association, American Psychological Association and Endocrine Society, is that gender-confirming surgeries can be medically necessary for some transgender individuals to mitigate distress associated with gender dysphoria. Surgeries include chest reconstruction and surgeries to create testes (scrotoplasty) and penises (phalloplasty or metoidioplasty, with or without urethral lengthening) for FTM's, and facial feminization, breast augmentation and surgeries to remove testes (orchiectomy) and create vaginas (vaginoplasty) for MTF's. That said, other transgender individuals do not want or require surgery to alleviate symptoms. A recent study noted that, "As the field matured, health professionals recognized that while many individuals need both hormone therapy and surgery to alleviate their gender dysphoria, others need only one of these treatment options and some need neither. Often with the help of psychotherapy, some individuals integrate their trans- or cross-gender feelings into the gender role they were assigned at birth and do not feel the need to feminize or masculinize their body. For others, changes in gender role and expression are sufficient to alleviate gender dysphoria. Some patients may need hormones, a possible change in gender role, but not surgery; others may need a change in gender role along with surgery but not hormones."⁵⁵

In considering the question of gender-confirming surgery among military personnel, it is important to recognize that regulations permit service members to have elective cosmetic surgeries at military medical facilities, and that some of those elective procedures risk post-operative complications that can be more serious than those of medically necessary gender-confirming surgeries.⁵⁶ For example, the LeFort osteotomy procedures and mandibular osteotomies that service members may elect to have are associated with a number of possible complications based upon the technique, surgical level, and anatomic site at which the surgery/osteotomies are performed.⁵⁷ The incidence of complications in craniofacial surgery depends upon the type of surgery and anatomic location at which the procedure is performed, and infection rates may range from approximately 1 to 3 percent.⁵⁸ Additional complications following mandibular osteotomies, such as sensory deficit, may range between 24 to 85 percent, and unfavorable fractures associated with sagittal split osteotomies may range between 3 to 23 percent.⁵⁹ Other studies cite complication rates of LeFort I osteotomies at 6.4 percent, including anatomic complications, bleeding requiring transfusion, infection, ischemic complications such as aseptic necrosis, and insufficient fixation.⁶⁰ Treatment for these complications may require additional surgical or other interventional procedures, antibiotics, and/or local wound care.

Even if the Military Health Service provided gender-confirming surgeries, however, the demand for such procedures would be low. Research on civilian employers whose insurance plans cover transition-related health care has found that very few employees submit claims for such benefits in any given year. If extrapolated to the active, Guard and reserve components of the military, the data suggest that if transgender service members were allowed to serve, and if the military covered medically necessary care related to gender transition, fewer than 2 percent of transgender service members, a total of 230 individuals, would seek gender-confirming surgery

in any particular year.⁶¹ A recent study reported the average cost of transition-related health care at \$29,929.⁶²

As with any surgical procedures, gender-confirming surgeries entail a risk of short-term and chronic post-operative complications.⁶³ Gender-confirming procedures that pertain to the breasts and chest tend to entail low complication rates. MTFs who undergo breast augmentation as a single surgery often are discharged the same day with pain medication and antibiotics. They leave their dressings intact for three days following surgery and the steri-strips along the points of incision are left in place for another week. Patients are generally comfortable within two days and return to regular activities within two weeks, though doctors recommend that they avoid exerting themselves for a month. Surgeries involving the genitourinary system can be riskier. For MTF individuals, surgery on the external genitalia typically entails a penectomy, bilateral orchiectomy, vaginoplasty (including formation of the labia major and minora), clitoroplasty, and urethral shortening. For vaginoplasty, patients are hospitalized for six to eight days. MTFs who have this surgery will start to feel more comfortable after one to two weeks and will be asked to return to the clinic for periodic follow-up visits, though strenuous activity typically is avoided for three months.

Despite the possibility of post-operative complications, research shows that their incidence rate is low. Across 15 studies from 1986 to 2001, 2.1 percent of patients had rectal-vaginal fistula, 6.2 percent with vaginal stenosis, 5.3 percent had urethral stenosis, 1.9 percent with clitoral necrosis, and 2.7 percent with vaginal prolapse.⁶⁴ A follow-up study of 80 women who had vaginoplasties found three post-operative complications and another determined that among 89 vaginoplasties, there was one major complication.⁶⁵ If transgender service members were allowed to serve and to have gender-confirming surgery while in the military, we estimate that ongoing post-operative complications would render ten MTF service members unfit for duty each year.⁶⁶

For FTM individuals, surgery on the genitalia can include a vaginectomy, either metoidioplasty (clitoral lengthening with or without urethral lengthening) or phalloplasty (either pedicled flap or free tissue transfer, with or without urethral lengthening), and scrotoplasty (with placement of testicular prostheses). Additionally, some individuals undergo hysterectomy and bilateral salpingo-oophorectomy. Phalloplasty is a lengthy multiple stage process, and a majority of FTM patients do not undergo any genital surgery except for a hysterectomy and the removal of the fallopian tubes and ovaries. For FTMs who desire both top (chest) and bottom (genital) surgeries, the timeline is more complex than for MTFs. The chest surgery can be completed at the same time as a hysterectomy and oophorectomy, and in most cases patients are discharged the following day. After a mastectomy, FTMs are back to their normal routines in one to two weeks but should avoid strenuous activity for four weeks. FTMs who have had a hysterectomy or oophorectomy can be required to wait four to six months until they can undergo additional genital surgeries, though hysterectomy and oophorectomy may be performed simultaneously with genital reconstruction. Those having urethral lengthening are generally hospitalized five to ten days. Phalloplasty is more complicated, and the expected hospital time can be ten to fourteen days, with a catheter required for up to three weeks.⁶⁷

Research suggests that a minority of individuals having female-to-male genital surgery may expect long-term complications that would require ongoing care.⁶⁸ In a study of 56 FTM patients

in France who had a phalloplasty, 25 percent had complications including infection and hematoma. In the same study, 29 percent of those with a penile prosthesis had mechanical or infective complications.⁶⁹ In another study in the UK of 115 FTMs who underwent total phallic reconstruction from 1998 to 2008, 10.4 percent experienced partial skin necrosis, 4.3 percent had infection, and 2.6 percent had phalluses that were lost.⁷⁰ That said, very few FTMs have genital surgery, and out of 1,594 FTMs who responded to a recent survey, only 48 individuals (3 percent) had genital surgery, including 24 who had metoidioplasty and phalloplasty, 1 who had just phalloplasty, and 23 who had just metoidioplasty.⁷¹ Given such low demand, even using conservative assumptions it is estimated that only 6 post-operative FTM transgender men would become unfit for duty each year as a result of ongoing, post-operative complications following genital surgery.⁷²

In sum, while the risks of genital surgery are real, they are no higher than risks associated with other genitourinary procedures, and they are lower than risks that accompany some elective non-transgender-related surgeries which the military allows and which, unlike genital surgeries for transgender individuals, are cosmetic and not medically necessary. As well, the low rate of demand for genital surgeries would mean that in absolute and relative terms, allowing such procedures would place almost no burden on the military.

4.d) Deployment

In explaining the military's ban on transgender service, and as noted above, spokespersons have emphasized non-deployability, medical readiness and constraints on fitness for duty as reasons why transgender service members should not be allowed to serve. While personnel policy must of course be designed to promote deployability and medical readiness, arguments invoked to oppose transgender service on these grounds do not withstand scrutiny. With few exceptions, transgender service members are deployable and medically ready. As noted in other sections of this report, cross-sex hormone treatment and mental health considerations do not, in general, impede the deployability of transgender service members, and the public record includes instances in which transgender individuals deployed after having undergone transition.⁷³ With two exceptions, all transgender service members who are otherwise fit would be as deployable as their non-transgender peers. The first exception is post-operative transgender service members whose genital surgeries result in long-term complications. Using conservative assumptions, as noted earlier, an estimated 16 post-operative service members (ten MTF transgender women and six FTM transgender men) would become permanently undeployable each year as a result of ongoing post-operative medical complications following genital surgery.

The second exception would be those undergoing surgical transition while in service. But the number of service members undergoing surgical transition in any given period would be low, both in relative and absolute terms, either because they would have already transitioned prior to joining the military, would prefer to wait until the end of military service to transition, or would not want to surgically transition, regardless of the timing. As discussed above, if the military's health care program paid for transition-related coverage, fewer than 2 percent of transgender service members, a total of 230 individuals, would seek gender-confirming surgery each year. With very few exceptions, transgender service members would be deployable and medically ready on a continuous basis.

Straightforward and fair-minded regulatory options are available for managing transgender military service and deployability. According to Army regulations, which, as explained above, do not apply to transgender-related conditions, “Personnel who have existing medical conditions may deploy” if deployment is unlikely to aggravate the condition, if an unexpected worsening of the condition would not pose a grave threat, if health care and medications are immediately available in theater, and if “no need for significant duty limitation is imposed by the medical condition.”⁷⁴ British military policy concerning transgender service and deployability is equally sensible: “Applicants who are about to undergo, or are still recovering from surgery to change the external appearance of their body into that of the acquired gender should be graded P8 [medically unfit], as with any other condition that is being treated or requires surgery at the time of application, until they are fully recovered from the surgery.”⁷⁵

Many non-transgender service members are temporarily or permanently non-deployable, but they are not automatically discharged as a result, and military policies accommodate them within reason. Defense Department regulations confirm that when evaluating a service member’s fitness for duty, non-deployability is not grounds for a determination of unfitness: “Inability to perform the duties of his or her office, grade, rank, or rating in every geographic location and under every conceivable circumstance will not be the sole basis for a finding of unfitness.”⁷⁶ Even service members who are permanently constrained by serious medical conditions and defects are allowed, under some circumstances, to remain in the military. According to DODI 1332.38, “A service member who has one or more of the listed conditions or physical defects is not automatically unfit,” including systemic diseases such as tuberculosis, leprosy, lymphoma, leukemia, or Hodgkin’s disease.⁷⁷ Regulations provide service members suffering from these and other serious, non-transgender-related, medical conditions with opportunities to serve in a limited capacity and to recover: “A member previously determined unfit and continued in a permanent limited duty status...may be determined fit when the member’s condition has healed or improved so that the member would be capable of performing his or her duties in other than a limited duty status.”⁷⁸

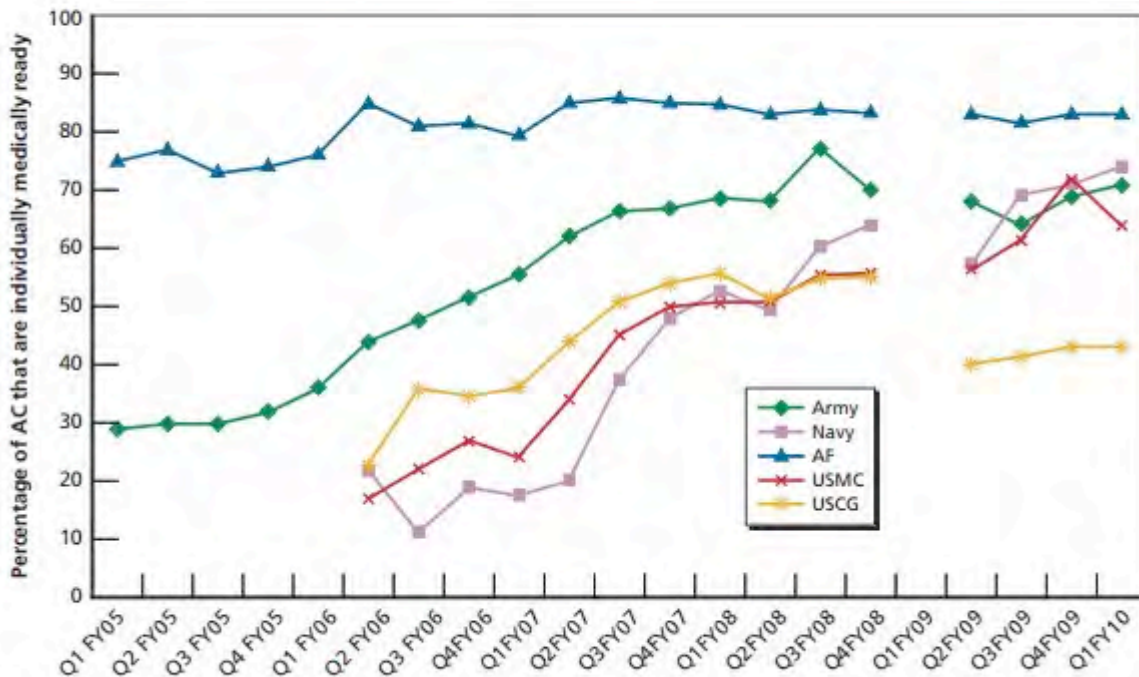
Although deployability is a crucial component of readiness, many non-transgender service members are temporarily or permanently non-deployable. According to a 2011 Defense Department study of health-related behaviors, 16.6 percent of active duty service members (244,000 service members) were unable to deploy during the twelve-month period prior to the survey’s administration, including 22.5 percent of Marines. Service members who were temporarily or permanently non-deployable cited a variety of factors including injuries (31.5 percent), illness or medical problems (23.4 percent), pregnancy (9.9 percent), mental health (8.1 percent), family reasons (3.3 percent) and other unspecified reasons (29.9 percent). Another 2.2 percent of the active component returned early from a deployment during the previous year.⁷⁹

Yet non-transgender, non-deployable service members are not automatically banned, and policies accommodate them to the extent possible. Indeed, the services have adopted leave and assignment policies that provide for prolonged absences and restrictions on duty as a result of medical conditions, as well as life choices that service members make. These include ordinary and advance leave. By law, members of the armed forces are entitled to 30 days of paid leave per year (generally referred to as “ordinary” or “annual” leave), accruing at a rate of 2½ days per month.⁸⁰ Service members need not provide any justification in order to take their annual leave. On the contrary, military commanders “shall encourage and assist all Service members to use” their

leave.⁸¹ Leave is scheduled “consistent with operational requirements, training workloads, and the desires of the Service member,” including “at least one extended leave period each year of approximately 14 consecutive days in length or longer.”⁸²

Service members are permitted to accumulate up to 60 days of ordinary leave under normal circumstances, and may accrue up to 120 days when deployed to certain areas or performing duties designated by the Secretary of Defense.⁸³ They may also be extended up to 30 days of “advance leave” after their ordinary leave has been used up.⁸⁴ While the operational needs of the service are critical considerations, existing military law and policy contemplate that members may be absent from duty for extended periods of time. On average, service members are expected to be absent one month out of every twelve, and military regulations provide for absences of up to 90 days per year without regard to medical needs or other special considerations.

Figure 2: Individual Military Readiness Rates, Active Component, 2005-2010



From *Medical Readiness of the Reserve Component*, Rand Corporation, 2012

Service members may also be granted special leave on top of their ordinary leave. This leave is in addition to the 30 days per year provided for by federal law and is not counted against the member’s ordinary leave balance. Some special leave, like the 60 days allowed on graduation from service academies such as West Point, is clearly not meant to be used more than once.⁸⁵ Other special leave, however, can be used multiple times. For example: the armed forces give special leave to personnel who have children while on active duty. New mothers can take up to 42 days of maternity leave after delivery, and a service member whose spouse gives birth can take 10 days of parental leave (formerly called “paternity leave”).⁸⁶ Adoptive parents are granted 21 days of special leave, which can be taken any time up to one year after the adoption is

complete.⁸⁷ The regulations do not restrict the number of times such leave can be taken. Mothers of newborn children and single parents who adopt also receive a 120-day deferment from assignments overseas where dependents are not authorized to travel typically, imminent danger or hostile fire areas.⁸⁸ Service members can elect to waive the deferment, but are not required to do so.⁸⁹

In addition to the elective leave programs, the services provide for situations in which a member may be absent owing to a medical condition or procedure. A member unable to be present for duty due to hospitalization is excused from duty while hospitalized. The absence is not counted against the member's leave balance. Members recovering from medical procedures or illnesses can also be granted convalescent leave of up to 30 days, as directed by their unit commander or by the commander of their military hospital; this leave is likewise not charged against their ordinary leave.⁹⁰ Longer periods of convalescence may be authorized under procedures determined by each service. In the Army, for example, any period of convalescent leave exceeding 30 days requires approval by the local military hospital commander.⁹¹

Military convalescent leave policy does not discriminate against elective procedures such as Botox treatments and "plastic surgery for unacceptable cosmetic appearance."⁹² Soldiers receiving such procedures may be expected to reimburse the service for their cost, but they "will be afforded convalescent leave and will not be required to use regular leave for their post-operative recovery."⁹³ Finally, the services recognize that members may on occasion have medical conditions which limit their availability to be assigned overseas. Members with such medical conditions may be deferred from reassignment for up to 12 months.⁹⁴ Personnel with more persistent medical needs are given assignment limitation codes and may be excluded from overseas service altogether, while still remaining on active duty.⁹⁵

The concerns of the judge in the *Alexander* case notwithstanding, existing military policies and procedures are designed to ensure a capable fighting force while at the same time anticipating and providing for prolonged absences by service members based on medical conditions, elective medical procedures, personal life choices, and morale and personal welfare. Transgender service members, however, are automatically discharged, in part because of assumed constraints on their deployability and medical readiness, even though such constraints would apply to no more than a few hundred transgender service members at any one time. In contrast, non-transgender service members are given multiple opportunities to demonstrate their deployability and fitness for duty despite medical limitations, and many are retained even if they are not fully deployable or fit. Even those service members deemed permanently unfit "may be retained as an exception to the general policy rule" if their skills or experience warrant continuing service.⁹⁶

4.e) Adaptability and Continuity of Care

While some experts have cited difficulties associated with the acquisition of competence as an argument against transgender military service, acquiring the skills necessary for providing transgender-related health care would advance military interests in a number of ways.⁹⁷ MHS's acquisition of competence would enhance the well-being of the estimated 15,450 transgender service members who serve currently. Medical research has demonstrated that "hormone therapy and surgery have been found to be medically necessary to alleviate gender dysphoria in many

people,” and that treatment is effective in promoting the emotional and physical well-being of transgender individuals.⁹⁸

MHS’s acquisition of competence in the provision of transgender-related health care would promote continuity of care between the MHS and the Veterans Health Administration (VHA). Military as well as VHA officials have acknowledged the importance of continuity of care as a cost-saving measure and because continuity improves health-related outcomes.⁹⁹ And officials representing both medical systems have expressed their commitment to promoting continuity for service members transitioning from the armed forces to veteran status.¹⁰⁰ The regulatory requirement for the VHA to provide all transgender-related health care (aside from gender-confirming surgery) and for the military to deny it undermines continuity of care and imposes unnecessary costs on the VHA. For example, a service member whose depression could have been avoided through the provision of proper care during active service may require, upon separation from the military, significantly more interventions from VHA clinicians than would have been the case if MHS had provided appropriate and timely care.

The VHA, the largest health care system in the country, has provided all transgender-related health care except for gender-confirming surgery since the June, 2011, promulgation of VHA Directive 2011-024, “Providing Health Care for Transgender and Intersex Veterans.” Since that time, VHA has disseminated its new treatment standard via internal mechanisms such as an intranet SharePoint site, and VHA’s Transgender Education Workgroup has produced webinar trainings about cultural competence, mental health and cross-sex hormone treatment. VHA’s Pharmacy Benefits Management Office has collaborated with LGBT Program Coordinators and experts in the Office of Health Equity to develop hormone treatment guidelines which have been distributed widely throughout the system. Permanent, recurring LGBT psychology fellowships have been established at nine VA facilities, and VHA has established four Transgender E-Consultation teams to support health care providers throughout the system. Medical systems of foreign militaries have adapted to the decision to provide transgender-related health care as well. It is clear that MHS will adapt and acquire the competence the VHA has worked to build when the ban on transgender military service is lifted.

MHS has demonstrated repeatedly that it is able to institute rapid, service-wide changes in policy and procedures when faced with new diseases, operational contingencies, legislative mandates, and economic and/or political requirements. For example, the management of battlefield injuries illustrates MHS’s ability to respond to changing external realities, in this case the evolving face of wartime trauma. The Iraq and Afghanistan theaters of operation produced a large number of casualties that were managed with the most modern advancements in diagnosis, transportation and treatment. Lessons learned in all three phases were rapidly transmitted service-wide, permitting bottom-up recommendations for policy changes at the highest levels of MHS and resulting in unprecedented success in reducing morbidity and mortality. Telemedicine expertise at Landstuhl Regional Medicine Center in Germany (usually the first tertiary medical facility to receive battlefield injuries from Iraq or Afghanistan) established a system that “allow[ed] (1) rapid dissemination of lessons learned, (2) establishment of process and problem ownership, (3) rapid dissemination of policy change recommendations, (4) improved medical/surgical management efficiencies, and (5) state-of-the-art innovations in overall trauma care and

development of standardized trauma clinical practice guidelines and protocols to facilitate reductions in mortality and morbidity rates in this unique trauma population.”¹⁰¹

Other examples of significant changes in MHS policies and protocols include: physical profiling of active duty members by measuring fitness capabilities;¹⁰² development of quality assurance programs in the delivery of health care;¹⁰³ development of executive skills required for management of major military treatment facilities;¹⁰⁴ development and evolution of dependent medical care;¹⁰⁵ changing weight standards for active duty personnel;¹⁰⁶ and, of course, the requisite changes following the repeal of “don’t ask, don’t tell.”¹⁰⁷

5) POLICY RECOMMENDATIONS

The regulatory revisions that this commission recommends are simple, straightforward and fair. They improve care for US service members without burdening the military’s pursuit of its vital missions.

Recommendation #1: Lift the ban on transgender military service. With respect to medical regulations, the Commander in Chief should order the Defense Department to eliminate bars to transgender military service by updating enlistment regulations that disqualify conditions that are defined physically (“abnormalities or defects of the genitalia such as change of sex”) and mentally (“psychosexual conditions, including but not limited to transsexualism”). These blanket enlistment bars should be deleted, along with other disqualifications that may arise from medically appropriate treatment of transgender-related conditions, such as amenorrhea or hypogonadism.¹⁰⁸ The Commander in Chief should order the Defense Department to eliminate retention regulations that specify gender identity disorder as a condition justifying administrative separation as well.¹⁰⁹

Recommendation #2: Do not write new medical regulations. Aside from these minor revisions, the Defense Department should not write new medical regulations or policies to address health care needs of transgender personnel, and should treat transgender service members in accordance with established medical practices and standards, as it does with the provision of all medical care. As we have documented throughout this report, transgender service members should be presumed to be fit. Any medical issue that interferes with an individual’s performance of duty is already subject to evaluation under existing medical standards, which are sufficient for enabling doctors to make determinations of fitness and deployability for transgender personnel. Transgender service members should not be held to different standards of self-sufficiency or fitness than any other service members.

Recommendation #3: Base new administrative guidance on foreign military and US government precedents. While no new medical rules are needed, the Defense Department should formulate administrative guidance to address fitness testing, records and identification, uniforms, housing and privacy. We encourage independent scholars as well as Pentagon analysts to study foreign military experiences that could inform the policy-making process. At least 12 countries including Australia, Belgium, Canada, the Czech Republic, Denmark, Israel, the Netherlands, New Zealand, Norway, Spain, Sweden, and the United Kingdom allow transgender personnel to serve; foreign military regulations that apply to transgender military service are straightforward and sensible, offering a sound model for US military policy.

Appendix – Statement by 16 current and former military university faculty members

We write to endorse the quality of research that informs the Report of the Transgender Military Service Commission, which determined that there is no compelling medical rationale for banning transgender military service. We believe that the Commissioners who completed this study engaged in careful and well-done research, and that their conclusions are based on a reasonable assessment of available evidence.*

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Dr. Gregory D. Foster, professor, National Defense University
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Dr. Elizabeth L. Hillman, former instructor, US Air Force Academy
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*The views expressed in this statement by current and former faculty at US Government Agencies are those of the individuals and do not necessarily reflect the official policy or position of their respective university, their Service, the Department of Defense or the US Government.

¹ We are grateful to the numerous individuals who contributed to this project including Jameson Casentini, Janelle Downing, Jacob Eleazer, Dr. Nathaniel Frank, Dr. Richard Frankenstein, Dr. Maurice Garcia, Dr. Jody Herman, Dr. Arnold Gass, Dr. Gary Gates, Dr. Louis Gooren, Dr. Jamison Green, Dr. Dan Grossman, Dr. Wylie Hembrie, Dr. Michael Kauth, Mara Keisling, Christopher Mathews, JD, Diane Mazur, JD, Dr. Christopher Neff, Paula Neira, Dr. Lealah Pollock, Kerri Ryer, Dr. Loren Schechter, Dr. Christopher Salgado, Dr. Jae Sevelius, Dr. Jillian Shipherd and Brynn Tannehill.

² See Gary Gates and Jody Herman (forthcoming). *Transgender Military Service in the United States*, Los Angeles, CA: Williams Institute. Drs. Gates and Herman are in the process of updating their calculations.

³ Adam F. Yerke and Valory Mitchell (2013). Transgender People in the Military: Don't Ask? Don't Tell? Don't Enlist!, *Journal of Homosexuality*, 60:2-3, 436-457.

⁴ Yerke and Mitchell, *Transgender People in the Military*, 445. Also see Jack Drescher, Peggy Cohen-Kettenis, and Sam Winter (2012), *Minding the Body: Situating Gender Identity Diagnoses in the ICD-11*, *International Review of Psychiatry*, 24(6), 573.

⁵ Ilan H. Meyer and Mary E. Northridge, eds. (2007). *The Health of Sexual Minorities: Public Health Perspectives on Lesbian, Gay, Bisexual and Transgender Populations*. New York, NY: Springer.

⁶ Nils Daulaire (November 12, 2013). A Victory for LGBT Health in the Americas. *Huffington Post*, accessed December 26, 2013 at www.huffingtonpost.com/nils-daulaire/a-victory-for-lgbt-health_b_4262367.html.

⁷ See *Fields v. Smith*, 653 F.3d 550 (7th Cir. 2011).

⁸ For example, “For many gender non-conforming people, transition as a framework has no meaning in expressing their gender – there may be no transition process at all, but rather a recognition of a gender identity that defies convention or conventional categories.” Jaime M. Grant, Lisa A. Mottet and Justin Tanis (2011). *Injustice at Every Turn: A Report of the National Transgender Discrimination Survey*. Washington, DC: National Center for Transgender Equality and National Gay and Lesbian Task Force, 26.

⁹ Cross-dressing by non-transgender individuals is beyond the scope of our analysis.

¹⁰ Gates and Herman, *Transgender Military Service*. Their veteran category includes 4,650 individuals in the standby and retired reserve. At the time of writing, the active, Guard and reserve components included 2,280,875 personnel.

¹¹ N = 1,261. Jack Harrison-Quintana and Jody L. Herman (2013). Still Serving in Silence: Transgender Service Members and Veterans in the National Transgender Discrimination Survey. *LGBTQ Policy Journal at the Harvard Kennedy School*, 5.

¹² The peer-reviewed studies are John R. Blosnich, George R. Brown, Jillian C. Shipherd, Michael Kauth, Rebecca I. Piegari, and Robert M. Bossarte (2013). Prevalence of Gender Identity Disorder and Suicide Risk Among Transgender Veterans Utilizing Veterans Health Administration Care. *American Journal of Public Health*, 103:10, 27-32; George R. Brown (1988). Transsexuals in the Military: Flight into Hypermasculinity. *Archives of Sexual Behavior*, 17:6, 527-537; Everett McDuffie and George R. Brown (2010). Seventy U.S. Veterans with Gender Identity Disturbances: A Descriptive Study. *International Journal of Transgenderism*, 12:1, 21-30; Franklin D. Jones, Michael G. Deeken and Steven D. Eshelman (1984). Sexual Reassignment Surgery and the Military: Case Reports. *Military Medicine*, 149:5, 271-275; Matthew F. Kerrigan (2012). Transgender Discrimination in the Military, The New Don't Ask, Don't Tell. *Psychology, Public Policy, and Law*, 18:3, 500–518; Jillian C. Shipherd, Lauren Mizock, Shira Maguen and Kelly E. Green (2012). Male-to-Female Transgender Veterans and VA Health Care Utilization. *International Journal of Sexual Health*, 24:1, 78-87; and Yerke and Mitchell, *Transgender People in the Military*. The three non peer-reviewed studies are Harrison-Quintana and Herman, *Still Serving in Silence*; Bryant and Schilt (2008), *Transgender People in the U.S. Military*, Santa Barbara, CA: Palm Center; and Tarynn M. Witten (2007). *Gender Identity and the Military: Transgender, Transsexual, and Intersex-identified Individuals in the U.S. Armed Forces*. Santa Barbara, CA: Palm Center.

¹³ *Doe v. Alexander*, 510 F. Supp. 900 (D. Minn. 1981).

¹⁴ *Leyland v. Orr*, 828 F. 2d 584 (9th Cir. 1987).

¹⁵ *DeGroat v. Townsend*, 495 F. Supp. 2d 845 (S.D. Ohio 2007).

¹⁶ Department of Defense Instruction (DODI) 6130.03, *Medical Standards for Appointment, Enlistment, or Induction in the Military Services*, April 28, 2010, Incorporating Change 1, September 13, 2011.

¹⁷ DODI 6130.03, *Medical Standards for Appointment*, at ¶ 4(c).

¹⁸ Paraphilia is sexual arousal to an atypical object. See American Psychiatric Association (2013). *Diagnostic and Statistical Manual* (5th ed.). Arlington, VA: American Psychiatric Publishing.

- ¹⁹ DODI 6130.03, *Medical Standards for Appointment*, Enclosure 2, at ¶ 3(b).
- ²⁰ AR 40-501, *Standards of Medical Fitness*, December 14, 2007, at ¶ 1-6(b).
- ²¹ Army Reg. 40-501, *Standards of Medical Fitness*, at ¶ 1-6(h).
- ²² Department of Defense Instruction 1332.38, *Physical Disability Evaluation*, November 14, 1996, Incorporating Change 2, April 10, 2013.
- ²³ DODI 1332.38, *Physical Disability Evaluation*, Enclosure 5, at ¶ 1.3.9.6.
- ²⁴ Department of Defense Instruction 1332.14, *Enlisted Administrative Separations*, August 28, 2008, Incorporating Change 3, September 30, 2011.
- ²⁵ DODI 1332.14, *Enlisted Administrative Separations*, Enclosure 3, at ¶ 3(a)8.
- ²⁶ See, for example, US Marine Corps MCIWEST-MCB CAMPEN ORDER 6000.1, *Reporting of Prescribed Medications and Medical Treatment Outside the Military Health System*, October 1, 2012.
- ²⁷ Jillian C. Shipherd, Lauren Mizock, Shira Maguen and Kelly E. Green (2012). Male-to-Female Transgender Veterans and VA Health Care Utilization. *International Journal of Sexual Health*, 24:1, 85.
- ²⁸ Harrison-Quintana and Herman, Still Serving in Silence, 6.
- ²⁹ Everett McDuffie and George R. Brown (2010). Seventy U.S. Veterans with Gender Identity Disturbances: A Descriptive Study. *International Journal of Transgenderism*, 12:1, 21-30.
- ³⁰ DODI 6130.03 requires a reference to diagnostic codes in the International Classification of Diseases (ICD-9), and the ICD does list diagnoses for both transsexualism and gender identity disorder. DOD translates DSM-IV diagnoses to the closest ICD code.
- ³¹ In the World Professional Association for Transgender Health Standards of Care, dysphoria refers to the distress itself, not the incongruence between gender identity and assigned sex. See Eli Coleman et al. (2011). Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People, Version 7. *International Journal of Transgenderism*, 13, 168. Indeed, non-transgender people can experience gender dysphoria. 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 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.
- ³² Coleman et al., Standards of Care, 168.
- ³³ Drescher, Cohen-Kettenis, and Winter, *Minding the Body*, 575.
- ³⁴ Drescher, Cohen-Kettenis, and Winter, *Minding the Body*, 569; 574.
- ³⁵ Meyer and Northridge, *The Health of Sexual Minorities*.
- ³⁶ Drescher, Cohen-Kettenis, and Winter, *Minding the Body*, 573.
- ³⁷ Coleman et al., Standards of Care, 230, citing findings of Jan Eldh, Agnes Berg and Maria Gustafsson (1997). Long-Term Follow Up After Sex Reassignment Surgery. *Scandinavian Journal of Plastic and Reconstructive Surgery and Hand Surgery*, 31, 1, 39-45; 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; M.H. Murad, M.B. Elamin, M.Z. Garcia, R.J. Mullan, A. Murad, P.J. Erwin and V.M. Montori (2010). Hormonal Therapy and Sex Reassignment: A Systematic Review and Meta-Analysis of Quality of Life and Psychosocial Outcomes. *Clinical Endocrinology*, 72, 2, 214-231; F. Pfäfflin and A. Junge (1998). Sex Reassignment. Thirty Years of International Follow-up Studies After Sex Reassignment Surgery: A Comprehensive Review, 1961-1991 (Translated from German into English by Roberta B. Jacobson and Alf B. Meier), retrieved from <http://web.archive.org/web/20070503090247/http://www.symposion.com/ijt/pfaefflin/1000.htm>; and Richard Green and Davis Fleming (1990). Transsexual Surgery Follow-Up: Status in the 1990s. *Annual Review of Sex Research*, 1, 1, 163-174.
- ³⁸ Coleman et al., Standards of Care, 230; Murad et al., Hormonal Therapy and Sex Reassignment; G. De Cuyper, G. T'Sjoen, R. Beerten, G. Selvaggi, P. De Sutter, P. Hoebeke and R. Rubens (2005). Sexual and Physical Health after Sex Reassignment Surgery. *Archives of Sexual Behavior*, 34, 6, 679-690; B. Kuiper and P. Cohen-Kettenis (1988). Sex Reassignment Surgery: A Study of 141 Dutch Transsexuals. *Archives of Sexual Behavior*, 17, 5, 439-457; R. N. Gorton (2011). The Costs and Benefits of Access to Treatment for Transgender People. Prepared for the San Francisco Department of Public Health, San Francisco.
- ³⁹ Anne Gaderman et al. (2012). Prevalence of DSM-IV Major Depression Among U.S. Military Personnel. *Military Medicine*, 177.
- ⁴⁰ Kim Murphy (April 7, 2012). A Fog of Drugs and War. *Los Angeles Times*.

- ⁴¹ Katherine Blakeley and Don J. Jansen (2013). *Post-Traumatic Stress Disorder and Other Mental Health Problems in the Military: Oversight Issues for Congress*. Washington, DC: Congressional Research Service, 2, citing Mental Disorders and Mental Health Problems, Active Component, US Armed Forces, 2000-2011 (June 2012). *Medical Surveillance Monthly Report*, 19, 6, 11-17.
- ⁴² Paul R. Sackett and Anne S. Mavor, eds. (2006). *Assessing Fitness for Military Enlistment Physical, Medical, and Mental Health Standards*. Washington, DC: The National Academies Press, 144.
- ⁴³ Ministry of Defence. *Policy for the Recruitment and Management of Transsexual Personnel in the Armed Forces*. January, 2009, London: UK.
- ⁴⁴ Coleman et al., Standards of Care, 189.
- ⁴⁵ Older MTFs, beyond the age of most service members, may risk cardiovascular disease as a consequence of hormone therapy. Testosterone may increase the risk of Type 2 diabetes, hypertension, and cardiovascular disease for older FTMs.
- ⁴⁶ H. Asscheman, E.J. Giltay, J.A. Megens, W.P. de Ronde, M.A. van Trotsenburg, and L.J. Gooren (2011). A Long-Term Follow-Up Study of Mortality in Transsexuals Receiving Treatment with Cross-Sex Hormones. *European journal of Endocrinology*, 164, 4, 635-42; Paul Van Kesteren et al. (1997). Mortality and Morbidity in Transsexual Subjects Treated with Cross-Sex Hormones. *Clinical Endocrinology*, 47, 3, 337-343; M. Colizzi, R. Costa, and O. 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.
- ⁴⁷ H. Asscheman et al. (August 14, 2013). Venous Thrombo-Embolism as a Complication of Cross-Sex Hormone Treatment of Male-to-Female Transsexual Subjects: A Review. *Andrologia*. Published online.
- ⁴⁸ Tom Waddell Health Center (2006). *Protocols for Hormonal Reassignment of Gender*. Accessed November 6, 2013 from: <http://www.sfdph.org/dph/comupg/oservices/medSvs/hlthCtrs/TransGendprotocols122006.pdf>.
- ⁴⁹ Department of Defense (2013), *Health Related Behaviors Survey of Active Duty Military Personnel 2011*, 119-120; 130-131; 248; 264-265.
- ⁵⁰ Department of Defense. *Policy Guidance for Deployment-Limiting Psychiatric Conditions and Medications*. 2006 at ¶4.2.3.
- ⁵¹ Andrew Tilghman (May 17, 2010). 'Any Soldier Can Deploy on Anything': Pentagon Rules Bar Some Drugs from Combat Zone, but Oversight is Suspect. *Army Times*.
- ⁵² Tilghman, 'Any Soldier Can Deploy on Anything'.
- ⁵³ Department of the Army. *Personnel Policy Guidance for Overseas Contingency Operations*, 2009 at ¶ 7-13(b)1.
- ⁵⁴ Erika Stetson, for example, served as an Army employee in Afghanistan in 2011 and 2012 under the Civilian Expeditionary Workforce program. Nicole Shouder was appointed to the rank equivalent of Lieutenant Commander in the Military Sealift Command in 2008 and subsequently deployed on four ships including the forward staging base USS Ponce. See Erika Stetson (March/April 2013). Deployed, Trans and Out. *OutServe Magazine*, 13-14; Brynn Tannehill (May/June 2013). A Life of Service. *OutServe Magazine*, 22-23; Brynn Tannehill, (April 25, 2013). Deployed While Trans: The Rachel Bolyard Story. *OutServe Magazine*, accessed at <http://outservemag.com/2013/04/deployed-while-trans-the-rachel-bolyard-story/>
- ⁵⁵ Coleman et al., Standards of Care, 170-171.
- ⁵⁶ For a list of 313 allowable, elective cosmetic procedures, see Tricare Management Activity, Uniform Business Office (2013). *Provider's Guide to the Elective Cosmetic Surgery Superbill*.
- ⁵⁷ Patel, Morris and Gassman show that these complications may include "airway, vascular, hemorrhage, vascular compromise, neurologic, infectious, skeletal, unfavorable osteotomy, tooth injury, nonunion, postoperative malocclusion, temporomandibular joint disorders, and unfavorable aesthetic results." See P. Patel, D. Morris, and A. Gassman (2007). Complications of Orthognathic Surgery. *Journal of Craniofacial Surgery*, 18, 4, 975-985. The military allows personnel to have elective cosmetic surgeries on a space-available basis and at their own expense.
- ⁵⁸ Patel, Morris, and Gassman, Complications of Orthognathic Surgery; F. Kramer. C. Baethge, G. Swennen et al. (2004). Intra- and Perioperative Complications of the LeFort I Osteotomy: A Prospective Evaluation of 1000 Patients. *Journal of Craniofacial Surgery*, 15, 6, 971-977; K. Jones (2006). Le Fort II and Le Fort III Osteotomies for Midface Reconstruction and Considerations for Internal Fixation. In A. Greenberg and J. Prein, eds. *Craniofacial Reconstructive and Corrective Bone Surgery*. New York, NY: Springer, 667-668.
- ⁵⁹ Patel, Morris, and Gassman, Complications of Orthognathic Surgery.
- ⁶⁰ Kramer, Baethge, Swennen et al., Intra- and Perioperative Complications.
- ⁶¹ Herman found in a recent study that the highest annualized utilization rate for large employers is 0.044 claimants per thousand employees annually (Table 8). If the military were similar to civilian firms, and given that the active, Guard and reserve components currently include 2,280,875 personnel, then one would expect 0.044x2,281=100 claimants per year if the Military Health System covered gender-confirming surgery. However, transgender people

are over-represented in the military (15,450/2,280,875 million = 0.68% military as compared to .3% of the civilian adult population.) Hence the figure of 100 claimants per year should be adjusted upward by $.68/.3 = 2.3x$. Hence, if the military paid for transition-related surgery, one would expect $2.3 \times 100 = 230$ claims per year. See Jody L. Herman (2013). *Costs and Benefits of Providing Transition-Related Health Care Coverage in Employee Health Benefits Plans*, Los Angeles, CA: Williams Institute.

⁶² Herman, *Costs and Benefits*, 6.

⁶³ Short-term surgical complications can include rectal injury, infection, delayed wound healing, bleeding, venous thromboembolism, and/or urethral stream abnormalities. While many of these complications are either self-limited or may be treated with local wound care, antibiotics, or anticoagulants, some, such as rectal injury, may require additional surgical procedures such as a temporary colostomy. Long-term complications can include vaginal stenosis and unsatisfactory appearance of the surgically reconstructed genitalia, and vaginal stenosis may require additional procedures such as skin grafts or intestinal transposition.

⁶⁴ A.A. Lawrence (2006). Patient-Reported Complications and Functional Outcomes of Male-to-Female Sex Reassignment Surgery. *Archives of Sexual Behavior*, 35, 6, 717-27.

⁶⁵ Cameron Bowman and Joshua M. Goldberg (2006). Care of the Patient Undergoing Sex Reassignment Surgery. *International Journal of Transgenderism*, 9, 135-165; Miroslav L. Djordjevic, Dusan S. Stanojevic and Marta R. Bizic (2011). Rectosigmoid Vaginoplasty: Clinical Experience and Outcomes in 86 Cases. *Journal of Sexual Medicine*, 8, 12, 3487-3494; Ji-Xiang Wu, Bin Li, Wen-Zhi Li, Yong-Guang Jiang, Jie-Xiong Liang, Chen-Xi Zhong (2009). Laparoscopic Vaginal Reconstruction Using an Ileal Segment. *International Journal of Gynecology and Obstetrics*, 107, 3, 258-261; L. Jarolim, J. Sedý, M. Schmidt, O. Nanka, R. Foltán and I. Kawaciuk (2009). Gender Reassignment Surgery in Male-to-Female Transsexualism: A Retrospective 3-Month Follow-Up Study with Anatomical Remarks. *Journal of Sexual Medicine*, 6, 6, 1635-1644; S. V. Perovic, D.S. Stanojevic and M.L.J. Djordjevic (2000). Vaginoplasty in Male Transsexuals Using Penile Skin and a Urethral Flap. *BJU International*, 86, 7, 843-850.

⁶⁶ Presumably, any post-operative MTF individuals with ongoing complications would be screened out at the time of enlistment. Hence the only MTF troops who would be unfit for duty would be those experiencing ongoing post-operative complications from genital surgeries they elected to have after joining the military. As explained previously, if the Military Health Service paid for transition-related care, one would expect 230 claimants per year. Approximately 90 percent of transgender troops are MTF's, thus suggesting $.9 \times 230 = 207$ claimants per year for MTF transition-related coverage. If 5 percent of such claims entailed ongoing post-operative complications, this would mean that 10 MTF transgender troops would become permanently unfit for duty each year.

⁶⁷ Short-term surgical complications related to the vaginectomy include bleeding, and those associated with scrotoplasty include loss of the testicular prostheses related to infection or erosion. Whether undergoing a metoidioplasty with urethral lengthening or phalloplasty, short-term complications include urethral stricture or fistulae, infection, delayed wound healing, and/or venous thromboembolism. These conditions may either be self-limited or require additional procedures such as dilation, stricture release, and/or buccal mucosal grafts, local wound care, antibiotics, or anticoagulation. Additional risks associated with phalloplasty include flap failure and delayed healing of the donor site (most commonly forearm, thigh, or back).

⁶⁸ S. Baumeister, M. Sohn, C. Domke, and K. Exner (2011). Phalloplasty in Female-to-Male Transsexuals: Experience from 259 Cases [Article in German]. *Handchir Mikrochir Plast Chir*, 43, 4, 215-21; J.E. Terrier, F. Courtois, A. Ruffion, N. Morel *Journal* (September 12, 2013). Surgical Outcomes and Patients' Satisfaction with Suprapubic Phalloplasty. *Journal of Sexual Medicine* [Epub ahead of print]; P.A. Sutcliffe, S. Dixon, R.L. Akehurst, A. Wilkinson, A. Shippam, S. White, R. Richards and C.M. Caddy (2009) Evaluation of Surgical Procedures for Sex Reassignment: A Systematic Review *Journal of Plastic, Reconstructive and Aesthetic Surgery*, 62, 3, 294-306; A. Leriche, M.O. Timsit, N. Morel-Journal, A. Bouillot, D. Dembele, A. Ruffion (2008). Long-Term Outcome of Forearm Flee-Flap Phalloplasty in the Treatment of Transsexualism. *BJU International*, 101, 10, 1297-1300; J.J. Hage and A.A. van Turnhout (2006). Long-Term Outcome of Metoidioplasty in 70 Female-to -Male Transsexuals. *Annals of Plastic Surgery*, 57, 3, 312-316; M. Sengezer, S. Oztürk, M. Deveci and Z. Odabaşı (2004). Long-Term Follow-Up of Total Penile Reconstruction with Sensate Osteocutaneous Free Fibula Flap in 18 Biological Male Patients. *Plastic and Reconstructive Surgery*, 114, 2, 439-452.

⁶⁹ Albert Leriche et al. (2008). Long-Term Outcome of Forearm Flee-Flap Phalloplasty in the Treatment of Transsexualism. *BJU international*, 101, 10, 1297-1300.

⁷⁰ Giulio Garaffa, Christopher A. Nim, and David J. Ralph (2010). Total Phallic Reconstruction in Female-to-Male Transsexuals. *European Urology* 57.4, 715-722.

⁷¹ These figures are derived from raw data that informed Grant, Mottet and Tanis, *Injustice at Every Turn*.

⁷² Presumably, any post-operative FTM individuals with ongoing complications would be screened out at the time of enlistment. Hence the only FTM troops who, as a class, would be unfit for duty would be those experiencing ongoing post-operative complications from genital surgeries they elected to have after joining the military. As explained previously, if the Military Health Service paid for transition-related care, one would expect 230 claimants per year. However, only 10 percent of transgender troops are FTMs, thus suggesting $.1 \times 230 = 23$ claimants per year for FTM transition-related coverage. If one quarter of such claims entailed ongoing post-operative complications, this would mean that 6 FTM transgender troops would become permanently unfit for duty each year.

⁷³ The stories of Erika Stetson, Nicole Shouder and Rachel Bolyard were referenced in a previous endnote.

⁷⁴ Department of the Army, *Personnel Policy Guidance for Overseas Contingency Operations*, 2009, at ¶ 7-9(e).

⁷⁵ Ministry of Defence, *Policy for the Recruitment and Management of Transsexual Personnel*.

⁷⁶ DODI 1332.38, *Physical Disability Evaluation*, Enclosure 3, at ¶ P3.4.1.3.

⁷⁷ DODI 1332.38, *Physical Disability Evaluation*, Enclosure 4, at ¶ 1.1.2.

⁷⁸ DODI 1332.38, *Physical Disability Evaluation*, Enclosure 3, at ¶ P3.4.3.

⁷⁹ Department of Defense. *Health Related Behaviors*.

⁸⁰ 10 U.S.C. § 701(a).

⁸¹ Department of Defense Instruction 1327.06, *Leave and Liberty Policy and Procedures*, June 16, 2009, Incorporating Change 2, effective August 13, 2013, Enclosure 2, at ¶ 1c.

⁸² DODI 1327.06, *Leave and Liberty Policy*, Enclosure 2, at ¶¶ 1j(1), 1a.

⁸³ 10 U.S.C. 701(b), (f).

⁸⁴ DODI 1327.06, *Leave and Liberty Policy*, Enclosure 2, at ¶ 1j(2).

⁸⁵ DODI 1327.06, *Leave and Liberty Policy*, Enclosure 2, at ¶ 1k(6).

⁸⁶ DODI 1327.06, *Leave and Liberty Policy*, Enclosure 2, at ¶¶ 1k(2), (5).

⁸⁷ DODI 1327.06, *Leave and Liberty Policy*, Enclosure 2, at ¶ 1k(4).

⁸⁸ DODI 1315.18, *Procedures for Military Personnel Assignments* (January 12, 2005), at ¶ 6.10.

⁸⁹ DODI 1315.18, *Procedures for Military Personnel Assignments*, at ¶¶ 6.10.3, 6.10.4. An alternative option for leave is the Navy's Career Intermission Pilot Program, which allows naval personnel to apply for a transfer from active service into the Individual Ready Reserve for up to three years.

⁹⁰ DODI 1327.06, *Leave and Liberty Policy*, Enclosure 2, at ¶ 1k(1).

⁹¹ Army Regulation 600-8-10, *Leave and Passes* (August 4, 2011 revision), at ¶5-3e.

⁹² Army Medical Command, OTSG/MEDCOM Policy Memo 12-076, *Revised Policy for Cosmetic Surgery Procedures and Tattoo/Brand Removal/Alteration in the Military Health System* (November 20, 2012), at ¶¶ 5e(15), 5f(2).

⁹³ Army Medical Command, *Revised Policy for Cosmetic Surgery*, at ¶ 5(e)(7).

⁹⁴ See, e.g., Department of the Air Force Instruction 36-2110, *Assignments* (Change 2, June 8, 2012), at ¶ 2.17.1.

⁹⁵ Department of the Air Force Instruction 36-2110, *Assignments*, at ¶ 2.17.3 and Table 2.2.

⁹⁶ DODI 1332.38, *Physical Disability Evaluation*, Enclosure 3, at ¶ P7.3.

⁹⁷ Yerke and Mitchell, *Transgender People in the Military*, 442.

⁹⁸ Coleman et al., *Standards of Care*, 170.

⁹⁹ Report of the Army Dismounted Complex Blast Injury Task Force, June 18, 2011, 31.

¹⁰⁰ Government Accountability Office (2012). *VA and DOD Health Care: Department-Level Actions Needed to Assess Collaboration Performance, Address Barriers, and Identify Opportunities*, GAO-12-992. Washington, DC; Government Accountability Office (2011). *DOD and VA Health Care: Action Needed to Strengthen Integration Across Care Coordination and Case Management Programs*, GAO 12-129T. Washington, DC.

¹⁰¹ D.M. Lam (2007). The Trauma Continuum-of-Care Quality Forum Integration Committee System-Wide Video Teleconference. *Military Medicine* 172, 6, 611.

¹⁰² S. Marble (2013). Origins of the Physical Profile. *Military Medicine* 178, 8, 887.

¹⁰³ E. Granger et al. (2010). Historical Evolution of Medical Quality Assurance in the Department of Defense. *Military Medicine* 175, 8, 581.

¹⁰⁴ B. Kerr (2007). The Joint Military Medical Executive Skills Initiative: An Impressive Response to Changing Human Resource Management Rules of Engagement. *Military Medicine* 172, 1, 49.

¹⁰⁵ T. Harold (2011). The Evolution of Dependent Medical Care in the U.S. Army. *Military Medicine* 176, 10, 1133.

¹⁰⁶ G. Bathalon (2006). The Effect of Proposed Improvements to the Army Weight Control Program on Female Soldiers. *Military Medicine* 171, 8, 800.

¹⁰⁷ Rapid Action Revision, September 13, 2011, to Army Regulation 601-270, OPNAVINST 1100.4C Ch-2, AFI36-2003_IP, MCO1100.75F, and COMDTINST M1100.2E, *Military Entrance Processing Station (MEPS)*, http://www.apd.army.mil/jw2/xmldemo/r601_270/main.asp

¹⁰⁸ DODI 6130.03, *Medical Standards for Appointment*, Enclosure 4 at ¶¶ 14-15, 25, 29.

¹⁰⁹ DODI 1332.38, *Physical Disability Evaluation*, Enclosure 5; DODI 1332.14, *Enlisted Administrative Separations*, Enclosure 3, at ¶ 3(a)(8)(a).

Dr. M. Joycelyn Elders, MD

Joycelyn Elders, the first person in the state of Arkansas to become board certified in pediatric endocrinology, was the sixteenth Surgeon General of the United States, the first African American and only the second woman to head the US Public Health Service. Long an outspoken advocate of public health, Elders was appointed Surgeon General by President Clinton in 1993.



Born to poor farming parents in 1933, Dr. Elders grew up in a rural, segregated, poverty-stricken pocket of Arkansas. She was the eldest of eight children, and she and her siblings had to combine work in the cotton fields from age five with their education at a segregated school thirteen miles from home. They often missed school during harvest time, September to December.

After graduating from high school, she earned a scholarship to the all-black liberal arts Philander Smith College in Little Rock. While she scrubbed floors to pay for her tuition, her brothers and sisters picked extra cotton and did chores for neighbors to earn her \$3.43 bus fare. In college, she enjoyed biology and chemistry, but thought that lab technician was likely her highest calling. Her ambitions changed when she heard Edith Irby Jones, the first African American to attend the University of Arkansas Medical School, speak at a college sorority. Dr. Elders—who had not even met a doctor until she was 16 years old—decided that becoming a physician was possible, and she wanted to be like Jones.

After college, Dr. Elders joined the Army and trained in physical therapy at the Brooke Army Medical Center at Fort Sam Houston, Texas. After discharge in 1956 she enrolled at the University of Arkansas Medical School on the G.I. Bill. Although the Supreme Court had declared separate but equal education unconstitutional two years earlier, Elders was still required to use a separate dining room—where the cleaning staff ate. She met her husband, Oliver Elders, while performing physical exams for the high school basketball team he managed, and they were married in 1960.

Dr. Elders did an internship in pediatrics at the University of Minnesota, and in 1961 returned to the University of Arkansas for her residency. She became chief resident in charge of the all-white, all-male residents and interns, earned her master's degree in biochemistry in 1967 and became an assistant professor of pediatrics at the university's medical school in 1971 and full professor in 1976.

Over the next twenty years, Dr. Elders combined her clinical practice with research in pediatric endocrinology, publishing well over a hundred papers, most dealing with problems of growth and juvenile diabetes. This work led her to study of sexual behavior and her advocacy on behalf of adolescents. She saw that young women with diabetes face health risks if they become pregnant too young—including spontaneous abortion and possible congenital abnormalities in the infant. She helped her patients to control their fertility and advised them on the safest time to start a family.

Governor Bill Clinton appointed Joycelyn Elders head of the Arkansas Department of Health in 1987. As she campaigned for clinics and expanded sex education, she caused a storm of controversy among conservatives and some religious groups. Yet, largely because of her lobbying, in 1989 the Arkansas Legislature mandated a K-12 curriculum that included sex education, substance-abuse prevention, and programs to promote self-esteem. From 1987 to 1992, she nearly doubled childhood immunizations, expanded the state's prenatal care program, and increased home-care options for the chronically or terminally ill.

In 1993, President Clinton appointed Dr. Elders US Surgeon General. Despite opposition from critics, she was confirmed and sworn in on September 10, 1993. During her fifteen months in office she faced skepticism regarding her policies yet continued to bring controversial issues up for debate. As she later concluded, change can only come about when the Surgeon General can get people to listen and talk about difficult subjects.

Dr. Elders left office in 1994 and in 1995 she returned to the University of Arkansas as a faculty researcher and professor of pediatric endocrinology at the Arkansas Children's Hospital. In 1996 she wrote her autobiography, *Joycelyn Elders, M.D.: From Sharecropper's Daughter to Surgeon General of the United States of America*. Now retired from practice, she is a professor emeritus at the University of Arkansas School of Medicine, and remains active in public health education.

Professor George R. Brown, MD, DFAPA

George R. Brown, MD, DFAPA, is Associate Chairman and Professor of Psychiatry at East Tennessee State University in Johnson City, TN. He is currently serving his third term on the Board of Directors for the World Professional Association for Transgender Health, the only international organization that focuses on transgender health, where he also serves as a member of the Incarceration/Institutionalization Committee and the Standards of Care Committee. He is a coauthor on the last three versions of the Standards of Care.



Dr. Brown served as Chief of Psychiatry at Mountain Home VAMC for 18 years and served 12 years in the US Air Force as a psychiatrist. He has worked with transgender active-duty service members and with veterans during his 30 years of active clinical work in the area of gender dysphoria, and continues to evaluate and treat transgender veterans. He has assisted with the VA national workgroups tasked with educating VHA clinicians about how to deliver competent and respectful transgender health care.

Actively involved in working with legal cases on behalf of transgender persons seeking access to nondiscriminatory transgender health care in the United States, Dr. Brown has served as an expert witness in several national precedent-setting cases that have benefitted transgender persons. He has published over 135 articles and scientific abstracts, as well as 22 book chapters, many of which have been on transgender health care issues. And, he has presented his work on transgender issues at one third of the medical schools in the US as well as in seven nations.

Dr. Brown is a University of Rochester School of Medicine graduate who subsequently did residency at Wright State University as an officer in the USAF. He is board certified in General Psychiatry and a Distinguished Fellow in the American Psychiatric Association. His areas of expertise include gender identity disorders/gender dysphoria and psychopharmacology. Dr. Brown supervises resident research electives at the VA and encourages residents to develop a better understanding of the potential contributions of research on clinical practice through his example as an accomplished clinical researcher.

Professor Eli Coleman, PhD

Professor Eli Coleman is director of the Program in Human Sexuality, Department of Family Medicine and Community Health, University of Minnesota Medical School in Minneapolis, where he holds the first and only endowed academic chair in sexual health. Dr. Coleman has authored articles and books on a variety of sexual health topics, including compulsive sexual behavior, sexual orientation, and gender dysphoria.



He is founding editor of the *International Journal of Transgenderism* and founding and current editor of the *International Journal of Sexual Health*. He is past president of the Society for the Scientific Study of Sexuality, the World Professional Association for Transgender Health (formerly the Harry Benjamin International Gender Dysphoria Association), the World Association for Sexual Health, and the International Academy for Sex Research. In 2013, he was elected President of the Society for Sex Therapy and Research for a two-year term

He has been a frequent technical consultant on sexual health issues to the World Health Organization (WHO), the Pan American Health Organization (the regional office of WHO), and the Centers for Disease Control and Prevention. And, he has been the recipient of numerous awards including the US Surgeon General's Exemplary Service Award for his role as senior scientist on *Surgeon General's Call to Action to Promote Sexual Health and Responsible Sexual Behavior*, released in 2001. He was given the Distinguished Scientific Achievement Award from the Society for the Scientific Study of Sexuality and the Alfred E. Kinsey Award by the Midcontinent Region of the Society for the Scientific Study of Sexuality in 2001. In 2007, he was awarded the Gold Medal for his lifetime contributions to the field of sexual health by the World Association for Sexual Health.

In 2007, he was appointed the first endowed Chair in Sexual Health at the University of Minnesota Medical School, and in 2009 he was awarded the Masters and Johnson Award by the Society for Sex Therapy and Research. In 2011, he received the John Money Award from the Eastern Region of the Society for the Scientific Study of Sexuality.

BG Thomas A. Kolditz, PhD, USA (Ret.)

General Kolditz is Professor in the Practice of Leadership and Management and Director of the Leadership Development Program at the Yale School of Management. He has been one of the nation's leading development experts for four decades in the public, private, and social sectors. A Professor Emeritus at the US Military Academy, General Kolditz led the Department of Behavioral Sciences and Leadership at West Point for twelve years. In that role, he was responsible for teaching, research, and outreach activities in management, leader development science, psychology, and sociology.



A highly experienced global leader, General Kolditz has served for more than 26 years in leadership roles on four continents. His career has focused both on leading organizations and studying leadership and leadership policy across sectors. He served for two years as a leadership and human resources policy analyst in the Pentagon, and a year as a concept developer in the Center for Army Leadership, and was the founding director of the West Point Leadership Center. He was instrumental in the design and formation of the Thayer Leader Development Group, and is the managing member of Saxon Castle LLC, a leader development consultancy.

Professor Kolditz is an internationally recognized expert on crisis leadership and leadership in extreme contexts and in the development of programs to inculcate leadership and leader development in everything from project teams to large organizations. He has published extensively across a diverse array of academic and leadership trade journals, and serves on the editorial and advisory boards of several academic journals. He is a fellow in the American Psychological Association and is a member of the Academy of Management. In 2007, while still on active duty, General Kolditz was appointed a visiting professor at the Yale School of Management, where he designed a crisis leadership course and taught in the school's MBA curriculum for three years.

His most recent book, *In Extremis Leadership: Leading as if Your Life Depended on It*, was based on more than 175 interviews conducted on the ground in Iraq during combat operations. He has been named as a leadership Thought Leader by the Leader to Leader Institute and as a Top Leader Development Professional by Leadership Excellence. In 2009, he was named to the Council of Senior Advisors, Future of Executive Development Forum.

RADM Alan M. Steinman, MD, USPHS/USCG (Ret.)

Rear Admiral Alan M. Steinman was commissioned in the United States Public Health Service as a lieutenant in July, 1972, to commence a military career of over 25 years in the United States Coast Guard and the Public Health Service. He served as senior medical officer at the USCG Support Center, Elizabeth City, NC, from July to September, 1972; as senior medical officer and flight surgeon at USCG Air Station, Cape Cod, MA, from 1973 to 1974; as senior medical officer and flight surgeon at USCG Air Station, Port Angeles, WA, from 1974 to 1976, as senior medical officer and flight surgeon at USCG Air Station, Astoria, OR, from 1976 to 1978; and as medical officer and flight surgeon at USCG Support Center, Kodiak, AK, from January to May, 1987.



During these operational assignments, Dr. Steinman flew on countless emergency medical helicopter evacuations of ill and injured seamen, fisherman, recreational boaters, loggers and military active duty personnel. His expertise in emergency medicine and in cold-weather operations, particularly in the areas of sea-survival, hypothermia and drowning, let to his initial assignment at Coast Guard Headquarters as the Chief of Special Medical Operations from 1978 to 1982.

Dr. Steinman served as Medical Advisor for search and rescue operations in the USCG HQ Search and Rescue Division of the Office of Operations from 1982 to 1984. He then attended the University of Washington in Seattle, WA, where he earned a Masters of Public Health. Following his tour of duty at Kodiak, AK, he returned to USCG HQ as the Chief of Clinical and Preventive Medicine from April, 1987, to September, 1990. Dr. Steinman next served under the US Surgeon General (Dr. C. Everett Koop) as the Deputy Director of Medical Affairs at USPHS HQ from September, 1989, to February, 1990, following which he served as Chief of the Medical Branch at USPHS HQ until February, 1991. He returned to USCG HQ as Chief of the Wellness Branch from February, 1991, to August, 1993.

RADM Steinman was selected for promotion to flag officer in August, 1993, for the position of Director of Health and Safety at USCG HQ (equivalent to both the Surgeon General and Chief of Safety Programs for the other branches of the armed forces). He retired from the Coast Guard and the Public Health Service in September, 1997. Following his retirement, Admiral Steinman was appointed to the Presidential Special Oversight Board for Department of Defense Investigations of Gulf-War Chemical and Biological Incidents, where he served under Senator Warren Rudman (R-NH) as the chief medical advisor for the Board from July, 1998, to January, 2001.

Admiral Steinman's educational degrees include a Bachelor of Science in 1966 from the Massachusetts Institute of Technology; a Doctor of Medicine in 1971 from the Stanford University School of Medicine; and a Master of Public Health in 1986 from the University of Washington. His first post-graduate year in medicine was at the Mayo Graduate School of Medicine in Rochester, MN, in 1971. Dr. Steinman also graduated from the US Navy School of Aerospace Medicine, where he earned the designation of US Navy Flight Surgeon in 1973.

Dr. Steinman is Board Certified in Occupational Medicine and is a Fellow of the American College of Preventive Medicine.

During his tenure as Director of Health and Safety, RADM Steinman managed a comprehensive health care program for over 160,000 beneficiaries with a budget of over \$250 million. He also served as the Director of the Coast Guard's Safety and Environmental Health programs, overseeing the safety of all USCG personnel. He has an international reputation in cold-weather medicine, hypothermia and sea-survival, and he is widely published in these areas, including numerous articles in medical journals and chapters in textbooks of emergency medicine and cold-weather medicine. He has lectured at various national and international conferences and universities on hypothermia, sea-survival and drowning.

RADM Steinman's decorations include the Distinguished Service Medal, the Legion of Merit, the Meritorious Service Medal, two USCG Commendation medals, the USCG Achievement medal, the USPHS Commendation medal, two USPHS Unit Commendation Medals, the USPHS Surgeon General's Medallion, and the USPHS Surgeon General's Exemplary Service Medal. RADM Steinman currently serves as a consultant in cold-weather medicine and holds the position of Professional Affiliate with the Health, Leisure and Human Performance Research Institute at the University of Manitoba. He is a scientific referee for various journals of environmental and occupational medicine. He serves on the Honorary Board of Directors for the Servicemembers Legal Defense Network, and he is co-founder of the Puget Sound Chapter of the American Veterans for Equal Rights.

RADM Steinman is the most senior military officer to self-identify as gay after his retirement; he served on the Military Advisory Council for Servicemembers Legal Defense Network, as an advisor for Servicemembers United, Service Women's Action Network and the Palm Center. He is also a founding member of the Puget Sound Chapter of American Veterans for Equal Rights. He was selected to brief President-elect Obama's transition team on the issue of Don't Ask, Don't Tell; he also met with the senior members of the Pentagon's working group on gays in the military, and he was invited by the White House to attend the Presidential Signing Ceremony repealing the Don't Ask, Don't Tell law. For the past five years, RADM Steinman has lectured to college classes on Joint Base Lewis-McChord on the issue of DADT. RADM Steinman lives with his seven-year-old adopted son and his husband in Olympia, WA.

Article

Medical Aspects of Transgender Military Service

Armed Forces & Society

1-22

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**M. Joycelyn Elders¹, George R. Brown²,
Eli Coleman³, Thomas A. Kolditz⁴,
and Alan M. Steinman⁵**

Abstract

At least eighteen countries allow transgender personnel to serve openly, but the United States is not among them. In this article, we assess whether US military policies that ban transgender service members are based on medically sound rationales. To do so, we analyze Defense Department regulations and consider a wide range of medical data. Our conclusion is that there is no compelling medical reason for the ban on service by transgender personnel, that the ban is an unnecessary barrier to health care access for transgender personnel, and that medical care for transgender individuals should be managed using the same standards that apply to all others. Removal of the military's ban on transgender service would improve health outcomes, enable commanders to better care for their troops, and reflect the military's commitment to providing outstanding medical care for all military personnel.

Keywords

transgender service members, medical care, mental health, "don't ask, don't tell"

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Introduction

At least eighteen countries allow transgender personnel to serve openly, but the United States is not among them.¹ When “don’t ask, don’t tell” was overturned in 2011, gay, lesbian, and bisexual personnel were allowed to serve openly, but regulations banning transgender military service remained in place. Unlike the rationales that justified excluding gays, lesbians, and bisexuals, and that emphasized operational issues including readiness, cohesion, recruitment and morale, the rules barring transgender military service are, for the most part, embedded in medical regulations, and are premised on assumptions about the medical fitness of transgender personnel.² Despite the repeal of “don’t ask, don’t tell,” and the fact that the Veterans Health Administration (VHA) enacted a 2011 policy mandating the provision of health care benefits to transgender veterans, medical regulations that bar the service of transgender personnel have not been updated.³ In this article, we conduct the first-ever analysis of the plausibility of rationales that justify regulations prohibiting transgender service.⁴ After a brief introduction, we discuss Defense Department regulations barring transgender service as well as the four medical rationales that justify them. Then, we assess the plausibility of each rationale.

The term *transgender* is a broad, umbrella term that refers to individuals who do not identify with the physical gender that they were assigned at birth.⁵ There are an estimated 700,000 transgender American adults, representing 0.3 percent of the nation’s adult population. While some military regulations and legal cases that we discuss refer to *transsexuals*, and while some transgender people use the term *transsexual* to describe someone who lives permanently with a gender different from their sex at birth, many view the term as outdated and no longer use it, which is why we use the term *transgender* in this article.

There is no single medical treatment for transgender individuals who undergo gender transition. Surgical transition refers to the use of gender-confirming surgery to change one’s gender while medical transition refers to the use of surgery and/or cross-sex hormone therapy (CSH) to do so. Survey data indicate that 76 percent of transgender individuals have had cross-sex hormone therapy and that only a small minority have had genital reconstructive surgery.⁶ The transition period for most people lasts between one and six months.⁷

Scholars estimate that 15,500 transgender individuals serve in the US armed forces, including 8,800 in the active component and 6,700 in the National Guard and Reserve components, and that 134,000 veterans are transgender.⁸ Transgender adult citizens are more than twice as likely as non-transgender Americans (2.2 percent transgender vs. 0.9 percent non-transgender) to serve currently in the military.⁹ We are only aware, however, of approximately two dozen service members who have been discharged because of their transgender identity in recent years.¹⁰

Defense Department Regulations Barring Transgender Service

Transgender individuals are not allowed to enlist or serve in the US armed forces, and the rules barring their participation in the military are articulated in medical regulations that govern accession and retention. Medical standards for enlistment and retention are designed to ensure that service members are free of conditions that would interfere with duty performance, endanger oneself or others, or impose undue burdens for medical care, and current regulations contain a list of disqualifying conditions that preclude applicants from joining or remaining in the military. Accession regulations that are articulated in Department of Defense Instruction (DODI) 6130.03, *Medical Standards for Appointment, Enlistment, or Induction in the Military Services* disqualify physical conditions including “abnormalities or defects of the genitalia including but not limited to change of sex, hermaphroditism, pseudo-hermaphroditism, or pure gonadal dysgenesis” and “learning, psychiatric, and behavioral” conditions such as “current or history of psychosexual conditions, including but not limited to transsexualism, exhibitionism, transvestism, voyeurism, and other paraphilias.”¹¹ Thus, the accession prohibition against transgender military service includes both a physical component barring “change of sex” and a psychological component barring “psychosexual conditions, including but not limited to transsexualism.”

Retention regulations contained in DODI 1332.14, *Enlisted Administrative Separations* include “sexual gender and identity disorders” as grounds for administrative separation at the discretion of a commander.¹² Even though retention regulations do not include a physical component such as “change of sex,” gender-confirming surgery would surely be taken as evidence of a “sexual gender and identity disorder” and would thus subject any service member who changed their gender surgically to discharge. Even transgender service members who do not wish to take hormones, have surgery, or undergo any other aspect of gender transition are subject to discharge under the psychological components of the accession and retention regulations.

Medical regulations generally allow for waivers of accession standards under some circumstances. Under DODI 6130.03, the services shall “Authorize the waiver of the standards [for entry] in individual cases for applicable reasons and ensure uniform waiver determinations.”¹³ Service-specific implementing rules affirm the possibility of accession waivers. By Army rules, for example, “Examinees initially reported as medically unacceptable by reason of medical unfitness . . . may request a waiver of the medical fitness standards in accordance with the basic administrative directive governing the personnel action.”¹⁴

While accession standards allow for the possibility of waivers, they also specify that accession waivers will not be granted for conditions that would disqualify an individual for the possibility of retention: “Waivers for initial enlistment or appointment, including entrance and retention in officer procurement programs, will not be

JANE DOE 2, et al.,)
)
 Plaintiffs,)
 v.) Civil Action No. 17-cv-1597 (CKK)
)
 DONALD TRUMP, et al.,)
)
 Defendants.)
_____)

DECLARATION OF STEPHANIE A. BARNA

I, Stephanie A. Barna, do hereby declare as follows:

1. I am the Acting Assistant Secretary of Defense (Manpower and Reserve Affairs), serving as the Senior Policy Advisor to the Under Secretary of Defense for Personnel and Readiness, within the Department of Defense (DoD). In this capacity, I advise the Under Secretary on matters related to Total Force management, including military readiness and training, and military personnel requirements. I have served in this capacity since February 2018. From June 2014 through the date of this memorandum, I served first as the Acting Assistant Secretary of Defense (Readiness and Force Management) and subsequently performed the duties of the Assistant Secretary of Defense (Manpower and Reserve Affairs), the duties of the Principal Deputy Under Secretary of Defense for Personnel and Readiness, and the duties of the Under Secretary of Defense for Personnel and Readiness. In these roles, I served as principal advisor to the Secretary of Defense and/or the Under Secretary of Defense (Personnel and Readiness) on all personnel matters, including civilian and military personnel policies, reserve affairs, Total Force Planning and Requirements, and diversity. I also served in senior leadership positions in the Department of the Army as a career senior executive, and retired from the U.S. Army Reserve in 2011 in the rank of Colonel.

2. In my current role, I have oversight responsibility for the drafting and implementation of policy concerning military service by transgender individuals.

3. In the exercise of my official duties, I have been made aware of this lawsuit and the related litigation involving DoD transgender service policy. The information in this declaration is based on my personal knowledge and on information made available to me in my official capacity.

4. On February 22, 2018, the Secretary of Defense, with the agreement of the Secretary of Homeland Security, sent the President a memorandum proposing a new policy regarding military service by transgender persons. The memorandum was accompanied by a 44-page report detailing the proposed policy and explaining the rationale for it. On March 23, 2018, the President issued a memorandum that revoked his August 2017 memorandum and any other directive he may have made on military service by transgender persons, thereby allowing the Secretaries of Defense and Homeland Security to implement their proposed policy.

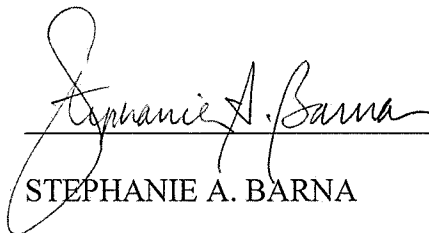
5. The proposed policy includes an exemption for “transgender Service members who were diagnosed with gender dysphoria by a military medical provider after the effective date of the Carter policy, but before the effective date of any new policy.” Report 43. Under the policy, these Service members “may 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.” *Id.*

6. The Department included this exemption because of its commitment to honor the reasonable expectations of 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” and because of the “substantial investment” it has made in them. *Id.* Consistent with these purposes, the Department will, if permitted to implement its proposed new policy, exempt any Service member who was diagnosed with gender dysphoria prior to the effective date of the Carter policy and has continued to serve and receive treatment pursuant to the Carter policy after it took effect. In addition, because the new policy is not yet in effect, at present the Department will exempt any current Service member who is diagnosed with gender dysphoria by a military medical provider before the effective date of the new policy.

Pursuant to 28 U.S.C. § 1746(2), I declare under the penalty of perjury that the foregoing is true and correct.

Executed on June 4, 2018


STEPHANIE A. BARNA

JANE DOE 2, et al.)	
)	
Plaintiffs,)	
v.)	Civil Action No. 17-cv-1597 (CKK)
)	
DONALD TRUMP, et al.)	
)	
Defendants.)	
_____)	

DECLARATION OF MAJ SEAN M. HEENAN
 (Pertaining to Plaintiff Dylan Kohere)

I, Sean M. Heenan, hereby declare as follows:

1. I am currently the Acting Professor of Military Science (PMS) and Executive Officer of the U.S. Army Reserve Officer Training Corps (ROTC) detachment at the University of Connecticut in Storrs, Connecticut, which oversees and administers the satellite ROTC program at the University of New Haven in New Haven, Connecticut. I have been in this position since May 22nd 2018. I am responsible for the administration of the ROTC program at the University of New Haven, including all personnel-related activities involving the participation and enrollment of students in ROTC. Due to my official duties related to these responsibilities, I have an understanding of U.S. Army Cadet Command’s policy regarding the various levels of students’ participation in the ROTC program.

2. I am aware of the allegations made by Dylan Kohere in the filings and his associated declaration in *Jane Doe 2 v. Trump*, No. 17-cv-1597, currently pending in the United States District Court for the District of Columbia. Based upon my knowledge of his allegations, and information that I have learned through my official duties, I offer the following:

a. Dylan Kohere is a self-identified transgender student at the University of New Haven who participated in ROTC as a freshman throughout the fall and spring semesters of the 2017-

2018 academic year. He was registered in the Military Science I (MS-I) classes both semesters and, in accordance with Cadet Command policy, was able to participate in certain labs that did not include physical activity.

b. While Mr. Kohere was only authorized to participate in ROTC his first semester, the Department of Defense updated its medical fitness standards for accession into the military, effective January 1, 2018. Based on this new policy guidance, the cadre at the University of New Haven attempted to contact Mr. Kohere on 7 February 2018 in person, 19 April 2018 via email, and 25 April 2018 in person, in order to discuss his potential eligibility to enroll in ROTC. Mr. Kohere, however, never responded to any of the cadre's communications, and has not otherwise attempted to discuss his potential enrollment. He also did not attend his MS-I classes for 2 days during the semester. Since then he has not communicated with my cadre and has not indicated whether he intends to continue participating or will attempt to enroll in ROTC during his sophomore year. Based on the information currently available to me, he has not registered for the MS-II class (or any other class in the ROTC curriculum) for the upcoming Fall semester.

c. I am aware of Dylan Kohere's allegation that he does not have the opportunity to apply for an academic scholarship. Based on the Department's new accessions guidance Mr. Kohere may apply and compete for a three- or two-year scholarship, but he is not eligible until he is enrolled as a cadet in ROTC. He cannot be enrolled, however, due to his non-compliance with my cadre's requests to discuss his enrollment, and therefore he is currently not eligible for a scholarship.

In accordance with 28 U.S.C. §1746, I declare under penalty of perjury that the foregoing is true and correct. Executed this 6th day of June 2018.



Sean M. Heenan
Major, U.S. Army
U.S. Army Cadet Command

**IN THE UNITED STATES DISTRICT COURT FOR
THE DISTRICT OF COLUMBIA**

_____)	
DOE, et al.,)	
)	
<i>Plaintiffs,</i>)	
)	
v.)	Civil Action No. 17-cv-1597 (CKK)
)	
DONALD TRUMP, et al.,)	
)	
<i>Defendants.</i>)	
_____)	

**DECLARATION OF JOSHUA D. SAFER, MD, FACP
IN SUPPORT OF PLAINTIFFS’ OPPOSITION TO DEFENDANTS’ MOTION TO
DISSOLVE THE PRELIMINARY INJUNCTION**

I, Joshua D. Safer, declare as follows:

1. I make this declaration based on my own personal knowledge.

PROFESSIONAL BACKGROUND

2. I am a Staff Physician in the Department of Medicine at the Mount Sinai Hospital and Mount Sinai Beth Israel Medical Center in New York, NY. I serve as Executive Director of the Center for Transgender Medicine and Surgery at Mount Sinai. I also hold an academic appointment as Senior Faculty in Mount Sinai’s Icahn School of Medicine. A true and correct copy of my CV is attached hereto as Exhibit A.

3. I am Board Certified in Endocrinology, Diabetes and Metabolism by the American Board of Internal Medicine, and I have been since 1997.

4. I graduated from the University of Wisconsin in Madison with a Bachelor of Science in 1986. I earned my Doctor of Medicine degree from the University of Wisconsin in 1990. I completed intern and resident training at Mount Sinai School of Medicine, Beth Israel Medical

Center in New York, New York from 1990 to 1993. From 1993 to 1994, I was a Clinical Fellow in Endocrinology at Harvard Medical School and Beth Israel Deaconess Medical Center in Boston, Massachusetts. I stayed at the same institution, serving as a Clinical and Research Fellow in Endocrinology under Fredric Wondisford, from 1994 to 1996.

5. Since 1997, I have evaluated and treated patients along with conducting research in endocrinology. Since 2004, the patient care and research has been the medicine/science specific to transgender individuals. I have led several other programs either in transgender medicine or in general endocrinology. In particular, I served as Medical Director of the Center for Transgender Medicine and Surgery, Boston Medical Center, Boston, MA (2016-2018); as Director of the Medical Education, Endocrinology Section, Boston University School of Medicine, Boston, MA (2007-2018); as Program Director of the Endocrinology Fellowship Training, Boston University Medical Center, Boston, MA (2007-2018); and as Director of the Thyroid Clinic, Boston Medical Center, Boston, MA (1999-2003).

6. I have authored or coauthored 71 papers in peer-reviewed journals, including many critical reviews; textbook chapters; and case reports in endocrinology and transgender medicine.

7. I have served as a Transgender Medicine Guidelines Drafting Group Member for the International Olympic Committee (“IOC”) since 2017.

8. I currently serve as the President of the United States Professional Association for Transgender Health (USPATH). I am also Secretary and Co-Chair of the Steering Committee of TransNet, the International Consortium for Transgender Medicine and Health Research. I have served in several other leadership roles in professional societies related to endocrinology and transgender health. These societies include the Alliance of Academic Internal Medicine, the American College of Physicians Council of Subspecialty Societies, the American Board of

Internal Medicine, the Association of Program Directors in Endocrinology and Metabolism, and the American Thyroid Association.

9. Since 2014, I have held various roles as a member of the World Professional Association for Transgender Health (“WPATH”), the leading international organization focused on transgender health care. WPATH has over 1,000 members throughout the world and is comprised of physicians, psychiatrists, psychologists, social workers, surgeons, and other health professionals who specialize in the diagnosis and treatment of transgender individuals. From 2016 to the present I have served on the Writing Committee for Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People.

10. I have served in various roles as a member of the Endocrine Society since 2014. I served as a Task Force member to develop the Endocrine Treatment of Transgender Persons Clinical Practice Guideline from 2014 to 2017. As part of this task force of nine experts, a methodologist, and a medical writer, I contributed to the “Endocrine Treatment of Gender-Dysphoria/Gender Incongruent Persons: An Endocrine Society Clinical Practice Guideline,” (“Endocrine Society Guidelines”).¹ These were an update to the “Endocrine Treatment of Transsexual Persons: An Endocrine Society Clinical Practice Guideline,” published by the Endocrine Society in 2009.

11. I served in the Wisconsin Army Reserve National Guard from 1987 to 1990 and remained in the Army Reserve until 1995. This service made me sympathetic to the unique needs of servicemembers and reflected my support for the military as an institution. Since then, I

¹ Wylie C. Hembree, Peggy T. Cohen-Kettenis, Lous Gooren, Sabine E. Hannema, Walter J. Meyer, M. Hassan Murad, Stephen M. Rosenthal, Joshua D. Safer, Vin Tangpricha & Guy T’Sjoen, “Endocrine Treatment of Gender-Dysphoria/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline,” *The Journal of Clinical Endocrinology & Metabolism*, Vol. 102, pp. 3869-3903 (Nov. 2017).

have continued to devote a significant part of my career to assisting people in the military and veterans, including from 2001 to 2006 when I served as a Staff Physician at the Veterans Administration Boston Health Care System in Boston, Massachusetts.

**CONSULTING FOR THE DEPARTMENT OF DEFENSE WORKING GROUP BEFORE
RELEASE OF THE OPEN SERVICE POLICY**

12. In 2014 and 2015, the Department of Defense (“DOD”) began a review of whether transgender people should be permitted to serve openly in the Armed Forces. In July 2015, then-Secretary of Defense Ashton Carter issued an order establishing a Working Group to carry out the analysis of this issue. It is my understanding that the Working Group met to discuss issues relating to military service by transgender people over the course of about a year, consulting personnel, training, readiness, and medical specialists from across the Department of Defense. The Working Group also consulted civilian medical professionals of which I was one. To assist the Working Group, I went to the Pentagon to advise the Working Group, answered questions from military and civilian leadership, and provided advice on endocrinology and transgender health.

CONSULTING FOR THE DEPARTMENT OF DEFENSE PANEL OF EXPERTS

13. Following his July announcement to the public over Twitter, President Donald Trump released a memorandum (“August 25 Memorandum”) containing a formal directive to the current Secretary of Defense, Secretary James N. Mattis, and the Secretary of Homeland Security that, among other things, required the Secretary of Defense, in consultation with the Secretary of Homeland Security, to “submit to [the President] a plan for implementing” the ban on service by transgender people within six months.

14. Secretary Mattis, in turn, set up a process for “developing an Implementation Plan on military service by transgender individuals, in which the Deputy Secretary of Defense and the

Vice Chairman of the Joint Chiefs of Staff would be “supported by a panel of experts.” (“Review Panel”).

15. I reprised my earlier role as an advisor to the Working Group by serving as one of the outside expert consultants for the Review Panel. On November 9, 2017, Dr. Jillian Shipherd, a Clinical Psychologist and Director of the LGBT Health Program at the Veterans Health Administration; Dr. Loren Schechter, Visiting Clinical Professor of Surgery at the University of Illinois in Chicago and Director of the Center for Gender Confirmation Surgery at Weiss Memorial Hospital in Chicago; and I met with the Review Panel. About 15 to 20 people were present. Some of them were the same people who were on the Working Group conducted under Secretary of Defense Ashton Carter.

A. COSTS

16. After some preliminary discussion, costs of medical care for transgender service members did not appear to be a big concern for the Review Panel because the cost figures associated with transgender military health services were so low relative to the costs of other health conditions and to the overall military health budget.

B. DEPLOYABILITY

17. The Review Panel’s main focus was deployability, and in particular, the impact of hormone treatment on deployability. The Review Panel members also wanted information regarding how long an already-serving member of the Armed Forces would have to be on leave, nondeployable, or on limited duty as a result of initiating or being on hormone therapy as part of transgender medical treatment. In response to questions and in discussions, I stated that based on current research, I believe that the initiation of hormone therapy or being on hormone therapy would not prevent a servicemember from carrying out their military duties.

18. Secretary Mattis's February 22 Memorandum to the President cites the Endocrine Society Guidelines that I worked to develop to say that a person needs blood work to be done by a laboratory every 90 days for the first year of hormone therapy.² This is a misrepresentation of what my colleagues and I wrote in the Endocrine Society Guidelines. The Endocrine Society Guidelines suggest that clinicians measure hormone levels during treatment to ensure that "administered sex steroids are maintained in the normal physiologic range for the affirmed gender."³ They also state, "We suggest regular clinical evaluation for physical changes and potential adverse changes in response to sex steroid hormones and laboratory monitoring of sex steroid hormone levels every 3 months during the first year of hormone therapy for transgender males and females and then once or twice yearly."⁴

19. The language we used made clear this was just a *suggestion*, not a requirement. The 3-month schedule is one that facilitates a relatively rapid dose advancement regimen within medically accepted standards. But that is not to say that a slower regimen would be less safe or not medically acceptable.

20. The Guidelines were written to aid endocrinologists in providing care for transgender patients. They do not state mandatory or essential treatment protocols.

21. When it is not practicable to perform quarterly blood work in the first year of hormone therapy, the patient's medication may simply be maintained at the prescribed level. The quarterly blood work is not necessary care. A doctor should check blood work after changing a

² Pages 22 and 33.

³ Para. 3.3

⁴ Para. 4.1.

patient's dose, but if a deployed service member cannot have a doctor check blood work, a patient can be maintained at the last known safe dose with no negative health consequences and no impact on readiness.

22. When I met with the Review Panel, I explained that while hormone therapy is necessary medical treatment for some transgender patients, temporarily (even for up to a 12 month deployment period where laboratory monitoring was not available) freezing the level of hormones a service member receives does not risk any provision of inadequate treatment; nor does it pose any medical or mental health risks *per se*.

23. The February 22 Memorandum is not consistent with the statements and recommendations I made when I met with the Review Panel.

24. There is no genuine issue regarding whether hormones can be taken into the field just as other medications are. Hormone therapies do not generally require special care or treatment such as refrigeration. There are versions that are stable and transportable.

25. A person receiving hormone therapy is in a steady state with hormones within weeks. There are no negative mental health consequences associated with not changing those levels for an extended period of time once a person's levels are in steady state.

26. The February 22 Memorandum states that "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."⁵ As an expert in the field of endocrinology and transgender health, I

⁵ Page 35.

do not agree with this statement. My remarks to the Review Panel are not consistent with that conclusion.

C. LETHALITY

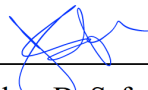
27. The Review Panel was also interested in lethality. I believe, and so stated, that there is no known correlation between hormone levels and lethality.

CONCLUSION

28. The February 22 Memorandum does not reflect the recommendations that I made to the Review Panel. As an expert qualified in the field of endocrinology and transgender health, it is my opinion that the February 22 Memorandum does not reflect the established scientific literature in this area. Based on my understanding of current data, statements that transgender people will be limited in their readiness to deploy based on hormone therapy needs are incorrect.

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

DATED: May 14, 2018



Joshua D. Safer, M.D.

EXHIBIT A

Joshua D. Safer, MD, FACP

March 1, 2018

Office Address: 17 E. 102nd Street, Room D-240

New York, NY 10128

Tel: (212) 241-5484

E-mail: jsafer0115@gmail.com

Academic Training

1990 MD University of Wisconsin School of Medicine, Madison, WI
1986 BS University of Wisconsin, Madison, WI, Economics

Postdoctoral Training

1994-1996 Clinical and Research Fellow, Endocrinology, under Fredric Wondisford, Harvard Medical School and Beth Israel Deaconess Medical Center, Boston, MA
1993-1994 Clinical Fellow, Endocrinology, Harvard Medical School and Beth Israel Deaconess Medical Center, Boston, MA
1990-1993 Intern and Resident, Department of Medicine, The Mount Sinai School of Medicine, Beth Israel Medical Center, New York City, NY

Academic Appointments

2018-present Senior Faculty, Icahn School of Medicine at Mount Sinai, New York, NY
2006-2018 Associate Professor of Medicine and Molecular Medicine, Boston University School of Medicine
1999-2006 Assistant Professor of Medicine, Boston University School of Medicine
1996-1999 Instructor in Medicine, Harvard Medical School
1993-1996 Fellow in Medicine, Harvard Medical School

Hospital Appointments

2018-present Staff Physician, Department of Medicine, The Mount Sinai Hospital, New York City, NY
2018-present Staff Physician, Department of Medicine, Mount Sinai Beth Israel Medical Center, New York City, NY
1999-2018 Staff Physician, Department of Medicine, Boston University Medical Center, Boston, MA
2001-2006 Staff Physician, Veterans Administration Boston Health Care System, Boston, MA
1996-1999 Staff Physician, Department of Medicine, Beth Israel Deaconess Medical Center, Boston, MA
1990-1993 House Staff, Department of Medicine, Beth Israel Medical Center, New York City, NY

Other Medical Staff Appointments

2004-2013 Staff Physician, Massachusetts Institute of Technology Medical Center, Cambridge, MA
1994-1999 Physician, Adult Urgent Care, Harvard Vanguard Medical Associates, Boston, MA
1987-1996 Captain, United States Army Reserve, Medical Corps

Honors:

2017	Lesbian, Gay, Bisexual and Transgender Health Award, Massachusetts Medical Society
2012	Outstanding Service Award, Association of Program Directors in Endocrinology and Metabolism
2007	Fellow, American College of Physicians
2004	Boston University School of Medicine Outstanding Student Mentor Award
2001	Abbott Thyroid Research Advisory Council Award
1996	Knoll Thyroid Research Clinical Fellowship Award, Endocrine Society
1995	Trainee Investigator Award for Excellence in Scientific Research, American Federation for Clinical Research (AFCR)
1994	Trainee Investigator Award for Excellence in Scientific Research, AFCR
1990	The University of Wisconsin Medical Alumni Association Award
1988-1990	Senior Class President, University of Wisconsin, School of Medicine

Licensure and Certification

1997	Board Certification in Endocrinology, Diabetes and Metabolism, American Board of Internal Medicine, recertified 2007, 2017
1994	Board Certification in Internal Medicine, American Board of Internal Medicine, recertified 2007
1993	MA License Registration #77459
1990	New York License Registration #187263-1

Departmental and University Committees

Boston Medical Center

2016-2018	Physician Satisfaction Task Force, Department of Medicine
2016-2018	Transgender Patient Task Force
2006-2017	Pharmacy and Therapeutics Committee, Health Net Plan

Boston University School of Medicine

2009-2018	Admissions Committee
2005	Review Committee, Department of Medicine Pilot Project Grants
2000	Residency and Fellowship Core Curriculum Committee,
2000-2018	Internship Selection Committee, Residency Program in Medicine

Boston University Goldman School of Dental Medicine

2003-2018	Course Directors Committee, Goldman School of Dental Medicine
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Teaching Experience and Responsibilities

Tufts University School of Medicine

2016-2018	Lecturer in Endocrinology, Second-year Pathophysiology Course
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Boston University School of Medicine

March 1, 2018

2003-2018 Course Director, Disease and Therapy - Endocrinology Section
1999-2018 Regular lectures to medical students, residents, and fellows on thyroid disease, diabetes insipidus, and transgender medicine

Boston University Goldman School of Dental Medicine

2002-2018 Course Director, General Medicine and Dental Correlations
2002-2018 Course Director, Medical Concerns in the Dental Patient

Major Mentoring Activities

Physician Career/Peer Advising

Year	Mentee	Most Recent Title
1995-present	Cohen, Ron, MD Ongoing career guidance	<ul style="list-style-type: none"> Associate Professor of Medicine and Interim Chief, Division of Endocrinology, University of Chicago School of Medicine
1999-present	Tangpricha, Vin, MD, PhD Ongoing career guidance	<ul style="list-style-type: none"> Associate Professor of Medicine and Program Director, Endocrinology Fellowship, Emory University School of Medicine
2003-present	McDonnell, Marie, MD Ongoing career guidance	<ul style="list-style-type: none"> Director, Inpatient Diabetes Service, Brigham and Women's Hospital
2003-present	Arum, Seth, MD Ongoing career guidance.	<ul style="list-style-type: none"> Faculty, Endocrinology Section, University of Massachusetts Medical Center
2004-present	Ananthakrishnan, Sonia, MD Ongoing career guidance	<ul style="list-style-type: none"> Evans Educator, Endocrinology Section, Boston University Medical Center
2007-present	Vimalananda, Varsha, MD Ongoing career guidance	<ul style="list-style-type: none"> Faculty, Endocrinology Section, Boston University Medical Center and Boston VA Hospital
2008-present	Port, Ava, MD Ongoing career guidance	<ul style="list-style-type: none"> Faculty, Endocrinology Section, University of Maryland Medical Center
2009-2013	Choong, Karen, MD Ongoing career guidance	<ul style="list-style-type: none"> Private Practice, MA
2009-2010	Kannan, Subramanian, MD Ongoing career guidance	<ul style="list-style-type: none"> Completed Endocrinology Fellowship Cleveland Clinic
2010-present	Spitzer, Matthew, MD Ongoing career guidance	<ul style="list-style-type: none"> Private Practice, Amherst, MA
2011-present	Steenkamp, Devin, MD Ongoing career guidance	<ul style="list-style-type: none"> Faculty, Endocrinology Section, Boston University Medical Center
2014-present	Thomas, Dylan, MD Ongoing career guidance	<ul style="list-style-type: none"> Endocrinology Fellow, Department of Medicine, Boston University Medical Center
2017-present	Korpaisarn, Sira, MD Ongoing career guidance	<ul style="list-style-type: none"> Endocrinology Fellow, Department of Medicine, Boston University Medical Center

Student Research Mentor and/or Thesis Advisor

Year	Mentee	Most Recent Title
1996-1997	Martin, Andrew Used DNA manipulation and tissue culture techniques to analyze <i>in vitro</i> functional impact of thyroid hormone resistance mutations.	▪ Matriculated University of Virginia September, 1997
1998	Wong, Jenny Used DNA manipulation and tissue culture techniques to analyze <i>in vitro</i> functional impact of thyroid hormone resistance mutations.	▪ Matriculated Harvard College September, 1998
1998	Song, Hyang Yeon Used DNA manipulation and tissue culture techniques to analyze <i>in vitro</i> functional impact of thyroid hormone resistance mutations.	▪ Graduated Mount Holyoke College
1999-2001	Fraser, Lisa Used DNA manipulation and tissue culture techniques to analyze <i>in vitro</i> functional impact of thyroid hormone resistance mutations. Learned and performed tissue culture assays in order to assess thyroid hormone action on skin cell lines. Assisted in design and implementation of experiments to assess thyroid hormone action on the skin of animals.	▪ Working in biotechnology
2000	Hoa, Michael Learned and performed tissue culture assays in order to assess thyroid hormone action on skin cell lines. Assisted in design and implementation of experiments to assess thyroid hormone action on the skin of animals.	▪ Matriculated Boston University School of Medicine September, 2000
2001-2004	Crawford, Tara Learned and performed tissue culture/gene expression/protein expression assays in order to assess thyroid hormone action on skin cell lines. Assisted in design and implementation of experiments to assess thyroid hormone action on the skin of animals.	▪ Works in recruitment for Ross Medical School
2003-2004	Vaghasia, Pramil Learned and performed tissue culture/gene expression/protein expression assays in order to assess thyroid hormone action on skin cell lines	▪ Graduated Boston University, 2004
2003	Ladhani, Anil Learned and performed tissue culture/gene expression/protein expression assays in order to assess thyroid hormone action on skin cell lines.	▪ Graduated Boston University, 2004
2003	Belardo, Sheila Learned and performed tissue culture/gene expression/protein expression assays in order to assess thyroid hormone action on skin cell lines.	▪ Graduated Boston University, 2005

Year	Mentee	Most Recent Title
2004	Mohan, Shaulnie Learned and performed tissue culture/gene expression/protein expression assays in order to assess thyroid hormone action on skin cell lines.	▪ Graduated Boston University, 2005; matriculated Boston University School of Medicine
2004	Patel, Nathan Learned and performed tissue culture/gene expression/protein expression assays in order to assess thyroid hormone action on skin cell lines.	▪ Graduated Boston University, 2005
2004	Sharma, Aman Learned and performed tissue culture/gene expression/protein expression assays in order to assess thyroid hormone action on skin cell lines.	▪ Graduated Boston University, 2005; matriculated SUNY-Downstate School of Medicine
2006-2007	Holland (now Rogers), Kathryn Learned and performed tissue culture/gene expression/protein expression assays in order to assess thyroid hormone action on skin cell lines. Assisted in design and implementation of experiments to assess thyroid hormone action on the skin of animals. Learned and performed in vivo methodologies with mice. Coauthored a publication from the data.	▪ Graduated Boston University, 2005; working as a school teacher
2006-2008	Huang, Max Learned and performed tissue culture/gene expression/protein expression assays in order to assess thyroid hormone action on skin cell lines. Assisted in design and implementation of experiments to assess thyroid hormone action on the skin of animals. Learned and performed in vivo methodologies with mice. First authored a poster presented at a national meeting. First authored a publication from the data.	▪ MS from Boston University; matriculated medical school
2006-2008	Mehta, Meetal Learned and performed tissue culture/gene expression/protein expression assays in order to assess thyroid hormone action on skin cell lines. Coauthored a publication from the data.	▪ MS from Boston University; matriculated medical school
2006-2007	O'Mara, Rosemary Learned and performed tissue culture/gene expression/protein expression assays in order to assess thyroid hormone action on skin cell lines. Assisted in design and implementation of experiments to assess thyroid hormone action on the skin of animals. Learned and performed in vivo methodologies with mice. Coauthored a publication from the data.	▪ BA from Boston University

Year	Mentee	Most Recent Title
2007	Abuzahra, Hilal Assisted in design and implementation of experiments to assess thyroid hormone action on the skin of animals. Learned and performed in vivo methodologies with mice. Coauthored a publication from the data.	▪ MS from Boston University; matriculated Boston University School of Medicine
2007	Tannenbaum, Andrew Assisted in design and implementation of experiments to assess thyroid hormone action on the skin of animals. Learned and performed in vivo methodologies with mice. Coauthored a publication from the data.	▪ MS from Boston University; matriculated Boston University School of Medicine
2007-2008	Yoo, David Learned and performed tissue culture/gene expression/protein expression assays in order to assess thyroid hormone action on skin cell lines.	▪ MS from Boston University
2007-2008	Pagano, Joe Learned and performed tissue culture/gene expression/protein expression assays in order to assess thyroid hormone action on skin cell lines.	▪ MS from Boston University
2007-2009	Bhakit, Mena Learned and performed tissue culture/gene expression/protein expression assays in order to assess thyroid hormone action on skin cell lines. Assisted in design and implementation of experiments to assess thyroid hormone action on the skin of animals. Learned and performed in vivo methodologies with mice. Coauthored a publication from the data.	▪ MS from Boston University; matriculated medical school
2007-2008	Chan, Yvonne Learned and performed tissue culture/gene expression/protein expression assays in order to assess thyroid hormone action on skin cell lines.	▪ MS from Boston University; matriculated graduate school
2007-2008	Lee, Monica Learned and performed tissue culture/gene expression/protein expression assays in order to assess thyroid hormone action on skin cell lines.	▪ MS from Boston University
2007-2008	Grasso, Victoria Learned and performed tissue culture/gene expression/protein expression assays in order to assess thyroid hormone action on skin cell lines.	▪ MS from Boston University
2007-2008	Bokhari, Matthew Learned and performed tissue culture/gene expression/protein expression assays in order to assess thyroid hormone action on skin cell lines.	▪ BA from Boston University

Year	Mentee	Most Recent Title
2008-2010	Watto, Matthew Career guidance.	▪ Matriculated Temple University Internal Medicine Residency Program
2008-2011	Agee, Erin Master's Thesis Advisor. Learned and performed tissue culture/gene expression/protein expression assays in order to assess thyroid hormone action on skin cell lines.	▪ MS from Boston University
2009-2010	Wang, Yun Master's Research and Thesis Advisor. Learned and performed tissue culture/gene expression/protein expression assays in order to assess thyroid hormone action on skin cell lines.	▪ MS from Boston University
2009-2011	Nishtala, Arvind Research Advisor. Learned and performed tissue culture/gene expression/protein expression assays in order to assess thyroid hormone action on skin cell lines.	▪ Matriculated Medical School, Boston University
2009-2010	Chen, Bridgett Master's Research Project and Thesis Advisor. Learned and performed tissue culture/gene expression/protein expression assays in order to assess thyroid hormone action on skin cell lines.	▪ Matriculated Medical School, Albany Medical College
2009	Esochaghi, Sorochi Master's Research Project and Thesis Advisor. Learned and performed tissue culture/gene expression/protein expression assays in order to assess thyroid hormone action on skin cell lines.	▪ MS from Boston University
2009-2011	Kim, Kyeonghee Master's Research and Thesis Advisor. Learned and performed tissue culture/gene expression/protein expression assays in order to assess thyroid hormone action on skin cell lines.	▪ MS from Boston University
2010-2011	Faruqi, Adnan Master's Research Project and Thesis Advisor. Learned and performed tissue culture/gene expression/protein expression assays in order to assess thyroid hormone action on skin cell lines.	▪ MS from Boston University
2010-2011	Fink, Kyle Master's Research Project and Thesis Advisor. Learned and performed tissue culture/gene expression/protein expression assays in order to assess thyroid hormone action on skin cell lines.	▪ Matriculated Medical School at New York Medical College

Year	Mentee	Most Recent Title
2010-2011	Heath, Alyson Master's Thesis Advisor. Learned and performed tissue culture/gene expression/protein expression assays in order to assess thyroid hormone action on skin cell lines.	▪ MS from Boston University
2010-2011	Mouchati, Alex Master's Research and Thesis Advisor. Learned and performed tissue culture/gene expression/protein expression assays in order to assess thyroid hormone action on skin cell lines. First authored an abstract at a local meeting.	▪ MS from Boston University
2010-2011	Porter, Drew Learned and performed tissue culture/gene expression/protein expression assays in order to assess thyroid hormone action on skin cell lines.	▪ BS from Boston University
2010	Rosenbaum, Lucy Learned and performed tissue culture/gene expression/protein expression assays in order to assess thyroid hormone action on skin cell lines.	▪ Matriculated Boston University School of Medicine
2011-2012	Stratton, Michael Master's Research and Thesis Advisor. Learned and performed tissue culture/gene expression/protein expression assays in order to assess thyroid hormone action on skin cell lines.	▪ Matriculated Boston University School of Medicine
2011-2012	Feeley, Brigid Master's Research and Thesis Advisor. Learned and performed tissue culture/gene expression/protein expression assays in order to assess thyroid hormone action on skin cell lines.	▪ MS from Boston University
2011-2012	Gonzales, Christopher Master's Research and Thesis Advisor. Learned and performed tissue culture/gene expression/protein expression assays in order to assess thyroid hormone action on skin cell lines.	▪ MS from Boston University
2011-2012	Mahmood, Sundis Master's Research and Thesis Advisor. Learned and performed tissue culture/gene expression/protein expression assays in order to assess thyroid hormone action on skin cell lines.	▪ MS from Boston University

Year	Mentee	Most Recent Title
2011-2012	Berman, Reena Research and undergraduate thesis advisor. Assisted in design and implementation of experiments to assess thyroid hormone action on the skin of animals. Learned and performed in vivo methodologies with mice. First authored a poster presentation at a local meeting from the data.	▪ BA from Boston University
2011-2012	Dwivedi, Sashank Research advisor. Learned and performed tissue culture/gene expression/protein expression assays in order to assess thyroid hormone action on skin cell lines.	▪ BA from Boston University
2012-2013	Carey, Katelyn Learned and performed tissue culture/gene expression/protein expression assays in order to assess thyroid hormone action on skin cell lines.	▪ MS from Boston University
2012-2013	Moroney, James Learned and performed tissue culture/gene expression/protein expression assays in order to assess thyroid hormone action on skin cell lines.	▪ MS from Boston University
2012-2013	Sayed, Sabina Learned and performed tissue culture/gene expression/protein expression assays in order to assess thyroid hormone action on skin cell lines.	▪ MS from Boston University
2012-present	Meyers, Steven Developed and analyzed clinical data sets for quality projects and research projects in Transgender Medicine. First author of two publications.	▪ BS from Hampshire College
2012-present	Gardner, Ivy Learned and performed tissue culture/gene expression/protein expression assays in order to assess androgen action on endometrial cell lines. First author of data presented at two meetings. First author of publication.	▪ MD from Boston University; matriculated general surgery residency
2012-2013	Bonzagni, Anthony Developed and analyzed data for research projects in Transgender Medicine.	▪ MS from Boston University
2012-2014	Ma, Peter Developed and analyzed data for research projects in Transgender Medicine.	▪ BS from Boston University
2013-present	Fong, Elias Developed and analyzed data for research projects in Transgender Medicine.	▪ BS from Boston University

Year	Mentee	Most Recent Title
2013-present	Weinand, Jamie Developed and analyzed data for research projects in Transgender Medicine. First author of data presented at two meetings. First author of publication.	▪ MD from Boston University; matriculated family medicine residency
2014-present	Eriksson, Sven Developed and analyzed data for research projects in Transgender Medicine. First author of publication.	▪ MS from Boston University; matriculated medical school
2015-present	Liang, Jennifer Developed and analyzed data for research projects in Transgender Medicine. First author of two publications	▪ Medical Student at Boston University
2015-present	Lu, Simon Developed and analyzed data for research projects in Transgender Medicine. Publication co-author	▪ MD from Boston University; matriculated obstetrics-gynecology residency
2015-present	Qian, Ray Developed and analyzed data for research projects in Transgender Medicine. First author of publication.	▪ Medical Resident at Boston University Medical Center
2016-present	Kailas, Maya Developed and analyzed data for research projects in Transgender Medicine. First author of publication.	▪ Medical Student at Boston University
2016-present	Jolly, Divya Developed and analyzed data for research projects in Transgender Medicine. Manuscript in progress	▪ Medical Anthropology Graduate Student at Boston University
2016-present	Chan, Kelly Developed and analyzed data for research projects in Transgender Medicine. Manuscript in progress	▪ Masters Student at Harvard University
2017-present	Park, Jason Developed and analyzed data for research projects in Transgender Medicine. Manuscript in progress	▪ Medical Student at Boston University
2017-present	Bisson, Jason Developed and analyzed data for research projects in Transgender Medicine. Manuscript in progress	▪ College Student at Northeastern University

Major Administrative Responsibilities

2018-present Executive Director, Center for Transgender Medicine and Surgery, Mount Sinai Health System, New York City, NY
2016-2018 Medical Director, Center for Transgender Medicine and Surgery, Boston Medical Center, Boston, MA
2007-2018 Director, Medical Education, Endocrinology Section, Boston University School of Medicine, Boston, MA
2007-2018 Program Director, Endocrinology Fellowship Training, Boston University Medical Center, Boston, MA
1999-2003 Director, Thyroid Clinic, Boston Medical Center, Boston, MA

Other Professional Activities

Professional Societies: Memberships

2016-present United States Professional Association for Transgender Health (USPATH)
2014-present World Professional Association for Transgender Health (WPATH)
2007-present Association of Program Directors in Endocrinology and Metabolism (APDEM)
2007-present Association of Specialty Professors (ASP), Alliance of Academic Internal Medicine (AAIM)
1999-present American Association of Clinical Endocrinologists
1998-present American Thyroid Association
1995-present Endocrine Society
1994-present American College of Physicians
1994-1996 American Federation for Medical Research
1993-present MA Medical Society

Professional Societies: Offices Held and Committee Assignments

International

International Olympic Committee (IOC)

2017-present Drafting Group Member, Medical Guidelines, International Olympic Committee

World Professional Association for Transgender Health (WPATH)

2016-present Writing Committee Member, Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People
2016-present Co-Chair, Scientific Committee, International Meeting, Buenos Aires - 2018
2015-2016 Chair, Scientific Committee, International Meeting, Amsterdam - 2016
2015-present Task Force Member, Global Education Initiative
2015-present Media Liaison

TransNet – International Consortium for Transgender Medicine and Health Research

2014-present Secretary and Co-Chair, Steering Committee

National

United States Professional Association for Transgender Health (USPATH)

2018-present President

Alliance of Academic Internal Medicine

2016-present Chair, Compliance Committee
2016-2017 Committee member, Compensation
2015-2016 President, Association of Specialty Professors (ASP)
2014-2017 Council member
2014-present Task Force member, Program Planning
2014-present Work Group member, Survey Center
2013-2015 Chair, Program Planning Committee, ASP
2012-2017 Council member, ASP
2012-2013 Chair, Membership Services Committee, ASP
2010-2015 Chair, Program Directors Site Visit Training Seminar, ASP
2007-2013 Committee member, Membership Services, ASP

American College of Physicians

2016-present Council of Subspecialty Societies member

Endocrine Society

2017-present Advisory Board member, Transgender/Disorders of Sex Development
2017-present Committee member, Clinical Endocrine Education
2014-present Media Liaison for Transgender Medicine
2014-2017 Task Force member, Endocrine Treatment of Transgender Persons Clinical Practice Guideline

American Board of Internal Medicine

2013-present Task Force member, Endocrinology Procedures
2013 Task Force member, ASP/AAIM/ACGME/ABIM Joint Next Accreditation System Internal Medicine Subspecialty Milestones

Association of Program Directors in Endocrinology and Metabolism

2017-present Secretary-Treasurer
2012-present Task Force member, Next Accreditation System Endocrinology Milestones
2011-2012 Task Force member, Procedures Accreditation
2010-2012 Council member
2009-2016 Chair, Site Visit/Curriculum Web-Toolbox Committee

American Thyroid Association

2006-2009 Publications Committee member
2004 Program Committee member

Editorships and Editorial Boards

2018-present Associate Editor, *Transgender Health*
2017-present Editorial Advisory Board, *Endocrine News*

2016-present Transgender Section Co-Editor, *UpToDate*
2015-present Editorial Board, *Transgender Health*
2015-present Editorial Board, *International Journal of Transgenderism*
2013-present Associate Editor, *Journal of Clinical & Translational Endocrinology*
2007-present Editorial Board, *Endocrine Practice*

External Medical Advising and Consulting

International

2016-present International transgender athlete guidelines, Medical and Scientific Commission, International Olympic Committee

National

2017-present Transgender medical and surgical treatment, National Collegiate Athletic Association,
2017-present Safety for transgender medical treatment, Food and Drug Administration, United States
2015-present Transgender workforce and military readiness, Department of Defense, United States
2014 Transgender prison population health, Federal Bureau of Prisons, United States

Regional

2011-present Transgender prison population health, Massachusetts Department of Correction

Past Other Support

2015-2016 R13 HD084267, **Multi-PI: Joshua D. Safer**, TransNet: Developing a Research Agenda in Transgender Health and Medicine

2014-2015 Boston Foundation, Equality Fund, **PI: Joshua D. Safer**, Pilot Program to Educate Physicians in Transgender Medicine

2013-2014 Evans Foundation, **PI: Joshua D. Safer**, A Pilot Curriculum in Transgender Medicine

2001-2003 Thyroid Research Advisory Council, **PI: Joshua D. Safer**, Thyroid Hormone Action on Skin

2001-2002 Evans Foundation, **PI: Joshua D. Safer**, Thyroid Hormone Action on Skin

1996-2001 K08 DK02423, **PI: Joshua D. Safer**, Characterization of Central Resistance to Thyroid Hormone

Conferences Organized

International Conferences

World Professional Association for Transgender Health (WPATH)

June, 2018 Bi-annual meeting, Scientific Co-Chair, Buenos Aires, Argentina (scheduled)

June, 2016 Bi-annual meeting, Scientific Co-Chair, Amsterdam, Netherlands

November, 2015 Global Education Initiative, inaugural conference, Chicago, IL

TransNet – International Consortium for Transgender Health and Medicine Research

May, 2016 International meeting to set transgender medicine research priorities, Amsterdam, Netherlands

May, 2015 NIH conference to set transgender medicine research priorities, Bethesda, MD

June, 2014 Inaugural meeting, Chicago, IL

National Conferences

April, 2018 Live Surgery Course for Gender Affirmation Procedures, Mount Sinai Hospital and WPATH, New York City, NY (scheduled)

January, 2017 United States Professional Association for Transgender Health (USPATH) bi-annual meeting, Los Angeles, CA

November, 2015 NIH/Alliance for Academic Internal Medicine - Physician Researcher Workforce Taskforce Meeting, Washington, DC

October, 2015 National Internal Medicine Subspecialty Summit, Atlanta, GA

June, 2013 Special Symposium: “Transgender Medicine – What Every Physician Should Know” Annual Meeting of the Endocrine Society, San Francisco, CA

April, 2011 2011 ASP Accreditation Seminar "Meeting the ACGME and RRC-IM Standards for Successful Fellowship Programs" Arlington, VA

Alliance for Academic Internal Medicine

April, 2015 2015 ASP Accreditation Seminar “Moving Your Fellowship Program Forward” Spring Meeting, Houston, TX

April, 2014 2014 ASP Accreditation Seminar “NAS for Medical Subspecialties Is Almost Here” Spring Meeting, Nashville, TN

May, 2013 2013 ASP Accreditation Seminar “A Changing Landscape in Subspecialty Fellowship Education” Spring Meeting, Lake Buena Vista, FL

March 1, 2018

April, 2012 2012 ASP Accreditation Seminar “Meeting ACGME and RRC-IM Standards for Successful Fellowship Programs” Spring Meeting, Atlanta, GA

Invited Lectures and Presentations

International

February, 2017 “A 21st-Century Framework to for Transgender Medical Care” Sheba Hospital, Tel Aviv, Israel

October, 2016 “A 21st-Century Approach to Hormone Treatment of Transgender Individuals” EndoBridge, Antalya, Turkey

May, 2016 “Transgender Women” International Olympic Committee Headquarters, Lausanne, Switzerland

October, 2015 “Workshop on Guidelines for Transgender Health Care” Canadian Professional Association for Transgender Health, Halifax, NS

March, 2015 “Endocrinology - Hormone Induced Changes” Transgender Health Care in Europe, European Professional Association for Transgender Health, Ghent, Belgium

June, 2014 “What to Know to Feel Safe Providing Hormone Therapy for Transgender Patients” International Congress of Endocrinology, Chicago, IL

September, 2011 “Transgender Therapy – The Endocrine Society Guidelines” World Professional Association for Transgender Health, Atlanta, GA

February, 2007 “Treating skin disease by manipulating thyroid hormone action” Grand Rounds, Meier Hospital, Kfar Saba, Israel

March, 2004 “New Directions in Thyroid Hormone Action: Skin and Hair” Grand Rounds, Meier Hospital, Kfar Saba, Israel

National

October, 2018 “Transgender Therapy – The Endocrine Society Guidelines” Endocrine Society: Clinical Endocrinology Update, Anaheim, CA

September, 2018 “Transgender Therapy – The Endocrine Society Guidelines” Endocrine Society: Clinical Endocrinology Update, Miami, FL

September, 2018 “Current Guidelines and Strategy for Hormone Treatment of Transgender Individuals” Minnesota-Midwest Chapter - American Association of Clinical Endocrinologists Annual Meeting, Minneapolis, MN (scheduled)

July, 2018 “Current Guidelines and Strategy for Hormone Treatment of Transgender Individuals” Upper Ohio Valley Chapter - American Association of Clinical Endocrinologists Annual Meeting, Indianapolis, IN (scheduled)

March 1, 2018

- May, 2018 “A 21st-Century Strategy for Hormone Treatment of Transgender Individuals” American Association of Clinical Endocrinologists Annual Meeting, Boston, MA (scheduled)
- March, 2018 “21st-Century Strategies for Transgender Hormone Care” New Jersey Chapter - American Association of Clinical Endocrinologists Meeting, Morristown, NJ
- February, 2018 “A Strategy for the Medical Care of Transgender Individuals” Keynote Address for the International Society for Clinical Densitometry Annual Meeting, Boston, MA
- November, 2017 “A 21st-Century Strategy for Hormone Treatment of Transgender Individuals” National Transgender Health Summit, Oakland, CA
- September, 2017 “Transgender Therapy – The Endocrine Society Guidelines” Endocrine Society: Clinical Endocrinology Update, Chicago, IL
- May, 2017 “Transgender Medicine – a 21st Century Strategy for Patient Care” University of Arizona College of Medicine, Tucson, AR
- April, 2017 “Transgender Care Across the Age Continuum” Annual Meeting of the Endocrine Society, Orlando, FL
- March, 2017 “A 21st-Century Approach to Hormone Treatment of Transgender Individuals” Brown University School of Medicine, Providence, RI
- March, 2017 “What to Know: A 21st-Century Approach to Transgender Medical Care” United States Food and Drug Administration (FDA), Washington, DC
- February, 2017 “A 21st-Century Approach to Transgender Medical Care” United States Professional Association for Transgender Health, Los Angeles, CA
- February, 2017 “A 21st-Century Approach to Hormone Treatment of Transgender Individuals” Southern States American Association of Clinical Endocrinologists Annual Meeting, Memphis, TN
- December, 2016 “Transgender Medical Care in the United States Armed Forces” Global Education Initiative, World Professional Association for Transgender Health, Arlington, VA
- December, 2016 “Foundations in Hormone Treatment” Global Education Initiative, World Professional Association for Transgender Health, Arlington, VA
- November, 2016 “Developing a Transgender/Gender-Identity Curriculum for Medical Students” Association of American Medical Colleges National Meeting, Seattle, WA
- September, 2016 “A 21st-Century Approach to Hormone Treatment of Transgender Individuals” Endocrine Society: Clinical Endocrinology Update, Seattle, WA
- August, 2016 “A 21st-Century Approach to Hormone Treatment of Transgender Individuals” Oregon Health and Science University Ashland Endocrine Conference, Ashland, OR

- March, 2016 “State-of-the-Art: Use of Hormones in Transgender Individuals” Annual Meeting of the Endocrine Society, Boston, MA
- October, 2015 “What Every Endocrinologist Should Know to Feel Safe Providing Hormone Therapy for Transgender Patients” University of Utah School of Medicine, Salt Lake City, UT
- April, 2015 “What to Know –to Feel Safe Providing Hormone Therapy for Transgender Patients” Pritzker School of Medicine, University of Chicago, Chicago, IL
- March, 2015 “What to Know –to Feel Safe with Hormone Therapy for Transgender Patients” Annual Transgender Health Symposium, Medical College of Wisconsin, Milwaukee, WI
- May, 2014 “Transgendorinology” Annual Meeting of the American Association of Clinical Endocrinologists, Las Vegas, NV
- May, 2013 “Transgender Therapy – Hormone Action and Nuance” National Transgender Health Summit, Oakland, CA
- April, 2013 “Transgender Therapy – What Every Provider Needs to Know” Empire Conference: Transgender Health and Wellness, Albany, NY
- April, 2013 “Transgender Therapy – What Every Endocrinologist Needs to Know” University of Maryland School of Medicine, Baltimore, MD
- November, 2012 “Transgender Therapy – What Every Endocrinologist Should Know” New York University School of Medicine, New York, NY
- May, 2010 “Transgender Treatment: What Every Endocrinologist Needs to Know” Brown University School of Medicine, Providence, RI
- November, 2009 “New Directions in Thyroid Hormone Action: Skin and Hair” Emory University School of Medicine, Atlanta, GA
- November, 2009 “Primary Care Update in the Treatment of Thyroid Disorders” Emory University School of Medicine, Atlanta, GA
- October, 2008 “Topical Iopanoic Acid Stimulates Epidermal Proliferation through Inhibition of the Type 3 Thyroid Hormone Deiodinase” Annual Meeting of the American Thyroid Association, Chicago, IL
- February, 2005 “New Directions in Thyroid Hormone Action: Skin and Hair” Endocrinology Grand Rounds, University of Minnesota, Minneapolis, MN
- February, 2005 “Thyroid Hormone Action on Skin and Hair: What We Thought We Knew” Dermatology Grand Rounds, University of Minnesota, Minneapolis, MN
- December, 2004 “Transgender Therapy: The Role of the Endocrinologist” Endocrinology Grand Rounds, Brown Medical Center, Providence, RI

November, 2003 “New Directions in Thyroid Hormone Action: Skin and Hair” Endocrinology Grand Rounds, Dartmouth Medical Center, Hanover, NH

Regional

February, 2018 “Transgender Medicine – 21st Century Strategies for Patient Care” Medicine Rounds, Newton-Wellesley Hospital, Newton, MA (scheduled)

October, 2017 “Transgender Medicine – 21st Century Strategies for Patient Care” Medicine Rounds, Beth Israel-Milton Hospital, Milton, MA

September, 2017 “Transgender Medicine – 21st Century Strategies for Patient Care” Obstetrics-Gynecology Grand Rounds, Brigham and Women’s Hospital, Boston, MA

June, 2017 “State-of-the-Art: Hormone Therapy for Transgender Patients” Reproductive Endocrinology Rounds, Massachusetts General Hospital, Boston, MA

May, 2017 “A 21st-Century Strategy for Medical Treatment of Transgender Individuals” Boston Medical Center and Boston University School of Medicine, Boston, MA

March, 2017 “A 21st-Century Strategy for Medical Treatment of Transgender Individuals” Tufts Medicine Grand Rounds, Boston, MA

January, 2017 “What to Know: A 21st-Century Approach to Transgender Medical Care” Internal Medicine Rounds, Brigham and Women’s Hospital, Boston, MA

March, 2016 “State-of-the-Art: Hormone Therapy for Transgender Patients” Obstetrics-Gynecology Rounds, Brigham and Women’s Hospital, Boston, MA

November, 2015 “What Every Endocrinologist Should Know to Feel Safe Providing Hormone Therapy for Transgender Patients” Endocrinology Rounds, Tufts Medical Center, Boston, MA

May, 2015 “What Every Endocrinologist Should Know to Feel Safe Providing Hormone Therapy for Transgender Patients” Endocrinology Rounds, Massachusetts General Hospital, Boston, MA

December, 2014 “What to Know to Feel Safe Providing Hormone Therapy for Transgender Patients” Endocrinology Rounds, Beth Israel Deaconess Medical Center, Boston, MA

November, 2013 “Transgender Therapy – What Every Physician Should Know” Medicine Grand Rounds, Boston Veterans Administration Hospital, Boston, MA

May, 2005 “Transgender Therapy: The Role of the Endocrinologist”, Endocrinology Rounds, Tufts-New England Medical Center, Boston, MA

January, 2004 “New Directions in Thyroid Hormone Action: Skin and Hair”, Endocrinology Rounds, Brigham and Women’s Hospital, Boston, MA

October, 1999 “The Many Faces of Hypothyroidism”, Medicine Grand Rounds, Bedford Veterans Administration Hospital, Bedford, MA

March 1, 2018

Institutional, Icahn School of Medicine at Mount Sinai, New York, NY

April, 2018 “State of the Art Hormone Therapy for Transgender Patients”, Section of Infectious Disease

Institutional, Boston University School of Medicine, Boston, MA

March, 2017 “State of the Art Hormone Therapy for Transgender Patients”, Section of Infectious Disease

January, 2017 “What you need to know – to supervise care for our transgender patients at BMC”,
Section of Endocrinology

February, 2016 “State of the Art Hormone Therapy for Transgender Patients”, Department of Medicine

November, 2015 “What the Family Medicine Physician Should Know to Feel Safe Providing Hormone Therapy
for Transgender Patients”, Department of Family Medicine

November, 2014 “What the Anesthesiologist Should Know to Feel Safe Providing Hormone Therapy for
Transgender Patients”, Department of Anesthesia

January, 2014 “Update on the Current Guidelines for Transgender Hormone Therapy”, Section of
Endocrinology

October, 2011 “Transgender Therapy – What Every Physician Should Know”, Department of Medicine

February, 2011 “Current Guidelines for Transgender Hormone Therapy: What Every Endocrinologist Should
Know”, Section of Endocrinology

November, 2005 “Thyroiditis and Other Insults to Thyroid Function” Core Curriculum in Adult Primary Care
Medicine

November, 2005 “Interpretation of Thyroid Function Tests Made Easy” Core Curriculum in Adult Primary Care
Medicine

January, 2005 “Transgender Therapy: The Role of the Endocrinologist” Endocrinology Grand Rounds

December, 2004 "Update in Endocrinology: Thyroid" Medicine Grand Rounds

January, 2004 “New Directions in Thyroid Hormone Action: Skin and Hair” Medicine Grand Rounds

March, 2003 “Thyroid Hormone Action on Hair and Skin” Endocrinology Grand Rounds

November, 1999 “Central Resistance to Thyroid Hormone – From Bedside to Bench” Endocrinology Grand
Rounds

Curriculum development with external dissemination

2014-present Web site for Association of Program Directors of Endocrinology and Metabolism (APDEM), which serves as *the primary resource for endocrinology fellowship program directors throughout the United States and Canada.*

- Sample curricula
- Streaming lectures to support specific curricular needs to fill programmatic gaps at certain programs
- New assessment forms that map skills to milestones that conform to Next Accreditation System (NAS) standards of the Accreditation Council for Graduate Medical Education (ACGME)

2013-present Dissemination of Transgender Medicine Curriculum with local modification to institutions in the United States and Canada

Curriculum adopted

Johns Hopkins School of Nursing (sample video:
<http://vimeo.com/jhunursing/review/97477269/abbcf6d33a>)

Ohio State University College of Medicine
University of British Columbia, Faculty of Medicine
University of Central Florida College of Medicine
Tufts University School of Medicine

Curriculum in development

Dartmouth School of Medicine
University of Vermont College of Medicine

Work in progress in preparation for sharing transgender curriculum

Albany Medical College
Emory School of Medicine
George Washington University Medical School
Hofstra School of Medicine
University of California – San Diego School of Medicine
University of Kentucky College of Medicine
University of Louisville School of Medicine
University of Michigan Medical School
University of Minnesota Medical School
University of Nebraska School of Medicine
University of Pennsylvania School of Medicine
Washington University School of Medicine

2013-2015 Co-author of the *Medical Subspecialty Reporting Milestones used for evaluation of Internal Medicine subspecialty medicine fellowship programs throughout the United States* by the Accreditation Council for Graduate Medical Education (ACGME).

<https://www.acgme.org/acgmeweb/Portals/0/PDFs/Milestones/InternalMedicineSubspecialtyMilestones.pdf>

2011-2014 Web site content expert for APDEM, which served as *the primary resource for endocrinology fellowship Program directors throughout the United States and Canada*. Materials included sample curricula, streaming lectures to support specific curricular needs to fill programmatic gaps at certain programs, and guidance dealing with ACGME site-visits

Other curriculum development

2016-present Curricular Content to teach transgender hormone therapy in the LGBT elective at Harvard Medical School

2016-present Curricular Content to teach transgender hormone therapy at Tufts University School of Medicine.

2011-present Fully revised curriculum for the Boston University Medical Center Fellowship Training Program in Endocrinology, Diabetes and Nutrition.

2010-present Curricula to teach transgender hormone therapy at Boston University School of Medicine.

2006-2014 Written examination in endocrinology to complement the multiple choice examination for medical students — validation relative to success later in medical school is in progress.

Bibliography: (ORCID  # 0000 0003 2497 8401)

Names of mentees are underlined throughout the bibliography section

**5 currently most influential papers are noted with double asterisks

Original, Peer-Reviewed Articles

1. **Safer JD**, Langlois MF, Cohen R, Monden T, John-Hope D, Madura J, Hollenberg AN, Wondisford FE. Isoform variable action among thyroid hormone receptor mutants provides insight into pituitary resistance to thyroid hormone. *Mol Endocrinol* 1997;11(1):16-26. PMID 8994184
2. Langlois MF, Zanger K, Monden T, **Safer JD**, Hollenberg AN, Wondisford FE. A unique role of the beta-2 thyroid hormone receptor isoform in negative regulation by thyroid hormone - mapping of a novel amino-terminal domain important for ligand-independent activation. *J Biol Chem* 1997;272(40):24927-24933. PMID 9312095
3. **Safer JD**, Cohen RN, Hollenberg AN, Wondisford, FE. Defective release of corepressor by hinge mutants of the thyroid hormone receptor found in patients with resistance to thyroid hormone. *J Biol Chem* 1998;273(46):30175-30182. PMID 9804773
4. **Safer JD**, O'Connor MG, Colan SD, Srinivasan S, Tollin SR, Wondisford FE. The TR-beta gene mutation R383H is associated with isolated central resistance to thyroid hormone. *J Clin Endocrinol Metab* 1999;84(9):3099-3109. PMID 10487671
5. **Safer JD**, Fraser LM, Ray S, Holick MF. Topically applied triiodothyronine stimulates epidermal proliferation, dermal thickening, and hair growth in mice and rats. *Thyroid* 2001;1(8):717-724. PMID 11525263
6. Tangpricha V, Chen BJ, Swan NC, Sweeney AT, de las Morenas A, **Safer JD**. Twenty-one gauge needles provide more cellular samples than twenty-five gauge needles in fine needle aspiration biopsy of the thyroid. *Thyroid* 2001;11(10):973-976. PMID 11716046
7. **Safer JD**, Crawford TM, Fraser LM, Hoang M, Ray S, Chen TC, Persons K, Holick MF. Thyroid hormone action on skin: diverging effects of topical versus intraperitoneal administration. *Thyroid* 2003;13(2):159-165. PMID 12699590
8. Santini F, Ceccarini G, Montanelli L, Rosellini V, Mammoli C, Macchia P, Gatti G, Pucci E, Marsili A, Chopra IJ, Chiovato L, Vitto P, **Safer JD**, Braverman LE, Martino E, Pinchera A. Role for inner ring deiodination preventing transcutaneous passage of thyroxine. *J Clin Endocrinol Metab* 2003;88(6):2825-2830. PMID 12788895
9. **Safer JD**, Crawford TM, Holick MF. A role for thyroid hormone in wound healing through keratin gene expression. *Endocrinology* 2004;145(5):2357-2361. PMID 14736740
10. **Safer JD**, Crawford TM, Holick MF. Topical thyroid hormone accelerates wound healing in mice. *Endocrinology* 2005;146(10):4425-4430. PMID 15976059

11. Saha AK, Persons K, **Safer JD**, Luo Z, Holick MF, Ruderman NB. AMPK regulation of the growth of cultured human keratinocytes. *Biochem Biophys Res Co* 2006;349(2):519-24. PMID 16949049
12. **Safer JD**, Ray S, Holick MF. A topical PTH/PTHrP receptor antagonist stimulates hair growth in mice. *Endocrinology* 2007;148(3):1167-1170. PMID 17170098
13. **Safer JD**, Persons K, Holick MF. A thyroid hormone deiodinase inhibitor can decrease cutaneous cell proliferation in vitro. *Thyroid* 2009;19(2):181-185. PMID 19191748
14. Ariza MA, Loken WM, Pearce EN, **Safer JD**. Male sex, African-American race/ethnicity, and T3 levels at diagnosis are predictors of weight gain following medication and radioactive iodine treatment for hyperthyroidism. *Endocr Pract* 2010;16(4):609-616. PMID 20350916
15. Abraham TM, de las Morenas A, Lee SL, **Safer JD**. In thyroid fine needle aspiration, use of bedside-prepared slides significantly increased diagnostic adequacy and specimen cellularity relative to solution-based samples. *Thyroid* 2011;21(3):237-242. PMID 21323589
16. Huang MP, Rodgers KA, O'Mara R, Mehta M, Abuzahra HS, Tannenbaum AD, Persons K, Holick MF, **Safer JD**. The thyroid hormone degrading Dio3 is the primary deiodinase active in murine epidermis. *Thyroid* 2011;21(11):1263-1268. PMID 21936673
17. Toraldo G, Bhasin S, Bakhit M, Guo W, Serra C, S, **Safer JD**, Bhawan J, Jasuja R. Topical androgen antagonism promotes cutaneous wound healing without systemic androgen deprivation by blocking beta-catenin nuclear translocation and cross-talk with TGF-beta signaling in keratinocytes. *Wound Repair Regen* 2012;20:61-73. PMID 22276587
- 18**. **Safer JD**, Pearce EN. A simple curriculum content change increased medical student comfort with transgender medicine. *Endocr Pract* 2013;19(4):633-637. PMID 23425656
 - First ever demonstration of the effectiveness of an evidence-based approach to teaching transgender medicine to medical students
- 19**. Thomas DD, **Safer JD**. A simple intervention raised resident-physician willingness to assist transgender patients seeking hormone therapy. *Endocr Pract* 2015;21(10):1134-42. PMID 26151424
 - First ever demonstration of the effectiveness of an evidence-based approach to teaching transgender medicine to physician trainees
20. Mundluru SN, **Safer JD**, Larson, AR. Unforeseen ethical challenges for isotretinoin treatment in transgender patients. *Int J of Womens Dermatol* 2016;2(2):46-48. PMID 28492004
21. Eriksson SES, **Safer JD**. Evidence-based curricular content improves student knowledge and changes attitudes towards transgender medicine. *Endocr Pract* 2016;22(7):837-841. PMID 27042742
22. Chan B, Skocylas R, **Safer JD**. Gaps in transgender medicine content identified among Canadian medical school curricula. *Transgender Health* 2016;1(1):142-150. PMID 29159305
23. Myers SC, **Safer JD**. Increased rates of smoking cessation observed among transgender women receiving hormone treatment. *Endocr Pract* 2017;23(1):32-36. PMID 27682351

24. Berli J, Knudson G, Fraser L, Tangpricha V, Ettner R, Ettner F, **Safer JD**, Graham j, Monstrey S, Schechter L. Gender confirmation surgery: What surgeons need to know when providing care for transgender individuals. *JAMA Surgery* 2017;152(4):394-400. PMID 28196182
25. Kailas M, Lu HMS, Rothman EF, **Safer JD**. Prevalence and types of gender-affirming surgery among a sample of transgender endocrinology patients prior to state expansion of insurance coverage. *Endocr Pract* 2017;23(7):780-786. PMID 28448757
26. Liang JJ, Gardner IH, Walker JA, **Safer JD**. Observed deficiencies in medical student knowledge of transgender and intersex health. *Endocr Pract* 2017;23(8):897-906. PMID 28534684
27. Park JA, **Safer JD**. Clinical exposure to transgender medicine improves students' preparedness above levels seen with didactic teaching alone: A key addition to the Boston University model for teaching transgender health care. *Transgender Health* 2018;3(1),10-16. PMID 29344576
28. Liang JJ, Jolly D, Chan KJ, **Safer JD**. Testosterone levels achieved by medically treated transgender women in a United States endocrinology clinic cohort. *Endocr Pract* 2018; In Press. PMID 29144822
29. Chan KJ, Jolly D, Liang JJ, Weinand JD, **Safer JD**. Estrogen levels do not rise with testosterone treatment for transgender men. *Endocr Pract* 2018; In Press. PMID

Case Reports, Reviews, Chapters:

Editorials and Critical Reviews:

30. **Safer JD**, Colan SD, Fraser LM, Wondisford FE. A pituitary tumor in a patient with thyroid hormone resistance: A diagnostic dilemma. *Thyroid* 2001;11(3):281-291. PMID 11327621
31. **Safer JD**, Hennessey JV, Braverman LE. Substituting brand name levothyroxine preparations with generics would increase treatment cost. *Ann Intern Med* 2005; on-line available at <http://www.annals.org/cgi/eletters/142/11/891#1882>
32. Pietras SM, **Safer JD**. A spurious elevation of both total thyroid hormone and thyroid hormone uptake measurements in the setting of autoantibodies may result in diagnostic confusion: A case report and review of the related literature. *Endocr Pract* 2008;14(6):738-742. PMID 18996795
33. **Safer JD**, Tangpricha V. Out of the Shadows: It is time to mainstream treatment for transgender patients. *Endocr Pract* 2008;14(2):248-50. PMID 18308667
34. Feldman J, **Safer JD**, Hormone therapy in adults: Suggested revisions to the sixth version of the Standards of Care. *Int J Transgenderism* 2009;11(3):146-182.
35. Bhasin S, **Safer JD**, Tangpricha V. The Hormone Foundation's patient guide to the endocrine treatment of transsexual persons. *J Clin Endocrinol Metab* 2009;94(9).
36. **Safer JD**. Thyroid hormone action on skin. *Dermatoendocrinol* 2011;3(3):1-5. PMID 22110782

37. Kannan S, Safer JD. Finding the right balance between resistance & sensitivity -- A case report and brief review of the cardiac manifestations of the syndrome of resistance to thyroid hormone and the implications for treatment. *Endocr Pract* 2012; 18(2):252-255. PMID 22068246
38. **Safer JD**. Thyroid hormone action on skin. *Curr Opin Endocrinol Diabetes Obes* 2012;19(5):388-293. PMID 22914563
39. **Safer JD**. Thyroid hormone and wound healing. *J Thyroid Res* 2013;doi:10.1155/2013/124538. PMID 23577275
40. **Safer JD**. Transgender medical research, provider education, and patient access are overdue. *Endocr Pract* 2013;19(4):575-6. PMID 23337168
41. Gardner IH, Safer JD. Progress on the road to better medical care for transgender patients. *Curr Opin Endocrinol Diabetes Obes* 2013;20(6):553-558. PMID 24468757
42. Gitlin SD, Flaherty J, Arrighi J, Swing S, Vasiliadis J, Brater DC, Breida M, Caverzagie K, Kane GC, Nelson Grier C, Parsons P, Smith B, Morrison L, Radwany S, Quill T, Kapur V, Roberts B, Silber M, DiBisceglie A, Fix O, Koteish A, Palumbo P, Trence D, Berkowitz L, Holmboe E, Hood S, Iobst W, Levin S, Yaich S, Foster J, Jackson M, Juvin J, Williams E, Addrizzo-Harris D, Buckley J, Markowitz P, Sessler C, Torrington K, Richter S, Szykowski R, Alguire P, Cooke M, Bolster M, Brown C, Jones T, Marks L, Pardi D, Rose Z, Shah B, Busby-Whitehead J, Granville L, Leipzig R, Collichio F, Raymond M, Von Roenn J, Albertson D, Coyle W, Sedlack R, Abbott B, Fessler H, Balasubramanian A, Danoff A, Gopalakrishnan G, Piquette C, Schulman D, Geraci M, Rockey D, **Safer J**, Armstrong W, Havlichek Jr D, Helmy T, Kolansky D, Patores S, Spevetz A, Biller B, Cantelmi A. The Internal Medicine Subspecialty Milestone Project, a joint initiative of the Accreditation Council for Graduate Medical Education and the American Board of Internal Medicine, in collaboration with the Alliance for Academic Internal Medicine. 2014; online available at <https://www.acgme.org/acgmeweb/Portals/0/PDFs/Milestones/InternalMedicineSubspecialtyMilestones.pdf>
- 43**. Saraswat A, Weinand JD, Safer JD. Evidence supporting the biological nature of gender identity. *Endocr Pract* 2015; 21(2):199-204. PMID 25667367
- Review of the biological nature of transgender identity most referenced by popular media (Google)
- 44**. Weinand JD, Safer JD. Hormone therapy in transgender adults is safe with provider supervision; A review of hormone therapy sequelae for transgender individuals. *J Clin Transl Endocr* 2015; 2:55-60. PMID 28090436
- The most comprehensive recent review of the relative safety of transgender hormone therapy
45. Boh B, **Safer JD**. State-of-the-art: Use of hormones in transgender individuals. *Endocrine Society* 2016; online available at <http://dx.doi.org/10.1210/MTP5.9781943550043.ch55>
46. **Safer JD**, Coleman E, Hembree, W. There is reason for optimism: an introduction to the special issue on research needs in transgender health and medicine. *Curr Opin Endocrinol Diabetes Obes* 2016; 23(2):165-167. PMID 26702853

- 47**. **Safer JD**, Coleman E, Feldman J, Garofalo R, Hembree W, Radix A, Sevelius J. Barriers to healthcare for transgender individuals. *Curr Opin Endocrinol Diabetes Obes* 2016; 23(2):168-171. PMID 26910276
- The most current review of barriers to delivery of transgender healthcare in the United States in the medical system, medical curriculum, and medical culture
48. Feldman J, Brown GR, Deutsch MB, Hembree W, Meyer W, Meyer-Bahlburg HFL, Tangpricha V, T'Sjoen G, **Safer JD**. Priorities for transgender medical and healthcare research. *Curr Opin Endocrinol Diabetes Obes* 2016; 23(2):180-187. PMID 26825469
49. Reisner SL, Deutsch MB, Bhasin S, Bockting W, Brown GR, Feldman J, Garofalo R, Kreukels B, Radix A, **Safer JD**, Tangpricha V, T'Sjoen G, Goodman M. Advancing Methods for U.S. Transgender Health Research. *Curr Opin Endocrinol Diabetes Obes* 2016; 23(2):198-207. PMID 26845331
50. **Safer JD**. The large gaps in transgender medical knowledge among providers must be measured and addressed. *Endocr Pract* 2016;22(7):902-903. PMID 27214166
51. Bouman WP, Suess Schwend A, Motmans J, Smiley A, **Safer JD**, Deutsch MB, Adams NJ, Winter S. Language and trans health. *Int J Transgenderism* 2017;18(1):1-6.
52. **Safer JD**. The recognition that gender identity is biological complicates some previously settled clinical decision making. *AACE Clinical Case Rep* 2017;3(3):e289-e290. PMID 27967232
- 53**. Hembree WC, Cohen-Kettenis P, Gooren L, Hannema SE, Meyer WJ, Murad M, Rosenthal S, **Safer JD**, Tangpricha V, T'Sjoen G. Endocrine treatment of gender-dysphoric/gender-incongruent persons: an endocrine society clinical practice guideline. *J Clin Endocrinol Metab* 2017; 102(11):1-35. PMID 28945902
- The most respected guideline for hormone treatment of transgender individuals
54. **Safer JD**. Transgender patients and health care providers. *Health Affairs* 2017;36(12):2213. PMID 29200359
55. Tangpricha V, Hannema SE, Irwig M, Meyer WJ, **Safer JD**, Hembree WC. 2017 American Association of Clinical Endocrinologists/Endocrine Society update on transgender medicine: case discussions. *Endocr Pract* 2017;23(12):1430-1436. PMID 29320643
56. **Safer JD**. Managing intersex and transgender health across the globe requires more than just understanding the science. *AACE Clinical Case Rep* 2018; In Press. PMID

Textbook Chapters:

57. **Safer JD**, Wondisford, FE. 1997 TSH, normal physiology, *Contemporary Endocrinology: Diseases of the Pituitary*, Wierman ME, ed., Humana Press Inc., Totowa, NJ, 283-293
58. **Safer JD**. 2003 Resistance to thyroid hormone, *Contemporary Endocrinology: Diseases of the Thyroid*, 2nd Edition, Braverman LE, ed., Humana Press Inc., Totowa, NJ, 199-216

59. **Safer JD.** 2005 The skin in thyrotoxicosis, *Werner and Ingbar's The Thyroid*, 9th Edition, Braverman LE and Utiger RD, eds., Lippincott Williams and Williams, Philadelphia, PA, 553-558
60. **Safer JD.** 2005 The skin and connective tissue in hypothyroidism, *Werner and Ingbar's The Thyroid*, 9th Edition, Braverman LE and Utiger RD, eds., Lippincott Williams and Williams, Philadelphia, PA, 769-773
61. **Safer JD, Holick MF.** 2008 Potential therapeutic uses of thyroid hormone, *Thyroid Disorders with Cutaneous Manifestations*, Heymann WR, ed., Springer-Verlag, London, UK, 181-186
62. Leung AM, **Safer JD.** 2012 Thyrotoxicosis of extra thyroid origin, *Werner and Ingbar's The Thyroid*, 10th Edition, Braverman LE and Cooper D, eds., Lippincott Williams and Williams, Philadelphia, PA, 429-433
63. Kurani PN, Goldberg LJ, **Safer JD.** 2017 Evaluation and management of hirsutism in postmenopausal women, *Essentials of Menopause Management: A Case-Based Approach*, Pal L and Sayegh RA, eds., Springer, London, UK, 209-221
64. Sloan CA, **Safer JD.** 2017 The high risk client: Comorbid conditions that affect care, *Adult Transgender Care: An Interdisciplinary Approach for Training Mental Health Professionals*, Kauth MR and Shipherd JC, eds., Routledge, Taylor and Francis, London, UK
65. Webb R, **Safer JD.** 2018 Transgender hormonal treatment, *Yen and Jaffe's Reproductive Endocrinology, edition 8*, Strauss JS and Barbieri JL, eds., Elsevier, Maryland Heights, MO, In Press
66. Myers SC, **Safer JD.** 2018 Hormone therapy in transgender adults, *Manual of Endocrinology and Metabolism, 5th Edition*, Lavin N, ed., Walters Kluwer, Alphen aan den Rijn, The Netherlands, In Press

Case Reports:

67. Koutkia P, **Safer JD.** Adrenal metastasis secondary to papillary thyroid carcinoma. *Thyroid* 2001;11(11):1077-1079. PMID 11762719
68. Choong K, **Safer JD.** Graves disease and gynecomastia in two roommates. *Endocr Pract* 2011;17(4):647-650. PMID 21613048
69. Safer DL, Bullock KD, **Safer JD.** Obsessive-compulsive disorder presenting as gender dysphoria/gender incongruence: a case report and literature review. *AACE Clinical Case Rep* 2016;2:e268–e271.
70. Stevenson MO, Wixon N, **Safer JD.** Scalp Hair Regrowth in Hormone-Treated Transgender Woman. *Transgender Health* 2017;1(1):202-204. PMID 28861534
71. Sullivan CA, Hoffman JD, **Safer JD.** 17- β -hydroxysteroid dehydrogenase type 3 deficiency: Identifying a rare cause of 46, XY female phenotype in adulthood. *J Clin Transl Endocr Case Reports* 2018; 7:5-7.

Dissemination Through Lay Press and Social Media

Mass Audience Programming:

“Transgender Health AMA” Reddit. July 24, 2017. Expert responses to questions about transgender medicine. https://www.reddit.com/r/science/comments/6p7uhb/transgender_health_ama_series_im_joshua_safer/ over 150,000 views, over 4200 comments

“Gender Revolution with Katie Couric” National Geographic Channel. Kouric, Katie. February 6, 2017. Extended interview with Katie Couric threaded into a 2-hour television special. Trailer: <https://www.youtube.com/watch?v=y93MsRaC6Zw> broadcast in 143 countries

“Is gender identity biologically hard-wired?” Judd, Jackie. PBS NewsHour. May 13, 2015. Extended interview for Jackie Judd <http://www.pbs.org/newshour/bb/biology-gender-identity-children/> estimated just over 1,000,000 viewers per Nielsen

Innovation	Significance/impact
<i>Development and leadership of the Transgender Medicine Clinical Center at Boston Medical Center</i>	<ul style="list-style-type: none"> • The Center for Transgender Medicine and Surgery at BMC is the first comprehensive center for transgender medical care in New England • The Center is one of only several such centers in North America that are housed in academic teaching hospitals where care can be integrated • The Center is a model for such care delivery in North America.
<i>Development and dissemination of the seminal reviews that are most widely cited in the lay press that explain the concept that gender identity is a biological phenomenon (see bibliography section above, e.g. PMID: 25667367).</i>	<ul style="list-style-type: none"> • The concept that gender identity is a biological phenomenon has been a key component of the recent culture change in favor of mainstream medical care for transgender individuals (see media section above)
<i>Development and dissemination of new and influential curricular content to teach the biology of gender identity in conventional medical education (see curriculum section above)</i>	<p>The teaching of evidence-based approaches to transgender medical care to:</p> <ul style="list-style-type: none"> • Medical students (see bibliography section above, e.g. PMID 23425656 and PMID 27042742) • Physician trainees (see bibliography section above, e.g. PMID 26151424) • Practicing physicians (see invited lectures section above) serves as a crucial component to the gained credence given to care for transgender individuals in conventional medical settings.
<i>Development and dissemination of seminal reviews supporting the safety of transgender hormone treatment regimens (see invited lectures section above)</i>	<ul style="list-style-type: none"> • Once mainstream medical providers learn of the biology underlying gender identity, their biggest concern is the relative safety of the medical interventions relative to the benefit. • The development and dissemination of the seminal reviews and lectures supporting the safety of current treatment regimens serves as a further crucial component to the culture change among conventional medical providers in favor of routine medical care for transgender individuals

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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1 General Neller, and Admiral Richardson have told me that
2 they have seen zero reports of issues of cohesion,
3 discipline, and morale, as a result of open transgender
4 service in their respective service branches. Are you aware
5 of any specific issues of unit cohesion, disciplinary
6 problems, or issues of morale resulting from open
7 transgender service members in the Air Force?

8 General Goldfein: Not the way you have presented the
9 question, ma'am, I am not. I will tell you that I have
10 talked commanders in the field, first sergeants, senior
11 NCOs, and I am committed to ensure that they have the right
12 levels of guidance to understand these very personal issues
13 that they are dealing with. And so we continue to move
14 forward to ensure that we understand the issues.

15 Senator Gillibrand: And have you personally met with
16 transgender service members?

17 General Goldfein: Yes, ma'am, I have.

18 Senator Gillibrand: And what did you learn from those
19 meetings?

20 General Goldfein: A combination of, one, commitment to
21 serve by each of them, and then number two, how individual
22 each particular case is. It is not a one-size-fits-all
23 approach. It is very personal to each individual. And that
24 is why I go back to we have an obligation to ensure that we
25 understand this medically and that we can provide our

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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1 told me, last week, that there were, quote, "precisely zero
2 reports of issues of cohesion, discipline, morale, and all
3 sorts of things in the Army as a result of open transgender
4 service." Are you aware of any issue of unit cohesion,
5 disciplinary problems, or issues with morale resulting from
6 open transgender service?

7 Admiral Richardson: Senator, I'll go first on that.
8 You know, by virtue of being a Navy sailor, we treat every
9 one of those sailors, regardless, with dignity and respect
10 that is warranted by wearing the uniform of the United
11 States Navy. By virtue of that approach, I am not aware of
12 any issues.

13 Senator Gillibrand: General Neller?

14 General Neller: Senator, by reporting, those marines
15 that have come forward -- there's 27 marines that have
16 identified as transgender, one sailor serving -- I am not
17 aware of any issues in those areas. The only issues I have
18 heard of is, in some cases, because of the medical
19 requirements of some of these individuals, that there is a
20 burden on the commands to handle all their medical stuff.
21 But, discipline, cohesion of the force, no.

22 Senator Gillibrand: Can you amplify what burdens on
23 the command are related to medical issues?

24 General Neller: Some of these individuals -- and, you
25 know, they've resolved whatever it was that -- as they went

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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1 and want to make sure that they are, in fact, treated with
2 dignity and respect. And no, I have received precisely zero
3 reports --

4 Senator Gillibrand: Okay.

5 General Milley: -- of issues of cohesion, discipline,
6 morale, and all those sorts of things. No.

7 Senator Gillibrand: That's good news.

8 I know that the Secretary spoke with transgender
9 soldiers recently. Of all the ones that you have personally
10 spoke with of the Active Duty transgender soldiers, were you
11 concerned by any of them continuing to serve?

12 Dr. Esper: Well, I actually met with them in the first
13 30 days on the job, Senator. And no, nothing came up that
14 would cause me concern. I was, you know, impressed by what
15 I heard.

16 Senator Gillibrand: And have either of you spoken to
17 any transgender servicemembers since this set of
18 recommendations was released by the administration in March?
19 And, if you have, what did you hear?

20 Dr. Esper: No, ma'am.

21 General Milley: I have not. I did before. I have
22 not. But, let -- you know, the case, as you are well aware,
23 is in litigation. It's in four different courts. So, the -
24 - we're limited in, actually, what we should or could say
25 right this minute, because it could, either one way or the

**IN THE UNITED STATES DISTRICT COURT FOR
THE DISTRICT OF COLUMBIA**

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DOE, et al.,)	
)	
<i>Plaintiffs,</i>)	
)	
v.)	Civil Action No. 17-cv-1597 (CKK)
)	
DONALD TRUMP, et al.,)	
)	
<i>Defendants.</i>)	
_____)	

**DECLARATION OF GEORGE RICHARD BROWN, MD, DFAPA IN SUPPORT OF
OPPOSITION TO DEFENDANTS’ MOTION TO DISMISS AND MOTION TO
DISSOLVE THE PRELIMINARY INJUNCTION**

1. I, George R. Brown, have been retained by counsel for Plaintiffs as an expert in connection with the above-captioned litigation.
2. My professional background and qualifications are set forth in my previous declaration in this case dated August 30, 2017. *See* Dkt. Nos. 13-11 & 13-12. A copy of that declaration is attached as Exhibit A.
3. The purpose of this supplemental declaration is to offer my expert opinion on the “Department of Defense Report and Recommendations of Military Service By Transgender Persons,” which I refer to in this declaration as the “Implementation Report.”
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.
5. As noted in my previous declaration, I am being compensated at an hourly rate for actual time devoted, at the rate of \$400 per hour for work that does not involve depositions or court testimony (e.g., review of materials, emails, preparing reports); \$500 per hour for

depositions (there is a half-day fee for depositions); \$600 per hour for in-court testimony; and \$4000 per full day spent out of the office for depositions and \$4800 per full day out of the office for trial testimony. Travel days necessary for work are billed at half the “work day” rate plus expenses. My compensation does not depend on the outcome of this litigation, the opinions I express, or the testimony I provide.

**THE IMPLEMENTATION REPORT REJECTS THE OVERWHELMING
MEDICAL CONSENSUS REGARDING TRANSGENDER IDENTITY AND
TREATMENT FOR GENDER DYSPHORIA**

6. Although the Implementation Report refers to a study conducted by a “Panel of Experts,” the referenced panel does not appear to have included any experts in treating gender dysphoria or any medical experts at all. The Implementation Report indicates that the panel consulted with such experts, but the Implementation Report appears to have consistently disregarded what those experts say. *See* Implementation Report at 17.

7. As a result, the Implementation Report relies on notions of gender dysphoria and transgender identity that have no basis in fact, science, or medicine and that have been rejected by the mainstream medical community.

8. In my previous declaration, I explained that arguments that the mental health of transgender persons could justify prohibiting such individuals from serving in the military are wholly unfounded and unsupported in medical science. *See* Exhibit A, August 30, 2017 Brown Decl. ¶37. Being transgender—and living in accordance with one’s gender identity—is not a mental defect or disorder. To the extent the misalignment between gender identity and assigned birth sex creates clinically significant distress (gender dysphoria), that distress is curable through appropriate medical care that allows the individual to live consistently with their gender identity.

As a class, transgender individuals have suffered, and continue to suffer, severe persecution and discrimination. Being transgender does not limit one's ability to contribute to society.

9. Only a subset of transgender people have gender dysphoria. If a transgender person is able to live in accordance with their gender identity from an early age, they may never develop gender dysphoria as an adult. If a transgender person develops gender dysphoria, they can receive appropriate transition-related care that resolves the clinically significant distress. For transgender people who have resolved symptoms of gender dysphoria, the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (2013) ("DSM-5") provides a separate "post-transition" diagnostic subtype to reflect that the gender dysphoria is in remission and that the person may only need a maintenance dose of cross-sex hormones.

10. The Implementation Report turns this understanding on its head by requiring transgender people to live in accordance with the sex assigned to them at birth. The Implementation Report conceives of a transgender person without gender dysphoria as someone who comfortably lives and functions according to the sex assigned to them at birth without suffering any distress from the incongruence with their gender identity. That hypothetical person is likely not someone who is transgender.

11. The Implementation Report directly contradicts the medical consensus about the nature of gender dysphoria by treating every transgender person who lives according to the person's gender as having a disabling mental health condition even when the person no longer experiences gender dysphoria. The medical community has definitively rejected that view. In response to the Implementation Report, the American Psychological Association stated that it "is 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.” *See* Exhibit C, APA Statement Regarding Transgender Individuals Serving in Military. The American Medical Association released a similar statement reaffirming that “there is no medically valid reason—including a diagnosis of gender dysphoria—to exclude transgender individuals from military service” and expressing concern that the Implementation Report “mischaracterized and rejected the wide body of peer-reviewed research on the effectiveness of transgender medical care.” *See* Exhibit D, AMA Letter to Secretary James Mattis. The American Psychiatric Association also released a statement denouncing the Implementation Report and reiterating that “[t]ransgender people do not have a mental disorder; thus, they suffer no impairment whatsoever in their judgment or ability to work.” *See* Exhibit E, APA Statement.

12. Decades of research have demonstrated that attempting to treat gender dysphoria by forcing transgender people to live in accordance with their sex assigned at birth—to “convert” them out of being transgender—is ineffective, unethical, and dangerous. The mainstream medical community overwhelmingly condemns this “conversion therapy.”

13. The Implementation Report appears to dispute the consensus of the mainstream medical community that gender dysphoria is amenable to treatment through social and medical transition. The American Medical Association, the Endocrine Society, the American Psychiatric Association, and the American Psychological Association all agree that medical treatment for gender dysphoria is medically necessary and effective. *See* American Medical Association, Resolution 122 (A-08) (2008); American Psychiatric Association, Position Statement on Discrimination Against Transgender & Gender Variant Individuals (2012); Endocrine Treatment of Transsexual Persons: An Endocrine Society Clinical Practice Guideline (2017); American

Psychological Association Policy Statement on Transgender, Gender Identity and Gender Expression Nondiscrimination (2009). *See* Exhibit A, August 30, 2017 Brown Decl. ¶¶ 21-25.

14. Sixty years of clinical experience and data have demonstrated the efficacy of treatment for the distress resulting from gender dysphoria (*see*, for example, the recently published multi-country, long-term follow up study: Tim C. van de Grift et al., Effects of Medical Interventions on Gender Dysphoria and Body Image: A Follow-Up Study, 79 *Psychosomatic Med.* 815 (Sept. 2017)). The Implementation Report asserts that this evidence is unreliable because there are no “double-blind” scientific studies regarding the efficacy of surgical care for gender dysphoria. But medical standards of care are not determined solely by double-blind studies, especially in the context of surgery. Double-blind studies with “sham” surgeries are often impossible or unethical to conduct.

14. If the military limited all medical care to surgical procedures supported by prospective, controlled, double-blind studies, then only a very few medical conditions would ever be treated. For example, one of the most common surgical procedures performed in the United States is a tonsillectomy, with over 530,000 cases completed a year, using multiple, competing surgical techniques. However, a review of the evidence base for this very common procedure, including when to apply it and the best surgical techniques to utilize, is not supported by “double blind” controlled studies in spite of the common use of this treatment over centuries. *See* Reginald F. Baugh et al., *Clinical Practice Guideline: Tonsillectomy in Children*, 144 *Otolaryngology–Head and Neck Surgery* S1 (2011)). Baugh and coauthors noted: “While there is a body of literature from which the guidelines were drawn, significant gaps remain in knowledge about preoperative, intraoperative, and postoperative care in children who undergo tonsillectomy.” *Id.* at S22.

15. Similarly, acute appendicitis is one of the most common causes of acute abdominal pain in the United States. However, it remains unclear whether the common approach of appendectomy is superior to nonsurgical treatment with antibiotics in many patients. A recent Cochrane review was inconclusive: “We could not conclude whether antibiotic treatment is or is not inferior to appendectomy. Because of the low to moderate quality of the trials, appendectomy remains the standard treatment for acute appendicitis.” See Ingrid M. H.A. Wilms et al., *Appendectomy Versus Antibiotic Treatment for Acute Appendicitis*, Cochrane Database of Systematic Rev. (2011). In other words, the prevailing standard of care, in spite of the “low quality” of evidence in support of surgery over a nonsurgical alternative, remains the accepted standard.

16. By insisting that treatment for gender dysphoria—unlike treatment for virtually every other medical condition—be supported by “double blind” studies, the Implementation Report holds the robust medical consensus surrounding treatment for gender dysphoria to an impossible standard—and a standard that few if any medical conditions are required to meet.

17. The Implementation Report also mischaracterizes a recent decision by the U.S. Department of Health & Human Services Center for Medicare and Medicaid Services (“CMS”). See Implementation Report at 24–26. In 2014, an impartial adjudicative board in the Department of Health & Human Services concluded, based on decades of studies, that surgical care to treat gender dysphoria is safe, effective, and not experimental. See Exhibit F, NCD 140.3, Transsexual Surgery. The decision specifically noted that, regardless of whether the studies were randomized double-blind trials, there was sufficient evidence to prove “a consensus among researchers and mainstream medical organizations that transsexual surgery is an effective, safe and medically necessary treatment for [gender dysphoria].” *Id.* at 20. Ever since the

adjudicative board's decision, Medicare has provided coverage for transition-related surgery based on patients' individual needs.

18. In the document referenced by the Implementation Report, CMS decided to continue covering surgery based on patients' individual needs and refrain from issuing national standards regarding how to determine medical necessity in individualized cases. *See* CMS Report. The Implementation Report incorrectly states that CMS "found insufficient scientific evidence to conclude that such surgeries improve health outcomes for persons with gender dysphoria." Implementation Report at 24 n.82. In fact, the decision specifically clarified that "GRS [gender reassignment surgery] may be a reasonable and necessary service for certain beneficiaries with gender dysphoria," but "[t]he current scientific information is not complete for CMS to make a [national coverage determination] that identifies the precise patient population for whom the service would be reasonable and necessary." CMS Report at 54 (emphasis added). In particular, CMS expressed concern that the Medicare population includes "older adults [who] may respond to health care treatments differently than younger adults." *Id.* at 57. 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." *Id.* The CMS memorandum concluded that the appropriateness of surgical care for this population should be determined on an individualized basis. Indeed, most medical and surgical care provided to patients should be individualized, taking into account each patient's unique clinical circumstances.

**INDIVIDUALS WHO HAVE UNDERGONE GENDER TRANSITION
ARE MEDICALLY FIT TO ENLIST**

19. To justify prohibiting transgender people from serving even if they have resolved the distress associated with gender dysphoria, the Implementation Report attempts to use a

transgender person's history of gender dysphoria as a proxy for other mental health conditions such as anxiety, depression, and suicidal behavior.

20. Statistically, transgender people as a group are at greater risk of experiencing those conditions as a result of the stressors inherent in being prevented from transitioning or obtaining medical care throughout all, or much, of their lives. Some studies have documented that these health disparities can persist even after transition-related treatment because of the continuing effects of discrimination and the reality that gender dysphoria-specific treatments are not panaceas for all problems that a person may experience in their life (nor were these treatments designed to be). *See, e.g.,* Implementation Report at 25 (citing Cecilia Dhejne et al., Long-Term Follow-Up of Transsexual Persons Undergoing Sex Reassignment Surgery: Cohort Study in Sweden, 6 PloS One, 6 (2011)). Transgender people as a group represent a very small subset of society and lack the sort of political power other groups might harness to protect themselves from discrimination.

21. But there is no evidence to support the notion that every individual transgender person is at risk of developing one of these conditions, particularly for those who have been treated early in their lives, as opposed to those who never received treatment or who may have come to treatment much later in life, such as the transgender veterans studied by my research group and cited in the Implementation Report at 21 n.60 (citing 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, 3 LGBT Health 128 (2016)).

21. Under the Open Service policy, all prospective military service members must undergo a rigorous examination to identify any pre-existing mental health diagnoses that would

preclude enlistment. There is no reason to use a person's transgender status as a proxy for depression, anxiety, or suicidal ideation because the military directly screens for those conditions. Anyone with a history of suicidal behavior—whether transgender or not—is categorically barred from enlisting. *See* DODI 6130.03, Enclosure 4 § 29(n). Anyone with a history of anxiety or depression—whether transgender or not—is barred from enlisting unless, inter alia, they have been stable and without medical treatment for 24 consecutive months or 36 consecutive months respectively. *See id.* §§ 29(f), (p). As a result, any transgender individual who actually has one of those conditions is already screened out without a need for a categorical ban.

22. There is no medical basis for using a transgender person's history of gender dysphoria as a proxy for other medical conditions that the person does not actually have. This approach is akin to assuming non-transgender female applicants are, or should be considered, clinically depressed, as it is well known that depressive disorders are about twice as common in non-transgender females than in non-transgender males. *See* Paul R. Albert, *Why Is Depression More Prevalent in Women?* 40 *J. of Psychiatry & Neuroscience* 219-21 (2015). Women are twice as likely as men to have anxiety disorders, but the military does not bar women from military service. Depression, anxiety, and suicide are more common among white people than black people, but the military does not bar white people from military service. One study of California school children shows that children of service members are more than 50 percent more likely to have attempted suicide than the general population. *See* Exhibit B, Vice Admiral Donald C. Arthur, USN (Ret.), Former Surgeon General of the U.S. Navy, et al., *DoD's Rationale for Reinstating the Transgender Ban is Contradicted by Evidence*, Palm Center (April 2018). Yet the military does not bar individuals in this highrisk group from entry. If a

transgender individual who seeks to enlist in the military has already transitioned, no longer experiences gender dysphoria, and has been screened for other mental health conditions (including depression, anxiety, and suicidal ideation) there is no reason to conclude that individual is at elevated risk of developing one of these comorbidities in the future.

23. The Implementation Report distorts my own work by citing a recent study in which I documented that some transgender veterans who have received treatment after years of living in the shadows continue to have health disparities even after their gender dysphoria is resolved through treatment. *See* Implementation Report at 21 n.60. The veterans in my study were untreated veterans for a long period of time and survived—but did not thrive—while living an inauthentic life in the shadows on active duty. Many of the transgender veterans included in this large study had never received treatment for gender dysphoria. Clearly, the population group of transgender individuals in that study is not comparable to the population group of people who have already received medical care, resolved their gender dysphoria, and are coming to the military openly stating they are transgender.

24. The Implementation Report also states that data regarding existing service members has called into question assumptions about the mental health of transgender service members. *See* Implementation Report 21. I have reviewed USDOE 2633-2664, which appears to be a slide-show presentation of the data on which the Implementation Report relies. *See* Exhibit H, USDOE 2633-2664 (produced by Defendants as USDOE 2633-2664 (AF_00007405-7436) and filed as Docket No. 139-27 in the related matter of Stone, et al. v. Trump, et al, No. 17-CV-02459-MJG (D. Md.)). It should be noted that my career as an academic research psychiatrist, including conducting extensive research within the Department of Defense and the

Department of Veterans Affairs for many years, enables me to critically assess research design, methodology, and outcomes.

25. As an initial matter, none of the data relates to service members who have completed transition and are enlisting for the first time—the group of people who meet the Open Service standards and began the process of enlisting on or after January 1, 2018. The data are exclusively from service members who were diagnosed with gender dysphoria while already serving, in some cases well before any guidance was provided by DOD for treatment. Again, this means that the data reflects a group of people who were serving in the shadows for years before they were allowed to serve openly.

26. Even with respect to these service members, the data is fundamentally flawed and presented in a grossly misleading manner. The study period for the data was for the 22-month period from October 1, 2015 to July 26, 2017. But Secretary Carter’s Open Service Directive was not issued until June 30, 2016, and the military did not issue force-wide treatment protocols for gender dysphoria until October 1, 2016. As a result, for 12 out of the 22 months in the study, the service members were, with few exceptions, not serving openly and not receiving DOD-sanctioned treatments for gender dysphoria.

27. If the purpose of the study is to draw conclusions about the health of transgender service members under the Open Service policy, it is fundamentally illegitimate to include data from before that policy went into effect and before those service members were allowed to receive health care under DOD guidelines to treat their gender dysphoria.

28. For example, the Implementation Report cites data from the study for the proposition that transgender service members had an average of 28.1 mental health encounters over a 22-month period. *See* Implementation Report at 24; Exhibit H, USDOE 2633-2664 at 8.

But it is impossible to determine whether these mental health encounters occurred before or after the Open Service policy went into effect. If the utilization rate dropped once service members started receiving care for gender dysphoria, then the data would actually support the efficacy of the Open Service policy.

29. The Implementation Report also ignores the critical fact that service members were required to meet with mental health providers numerous times to document their gender dysphoria as a precondition for receiving health care for gender dysphoria, and for continued access to cross-sex hormones. It is unknown how many of these visits were mandated/required, as opposed to visits voluntarily requested by service members for mental health care. As a result, without more specific data, there is no reason to conclude that mental health visits by transgender service members who are initiating transition-related care are a sign of co-morbid mental health conditions. The report is quite misleading in this regard, as it implies that all mental health visits by transgender service members were initiated for the treatment of mental illnesses, when this is far from the truth.

30. Similarly, the Implementation Report cites data from the study for the proposition that service members with gender dysphoria are “eight times more likely to attempt suicide than Service members as a whole.” Implementation Report at 12. In fact, the underlying data refer to “suicidal ideation,” not actual suicide attempts. Exhibit H, USDOE 2633-2664 at 9. Moreover, with respect to suicidal ideation, the data does not reveal whether the suicidal ideation was reported before or after the service member was allowed to serve openly and receive treatment. Given the fundamental flaws with the study methodology and the low number of observed events, the data presented on this, and other, mental health questions are not interpretable in any meaningful way.

31. In short, transgender individuals should be screened and evaluated for mental health conditions the same way every other person is screened and evaluated. There is no medical basis to using a transgender individual's history of gender dysphoria as a proxy for other mental health conditions that they do not have.

**TRANSGENDER SERVICE MEMBERS WHO HAVE TRANSITIONED ARE
PHYSICALLY FIT TO ENLIST AND DEPLOY**

32. The argument that cross-sex hormone treatment should be a bar to service for transgender individuals is not supported by medical science or current military medical protocols. Experts in the endocrine treatment of transgender people have previously advised military medical providers that cross-sex hormone treatments can be accomplished without difficulty, both before accession and after service has begun. *See* WPATH Timeline Guide for United States Armed Service Members Going Through Transgender Hormonal or Surgical Transition (Jan. 2017), <https://www.wpath.org/newsroom/policies> (attached as Exhibit I).

33. The military allows people with a history of other medical conditions to enlist even when the condition is currently being managed by medication. Individuals with abnormal menstruation, dysmenorrhea, and endometriosis may enlist if their conditions are adequately managed through hormone medication. *See* DODI 6130.03, Enclosure 4 §§ 14(a), (d), (e). Individuals with Gastro-Esophageal Reflux Disease or high cholesterol may enlist if they are taking medication with no relevant side effects. *Id.* §§ 13(a), 25(i).

34. The Implementation Report asserts that transgender service members receiving cross-sex hormone therapy would risk having their treatment disrupted if they are deployed. But the same concerns about interruptions apply to every service member who is deployed while taking medication. These concerns have not been a barrier to deployment for service members

who require hormones for other medical conditions or who require medications for other mental health conditions that allow for deployment.

35. Military policy also allows service members to take a range of medications, including hormones, while deployed in combat settings. Access to medication is predictable, as “[t]he Military Health Service maintains a sophisticated and effective system for distributing prescription medications to deployed service members worldwide.” *See* M. Joycelyn Elders et al., *Medical Aspects of Transgender Military Service*, 41 *Armed Forces & Soc’y* 199, 207 (Aug. 2014) (the “Elders Commission Report”).

36. Hormone therapy is neither too risky nor too complicated for military medical personnel to administer and monitor. The risks associated with use of cross-sex hormone therapy to treat gender dysphoria are low and not any higher than for the hormones that many non-transgender active duty military personnel currently take. The medications do not have to be refrigerated, and alternatives to injectables are readily available, further simplifying treatment plans. Clinical monitoring for risks and effects is not complicated and, with training and/or access to consultations, can be performed by a variety of medical personnel in the DOD, just as is the case in the VHA. This is the military services’ current practice in support of the limited medical needs of their transgender troops in CONUS (Continental United States) and in deployment stations worldwide. Guidance on this issue was provided in January 2017 to military medical providers who care for transgender service members and shows that stable, transitioned troops require only yearly laboratory monitoring for cross-sex hormone treatment (which is consistent with the yearly, routine laboratory health screenings that all active duty troops receive). *See* Exhibit I, WPATH Timeline Guide.

37. Transgender service members—including service members who receive hormone medication—are just as capable of deploying as service members who are not transgender. DOD rules expressly permit deployment, without need for a waiver, for a number of medical conditions that present a much more significant degree of risk in a harsh environment than simply being transgender. For example, hypertension is not disqualifying if controlled by medication, despite the inherent risks in becoming dehydrated in desert deployment situations. Heart attacks experienced while on active duty or treatment with coronary artery bypass grafts are also not disqualifying, if they occur more than a year preceding deployment. These are very serious, life-threatening medical conditions with a high rate of recurrence, yet these service members with cardiac disease are nonetheless allowed to stay on active duty and deploy under prescribed conditions.

38. Under the Department of Defense’s generally applicable policies, service members may deploy with certain psychiatric conditions, if they demonstrate stability under treatment for at least three months. *See* DODI 6490.07, Enclosure 3 § h(2); Dep’t of Defense, Clinical Practice Guidance for Deployment-Limiting Mental Disorders and Psychotropic Medications (2013). Army regulations specifically provide that “[a] psychiatric condition controlled by medication should not automatically lead to non-deployment.” *See* AR 40-501 § 5-14(8)(a).

39. Instead of discussing these medical conditions, the Implementation Report compares cross-sex hormone therapy for gender dysphoria with other medical conditions that are plainly not comparable. For example, the Implementation Report states that “[a]ny 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.” Implementation

Report at 34. As I previously explained, gender dysphoria is a treatable and curable condition. With medically appropriate care, it is possible for transgender service members to resolve the clinically significant gender dysphoria without any residual symptoms or impairment. Comparisons made to schizophrenia and bipolar disorder in the Implementation Report are inappropriate, as these two conditions constitute serious mental illnesses for which treatments are often ineffective and for which the notion of “cure” is nonsensical.

40. In any case, the military recently adopted universal deployment standards that already mandate the discharge of service members who are nondeployable “for more than 12 consecutive months, for any reason.” Exhibit G, Memorandum for Secretaries of Military Departments, “DoD Retention Policy for Non-Deployable Service Members,” February 14, 2018.

SERVICE MEMBERS WHO TRANSITION WHILE IN SERVICE CAN MEET THE SAME RETENTION STANDARDS THAT APPLY TO NON-TRANSGENDER SERVICE MEMBERS

41. Service members who are diagnosed with gender dysphoria after already enlisting can transition while in service and still meet the same retention standards that apply to non-transgender service members. The military has generally applicable standards for determining whether a service member may continue to serve despite periods of limited non-deployability. If a transgender service member’s limited period of non-deployability complies with those generally applicable standards, there is no reason why the service member should be automatically discharged simply because they were receiving surgery for gender dysphoria as opposed to a different medical condition. A determination of non-deployability must be based on the status of the individual and not on arbitrary, non-evidence based determinations. There is some evidence that the latter is occurring, based on the widely disparate between-service data

reported on days of limited duty for service members receiving treatment for gender dysphoria as reported by the various services. *See* Exhibit H, USDOE 2633-2664 at 17. This DOD data strongly suggests that non-medical factors are playing an outsized role in determination of days spent in other than full-duty capacities for transgender service members on service-level treatment plans.

42. Although the Implementation Report states that one commander predicted that transgender service members beginning a course of hormone therapy will be non-deployable for as long as two-and-a-half years, the Implementation Report does not cite any data to support that assertion. Implementation Report at 33–34. To the contrary, the presentation of the data states that service members initiating hormone therapy were non-deployable for 3–6 months in the Navy and for an average of 5–6 months in the Army and Air Force. Exhibit H, USDOE 2633-2664 at 17. There is no medical basis for the Implementation Reports suggestion that cross-sex hormone therapy could render a transgender service member non-deployable for a full twelve months. Implementation Report at 23. In fact, expert guidance on this very issue was provided to military medical providers by WPATH in January 2017, as previously noted.

43. There is also no basis to presume that surgical care for gender dysphoria will render transgender service members non-deployable for extended periods of time. The recovery time for non-genital surgeries, which are the most common procedures performed, is only 2–8 weeks. Exhibit H, USDOE 2633-2664 at 19.

44. Moreover, transgender service members can schedule medical procedures to ensure that they do not interfere with deployment. This approach is routinely done for other medically necessary procedures, such as orthopedic surgeries that allow for flexibility in the timing of the surgery. As the Implementation Report acknowledges, “[t]his conclusion was

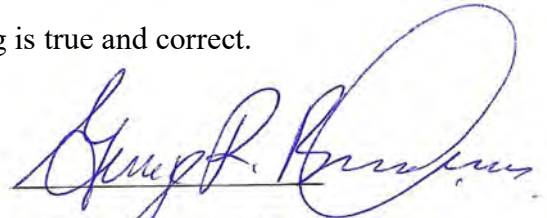
echoed by some experts in endocrinology who found no harm in stopping or adjusting hormone therapy treatment to accommodate deployment during the first year of hormone use.”

Implementation Report at 34.

45. To be sure, there may be some transgender service members whose individualized medical needs make it impossible to transition while satisfying the military’s generally applicable standards for deployment and retention. But those determinations can and should be made on a case-by-case basis depending on the individual’s fitness to serve, as is done with other treatable conditions. There is no medical basis to conclude that all, or even most, service members undergoing treatment for gender dysphoria are categorically unfit to serve.

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

Executed this 11th day of May, 2018



George R. Brown, M.D.

**IN THE UNITED STATES DISTRICT COURT FOR
THE DISTRICT OF COLUMBIA**

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DOE, et al.,)	
)	
<i>Plaintiffs,</i>)	
)	
v.)	Civil Action No. 17-cv-1597 (CKK)
)	
DONALD TRUMP, et al.,)	
)	
<i>Defendants.</i>)	
_____)	

**DECLARATION OF BRAD R. CARSON IN SUPPORT OF PLAINTIFFS’ JOINT
OPPOSITION TO MOTION TO DISSOLVE THE PRELIMINARY INJUNCTION**

1. I, Brad R. Carson, have been retained by counsel for Plaintiffs as an expert in connection with the above-captioned litigation.
2. My professional background and qualifications are set forth in my previous declaration dated August 28, 2017. *See* Dkt. No. 13-3. A copy of that declaration is attached as Exhibit A.
3. 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”).
4. 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.”

5. 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

6. 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").

7. 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.

8. 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.

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

10. 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.

11. 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

12. 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.

13. 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.

14. 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

15. 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.

16. 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.

17. 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.

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

19. 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.

20. 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.

21. 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

22. 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.

23. 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

24. 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.

25. 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.

26. 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.

27. 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.

28. 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.

29. 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.

Executed this 17th day of April, 2018

A handwritten signature in black ink, appearing to read "Brad R. Carson". The signature is written in a cursive style with a large initial "B" and "C".

Brad R. Carson

JANE DOE 1, et al.,)
)
 Plaintiffs,)
 v.) Civil Action No. 17-cv-1597 (CKK)
)
 DONALD TRUMP, et al.,)
)
 Defendants.)
 _____)

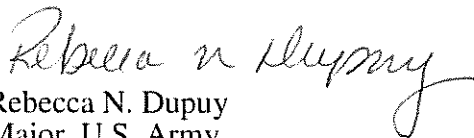
DECLARATION OF MAJ REBECCA N. DUPUY
 (Pertaining to Plaintiff Jane Doe 4)

I, Rebecca Dupuy, hereby declare as follows:

1. I am a Major in the U.S. Army currently assigned as the Deputy G1 for Headquarters, Texas Army National Guard (TXARNG) stationed at Camp Mabry, Austin, Texas. I have served in the U.S. Army for 26 years, and I have been assigned in this position for ONE years and ONE month. I am responsible to The Adjutant General (TAG), TXARNG, through my principal, the G1, for all personnel-related activities within the organization, to include strength management, assignments, awards, evaluations, and other personnel policies. Due to my official duties, I have authorized access to Soldiers’ official personnel records that are stored within official Army databases. I make this declaration based on my personal knowledge and on information provided to me in the course of my official duties. I submit this declaration in support of the defendants’ motion to dissolve the preliminary injunction. In particular, I address below the current status of the plaintiff referred to as Jane Doe 4 in the present litigation.

2. I have reviewed the records of the plaintiff Jane Doe 4. Jane Doe 4 received a diagnosis of gender dysphoria from a medical provider in October 2016, and her transition request to update her gender marker in DEERS to female was approved by her chain of command on March 15, 2017.

In accordance with 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct. Executed this 23 day of March 2018.


Rebecca N. Dupuy
Major, U.S. Army
Camp Mabry, Texas

JANE DOE 1 *et al.*,

Plaintiffs,

v.

DONALD J. TRUMP *et al.*,

Defendants.

Civil Action No. 17-cv-1597 (CKK)

DECLARATION OF COLONEL MARK J. BROOKS

(Relating to Plaintiff Jane Doe 5)

I, Col Mark J. Brooks, hereby declare as follows:

1. I am a Colonel in the United States Air Force currently assigned as Deputy Commander of the 59th Medical Operations Group (59 MDOG), 59th Medical Wing, Wilford Hall Ambulatory Surgery Center, Joint Base San Antonio—Lackland located in the State of Texas. I have served in the U.S. Air Force for 25 years and began my current assignment in August of 2016.

2. In addition to my role as the 59 MDOG Deputy Commander, I also provide oversight for the Air Force's Medical Multidisciplinary Team ("MMDT") and have served in that role since February of 2017.

3. I have reviewed the records of the Plaintiff proceeding in this case under the pseudonym Jane Doe 5.

4. Jane Doe 5 received a diagnosis of gender dysphoria from a military medical provider on October 23, 2015, and it was confirmed by the MMDT on January 10, 2018.

In accordance with 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct. Executed this 22d day of March 2018.



MARK J. BROOKS, Colonel, USAF
Deputy Commander, 59 MDOG

IN THE UNITED STATES DISTRICT COURT FOR THE DISTRICT OF COLUMBIA

JANE DOE 1, et al.,
Plaintiffs,
v.
DONALD TRUMP, et al.,
Defendants.
Civil Action No. 17-cv-1597 (CKK)

DECLARATION OF CPT [REDACTED] (Pertaining to Plaintiff Jane Doe 2)

I, [REDACTED] hereby declare as follows:

1. I am a Captain in the U.S. Army currently in command of [REDACTED]

[REDACTED]

[REDACTED] I have been in the Army for over 12 years. I have been in command of [REDACTED] since October 2016. As a company commander, I am the senior officer within my unit and responsible for all the personnel and equipment within my unit, including accomplishing the unit's assigned tasks and missions. I make this declaration based on my personal knowledge and on information provided to me in the course of my official duties. I submit this declaration in support of the defendants' motion to dismiss the above-captioned action and in opposition to the plaintiffs' motion for a preliminary injunction. In particular, I address below the current status of [REDACTED] who is referred to as Jane Doe 2 in the present litigation. Currently, the Army's official policy is to recognize a soldier's gender by the gender marker in the Defense Enrollment Eligibility Reporting System (DEERS). Jane Doe 2's gender marker in DEERS is male. However, for the convenience of the Court and the parties, I will refer to Jane Doe 2 using female pronouns for the remainder of this declaration, which correspond to Jane Doe 2's gender identity referenced in the complaint.

2. I am currently the company commander for Jane Doe 2, who arrived at my unit on [REDACTED]. Upon her arrival, she informed me of her transition. On September 14, 2017, the Secretary of Defense's issued Interim Guidance prohibiting the involuntary separation or discharge of a soldier due to his or her transgender status or diagnosis of gender dysphoria. In compliance with this policy, no soldier in my unit, to include Jane Doe 2, is currently pending separation or discharge due to their transgender status or gender dysphoria diagnosis. Nor will any soldier in my unit face such a separation, absent a change in the existing policy. Further, no soldier in my unit whose term of service expires while the Interim Guidance is in effect will be denied re-enlistment due to his or her transgender status. Accordingly, Jane Doe 2 will not be discharged due to his transgender status while the Interim Guidance is in effect.

In accordance with 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct. Executed this 04 day of October 2017.

[REDACTED]
Date: 2017.10.04 09:47:17 -06'00'
[REDACTED]
Captain, U.S. Army
[REDACTED]

Case 1:17-cv-01597-CKK Document 56-3 Filed 10/20/17 Page 1 of 3
IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

JANE DOE 1, et al.,)
)
Plaintiffs,)
v.) Civil Action No. 17-cv-1597 (CKK)
)
DONALD TRUMP, et al.,)
)
Defendants.)
_____)

DECLARATION OF CPT [REDACTED]
(Relating to Plaintiff Jane Doe 3)

I, [REDACTED] hereby declare as follows:

1. I am a Captain in the U.S. Army currently assigned as the commander of [REDACTED]
[REDACTED] I
have served in the U.S. Army for over 20 years, and have been in command of [REDACTED]
since August 2016. As the company commander, I am the senior officer within my unit and
responsible for all the personnel and equipment within my unit, including accomplishing the
unit's assigned tasks and missions. I make this declaration based on my personal knowledge and
on information provided to me in the course of my official duties. I submit this declaration in
support of the defendants' motion to dismiss the above-captioned action and in opposition to the
plaintiffs' motion for a preliminary injunction. In particular, I address below the current status of
[REDACTED] who is referred to as Jane Doe 3 in the present litigation. Currently,
the Army's official policy is to recognize a soldier's gender by the gender marker in the Defense
Enrollment Eligibility Reporting System (DEERS). Jane Doe 3's gender marker in DEERS is
male. However, for the convenience of the Court and the parties, I will refer to Jane Doe 3 using
female pronouns for the remainder of this declaration, which correspond to Jane Doe 3's gender
identity referenced in the complaint.

2. [REDACTED] is currently in the process of deploying in support of U.S. military operations in Iraq. The majority of the brigade has already deployed through several phases beginning at the end of August 2017. Until I deploy, part of my official duties include being the responsible officer within the battalion that handles personnel issues on behalf of other company commanders while they are forward deployed.

3. Based upon my official duties, I am familiar with Jane Doe 3, a soldier currently assigned to [REDACTED] and that Jane Doe 3 has requested gender transition. Jane Doe 3 deployed to northern Iraq on or about [REDACTED]

[REDACTED]
[REDACTED] That date is subject to change based upon operational requirements.

4. My brigade and battalion are in receipt of the Interim Guidance regarding transgender service issued by Secretary Mattis on September 14, 2017. Based upon this guidance, no soldier within [REDACTED] will be subject to discharge or separation based upon their transgender status or diagnosis for gender dysphoria, absent a future change to the Secretary's policy. Jane Doe 3 is not subject to discharge under this current policy. In addition, based upon the Interim Guidance, an otherwise qualified soldier whose term of service expires while the Interim Guidance remains in effect may, at the soldier's request, be re-enlisted in the service under existing procedures.

5. I am also aware of allegations that Jane Doe 3 is concerned her request for gender transition packet is not being processed or will not be approved. I am familiar with the requirements for requesting gender transition pursuant to Department of Defense Instruction 1300.28 and Army Directive 2016-35. Jane Doe 3 submitted the request to his chain of command

on [REDACTED] My brigade commander approved the packet on [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

In accordance with 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct. Executed this 4th day of October 2017.

[REDACTED]

Captain, U.S. Army

[REDACTED]

IN THE UNITED STATES DISTRICT COURT FOR THE DISTRICT OF COLUMBIA

JANE DOE 1, et al.,
Plaintiffs,
v.
DONALD TRUMP, et al.,
Defendants.
Civil Action No. 17-cv-1597 (CKK)

DECLARATION OF SGM [REDACTED] (Pertaining to Plaintiff Jane Doe 4)

I, [REDACTED] hereby declare as follows:

1. I am a Sergeant Major in the U.S. Army currently assigned as the G1 Sergeant Major for [REDACTED]

I have served in the U.S. Army for 27 years, and I have been assigned in this position for two years and two months. I am responsible to [REDACTED] through my principal, the G1, for all personnel-related activities within the organization, to include strength management, assignments, awards, evaluations, and other personnel policies. Due to my official duties, I have authorized access to soldiers' official personnel records that are stored within official Army databases. I make this declaration based on my personal knowledge and on information provided to me in the course of my official duties. I submit this declaration in support of the defendants' motion to dismiss the above-captioned action and in opposition to the plaintiffs' motion for a preliminary injunction. In particular, I address below the current status of plaintiff [REDACTED] who is referred to as Jane Doe 4 in the present litigation.

2. I am aware of Jane Doe 4's attempt to re-enlist in the U.S. Army. She is a soldier in the [REDACTED] and also currently works at [REDACTED] as a civilian employee.

Based upon her official personnel records, her current term of enlistment was set to expire on

[REDACTED]

However, effective [REDACTED] Jane Doe 4 re-enlisted in the [REDACTED]

[REDACTED]

[REDACTED]

and extended her commitment for a period of [REDACTED]

[REDACTED]

Based on this extension, her new enlistment termination date is [REDACTED]

[REDACTED]

In accordance with 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct. Executed this 28th day of September 2017.

[REDACTED]

Sergeant Major, U.S. Army

[REDACTED]

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

JANE DOE 1 *et al.*,

Plaintiffs,

v.

DONALD J. TRUMP *et al.*,

Defendants.

Civil Action No. 17-cv-1597 (CKK)

DECLARATION OF
DANIEL R. SITTERLY,
ACTING ASSISTANT SECRETARY
OF THE AIR FORCE,
MANPOWER AND RESERVE AFFAIRS

I, Daniel R. Sitterly, declare as follows:


1. I, Daniel R. Sitterly, am Acting Assistant Secretary of the Air Force (Manpower and Reserve Affairs).
2. I am aware that a lawsuit has been instituted in the above-captioned case. I am also aware that Jane Doe 5 is a plaintiff in that lawsuit and that she claims she is currently serving in the United States Air Force. I am aware that she claims that she will be negatively impacted by future Department of Defense policy discussed in the Presidential Memorandum for the Secretary of Defense and the Secretary of Homeland Security, dated August 25, 2017.
3. In accordance with the interim guidance laid out in the memorandum entitled *Military Service by Transgender Individuals—Interim Guidance*, issued by Secretary of Defense James N. Mattis on September 14, 2017, the United States Air Force is not taking any action to involuntarily separate or discharge any otherwise qualified member of the United States Air Force solely on the basis of a gender dysphoria diagnosis or

transgender status.

4. Furthermore, an otherwise qualified transgender member of the United States Air Force whose term of service expires while the Interim Guidance remains in effect may, at the member's request, re-enlist in service under existing procedures.
5. This Interim Guidance applies to all members currently serving in the United States Air Force.

Pursuant to 28 U.S.C. § 1746, I, Daniel R. Sitterly, hereby declare under penalty of perjury that the foregoing is true and correct.

28 Sep 17
Date



DANIEL R. SITTERLY
Acting Assistant Secretary of the Air Force (Manpower and Reserve Affairs)

Case 1:17-cv-01597-CKK Document 56-6 Filed 10/20/17 Page 1 of 3
IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

JANE DOE 1, et al.,)
)
Plaintiffs,)
v.) Civil Action No. 17-cv-1597 (CKK)
)
DONALD TRUMP, et al.,)
)
Defendants.)
_____)

DECLARATION OF [REDACTED]
(Pertaining to Plaintiff John Doe 1)

I, [REDACTED] hereby declare as follows:

1. I am a Colonel in the U.S. Army currently assigned as [REDACTED]. [REDACTED] I am a medical physician who is board certified in plastic surgery. I have served in the U.S. Army for over 20 years. This declaration relates to [REDACTED] who is referred to as John Doe 1 in the present litigation, and is one of my patients. I make this declaration based on my personal knowledge and on information provided to me in the course of my official duties. I submit this declaration in support of the defendants' motion to dismiss the above-captioned action and in opposition to the plaintiffs' motion for a preliminary injunction.

2. I am aware of allegations that John Doe 1's surgery consult scheduled for [REDACTED] [REDACTED] was suspended, and that he feared he would not receive necessary medical treatment, due to President Trump's announcement regarding the military service of transgender personnel. However, since the Secretary of Defense issued his Interim Guidance, John Doe 1 currently has a scheduled surgery date of [REDACTED].

3. John Doe 1 is stationed at [REDACTED]. On [REDACTED] he was referred to me

by medical providers from [REDACTED] as a candidate for transgender-related surgery. I agreed to evaluate the patient, so long as he could remain in the local area for two to three weeks following his surgery, and that he would be able to receive follow-on care at [REDACTED]

4. On July 27, 2017, I received informal guidance from the Office of the Surgeon General (OTSG) to pause any elective transgender surgical cases. Then, on August 17, 2017, I received updated guidance from OTSG to cancel any scheduled surgeries for gender transition, and not to reschedule any procedures until I received further guidance. However, the guidance did not proscribe surgical evaluations, so I continued to see new referrals for transgender surgery.

5. On [REDACTED] I had my initial meeting with John Doe 1 at [REDACTED] I performed a full surgical consultation and found him to be a good surgical candidate. I offered him surgery at that time, but we did not set a date for the surgery because I do not schedule surgeries during initial consultations due to time constraints. Further, the guidance from OTSG at that time was not to schedule any transgender surgeries until further notice, which I relayed to John Doe 1.

6. The following day, on [REDACTED] I received an update from my Nurse Case Manager that OTSG had authorized transgender surgeries. [REDACTED]

[REDACTED] On [REDACTED] I called John Doe 1 and informed him that I could not schedule his surgery yet, but was seeking clarification from the proper authorities. I notified him again on [REDACTED] that I was still seeking clarification.

7. On September 15, 2017, I received interim guidance from my hospital leadership to provide medically necessary services for approved treatment plans until final guidance is issued. On September 17th, OTSG confirmed that we could schedule new surgeries pending final

guidance. I received a second confirmation from OTSG on September 19th.

8. After receiving confirmation, I called John Doe 1 on [REDACTED] to schedule his surgery, and followed up with him through email. We scheduled his surgery for [REDACTED]

[REDACTED] However, on [REDACTED] the patient called me to reschedule his surgery because of a scheduling conflict. He is now scheduled for surgery on [REDACTED]

9. Throughout this whole process, I provided the patient the most up-to-date information I could, based upon the guidance I was given at the time. There were no intentional delays by the clinic staff or by me.

In accordance with 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct. Executed this 28th day of September 2017.

[REDACTED]

Colonel, U.S. Army

[REDACTED]

**IN THE UNITED STATES DISTRICT COURT FOR
THE DISTRICT OF COLUMBIA**

_____)	
DOE, et al.,)	
)	
<i>Plaintiffs,</i>)	
)	
v.)	Civil Action No. 17-cv-1597 (CKK)
)	
DONALD TRUMP, et al.,)	
)	
<i>Defendants.</i>)	
_____)	

**SUPPLEMENTAL DECLARATION OF RAYMOND EDWIN MABUS, JR.
IN SUPPORT OF PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION**

I, Raymond Edwin Mabus, Jr., declare as follows:

1. As set forth in my earlier declaration signed and dated August 29, 2017, I was part of a Working Group that comprehensively reviewed military policy with regard to transgender people serving across the service branches. It was based upon that review and the recommendations of that group that the Department of Defense announced in June 2016 that it would begin allowing transgender people to serve openly in the military.

2. As further set forth in that declaration, I am aware that in a series of announcements made on Twitter on July 26, 2017, and then again in a formal memorandum issued by the White House on August 25, 2017, President Trump announced the reversal of military policy stating that transgender individuals would no longer be able to serve in any capacity. The memorandum set March 23, 2018 as the date when military policy would revert to the pre-June 2016 policy whereby transgender individuals are subject to discharge upon disclosure of their transgender status.

3. Based on my experience in military personnel and operations, the recently announced policy change is presently causing significant harms to current servicemembers who have disclosed that they are transgender. Those harms are not speculative or future harms. They are current harms that prevent transgender service members from serving on equal terms with non-transgender service members and that impose substantial limitations on their opportunities within the military.

4. Consideration of the ways in which deployment decisions are made highlights the current limitations and lost opportunities being experienced by transgender service members. Consistent with naval operations, ships may deploy for up to 9 months at a time. Commanders making decisions about how to staff naval operations must consider the length of time that a sailor will be available for a deployment. If a sailor may not be available for the full length of a deployment, command knows that they will have to expend significant resources to backfill staffing needs in order to address the diminishment of resources. Rather than face those challenges, command will predictably make assignments based on certainty about sailors' ability to serve the full length of deployment.

5. Because of the announcement of the ban on transgender people being able to serve after March 2018, command lacks the requisite certainty that transgender service members will be able to complete the terms of their deployments where they extend beyond that date.

6. Similarly, command must regularly make personnel decisions that relate to "permanent change of station" (PCS) moves. PCS moves are made to ensure maximum utilization of personnel and to achieve military missions. PCS moves involve transporting service members and their families to a different base and duty station, often across the country or the world. The introduction of any uncertainty with regard to a service member's future

service, or status, changes command's consideration of PCS moves and military operations staffing. Based on my experience, the announced ban on transgender people serving is impacting PCS moves.

7. As a result of the announced ban, transgender service members are losing opportunities for assignments that they are capable of doing. These include lost opportunities for deployment, training, and assignments. These lost opportunities are based not on individual assessment of the service member's merit but rather based on whether the person is transgender. These lost opportunities, in addition to depriving transgender members of the military of the ability to serve on equal footing with their peers, hinder transgender service members opportunities for advancement and promotions as well.

8. The impact of this immediate harm reaches beyond the individual service member and affects the institution of the military as a whole. The military is designed to be a meritocracy where individuals receive opportunities and tackle assignments based on their ability to do the job. The institution is weakened when people are denied the ability to serve not because they are unqualified or because they cannot do the job but because of who they are.

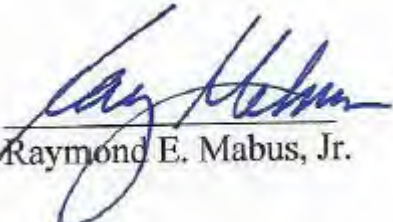
9. The ban on transgender service members weakens the military in a second way as well. With an all-volunteer force, which is the current structure of the military, a small segment of the population is responsible for the security of the whole. In this circumstance, it becomes even more important to have a diverse military in order to maintain a strong connection between those who serve to protect society and the society that the force is protecting. Banning a segment of the community from service weakens the bond of that connection between the military and society and sends a message that certain segments of the community are not within the scope of the mission. That message interferes with and diminishes military readiness and lethality.

10. Finally, based on my military experience and in my former role as Secretary of the Navy, I know of no instance where a Midshipman was allowed to complete their education at the Naval Academy where an individual experienced a condition which rendered them ineligible to commission into the Navy and where the Midshipman had two years remaining at the Academy.

11. In addition, I know of no instance either prior to June 2016 or since when a transgender person seeking to enlist was granted a waiver to the ban on service. In any case, it would be futile for a transgender person to seek a waiver to join the military at this point in time since, according to the announced policy, they would be subject to administrative discharge as soon as March 2018.

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

DATED: October 12, 2017



Raymond E. Mabus, Jr.

**IN THE UNITED STATES DISTRICT COURT FOR
THE DISTRICT OF COLUMBIA**

_____)	
DOE, et al.,)	
)	
<i>Plaintiffs,</i>)	
)	
v.)	Civil Action No. 17-cv-1597 (CKK)
)	
DONALD TRUMP, et al.,)	
)	
<i>Defendants.</i>)	
_____)	

**SUPPLEMENTAL DECLARATION OF DEBORAH LEE JAMES
IN SUPPORT OF PLAINTIFFS’ MOTION FOR PRELIMINARY INJUNCTION**

I, Deborah Lee James, declare as follows:

1. As noted in my prior declaration, I served as the Secretary of the United States Air Force (“USAF”) from December 20, 2013 to January 20, 2017. As Secretary, I was responsible for supervising the Department of the Air Force’s participation in a working group convened by the Department of Defense in 2015 to identify the practical issues related to transgender Americans serving openly in the Armed Forces, and to develop an implementation plan that addressed those issues with the goal of maximizing military readiness (the “Working Group”).

2. Based on the Working Group’s analysis and recommendations, the Department of Defense announced in June 2016 that it would begin to allow transgender people to serve openly in the Armed Forces.

3. 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. The President's memorandum stated that the military would return to the pre-June 2016 policy on March 23, 2018.

4. Based on my experience regarding military personnel, and in particular personnel and operations of the USAF, the President's announced decision to ban openly transgender people from serving in the military effective March 23, 2018 is presently harming transgender people currently serving in the military in several significant respects.

5. Airmen are typically deployed for periods of time that exceed several months, and planning for a deployment begins several months in advance of the deployment. Commanders in charge of overseeing deployments must take into account the certainty with which Airmen will be available for the entire length of a deployment when making assignment decisions.

6. Given the President's announcement that transgender service members will be subject to separation from the military beginning March 23, 2018, commanders cannot rely on transgender Airmen being able to complete deployments that continue beyond that date. Transgender Airmen with deployment terms that extend beyond March 2018 will thus lose opportunities for assignments because command will not be able to determine with certainty that transgender Airmen will be present for the entire duration of the deployment. In addition to negatively impacting individual Airmen, this uncertainty harms USAF readiness and capabilities where commanders are not able to make assignments based solely on the capabilities and experiences of those under their command.

7. Even outside the deployment context, transgender Airmen will lose out on assignments, opportunities, and experiences they would otherwise receive but for the President's

announcement that they will be subject to separation in March 2018. Commanders will be reluctant to invest time and money on training transgender Airmen for important or significant assignments or tasks where commanders believe the Airmen will be expected to leave the USAF in the near future.

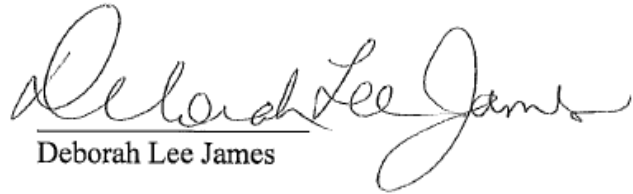
8. In addition, the President's announced ban on transgender people serving in the military creates a sub-class of service members, placing transgender people on unequal footing as compared to their non-transgender peers for reasons having nothing to do with their capabilities or past performance, and suggesting that transgender Airmen are unworthy of their comrades' trust and support. A lack of trust among service members is deeply concerning, as trust and respect throughout the chain of command is essential to promote military effectiveness. Thus, in addition to causing present harm to transgender Airmen, the President's ban will have a deleterious effect on the USAF's effectiveness and capabilities as well.

9. The President's announced ban is also anathema to the ethos of the military in general, and in particular the USAF. In the USAF, individual Airmen are given assignments and receive commendations and promotions on the basis of their individual merit and skill set. The USAF, and the military in general, are weakened when this fundamental building block of their identities is fractured through suggesting that service members should be judged based on characteristics having nothing to do with their ability to perform their job.

10. Finally, I am not aware of any instance – before or after June 2016 – where a transgender person seeking to join the military was granted a waiver to the ban on service of openly transgender individuals. Even if a transgender person were to seek a waiver at this time, doing so would be futile in light of the President's order making transgender service members subject to separation beginning in March 2018.

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

DATED: October 12, 2017


Deborah Lee James
Deborah Lee James

**IN THE UNITED STATES DISTRICT COURT FOR
THE DISTRICT OF COLUMBIA**

_____)	
DOE, et al.,)	
)	
<i>Plaintiffs,</i>)	
)	
v.)	Civil Action No. 17-cv-1597 (CKK)
)	
DONALD TRUMP, et al.,)	
)	
<i>Defendants.</i>)	
_____)	

**SUPPLEMENTAL DECLARATION OF ERIC K. FANNING
IN SUPPORT OF PLAINTIFFS’ MOTION FOR PRELIMINARY INJUNCTION**

I, Eric K. Fanning, declare as follows:

1. As set forth in my earlier declaration signed and dated August 28, 2017, I oversaw the Department of the Army’s participation in the Working Group that comprehensively reviewed military policy with regard to transgender persons serving openly in each of the service branches and which attempted to identify any practical, objective impediments to such service. It was based upon that review and the recommendations of that group that the Department of Defense announced on June 30, 2016, that transgender service members could openly serve in the U.S. military.

2. My earlier declaration also sets forth my awareness of the announcements of a new policy on transgender service, both through Twitter in late July 2017, and then in a Presidential Memorandum (“the Memorandum”) issued by the White House on August 25, 2017. Although providing the Secretaries of Defense and Homeland Security the opportunity to review the current policies, the Memorandum sets March 23, 2018 as the date by which the June 2016

policy “shall” be reversed (section 3) and transgender individuals will be subject to discharge as a result of disclosure of their transgender status.

3. Based on my knowledge and experience in military personnel and readiness challenges, as a result of service as a senior executive in each of the three military departments as well as Chief of Staff to the Secretary of Defense, the recently announced policy change is causing significant harm to current servicemembers who have already disclosed their status as an individual who is also transgender to their commanders.

4. The Memorandum asserts that the “previous Administration” had an “[in]sufficient basis” for allowing open service, and therefore, this Administration is directing the reversal of policy changes that had enabled open service based on its “meaningful concerns” about the impact of open service on “under military effectiveness and lethality, disrupt unit cohesion, or tax military resources.”

5. In my experience, this communicates that the Commander in Chief of the U.S. military believes that transgender service members are unfit for military duty solely because of their transgender status. It degrades the value of transgender individuals not only to those service members themselves, but gives license to their leaders and fellow service members to do the same, in an environment where the ability to unqualifiedly and mutually rely on each other is an indispensable element of service. The Memorandum on its face marks these service members as deserving of impending involuntary discharge.

6. The Memorandum alone, and certainly when animated by the President’s tweets, causes harm by preventing transgender service members from serving on equal terms with other service members based on their merit; serves to substantially limiting their advancement and promotion opportunities in the military; and undermines their standing with superiors and peers,

as described above. Opportunity to succeed and advance in the military should not depend on gender identity, nor any other factor other than ability to meet the required standards.

7. The harm extends beyond the individuals involved to the whole ethos of the military as a meritocracy where all Americans who want to serve and can meet its standards should be afforded the opportunity to do so. Unjustified, categorical bans on Americans qualified and ready to serve diminishes that organizing principle.

8. Furthermore, the Presidential Memorandum and Secretary of Defense Jim Mattis' August 29, 2017 announcement that he will "carry out the president's policy direction" by "develop[ing] a study and implementation plan" sends the clear message to American society that the U.S. Army is not, as General Mark Milley, the Army's Chief of Staff and highest ranked officer, declared in 2016 "open to all Americans who meet the standard, regardless of who they are."

9. That declaration is essential to ensuring the military has access to the best and brightest America has to offer and that those who seek to serve know that they will be judged by their performance alone, rather than the artificial prejudices that once hampered the advancement and acceptance of African Americans, women, religious minorities, and gays and lesbians in our nation's armed forces.

10. In addition, when the military fails to keep pace with the demographic change of our nation and departs from the core principle of opportunity for all that can meet its high standards, it results in an erosion of understanding between those who serve and those who freedom those service members defend. The President's tweets and directive undoubtedly exacerbate this divide, both by creating a single class of Americans he deems unfit to serve and dividing the nation by telling them that only these individuals are unfit.

11. Finally, during my tenure as Secretary of the Army, I am unaware of any instance prior to or after June 2016 when a transgender person seeking to enlist or accept a commission in the Army was granted a waiver from the Army's medical accession standards.

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

DATED: October 15, 2017



Eric K. Fanning

**IN THE UNITED STATES DISTRICT COURT FOR
THE DISTRICT OF COLUMBIA**

_____)	
DOE, et al.,)	
))	
<i>Plaintiffs,</i>)	
))	
v.)	Civil Action No. 17-cv-1597 (CKK)
))	
DONALD TRUMP, et al.,)	
))	
<i>Defendants.</i>)	
_____)	

**DECLARATION OF MARK J. EITELBERG
IN SUPPORT OF PLAINTIFFS’ MOTION FOR PRELIMINARY INJUNCTION**

I, Mark J. Eitelberg, declare as follows:

1. I am a Professor Emeritus at the Naval Postgraduate School in Monterey, California. I have personal knowledge of the matters stated in this declaration and can competently testify to these facts.

2. I received a Master of Public Administration degree from New York University in 1973 and a Ph.D. in Public Administration in 1979, also from New York University. I joined the faculty of the Naval Postgraduate School as an Adjunct Research Associate Professor in 1982. I was tenured as an Associate Professor in 1995 and promoted to Professor of Public Policy in 1999. I retired from federal service in April 2017. Upon retirement, in recognition of my distinguished service, I was designated Emeritus Professor of the Naval Postgraduate School. I served with the New Jersey Army National Guard and the U.S. Army Reserve from 1970 to 1976, the last two years as Staff Sergeant.

3. My teaching and research at the Naval Postgraduate School focused on military manpower and personnel policy analysis and military sociology/psychology. Among my research interests are the following: population participation (“representation”) in the military; the All-Volunteer Force; military force management and manpower policy; military manpower selection, classification, and utilization; and equal opportunity and diversity management. My honors include the Robert M. Yerkes Award (for outstanding contributions to military psychology by a non-psychologist) from the Society for Military Psychology, a division of the American Psychological Association, and the Department of the Navy Superior Civilian Service Award. I have served on the Board of Editors of the journals *Armed Forces & Society* and *Military Psychology*. I was Editor-in-Chief of *Armed Forces & Society* from 1998 through 2001. A true and correct copy of my curriculum vitae and a list of my publications are attached to this declaration as Exhibit A.

4. I am aware that, on June 30, 2016, the Department of Defense announced it would begin allowing transgender persons to serve openly in the military. As stated in the official announcement and news release (NR-246-16): “Effective immediately, service members may no longer be involuntarily separated, discharged or denied reenlistment solely on the basis of gender identity. Service members currently on duty will be able to serve openly.” This change in policy followed a careful review by a comprehensive working group that included high-ranking uniformed and civilian personnel as well as medical experts and other highly knowledgeable persons. The new policy assured current service members that they could reveal their gender identity if they chose to do so. The policy also established procedures for transgender service members to receive appropriate medical care for gender transition. Subsequently, many

transgender service members informed their chain of command and their peers that they are transgender.

5. I am also aware that, in a series of informal comments on July 26, 2017, and later in a formal memorandum on August 25, 2017, President Donald Trump directed that the policy allowing transgender individuals to serve openly in the military “return to the longstanding policy and practice” that prohibited transgender persons from serving in any capacity. Up to this point, for over one year previously, transgender service members were told that the Department of Defense had “ended” its ban on transgender Americans serving in the U.S. military. Under this policy and a forthcoming implementation plan, transgender service members will once again be subject to discharge by the Department of Defense on March 23, 2018.

6. Based on my knowledge, experience, and research in the fields of military manpower and personnel policy, military sociology, and military psychology, the newly announced policy is significantly harming service members who have disclosed they are transgender. This is not merely a potential problem or future hardship due to the scheduled March 23, 2018 date on which they will become subject to being separated. The new policy prevents transgender service members from serving equally with their peers; it imposes substantial limitations on their opportunities within the military; and it negatively impacts their day-to-day relationships with co-workers and other service members.

7. Military service opportunities are generally structured through career tracking by occupational area within each separate service, with scheduled training and skill-level assessments, operational assignments (or tours) and deployments, windows for advancement, and increased responsibilities based on experience, time-in-service, conduct, and performance. At the same time, as with any occupation, discretionary judgments or decisions within a service

member's chain of command can have a strong impact on one's job opportunities or daily life. Naturally, these decisions are influenced by expectations regarding a service member's future in the military. From an operational perspective, commanders understandably are reluctant to invest significant resources in the training or development of individuals who might leave military service in the near future, or to entrust them with important assignments. This dynamic is similar to what occurs in other large organizations when an employee is known to be departing several months in advance. Transgender service members who informed others of their gender identity based on the government's pledge that they could serve openly as of June 30, 2016, believing that "ending the ban" would not be temporary, have no secure future in the military beyond March 23, 2018.

8. Transgender service members leaving military service would likely be held in their present duty location, pending a confirmed date of their involuntary separation. Lost opportunities and personal problems would ensue, particularly if the service member has a family, children in school, or other dependents. Previously scheduled training, deployment, change of duty station, or other planned career events would be canceled by the military to save related costs, minimize organizational disruption, and simplify discharge. Some of these service members would continue to work in their present positions until separation; others would be temporarily "stashed" in another work unit; and some might be placed in a "make-work" situation or "holding pattern" while awaiting separation. If the person has a particularly important skill, knowledge, or expertise, she or he may be asked to train a replacement. In other cases, an individual scheduled for discharge may be gradually relieved of duties or assignments as their responsibilities are delegated to others. Depending on the supervisor's views and management style, this might mean the person slated for discharge will be required to perform

tasks no one else wants or be assigned less challenging, repetitive tasks that do not enhance their skill development.

9. Such reductions in responsibility have an impact even on service members whose departure from the military is voluntary and who have begun to make plans for their post-military life. The impact is much more severe for those who had been planning to remain in the military but are unexpectedly facing the prospect of involuntary separation, because their accumulated efforts to excel or advance and their career aspirations essentially disappear upon discharge. The potential harm to these women and men economically is undeniable; added to this is the psychological distress of being told that their performance in service to the nation is meaningless when measured against their gender identity. They had volunteered to serve their country, to accept the associated risks, and to perform well and honorably. The military considered them qualified to serve when they joined. Surely, many would want to understand why their gender identity now makes them unqualified to serve their country, and to such a degree that they should be removed from the military.

10. The President's memorandum also harms transgender service members in another way. According to the memorandum, "the previous Administration failed to identify a sufficient basis to conclude" that terminating the ban on transgender persons "would not hinder military effectiveness and lethality, disrupt unit cohesion, or tax military resources." Consequently, "meaningful concerns" remain regarding the "negative effects" of removing a ban on transgender persons. In essence, the President's directive reestablishes the *reasons* for prohibiting military service by transgender persons prior to the policy change of June 30, 2016, negating the conclusions of the comprehensive working group that supported removing the ban as well as any

training, guidance, regulations and forms, protocols, and supporting networks developed by the military to facilitate transition.

11. In reversing the previous policy, the President's directive instructs commanders and other service members that transgender individuals are detrimental to the military. No further explanation is provided, merely a statement that the present basis for concluding otherwise is insufficient. Although commanders would attempt to ensure that transgender personnel continue to be treated with dignity and respect, as emphasized in training, the President's directive to discharge transgender personnel erodes the value that members serving with them place on their contributions or performance. Reestablishing reasons for discharging transgender personnel legitimizes any bias or prejudice that may have existed among non-transgender members prior to training. As a result, transgender service members are being currently harmed and restricted artificially from being able to serve as equals with their peers.

12. In previous cases of involuntary discharge, service members slated for separation are viewed commonly as a nuisance and may be harassed by co-workers or treated differently by commanders prior to the member's departure. Additionally, as a service member approaches involuntary discharge, documented cases indicate that superiors may be less than complimentary in evaluating the member's performance, perhaps motivated to confirm the basis for separation. For transgender personnel facing involuntary discharge under the new policy, this could mean an unfairly low or negative performance rating rather than one based solely on merit. Consequently, the announced ban has the current effect of inducing conscious and unconscious bias among peers and commanders that ultimately harms transgender personnel by limiting their service opportunities and chances for advancement and promotion.

13. The President's memorandum identifies the potential disruption of unit cohesion as a key factor in reversing the policy of June 2016 and discharging transgender service members. Clearly, unit cohesion is a critical element in the military. Historically, this purported concern has been used to justify U.S. military policies of racial and gender segregation. More recently, unit cohesion served as a reason for the policy known as "Don't Ask, Don't Tell" (DADT). DADT itself stimulated considerable research by scholars to better understand unit cohesion and how it can be improved in the military. Previous studies have identified "task cohesion" (compared with "social cohesion") as most important in accomplishing a military mission. Strong bonds among service members are important in undertaking a mission and are particularly apparent in smaller military units, among persons on deployments, and among those who serve under dangerous conditions.

14. As noted, the President's directive places transgender personnel in a "holding pattern," subject to involuntary discharge on March 23, 2018. Knowing this, military commanders and co-workers are obviously less likely to bond with transgender service members and more inclined to keep them at a distance. Transgender personnel are thus more prone to be viewed as unimportant to a unit's cohesiveness and treated as such when working with their peers. Mutual trust and respect erode as co-workers see transgender personnel as "them," on the way out. Clearly, working relationships, as well social relationships, will suffer. Transgender personnel may feel isolated and alone. Added to this is the understanding among co-workers and commanders alike that transgender personnel are identified by the new policy as a potential detriment to military effectiveness and unit cohesion. Based upon current understanding of unit cohesion, the President's directive will damage the bond between transgender personnel and

their co-workers and thus disrupt the very unit cohesion that it seeks to protect. It also puts transgender troops in harm's way while serving, especially when deployed in active combat.

15. Being branded as disruptive or unworthy of service also carries consequences that are unique to the military context and differ from the dignitary harms suffered by those who face discrimination in civilian life. Military service is widely understood as an integral element of citizenship, and many regard it as a civic duty. Historically, the military has served as a path for members of minority groups, immigrants, and social outcasts to gain recognition as true and loyal citizens. When the military adopts a policy that degrades or demeans a group of service members, the message goes out to the larger society that such treatment is acceptable. This is especially observable during times when the military is held in high esteem by the general public. Indeed, according to annual Gallup polling, the U.S. military is “the most trusted institution” in the country. This has been true from 1989 to 1996 and from 1998 to 2017, with 72 percent of adult Americans presently expressing “a great deal” or “quite a lot” of confidence in the military. Barring individuals who are physically, medically, intellectually, educationally, emotionally, and morally qualified to serve based on a personal characteristic that is irrelevant to their ability sends a powerful message that the government distrusts or disapproves of the excluded group or sees them as unfit. African-Americans, Japanese-Americans, women, and gay and lesbian people once faced such official disapproval. Barring demographic groups from equal service gives them the overt stigma of civic inferiority.

16. Being labeled unworthy to serve also impairs service members' ability to carry out their duties safely and effectively. Since people serving in the military depend upon each other so much, particularly under life-threatening circumstances, being isolated or mistrusted can have enormous consequences. If others see someone in the unit as not being as of equal value,

they may not work as effectively with them or protect them as well as they would other unit members. And, unlike in civilian life, it is often difficult to escape the military workplace, which may be on a ship at sea, deployed overseas, or living on a base in close quarters with one's peers.

17. One final harm should be mentioned. The President's memorandum brands transgender personnel in a way that will follow them well into the future. Stained by the claim they are disruptive or damaging to a working unit's effectiveness—followed by their consequent separation from the military—transgender personnel may be irreparably harmed in finding post-service employment. Military recruiting advertisements often say that "it's a great place to start" and that military training and experience are invaluable to those seeking employment in the civilian job market. A natural result of the ban for transgender personnel is to diminish their opportunities for civilian employment following military service.

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

DATED: October 15, 2017


Mark J. Eitelberg

Exhibit A

Mark Jan Eitelberg, Ph.D.

Biographical Summary

Dr. Mark J. Eitelberg is an internationally recognized authority on military human resources policy and America's All-Volunteer Force. In April 2017, he retired from federal service as Professor of Public Policy in the Graduate School of Business and Public Policy, Naval Postgraduate School (NPS), Monterey, California. Upon his retirement, he was designated Emeritus Professor of the Naval Postgraduate School. In nearly 35 years at NPS, he taught courses in policy analysis, military sociology/psychology, and research methods. He advised over 250 Master's theses along with several doctoral dissertations. He held a number of administrative positions, founded and directed a research center, and served on the school's Institutional Review Board for thirteen years. Prior to joining the faculty at NPS in 1982, Dr. Eitelberg was a Senior Scientist with the Human Resources Research Organization (HumRRO), where he directed numerous studies, co-designed a GI Bill educational benefits program, and conducted groundbreaking research for the Department of Defense. Between 1976 and 2017, he directed more than 34 research projects for the Office of the Secretary of Defense and U.S. Defense agencies.

Dr. Eitelberg is the author or co-author of approximately 120 publications and professional papers. Over the past several years, his research and writing have focused on issues related to population participation in the American military, a subject treated in several works: *Military Representation* (1979), *Blacks and the Military* (1982), *Screening for Service* (1984), *Manpower for Military Occupations* (1988), *Becoming Brass* (1991), and *Marching Toward the 21st Century* (edited, 1994). More recently, he coauthored *Profiles of American Youth* (2013), a book on the results of a nationwide administration of the military's enlistment test.

Dr. Eitelberg has been a consultant with a number of government agencies, commissions, and private organizations. These include the Brookings Institution, the RAND Corporation, the Atlantic Council of the United States, The Technical Cooperation Program (TTCP, an international consortium of defense scientists), the Defense Equal Opportunity Management Institute, the National Defense University, the Center for Strategic and International Studies, UC-Berkeley's National Commission on Testing and Public Policy, Grey Advertising, Campbell-Ewald, and several publishers, among many others. He has served on two committees of the National Research Council (National Academy of Sciences). He is the former Editor-in-Chief of *Armed Forces & Society*, a leading scholarly publication and the official journal of the Inter-University Seminar on Armed Forces and Society. He is a recipient of the U.S. Navy Superior Civilian Service Award and the Robert M. Yerkes Award of the American Psychological Association (Division 19), for outstanding contributions to military psychology by a non-psychologist. In 2001-2002, he was a Visiting Scholar with the Office of Population Research, Woodrow Wilson School of Public and International Affairs, Princeton University.

Dr. Eitelberg is a graduate of Franklin and Marshall College, where he majored in Government and in Religious Studies. He holds an M.P.A. and a Ph.D. in Public Administration from New York University. He is a former professional artist and metal sculptor. He served with the New Jersey Army National Guard and the U.S. Army Reserve; his final assignment was senior training coordinator with a basic training battalion of the US Women's Army Corps (WAC), where he gained the distinction of being one of few "male WACs" in U.S. history.

Selected Career Highlights

- ❖ Early in his career at HumRRO, the Office of the Secretary of Defense (OSD) identified him as one of the nation's leading authorities on "GI Bill" educational benefits, including their importance to the continued success of the All-Volunteer Force (AVF). In May 1976, after President Ford proposed eliminating all GI Bill benefits for new service members, Eitelberg and two associates developed a compromise program to replace the GI Bill (on a napkin in the John Bull Restaurant in Alexandria, Virginia). The U.S. Senate Committee on Veterans' Affairs and OSD were chief advocates of the plan, which became the Post-Vietnam Era Veterans Educational Assistance Program (also known as VEAP). VEAP replaced the GI Bill for new recruits in January 1977; since then, nearly 800,000 veterans have participated in the program. Eitelberg subsequently assisted OSD in further defining its educational benefits policy; he also developed and co-authored four OSD reports to Congress on VEAP, an experimental program with several innovative features.
- ❖ In 1976-1977, the US Army Research Institute for the Behavioral and Social Sciences (ARI) asked Dr. Eitelberg to study population representation in the military, a subject of heated debate prior to the end of the draft. Within a year, he became a national authority on the topic. Bernard Rostker, in his epic history of the AVF (*I Want You!*, RAND, 2006), writes: "Possibly the most rigorous assessment of representativeness came in a 1977 report by Mark Eitelberg of the Human Resources Research Organization for the Army Research Institute." This assessment laid the foundation for Eitelberg's doctoral dissertation at New York University (1979). The Brookings Institution subsequently hired Eitelberg for its Associated Staff, and his dissertation research contributed importantly to a Brookings Study in Defense Policy, *Blacks and the Military* (Binkin & Eitelberg, 1982).
- ❖ *Blacks and the Military*, by Martin Binkin and Mark J. Eitelberg, became an instant "best-seller" for Brookings, since it was the first study of its type and it addressed a topic that was of increasing interest to many. The day after publication, the book's major findings appeared in well over 350 newspapers and other periodicals throughout the world—as well as in all US television network news shows. A *Washington Post* Sunday Book Review featured the book. Coverage later appeared in newspaper editorials, syndicated columns, and in various news and opinion magazines. Binkin was interviewed on NBC's *Today Show* and on several other national television news outlets, such as CNN. Eitelberg, the shy one, declined numerous invitations to appear on popular network television and radio talk shows, including *The Larry King Show*. Many now refer to the groundbreaking book as a "classic" of its genre.
- ❖ Eitelberg's work on population representation in the military led to many other opportunities. By the early 1980s, OSD considered Eitelberg their "go-to authority." He presented papers and wrote extensively on the subject. He ghost-wrote reports to Congress, including several of OSD's annual reports to Congress on population representation in the AVF. In the mid-1980s, OSD asked him to redesign the annual representation report. He developed new statistical indicators and recommended that women be included as a primary focus in the report; apparently, no one had noticed that women were missing entirely from the document up to that point. Soon after Operations Desert Storm/Desert Shield concluded, OSD commissioned Eitelberg to write the official history of population participation in the first Gulf War. Many of Eitelberg's innovations and approaches to studying representation are still used by DoD and continue to appear in their annual report decades later. His expertise on population participation in the military also led to extensive research and writing over the years on equal opportunity, population diversity, gender and minority integration, and other related topics. He consulted

often with the Defense Equal Opportunity Management Institute and with a number of organizations in OSD. He worked closely with the Defense Advisory Committee on Women in the Services and with various government commissions on integration and equal opportunity. He advised over 100 Master's theses, a few doctoral dissertations, as well as dozens of student projects on population diversity themes. He was also the only person invited to present a paper (later two book chapters) at both DoD conferences celebrating anniversaries of America's All-Volunteer Force (convened at the US Naval Academy in 1983 and in 1993).

- ❖ In the 1980s, Eitelberg also established himself as a national authority on the selection and screening of applicants for military enlistment and commissioning in the officer corps. He was a primary author of DoD's study of national testing data. Publication of the final report, titled *Profile of American Youth: 1980 Nationwide Administration of the Armed Services Vocational Aptitude Battery* (1982), was covered widely by the national media, including *The Washington Post*, where it became the lead story on the front page of a Sunday edition. Eitelberg used Profile of American Youth data for a co-authored book, *Screening for Service* (1984), and a single-authored book, *Manpower for Military Occupations* (1988), which became a "minor classic" among scholars in the field. In 1989, with funding from the National Commission on Testing and Public Policy (UC-Berkeley), Eitelberg led a team of researchers in studying the testing and selection of U.S. military officers. He produced the first (and only) study using the SAT scores of military officers. When the results were published initially in *Becoming Brass*, the *Navy Times* reported the findings in a cover story, "Brains on Board," along with several related articles. Years later, Eitelberg was invited to coauthor a DoD study of the second Profile of American Youth, administered to establish new scoring norms for the military's enlistment test. This resulted in a 300-page, book-length manuscript, *Profiles of American Youth: Generational Changes in Cognitive Ability* (2013), after years of effort.
- ❖ Many scientists and policy analysts over the years have used Dr. Eitelberg's "Population Representation Model," which he developed in the late 1970s. This includes scholars and practitioners from around the world (including the governments of Australia, Canada, New Zealand, and the United Kingdom), the Congressional Budget Office, the Government Accountability Office, the U.S. military services and DoD, among many others. Most recently, his model has served as a central organizing theme in several Master's theses at NPS: two students (individually) from Turkey and students from Greece, the Republic of Korea, and Germany. The model holds a universal appeal for scholars internationally, and Eitelberg often presented seminars on the model for visiting international dignitaries and defense leaders through the NPS Center for Civil-Military Relations (CCMR).
- ❖ In 1992, as part of the "Army Futures" project, Dr. Eitelberg and his colleague, Dr. Stephen Mehay, organized a two-day, major conference in Arlington, Virginia. The conference, chaired by Dr. Eitelberg, featured over 20 speakers, including senior officials from the U.S. Army and Department of Defense, distinguished scholars, and subject area experts from several government agencies. The conference resulted in a book, *Marching Toward the 21st Century*, edited by Eitelberg and Mehay for Greenwood Press (1994).
- ❖ Eitelberg has assisted many organizations and groups, as noted elsewhere. Among the most significant are ten years of service (several appointments from 1990 to 2001) as a DoD representative on The Technical Cooperation Program (TTCP), an international consortium of defense scientists. Additionally, he served on two committees of the prestigious National Academy of Sciences, both of which resulted in the publication of a committee-authored book.

Dr. Eitelberg also served for nearly 13 years on the NPS Institutional Review Board (IRB). No one has served longer on the NPS IRB.

- ❖ In 1998, Eitelberg was Faculty Team Leader and U.S. Chair for a two-day conference in Moscow. Over 100 senior leaders from Russia's military, civilian defense establishment, and legislature attended the conference. The conference was sponsored jointly by the Council on Foreign and Defense Policy (Russia), the *Independent Military Review* (Russia), and CCMR (NPS). Russian newspapers covered the entire conference and published excerpts from recorded transcripts. The U.S. team was there to assist Russia in determining the feasibility of ending its military draft, and the conference became a significant event in U.S.-Russian relations and military cooperation relatively soon after the end of the long Cold War.
- ❖ In 1999, Eitelberg founded the NPS Center for Recruiting Innovation with significant funding from OSD and the Department of Navy (DoN). The Center's research and development activities supported the Navy's modernization of recruiting with an online presence and improved use of technology. "America's Army," the widely popular U.S. Army interactive game, is based on a concept developed originally for OSD and DoN by Dr. Eitelberg and his associates. Additionally, Dr. Eitelberg co-created the Navy's "Life Accelerator" (an interest inventory similar to DoD's "Interest Finder"), launched on Navy.com in March 2001. He updated the award-winning feature on his own in 2005. The very same interest inventory that Dr. Eitelberg produced in 2005 is still used today as the Navy "Life Ops Test" on Navy.com. It is estimated that well over 8 million young men and women, potential Navy recruiting prospects, have taken the "Life Accelerator" or "Life Ops Test" since it was first introduced in 2001.
- ❖ From 1998 through 2001, Dr. Eitelberg served as Editor-in-Chief of *Armed Forces & Society*, a highly respected, interdisciplinary scholarly journal with subscribers in over 55 countries. The primary editorial office was located at NPS during this time. Eitelberg supervised an editorial assistant, funded by NPS, three book review editors from the NPS faculty, 25 associate editors, and a copy editor who resided in Baltimore, Maryland. Each issue of the quarterly journal typically included six double-blind, peer-reviewed articles and ten book reviews. Eitelberg was invited to continue as editor for another term, but NPS declined to provide the required editorial support.
- ❖ From 1993 through 2014, Eitelberg directed an NPS study of the controversial DoD policy known as "Don't Ask, Don't Tell." A survey of NPS students was developed and first administered in 1994. Thereafter, for the next 20 years, the same survey was re-administered periodically and reported in seven NPS Master's theses. These surveys were sanctioned, yet unique, due to a longstanding DoD prohibition on surveys of active-duty personnel regarding the policy. The last administration of the survey occurred in 2013 to study changing attitudes after removal of the policy. The results are reported in two separate theses by teams of two students on each study. During the 20-year period, Eitelberg advised a number of other Master's theses related to the policy. He served on a University of California Blue Ribbon Commission to estimate the costs of the policy. He also wrote published reviews of two books on the policy, presented conference papers, assisted researchers at several universities, sponsored a speaker's program at NPS, and assisted the DoD Comprehensive Review Working Group, which developed a phased plan to remove the policy.
- ❖ In Dr. Eitelberg's 34+ years at NPS, he advised about 250 Master's theses and taught roughly 3,000 students in resident courses, amassing over 12,000 student-contact hours. He

created two popular resident courses, MN4114 Foundations of Military Sociology/Psychology and GB4044 Defense-Focused Managerial Inquiry. He created a LEAD Curriculum Course (distance learning at the U.S. Naval Academy), MN4113 Leadership Dimensions of Military Psychology/Sociology. He completely redesigned two other courses at NPS, GB3041 Analytical Tools for Managerial Decisions and MN4106 Military Manpower Policy Analysis, the capstone course in the Manpower Systems Analysis Curriculum. He served as Principal Investigator on many NPS research projects with considerable funding from external sponsors. From 1983-1990, he also served as Contracting Officer's Technical Representative (COTR) for NPS on research contracts worth several million dollars.

- ❖ Trivia: He was hired by NPS in 1982 as an Adjunct Research Associate Professor of Public Administration and the very first member of the newly formed Manpower Research Center. In 1986, the research center disbanded and transformed into the Department of Defense Personnel Security Research and Education Center (PERSEREC), still located in Monterey as part of the Office of Personnel Analytics under the Office of the Under Secretary of Defense (Personnel and Readiness). Eitelberg maintained joint offices in PERSEREC and in NPS for some years thereafter.
- ❖ Trivia: In August 2000, Dr. Eitelberg received the American Psychological Association's (Division 19/Society for Military Psychology) Robert M. Yerkes Military Psychology Award for outstanding contributions to military psychology by a non-psychologist. Yerkes is the "founding father" of military psychology. Other recipients of the annual award include General Maxwell Thurman, Senator Daniel Inouye, Senator Elizabeth Dole, and Senator Kay Bailey Hutchison.
- ❖ Trivia: He developed and supervised the first M-16 rifle training and qualification program for women reservists while serving with the 1st U.S. Women's Army Corps (WAC) Basic Training Battalion, 80th Division (Training), U.S. Army Reserve, Alexandria, Virginia.
- ❖ Trivia: He is a graduate of Columbia High School in Maplewood, New Jersey, where he was School President in his senior year. A large, regional public school (over 2,000 students) with a rich history, Columbia is well-known for its *many* notable alumni: [https://en.wikipedia.org/wiki/Columbia_High_School_\(New_Jersey\)](https://en.wikipedia.org/wiki/Columbia_High_School_(New_Jersey))
- ❖ Trivia: As a junior in high school, he painted a large mural that was placed on permanent display in the New Jersey State Fire Museum.

Education

Ph.D.	1979	New York University (Public Administration: Public Policy and National Security)
M.P.A.	1973	New York University, Wagner School of Public Service (Public Administration Theory and Practice)
A.B.	1970	Franklin and Marshall College (Government and Religious Studies)

Professional Experience

*Graduate School of Business and Public Policy
U.S. Naval Postgraduate School
Monterey, California*

2017-Present	Emeritus Professor of the Naval Postgraduate School
1999-2017	Professor of Public Policy
1989-1999	Associate Professor of Public Administration and Associate Chair for Research (Tenured, 1995)
1982-1989	Adjunct Research Associate Professor of Public Administration

Major Activities:

- Associate Dean for Faculty Affairs. (2007-2008)
- Founding Director, Center for Recruiting Innovation. (1999-2004)
- Associate Chair (Research), Department of Systems Management, and Charter Member, Naval Postgraduate School Research Board. (1995-1999)
- Academic Associate (Program Director) for the Manpower, Personnel, and Training Analysis Curriculum. (1990-1993)
- Director of research projects for the Office of the Secretary of Defense, the Department of the Army, the Department of the Navy, and other government agencies. (1982-Present)
- Teaching professor (Introduction to Manpower, Personnel, and Training Analysis; Manpower/Personnel Policy Analysis; Manpower/Personnel Seminar; Selected Topics in Management Science; Foundations in Military Sociology and Military Psychology; Research Methods; Defense-Focused Managerial Inquiry). Recognized as among “Top Five Percent” in Award for Teaching Excellence, 1997. (1983-Present)
- Faculty Team Leader, Russia Seminar (Moscow), Center for Civil-Military Relations. (1997-1998)
- Faculty, Center for Civil-Military Relations. Lecturer in several seminar programs. (1997-2005)
- Faculty, Leadership Development and Education Program, United States Naval Academy and Naval Postgraduate School. (1997-1999)
- Thesis advisor in the Manpower Systems Analysis Curriculum. (Over 250 Master’s theses, 1983-Present)

- Contracting Officer's Technical Representative (COTR) on research contracts totaling several million dollars. (1983-1990)
- Author; consultant in military manpower policy and national security; frequent contributor to national news media; manuscript reviewer for commercial publishers; and reviewer for academic journals in national security and military psychology.

Human Resources Research Organization

Alexandria, Virginia

1979-1982	Senior Scientist
1976-1979	Research Scientist
1975-1976	Research Associate
1975	Research Assistant

Major Activities:

- Research project director and principal investigator; author of numerous technical reports, papers, and government documents. Recipient of Professional Performance Merit Award, "HumRRO Researcher of the Year" (1982).
- Consultant to Office of the Assistant Secretary of Defense (Manpower, Reserve Affairs, and Logistics). Recipient of Office of the Secretary of Defense Certificate of Appreciation for "valuable contributions to military manpower research" (1982).
- Deputy Director of Management Sciences Group. (1976-1979)

Other Positions (Selected)

- Visiting Research Collaborator, Office of Population Research, Woodrow Wilson School of Public and International Affairs, Princeton University. (Sabbatical, 2001-2002)
- U.S. Department of Defense representative on The Technical Cooperation Program (TTCP), an international, cooperative program in the defense sciences and technologies. Member of HUM-TP3 (formerly UTP-3), panel on "Military Human Resource Issues." (1990-2001)
- Editor-in-Chief, *Armed Forces & Society*, the official journal of the Inter-University Seminar on Armed Forces and Society (IUS). Founded in 1974 (the original Board of Editors included Morris Janowitz, Raymond Aron, Samuel E. Finer, and Jacques Van Doorn), *AF&S* now reaches scholars from many disciplines in over 50 countries. The editor supervises an editorial assistant, a managing editor, and three book review editors, and is assisted by 25 associate editors as well as numerous manuscript reviewers from around the world. (1998-2001)
- Member and Contributing Author, Committee on the Youth Population and Military Recruitment: Physical, Medical, and Mental Health Standards, National Research Council of the National Academies. (2004-2005)

- Member and Contributing Author, Committee on Techniques for the Enhancement of Human Performance, National Research Council, National Academy of Sciences. (1997-2000)
- Consultant, RAND Corporation. (1998-2000)
- Consultant, Campbell-Ewald, Warren, Michigan. (2000-2010)
- Consultant and Author, National Commission on Testing and Public Policy, University of California, Berkeley. (1988-1989)
- Consultant and Author, Global Demographic Trends Group, President's Commission on Integrated Long-Term Strategy, National Defense University, Washington, DC. (1987-1988)
- Consultant, Human Resources Research Organization (HumRRO). (1983-1986; 2005-2010)
- Associated Staff, Foreign Policy Studies Program, Brookings Institution, Washington, DC. (1980-1982)
- Member and Contributing Author, Military Service Working Group, The Atlantic Council of the United States, Washington, DC. (1980-1981)
- Personnel Analyst, State of New Jersey. (1975)

Board and Other Commission Memberships

- Board of Editors, *Armed Forces & Society*. (2001-Present)
- Board of Editors, *Military Psychology*. (2001-2005)
- Board of Directors, Toro Little League and Board of Directors, Toro Pony League (Toro Park, Corral de Tierra, and Salinas, California). (1997-2001)
- University of California Blue Ribbon Commission on Estimating the Costs of Excluding Homosexuals from the US Military. (2005-2006)
- Institutional Review Board, Naval Postgraduate School. (2004-2017)

Current Professional Affiliations and Selected Awards

Department of the Navy Superior Civilian Service Award, April 2017.

Elected Member (formerly, four terms) of Governing Council and Fellow, Inter-University Seminar on Armed Forces and Society, Chicago, Illinois. Founder and Chair of the Pacific Coast Chapter.

American Psychological Association, Division 19 (Society for Military Psychology), Washington, DC. Recipient of “Robert M. Yerkes Award” for outstanding contributions to military psychology by a non-psychologist, August 2000.

International Military Testing Association, Washington, DC.

Military Service

Honorable Discharge, United States Army (Reserve), 1976.

Staff Sergeant, Command Group, 1st U.S. Women’s Army Corps Basic Training Battalion, 80th Division (Training), U.S. Army Reserve, Alexandria, Virginia. (1975-1976)

From Private to Staff Sergeant, Headquarters and Headquarters Troop, 5th Squadron, 117th Cavalry, 50th Armored Division, New Jersey Army National Guard, Westfield, New Jersey. (1970-1975)

Selected Publications and Presentations

Books

Sackett, Paul R., Eitelberg, Mark J., and Sellman, W.S. *Profiles of American Youth: Generational Changes in Cognitive Ability* (Under Review for Publication).

Committee on the Youth Population and Military Recruitment, National Research Council, *Assessing Fitness for Military Enlistment: Physical, Medical, and Mental Health Standards*. Washington, DC: The National Academies Press, 2006.

Committee on Techniques for the Enhancement of Human Performance, National Research Council, *The Changing Nature of Work: Implications for Occupational Analysis*. Washington, DC: National Academy Press, 1999.

Eitelberg, Mark J. and Mehay, Stephen L., eds. *Marching Toward the 21st Century: Military Manpower and Recruiting*. Westport, CT: Greenwood Press, 1994.

Eitelberg, Mark J., Laurence, Janice H., and Brown, Dianne C. *Becoming Brass*. (See same title under “Chapters in Books.” Subject of cover story, “Brains on Board,” *Navy Times*, 14 August 1989, pp. 14-16.)

Eitelberg, Mark J. *Manpower for Military Occupations*. Washington, DC: Office of the Assistant Secretary of Defense (Force Management and Personnel), April 1988. (Monograph Series)

Eitelberg, Mark J., Laurence, Janice H., and Waters, Brian K. (with Perelman, Linda S.). *Screening for Service*. Washington, DC: Office of the Assistant Secretary of Defense (Manpower, Installations, and Logistics), September 1984. (Monograph Series)

Binkin, Martin and Eitelberg, Mark J. *Blacks and the Military*. Washington, DC: The Brookings Institution, 1982.

Doctoral Dissertation

Eitelberg, Mark J. *Military Representation: The Theoretical and Practical Implications of Population Representation in the American Armed Forces*. Doctoral Dissertation. New York University, October 1979. (Principal Advisor: Frank N. Trager.) Summarized in *Dissertation Abstracts International*, Volume 40, No. 11, May 1980, p. 6000-A. (Order No. 8010342.)

Chapters in Books

Eitelberg, Mark J. "Women and Minorities in the Military: Charting a Course for Research," in *Managing Diversity in the Military*. Edited by Mickey R. Dansby, James B. Stewart, and Schuyler C. Webb. New Brunswick, NJ: Transaction Publishers, 2001.

Eitelberg, Mark J. "The All-Volunteer Force after Twenty Years," in *Professionals on the Front Line: Two Decades of the All-Volunteer Force*. Edited by J. Eric Fredland, Curtis L. Gilroy, Roger D. Little, and W.S. Sellman. Washington, DC.: Brassey's, 1996.

Eitelberg, Mark J. and Little, Roger D. "Influential Elites and the American Military after the Cold War," in *US Civil-Military Relations: In Crisis or Transition?* Edited by Don M. Snider and Miranda A. Carlton-Carew. Washington, DC: The Center for Strategic and International Studies, 1995).

Eitelberg, Mark J. and Mehay, Stephen L. "The Shape of Things to Come," in *Marching Toward the 21st Century: Military Manpower and Recruiting*. Edited by Mark J. Eitelberg and Stephen L. Mehay. Westport, Connecticut: Greenwood Press, 1994.

Eitelberg, Mark J. and Mehay, Stephen L. "Demographics and the American Military at the End of the Twentieth Century," in *U.S. Domestic and National Security Agendas: Into the 21st Century*. Edited by Sam C. Sarkesian and John Flanagan. Westport, Connecticut: Greenwood Press, 1994.

Eitelberg, Mark J. "Military Manpower and the Future Force," in *American Defense Annual, 1993*. Edited by Joseph Kruzel. New York: Lexington Books, 1993.

Eitelberg, Mark J., Laurence, Janice H. and Brown, Dianne C. "Becoming Brass: Issues in the Testing, Recruiting, and Selection of American Military Officers" in *Testing Policy in Defense: Lessons from the Military for Education, Training and Employment*. Edited by Bernard Gifford and Linda Wing. Boston, MA: Kluwer Academic Publishers, 1991, pp. 1-141.

Binkin, Martin and Eitelberg, Mark J. "Women and Minorities in the All-Volunteer Force," in *The All-Volunteer Force After a Decade*. Edited by William Bowman, Roger Little, and G. Thomas Sicilia. Elmsford, New York: Pergamon-Brassey's, 1986.

Eitelberg, Mark J. and Binkin, Martin. "Military Service in American Society," in *Toward a Consensus on Military Service*. Edited by Andrew J. Goodpaster, Lloyd H. Elliott, and J. Allen Hovey, Jr. Elmsford, New York: Pergamon Press, 1982.

Journal Articles and Reviews

Eitelberg, Mark J. "Review of *I Want You! The Evolution of the All-Volunteer Force*," *Armed Forces & Society* (Summer 2010): 571-579.

Eitelberg, Mark J. "Review of *Don't Ask, Don't Tell: Debating the Gay Ban in the Military*," *Armed Forces & Society* (Spring 2004): 488-491.

Eitelberg, Mark J. "Review of *Gays and Lesbians in the Military: Issues, Concerns, Contrasts*," *Armed Forces & Society* (Winter 1996): 314-316.

Foster, Gregory D. et al., "Global Trends to the Year 2010: Implications for U.S. Security," *The Washington Quarterly* (Spring 1989): 5-24.

Eitelberg, Mark J. "American Youth and Military Representation: In Search of the Perfect Portrait," *Youth and Society* 10 (September 1978): 5-31.

Notes and Other Short Pieces

Eitelberg, Mark J. "Barbie Selected for QM1 as Role Models Change," *Navy Times*, 10 June 1991, p. 23.

Eitelberg, Mark J. "AVF's Success In War Will Generate Praise and Appraisal," *Navy Times*, 11 March 1991, p. 25.

Eitelberg, Mark J. "Gulf Victory Proves All-Volunteer Force Works," *Air Force Times*, 8 April 1991, p. 23.

Eitelberg, Mark J. "U.S. Military is a Mean Machine, But is it Fit to Fight?" *Air Force Times*, 1 August 1988, pp. 21, 34.

Eitelberg, Mark J. "Fatal Weakness May be Lurking in Our National Armor," *Navy Times*, 25 July 1988, p. 27.

Eitelberg, Mark J. "Test-Scoring Errors May Have Saved All-Volunteer Force," *Navy Times*, 12 September 1988, p. 25.

Eitelberg, Mark J. "'Misnormed' Test Helped Volunteer System Succeed," *Army Times*, 12 September 1988, pp. 25, 50.

Eitelberg, Mark J. "Test 'Misnorming' Helped All-Volunteer Force Succeed," *Air Force Times*, 12 September 1988, pp. 25, 36.

Eitelberg, Mark J. "For Military Manpower, Tough Times Ahead," *Wings of Gold*, Summer 1988, pp. 27-29.

Conference Papers, Proceedings, and Presentations

Eitelberg, Mark J. "Confessions of a Cranky Journal Editor," Panel on Tips for Academic Writers, Biennial Conference of the Inter-University Seminar on Armed Forces & Society, Chicago, IL, October 2003.

Eitelberg, Mark J. "Spacemen, Scholars, and Sailors: Another Look at the Military's Treatment of Gays." Paper presented at Annual Conference of the American Psychological Association, Toronto, Canada, August 2003.

Eitelberg, Mark J. "America's All-Volunteer Force: Who Serves and Why Should We Care?" Invited paper presented at "Notestein Seminar," Office of Population Research, Woodrow Wilson School of Public and International Affairs, Princeton University, December 2001.

Eitelberg, Mark J. "Bridging the Gap Between Defense and Public Administration." Remarks presented at the Annual Meeting of the American Society for Public Administration, Newark, NJ, March 2001.

Eitelberg, Mark J. "Military Recruiting for the 21st Century: Where Do We Go From Here?" Paper presented at *Symposium on Strategic Approaches to Military Recruiting: An International Perspective*, 41st Annual Conference of the International Military Testing Association, Monterey, CA, November 1999.

Eitelberg, Mark J. "The Demography of Diversity." Paper presented at "Managing Diversity Workshop" for newly-selected Admirals (US Navy) and Generals (US Marine Corps), Washington, DC, January 1999.

Eitelberg, Mark J. "The All-Volunteer Force and Society." Paper presented at *Seminar on Transition to an All-Volunteer Force*, sponsored jointly by the Council on Foreign and Defense Policy (Russia), the *Independent Military Review* (Russia), and the Center for Civil-Military Relations (Naval Postgraduate School), Moscow, Russia, January 1998.

Eitelberg, Mark J. "Women and Minorities in the Military: Research Trends and Future Directions." Invited paper presented at the Equal Opportunity Research Symposium, Defense Equal Opportunity Management Institute (DEOMI), Cocoa Beach, FL, December 1997. In *DEOMI, 1997 EO/EEO Research Symposium Proceedings*, Patrick AFB: DEOMI, April 1998.

Eitelberg, Mark J. "Selected Issues in Defense Human Resources." Series of presentations for HUM-TP3, Panel on Military Human Resource Issues, The Technical Cooperation Program (TTCP), Portsmouth, United Kingdom, July 1997.

Eitelberg, Mark J. "Selected Issues in Defense Human Resources." Series of presentations for UTP-3, Panel on Military Human Resource Issues, The Technical Cooperation Program (TTCP), Victoria, British Columbia, Canada, July 1996.

Eitelberg, Mark J. "Women in the Military: Trends and Data Resources." Presented at Defense Advisory Committee on Women in the Services, Subcommittee on Forces

- Development and Utilization, Joint-Service Working Group, Monterey, CA, August 1996.
- Eitelberg and Mehay, Stephen L. "NPS Study of Minority Officers: Promotion Outcomes During the Pre-Drawdown and Drawdown Periods." Paper presented at the Biennial Conference of the Inter-University Seminar on Armed Forces and Society, Baltimore, MD, October 1995. (Part of panel, "Minority Officers in the Military: Current Issues and Trends," organized and chaired by the authors.)
- Eitelberg, Mark J. and Little, Roger D. "Influential Elites and the American Military After the Cold War." Paper presented at the Biennial Conference of the Inter-University Seminar on Armed Forces and Society, Baltimore, MD, October 1995. (Part of panel, "The Military, the Media, and Congress: Tensions and Resolve in the Post-Cold War Era," organized and chaired by the authors.)
- Eitelberg, Mark J. "Population Participation in the American Military." Series of presentations for UTP-3, Panel on Military Human Resources Issues, The Technical Cooperation Program (TTCP), Portland, OR, July 1995.
- Eitelberg, Mark J. and Little, Roger D. "Influential Elites and the American Military." Paper presented at conference on "Civil-Military Relations," hosted by the Center for Strategic and International Studies, U.S. Army War College, Carlisle, PA, September 1994.
- Eitelberg, Mark J. "Population Participation in the American Military: Current Issues." Paper presented at international meeting on "Defense Human Resources," Shelly Bay Air Force Base, Wellington, New Zealand, July 1994.
- Eitelberg, Mark J. "The All-Volunteer Force After Twenty Years." Paper presented at *A Military of Volunteers: Yesterday, Today, and Tomorrow*, a conference commemorating the twentieth anniversary of the All-Volunteer Force, U.S. Naval Academy, Annapolis, Maryland, September 1993.
- Eitelberg, Mark J. "A Presidential Politician's Guide to the Defense Downsizing." Paper presented at the Annual Meeting of the Military Testing Association, San Diego, California, October 1992.
- Eitelberg, Mark J. and Mehay, Stephen L. "The Shape of Things to Come." Paper presented at "Workshop on Sociocultural Designs for the Future Army," University of Maryland, March 1992.
- Eitelberg, Mark J. and Mehay, Stephen L. "Demographics and the American Military at the End of the Twentieth Century." Paper presented at "Workshop on U.S. Domestic and National Security Agendas," Cantigny, Illinois, September 1992. (Sponsored by the U.S. Army War College, the National Strategy Forum, and the Robert R. McCormick Tribune Foundation.)
- Eitelberg, Mark J. "Opening Remarks" and "Marching Toward the 21st Century: A Conference on Manpower and Recruiting Issues for the Future," Arlington, Virginia, January 1992. (Conference Chair and Co-Director.)

- Eitelberg, Mark J. "The Effects of Military Downsizing on Opportunities for Minorities." Paper presented at the Department of Education Conference on "The Role of Education in Restructuring Defense and Other Industries," Washington, DC, May 1991.
- Eitelberg, Mark J. "Preliminary Assessment of Population Representation in Operations Desert Shield and Desert Storm." Paper presented at the Biennial Conference of the Inter-University Seminar on Armed Forces and Society, Baltimore, Maryland, October 1991.
- Eitelberg, Mark J. "Preliminary Assessment of Population Representation in Operations Desert Shield and Desert Storm." Paper presented at the 99th Annual Meeting of the American Psychological Association, San Francisco, California, August 1991. (Appears on "Current Events and Social Representation in the Military," Audiotape No. APA-91-039, Sound Images, Inc., Aurora, Colorado, 1991.)
- Eitelberg, Mark J. "Increased Use of Women and Minorities in Military Aviation," in *Proceedings of the Fourth Federal Aviation Administration Meeting on Human Factors Issues in Aircraft Maintenance and Inspection*. Washington, DC: Office of Aviation Medicine, Federal Aviation Administration, June 1991, pp. 154–178.
- Eitelberg, Mark J. "Your Mother Wears Combat Boots . . . But Should She Pack A Gun?" Paper presented at the 98th Annual Meeting of the American Psychological Association, Boston, Massachusetts, August 1990.
- Eitelberg, Mark J. "Marginal Man and the Military: Past, Present, and Prospects." Paper presented at the 98th Annual Meeting of the American Psychological Association, Boston, Massachusetts, August 1990.
- Eitelberg, Mark J. "A Review of American Military Manpower Issues." Seminar papers presented at the Australian Defence Force Academy, Canberra, Australia, October 1990.
- Eitelberg, Mark J. "War or Welfare: The Military as an Agent of Social Change." Paper presented at the Biennial Conference of the Inter-University Seminar on Armed Forces and Society, Baltimore, Maryland, October 1989.
- Eitelberg, Mark J. "Military Representation: Reflections and Random Observations." Paper presented at the Biennial Conference of the Inter-University Seminar on Armed Forces and Society, Baltimore, Maryland, October 1989.
- Eitelberg, Mark J. "Military Representation: Reflections and Random Observations." Paper presented at the 97th Annual Convention of the American Psychological Association, New Orleans, Louisiana, August 1989. (Appears on "Social Representation in the Military," Audiotape No. APA-89-190, Sound Images, Inc., Aurora, Colorado, 1989.)
- Eitelberg, Mark J. "Aptitude Test Scores of Military Personnel Assigned to C³I Jobs: Trends and Prospects." Presented at the Forty-Third International Convention and Exposition of the Armed Forces Communications and Electronics Association, Washington, DC, June 1989. Summarized in "How to Acquire and Train Skilled Personnel to Employ and Maintain Complex Developing C3I Systems," *Signal*, September 1989, pp. 101–103.
- Eitelberg, Mark J. "Job Placement in Today's Military: Who Gets What and Why (and, Boy,

- Have Times Changed).” Paper presented at the 94th Annual Convention of the American Psychological Association, Washington, DC, August 1986.
- Eitelberg, Mark J. “And They Shall Turn Their Guns into Umbrellas: Today’s High-Tech Military and Its Changing Workforce.” Paper presented at the Forty-Seventh National Conference of the American Society for Public Administration, Anaheim, California, April 1986.
- Eitelberg, Mark J. “The Implications of Changing Military Enlistment Test Norms in 1985.” Paper presented at the 93rd Annual Convention of the American Psychological Association, Los Angeles, California, August 1985. Also in Department of Defense, *Implications of New Reference Population on Military Manpower: Symposium Proceedings*. Technical Memorandum 84-2. Washington, DC: Directorate for Accession Policy, September 1985.
- Eitelberg, Mark J. “Evaluation of Education Standards for Military Enlistment.” Research paper prepared for Joint-Service Working Group on Enlistment Standards, Directorate for Accession Policy, Office of the Secretary of Defense, November 1983.
- Eitelberg, Mark J. “Population Representation and Military Manpower Policy.” Seminar paper presented at General and Flag Officer Orientation, Institute of Higher Defense Studies, National Defense University, Washington, DC, March 1983.
- Eitelberg, Mark J. “Enlistment Eligibility and Participation in the All-Volunteer Force: Follow the Yellow Brick Road.” Paper presented at the Annual Conference of the Military Testing Association, San Antonio, Texas, November 1982.
- Eitelberg, Mark J., and Doering, Zahava D. “Profile in Perspective: Policy and Research Implications of the ‘Profile of American Youth.’” Paper presented at the Annual Meeting of the American Psychological Association, Washington, DC August 1982. Also in Department of Defense, *The Profile of American Youth: Results and Implications*, Technical Memorandum 82-2. Washington, DC: Office of the Secretary of Defense, September 1982.
- Eitelberg, Mark J., Doering, Zahava D., and Sellman, Wayne S. “Government Scientists Meet the Press: Reactions to the Release of the ‘Profile of American Youth.’” Paper presented at the 90th Annual Convention of the American Psychological Association, Washington, DC, August 1982.
- Doering, Zahava D., Eitelberg, Mark J., and Sellman, Wayne S. “Uniforms and Jeans: A Comparison of 1981 Military Recruits with 1980 National Youth Population.” Paper presented at the 90th Annual Convention of the American Psychological Association, Washington, DC, August 1982.
- Eitelberg, Mark J. and Waters, Brian K. “Relatively Bright and Ready to Fight: A Qualitative Comparison of Military Recruits and American Youth.” Paper presented at the Annual Meeting of the American Educational Research Association, New York, New York, March 1982.

- Laurence, Janice H. and Eitelberg, Mark J. "Subpopulation Analyses of 1980 Youth Population Aptitudes." Paper presented at the Annual Meeting of the American Educational Research Association, New York, New York, March 1982.
- Eitelberg, Mark J., Laurence, Janice H., Waters, Brian K., and Sellman, Wayne S. "Subpopulation Analyses of Current Youth Aptitudes." Paper presented at the Annual Conference of the Military Testing Association, Arlington, Virginia, October 1991.
- Waters, Brian K., Sellman, Wayne S., and Eitelberg, Mark J. "Military and Civilian Test Score Trends." Paper presented at the Annual Conference of the Military Testing Association, Arlington, Virginia, October 1981.
- Eisenman, Richard L., Eitelberg, Mark J., and Hunter, Richard W. "GI Bill Program Analysis." Paper presented at the National Meeting of the Operations Research Society of America and The Institute of Management Sciences (ORSA/TIMS), Philadelphia, Pennsylvania, 1976.

Reports and Selected Research Papers

[Two NPS technical reports in progress for publication in late 2017.]

- Belkin, Aaron, Barrett, Frank J., Eitelberg, Mark J., and Ventresca, Marc J. *Discharging Transgender Troops Would Cost \$960 Million*. San Francisco, CA: Palm Center, August 2017.
- Eitelberg, Mark J., Aten, Kathryn J., and Smith, Michael K. *Comparison of Women's Policies in Six International Navies*. NPS-GSBPP-15-001. Monterey, CA: Naval Postgraduate School, December 2014.
- Sackett, Paul R., Eitelberg, Mark J., and Sellman, W.S. *Profiles of American Youth: Generational Changes in Cognitive Ability*. FR-09-22. Alexandria, VA: Human Resources Research Organization, July 2013 (Revised).
- Eitelberg, Mark J. and Flyer, Eli S. "Tobacco Use: A Powerful Predictor of First-Term Attrition." Working Paper Prepared for the National Research Council, June 2005.
- Flyer, Eli S. and Eitelberg, Mark J. "Pre-service Cigarette Smoking and Behavioral Adjustment of Navy Recruits." Research Note. Monterey, CA: Naval Postgraduate School, October 2004.
- Eitelberg, Mark J. "Evaluation of the Active-Duty Military Officer Cohort File." Report Prepared for the Office of the Undersecretary of Defense for Personnel and Readiness. Monterey, CA: Naval Postgraduate School, December 2003.
- Eitelberg, Mark J., Kamel, Magdi, Crawford, Alice, Carney, Diane, and Roberts, Benjamin. *The Online Recruiting Station: Vision, Planning, and Preliminary Requirements*. Monterey, CA: Naval Postgraduate School, August 2000. (Limited Distribution.)

Eitelberg, Mark J. "A Military of Volunteers: Yesterday, Today, and Tomorrow: Report of a Conference Held at the U.S. Naval Academy." Monterey, CA: Naval Postgraduate School, January 1994.

Eitelberg, Mark J. and Mehay, Stephen L. *The Shape of Things to Come: Trends and Projections Affecting Military Recruiting and Manpower in the 21st Century*. NPS-AS92-023. Monterey, California: Naval Postgraduate School, 1992. Also appears in *Sociological Designs for the Future Army: Workshop Proceedings*. Edited by David R. Segal. ARI Research Note 93-14. Alexandria, Virginia: U.S. Army Research Institute for the Behavioral and Social sciences, March 1993, pp. 67-114.

Wilson, F.P., Eitelberg, M.J., and Fodor, D.B. *Ethnic Participation in the Militaries of TTCP Countries*. Ontario, Canada: The Technical Cooperation Program (TTCP) and the Canadian Forces Personnel Applied Research Unit, July 1993.

Eitelberg, Mark J. *American Demographic Trends and National Security: Issues for the 21st Century*, NPS-54-88-001. Monterey, CA: Naval Postgraduate School, February 1988.

Eitelberg, Mark J. *Representation and Race in America's All-Volunteer Military*. NPS-54-85010. Monterey, California: Naval Postgraduate School, September 1986.

Eitelberg, Mark J. "Historical Data on Hispanics in the U.S. Military," in *Hispanic Subpopulations and Naval Service*, SI/MRAS/TR-11. Edited by H. Wallace Sinaiko et al. Washington, DC: Smithsonian Institution, May 1985.

Lee, Gus C., Flyer, Eli S., Eitelberg, Mark J., and Orend, Richard. *Trends in the DoD High School Testing Program and the Supplementary Use of Commercial Test Information*. FR-MPAD-82-2. Alexandria, VA: Human Resources Research Organization, 1982.

Eitelberg, Mark J. "Characteristics of the Enlisted Force." Background paper for Office of the Secretary of Defense and Interagency Working Group, President's Task Force on Military Manpower, April 1982.

Eitelberg, Mark J. *Subpopulation Differences in Performance on Tests of Mental Ability: Historical Review and Annotated Bibliography*. Technical Memorandum 81-3, Washington, DC: Office of the Secretary of Defense, August 1981.

Eitelberg, Mark J. "The Attitudes, Experiences, and Expectations of VEAP Participants." Paper presented at the Congressional Budget Office Seminar on "Educational Assistance for the Military," Senate Office Building, Washington, DC, October 1980.

Eitelberg, Mark J. and Richards, John A. *Survey of Participants and Inactive/ Former Participants in the Post-Vietnam Era Veterans' Educational Assistance Program: Results and Conclusions*. FR-ETSD-80-11. Alexandria, VA: Human Resources Research Organization, 1980.

Eitelberg, Mark J., Richards, John A., and Rosenblatt, Richard D. *The Post-Vietnam Era Veterans' Educational Assistance Program: Participation during the First Year*. FR-ED78-12. Alexandria, VA: Human Resources Research Organization, 1978.

Eitelberg, Mark J. *Evaluation of Army Representation*. SR-ED-76-45. Alexandria, VA: Human Resources Research Organization, 1976.

Eitelberg, Mark J. *Evaluation of Army Representation*. TR-77-A9. Alexandria, VA: U.S. Army Research Institute for the Behavioral and Social Sciences, August 1977.

Purcell, Agnes C., Eisenman, Richard L., and Eitelberg, Mark J. *Army Representativeness: The National Longitudinal Study*. SR-ED-76-1. Alexandria, VA: Human Resources Research Organization, 1976.

Eisenman, Richard L., Eitelberg, Mark J., Purcell, Agnes C., Richmond, Barry M. and Wagner, Curtis L. III. *Educational Benefits Analysis*. SR-ED-75-25. Alexandria, VA: Human Resource Research Organization, 1975. Also in U.S. Senate, Committee on Veterans' Affairs, "Veterans Education and Employment Assistance Act of 1976" (Part 3), Hearings on S969 and Related Bills, 94th Congress, 1st Session, October 1 and 2, 1975. Washington, DC: Government Printing Office, 1977, pp. 2155–2306.

Eisenman, Richard L. and Eitelberg, Mark J. *Conclusions and Implications from the Analysis of Educational Benefits*. Special Report. Alexandria, VA: Human Resources Research Organization, 1976. Also in U.S. Senate Committee on Veterans' Affairs, *op. cit.*, pp. 2307–2343.

Government Documents

Department of Defense. *Career Progression of Minority and Women Officers*. Washington, DC: Office of the Under Secretary of Defense for Personnel and Readiness, August 1999. (Contributing Author.)

Department of Defense, "Defense Advisory Committee on Women in the Services: Utilization of Women Indicator Report." Monterey, CA: Defense Manpower Data Center/Naval Postgraduate School, September 1996. (Contributing Author and Editor.)

Department of Defense. "Evolution of Policy and Programs," Chapter 2 in *Family Status and Initial Term of Service, Volume II - Trends and Indicators*. Washington, DC: Office of the Assistant Secretary of Defense (Personnel and Readiness), December 1993. (Sole Author.)

Department of Defense, *Human Resource Development in the Department of Defense: Issues and Initiatives for Military Selection*. Washington, DC: Office of the Assistant Secretary of Defense (Force Management and Personnel), September 1991. (Contributing Author and Editor.)

Department of Defense. "A Preliminary Assessment of Population Representation in Operations Desert Shield and Desert Storm," Appendix D in *Population Representation in the Military Services, Fiscal 1990*. Washington, DC: Office of the Assistant Secretary (Force Management and Personnel), August 1991. (Sole Author.)

Department of Defense. *Human Resource Development in the Department of Defense: Issues and Initiatives for Military Selection and Classification*. Washington, DC: Office of the

- Assistant Secretary of Defense (Force Management and Personnel), *July 1990*.
(Contributing Author and Editor.)
- Department of Defense. *A Comparison of Current Army and Marine Corps Recruit Quality Requirements*. Washington, DC: Office of the Assistant Secretary of Defense (Force Management and Personnel), May 1986. (Sole Author.)
- Department of Defense. *Population Representation in the Active Duty Military Services*. Washington, DC: Office of the Assistant Secretary of Defense (Manpower, Installations, and Logistics), *June 1985, June 1986, and August 1987* editions. (Contributing Author and Editor.)
- Department of Defense. "ASVAB Testing in Languages Other Than English." Information Paper. Washington, DC: Office of the Assistant Secretary of Defense (Manpower, Installations, and Logistics), 1985. (Sole Author.)
- Department of Defense. *Profile of American Youth: 1980 Nationwide Administration of the Armed Services Vocational Aptitude Battery*. Washington, DC: Office of the Assistant Secretary of Defense (Manpower, Reserve Affairs and Logistics), March 1982. (Principal Author and Editor.)
- Department of Defense. *Third Annual Report to Congress on the Post-Vietnam Era Veterans' Educational Assistance Program*. Washington, DC: Office of the Assistant Secretary of Defense (Manpower, Reserve Affairs, and Logistics), June 1980. (Principal Author and Editor.)
- Department of Defense. *Educational Incentives Study*. Washington, DC: Office of the Assistant Secretary of Defense (Manpower, Reserve Affairs, and Logistics), February 9, 1980. (Principal Author.)
- Department of Defense. *First Annual Report to Congress on the Post-Vietnam Era Veterans' Educational Assistance Program*. Washington, DC: Office of the Assistant Secretary of Defense (Manpower, Reserve Affairs, and Logistics), May 1978. (Principal Author and Editor.)
- Department of Defense. *The Post-Vietnam Era Veterans' Educational Assistance Program: Implementation Report*. Washington, DC: Office of the Assistant Secretary of Defense (Manpower, Reserve Affairs, and Logistics), April 1977. (Principal Author and Editor.)

IN THE UNITED STATES DISTRICT COURT FOR
THE DISTRICT OF COLUMBIA

_____)	
DOE, et al.,)	
)	
<i>Plaintiffs,</i>)	
)	
v.)	Civil Action No. 17-cv-1597 (CKK)
)	
DONALD TRUMP, et al.,)	
)	
<i>Defendants.</i>)	
_____)	

SUPPLEMENTAL DECLARATION OF GEORGE RICHARD BROWN, MD, DFAPA

I, George R. Brown, declare as follows:

1. I make this declaration based on my own personal knowledge.
2. I previously submitted a declaration in the above-captioned case describing my professional education, experience, and background, including my awareness of the extensive process that led to the adoption of a Department of Defense policy in June 2016 permitting transgender people to serve in the military.

THE CATEGORIZATION OF MEDICAL CONDITIONS RELATED TO GENDER IDENTITY IN THE ICD-10 AND THE FORTHCOMING ICD-11

3. The World Health Organization (WHO) is in the process of developing the eleventh revision of the International Classification of Diseases and Related Health Problems (ICD-11), which is expected to be approved by the World Health Assembly in May 2018. *See* Exhibit A, Geoffrey M. Reed et al., “Disorders related to sexuality and gender identity in the ICD-11: revising the ICD-10 based on current scientific evidence, best clinical practices, and human rights considerations,” *World Psychiatry* 15:3, 205 (October 2016) [hereinafter Reed].

4. The ICD-10 was approved in 1990, nearly thirty years ago. The current period between revisions is the longest in the history of the ICD, which has resulted in some portions of the ICD-10 being significantly outdated. In particular, the portions of the ICD-10 relating to gender identity required significant revision in order to reflect advances in the research and the current scientific understanding of gender identity, transgender people, and the medical treatments for medical conditions relating to gender identity and gender dysphoria.

5. In order to provide scientifically and clinically sound recommendations about these needed revisions, the WHO Departments of Mental Health and Substance Abuse and of Reproductive Health and Research appointed a Joint Working Group to develop specific recommendations for how to revise the ICD-10 categories relating to gender identity. The Joint Working Group reviewed available scientific evidence as well as relevant information on health policies and health professionals' experience with the ICD-10 categories, in addition to other relevant materials, including what were then proposals for revising the American Psychiatric Association's DSM-5. The Joint Working Group made specific proposals regarding the placement and organization of categories and drafted diagnostic guidelines for the ICD-11 recommended diagnostic categories. I was invited to present my ideas on these matters at a meeting of this group in Oslo, Norway, and I had the opportunity to meet with Mr. Reed personally regarding the revisions.

6. The Joint Working Group recommended retaining diagnoses for gender incongruence (a new term that replaces Transsexualism and Gender Identity Disorder, but applies to the same patients previously diagnosed with these conditions) in order to preserve access to health service for transgender people, but moving these categories out of the ICD-11 chapter on Mental and Behavioral Disorders to the proposed new ICD-11 chapter on Conditions Related to Sexual

Health. The Working Group recommended changing the ICD-10 category F64.0 Transsexualism to Gender Incongruence of Adolescence and Adulthood and the ICD-10 F64.2 Gender Identity Disorder of Childhood to Gender Incongruence of Childhood.

7. The main reason for moving and renaming these diagnoses was to reflect current scientific research and knowledge about gender identity and transgender people, which recognizes that being transgender is not a disorder, that transition-related care is a basic aspect of promoting health and well-being for transgender people, and that gender dysphoria is a curable condition.

8. In light of these proposed revisions, it would be inappropriate and inaccurate to rely upon the outdated categorization of transsexualism and other medical conditions related to gender identity in the ICD-10 in any current discussion of these conditions. Further, in the ICD-10 terminology of 1990, it was never the case that clinicians working in this field of medicine considered transsexualism or gender identity disorder a “personality disorder” even though the Subgrouping, Gender Identity Disorders, was listed under the Grouping “Disorders of adult personality and behavior” in the Chapter entitled “Mental and Behavioral Disorders” in ICD-10. This erroneous placement for gender identity disorders will be corrected in ICD-11, where it is made clear that the replacement term, “gender incongruence,” is not a personality or behavioral disorder. This important clarification is consistent with my professional opinion and those of the vast majority of researchers and clinicians who work with persons with gender incongruence/gender dysphoria (see Reed).

9. There is no medical or scientific basis for categorizing transsexualism, gender dysphoria or any other medical condition associated with transgender people as a personality or behavioral disorder.

WAIVERS

10. Because the new accessions policy articulated by Secretary Carter has not been put into effect, the pre-June 2016 military policy for transgender persons continues to govern the standards for accession/entry. That policy treats individuals with gender dysphoria differently than people with other curable conditions in a variety of ways, including that persons with clinically active gender dysphoria, or who have been treated for gender dysphoria in the past, are not able to obtain the same medical waivers that are available for most other medical conditions. For example, it is not uncommon for waivers to be granted for overweight individuals if the individual offers a critical skill for military readiness.

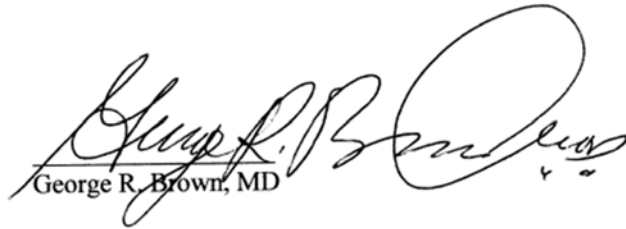
11. The enlistment policy allows for the possibility of waivers for a variety of medical conditions. However, entry waivers will not be granted for conditions that would disqualify an individual from the possibility of retention. Transgender people cannot obtain medical waivers to enter the military because being transgender is a disqualifying condition for retention.

12. The enlistment policy treats transgender individuals in an inconsistent manner compared with how the military addresses persons with other curable medical conditions. The result of this inconsistency is that transgender personnel are excluded or singled out for disqualification from enlistment, even when they are mentally and physically healthy.

13. In my 32 years of working as an active duty military psychiatrist or VHA psychiatrist, I am unaware of any waiver ever being granted for any transgender person seeking to enlist in any branch of the Armed Forces.

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

DATED: October 13, 2017



George R. Brown, MD

Exhibit A

Disorders related to sexuality and gender identity in the ICD-11: revising the ICD-10 classification based on current scientific evidence, best clinical practices, and human rights considerations

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In the World Health Organization's forthcoming eleventh revision of the International Classification of Diseases and Related Health Problems (ICD-11), substantial changes have been proposed to the ICD-10 classification of mental and behavioural disorders related to sexuality and gender identity. These concern the following ICD-10 disorder groupings: F52 Sexual dysfunctions, not caused by organic disorder or disease; F64 Gender identity disorders; F65 Disorders of sexual preference; and F66 Psychological and behavioural disorders associated with sexual development and orientation. Changes have been proposed based on advances in research and clinical practice, and major shifts in social attitudes and in relevant policies, laws, and human rights standards. This paper describes the main recommended changes, the rationale and evidence considered, and important differences from the DSM-5. An integrated classification of sexual dysfunctions has been proposed for a new chapter on Conditions Related to Sexual Health, overcoming the mind/body separation that is inherent in ICD-10. Gender identity disorders in ICD-10 have been reconceptualized as Gender incongruence, and also proposed to be moved to the new chapter on sexual health. The proposed classification of Paraphilic disorders distinguishes between conditions that are relevant to public health and clinical psychopathology and those that merely reflect private behaviour. ICD-10 categories related to sexual orientation have been recommended for deletion from the ICD-11.

Key words: International Classification of Diseases, ICD-11, sexual health, sexual dysfunctions, transgender, gender dysphoria, gender incongruence, paraphilic disorders, sexual orientation, DSM-5

(*World Psychiatry* 2016;15:205–221)

The World Health Organization (WHO) is in the process of developing the eleventh revision of the International Classification of Diseases and Related Health Problems (ICD-11). The ICD-11 is expected to be approved by the World Health Assembly in May 2018. The ICD-10 was approved in 1990, making the current period between revisions the longest in the history of the ICD.

In 2007, the WHO Department of Mental Health and Substance Abuse appointed the International Advisory Group for the Revision of ICD-10 Mental and Behavioural Disorders, to provide policy guidance and consultation throughout the development of the ICD-11 classification of mental and behavioural disorders¹. As the revision process advanced, a series of Working Groups in different disorder content areas were also appointed to review available evidence and develop recommendations regarding needed revisions in specific diagnostic groupings².

From early in the revision process, it was clear that there were a series of complex and potentially controversial issues associated with the ICD-10 categories related to sexuality and gender identity, including the following disorder groupings: F52 Sexual dysfunctions, not caused by organic disorder or disease; F64 Gender identity disorders; F65 Disorders of sexual preference; and F66 Psychological and behavioural disorders

associated with sexual development and orientation. During the more than 25 years since the approval of ICD-10, there have been substantial advances in research relevant to these categories, as well as major changes in social attitudes and in relevant policies, laws, and human rights standards.

Due to the complexity of this context and the need to take a broad perspective in order to develop scientifically and clinically sound recommendations that would facilitate access to health services, the WHO Departments of Mental Health and Substance Abuse and of Reproductive Health and Research have worked together to propose revisions in these areas. The two WHO departments appointed a joint Working Group on Sexual Disorders and Sexual Health to assist in the development of specific recommendations.

The first task of the Working Group was to review available scientific evidence as well as relevant information on health policies and health professionals' experience with the ICD-10 diagnostic categories identified above. These issues were examined within various settings, including primary care and specialist health care settings, as well as social service and forensic contexts. Also considered were human rights issues pertinent to diagnostic classification in each of the areas under the Working Group's purview. The Working Group was also asked to review what were then proposals for the American

Psychiatric Association's DSM-5³, and to consider the clinical utility of those proposals and their suitability for global implementation in various settings. Finally, the Working Group was asked to prepare specific proposals, including the placement and organization of categories, and to draft diagnostic guidelines for the ICD-11 recommended diagnostic categories, in line with the overall ICD revision requirements².

The following sections describe the main recommended changes for the above-mentioned four areas in the ICD-11 as compared to ICD-10. The ICD-10 Clinical Descriptions and Diagnostic Guidelines for Mental and Behavioural Disorders⁴, the version intended for use by specialist mental health professionals, is used as the frame of reference for this comparison. The rationale for changes, the evidence considered, and specific comments on differences from DSM-5 are also provided.

PROPOSED CHANGES TO F52 SEXUAL DYSFUNCTIONS, NOT CAUSED BY ORGANIC DISORDER OR DISEASE

The ICD-10 classification of Sexual dysfunctions (F52) is based on a Cartesian separation of "organic" and "non-organic" conditions. Sexual dysfunctions considered "non-organic" are classified in the ICD-10 chapter on Mental and Behavioural Disorders, and most "organic" sexual dysfunctions are classified in the chapter on Diseases of the Genitourinary System. However, substantial evidence has accumulated since ICD-10's publication indicating that the origin and maintenance of sexual dysfunctions frequently involves the interaction of physical and psychological factors⁵. The ICD-10 classification of sexual dysfunctions is therefore not consistent with current, more integrative clinical approaches in sexual health⁶⁻⁹.

The Working Group on Sexual Disorders and Sexual Health has proposed an integrated classification of sexual dysfunctions for ICD-11 (see Table 1) that is more closely informed by current evidence and best practices, to be included in a new ICD-11 chapter on Conditions Related to Sexual Health¹⁰. The proposed integrated classification encompasses the sexual dysfunctions listed in the ICD-10 chapter on Mental and Behavioural Disorders and many of those currently found in the chapter on Diseases of the Genitourinary System¹¹.

In the proposed diagnostic guidelines for ICD-11, sexual response is described as a complex interaction of psychological, interpersonal, social, cultural, physiological and gender-influenced processes. Any of these factors may contribute to the development of sexual dysfunctions⁸, which are described as syndromes that comprise the various ways in which people may have difficulty experiencing personally satisfying, non-coercive sexual activities.

The proposed ICD-11 diagnostic guidelines organize Sexual dysfunctions into four main groups: Sexual desire and arousal dysfunctions; Orgasmic dysfunctions; Ejaculatory dysfunctions; and Other specified sexual dysfunctions. In addition, a

separate grouping of Sexual pain disorders has been proposed. Where possible, categories in the proposed classification of sexual dysfunctions apply to both men and women, emphasizing commonalities in sexual response^{12,13} (e.g., Hypoactive sexual desire dysfunction, Orgasmic dysfunction), without ignoring established sex differences in the nature of these experiences¹⁴. Men and women exhibit similar central nervous system pathways of activation and deactivation and similar neurotransmitter activity related to sexual desire. Dynamic alterations of sexual response are similarly modulated and reinforced by behaviour, experience and neuroplasticity. Separate sexual dysfunctions categories for men and women are provided where sex differences are related to distinct clinical presentations (e.g., Female sexual arousal dysfunction in women as compared to Erectile dysfunction in men).

The proposed guidelines indicate that, in order to be considered a sexual dysfunction, the problem or difficulty should generally: a) have been persistent or recurrent over a period of at least several months; b) occur frequently, although it may fluctuate in severity; and c) be associated with clinically significant distress. However, in cases where there is an immediate acute cause of the sexual dysfunction (e.g., a radical prostatectomy or injury to the spinal cord in the case of Erectile dysfunction; breast cancer and its treatment in Female sexual arousal dysfunction), it may be appropriate to assign the diagnosis even though the duration requirement has not been met, in order to initiate treatment.

The proposed diagnostic guidelines make clear that there is no normative standard for sexual activity. "Satisfactory" sexual functioning is defined as being satisfying to the individual, i.e. the person is able to participate in sexual activity and in a sexual relationship as desired. If the individual is satisfied with his/her pattern of sexual experience and activity, even if it is different from what may be satisfying to other people or what is considered normative in a given culture or subculture, a sexual dysfunction should not be diagnosed. Unrealistic expectations on the part of a partner, a discrepancy in sexual desire between partners, or inadequate sexual stimulation are not valid bases for a diagnosis of sexual dysfunction.

The proposed ICD-11 classification uses a system of harmonized qualifiers that may be applied across categories to identify the important clinical characteristics of the sexual dysfunctions. A *temporal qualifier* indicates whether the sexual dysfunction is *lifelong*, i.e. the person has always experienced the dysfunction from the time of initiation of relevant sexual activity, or *acquired*, i.e. the onset of the sexual dysfunction has followed a period of time during which the person did not experience it. A *situational qualifier* is used to indicate whether the dysfunction is *generalized*, i.e. the desired response is absent or diminished in all circumstances, including masturbation, or *situational*, i.e. the desired response is absent or diminished in some circumstances but not in others (e.g., with some partners or in response to some stimuli).

An innovative feature of the proposed ICD-11 classification of Sexual dysfunctions and Sexual pain disorders, and an

Table 1 Classification of Sexual dysfunctions in ICD-11 (proposed), ICD-10 and DSM-5

Proposed ICD-11	ICD-10	DSM-5	Comments
<p>Chapter: Conditions Related to Sexual Health Grouping: Sexual dysfunctions</p>	<p>Chapter: Mental and Behavioural Disorders Grouping: Behavioural syndromes associated with physiological disturbances and physical factors Subgrouping: Sexual dysfunction, not caused by organic disorder or disease</p> <p>Chapter: Diseases of the Genitourinary System Grouping: Diseases of male genital organs Subgrouping: Other disorders of penis Grouping: Noninflammatory disorders of female genital tract Subgrouping: Pain and other conditions associated with female genital organs and menstrual cycle</p>	<p>Grouping: Sexual dysfunctions</p>	<ul style="list-style-type: none"> • In ICD-11, Sexual dysfunctions have been included in a new chapter called Conditions Related to Sexual Health. • ICD-11 Sexual dysfunctions proposals represent an integrated classification, including conditions listed in Mental and Behavioural Disorders chapter in ICD-10 and many of those currently found in Diseases of the Genitourinary System. • In ICD-11, there are four main groupings of sexual dysfunctions: Sexual desire and arousal dysfunctions; Orgasmic dysfunctions; Ejaculatory dysfunctions; and Other specified sexual dysfunctions. There is another separate grouping of Sexual pain disorders. • DSM-5 classification of Sexual dysfunctions excludes those caused by a nonsexual medical disorder, by the effects of a substance or medication, or by a medical condition. ICD-11 classification allows for a diagnosis of Sexual dysfunction when it represents an independent focus of treatment; contributory factors may be coded using etiological qualifiers.
<p>Category: Hypoactive sexual desire dysfunction</p>	<p>Category: Lack or loss of sexual desire</p>	<p>Category: Female sexual interest/arousal disorder; Male hypoactive sexual desire disorder</p>	<ul style="list-style-type: none"> • In ICD-11, Hypoactive sexual desire dysfunction can be applied to both men and women; In DSM-5, Female sexual interest/arousal disorder is separated from Male hypoactive sexual desire disorder.
<p>Category: Recommended for deletion</p>	<p>Category: Sexual aversion</p>	<p>Category: Not included</p>	<ul style="list-style-type: none"> • In ICD-11, the ICD-10 category Sexual aversion would be classified under Sexual pain-penetration disorder or under Specific phobia, depending on specific nature of symptoms. • In DSM-5, that category would similarly be classified as Genital-pelvic pain/penetration disorder or under Specific phobia.
<p>Category: Female sexual arousal dysfunction</p>	<p>Category: Failure of genital response; Lack of sexual enjoyment</p>	<p>Category: Female sexual interest/arousal disorder</p>	<ul style="list-style-type: none"> • In ICD-11, separate categories are provided for men and women to replace ICD-10 Failure of genital response, because of anatomical and physiological differences that underlie distinct clinical presentations. • In ICD-11, the psychological component of arousal involved in ICD-10 Lack of sexual enjoyment is also subsumed in women under Female sexual arousal dysfunction.
<p>Category: Erectile dysfunction</p>	<p>Category: Failure of genital response; Impotence of organic origin</p>	<p>Category: Erectile disorder</p>	<ul style="list-style-type: none"> • In ICD-11, separate categories are provided for men and women to replace ICD-10 Failure of genital response, because of anatomical and physiological differences that underlie distinct clinical presentations. • ICD-11 includes “organic” Erectile dysfunctions.
<p>Category: Orgasmic dysfunction</p>	<p>Category: Orgasmic dysfunction</p>	<p>Category: Female orgasmic disorder</p>	<ul style="list-style-type: none"> • In ICD-11, Orgasmic dysfunction can be applied to both men and women. • In ICD-11, there is a distinction between subjective experience of orgasm in men and ejaculation.

Table 1 Classification of Sexual dysfunctions in ICD-11 (proposed), ICD-10 and DSM-5 (*continued*)

Proposed ICD-11	ICD-10	DSM-5	Comments
<i>Category:</i> Early ejaculation	<i>Category:</i> Premature ejaculation	<i>Category:</i> Premature (early) ejaculation	<ul style="list-style-type: none"> Terminology in ICD-11 changed from Premature ejaculation to Early ejaculation.
<i>Category:</i> Delayed ejaculation	<i>Category:</i> Orgasmic dysfunction	<i>Category:</i> Delayed ejaculation	<ul style="list-style-type: none"> DSM-5 does not distinguish between subjective experience of orgasm and ejaculation in men.
<i>Category:</i> Other specified sexual dysfunction	<i>Category:</i> Other sexual dysfunction, not caused by organic disorder or disease; Other specified disorders of penis; Other specified conditions associated with female genital organs and menstrual cycle	<i>Category:</i> Other specified sexual dysfunction	<ul style="list-style-type: none"> DSM-5 classification of Sexual dysfunctions excludes those caused by a nonsexual medical disorder, by the effects of a substance or medication, or by a medical condition. ICD-11 classification allows for a diagnosis of Sexual dysfunction when it represents an independent focus of treatment; contributory factors may be coded using etiological qualifiers.
<i>Category:</i> Unspecified sexual dysfunction	<i>Category:</i> Unspecified sexual dysfunction, not caused by organic disorder or disease; Disorder of penis, unspecified; Unspecified condition associated with female genital organs and menstrual cycle	<i>Category:</i> Unspecified sexual dysfunction	<ul style="list-style-type: none"> DSM-5 classification of Sexual dysfunctions excludes those caused by a nonsexual medical disorder, by the effects of a substance or medication, or by a medical condition. ICD-11 classification allows for a diagnosis of Sexual dysfunction when it represents an independent focus of treatment; contributory factors may be coded using etiological qualifiers.
<i>Category:</i> Sexual pain-penetration disorder (in separate grouping of Sexual pain disorders)	<i>Category:</i> Nonorganic vaginismus; Vaginismus (organic)	<i>Category:</i> Genito-pelvic pain/penetration disorder	<ul style="list-style-type: none"> In ICD-11, Sexual pain penetration disorder includes Vaginismus and excludes Dyspareunia and Vulvodynia, which are classified in the Genitourinary chapter. In DSM-5, Genito-pelvic pain/penetration disorder groups includes Dyspareunia and Vulvodynia if it occurs during penetration attempts or vaginal intercourse.

important one for a system that does not attempt to divide “organic” and “non-organic” dysfunctions, is a system of *etiological qualifiers* that may be applied to these categories. These qualifiers are not mutually exclusive, and as many may be applied as are considered to be relevant and contributory in a particular case. Proposed qualifiers include the following:

- *Associated with disorder or disease classified elsewhere, injury or surgical treatment* (e.g., diabetes mellitus, depressive disorders, hypothyroidism, multiple sclerosis, female genital mutilation, radical prostatectomy)¹⁵⁻¹⁹;
- *Associated with a medication or substance* (e.g., selective serotonin reuptake inhibitors, histamine-2 receptor antagonists, alcohol, opiates, amphetamines)^{20,21};
- *Associated with lack of knowledge* (e.g., about the individual’s own body, sexual functioning, and sexual response)²²;
- *Associated with psychological or behavioural factors* (e.g., negative attitudes toward sexual activity, adverse past sexual experiences, poor sleep hygiene, overwork)^{23,24};
- *Associated with relationship factors* (e.g., relationship conflict, lack of romantic attachment)^{25,26};
- *Associated with cultural factors* (e.g., culturally-based inhibitions about the expression of sexual pleasure, the belief that loss of semen can lead to weakness, disease or death)^{27,28}.

Other changes that have been proposed include the elimination of the ICD-10 category F52.7 Excessive sexual drive from the classification of Sexual dysfunctions. The ICD-10 category F52.0 Loss or lack of sexual desire is more specifically categorized in ICD-11 as Hypoactive sexual desire dysfunction in women and men, Female sexual arousal dysfunction in women, or Erectile dysfunction in men. The ICD-10 category F52.10 Sexual aversion is classified in ICD-11 under Sexual pain-penetration disorder or under the grouping of Anxiety and fear-related disorders if it is used to describe a phobic response. The ICD-10 category F52.11 Lack of sexual enjoyment, which the ICD-10 indicates is more common in women, is captured primarily in the ICD-11 under Female sexual arousal dysfunction. Other possible reasons for lack of sexual enjoyment, including hypohedonic orgasm and painful orgasm²⁹, would be classified under Other specified sexual dysfunctions. The ICD-10 category F52.2 Failure of genital response is separated into two categories: Female sexual arousal dysfunction in women, and Erectile dysfunction in men.

Comparison with DSM-5

The proposed classification of sexual dysfunctions in ICD-11 is different from the DSM-5 in its attempt to integrate

dysfunctions that may have a range of etiological or contributory dimensions. The DSM-5 acknowledges that an array of factors may be relevant to etiology and treatment and may contribute to sexual dysfunctions; these include partner, relationship, individual vulnerability, cultural, religious, and medical factors. At the same time, the DSM-5 indicates that, if a sexual dysfunction is caused by a nonsexual medical disorder, the effects of a substance or medication, or a medical condition, a diagnosis of Sexual dysfunction would not be assigned. This is logical given the DSM-5's purpose as a classification of mental and behavioural disorders (even though it differs from the approach that DSM-5 has taken to Sleep-wake disorders and Neurocognitive disorders). Because ICD-11 is a classification of all health conditions, it provides the possibility for greater integration. The proposed ICD-11 classification allows for assigning a Sexual dysfunction diagnosis in situations in which this is an independent focus of treatment, regardless of presumed etiology. The presence of a variety of contributory factors may be recorded using the etiological qualifiers.

The DSM-5 has combined dysfunctions of sexual desire and sexual arousal in women in the category Female sexual interest/arousal disorder³⁰, which has proved to be quite controversial³¹⁻³⁵. In contrast, the proposed ICD-11 category Hypoactive sexual desire dysfunction can be applied to both men and women, while Female sexual arousal dysfunction is classified separately. The separation of desire and arousal in women into distinct dysfunctions is supported by several lines of evidence, including genetic evidence from twin studies³⁶, studies of specific single nucleotide polymorphisms and the use of serotonergic antidepressant medications^{37,38}, and neuroimaging studies³⁹. There is also evidence that Hypoactive desire disorder in women and men respond to similar treatments⁴⁰, and that these are different from treatments that are effective for Female sexual arousal disorder⁴¹⁻⁴³. Although there is significant comorbidity between desire and arousal dysfunction, the overlap of these conditions does not mean that they are one and the same; research suggests that management should be targeted toward their distinct features⁴⁴.

The proposed classification of sexual pain in ICD-11 provides the possibility of identifying specific types of pain syndromes without excluding those in which another medical condition is considered to be contributory. The DSM-5 category Genito-pelvic pain/penetration disorder includes vaginismus, dyspareunia and vulvodynia not completely attributable to other medical conditions. A similar category of Sexual pain-penetration disorder has been proposed for ICD-11, but it does not include dyspareunia and vulvodynia, which have been retained as separate categories in the ICD-11 genitourinary chapter. These syndromes are characterized by different etiologies, occur in different populations, and have distinct treatment approaches⁴⁵⁻⁴⁷.

Finally, the DSM-IV-TR category Male orgasmic disorder has been replaced in DSM-5 by Delayed ejaculation. This decision seems to have been largely based on a Medline search that indicated infrequent usage of terminology including or-

gasm as opposed to terminology specifying ejaculation for male disorders⁴⁸. Another rationale for DSM-5 to modify the term was the small number of cases of male orgasmic disorder seen in clinical practice⁴⁹. However, this was not only a modification of terminology but rather the lumping of two separate phenomena into a single category. The proposed ICD-11 classification of Sexual dysfunctions emphasizes the subjective experience of orgasm and separates it from the ejaculatory phenomenon, consistent with available research⁵⁰.

PROPOSED CHANGES TO F64 GENDER IDENTITY DISORDERS

Over the past several years, a range of civil society organizations as well as the governments of several Member States and the European Union Parliament have urged the WHO to remove categories related to transgender identity from its classification of mental disorders in the ICD-11⁵¹⁻⁵³.

One impetus for this advocacy has been an objection to the stigmatization that accompanies the designation of any condition as a mental disorder in many cultures and countries. The WHO Department of Mental Health and Substance Abuse is committed to a variety of efforts to reduce the stigmatization of mental disorders⁵⁴. However, the stigmatization of mental disorders *per se* would not be considered a sufficient reason to eliminate or move a mental disorder category. The conditions listed in the ICD Mental and Behavioural Disorders chapter are intended to assist in the identification of people who need mental health services and in the selection of appropriate treatments¹, in fulfillment of WHO's public health objectives.

Nevertheless, there is substantial evidence that the current nexus of stigmatization of transgender people and of mental disorders has contributed to a doubly burdensome situation for this population, which raises legitimate questions about the extent to which the conceptualization of transgender identity as a mental disorder supports WHO's constitutional objective of "the attainment by all peoples of the highest possible level of health"⁵⁵. Stigma associated with the intersection of transgender status and mental disorders appears to have contributed to precarious legal status, human rights violations, and barriers to appropriate health care in this population⁵⁶⁻⁵⁸.

The WHO's 2015 report on *Sexual health, human rights, and the law*⁵⁸ indicates that, in spite of recent progress, there are still very few non-discriminatory, appropriate health services available and accessible to transgender people. Health professionals often do not have the necessary competence to provide services to this population, due to a lack of appropriate professional training and relevant health system standards⁵⁹⁻⁶¹. Limited access to accurate information and appropriate health services can contribute to a variety of negative behavioural and mental health outcomes among transgender people, including increased HIV-related risk behaviour, anxiety, depression, substance abuse, and suicide⁶²⁻⁶⁵. Additionally,

Table 2 Classification of conditions related to gender identity in ICD-11 (proposed), ICD-10 and DSM-5

Proposed ICD-11	ICD-10	DSM-5	Comments ^{71,72}
<p>Chapter: Conditions Related to Sexual Health Grouping: Gender incongruence</p> <p>Category: Gender incongruence of adolescence and adulthood</p>	<p>Chapter: Mental and Behavioural Disorders Grouping: Disorders of adult personality and behaviour Subgrouping: Gender identity disorders</p> <p>Category: Transsexualism</p>	<p>Grouping: Gender dysphoria</p> <p>Category: Gender dysphoria in adolescents and adults</p>	<ul style="list-style-type: none"> • ICD-11 does not classify Gender incongruence as a mental and behavioural disorder; Gender dysphoria is listed as a mental disorder in DSM-5. • ICD-11's primary focus is experience of incongruence between experienced gender and assigned sex; DSM-5 emphasizes distress related to gender identity through name of category and criteria. • ICD-11 contains four broad essential features and two are required for diagnosis; DSM-5 contains six criteria and two are required for diagnosis. • In ICD-11, distress and functional impairment are described as common associated features, particularly in disapproving social environments, but are not required; DSM-5 requires clinically significant distress or impairment for diagnosis. • ICD-11 requires a duration of several months; DSM-5 requires six months.
<p><i>Recommended for deletion</i></p> <p>Category: Gender incongruence of childhood</p>	<p>Category: Dual-role transvestism</p> <p>Category: Gender identity disorder of childhood</p>	<p><i>Not included</i></p> <p>Category: Gender dysphoria in children</p>	<ul style="list-style-type: none"> • Recommended for deletion from ICD-11 due to lack of public health or clinical relevance (not in DSM-5). • ICD-11 contains three essential features, all of which are required for diagnosis; DSM-5 contains eight diagnostic criteria, six of which must be present. • In ICD-11, distress and functional impairment are described as common associated features, particularly in disapproving social environments, but are not required; DSM-5 requires clinically significant distress or impairment for diagnosis. • ICD-11 requires a duration of two years, suggesting that the diagnosis cannot be made before approximately age 5; DSM-5 requires six months and does not set a lower age limit.
<p><i>Recommended for deletion</i></p>	<p>Category: Other gender identity disorders</p>	<p>Category: Other specified gender dysphoria</p>	<ul style="list-style-type: none"> • Recommended for deletion in ICD-11 to prevent misuse for clinical presentations involving only gender variance.
<p><i>Recommended for deletion</i></p>	<p>Category: Gender identity disorder, unspecified</p>	<p>Category: Unspecified gender dysphoria</p>	<ul style="list-style-type: none"> • Recommended for deletion in ICD-11 to prevent misuse for clinical presentations involving only gender variance.

many transgender people self-administer hormones of dubious quality obtained through illicit markets or online without medical supervision^{66,67}, with potentially serious health consequences⁶⁸⁻⁷⁰. For example, in a recent study of 250 transgender people in Mexico City, nearly three-quarters of participants had used hormones, and nearly half of these had begun using them without medical supervision⁷¹.

In spite of WHO's concerted advocacy for mental health parity⁵⁴, a primary mental disorder diagnosis can exacerbate problems for transgender people in accessing health services, particularly those that are not considered to be mental health services. Even in countries that recognize the need for transgender-related health services and where professionals with relevant expertise are relatively available, private and public insurers often specifically exclude coverage for these

services⁵⁸. Classification as a mental disorder has also contributed to the perception that transgender people must be treated by psychiatric specialists, further restricting access to services that could reasonably be provided at other levels of care.

In most countries, the provision of health services requires the diagnosis of a health condition that is specifically related to those services. If no diagnosis were available to identify transgender people who were seeking related health services, these services would likely become even less available than they are now^{72,73}. Thus, the Working Group on Sexual Disorders and Sexual Health has recommended retaining gender incongruence diagnoses in the ICD-11 to preserve access to health services, but moving these categories out of the ICD-11 chapter on Mental and Behavioural Disorders (see Table 2). After consideration of a variety of placement options⁷², these

categories have been provisionally included in the proposed new ICD-11 chapter on Conditions Related to Sexual Health.

The Working Group has recommended reconceptualizing the ICD-10 category F64.0 Transsexualism as Gender incongruence of adolescence and adulthood⁷² and the ICD-10 category F64.2 Gender identity disorder of childhood as Gender incongruence of childhood⁷³. The proposed diagnostic requirements for Gender incongruence of adolescence and adulthood include the continuous presence for at least several months of at least two of the following features: a) a strong dislike or discomfort with primary or secondary sex characteristics due to their incongruity with the experienced gender; b) a strong desire to be rid of some or all of one's primary or secondary sex characteristics (or, in adolescence, anticipated secondary sex characteristics); c) a strong desire to have the primary or secondary characteristics of the experienced gender; and d) a strong desire to be treated (to live and be accepted as) a person of the experienced gender. As in the ICD-10, the diagnosis of Gender incongruence of adolescence and adulthood cannot be assigned before the onset of puberty. The duration requirement is reduced from two years in ICD-10 to several months in ICD-11.

The ICD-11 abandons ICD-10 terms such as "opposite sex" and "anatomic sex" in defining the condition, using more contemporary and less binary terms such as "experienced gender" and "assigned sex". Unlike ICD-10, the proposed ICD-11 diagnostic guidelines do not implicitly presume that all individuals seek or desire full transition services to the "opposite" gender. The proposed guidelines also explicitly pay attention to the anticipated development of secondary sex characteristics in young adolescents who have not yet reached the last physical stages of puberty, an issue that is not addressed in ICD-10.

The proposed ICD-11 diagnostic requirements for Gender incongruence of childhood are considerably stricter than those of ICD-10, in order to avoid as much as possible the diagnosis of children who are merely gender variant. All three of the following essential features must be present: a) a strong desire to be, or an insistence that the child is, of a different gender; b) a strong dislike of the child's own sexual anatomy or anticipated secondary sex characteristics, or a strong desire to have the sexual anatomy or anticipated secondary sex characteristics of the desired gender; and c) make believe or fantasy play, toys, games, or activities and playmates that are typical of the experienced gender rather than the assigned sex. The third essential feature is not meaningful without the other two being present; in their absence it is merely a description of gender variant behaviour. These characteristics must have been present for at least two years in a prepubertal child, effectively meaning that the diagnosis cannot be assigned prior to the age of approximately 5 years. The ICD-10 does not mention a specific duration requirement or a minimum age at which it is appropriate to assign the diagnosis.

The proposed diagnostic guidelines for both Gender incongruence of adolescence and adulthood and Gender incongruence of childhood indicate explicitly that gender variant behaviour and preferences alone are not sufficient for making a diagnosis;

some form of experienced anatomic incongruence is also necessary. Importantly, the diagnostic guidelines for both categories indicate that gender incongruence may be associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning, particularly in disapproving social environments and where protective laws and policies are absent, but that neither distress nor functional impairment is a diagnostic requirement.

The area of transgender health is characterized by calls for change in health system responses^{58,74,75}, by rapid change in social attitudes in some countries, and by controversy. As a part of this work, the Working Group on Sexual Disorders and Sexual Health received proposals and opinions from a wide range of civil societies, professional organizations, and other interested parties^{72,73}. The most controversial issue has been the question of whether the childhood diagnostic category should be retained⁷³. The main argument advanced against retaining the category is that stigmatization associated with being diagnosed with *any* health condition – not just a mental disorder diagnosis – is potentially harmful to children who will in any case not be receiving medical interventions before puberty⁷⁶. A more substantive critique is that, if it is the case that the problems of extremely gender-variant children arise primarily from hostile social reactions and victimization, assigning a diagnosis to the child amounts to blaming the victim⁷⁷. This latter concern suggests a need for further research as well as a broader social conversation. The Working Group has recommended retaining the category based on the rationale that it will preserve access to treatment for this vulnerable and already stigmatized group. Treatment most often consists of specialized supportive mental health services as well as family and social (e.g., school) interventions⁷³, while treatments aimed at suppressing gender-variant behaviours in children are increasingly viewed as unethical.

The diagnosis also serves to alert health professionals that a transgender identity in childhood often does not develop seamlessly into an adult transgender identity. Available research instead indicates that the majority of children diagnosed with DSM-IV Gender identity disorder of childhood, which was not as strict in its requirements as those proposed for ICD-11, grow up to be cisgender (non-transgender) adults with a homosexual orientation⁷⁸⁻⁸⁰. In spite of the claims of some clinicians to be able to distinguish between children whose transgender identity is likely to persist into adolescence and adulthood and those likely to be gay or lesbian, there is considerable overlap between these groups in all predictors examined⁸⁰, and no valid method of making a prediction at an individual level has been published in the scientific literature. Therefore, while medical interventions are not currently recommended for prepubertal gender incongruent children, psychosocial interventions need to be undertaken with caution and based on considerable expertise so as not to limit later choices^{59,81,82}. The inclusion of the category in the ICD-11 is intended to provide better opportunities for much-needed education of health professionals, the development of stand-

ards and pathways of care to help guide clinicians and family members, including adequate informed consent procedures, and future research efforts.

Finally, the ICD-10 category F64.1 Dual-role transvestism – occasionally dressing in clothing typical of another gender in order to “enjoy the temporary experience of membership of the opposite sex, but without any desire for a more permanent sex change”⁴ or accompanying sexual arousal – has been recommended for deletion from the ICD-11, due to its lack of public health or clinical relevance.

Comparison with DSM-5

The most important difference between the proposals for ICD-11 and the DSM-5 is that the latter has retained the categories related to gender identity as a part of its classification of mental disorders. Both childhood and adult forms of Gender identity disorder in DSM-IV have been renamed in DSM-5 as Gender dysphoria, defined by “marked incongruence between one’s experienced/expressed gender and assigned gender of at least 6 months’ duration” and “clinically significant distress or impairment in social, school, or other important areas of functioning”³. Both the name of the DSM-5 condition – dysphoria – and the diagnostic criteria, therefore, emphasize distress and dysfunction as integral aspects of the condition. They are also the central rationale for classifying these conditions as mental disorders; without distress or dysfunction, gender dysphoria would not fulfill the requirements of DSM-5’s own definition of a mental disorder.

In contrast, the proposal for ICD-11 is to include child and adult Gender incongruence categories in another chapter that explicitly integrates medical and psychological perspectives, Conditions Related to Sexual Health. The proposed ICD-11 diagnostic guidelines indicate that distress and dysfunction, although not necessary for a diagnosis of Gender incongruence, may occur in disapproving social environments and that individuals with gender incongruence are at increased risk for psychological distress, psychiatric symptoms, social isolation, school drop-out, loss of employment, homelessness, disrupted interpersonal relationships, physical injuries, social rejection, stigmatization, victimization, and violence. At the same time, particularly in countries with progressive laws and policies, young transgender people living in supportive environments still seek health services, even in the absence of distress or impairment. The ICD-11 approach provides for this.

A challenge to DSM-5 conceptualization of Gender dysphoria is, therefore, the question of whether distress and dysfunction related to the social consequences of gender variance (e.g., stigmatization, violence) can be distinguished from distress related to transgender identity itself^{83,84}. A recent study of 250 transgender adults receiving services at the only publicly funded clinic in Mexico City providing comprehensive services for transgender people⁷¹ found that distress and dysfunction associated with emerging transgender identity were very

common, but not universal. However, more than three-quarters of participants reported having experienced social rejection and nearly two-thirds had experienced violence related to their gender identity during childhood or adolescence. Distress and dysfunction were more strongly predicted by experiences of social rejection and violence than by features related to gender incongruence. These data provide further support for ICD-11’s conceptualization and the removal of gender incongruence from the classification of mental disorders.

Finally, there are several technical differences between the proposals for ICD-11 and DSM-5 in relation to these categories. The most substantive is that the DSM-5 diagnosis of Gender dysphoria of childhood requires a duration of only six months, in contrast to two years in the ICD-11 proposal, and does not specify a lower age limit at which the diagnosis can be applied.

PROPOSED CHANGES TO F65 DISORDERS OF SEXUAL PREFERENCE

From WHO’s perspective, there is an important distinction between conditions that are relevant to public health and indicate the need for health services versus those that are simply descriptions of private behaviour without appreciable public health impact and for which treatment is neither indicated nor sought. This distinction is based on the ICD’s central function as a global public health tool that provides the framework for international public health surveillance and health reporting. It is also related to the increasing use of the ICD over the past several decades by WHO Member States to structure clinical care and define eligibility for subsidized health services¹. The regulation of private behaviour without health consequences to the individual or to others may be considered in different societies to be a matter for criminal law, religious proscription, or public morality, but is not a legitimate focus of public health or of health classification.

This requirement is particularly pertinent to the classification of atypical sexual preferences commonly referred to as paraphilias. The Working Group on Sexual Disorders and Sexual Health noted that the diagnostic guidelines provided for ICD-10’s classification of Disorders of sexual preference often merely describe the sexual behaviour involved. For example, the ICD-10 diagnostic guidelines define F65.1 Fetishistic transvestism as “the wearing of clothes of the opposite sex principally to obtain sexual excitement”⁴, without requiring any sort of distress or dysfunction and without reference to the public health or clinical relevance of this behaviour. This is at odds with ICD-10’s general guidance for what constitutes a mental disorder and contradicts ICD-10’s own statement that “social deviance or conflict alone, without personal dysfunction, should not be included in mental disorder”⁴. According to this principle, specific patterns of sexual arousal that are merely relatively unusual^{85,86}, but are not associated with distress,

dysfunction or harm to the individual or to others^{87,88}, are not mental disorders. Labeling them as such does not contribute meaningfully to public health surveillance or to the design of health services, and may create harm to individuals so labeled⁸⁹. Thus, a major consideration for the recommended revisions for ICD-11 in this area was whether an atypical sexual arousal pattern represented a condition of public health significance and clinical importance.

The Working Group recommended that Disorders of sexual preference be renamed as Paraphilic disorders to reflect the terminology used in the current scientific literature and in clinical practice⁹⁰. The Group proposed that the paraphilic disorders included in ICD-11 consist primarily of patterns of atypical sexual arousal that focus on non-consenting others, as these conditions could be considered to have public health implications (see Table 3). The core proposed diagnostic requirements for a Paraphilic disorder in ICD-11 are: a) a sustained, focused and intense pattern of sexual arousal – as manifested by persistent sexual thoughts, fantasies, urges, or behaviours – that involves others whose age or status renders them unwilling or unable to consent (e.g., pre-pubertal children, an unsuspecting individual being viewed through a window, an animal); and b) that the individual has acted on these thoughts, fantasies or urges or is markedly distressed by them. There is no requirement in the proposed ICD-11 diagnostic guidelines that the relevant arousal pattern be exclusive or preferential.

This conceptualization has resulted in the recommendation to retain three ICD-10 categories in this section, each labeled specifically as a disorder rather than simply naming or describing the behaviour involved. These include Exhibitionistic disorder, Voyeuristic disorder, and Pedophilic disorder. In addition, two new named categories have been proposed: Coercive sexual sadism disorder and Frotteuristic disorder.

Coercive sexual sadism disorder is defined by a sustained, focused and intense pattern of sexual arousal that involves the infliction of physical or psychological suffering on a non-consenting person. This arousal pattern has been found to be prevalent among sex offenders treated in forensic institutions⁹²⁻⁹⁶ and among individuals who have committed sexually motivated homicides⁹⁷. The new proposed nomenclature of Coercive sexual sadism disorder was selected to clearly distinguish this disorder from consensual sadomasochistic behaviours that do not involve substantial harm or risk.

Frotteuristic disorder is defined by a sustained, focused and intense pattern of sexual arousal that involves touching or rubbing against a non-consenting person in public places. Frotteurism has been found to be among the most common of paraphilic disorders⁹⁸⁻¹⁰² and is a significant problem in some countries¹⁰³. It was also included in DSM-IV and has been retained in DSM-5.

In addition, the category Other paraphilic disorder involving non-consenting individuals is proposed for use when the other diagnostic requirements for a paraphilic disorder are met but the specific pattern of sexual arousal does not fit into any of the available named categories and is not sufficiently

common or well researched to be included as a named category (e.g., arousal patterns involving corpses or animals).

Based on the concerns described above, the Working Group proposed that three named ICD-10 categories – F65.0 Fetishism, F65.1 Fetishistic transvestism, and F65.5 Sadomasochism – be removed from the classification. Indeed, several countries (Denmark, Sweden, Norway and Finland) have already removed these categories from their national lists of accepted ICD-10 diagnoses, in response to similar concerns¹⁰⁴. Instead, the proposed additional category Other paraphilic disorder involving solitary behaviour or consenting individuals may be used when the pattern of sexual arousal does not focus on non-consenting individuals but is associated with marked distress or significant risk of injury or death (e.g., asphyxophilia, or achieving sexual arousal by restriction of breathing).

One additional requirement in the proposed diagnostic guidelines is that, when a diagnosis of Other paraphilic disorder involving solitary behaviour or consenting individuals is assigned based on distress, the distress should not be entirely attributable to rejection or feared rejection of the arousal pattern by others (e.g., a partner, family, society). In these cases, codes related to counselling interventions from the ICD-11 chapter on Factors Influencing Health Status and Contact with Health Services may be considered. These are non-disease categories that indicate reasons for clinical encounters and include Counselling related to sexual knowledge and sexual attitude, Counselling related to sexual behaviour and sexual relationships of the patient, and Counselling related to sexual behaviour and sexual relationship of the couple. These categories recognize the need for health services, including mental health services, that may be legitimately provided in the absence of diagnosable mental disorders¹¹.

The proposed diagnostic guidelines make clear that the mere occurrence or a history of specific sexual behaviours is insufficient to establish a diagnosis of a Paraphilic disorder. Rather, these sexual behaviours must reflect a sustained, focused, and intense pattern of paraphilic sexual arousal. When this is not the case, other causes of the sexual behaviour need to be considered. For example, many sexual crimes involving non-consenting individuals reflect actions or behaviours that may be transient or occur impulsively or opportunistically rather than reflecting either a persistent pattern of sexual arousal or any underlying mental disorder. However, sexual behaviours involving non-consenting individuals may also occur in the context of some mental and behavioural disorders, such as manic episodes or dementia, or in the context of substance intoxication. These do not satisfy the definitional requirements of a Paraphilic disorder.

The Working Group on Sexual Disorders and Sexual Health has also recommended that the proposed ICD-11 grouping of Paraphilic disorders be retained within the chapter on Mental and Behavioural Disorders rather than being moved to the proposed new chapter on Conditions Related to Sexual Health, for two main reasons. First, the assessment and treatment of Paraphilic disorders, which often takes place in forensic con-

Table 3 Classification of Paraphilic disorders in ICD-11 (proposed), ICD-10 and DSM-5

Proposed ICD-11	ICD-10	DSM-5	Comments ⁹⁰
Chapter: Mental and Behavioural Disorders Grouping: Paraphilic disorders	Chapter: Mental and Behavioural Disorders Grouping: Disorders of adult personality and behaviour Subgrouping: Disorders of sexual preference	Grouping: Paraphilic disorders	<ul style="list-style-type: none"> • ICD-11 name changed to be consistent with current scientific literature and clinical practice; brings it in line with DSM-5. • ICD-11 distinguishes between conditions that are relevant to public health and clinical psychopathology on the one hand and private behaviours that are not a legitimate focus of health classification on the other. • Requirements for named Paraphilic disorders in ICD-11 are: a) a sustained, focused and intense pattern of sexual arousal that involves others whose age or status renders them unwilling or unable to consent; and b) that the individual has acted on the arousal patterns or is markedly distressed by it.
Category: Exhibitionistic disorder	Category: Exhibitionism	Category: Exhibitionistic disorder	<ul style="list-style-type: none"> • DSM-5 diagnosis may be assigned based on functional impairment, though without specification of how impairment is to be evaluated or based on whose perspective. ICD-11 guidelines require either action or distress; not including functional impairment is consistent with overall guidance for ICD-11 Mental and Behavioural Disorders.
Category: Voyeuristic disorder	Category: Voyeurism	Category: Voyeuristic disorder	<ul style="list-style-type: none"> • DSM-5 diagnosis may be assigned based on functional impairment, though without specification of how impairment is to be evaluated or based on whose perspective. ICD-11 guidelines require either action or distress; not including functional impairment is consistent with overall guidance for ICD-11 Mental and Behavioural Disorders.
Category: Pedophilic disorder	Category: Paedophilic disorder	Category: Pedophilic disorder	<ul style="list-style-type: none"> • DSM-5 diagnosis may be assigned based on functional impairment, though without specification of how impairment is to be evaluated or based on whose perspective. ICD-11 guidelines require either action or distress; not including functional impairment is consistent with overall guidance for ICD-11 Mental and Behavioural Disorders. • In DSM-5, diagnosis may be assigned based on the presence of “interpersonal difficulty” due to the arousal pattern, in the absence of action, distress, or functional impairment. • DSM-5 includes a variety of specifiers, which have been criticized for lack of consistency and questionable validity⁹¹.
Category: Coercive sexual sadism disorder	<i>Not included</i>	<i>Not included</i>	<ul style="list-style-type: none"> • Defined by sustained, focused and intense pattern of sexual arousal that involves the infliction of physical or psychological suffering on a non-consenting person. • Not equivalent to DSM-5 Sexual sadism disorder or ICD-10 Sadomasochism, which do not distinguish between arousal patterns involving consenting and non-consenting others.
Category: Frotteuristic disorder	<i>Not included</i>	Category: Frotteuristic disorder	<ul style="list-style-type: none"> • DSM-5 diagnosis may be assigned based on functional impairment, though without specification of how impairment is to be evaluated or based on whose perspective. ICD-11 guidelines require either action or distress; not including functional impairment is consistent with overall guidance for ICD-11 Mental and Behavioural Disorders.
<i>Recommended for deletion</i>	Category: Sadomasochism	Category: Sexual masochism disorder	<ul style="list-style-type: none"> • If consensual behaviour is involved, may be classified as in ICD-11 as Other paraphilic disorder involving solitary behaviour or consenting individuals, if accompanied by marked distress that is not entirely attributable to rejection or feared rejection of the arousal pattern by others (e.g., a partner, family, society) or by significant risk of injury or death. • If arousal pattern focuses on the infliction of suffering on non-consenting individuals, may be classified in ICD-11 as Coercive sexual sadism disorder.
<i>Not included</i>	<i>Combined with Sexual masochism</i>	Category: Sexual sadism disorder	<ul style="list-style-type: none"> • In ICD-11, may be classified as Other paraphilic disorder involving solitary behaviour or consenting individuals, if accompanied by marked distress that is not entirely attributable to rejection or feared rejection of the arousal pattern by others (e.g., a partner, family, society) or by significant risk of injury or death.

Table 3 Classification of Paraphilic disorders in ICD-11 (proposed), ICD-10 and DSM-5 (continued)

Proposed ICD-11	ICD-10	DSM-5	Comments ⁹⁰
<i>Recommended for deletion</i>	Category: Fetishism	Category: Fetishistic disorder	<ul style="list-style-type: none"> In ICD-11, may be classified as Other paraphilic disorder involving solitary behaviour or consenting individuals, if accompanied by marked distress that is not entirely attributable to rejection or feared rejection of the arousal pattern by others (e.g., a partner, family, society) or by significant risk of injury or death.
<i>Recommended for deletion</i>	Category: Fetishistic transvestism	Category: Transvestic disorder	<ul style="list-style-type: none"> In ICD-11, may be classified as Other paraphilic disorder involving solitary behaviour or consenting individuals, if accompanied by marked distress that is not entirely attributable to rejection or feared rejection of the arousal pattern by others (e.g., a partner, family, society) or by significant risk of injury or death.
<i>Recommended for deletion</i>	Category: Multiple disorders of sexual preference	<i>Not included</i>	<ul style="list-style-type: none"> This ICD-10 category was not considered to be clinically informative. Multiple paraphilic disorder diagnoses may be assigned in both ICD-11 and DSM-5.
Category: Other paraphilic disorder involving non-consenting individuals	<i>Not included</i>	<i>Not included</i>	<ul style="list-style-type: none"> May be used when the diagnostic requirements for a Paraphilic disorder are met but the specific pattern of sexual arousal does not fit into available named categories (e.g., arousal patterns involving corpses or animals).
Category: Other paraphilic disorder involving solitary behaviour or consenting individuals	<i>Not included</i>	<i>Not included</i>	<ul style="list-style-type: none"> May be used when the pattern of sexual arousal does not focus on non-consenting individuals but is associated with marked distress or significant risk of injury or death.
<i>Recommended for deletion</i>	Category: Other disorders of sexual preference	Category: Other specified paraphilic disorder	<ul style="list-style-type: none"> Replaced in ICD-11 by above two “Other paraphilic disorder” categories, which specify whether arousal pattern involves: a) non-consenting individuals; or b) consenting individuals or solitary behaviour.
<i>Recommended for deletion</i>	Category: Disorder of sexual preference, unspecified	Category: Unspecified paraphilic disorder	<ul style="list-style-type: none"> Recommended for deletion in ICD-11 to prevent misuse for clinical presentations involving only relatively unusual patterns of sexual arousal that are not associated with distress, dysfunction, or harm to the individual or to others.

texts, requires specialized mental health expertise. Evidence-based treatments for Paraphilic disorders are almost entirely psychological and psychiatric in nature and require substantial mental health expertise to administer. When adjunctive somatic treatments are used (e.g., anti-androgen drugs), they are controversial and legally and clinically complex and must be administered within a psychiatric framework.

Second, a substantial portion of the assessment and treatment of Paraphilic disorders relates to the civil commitment, mitigation, and treatment of specific classes of sex offenders. This is a complex and controversial legal area that must be considered in defining how Paraphilic disorders should be classified. In many countries – including the US, Germany, the UK, Canada, and other countries whose legal systems are based on the British or German systems – there are laws that allow for the civil commitment and preventive detention of certain sexual offenders who are sometimes termed sexually violent predators. These laws permit involuntary commitment of such individuals to psychiatric facilities after they have completed mandatory prison sentences, to allow for continued treatment and minimization of risk to the community where these offenders are to be released.

In countries where the constitutionality of such laws has been challenged, they have been upheld¹⁰⁵. However, crucial to the finding of constitutionality has been the determination

by relevant courts that a risk of dangerousness by itself is not sufficient grounds for civil commitment under such statutes. Rather, the constitutional requirement specifically rests on a finding of the presence of a mental disorder as the basis for civil commitment because it “narrows the class of persons eligible for confinement to those who are unable to control their dangerousness”¹⁰⁶.

Although there are continuing controversies about the application of these laws in many countries^{107,108}, the Working Group on Sexual Disorders and Sexual Health did not consider that moving Paraphilic disorders out of the Mental and Behavioural Disorders chapter would be an appropriate or helpful way to address these concerns.

Comparison with DSM-5

The changes proposed for Paraphilic disorders in ICD-11 represent a major departure from ICD-10, which was developed during the late 1980s. In many ways, these changes align the ICD-11 more closely with the DSM-5. At the same time, there are substantive differences between the two systems. Sexual masochism disorder, Fetishistic disorder, and Transvestic disorder are included as named mental disorders in DSM-

5, while in ICD-11 these phenomena can be diagnosed under Other paraphilic disorder involving solitary behaviour or consenting individuals only if they are associated with significant distress or significant risk of injury or death.

The duration requirement proposed for Paraphilic disorders in ICD-11 is more flexible than the six-month requirement in DSM-5, which does not appear to have specific empirical support¹⁰⁹. The ICD-11 guidelines require a clinical judgment that the arousal pattern is sustained, focused, and intense, making clear that a single instance of behaviour or criminal act does not meet this requirement. Functional impairment is included relatively automatically in diagnostic criteria for DSM-5, but has not been included as a part of the proposed ICD-11 diagnostic guidelines for Paraphilic disorders, in keeping with the general principle for ICD-11 Mental and Behavioural Disorders that impairment should only be used when necessary to distinguish a disorder from normality¹.

PROPOSED CHANGES TO F66 PSYCHOLOGICAL AND BEHAVIOURAL DISORDERS ASSOCIATED WITH SEXUAL DEVELOPMENT AND ORIENTATION

The ICD-10 explicitly states that “sexual orientation by itself is not to be considered a disorder”⁴. Nevertheless, the ICD-10 grouping of Psychological and behavioural disorders associated with sexual development and orientation suggests that there do exist mental disorders uniquely linked to sexual orientation. These categories include F66.0 Sexual maturation disorder, F66.1 Egodystonic sexual orientation, and F66.2 Sexual relationship disorder (see Table 4).

The Working Group on Sexual Disorders and Sexual Health emphasized that, although the ICD-10 F66 categories mention gender identity in their definitions, historically they emerged from concerns related to sexual orientation⁸⁹. Over the last half century, international classification systems of mental disorders, including the ICD and the DSM, but also various national and regional classifications, have gradually removed diagnostic categories that defined homosexuality *per se* as a mental disorder. This reflects emerging human rights standards^{56,110}, the recognition that homosexual behaviour is a widely prevalent aspect of human behaviour¹¹¹, and the lack of empirical evidence to support pathologization and medicalization of variations in sexual orientation expression^{112,113}.

As noted earlier, the ICD-10 also indicates that “social deviance or conflict alone, without personal dysfunction, should not be included in mental disorder”⁴. The Working Group viewed this exclusion as essential to the consideration of diagnostic categories linked to sexual orientation⁸⁹. Given that expression of same-sex orientation continues to be heavily stigmatized in parts of the world^{56,110}, psychological and behavioural symptoms seen in non-heterosexual individuals may be products of persistently hostile social responses rather than expressions of inherent psychopathology. This perspective is supported by

robust empirical evidence from international studies¹¹⁴⁻¹¹⁶. Violence, stigma, exclusion and discrimination linked to same-sex orientations is a worldwide phenomenon and has been documented as especially vicious, often showing a high degree of brutality¹¹⁷. In some countries, criminal law is still applied to consensual same-sex sexual activity, though international, regional and national human rights bodies have explicitly called for States to end this practice⁵⁶. Thus, the Working Group concluded that, if a disease label is to be attached to a social condition, it is essential that the condition have demonstrable public health and clinical utility, for example by identifying a legitimate mental health need.

The core diagnostic features of F66.0 Sexual maturation disorder in the ICD-10 are: a) uncertainty about one’s gender identity or sexual orientation and b) distress *about the uncertainty* rather than about the particular gender identity or sexual orientation. Research has repeatedly demonstrated that same-sex sexual orientation emerges over time¹¹⁸, with the process typically beginning in late childhood or early adolescence. Often there is a substantial level of anti-gay stigma in the individual’s social environment that creates stress for the individual. As distress arising from stigma cannot be considered as indicative of a mental disorder under the ICD-10 social conflict exclusion, the Working Group considered that this category conflates normative developmental patterns observed in gay, lesbian, bisexual, and transgender people with psychopathological processes.

The concept of egodystonic homosexuality (F66.1 Egodystonic sexual orientation in ICD-10) first entered mental disorders classifications in DSM-III, as part of a negotiation related to removing homosexuality *per se* from that diagnostic system¹¹⁹. The compromise was that, while homosexuality itself might not be a disorder, homosexuality could still provide the basis for a psychiatric diagnosis, but only if the individual was distressed about it. This construction was dropped from American Psychiatric Association’s classification in 1987¹¹³. In what appears to have been a parallel process in the subsequent revisions leading to ICD-10, the concept of Egodystonic sexual orientation was incorporated in the ICD-10, approved in 1990, when the ICD-9 diagnostic category for homosexuality *per se* was removed. According to the ICD-10, it is theoretically possible to apply this category to individuals with a heterosexual orientation who wish it were otherwise, but is hard to see this as anything other than an attempt to deflect criticism regarding the purpose of the category¹²⁰.

Lesbian, gay, and bisexual individuals often report higher levels of distress than their heterosexual counterparts in international surveys, but this has been linked strongly to experiences of social rejection and stigmatization¹¹⁴⁻¹¹⁶. Because distress related to social adversity cannot be considered as indicative of a mental disorder, any more than can distress related to other socially stigmatized conditions such as poverty or physical illness, the Working Group considered the existence of this distress as lacking in evidentiary value.

F66.2 Sexual relationship disorder in ICD-10 describes a situation in which the individual’s sexual orientation (or gender

Table 4 Classification of disorders related to sexual orientation in ICD-11 (proposed), ICD-10 and DSM-5

Proposed ICD-11	ICD-10	DSM-5	Comments ⁸⁹
<i>Recommended for deletion</i>	Chapter: Mental and Behavioural Disorders Grouping: Disorders of adult personality and behaviour Subgrouping: Psychological and behavioural disorders associated with sexual development and orientation	<i>Not included</i>	<ul style="list-style-type: none"> • All categories in this ICD-10 grouping have been recommended for deletion. • These categories or their equivalents are not included in DSM-5, and were not included in DSM-IV. • No scientific interest in these conditions since ICD-10 was published. • No evidence-based treatments. • Working Group determined that these categories confound responses to adverse social circumstances, normal developmental patterns, and psychopathology. • If requirements for depression, anxiety, or another disorder are met, that diagnosis should be used. These diagnoses do not depend on thematic content of associated concerns. • Otherwise, Counselling related to sexuality codes from ICD-11 chapter on Factors Influencing Health Status and Contact with Health Services are more appropriate.
<i>Recommended for deletion</i>	Category: Sexual maturation disorder	<i>Not included</i>	<ul style="list-style-type: none"> • ICD-10 defines category based on uncertainty about gender identity or sexual orientation, which causes anxiety or depression.
<i>Recommended for deletion</i>	Category: Egodystonic sexual orientation	<i>Not included</i>	<ul style="list-style-type: none"> • According to ICD-10, should be used when the gender identity or sexual preference is not in doubt, but the individual wishes it were different because of associated psychological and behavioural disorders.
<i>Recommended for deletion</i>	Category: Sexual relationship disorder	<i>Not included</i>	<ul style="list-style-type: none"> • According to ICD-10, should be used when the gender identity or sexual preference abnormality is responsible for difficulties in forming or maintaining a relationship with a sexual partner. • Difficulties in intimate relationships are common, occur for many reasons, and are dyadic. Working Group concluded that there was no justification for category based on the co-occurrence of an issue related to sexual orientation or gender identity with a relationship problem.
<i>Recommended for deletion</i>	Category: Other psychosexual development disorder	<i>Not included</i>	<ul style="list-style-type: none"> • This is a residual category for the ICD-10 grouping, which is recommended for deletion in ICD-11.
<i>Recommended for deletion</i>	Category: Psychosexual development disorder, unspecified	<i>Not included</i>	<ul style="list-style-type: none"> • This is a residual category for the ICD-10 grouping, which is recommended for deletion in ICD-11.
<i>Recommended for deletion</i>	Qualifiers: (<i>May be applied to all categories in grouping</i>) <ul style="list-style-type: none"> • <i>Heterosexual</i> • <i>Homosexual</i> • <i>Bisexual</i> • <i>Other, including prepubertal</i> 	<i>Not included</i>	<ul style="list-style-type: none"> • These categories specify sexual orientation of individual receiving any of the above ICD-10 diagnoses, which are recommended for deletion.

identity) has created a disturbance in a primary sexual relationship. Difficulties in intimate relationships are common, occur for many reasons, and are, by their nature, dyadic. The Working Group concluded that there was no justification for creating a mental disorder category specifically based on the co-occurrence of an issue related to sexual orientation or gender identity with a relationship problem.

The Working Group's review concluded that gay, lesbian, and bisexual people receive mental health services for the same reasons that heterosexual people do, and also could find no evidence that concerns about sexual orientation that accompany other mental disorders such as depression or anxiety require different methods of treatment¹²¹. Further, there

are no evidence-based practices related to the F66 categories, and therapeutic attempts to change sexual orientation are considered to be outside the scope of ethical practice¹²². There is also a risk that misattributing symptoms of other mental disorders to conflicts about sexual orientation may interfere with appropriate treatment selection⁸⁹.

Moreover, the F66 categories have attracted no scientific interest since the ICD-10 was published. The Working Group conducted a search of Medline, Web of Science, and PsycINFO, and failed to find a single reference to Sexual maturation disorder or Sexual relationship disorder. The last peer-reviewed, indexed reference to "egodystonic homosexuality" was published more than two decades ago. The F66 categories do not

contribute meaningfully to public health surveillance, are not routinely reported by any country, and are not used in WHO's calculation of disease burden. At the same time, they selectively target individuals with same-sex orientation or gender nonconformity, with no apparent justification. Individuals with needs for information or who experience distress specifically related to sexual orientation that is not diagnosable as another disorder (e.g., Adjustment disorder) can still receive services through the use of codes related to counselling interventions from the ICD-11 chapter on Factors Influencing Health Status and Contact with Health Services described earlier in this paper.

The Working Group has therefore proposed the elimination of the entire grouping of F66 disorders from the ICD-11.

Comparison with DSM-5

The proposed changes for ICD-11 in this area bring it in line with DSM-5. No equivalent to any of the ICD-10 F66 categories is included in DSM-5 or was included in DSM-IV.

CONCLUSIONS

In the more than quarter century since the approval of the ICD-10, there have been substantial gains in scientific, clinical, social, and human rights understandings relevant to diagnostic categories related to sexuality and gender identity. These different streams of evidence have been considered in the development of a set of proposals for ICD-11 that departs markedly from the descriptions of categories related to sexuality and gender identity in the ICD-10. The inclusion of mental and behavioural disorders alongside all other diagnostic entities in health care is a central feature of the ICD, and has uniquely positioned the current revision effort to contemplate a broader and more integrative set of classification options with respect to these categories.

The ICD-10 classification of Sexual dysfunctions was substantially outdated in its view of psychological and physical causes of sexual dysfunction as separable and separate, making it inconsistent with current evidence regarding the etiology and treatment of these conditions. For the ICD-11, an innovative, integrated system has been proposed, including a set of qualifiers to indicate the range of factors that the clinician considers to be contributory. It must be emphasized that the WHO does not consider the ICD-11 chapters to constitute scope of practice boundaries between medical specialties, but intends and expects that psychiatrists and other mental health professionals with appropriate training will continue to engage in the treatment of these common and costly conditions and that the reformulated classification of these conditions will encourage broader availability of treatment.

The role of psychiatry in many countries is likely to evolve in substantive ways with respect to the evaluation and treatment of Gender incongruence, proposed to replace Gender identity

disorders in the ICD-10. The best health care services for transgender people are by definition multidisciplinary⁵⁹. But psychiatrists in some countries have been unfortunately positioned as gatekeepers to enforce elaborate and burdensome requirements in order to access these services⁸³, ostensibly in order to verify that transgender people are certain about their decision to seek health services to make their bodies align with their experienced identity. However, in the recent Mexican study described above⁷¹, the average delay between reported awareness of transgender identity and initiation of hormones – by far the most common treatment received – was found to be more than 12 years, and nearly half of participants had initiated hormones without medical supervision, exposing themselves to serious health risks. While these figures are not broadly generalizable, they are likely more reflective of the situation in most of the world than those reported in available studies from the US or Western Europe, given that more than 80% of the global population lives in low- and middle-income countries. Psychiatrists and other mental health professionals have a major role to play in improving the health status of this often mistreated population^{58,74,75}.

With respect to the classification of Paraphilic disorders, the Working Group on Sexual Disorders and Sexual Health has attempted to grapple with thorny issues related to how best to distinguish between conditions that are relevant to public health and clinical psychopathology on the one hand and private behaviours that are not a legitimate focus of health classification on the other. At the same time, proposals in this area affirm the status of persistent and intense sexual arousal patterns focusing on individuals who do not or cannot consent as psychiatric in their nature and management⁹⁰. In contrast, the Working Group concluded that there are no legitimate public health or clinical objectives served by mental disorder categories uniquely linked to sexual orientation⁸⁹.

In summary, the Working Group on Sexual Disorders and Sexual Health has proposed changes in the classification of these conditions that it considers to be: a) more reflective of current scientific evidence and best practices; b) more responsive to the needs, experience, and human rights of vulnerable populations; and c) more supportive of the provision of accessible and high-quality health care services. Proposed diagnostic guidelines for the disorders described in this paper will be made available for review and comment by members of WHO's Global Clinical Practice Network (<http://gcp.network>)¹²³, and subsequently for public review prior to finalization of the ICD-11. We hope that this paper will serve to encourage further scientific and professional discussion.

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REFERENCES

1. International Advisory Group for the Revision of ICD-10 Mental and Behavioural Disorders. A conceptual framework for the revision of the ICD-10 classification of mental and behavioural disorders. *World Psychiatry* 2011;10:86-92.
2. First MB, Reed GM, Hyman SE et al. The development of the ICD-11 clinical descriptions and diagnostic guidelines for mental and behavioural disorders. *World Psychiatry* 2015;14:82-90.
3. American Psychiatric Association. Diagnostic and statistical manual of mental disorders, 5th ed. Arlington: American Psychiatric Association, 2013.
4. World Health Organization. The ICD-10 classification of mental and behavioural disorders: clinical descriptions and diagnostic guidelines. Geneva: World Health Organization, 1992.
5. Perelman MA. The sexual tipping point: a mind/body model for sexual medicine. *J Sex Med* 2009;6:29:32.
6. Lewis RW, Fugl-Meyer KS, Corona G et al. Definitions/epidemiology/risk factors for sexual dysfunction. *J Sex Med* 2010;7:1598-607.
7. McCabe MP, Sharlip ID, Atalla E et al. Definitions of sexual dysfunctions in women and men: a consensus statement from the Fourth International Consultation on Sexual Medicine 2015. *J Sex Med* 2016;13:135-43.
8. McCabe MP, Sharlip ID, Lewis R et al. Risk factors for sexual dysfunction among women and men: a consensus statement from the Fourth International Consultation on Sexual Medicine 2015. *J Sex Med* 2016;13:153-67.
9. Carvalho J, Nobre P. Biopsychosocial determinants of men's sexual desire: testing an integrative model. *J Sex Med* 2011;8:754-63.
10. Chou D, Cottler S, Khosla R et al. Sexual health in the International Classification of Diseases (ICD): implications for measurement and beyond. *Reprod Health Matters* 2015;23:185-92.
11. World Health Organization. International statistical classification of diseases and related health problems, 10th revision (ICD-10). Geneva: World Health Organization, 1992.
12. Pfafs JG. Pathways of sexual desire. *J Sex Med* 2009;6:1506-33.
13. Kingsberg SA, Clayton AH, Pfafs JG. The female sexual response: current models, neurobiological underpinnings and agents currently approved or under investigation for the treatment of Hypoactive Sexual Desire Disorder. *CNS Drugs* 2015;29:915-33.
14. Basson R. The female sexual response: a different model. *J Sex Marital Ther* 2000;26:51-65.
15. Hackett G, Krychman M, Baldwin D et al. Coronary heart disease, diabetes, and sexuality in men. *J Sex Med* 2016;13:887-904.
16. Atlantis E, Sullivan T. Bidirectional association between depression and sexual dysfunction: a systematic review and meta-analysis. *J Sex Med* 2012;9:1497-507.
17. El Miedany Y, El Gaafary M, El Aroussy N et al. Sexual dysfunction in rheumatoid arthritis patients: arthritis and beyond. *Clin Rheumatol* 2012;31:601-6.
18. Mohammadi K, Rahnama P, Mohseni SM et al. Determinants of sexual dysfunction in women with multiple sclerosis. *BMC Neurol* 2013;13:83.
19. Catania L, Abdulcadir O, Puppo V et al. Pleasure and orgasm in women with female genital mutilation/cutting (FGM/C). *J Sex Med* 2007;4:1666-78.
20. Johnson SD, Phelps D, Cottler LB. The association of sexual dysfunction and substance use among a community epidemiological sample. *Arch Sex Behav* 2004;33:55-63.
21. Clayton AH, Croft HA, Handiwala L. Antidepressants and sexual dysfunction: mechanisms and clinical implications. *Postgrad Med* 2014;126:91-9.
22. Nobre PJ, Pinto-Gouveia J. Dysfunctional sexual beliefs as vulnerability factors to sexual dysfunction. *J Sex Res* 2006;43:68-75.
23. Dunn KM, Croft PR, Hackett GI. Association of sexual problems with social, psychological, and physical problems in men and women: a cross-sectional populations survey. *J Epidemiol Community Health* 1999;53:144-8.
24. Öberg K, Fugl-Meyer KS, Fugl-Meyer AR. On sexual well being in sexually abused Swedish women: epidemiological aspects. *Sex Relation Ther* 2002;17:329-41.
25. Brotto LA, Atallah S, Johnson-Agbakwu C et al. Psychological and interpersonal dimensions of sexual function and dysfunction. *J Sex Med* 2016;13:538-71.
26. Laumann EO, Nicolosi A, Glasser DB et al. Sexual problems among women and men aged 40-80 y: prevalence and correlates identified in the Global Study of Sexual Attitudes and Behaviors. *Int J Impot Res* 2005;17:39-57.
27. Atallah S, Johnson-Agbakwu C, Rosenbaum T et al. Ethical and sociocultural aspects of sexual function and dysfunction in both sexes. *J Sex Med* 2016;13:591-606.
28. Oniz A, Keskinoglu P, Bezircioglu I. The prevalence and causes of sexual problems among premenopausal Turkish women. *J Sex Med* 2007;4:1575-81.
29. Laan E, Rellini AH, Barnes T. Standard operating procedures for female orgasmic disorder: consensus of the International Society for Sexual Medicine. *J Sex Med* 2013;10:74-82.
30. Brotto LA. The DSM diagnostic criteria for hypoactive sexual desire disorder in women. *Arch Sex Behav* 2010;39:221-39.
31. Parish SJ, Hahn SR. Hypoactive sexual desire disorder: a review of epidemiology, biopsychology, diagnosis, and treatment. *Sex Med Rev* 2016;4:103-20.
32. DeRogatis LR, Clayton AH, Rosen RC et al. Should sexual desire and arousal disorders in women be merged? *Arch Sex Behav* 2011;40:217-9.
33. Sungur MZ, Gündüz A. A comparison of DSM-IV-TR and DSM-5 definitions for sexual dysfunctions: critiques and challenges. *J Sex Med* 2014;11:364-73.
34. Sarin S, Amsel RM, Binik YM. Disentangling desire and arousal: a classificatory conundrum. *Arch Sex Behav* 2013;42:1079-100.
35. Balon R, Clayton AH. Female sexual interest/arousal disorder: a diagnosis out of thin air. *Arch Sex Behav* 2014;43:1227-9.
36. Burri A, Greven C, Leupi M et al. A multivariate twin study of female sexual dysfunction. *J Sex Med* 2012;9:2671-81.
37. Bishop JR, Moline J, Ellingrod VL et al. Serotonin 2A-1438 G/A and G-protein Beta3 subunit C825T polymorphisms in patients with depression and SSRI-associated sexual side-effects. *Neuropsychopharmacology* 2006;31:2281-8.
38. Bishop JR, Ellingrod VL, Akroush M et al. The association of serotonin transporter genotypes and selective serotonin reuptake inhibitor (SSRI)-associated sexual side effects: possible relationship to oral contraceptives. *Hum Psychopharmacol* 2009;24:207-15.
39. Arnov BA, Millheiser L, Garrett A et al. Women with hypoactive sexual desire disorder compared to normal females: a functional magnetic resonance imaging study. *Neuroscience* 2009;158:484-502.
40. Pyke RE, Clayton AH. Psychological treatment trials for hypoactive sexual desire disorder: a sexual medicine critique and perspective. *J Sex Med* 2015;12:2451-8.
41. Berman JR, Berman LA, Toler SM et al. Safety and efficacy of sildenafil citrate for the treatment of female sexual arousal disorder: a double-blind, placebo controlled study. *J Urology* 2003;170:2333-8.
42. Brotto LA, Basson R, Luria M. A mindfulness-based group psychoeducational intervention targeting sexual arousal disorder in women. *J Sex Med* 2008;5:1646-59.
43. Brotto LA, Chivers ML, Millman RD et al. Mindfulness-based sex therapy improves genital-subjective arousal concordance in women with sexual desire/arousal difficulties. *Arch Sex Behav* (in press).
44. Maserejian NN, Shifren J, Parish SJ et al. Sexual arousal and lubrication problems in women with clinically diagnosed hypoactive sexual desire disorder: preliminary findings from the hypoactive sexual desire disorder registry for women. *J Sex Marital Ther* 2012;38:41-62.
45. Binik YM. Should dyspareunia be retained as a sexual dysfunction in DSM-V? A painful classification. *Arch Sex Behav* 2005;34:11-21.
46. Pukall CF, Goldstein AT, Bergeron S et al. Vulvodynia: definition, prevalence, impact, and pathophysiological factors. *J Sex Med* 2016;13:291-304.
47. Bornstein J, Goldstein AT, Stockdale CK et al. 2015 ISSVD, ISSWSH, and IPPS consensus terminology and classification of persistent vulvar pain and vulvodynia. *J Sex Med* 2016;127:745-51.

48. Segraves RT. Considerations for a better definition of male orgasmic disorder in DSM V. *J Sex Med* 2010;7:690-9.
49. Waldinger M. Male ejaculation and orgasm disorders. In: Balon R, Segraves R (eds). *Handbook of sexual dysfunction*. Boca Raton: Taylor and Francis, 2005:215-48.
50. Wylie K, Ralph D, Levin RJ et al. Comments on "Considerations for a better definition of male orgasmic disorder in DSM V". *J Sex Med* 2010;7:695-9.
51. Global Action for Trans* Equality. It's time for reform. *Trans health issues in the International Classification of Diseases*. Report on the GATE Experts Meeting, The Hague, November 2011.
52. European Commission. *Trans and intersex people: discrimination on the grounds of sex, gender identity and gender expression*. Luxembourg: European Union, 2012.
53. European Parliament. *Resolution of 28 September 2011 on human rights, sexual orientation and gender identity at the United Nations*. Strasbourg: European Parliament, 2011.
54. World Health Organization. *Mental health action plan 2013-2020*. Geneva: World Health Organization, 2013.
55. World Health Organization. *Basic documents, 48th ed*. Geneva: World Health Organization, 2014.
56. United Nations High Commissioner for Human Rights. *Discriminatory laws and practices and acts of violence against individuals based on their sexual orientation and gender identity*. New York: United Nations General Assembly, 2011.
57. Council of Europe. *Discrimination on grounds of sexual orientation and gender identity in Europe, 2nd ed*. Strasbourg: Council of Europe Publishing, 2011.
58. World Health Organization. *Sexual health, human rights and the law*. Geneva: World Health Organization, 2015.
59. World Professional Association for Transgender Health. *Standards of care for the health of transsexual, transgender and gender non-conforming people, version 7*. World Professional Association for Transgender Health, 2011.
60. United Nations Development Programme. *Discussion paper: Transgender health and human rights*. New York: United Nations Development Programme, 2013.
61. Sood N. *Transgender people's access to sexual health and rights: a study of law and policy in 12 Asian countries*. Kuala Lumpur: Asian-Pacific Resource and Research Centre for Women, 2009.
62. Nuttbrock L, Hwahng S, Bockting W et al. Psychiatric impact of gender-related abuse across the life course of male-to-female transgender persons. *J Sex Res* 2010;47:12-23.
63. Grossman AH, D'Augelli AR. *Transgender youth: invisible and vulnerable*. *J Homosex* 2006;51:111-28.
64. Sugano E, Nemoto T, Operario D. The impact of exposure to transphobia on HIV risk behavior in a sample of transgendered women of color in San Francisco. *AIDS Behav* 2006;10:217-25.
65. Grossman AH, D'Augelli AR, Salter NP. Male-to-female transgender youth: gender expression milestones, gender atypicality, victimization, and parents' responses. *J GLBT Fam Stud* 2006;2:71-92.
66. Rotondi NK, Bauer GR, Scanlon K et al. Nonprescribed hormone use and self-performed surgeries: "do-it-yourself" transitions in transgender communities in Ontario, Canada. *Am J Public Health* 2013;103:1830-6.
67. Sanchez NF, Sanchez JP, Danoff A. Health care utilization, barriers to care, and hormone usage among male-to-female transgender persons in New York City. *Am J Public Health* 2009;99:713-9.
68. Asscheman H, Giltay EJ, Megens JA et al. A long-term follow-up study of mortality in transsexuals receiving treatment with cross-sex hormones. *Eur J Endocrinol* 2011;164:635-42.
69. Hembree WC, Cohen-Kettenis P, Delemarre-van de Waal HA et al. Endocrine treatment of transsexual persons: an Endocrine Society clinical practice guideline. *J Clin Endocrinol Metab* 2009;94:3132-54.
70. Mueller A, Gooren L. Hormone-related tumors in transsexuals receiving treatment with cross-sex hormones. *Eur J Endocrinol* 2008;159:197-202.
71. Robles R, Fresán A, Vega-Ramírez H et al. Removing transgender identity from the classification of mental disorders: a Mexican field study for ICD-11. *Lancet Psychiatry* 2016;3:850-9.
72. Drescher J, Cohen-Kettenis P, Winter S. Minding the body: situating gender identity diagnoses in the ICD-11. *Int Rev Psychiatry* 2012;24:568-77.
73. Drescher J, Cohen-Kettenis PT, Reed GM. Gender incongruence of childhood in the ICD-11: controversies, proposal, and rationale. *Lancet Psychiatry* 2016;3:297-304.
74. Lo S, Horton R. Transgender health: an opportunity for global health equity. *Lancet* 2016;388:316-8.
75. Reisner SL, Poteat T, Keatley J et al. Global health burden and needs of transgender populations: a review. *Lancet* 2016;388:412-36.
76. Winter S, Settle E, Wylie K et al. Synergies in health and human rights: a call to action to improve transgender health. *Lancet* 2016;388:318-21.
77. Cabral M, Suess A, Ehrt J et al. Removal of gender incongruence of childhood diagnostic category: a human rights perspective. *Lancet Psychiatry* 2016;3:405-6.
78. Drescher J, Byne W. Gender dysphoric/gender variant (GD/GV) children and adolescents: summarizing what we know and what we have yet to learn. *J Homosex* 2012;59:501-10.
79. Drescher J, Byne W. *Treating transgender children and adolescents: an interdisciplinary discussion*. New York: Routledge, 2013.
80. Steensma TD, McGuire JK, Kreukels BP et al. Factors associated with desistance and persistence of childhood gender dysphoria: a quantitative follow-up study. *J Am Acad Child Adolesc Psychiatry* 2013;52:582-90.
81. Steensma TD, Biemond R, de Boer F et al. Desisting and persisting gender dysphoria after childhood: a qualitative follow-up study. *Clin Child Psychol Psychiatry* 2011;16:499-516.
82. Byne W, Bradley SJ, Coleman E, et al. Report of the APA Task Force on Treatment of Gender Identity Disorder. *Arch Sex Behav* 2012;41:759-96.
83. Bouman WP, Bauer GR, Richards C et al. World Professional Association for Transgender Health consensus statement on considerations of the role of distress (Criterion D) in the DSM diagnosis of gender identity disorder. *Int J Transgend* 2010;12:100-6.
84. Ehrbar RD, Wittly MC, Ehrbar HG et al. Clinician judgment in the diagnosis of gender identity disorder in children. *J Sex Marital Ther* 2008;34:385-412.
85. Joyal CC. How anomalous are paraphilic interests? *Arch Sex Behav* 2014;43:1241-3.
86. Joyal CC. Defining "normophilic" and "paraphilic" sexual fantasies in a population-based sample: on the importance of considering subgroups. *Sex Med* 2015;3:321-30.
87. Richters J, de Visser RO, Rissel CE et al. Demographic and psychosocial features of participants in bondage and discipline, "sadosomochism" or dominance and submission (BDSM): data from a national survey. *J Sex Med* 2008;5:1660-8.
88. Reiersøl O, Skeid S. The ICD diagnoses of fetishism and sadosomochism. *J Homosex* 2006;50:243-62.
89. Cochran SD, Drescher J, Kismödi E et al. Proposed declassification of disease categories related to sexual orientation in the International Statistical Classification of Diseases and Related Health Problems (ICD-11). *Bull World Health Organ* 2014;92:672-9.
90. Krueger RB, Reed GM, First MB et al. Paraphilic disorders in the International Classification of Disease and Related Health Problems, Eleventh Revision (ICD-11). *Arch Sex Behav* (in press).
91. Briken P, Fedoroff JP, Bradford JW. Why can't pedophilic disorder remit? *Arch Sex Behav* 2014;43:1237-9.
92. Becker JV, Stinson J, Tromp S et al. Characteristics of individuals petitioned for civil commitment. *Int J Offend Ther* 2003;47:185-95.
93. Berner W, Berger P, Hill A. Sexual sadism. *Int J Offend Ther* 2003;47:383-95.
94. Briken P, Bourget D, Dufour M. Sexual sadism in sexual offenders and sexually motivated homicide. *Psychiatr Clin North Am* 2014;37:215-30.
95. Elwood RW, Doren DM, Thornton D. Diagnostic and risk profiles of men detained under Wisconsin's sexually violent person law. *Int J Offend Ther* 2010;54:187-96.
96. Packard, RL, Levenson JL. Revisiting the reliability of diagnostic decisions in sex offender civil commitment. *Sexual Offender Treatment* 2006;1:1-15.
97. Krueger RB. The DSM diagnostic criteria for sexual sadism. *Arch Sex Behav* 2010;39:325-45.
98. Abel GG, Becker JV, Mittelman M et al. Self-reported sex crimes of nonincarcerated paraphiliacs. *J Interpers Violence* 1987;2:3-25.
99. Ahlers CJ, Schaefer GA, Mundt IA et al. How unusual are the contents of paraphilias? Paraphilia-associated sexual arousal patterns in a community-based sample of men. *J Sex Med* 2011;8:1362-70.
100. Bradford JMW, Boulet J, Pawlak A. The paraphilias: a multiplicity of deviant behaviors. *Can J Psychiatry* 1992;37:104-8.
101. Långström N. The DSM diagnostic criteria for exhibitionism, voyeurism, and frotteurism. *Arch Sex Behav* 2010;39:317-24.

102. Templeman TL, Stinnett RD. Patterns of sexual arousal and history in a "normal" sample of young men. *Arch Sex Behav* 1991;20:137-50.
103. Johnson RS, Ostermeyer B, Sikes KA et al. Prevalence and treatment of frotteurism in the community: a systematic review. *J Am Acad Psychiatry Law* 2014;42:478-83.
104. Nordic Centre for Classifications in Health Care. Removed ICD-10 codes in categories F64 and F65 in the Nordic Countries. Helsinki: Nordic Centre for Classifications in Health Care, 2015.
105. First MB, Halon RL. Use of DSM paraphilia diagnoses in sexually violent predator commitment cases. *J Am Acad Psychiatry Law* 2008;36:443-54.
106. US Supreme Court. *Kansas v. Hendricks*, 521 U.S. 346 (1997).
107. Janus E. Sexually violent predator laws: psychiatry in service to a morally dubious enterprise. *Lancet* 2004;364:50-1.
108. Zonana H. The civil commitment of sex offenders. *Science* 1997;278:1248-9.
109. First MB. DSM-5 and paraphilic disorders. *J Am Acad Psychiatry Law* 2014;42:191-201.
110. O'Flaherty M, Fisher J. Sexual orientation, gender identity and international human rights law: contextualising the Yogyakarta Principles. *Human Rights Law Rev* 2008;8:207-48.
111. Caceres CF, Konda K, Segura ER et al. Epidemiology of male same-sex behaviour and associated sexual health indicators in low- and middle-income countries: 2003-2007 estimates. *Sex Transm Infect* 2008;84(Suppl. 1):i49-56.
112. Hooker E. Reflections of a 40-year exploration: a scientific view on homosexuality. *Am Psychol* 1993;48:450-3.
113. Drescher J. Queer diagnoses: parallels and contrasts in the history of homosexuality, gender variance, and the Diagnostic and Statistical Manual. *Arch Sex Behav* 2010;39:427-60.
114. King M, McKeown E, Warner J et al. Mental health and quality of life of gay men and lesbians in England and Wales: controlled, cross-sectional study. *Br J Psychiatry* 2003;183:552-8.
115. Mays VM, Cochran SD. Mental health correlates of perceived discrimination among lesbian, gay, and bisexual adults in the United States. *Am J Public Health* 2001;91:1869-76.
116. Meyer IH. Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: conceptual issues and research evidence. *Psychol Bull* 2003;129:674-97.
117. Organization for Security and Cooperation in Europe/Office for Democratic Institutions and Human Rights. Hate crimes in the OSCE region – incidents and responses. Annual report for 2006. Warsaw: Organization for Security and Cooperation in Europe/Office for Democratic Institutions and Human Rights, 2007.
118. Calzo JP, Antonucci TC, Mays VM et al. Retrospective recall of sexual orientation identity development among gay, lesbian, and bisexual adults. *Dev Psychol* 2011;47:1658-73.
119. Spitzer RL. The diagnostic status of homosexuality in DSM-III: a reformulation of the issues. *Am J Psychiatry* 1981;138:210-5.
120. van Drimmelen-Krabbe JJ, Ustun TB, Thompson DH et al. Homosexuality in the International Classification of Diseases: a clarification. *JAMA* 1994; 272:1660.
121. American Psychological Association. Guidelines for psychological practice with lesbian, gay, and bisexual clients. *Am Psychol* 2012;67:10-42.
122. Pan American Health Organization. "Cures" for an illness that does not exist. Washington, DC: Pan American Health Organization, 2012.
123. Reed GM, First MB, Medina-Mora ME et al. Draft diagnostic guidelines for ICD-11 mental and behavioural disorders available for review and comment. *World Psychiatry* 2016;15:112-3.

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UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

JANE DOE 1 *et al.*,

Plaintiffs,

v.

DONALD J. TRUMP *et al.*,

Defendants.

Civil Action No. 17-cv-1597 (CKK)

DECLARATION OF ROBERT B. CHADWICK
(Relating to Midshipman Second Class Regan V. Kibby)

I, CAPTAIN ROBERT B. CHADWICK, UNITED STATES NAVY, do hereby state and declare as follows::

1. I am a Captain serving on active-duty in the United States Navy and currently assigned as Commandant of Midshipmen at the United States Naval Academy (USNA) in Annapolis, Maryland. I have served on active duty for twenty-six years, most recently commanding Destroyer Squadron 21. I make this declaration based on my personal knowledge and on information provided to me in the course of my official duties. I submit this declaration in support of the defendants' motion to dismiss the above-captioned action and in opposition to the plaintiffs' motion for a preliminary injunction. In particular, I address below the current status of plaintiff Midshipman (MIDN) Second Class Regan V. Kibby.
2. Based on my current position and past experience, I am familiar with the Department of the Navy's policies and regulations regarding accession and retention requirements, including those found in Department of Defense (DoD) Instruction 6130.03, Chief of Naval Operations Instruction (OPNAVINST) 3110.1J, USNA Instruction 1531.49B, and USNA Director of Athletics Instruction 6100.1; policies and regulations relating to service by transgender

individuals, including DoD Instruction 1300.28; ALNAV 053/16; and the Secretary of Defense's Interim Guidance issued on 14 September 2017.

3. Midshipman (MIDN) Second Class Regan V. Kibby is currently enrolled at USNA, and is on a medical leave of absence. MIDN Kibby's official files at USNA and in the Defense Enrollment Eligibility Reporting System (DEERS) currently identify MIDN Kibby as female. For the remainder of this declaration, I will refer to MIDN Kibby using male pronouns, which correspond to MIDN Kibby's gender identity.
4. In my role as Commandant of Midshipmen, I am responsible for the professional development and day-to-day activities of all midshipmen in the Brigade of Midshipmen. MIDN Kibby's leave of absence was approved by the Superintendent prior to my arrival at USNA. However, based on the information I received from my predecessor and support staff during turnover, my review of MIDN Kibby's leave of absence request, and his personnel records at USNA, I am aware of MIDN Kibby's history at USNA; his current status; and his plans for his gender transition, program of study at USNA, and eventual service as a Naval Officer. I am further aware that MIDN Kibby was afforded much support from the Brigade Medical Unit, his chain of command, and my legal advisors in developing his plan and submitting his request.
5. MIDN Kibby was inducted into USNA on 1 July 2015. He first notified USNA of his transgender status through his company officer during the 2016 spring semester, which was during his first year of his four-year course of study.
6. Upon induction to USNA, all midshipman sign an agreement (USNA BBA 1531/178) outlining their statutory service obligations incurred as a result of their attendance at USNA. Pursuant to 10 U.S.C. §§ 2005, 6959 and SECNAVINST 1531.4, midshipmen who enter USNA directly from a civilian status do not incur a future service or financial obligation during

their first two years at USNA. Upon graduation from USNA, midshipmen who are offered a commission must accept that commission and normally serve on active duty for at least five years. Any USNA graduate who does not fulfill this obligation may be required to reimburse the Government for the cost of the educational benefits received at USNA. Similarly, once a midshipman begins the third academic year of study at USNA, that midshipman may be ordered to active duty in an enlisted status for at least two years if the midshipman resigns or is disenrolled from USNA. If that midshipman is disqualified, unfit, or unsuited for enlisted military service, the midshipman may be required by the Secretary of the Navy to reimburse the Government for the cost of the educational benefits received at USNA. However, the Superintendent of USNA may request that the Secretary of the Navy waive any obligations resulting from a midshipman's voluntary or involuntary disenrollment after incurring an obligation. Additionally, when a midshipman is involuntarily disenrolled from USNA due to a medical condition or otherwise unable to fulfill their service obligation because of the same, reimbursement is not required.

7. Because MIDN Kibby has not begun his third year of study at USNA, he has incurred neither a service obligation nor a financial obligation.
8. After disclosing his transgender status and after the release of DoD Instruction 1300.28 on 30 June 2016, MIDN Kibby began meeting with medical personnel and USNA administrators to plan his gender transition.
9. MIDN Kibby completed his plan and submitted it for approval on 25 April 2017. On 22 May 2017, the Superintendent approved MIDN Kibby's transition and leave of absence request, and that transition plan remains in place.

10. Under the terms of the approved plan, MIDN Kibby began a medical leave of absence in late June 2017. This date was requested and approved in order to allow MIDN Kibby to complete his summer training in 2017. The purpose of the leave is to allow MIDN Kibby to undergo hormone treatment, and to a period of gender stability of sufficient length under current policy and guidance to ensure his eligibility to accept a commission in May 2020 if he successfully completes the course of instruction upon returning to USNA.
11. The transition-related medical treatment currently being provided to MIDN Kibby is at DoD expense. I am not aware of any interruption in MIDN Kibby's care during his medical leave.
12. The medical leave of absence is scheduled to last for eleven months, and to end in May of 2018.
13. In accordance with the approved plan, when MIDN Kibby again resumes his studies at the USNA, his official gender marker will remain female. Once MIDN Kibby's gender transition is officially complete, he may request to have his gender marker in DEERS changed. According to the plan, this request will be made in November 2018.
14. Once MIDN Kibby's gender marker is changed to male in DEERS, he will be subject to the male physical fitness standards found in OPNAVINST 3110.1J and USNA Director of Athletics Instruction 6100.1.
15. The USNA male physical fitness standards require a body fat percentage of 22% or less, and require that a midshipman complete at least 65 curl-ups (sit-ups) in two minutes, 45 push-ups in two minutes, and a one and a half mile run in ten minutes and thirty seconds or less. By comparison, the USNA female standards require a body fat percentage of 33% or less, and the completion of at least 65 curl-ups in two minutes, 20 push-ups in two minutes, and a one and a

half mile run in twelve minutes and forty seconds or less. Meeting these minimum requirements is prerequisite to graduation.

16. In addition to meeting these physical fitness standards, satisfactory completion of a defined course of study with certain minimum scores, achieving passing scores in military performance, and being satisfactory in honor and conduct are all prerequisite to graduation from USNA. Once a midshipman is graduated, he or she must accept a commission in the Navy or Marine Corps if one is offered. Commissions are offered to graduates who meet the prerequisites of the individual branch of service, which are a matter of the policies in place at the time of commissioning.
17. Under MIDN Kibby's current transition plan, and due to his current medical leave of absence, the earliest that he will be eligible to accept a commission is May of 2020.

Pursuant to 28 U.S.C. § 1746, I hereby declare under penalty of perjury that the forgoing is true and correct.

Executed this ~~20~~²⁹th day of September 2017, Annapolis, Maryland.



ROBERT B. CHADWICK
Captain, U.S. Navy

JANE DOE 1, et al.,
Plaintiffs,
v.
DONALD TRUMP, et al.,
Defendants.
Civil Action No. 17-cv-1597 (CKK)

DECLARATION OF MR. ROBERT O. BURNS
(Relating to Plaintiff Dylan Kohere)

I, Mr. Robert O. Burns, hereby state and declare as follows:

1. I am currently employed as the Deputy Chief of Staff for Personnel, G1, for the United States Army Cadet Command (USACC), Fort Knox, Kentucky. USACC is the command responsible for overseeing the Reserve Officers' Training Corps (ROTC) program by partnering with universities through local ROTC detachments in order to recruit, educate, train, develop, and commission officers in the U.S. Army. I have been in this position for five years and four months. I am responsible to the Commanding General (CG), USACC, for personnel-related activities within the organization, to include strength management, assignments, awards, evaluations, and other personnel policies. Due to my official duties related to this responsibility, I have an understanding of USACC's policy regarding the various levels of students' participation in the ROTC program. I make this declaration based on my personal knowledge and on information that has been provided to me in the course of my official duties. I submit this declaration in support of the defendants' motion to dismiss the above-captioned action and in opposition to the plaintiffs' motion for a preliminary injunction. In particular, I address below the current status of plaintiff Dylan Kohere with respect to the ROTC program. US Army Cadet Command's current policy is to recognize an ROTC student's gender according to the gender recognized by the student's university registrar. Dylan Kohere is registered as a female with her

university. However, for the convenience of the Court and the parties, I will refer to Dylan using male pronouns for the remainder of this declaration, which corresponds to his gender identity referenced in the amended complaint. In sum, Dylan Kohere is currently registered in an ROTC academic class for freshmen, for academic credit, and is able to participate in certain labs that do not include physical activity. Based upon current ROTC policies, he may continue this level of participation. Further, because he is a first year student, he would not be eligible to receive an appointment until he graduates, which if he follows a four-year program, would be in the spring of 2021.

2. Students interacting with the ROTC program fall into four categories:

a. *Auditing* students may observe academic classes in the Military Science (MS) Basic Course and the Advance Course curricula; however, they do not receive academic credit for taking Military Science classes and do not receive a grade. The Basic Course consists of the MS-I (i.e., freshman) and MS-II (i.e., sophomore) academic classes while the Advanced Course consists of the MS-III (i.e., junior) and MS-IV (i.e., senior) academic classes. Auditing is available to any student registered with the university if permitted by the school and approved by the Professor of Military Science (PMS), if the school's course catalogue requires the PMS to approve an auditing student.

b. *Participating* students are students who are registered/taking a Military Science academic class in either the Basic or Advance Courses, but are either ineligible to enroll, or choose not to enroll, in the ROTC program. Participating students receive academic credit for a course but not commissioning credit. Participating students may attend academic labs that are required to be taken as part of an academic ROTC course in either the Basic or Advance Courses of instruction, but not labs that are physically oriented. Participating students may not wear uniforms or equipment and may not participate in activities requiring physical training or physical activity. The primary reason for restricting physical activities outside of approved

Participating students are not “designated applicants” under Title 10, United States Code, because they are not enrolled in ROTC, and therefore are not eligible for medical care under Title 10, related statutes, and regulations in the event of an injury.

c. *Enrolled* students are students who are enrolled in a Military Science academic class and are also enrolled in the ROTC program. They must complete a medical screening and complete a Cadet Command Form 139-R (Cadet Application and Enrollment Record) to complete the Cadet Command enrollment process. Although enrolled, they have not yet signed a contract with the Army. Enrolled students are classified as cadets, and may participate in all aspects of the ROTC Basic Course program for both academic and commissioning credit. An enrolled student that does not contract prior to the student’s MS-III (i.e., junior) year can continue to take Advance Course classes for academic credit (as a participating cadet) but not commissioning credit. Enrolled cadets meet the criteria as defined by the term “designated applicant” found in Title 10 U.S.C.

d. *Contracted* students swear an oath of loyalty and sign a contract committing them to a service obligation in the U.S. Army following their completion of the program. They also enlist in the Individual Ready Reserves of the Armed Forces. Contracted students are cadets, and may participate in all aspects of the ROTC Basic Course and Advanced Course programs. They are also eligible for a an ROTC academic scholarship.

e. In sum, there is a distinction between taking ROTC courses that are offered in a university course catalogue and being a qualified student/cadet in either the Basic or Advance programs of ROTC. Any university student can take any ROTC course if they meet the prerequisites in the course catalogue, but this does not mean they are in the Basic or Advanced programs of ROTC working toward a commission.

3. Certain students enrolled in the ROTC program are eligible for academic scholarships. A

cadet's eligibility for a scholarship is based upon his or her demonstrated excellence as a scholar, athlete, and leader. In addition, only contracted cadets may receive a scholarship.

a. Four-year scholarships and three-year Advanced Designee scholarships are administered at the national level and are selected by a scholarship selection board. A three-year Advanced Designee scholarship is awarded while the applicant is still in high school; however, because it is only a three-year scholarship and not four, the applicant does not receive any scholarship benefits during their freshmen year.

b. Eligible candidates typically communicate their interest in a scholarship with the ROTC program prior to the start of their first undergraduate year. For students who enter a university in the fall after graduating from high school in the spring, this is typically done prior to high school graduation. Each year, an application period is opened for on line applications (recent years the window has opened in June and closed in January). Subsequent to the application window closing, a scholarship board convenes to select a limited number of candidates to receive four-year scholarships and Three Year Advanced Designee scholarships.

c. Three-year (non-Advanced Designee) and two-year scholarships, which are administered at the campus level, are available for a small number of Cadets. Due to the limited number of available scholarships, these three-year and two-year scholarships are highly competitive. Candidates for these scholarships are nominated by their local ROTC detachment and approved by Headquarters, USACC.

4. There are two general options for entering the ROTC program:

a. Students may enter through *progression*, which is when a student begins ROTC in the MS-I (i.e., freshman) year and progresses all the way through the program to MS-IV (i.e., senior) year. In the Basic Course portion of ROTC, a student may be classified as participating, enrolled, or contracted. The normal progression timeline is for a student to take the MS-I classes during their first undergraduate year, one per semester, and the MS-II class during their second year.

However, the PMS may authorize accelerated progression by allowing the cadet to take more than one course per semester or academic year in order to complete the Basic Course on-time if the cadet has only three years remaining before graduation. Upon completion of the Basic Course, cadets are then eligible to enter the Advanced Course. While participating students are allowed in the Basic Course, students in the Advanced Course must either be enrolled or contracted cadets in order to receive commissioning credit. For students registered in a four-year degree program, the Advanced Course's MS-III and MS-IV classes are typically completed during the student's third (i.e., junior) and fourth (i.e., senior) academic years, respectively.

b. The second option for entry into the ROTC program is *lateral entry*, which includes any method of entry into the Advanced Course other than through progression. One lateral entry option is when a non-scholarship Cadet attends the Basic Camp after their MS-II academic year (i.e., normally the sophomore or second academic year) in lieu of completing the Basic Course. The Basic Camp is a condensed four-week summer training program that trains Cadets on the leadership fundamentals they will need to successfully complete the ROTC program and commission into the Service. This allows the program to recruit students who are further along in their undergraduate timeline to still enroll in ROTC and commission on-time after graduation.

c. Students may also qualify for placement credit, which provides constructive credit for completing ROTC program requirements based upon prior military service or prior enrollment in a Senior ROTC (university level) or Junior ROTC (high school level) program. The amount of credit depends on the level of prior experience.

d. Alternate Entry Option (AEO) is when a non-scholarship Cadet attends the Basic Camp after their MS-III academic year (i.e., normally the junior or third academic year) in lieu of completing the Basic Course. This allows the program to recruit students who are further along in their undergraduate timeline who missed the Basic Camp prior to their MS-III year. These students will then attend the Advance Camp and commission after graduation. AEO is only open

e. The Accelerated Cadet Commissioning Training (ACCT) Program is for students who have missed the window for placement through the Basic Camp option, who also demonstrate exceptional skills as a scholar, athlete, and leader. These students may contract at the beginning of their MS-III academic year after completing a training program of critical tasks that must be mastered prior to contracting. Candidates for entry through ACCT must be approved by the Commanding General, USACC.

f. There are other lateral entry options into ROTC for students pursuing engineering or nursing degrees, or cadets from Sister Service ROTC programs that wish to cross-commission into the U.S. Army.

5. Cadets who successfully complete the ROTC educational and training requirements, and are otherwise qualified based upon age, security clearance, citizenship, character, education, and physical and medical fitness, are eligible to receive a Presidential appointment into the U.S. Army as a commissioned officer. ROTC graduates must take an oath of office, which constitutes the acceptance of the officer's appointment.

6. USACC has a formal policy prescribing the authorized participation of transgender students within the ROTC training program (attached). The policy distinguishes between students who are applicants; non-contracted, enrolled cadets; or contracted cadets. Transgender applicants are allowed to participate in the Basic and Advanced Courses (see para. 2(b) above) for academic credit, and are treated based upon the gender recognized by the university registrar. At this time, transgender applicants are not allowed to enroll or contract, although those already in that status may remain so.

7. Current Department of Defense policy precludes contracted, transgender Cadets from commissioning. However, USACC intends to re-visit the policies in paragraph 6 and in the attached memoranda pending the final outcome of the Secretary of Defense's implementation

2017 memorandum, *Military Service by Transgender Individuals*. This includes the potential, dependent upon the outcome of the policy, for students to receive credit towards commissioning based upon successfully completing Basic or Advanced Course academic courses as participating students.

8. I am generally aware of the allegations made by Dylan Kohere in the filings and his associated declaration in *Jane Doe 1 v. Trump*, No. 17-cv-1597, currently pending in the United States District Court for the District of Columbia. Based upon my knowledge of his allegations, and information that I have learned through my official duties as the G1, I provide the following

a. Dylan Kohere is a student at the University of New Haven in New Haven, Connecticut. The University of New Haven's ROTC program is administered by the ROTC detachment from the University of Connecticut in Storrs, Connecticut. After the start of the fall semester, Dylan Kohere expressed his interest in the ROTC program to Sergeant First Class (SFC) David Andino and Captain (CPT) Christopher Mace, ROTC cadre at the University of New Haven. They, in-turn, advised the Professor of Military Science (PMS), Lieutenant Colonel (LTC) Tanya Wahlberg, at the University of Connecticut. During the conversation with the ROTC cadre at University of New Haven, Dylan Kohere identified as transgender. He was informed that, due to his self-identification as transgender, while he could not formally enroll in ROTC, he was eligible to participate in the MS-I academic class in accordance with USACC's interim policy. He is currently registered in the MS-I class and is able to participate in certain labs that do not include physical activity. For the fall semester, the labs he can participate in include a brief on the Judge Advocate General's Corps, and two training events on military communications and weapons systems.

b. I am aware Dylan Kohere is not presently receiving an ROTC scholarship as the scholarships for this academic year were awarded in the spring of 2017 and he never applied to

academic year because the deadline to apply has passed (for this year: June 2016 to February 2017). A non-transgender student in Dylan's same position (of failing to apply during the application open window) would not be eligible for a four-year scholarship, either. Further, the opportunity to apply for campus-managed three-year or two-year scholarships has not yet approached. A three-year scholarship would be awarded during the summer between a student's freshman and sophomore years. His opportunity to apply for a three-year or two-year scholarship will not occur until after the Secretary of Defense's implementation plan is due to the President. Similarly, his eligibility for such scholarships will not be determined until after the implementation plan date.

c. I am also aware of Dylan Kohere's allegation that he fears he will not be able to continue in ROTC or ultimately serve in the military. Dylan Kohere is a freshman and is currently allowed to participate in the Basic Course academic classes through his sophomore year. The current policy will also allow him to participate in Advanced Course academic classes his junior and senior years, and could potentially receive credit toward commissioning if he successfully completes the courses and depending on the final outcome of Department of Defense's accessions guidance. Based upon his current timeline, he would not be eligible to receive an appointment until he graduates, which based upon a four-year program, would be in the spring of 2021. In addition, the deadline for the Secretary of Defense's implementation plan is scheduled to occur during his freshman year. Depending on the outcome of the final accessions policy, Dylan could still be eligible for entry into the ROTC program through both the progression and lateral entry options. Based upon these options, it is difficult, if not impossible, to assess any prejudice Dylan will encounter towards completing the ROTC program until the final guidance is issued.

is true and correct. Executed this 4th day of October 2017.

Robert O. Burns
Robert O. Burns
Deputy Chief of Staff, G1
U.S. Army Cadet Command
Fort Knox, Kentucky

**UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA**

JANE DOE 1, JANE DOE 2, JANE DOE 3,
JANE DOE 4, JANE DOE 5, JOHN DOE 1,
REGAN V. KIBBY, and DYLAN KOHERE,

Plaintiffs,

v.

DONALD J. TRUMP, in his official capacity as
President of the United States; JAMES N.
MATTIS, in his official capacity as Secretary of
Defense; JOSEPH F. DUNFORD, JR., in his
official capacity as Chairman of the Joint Chiefs
of Staff; the UNITED STATES DEPARTMENT
OF THE ARMY; RYAN D. MCCARTHY, in
his official capacity as Secretary of the Army;
the UNITED STATES DEPARTMENT OF
THE NAVY; RICHARD V. SPENCER, in his
official capacity as Secretary of the Navy; the
UNITED STATES DEPARTMENT OF THE
AIR FORCE; HEATHER A. WILSON, in her
official capacity as Secretary of the Air Force;
the UNITED STATES COAST GUARD;
ELAINE C. DUKE, in her official capacity as
Secretary of Homeland Security; the DEFENSE
HEALTH AGENCY; RAQUEL C. BONO, in
her official capacity as Director of the Defense
Health Agency; and the UNITED STATES OF
AMERICA,

Defendants.

Civil Action No. 17-cv-1597 (CKK)

FILED UNDER SEAL

**DECLARATION OF CHRISTOPHER R. LOONEY IN SUPPORT OF
PLAINTIFFS' APPLICATION FOR A PRELIMINARY INJUNCTION**

I, Christopher R. Looney, hereby declare:

1. All facts set forth herein are based on my personal knowledge, and if called upon to testify as to the contents of this Declaration, I could and would do so.

2. I am an attorney with the law firm of Wilmer Cutler Pickering Hale and Dorr,

counsel for Plaintiffs in the above-captioned matter.

3. I provide this Declaration in support of Plaintiffs' Application for a Preliminary Injunction.

4. Attached hereto as **Exhibit A** is a true and correct copy of the Declaration of [REDACTED] referred to in the Amended Complaint for Declaratory and Injunctive Relief ("Complaint") and the Application for Preliminary Injunction as Jane Doe 1.

5. Attached hereto as **Exhibit B** is a true and correct copy of the Declaration of [REDACTED] referred to in the Complaint and the Application for Preliminary Injunction as Jane Doe 2.

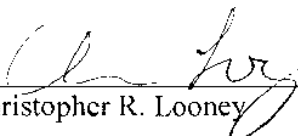
6. Attached hereto as **Exhibit C** is a true and correct copy of the Declaration of [REDACTED] referred to in the Complaint and the Application for Preliminary Injunction as Jane Doe 3.

7. Attached hereto as **Exhibit D** is a true and correct copy of the Declaration of [REDACTED], referred to in the Complaint and the Application for Preliminary Injunction as Jane Doe 4.

8. Attached hereto as **Exhibit E** is a true and correct copy of the Declaration of [REDACTED], referred to in the Complaint and the Application for Preliminary Injunction as John Doe 1.

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

Dated: August 31, 2017
Boston, Massachusetts


Christopher R. Looney

4. From the time I joined the National Guard, I served as a [REDACTED]. During this time, I only saw the people in my Guard unit once a month, so it was easy to tamp down my feelings and put on a masculine façade. I felt like I was able to express myself better when I was home.

5. I met my wife [REDACTED] at the civilian job I held while I was in the National Guard. We married in [REDACTED]. She soon became pregnant, and I made the decision to go on active duty with the U.S. Army so I could obtain health care benefits to support my growing family. Our first child was born in [REDACTED] and we had two more children in [REDACTED].

6. I continued working as a [REDACTED] once I had moved to active-duty status. My superiors recognized that I was very driven and dedicated to my job, and they recommended that I be promoted ahead of schedule.

7. During my time on active duty, I deployed overseas on multiple occasions. I served in South Korea from [REDACTED] and again from [REDACTED]. I also deployed to Kandahar in Afghanistan from [REDACTED].

8. Unlike in the National Guard, where I would only see my unit infrequently, I saw the other soldiers in my unit every day while I was on active duty. It became much harder to hide who I was. I tried to repress my identity as a woman, but the difficulty of this effort left me feeling angry and led me to drink alcohol more frequently than I should have.

9. Finally, [REDACTED] I couldn't repress my feelings any longer and told my wife that I was transgender. She told me that she thought that explained why I had seemed so angry. Once I told her, it was like a weight had been lifted—I felt more connected to my wife, and I stopped drinking.

10. I did not tell anyone else that I was transgender until late in 2015, when the Department of Defense issued an order saying that nobody would be discharged from the military for being transgender while the Department conducted its review of whether transgender people would be allowed to serve openly on a permanent basis. The day after that regulation was issued, I made a public post on Facebook saying that I was a transgender woman.

11. My company commander, who I had met when our units were attached in Afghanistan, was very supportive when she saw my Facebook post. Her support gave me hope that I would be able to serve openly as a transgender person.

12. Around the time I came out, I began seeing a therapist through the Army's Behavioral Health Services. Because transgender people still were technically not permitted to serve openly, my formal diagnosis at the time was for "adjustment disorder with anxiety." When I spoke with my therapist, however, we worked together on a plan for how I would move forward with my transition if and when the ban on transgender servicemembers was lifted.

13. In June 2016, when Secretary of Defense Ash Carter announced that transgender people could serve openly, my formal diagnosis was changed to gender dysphoria. My therapist then gave me a referral to my military health care provider so I could begin receiving medical care for my transition. I began receiving hormone therapy in [REDACTED]

14. On July 26, 2017, President Trump tweeted that transgender people would not be allowed to serve in the military "in any capacity." I was shocked to see the tweets, but I also had felt on some level that this was coming—a month before, the Department of Defense had delayed allowing transgender people to accede to the Armed Forces, and I felt like transgender people who were already serving would be next on the chopping block. Shortly after the tweets, I received numerous calls from other transgender people I knew in the military; we all worried

that even though the tweets had not yet been implemented as formal policy, we would be discharged from service. On August 25, 2017, when the President signed the order formally implementing his ban, it made things feel all the more real. Under the terms of the order, as of March 23, 2018, I will not longer be permitted to serve in the military and will be subject to discharge at any time. Now, although I still work hard to fulfill my duties on a day to day basis, I constantly worry about how I will take care of my family.

15. I had joined a new unit in [REDACTED] around the time of the President's tweets, as I had just returned from my second deployment to South Korea. Since I have joined the new unit, I have been on a detail that has me driving far from my base all day, every day. I am supposed to be in charge of four or five other soldiers, but I have yet to meet them. Other soldiers in my unit have asked me who I pissed off such that I was given this detail so constantly, as the detail used to rotate between numerous different people before I arrived. I believe I am being kept separated from the rest of my unit because I am transgender and because of the President's ban, as I never had any problems with this kind of treatment in my old unit and do not know of any other reason why I would be treated this way.

16. I had been hoping to serve for twenty years in the military, as twenty years of service would entitle me to retirement benefits from the military, including a pension and access to health care services for my family on base. I have built my retirement income plans around having access to these benefits. Between my National Guard and active-duty service in the Army, I have accrued 12 to 13 years of time towards these benefits. The new policy will result in my being separated from military service before I can serve a full twenty years, meaning that I will not receive the retirement benefits I have planned my future around.

17. I am also distressed about having my discharge from the military labeled as a medical discharge or a mental health discharge, as the pre-June 2016 policy required. The kind of discharge one receives when leaving the military can have a major effect on getting civilian employment, and I am concerned that being discharged for being transgender would make it difficult for me to provide for my wife and three children.

18. My wife and children receive their health insurance through TRICARE, which provides health insurance to servicemembers and their families. My wife and oldest daughter both are on medication that is provided through TRICARE, and I worry that when I am separated from the Army because I am transgender, my family will lose access to the insurance that allows them to continue receiving the medication they need. In addition, I will lose access to the doctors who have been providing me with the medication I take for my transition.

19. The directive barring transgender people from serving in the military has left me feeling excluded, and it hurts that people like me are being singled out and told that we aren't good enough to serve our country based on a characteristic that has no relevance at all to our abilities or fitness to serve. I love this country and have served it faithfully and well. To be told that I am no longer worthy to serve is a terrible blow. It affects how I see myself, and I know that it casts me in a negative light that will affect every aspect of my life, including my prospects for future civilian employment.

20. The fact that I am transgender in no way stops me from being able to do my job successfully, and I am not aware of any problems, major or minor, that inclusion of transgender people has caused since the Department of Defense began allowing us to serve openly last summer. All I want is to be allowed to serve my country and to be evaluated based on my job performance rather than on my status as a transgender person.

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

DATED: August 29, 2017



IN THE UNITED STATES DISTRICT COURT FOR
THE DISTRICT OF COLUMBIA

_____)
DOE, et al.,)
)
 Plaintiffs,)
)
v.) Civil Action No. 17-cv-1597 (CKK)
)
DONALD TRUMP, et al.,)
)
 Defendants.)
_____)

DECLARATION OF [REDACTED]
IN SUPPORT OF PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION

I, [REDACTED] declare as follows:

1. I grew up as [REDACTED] in Southern California. By the time I was eight, I realized that I was "different" somehow. I consistently preferred things that were feminine. I was uncomfortable in male clothing and asked to wear dresses instead of suits at major family events. By age twelve, I began to understand that the experiences I was having and the emotions I was feeling were because I was transgender. I did not tell people. I felt that I would have to deal with it on my own.

2. I graduated from high school in [REDACTED]. Before graduating, I enlisted in the Army at a Military Entrance Processing Station. I did this partly in hopes of making more of a man of myself. As detailed below, that strategy did not work.

3. After I joined the Army, I spent two months in the Delayed Entry Program. I shipped out to basic training in [REDACTED]. Before I left, I heard about an upcoming change in the Department of Defense policy relating to the service of transgender people. Hearing about

this gave me some hope that the Army might come to accept me as transgender and that I might be able to come out while a soldier.

4. I completed basic training and was stationed at [REDACTED] I was there for two months before being deployed to Afghanistan in [REDACTED] as part of the [REDACTED] This deployment lasted six months.

5. After my deployment, I returned to [REDACTED] where I have been stationed ever since. I am currently a [REDACTED] I achieved this rank ahead of schedule because I have demonstrated skill and leadership qualities in the field.

6. I am scheduled to deploy again in [REDACTED] this time to Iraq. I will be going as a team leader, with soldiers reporting to me.

7. After I had been in the Army for several months, I learned from a friend who is also transgender that I could talk about my feelings about my gender with the Army's Behavioral Health service on a confidential basis. Based on this friend's recommendations, I went to the Behavioral Health Services in [REDACTED] and told them that I was transgender. This was a relief, because I felt that I could not continue to present as male. I was referred to a therapist with experience working with transgender people. The therapist diagnosed me with gender dysphoria.

8. After June 2016, I was aware that military policy permitted me to serve openly as a transgender person. However, I did not immediately tell anyone other than my friend and the people at Behavioral Health that I was transgender.

9. I have continued to see the therapist and to work toward developing a transition and treatment plan with the therapist and a physician's assistant (PA). In [REDACTED], the write-up of the plan had been completed, had been submitted to Medical Command, and had been approved by the Major who supervises the PA's work. I have not yet begun any of the treatment steps, which include surgery. I am still listed as male in DEERS and must comply with male grooming standards.

10. Before President Trump's tweets, I had not come out to anyone in my chain of command. After the tweets, I decided to have a conversation with my Company Commander during his "open door" office hours. That meeting was the hardest thing I have ever done in my life, but I felt that my chain of command would support me based on the policy announced in June 2016. The Commander expressed surprise and shock. I explained that I had come to talk with him in part because I was worried that I would not be permitted to deploy with my unit because of the president's tweets, and I am committed to being deployed.

11. The Commander was not supportive. He suggested that perhaps I would be separated under honorable conditions. I was discouraged that he did not provide me with any reassurance. I also came out to my squad leader, who then informed my platoon sergeant, and to a friend in my unit. All three have been supportive after my disclosure.

12. Since coming out to my chain of command, I have continued to prepare for deployment. I understand that I cannot begin treatment until after I return from the deployment. While it will be hard to wait, I will not put my personal needs ahead of the needs of the mission and my fellow soldiers.

13. My unit command structure (Battalion Commander and Brigade Commander) must approve my transition plan. During the week of [REDACTED] I began the process of

submitting the plan for approval. I spoke again with my Company Commander to advise him that I was submitting the plan and as a courtesy before I sent it to the Battalion Commander. He asked why I was transmitting it to him, and he expressed skepticism that it would be approved. He also suggested that I submit it when I return from deployment instead of now. Although I have said that I am willing to wait to begin treatment, he expressed the view that submitting the plan might make me non-deployable, because the plan says that treatment is “medically necessary.” I explained that I was submitting it now so that I could begin treatment promptly upon my return from deployment.

14. The plan has now been submitted to all appropriate people in my chain of command.

15. I have not told anyone else at my rank or below that I am transgender. Thus, I was able to hear an unfiltered reaction to the President’s announcement right after he tweeted it. Some made ugly remarks about transgender servicemembers, while others remarked people who kill transgender people should not be punished. After the tweets, people seemed emboldened to express hostility to transgender people.

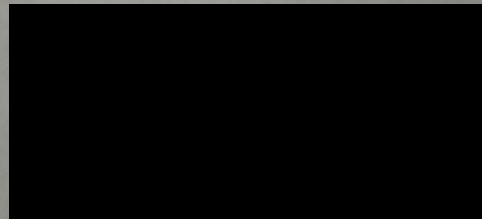
16. On August 16, I learned that transition-related treatment had been halted for many of my transgender colleagues. I was and remain very troubled by this development. I am also aware that on August 25, the President issued a memorandum that formally changes military policy to exclude transgender people from openly serving. In addition to reversing the policy permitting transgender people to serve openly – and so making me subject to separation – he also directed that surgical care for gender transition be halted. My current contract is up in [REDACTED] [REDACTED] I intended to renew, but if the ban is permitted to go into effect, I will not be able to do so.

It also seems that my transition plan will not be approved because of the President's announcements, because it would require surgical care.

17. Many transgender soldiers, sailors, marines, and airmen are being hurt by these new developments. But I believe in myself and other transgender members of the service, so I want to step up and work to enforce our rights. Every trans service member is family to me, and we will work together to overcome the injustice and unfairness of what the President is trying to do to us. I am still getting my boots on every morning and doing my job to the fullest.

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

DATED: August 28, 2017



MATERIAL UNDER SEAL DELETED
**IN THE UNITED STATES DISTRICT COURT FOR
THE DISTRICT OF COLUMBIA**

DOE, et al.,
Plaintiffs,
v.
DONALD TRUMP, et al.,
Defendants.

Civil Action No. 17-cv-1597 (CKK)

**DECLARATION OF [REDACTED]
IN SUPPORT OF PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION**

I, [REDACTED], declare as follows:

1. I am a [REDACTED] in the [REDACTED] Army National Guard, stationed at Guard headquarters in [REDACTED]. I am also a civilian employee of the Department of Defense, working as a [REDACTED]. I am [REDACTED] years old and have been serving in the United States military since [REDACTED].

2. I am a transgender woman, but I did not truly come to understand and accept that until [REDACTED]. My family and my husband, to whom I have been married since [REDACTED] have been supportive.

3. I was born in [REDACTED]. When I was young, my parents separated and my mother worked and took care of me on her own. My mother later met and fell in love with a man in the United States. She emigrated to the United States and I joined her a short time later, finishing high school in a very small town in [REDACTED]. After a period of adjustment, I grew

to love my adopted country. There is so much opportunity in the United States, and this country enables people to reach and attain goals that would not be possible in other countries.

4. After high school, I felt that I had an obligation to give back to this country. I saw a documentary on basic training in the Army and decided that I wanted to join the military. In [REDACTED], I visited an Army recruitment office and told the recruiter that I wanted to serve my country, because it had done so much for me and my mother. I also hoped that the Army could help me improve myself, develop skills, and build a career.

5. I attended Basic Training at [REDACTED]. After Basic Training, I was assigned to serve as a [REDACTED]. After receiving further specialty training, I was assigned to serve overseas in South Korea. I had served in Korea for about a year when the 9/11 terrorist attacks happened. I was then called back to the United States and stationed as a [REDACTED]. I served at [REDACTED] for about three years.

6. In [REDACTED] I began a tour at [REDACTED] in Baghdad, Iraq. As a [REDACTED] [REDACTED] at [REDACTED] I helped my fellow soldiers who were looking for spiritual guidance in an incredibly difficult and dangerous environment. I finished my tour in Iraq in [REDACTED] and returned to be stationed again at [REDACTED].

7. While I was back at [REDACTED], my enlistment contract period was coming to an end. I decided to not to continue on active duty, but rather to reenlist in the [REDACTED] Army National Guard.

8. My commander in the Guard suggested that I should have another military specialty, so I received training in [REDACTED].

9. After some time in the Guard, my commander asked if I wanted to join the Active Guard Reserve (“AGR”). AGR soldiers serve on active duty full time in units of the Army Reserve, or in units or organizations that directly support the Army Reserve. I agreed to join AGR, where I served for five years. I resigned from the AGR to continue my schooling.

10. Since resigning from the AGR, I have maintained my status in the [REDACTED] Army National Guard. I have also been employed by the Department of Defense (“DoD”) as a civilian [REDACTED]. As a [REDACTED] [REDACTED] for DoD, I focus mostly on [REDACTED]

Although I am in a civilian position with the DoD, I wear my military uniform while at work.

11. In [REDACTED], while serving in the [REDACTED] Army National Guard and working as a civilian specialist for DoD, I came to fully understand and accept that I am transgender. I was taking a course on diversity in the classroom, which included a discussion on how teachers can foster inclusive environments to benefit LGBTQ students. Through my studies and class discussions, I began to better understand the feelings I had been experiencing my whole life. On the one hand, I had a great sense of freedom that came from finally understanding and accepting who I am. But on the other hand, I feared that if I disclosed my gender identity at work I would be discharged from the Guard. I would also lose my job at DoD as a result, because DoD requires that, in order to serve in my position as a civilian DoD specialist, I must remain in the Guard.

12. Ultimately, this contradiction between my personal and professional lives was becoming very stressful. I began to have difficulty focusing on my work and felt ashamed that the military that I loved would stop respecting my service if I came out. Because this stress was

becoming difficult to bear, I had started to plan to talk to my commander about being transgender when, in June 2016, Secretary of Defense Ashton Carter announced that the military was lifting its ban on transgender people serving openly. Secretary Carter's announcement was a huge relief. Finally, I could be true to myself and still serve the country that I love.

13. Shortly after the announcement was made, I planned to come out as transgender to my unit Commanding Officer, a Major, but wanted to talk to the senior Non-Commissioned Officer ("NCO") in my unit first. My senior NCO said that she supported me "100%," and offered to go with me when I spoke to our Commanding Officer. When I came out as transgender to the Major, he acknowledged that he was not very knowledgeable about the experiences of transgender people, but told me that he and the rest of our unit would support and work with me through the process as DoD finalized the policy. I was not expecting that level of commitment and support from our Commanding Officer, and I was very grateful for it. I also was relieved to find that my fellow soldiers and DoD employees were learning more about transgender people and were accepting and supportive.

14. The change in policy allowing transgender soldiers to serve openly has changed my life in the military. My fellow soldiers in my unit and my senior leaders have told me that they have noticed how much happier I am. It has been incredibly empowering to be true to who I am at work while serving my country, and to have my team members be so encouraging and supportive.

15. Then in July 2017, President Trump announced that transgender service members would no longer be allowed to serve in the military "in any capacity." This was devastating to me. The President's announcement made me feel ashamed, and I was deeply saddened that he was ordering the Army, which I had been a part of for so long and which I loved so much, to

stop treating me with respect. After the President's announcement, my fellow soldiers in my unit remained very supportive of me. They do not see me as a transgender soldier. They see me as [REDACTED]. But every day that goes by, I worry that will change. The uncertainty that the President's announcement caused over the past several weeks has been distressing. I went to work each day wondering whether I would be discharged, not because of any problem with my job performance or my commitment to serving this country, but solely because of my gender identity.

16. On or about [REDACTED] I applied to reenlist in the [REDACTED] Army National Guard for two additional years. If I complete two years of additional service, I will have a total of twenty years of military service. This milestone is important to me, not only because of the accompanying retirement benefits that service members receive after twenty years, but also because my two decades of service will serve as a powerful demonstration of my commitment to and love for this country.

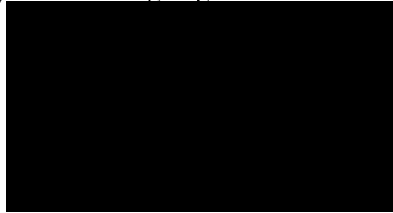
17. In prior years, all of my applications to reenlist have been approved within approximately one week. But for reasons that have not been explained to me, I have yet to receive approval of my reenlistment application. In none of the previous times that I have applied to reenlist have I encountered a similar level of delay and difficulty. In light of this and the highly public nature of the President's announcement, I can only conclude that my current application is being held up in response to the President's reversal of the DoD policy to allow transgender service members to serve openly, and that ultimately my application to reenlist will be denied solely because I am transgender.

18. I am also aware that on August 25, the President issued a memorandum that formally reverses the policy permitting transgender people to serve openly, and also halts

surgical care for gender transition. In addition to depriving me of my job, my livelihood, and my eligibility for important retirement benefits, this would be a devastating rebuke in the face of my many years of commitment to serving and defending this nation.

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

DATED: August 28, 2017



MATERIAL UNDER SEAL DELETED

IN THE UNITED STATES DISTRICT COURT FOR
THE DISTRICT OF COLUMBIA

_____)	
DOE, et al.,)	
))	
<i>Plaintiffs,</i>)	
))	
v.)	Civil Action No. 17-cv-1597 (CKK)
))	
DONALD TRUMP, et al.,)	
))	
<i>Defendants.</i>)	
_____)	

DECLARATION OF [REDACTED]
IN SUPPORT OF PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION

I, [REDACTED] declare as follows:

1. I am a [REDACTED] in the United States Army [REDACTED]
[REDACTED] [REDACTED] I have served in the Army since
2014. I make this declaration based on my own personal knowledge.

2. I am transgender. From an early age, although I did not understand what it meant to be transgender, I identified as male, going by male names as a child and through high school instead of my birth name. However, when I was a child, I did not have a name for this mismatch between my body and my identity.

3. My family has a proud history of serving in the Armed Forces. My great grandfather served in Europe in World War II. My father served in the United States Air Force, and was deployed to Honduras shortly after I was born at [REDACTED]
[REDACTED] My father was awarded the Bronze Star for valor in connection with his service in Honduras. My aunt served in the [REDACTED], and my uncle was a United States

Marine who was wounded and paralyzed by an improvised explosive device during Operation Desert Storm. Beginning as a child and throughout my early life and adolescence, I idolized those who serve their country in the military. I saw it as a uniquely honorable profession.

4. In [REDACTED] I entered the [REDACTED] on a full academic scholarship. It was during college that I decided to join the military. In addition to my family's military history, my best friend in college was in the service. Talking with him about his experiences as an officer, deploying to the Middle East, and the esprit de corps of the military confirmed my resolve to join.

5. In [REDACTED], I graduated *magna cum laude* from the [REDACTED] with a Bachelor of Arts Degree in [REDACTED]. I then entered the Army Reserve Officers' Training Corps (ROTC) program at [REDACTED] to pursue a Master's Degree in [REDACTED]. While typically cadets entering ROTC during graduate school must complete a mandatory training camp, I was waived into my ROTC contract because of my prior strong academic performance.

6. My fellow cadets in ROTC knew that I was transgender and were supportive. I was ranked third in my class of ROTC cadets, most of whom had previously been in a four-year undergraduate program, and perhaps as a result, my superiors were also generally supportive. For example, I was a member of the Color Guard for my ROTC unit, which required that I often wear a dress uniform. While regulations required that I wear a female dress uniform – my gender marker at that time was female – I was issued and allowed to wear a male dress uniform.

7. While serving in the Army ROTC program, I joined the [REDACTED] National Guard, [REDACTED] through the Simultaneous Membership Program. The Simultaneous Membership Program allows ROTC cadets to serve and drill with

the Guard. The first National Guard drill that I attended was in [REDACTED]
[REDACTED]

8. The National Guard paid me as an enlisted service member (E5), but during my time in the Guard, I functioned in effect as the Executive Officer (“XO”) for my unit. As XO, I worked directly under the Commanding Officer, managing maintenance, training, and helping with personnel matters such as writing promotions and organizing ceremonies.

9. During graduate school at [REDACTED], I met my future wife, [REDACTED] the love of my life and a constant source of support. We married in [REDACTED] and have a two-year-old son, [REDACTED].

10. On April 4, 2016, while in graduate school and the ROTC program, I changed my legal name to [REDACTED] and submitted paperwork to the ROTC/Cadet Command and National Guard to reflect the change. Shortly thereafter, my ROTC professor of military science and I discussed the fact that the Department of Defense was considering amending its policy banning transgender individuals from openly serving in the military, but that no such change had been made yet. My Senior Military Instructor told me that I needed to “play by the rules” while I completed the ROTC program. From that point forward, I was no longer allowed to wear a male dress uniform while in ROTC.

11. Prior to commissioning, I participated in the Cadet Leadership Course (“CLC”) at [REDACTED]. While at CLC, I suffered a shoulder injury and struggled during the field training exercise. But although I was hurt, I toughed it out and finished.

12. In [REDACTED] I obtained a Master’s Degree in [REDACTED] [REDACTED] and was commissioned as a [REDACTED] in the Army on [REDACTED] I was also designated as a Distinguished Military Graduate for being ranked on the Order of Merit List

in the top 20% of Army ROTC cadets across the nation. Because the Army was not ready to assign me to my future post at the time, I was commissioned into the Individual Ready Reserve (“IRR”).

13. In June 2016, Secretary of Defense Ashton Carter announced that transgender people would be able to serve openly in the U.S. Armed Forces. While I had received support from my commanders and fellow officer peers prior to the change in policy, the change signaled to me in official terms that the Army valued who I was and valued the contributions I could make in performing my duties and responsibilities. It signaled the respect I had from the Army and helped confirm that serving in the Army was my life’s true calling.

14. On [REDACTED] I began training at the [REDACTED] Basic Officer Leadership Course (BOLC) at [REDACTED]. At BOLC, I came out as transgender to my platoon instructors, who were very supportive, and also to my peers. At the time, my gender marker in the Defense Enrollment Eligibility Reporting System (DEERS) was “female.” I was therefore technically supposed to adhere to female standards concerning dress, grooming, housing, and use of facilities. But my superiors and fellow officers at BOLC recognized that I was male, regardless of my designation in DEERS, and treated me as such.

15. For example, while in the field I was supposed to sleep in the female tent, but my teammates strung up ponchos to make a barrier to respect my privacy and to make sure that I was comfortable. My superiors at BOLC also devised a system to allow for a block of time in the field for me to shower on my own. And during the BOLC graduation ceremony, my superiors allowed me to wear my Operational Camouflage Pattern daily uniform, as opposed to a female dress uniform. I was ranked “superior” in every category at BOLC. Throughout my time at BOLC, I benefited from the tremendous camaraderie, team spirit, and mutual respect that is

expressed among the Army officer ranks. My experiences in the Army up until the recent reversal of policy have made me feel honored to serve, defend, and be willing to die for my country.

16. Following BOLC, I was stationed at my current post as a [REDACTED]

[REDACTED] [REDACTED] [REDACTED]
[REDACTED] I am the XO for my unit, performing administrative tasks on behalf of and reporting directly to our unit Commanding Officer. As XO, I serve as both the maintenance and supply officer for my unit. I manage our fleet of vehicles to ensure operational status and readiness. I also assist in managing in excess of \$50 million worth of [REDACTED]. And I fulfill a critical additional duty in my unit of Unit Movement Officer, which means I am in charge of preparing my unit for deployment into theater. Until recent events, I was preparing for deployment in mid-2018, and was excited about the opportunity to deploy with my unit.

17. At my first meeting with my Commanding Officer at [REDACTED], I came out to her as transgender. I stressed to my Commanding Officer that my first priority was being a soldier, and that in crafting an approved plan for medical treatment under the new policy, it was extremely important to me to make sure that my plan would not interfere with my duties. I would not allow any medical procedures or appointments to prevent me from participating with my unit in field exercises or deployments or to affect unit readiness. Both my Company and Battalion Commanders at [REDACTED] have been very supportive beyond my greatest expectations. To me, they have set the standard for leadership.

18. On [REDACTED] my medical treatment plan was authorized and approved by the [REDACTED]. As part of my approved treatment plan, I scheduled a surgery consult at [REDACTED]

just outside [REDACTED] My planned surgery was encouraged and fully supported by my command team at every level up to and including my Brigade Commander.

19. During [REDACTED], I took steps to revise my legal documentation to reflect my gender. In [REDACTED], I acquired an updated driver's license with a male gender marker. In [REDACTED] I obtained a new passport on which I was identified as male. On [REDACTED] I submitted a request to change my gender marker in DEERS to male. My request for a gender marker change in DEERS was approved and took effect on [REDACTED] As a result, I am now treated the same as other male service members in all respects, including the standards for uniform, grooming, physical fitness, and any other requirements that differ by gender.

20. During the summer of 2017, my military medical care provider notified me that Secretary of Defense James Mattis was collecting information about the experience of transgender service members regarding medical appointment frequency, days on non-deployable profiles, and impact on unit cohesion and command. I submitted information in response to the Secretary's request on [REDACTED] In addition to describing my experiences, I submitted the following Personal Statement:

I serve the people of the United States, and live the Army values. It is my personal belief that selfless service is the foundation of LDRSHIP and I strive to embody that trait every day. I did not join the military out of a selfish desire for the benefits it would bring, medical or otherwise. I volunteered because I was instilled with a profound sense of patriotism as a child and raised on the belief that military service is one of the most esteemed honors an individual can fulfill in their lifetime. If my commitment to selfless service requires me to pay out of pocket for any transition related care, I will do so without hesitation. If my commitment requires me to cease all transition related treatment, I will do so if necessary. All that I ask is that I be allowed to fulfill my oath to serve this country like my father before me, and as my brothers and sisters in arms that are currently serving.

“LDRSHIP” is an acronym that summarizes the Army’s core values of loyalty, duty, respect, selfless service, honor, integrity, and personal courage.

21. In response to my submission, Colonel Mary V. Krueger, Assistant Deputy Health Affairs at the Pentagon, wrote to me to say, “Thank you very much for sharing your story. Your narrative reflects a commitment to excellence and duty. This perspective is very helpful in giving Senior Leaders a picture of transition from the front lines.”

22. The day after I made this submission to the Secretary of Defense—July 26, 2017—the President tweeted that transgender service members would no longer be allowed to serve in the military “in any capacity.”

23. The day of that announcement was extremely distressing. Earlier that day, I had undergone Lasik eye surgery for which I had been administered tranquilizing pain medications. When I emerged from surgery groggy and with limited eyesight, my phone was all but exploding with the volume of text and emails I was receiving from family, friends, and former BOLC classmates about the tweets. Despite the medications I had received, the situation was so distressing that I could not sleep. I paced around my house worrying that I was going to lose my job and my home, and wondering how on earth I was going to take care of my family and protect them from fallout of the President’s announcement. Since that day, I continue to worry about my standing in the Army.

24. On [REDACTED] as my scheduled surgery consult approached, my military medical care provider told me that all gender transition related surgeries had been suspended. In her message, my provider added, “[t]his is incredibly frustrating and pretty terrible in my opinion and I am really sorry to have to give you this news today[.]” I understand that on the same day

as my doctor's message to me, [REDACTED] others also had medical procedures cancelled or put "on hold."

25. On August 25, the President issued a memorandum reversing the current policy that allows me to serve openly and stated that as of March 23, 2018, the policy permitting openly transgender people to serve in the military will no longer be in effect, and the old policy prohibiting such service will be reinstated.

26. I am devastated by the President's cancellation of the policy I had relied upon to notify command of the fact that I am transgender and to take steps forward in treatment for gender transition. I grew up idolizing the military and wanting to serve my country. Before the President's announcement of July 26, my experiences while serving in the military were overwhelmingly positive. Each morning when I put on the uniform, I was fully invested, filled with pride and excitement about my job and the chance to serve alongside my brothers and sisters in the Army I love.

27. But the President's announcements that transgender people will face separation from service, and the steps toward cutting off medical care for transgender soldiers, have caused me distress and will have a devastating impact on my future. It has made every day difficult. I have planned for a future in the Army. If I am separated, as the new policy requires, I face serious negative financial consequences, uncertainty about my future career path, and the likely inability to provide for the health and welfare of my family. I carry a strong desire in my heart to serve my country, and despite the recent change in policy, still want to be part of the Army and to lead soldiers.

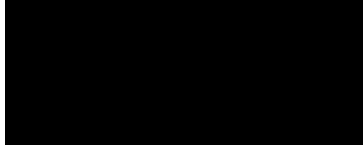
28. The situation is also distressing for my wife. She and my son [REDACTED] receive health insurance through TRICARE, the program that provides health care coverage for uniformed

service members and their families. [REDACTED] has a history of respiratory and ear infection problems. He has had surgery on his ears and adenoids and has a follow up with an Ear Nose and Throat Specialist next month because he is still having significant problems. Loss of military health care coverage will be devastating to our family.

29. [REDACTED] also attends the base daycare, and it is heartbreaking to think that he might have to leave his school because his father is no longer wanted in the Army.

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

DATED: August 28, 2017



**IN THE UNITED STATES DISTRICT COURT FOR
THE DISTRICT OF COLUMBIA**

_____)	
DOE, et al.,)	
)	
<i>Plaintiffs,</i>)	
)	
v.)	Civil Action No. 17-cv-1597 (CKK)
)	
DONALD TRUMP, et al.,)	
)	
<i>Defendants.</i>)	
_____)	

DECLARATION OF BRAD R. CARSON

I, Brad Rogers 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 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.

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

DATED: August 28, 2017


/s/ Brad R. Carson

IN THE UNITED STATES DISTRICT COURT FOR
THE DISTRICT OF COLUMBIA

_____)	
DOE, et al.,)	
)	
<i>Plaintiffs,</i>)	
)	
v.)	Civil Action No. 17-cv-1597 (CKK)
)	
DONALD TRUMP, et al.,)	
)	
<i>Defendants.</i>)	
_____)	

**DECLARATION OF DEBORAH LEE JAMES
IN SUPPORT OF PLAINTIFFS’ MOTION FOR PRELIMINARY INJUNCTION**

I, Deborah Lee James, declare as follows:

Background and Experience

1. I served as the Secretary of the United States Air Force (“USAF”) from December 20, 2013 to January 20, 2017.
2. I hold a Bachelor’s Degree in Comparative Area Studies from Duke University (1979), and a Master’s Degree in International Affairs from Columbia University (1981). From 1983 until 1993, I worked as a professional staff member for the Armed Services Committee of the United States House of Representatives, including as a senior advisor to the Subcommittee for Military Personnel and Compensation. From 1993 to 1998, I served as Assistant Secretary of Defense for Reserve Affairs, responsible for advising the Secretary of Defense on all matters pertaining to roughly 1.8 million National Guard and Reserve personnel. I then held a variety of senior positions at Science Applications International Corporation (SAIC), including as President of the Technical and Engineering Sector overseeing more than 8,000 employees.

3. As Secretary of the USAF, I functioned as the chief executive of the Department of the Air Force, with the authority to conduct all of its affairs, subject to the authority, direction, and control of the Secretary of Defense. As Secretary, I had comprehensive oversight responsibility for (i) the Department of the Air Force's annual budget, (ii) overseeing the organization, training, supplying, equipping and mobilization of USAF personnel, and (iii) overseeing the construction and maintenance of military equipment, buildings, and structures. In connection with my personnel-related oversight responsibilities, I administered the development and implementation of recruitment, retention, and medical policies for active duty and reserve USAF personnel. Among the people who directly reported to me was the Chief of Staff of the USAF, the most senior uniformed USAF officer.

The Air Force

4. The USAF is the aerial warfare service branch of the United States Armed Forces. It is one of the three military departments of the Department of Defense ("DoD"). The USAF, with an annual budget of more than \$139 billion, operates thousands of military and surveillance aircraft and controls hundreds of intercontinental ballistic missiles and military satellites. It employs over 600,000 Airmen and civilian employees. The USAF, including the Air Force Reserve and Air National Guard, operates over 300 flying squadrons, consisting of 8 to 24 aircraft each, worldwide. Air Force bases are located across the United States and span the globe.

5. The USAF has several core missions. First, it ensures American superiority in air and space across the globe. This superiority protects all of our other armed services from air attack during their operations. Second, the USAF is responsible for intelligence, surveillance, and reconnaissance, a function that is also essential to the integrated operation of the Armed

Forces. Third, it is also a core mission to enable rapid global mobility. The USAF projects American power rapidly across the face of the earth and enables swift deployment as well as the ability to sustain operations by delivering essential equipment, supplies, and personnel. Fourth, the USAF has its global strike capabilities as an essential mission. The ability to strike globally underlies our deterrence; the USAF's combat capabilities allow it to threaten, disable, or destroy any target around the globe. Lastly, the USAF is also charged with command and control. It provides access to reliable communications and information networks so that the military services as a whole can operate jointly in a coordinated fashion globally and at a high level of intensity.

6. The USAF is one of the most technologically sophisticated organizations on the planet, dwarfing the technological capabilities of individual companies in the private sector. Our aircraft, spacecraft, weapons, and surveillance equipment contain the most advanced new technologies devised by human ingenuity. Many USAF personnel train for years to function effectively in the USAF. Recruitment and retention of capable and qualified Airmen is of critical importance to the readiness of the USAF.

Change and Development of DoD Policy

7. By 2014, it had become clear that the United States Armed Service, including the USAF, had valued members who were transgender with specialized skills. Starting in 2014, the DoD took steps to consider military policy concerning the open service of transgender service members against the backdrop of the military's critical need for qualified personnel.

8. In August 2014, the Department of Defense issued a new regulation, DODI 1332.18, *Disability Evaluation System (DES)*. The regulation eliminated a department-wide list of conditions that would disqualify persons from retention in military service, including the

categorical ban on open service by transgender persons. This new regulation instructed each branch of the Armed Forces to reassess whether disqualification based on these conditions, including the ban on service by transgender persons, was justified. As of August 2014, there was no longer a department-wide position on whether transgender persons should be disqualified for retention.

9. On July 28, 2015, Secretary of Defense Ashton Carter ordered Brad Carson, Acting Undersecretary of Defense for Personnel and Readiness, to convene a working group to identify the practical issues related to transgender Americans serving openly in the Armed Forces, and to develop an implementation plan that addressed those issues with the goal of maximizing military readiness (the “Working Group”).

10. As Secretary of the Air Force, I was responsible for supervising the Department of the Air Force’s participation in the Working Group. The Working Group met both as a whole and in smaller groups tasked with investigating and analyzing specific issues. I met regularly with members of the Working Group to discuss their progress and the Air Force’s positions on the issues discussed.

11. The Working Group engaged in a comprehensive examination of the issues presented by permitting transgender people to serve openly. The goal was to be as comprehensive as possible, considering all available scholarly literature and evidence, and to thoroughly investigate any possible issues or concerns about how permitting open service might affect any aspect of military efficiency or readiness.

12. The Working Group included military and civilian personnel, readiness and medical experts from each of the services along with medical experts from the Defense Health Agency. It solicited information from both senior military personnel who supervised transgender

service members and transgender people on active duty. It also examined the experiences of civilian employers and of foreign militaries who permit transgender people to serve openly.

13. The Working Group also considered a report from the RAND Corporation, a federally funded research center that regularly provides research and analysis to the Armed Forces. The RAND Corporation was asked by the Under Secretary of Defense for Personnel and Readiness 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 implications of allowing transgender members to serve openly; and (3) review the experiences of foreign militaries that permit transgender service members to serve openly.” A true and accurate copy of the report, entitled *Assessing the Implications of Allowing Transgender Personnel to Serve Openly* (“RAND Report”), is attached as Exhibit A.

14. The RAND Report concluded that the cost of caring for the medical needs of transgender personnel would amount to “an exceedingly small proportion of ... overall DoD health care expenditures.” It found that the Military Health Service (MHS) has the capacity to provide this care, and that doing so would improve the capacity of the MHS by helping MHS surgeons “maintain a vitally important skill required of military surgeons to effectively treat combat injuries.” (8.) Considering a variety of utilization data, including data from the Veterans Health Administration, the RAND Report concluded that only a very small number of service members will access some type of gender transition-related treatment annually. (30.) The RAND Report found that the costs of providing health care for transgender service members would likewise be very small, amounting to an insignificant percentage of the overall DoD healthcare budget: “[E]ven in the most extreme scenario we were able to identify using the

private health insurance data, we expect only a 0.13-percent (\$8.4 million out of \$6.2 billion) increase in AC health care spending.” (36.)

15. The RAND Report concluded that permitting transgender people to serve openly would have no significant impact on military readiness or efficiency. The RAND Report examined the deployability of transgender persons before transition, during transition, and post-transition. It concluded that even assuming the highest estimates of utilization rates, the impact of permitting transgender soldiers to serve openly and to obtain appropriate health care would be minimal, amounting to “0.0015 percent of available deployable labor-years across the AC and SR.” (42.)

16. The RAND Report also found no evidence that permitting transgender soldiers to serve openly would have any significant negative impact on unit cohesion. Rather, the available evidence, including the experience of permitting service by openly gay personnel, suggests the opposite. In particular, the available evidence indicates that “direct interactions with transgender individuals significantly reduce negative perceptions and increase acceptance.” (44.)

17. The RAND Report found that available research on foreign militaries showed no evidence that “allowing transgender people to serve openly has had any negative effects on operational effectiveness, cohesion, or readiness.” (45.) The Working Group also met directly with representatives from some of these foreign militaries, who confirmed that permitting open service had no significant deleterious effects.

18. The Working Group compared the potential loss of deployability associated with transition-related health care with the loss of deployability associated with other, much more common medical conditions. The Working Group considered impacts to readiness and advice from experts indicating that the circumstance should not be treated differently.

19. The Working Group also considered that both private and public employers increasingly are providing coverage for transition-related health care, including the health insurance coverage available to civilian federal employees.

20. The Working Group also considered that banning transgender service members results in the loss of otherwise qualified personnel, which may leave critical positions unexpectedly vacant, as well as the financial loss involved in having to replace trained and, in some instances, highly skilled personnel.

21. The Working Group also considered that barring service by transgender people reduces the pool of potential qualified recruits and irrationally excludes individuals based on a characteristic that has no relevance to their ability to serve.

22. Based on its comprehensive and careful review, the Working Group agreed that transgender people should be permitted both to enlist and to serve openly in the United States military.

23. With regard to accession, the Working Group agreed that transgender persons should be subject to the same medical standards applied to persons with other medical conditions. Those standards are designed to ensure that those entering service are free of medical conditions or physical defects that may require excessive time lost from duty. The Working Group therefore agreed that applicants with a history of gender dysphoria or of treatment for gender dysphoria be permitted to enlist only if they have completed all medical treatment associated with gender transition and been stable in the preferred gender for a specified period of time.

24. The Working Group agreed upon a variety of other changes to related military policy, based on the same principle of securing equal treatment of transgender persons under existing standards.

25. On June 30, 2016, Secretary of Defense Ashton Carter issued Directive-type Memorandum (DTM) 16-005, entitled “Military Service of Transgender Service Members” (“DTM 16-005”), a true and accurate copy of which is attached as Exhibit B.

26. The purpose of DTM 16-005 was to “[e]stablish[] policy, assign[] responsibilities, and prescribe [] procedures for the standards for retention, accession, separation, in-service transition, and medical coverage for transgender personnel serving in the Military Services.” DTM 16-005 was applicable to all Military Departments, including the USAF, as well as all organizational entities within the DoD, including the Joint Chiefs of Staff.

Change, Development, and Implementation of USAF Policy

27. To implement DTM 16-005 as applied to the Air Force, on October 6, 2016, I issued an Air Force Policy Memorandum entitled “*Air Force Policy Memorandum for In-Service Transition for Airmen Identifying as Transgender*” (the “AFPM”) jointly with the U.S. Air Force Chief of Staff, General David Goldfein. General Goldfein is a fighter pilot who has served in the Air Force for over 30 years (including multiple combat deployments). A true and accurate copy of the AFPM is attached hereto as Exhibit C.

28. The policy and guidance in the AFPM, which was effective immediately for all USAF personnel, “provides unit personnel, supervisors, commanders, transgender Airmen and the medical community a construct by which transgender Airmen may transition gender while serving,” and “outlines policies for accessing, separating, and retaining transgender Airmen.” Further, the policies and procedures reflected in the AFPM “are premised on the conclusion that

open service by transgender Airmen who are subject to the same standards and procedures as other members of the same gender with regard to their medical fitness for duty, physical fitness, dress and appearance standards, deployability, and retention, is consistent with military service and readiness.” The AFPM thus provides that “no otherwise qualified Airman may be involuntarily separated, discharged or denied reenlistment or continuation of service solely on the basis of their gender identity.”

29. With respect to individuals presently serving in the USAF, the AFPM states that transgender Airmen will be responsible to meet all standards for uniforms and grooming, physical fitness, and use of facilities according to the Airmen’s gender marker in the Military Personnel Data System (“MilPDS”), subject to the approval of an Exception to Policy (“ETP”) request.

30. The AFPM further provides that when a transgender Airman’s medical provider formally advises the Airman’s commander that the Airman’s transition is complete, the Airman can “provid[e] ... either a certified copy of a state birth certificate reflecting the member’s preferred gender, a certified copy of a court order reflecting the member’s preferred gender, or a United States passport reflecting the member’s preferred gender.” And, per the AFPM, the Airman’s commander may then authorize an update to the Airman’s gender marker in MilPDS, which then “will be transmitted to and updated in DEERS.” The Airman will thereafter be responsible for meeting all gender-related standards in accordance with the updated gender marker.

31. To allow USAF commanders to address medical needs in a manner consistent with military mission and readiness, the AFPM sets forth detailed procedures concerning medical treatment for transgender Airmen with a diagnosis from a medical military provider

indicating that gender transition is medically necessary. Airmen with such a diagnosis must notify their commander and “identify all medically necessary care and treatment that is part of the Airman’s medical treatment plan and a projected schedule for such treatment, including an estimated date for a change in the member’s gender marker in MilPDS.” A military medical provider’s diagnosis must be confirmed by the Medical Multidisciplinary Team, taking into account “the severity of the transgender Airman’s medical condition and the urgency of any proposed medical treatment.” All gender transition plans must include timing, as approved by the Airman’s unit commander in consultation with the Airman and military medical personnel.

32. The AFPM also provides that “[t]ransgender Airmen selected for deployment will not be prevented from deploying if they are medically qualified.” “Any determination that a transgender Airman is non-deployable at any time will be consistent with established Air Force standards, as applied to other Airmen whose deployability is similarly affected in comparable circumstances unrelated to gender transition.”

33. In addition, the AFPM identified the following Air Force Instructions (“AFI”) to be revised to conform with the updated DoD policy concerning service of transgender individuals, consistent with the policy announced in the AFPM: (i) AFI 36-3206, Administrative Discharge Procedures for Commissioned Officers; (ii) AFI 36-2905, Fitness Program; (iii) AFI 36-2903, Dress and Personal Appearance of Air Force Personnel; (iv) AFI 36-3208, Administrative Separation of Airmen; (v) AFI 36-3209, Separation and Retirement Procedures for Air National Guard and Air Force Reserve Members; (vi) AFI 48-123, Medical Examinations and Standards; and (vii) AFI 32-6005, Unaccompanied Housing Management.

34. On September 30, 2016, the Department of Defense issued Transgender Service in the Military, An Implementation Handbook (“DoD Handbook”). A true and accurate copy of

the DoD Handbook is attached hereto at Exhibit D. The DoD Handbook is intended as a practical day-to-day guide to assist all service members in understanding the Department of Defense's policy of allowing the open service of transgender service members. To that end, the DoD Handbook instructs all service members:

The cornerstone of DoD values is treating every Service member with dignity and respect. Anyone who wants to serve their country, upholds our values, and can meet our standards, should be given the opportunity to compete to do so. Being a transgender individual, in and of itself, does not affect a Service member's ability to perform their job.

The Harms Caused by the Recent Reversal of Policy

35. Relying on the DTM 16-005 and the Air Force Policy Memorandum, many service members disclosed their transgender status to their commanding officers and took other steps in reliance on the policy permitting service by openly transgender personnel. I am unaware of any evidence that this caused any harm to Air Force operations.

36. 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.

37. 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."

38. I am not aware of any evidence to support President Trump's stated rationales for reversing the policy permitting open service. The Working Group spent months carefully collecting and considering the available evidence related to this issue, including examining how permitting open service by transgender persons would affect the very factors referenced in the August 25 memorandum. The Working Group did not find that permitting transgender soldiers to serve would impose any significant costs or have a negative impact on military effectiveness or readiness. The Working Group also found that barring transgender people from military service causes significant harms to the military, including arbitrarily excluding potential qualified recruits based on a characteristic with no relevance to their ability to serve.

39. In addition to being contrary to the careful study performed and conclusions drawn by the Working Group and the Secretary of Defense, it is my assessment, based on my experience as Secretary of the Air Force and in other leadership positions within the DoD and other defense-related institutions, that banning transgender people from enlisting or openly serving in the military would harm both the military and the broader public interest, for several reasons.

40. **Loss of Qualified Personnel.** First, banning current transgender service members from enlisting or serving in the military will result in the loss of qualified recruits and trained personnel, reducing readiness and operational effectiveness. Some transgender service members are senior and hold important leadership positions. The military has invested significant resources in the education and training of these personnel. Those resources are squandered when they are separated for reasons unrelated to their ability or performance.

41. The loss of qualified personnel as a result of separating transgender service members could be particularly acute at USAF. The USAF is currently facing a reduced pool of

qualified potential recruits. Unlike many private-sector companies, which can fill vacancies by simply tapping an experienced and flexible labor pool, the USAF has to grow its own set of skilled specialists, and that can take years. If the USAF were to lose any pilots because of the ban on transgender service members, that would be especially expensive given the crisis level of pilots who cost millions of dollars to train.

42. Deployability. Allowing transgender service members to openly serve does not create any unique issues relating to deployability. Any time that a given service member cannot deploy, we rely on force management models, the reserve component, and in some cases, civilian support to meet mission requirements. Military processes exist to manage any exigencies as they arise. Responding to any deployability issues to the extent that they may arise for some individual transgender service members creates no greater challenges than those recently addressed by, for example, a change in maternity leave policies for pregnant service members.

43. Erosion of Trust in Command. Second, the President's abrupt reversal of policy is harmful to military readiness because it erodes service members' trust in their command structure and its professionalism. The military's effectiveness depends on a relationship of mutual trust between leaders and followers. That trust, and the prompt following of commands, is essential to the unit cohesion and rapid response required to address unexpected crises or challenges. Following the adoption of the policy permitting open service by transgender persons in 2016, military leaders instructed service members that they should not discriminate against their transgender colleagues. For that policy to be abruptly reversed will inevitably erode trust in the reliability and integrity of military decision making.

44. This sudden reversal is harmful both to transgender service members and to other formerly disfavored groups that have been recently integrated into the military and into combat

roles. In 2011, the Don't Ask, Don't Tell policy prohibiting gay, lesbian and bisexual people from openly serving in the military was repealed. More recently, DoD also removed remaining barriers for women serving in certain combat positions. The sudden reversal of the DoD's recently adopted policy of inclusion sends a dangerous message that policies promoting the inclusion and equal treatment of other groups may similarly be arbitrarily reversed.

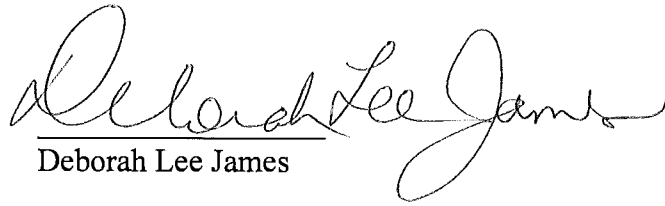
45. **Readiness and Morale.** Third, the sudden reversal of a policy adopted after substantial deliberation will also have a deleterious effect on morale, as it undermines the confidence of service members that important military policy decisions will be based on a rational, careful, and thoughtful process. Airmen and other service members must believe that the orders and policies they are required to follow are based on reasonable decisions, not impulse or whim. This trust in the rationality and professionalism of our military leadership is also a key factor in recruiting and retaining talented personnel. The sudden reversal of the June 2016 policy undermines that trust.

46. Banning openly transgender service members will also have a negative impact on recruitment and retention, which are critical concerns in our all-volunteer services. Such a ban will arbitrarily eliminate otherwise highly qualified and valuable individuals who wish to serve, including those who are already enrolled in Reserve Officer Training Corp programs and military academies, based on a characteristic that has no bearing on fitness for military service. Preventing the accession of transgender individuals who have met the rigorous requirements for enrollment in a military academy is particularly senseless and damaging and will result in the loss of extremely talented and well-qualified future leaders. The negative impact of such irrational and prejudicial policies on the public perception of the Armed Services—including the perception of potential recruits—should not be underestimated.

47. The impact to morale engendered by the abrupt reversal of the policy permitting open service by transgender people will not only have an effect on the morale of our current service members. Any suggestion that those serving to protect and defend our country will not have the fullest support of their entire chain of command will also have a negative impact on the USAF's ability to recruit highly qualified candidates who can perform at the highest levels necessary to complete the USAF's core missions.

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

DATED: August 29th, 2017


Deborah Lee James

**IN THE UNITED STATES DISTRICT COURT FOR
THE DISTRICT OF COLUMBIA**

_____)	
DOE, et al.,)	
))	
<i>Plaintiffs,</i>)	
))	
v.)	Civil Action No. 17-cv-1597 (CKK)
))	
DONALD TRUMP, et al.,)	
))	
<i>Defendants.</i>)	
_____)	

**DECLARATION OF ERIC K. FANNING
IN SUPPORT OF PLAINTIFFS’ MOTION FOR PRELIMINARY INJUNCTION**

I, Eric K. Fanning, declare as follows:

Background and Experience

1. I served as Secretary of the Army from May 18, 2016 to January 20, 2017.
2. I received a Bachelor’s Degree in History from Dartmouth College in 1990. From 1991 until 1996, I worked in various government positions in Washington, D.C., as a research assistant with the House Armed Services Committee, a special assistant in the Office of the Secretary of Defense, and Associate Director of Political Affairs at the White House. From 1997 to 1998, I worked on the national and foreign assignment desks at CBS News in New York. Subsequently, I worked at Robinson, Lerer & Montgomery, a strategic communications firm. From 2001 to 2006, I was Senior Vice President for Strategic Development at Business Executives for National Security, a Washington, D.C.-based think tank, where I was in charge of

international programs and all regional office operations in six cities across the country. I next served as managing director at CMG, another strategic communications firm. From 2008 to 2009, I was Deputy Director of the Commission on the Prevention of Weapons of Mass Destruction Proliferation and Terrorism, which issued its report in December of 2008.

3. From 2009 to 2013, I served as the Deputy Under Secretary of the Navy and Deputy Chief Management Officer. In this role, I led the department's business transformation and governance processes and coordinated efforts to identify enterprise-wide efficiencies. From April 18, 2013 to February 17, 2015, I served as Under Secretary of the Air Force after being nominated by the President to that position and confirmed by the Senate. From June 21, 2013 through December 20, 2013, I served as Acting Secretary of the Air Force.

4. In March 2015, I was assigned as the Special Assistant to the Secretary and Deputy Secretary of Defense (Chief of Staff). In this role, I helped manage Secretary of Defense Ashton Carter's transition into office, built his leadership team, and oversaw the day-to-day staff activities of the Office of the Secretary of Defense.

5. On June 30, 2015, President Barack Obama directed me to serve as Acting Under Secretary of the Army and Chief Management Officer. In that position, I served as the Secretary of the Army's senior civilian assistant and principal adviser on matters related to the management and operation of the Army, including development and integration of the Army Program and Budget. From November 3, 2015 to January 11, 2016, I served as Acting Secretary of the Army. On November 3, 2015, President Obama nominated me to serve as Secretary of the Army, and the Senate confirmed my nomination on May 17, 2016.

6. As Secretary of the Army, I was head of the Department of the Army and had statutory responsibility for all matters relating to the United States Army: manpower, personnel, reserve affairs, installations, environmental issues, weapons systems and equipment acquisition, communications, and financial management. Subject to the authority, direction, and control of the Secretary of Defense, the Secretary of the Army is responsible for all affairs of the Department of the Army, including the morale and welfare of personnel. My personnel-related oversight responsibilities included the development and implementation of recruitment, training, retention, and medical policies for active duty and reserve Army personnel. For duties other than those as a member of the Joint Chiefs of Staff, the Chief of Staff of the Army, the most senior uniformed Army officer, operated under my authority, direction, and control.

The Army

7. The Army is the largest of the service branches of the United States Armed Forces and performs land-based military operations. The Department of the Army is one of the three military departments of the Department of Defense (“DoD”). The Army has an annual budget of more than \$140 billion, inclusive of funding for Overseas Contingency Operations. For fiscal year 2017, the projected end strength for the Active Army is 460,000 soldiers, with an additional 335,000 soldiers in the Army National Guard, and 195,000 in the United States Army Reserve, for a total of 990,000. As of 2016, the Army had approximately 190,000 soldiers deployed to 140 countries in support of U.S. geographic Combatant Command missions. The Army’s command structure includes three Army Commands, ten Army Service Component Commands,

and thirteen Direct Reporting Units, operating in the field and from bases and facilities located across the United States and around the world.

8. The Army's core mission is to fight and win our Nation's wars by providing prompt, sustained land dominance across the full range of military operations and spectrum of conflict in support of combatant commanders. It does this by executing statutory directives, including organizing, equipping, and training forces for the conduct of prompt and sustained combat operations on land, and by accomplishing missions assigned by the President, Secretary of Defense and combatant commanders.

9. The Army is the most formidable ground combat force on earth and one of the largest employers in the United States. The Army's continued excellence in executing its many missions is largely due to deliberate investments in soldier training, equipping, and leader development. Soldiers receive training at the highest level, not only in the classroom, but also through rigorous instruction under intense pressure and realistic battlefield conditions. Many Army personnel are employed in highly technical roles that require lengthy and expensive specialized training. Particularly in light of these investments in personnel, recruitment and retention of capable and qualified soldiers is crucial to Army readiness.

Development of DoD Policy

10. In 2010, Congress voted to repeal the so-called Don't Ask, Don't Tell statute that previously had prevented gay, lesbian, and bisexual persons from serving openly in the military. The repeal statute required the President, the Secretary of Defense, and the Chairman of the Joint Chiefs of Staff to certify that allowing individuals to serve openly regardless of their sexual

orientation would be consistent with the standards of military readiness, military effectiveness, unit cohesion, and recruiting and retention of the Armed Forces. That certification was provided to Congress on July 22, 2011, following a process of review, both before and after passage of the repeal statute, of the impact of the change and of the training and other policy changes that would be necessary to implement it.

11. The repeal of Don't Ask, Don't Tell raised questions about the Armed Forces' policy on service by transgender individuals. Particularly among commanders in the field, there was an increasing awareness that there were already capable, experienced transgender service members in every branch, including on active deployment on missions around the world.

12. In August 2014, the Department of Defense issued a new regulation, DODI 1332.18, *Disability Evaluation System (DES)*. The regulation eliminated a DoD-wide list of conditions that would disqualify persons from retention in military service, including the categorical ban on open service by transgender persons. This new regulation instructed each branch of the Armed Forces to reassess whether disqualification based on these conditions, including the ban on service by transgender persons, was justified. As of August 2014, there was no longer a DoD-wide position on whether transgender persons should be disqualified for retention.

13. In February 2015, just a few days after Secretary of Defense Ashton Carter took office, I accompanied him on a trip to Kandahar, Afghanistan, in my capacity as his chief of staff. At an open town hall-style meeting with service members, Secretary Carter was asked about his views on service by transgender service members in an austere environment like

Afghanistan. The Secretary's response was that he had not given the issue much study, but his "fundamental starting point" was "that we want to make our conditions and experience of service as attractive as possible to our best people in our country." He stated that the "important criteria" was, "Are they going to be excellent service members?"

14. The Kandahar town hall received significant media coverage. As a result, senior officials, including the offices of the Joint Chiefs of Staff, began to inquire about the Secretary's plans concerning the policy on transgender service members.

15. On July 28, 2015, after consultations with the secretaries of the military departments, Secretary Carter directed Brad Carson, Acting Undersecretary of Defense for Personnel and Readiness, to convene a working group ("the "Working Group") to study the policy and readiness implications allowing transgender persons to serve openly in the Armed Forces. The Working Group was asked to start with the presumption that transgender persons could serve openly unless objective, practical impediments were identified, and to develop an implementation plan that addressed those issues with the goal of maximizing military readiness. A true and accurate copy of this directive is attached hereto as Exhibit A.

16. By the time Secretary Carter directed the formation of the Working Group, I had moved out of my position in his office to become Acting Under Secretary of the Army. Subsequently, from November 3, 2015 to January 11, 2016, I served as Acting Secretary of the Army, and then as Secretary of the Army beginning May 18, 2016. During my time as Acting Secretary and Secretary, I oversaw the Department of the Army's participation in the Working Group. The Working Group met as a whole and also assigned various sub-groups to research

and analyze discrete issues and report their findings. I met regularly with members of the Working Group to discuss their progress and the Army's input on the issues discussed.

17. The Working Group considered information from a variety of sources, including medical and other experts, drawn from both within and outside of the Department of Defense; senior military personnel who supervised transgender service members; and transgender people on active duty. The input of commanders reflected their high regard for the transgender staff serving under their command.

18. Members of the Working Group discussed the evidence relating to the costs of permitting transgender persons to serve openly in the military, and the evidence relating to the impact of service by transgender people on operational effectiveness and readiness. Members of the Working Group noted that while transgender service members might have short periods when they were not deployable due to their medical treatment, such periods are not unusual for service members generally, who may take time off due to medical conditions or other reasons.

19. The Working Group also considered that providing medical care for transgender individuals is becoming increasingly prevalent in both public and private sectors alike. Over a third of Fortune 500 companies currently offer employee health insurance plans with transgender-inclusive coverage. Similarly, nondiscrimination policies at two-thirds of Fortune 500 companies now cover gender identity.

20. With respect to the public sector, the Working Group learned that all civilian federal employees have access today to a health insurance plan that provides comprehensive coverage for transgender-related care and medical treatment.

21. Members of the Working Group also discussed the disruptive effect of banning service by transgender people, since such a ban necessitates 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.

22. Members of the Working Group also discussed the negative impact of continuing to ban service by transgender people on overall military readiness because it reduces the pool of potential, qualified recruits for military service.

23. The Working Group also considered the 2016 report of a study that the DoD had commissioned from the RAND Corporation, a federally funded research center sponsored by the Defense Secretary's Office, the Joint Staff, the Unified Combatant Command, and the defense Intelligence Community, about the healthcare needs of transgender service members, the associated costs of extending healthcare coverage for transition-related treatments, and the potential readiness implications of allowing transgender service members to serve openly. A true and accurate copy of the report, entitled *Assessing the Implications of Allowing Transgender Personnel to Serve Openly* ("RAND Report"), is attached as Exhibit B.

24. The RAND Report concluded that the cost of caring for the medical needs of transgender personnel would amount to "an exceedingly small proportion of ... overall DoD health care expenditures." (xi-xii.) The RAND Report further noted that there was no evidence that allowing transgender people to serve openly would negatively impact unit cohesion, operational effectiveness, or readiness. Among other things, the RAND Report found that eighteen other countries that permit open service by transgender personnel—including Israel,

Australia, the United Kingdom, and Canada—had not identified any negative impacts on operational effectiveness or readiness. Based on its analysis of allied militaries and the expected rate at which American transgender service members would require medical treatment that would affect their fitness for duty or deployability, RAND’s analysis concluded that there would be “minimal impact on readiness from allowing transgender personnel to serve openly.” (47.)

25. At the conclusion of its discussion and analysis, the members of the Working Group did not identify any basis for a blanket prohibition on open military service of transgender people. Likewise, no one suggested to me that a bar on military service by transgender persons was necessary for any reason, including readiness or unit cohesion.

26. The Working Group communicated its conclusions to the Secretary of Defense, including that permitting transgender people to serve openly in the United States military would not pose any significant costs or risks to readiness, unit cohesion, morale, or good order and discipline.

27. The Working Group also agreed that the accession policy should be changed to allow transgender people to enlist. The Working Group agreed that the medical standards for accession into the Military Services by transgender persons should be based upon the same standards applied to persons with other medical conditions, which seek to ensure that those entering service are free of medical conditions or physical defects that may require excessive time lost from duty. Based upon that standard, the Working Group agreed that an applicant with a history of gender dysphoria or of treatment for gender dysphoria should be able to accede when

the applicant has completed all medical treatment associated with the applicant's medical condition and has been stable in the preferred gender for a specified period of time.

28. The Working Group also provided comprehensive input regarding all aspects of implementing any change to related military policy. That included addressing practical concerns, like housing and uniform standards for transgender personnel, including when a transitioning service member should be authorized to conform to the standard of the gender to which they were transitioning.

29. The guiding principle behind the Working Group deliberations was that all who are qualified to serve should have the opportunity to do so. The ban on transgender service members was the last categorical ban on otherwise qualified potential service members. No qualified American who can meet the enlistment and retention standards should be excluded from the opportunity to serve.

30. On June 30, 2016, Secretary of Defense Ashton Carter issued Directive-type Memorandum (DTM) 16-005, entitled "Military Service of Transgender Service Members" ("DTM 16-005"), a true and accurate copy of which is attached as Exhibit C.

31. The purpose of DTM 16-005 was to "[e]stablish [] policy, assign [] responsibilities, and prescribe [] procedures for the standards for retention, accession, separation, in-service transition, and medical coverage for transgender personnel serving in the Military Services." DTM 16-005 was applicable to all Military Departments, including the Army, as well as all organizational entities within the DoD, including the Joint Chiefs of Staff.

32. In DTM 16-005, the Secretary of Defense noted that the “defense of the Nation requires a well-trained, all-volunteer force comprised of Active and Reserve Component Service members ready to deploy worldwide on combat and operational missions.” Consistent with and in service to that requirement, DTM 16-005 set forth the policy of the DoD:

The policy of the Department of Defense is that service in the United States military should be open to all who can meet the rigorous standards for military service and readiness. Consistent with the policies and procedures set forth in this memorandum, transgender individuals shall be allowed to serve in the military.

33. In DTM 16-005, the Secretary of Defense set forth DoD’s “position, consistent with the U.S. Attorney General’s opinion, that discrimination based on gender identity is a form of sex discrimination.”

34. Through DTM 16-005, the Secretary of Defense ordered the Secretaries of the Military Departments, including the Army to identify all DoD, Military Department, and Service issuances in need of revision in light of the DoD change in policy, and to submit proposed revisions to the Undersecretary of Defense for Personnel and Readiness (“USD P&R”). USD P&R was tasked with drafting revisions to all necessary issuances consistent with DTM 16-005.

35. DTM 16-005 also detailed procedures with respect to military service of transgender individuals concerning (i) separation and retention, (ii) accessions, (iii) in-service transition, (iv) medical policy, (v) equal opportunity, (vi) education and training, and (vii) implementation and timeline.

36. With respect to separation and retention, DTM 16-005 provided that, “[e]ffective immediately, no otherwise qualified Service member may be involuntarily separated, discharged or denied reenlistment or continuation of service, solely on the basis of their gender identity.” In

addition, transgender service members would “be subject to the same standards as any other Service member of the same gender[.]”

37. Concerning accessions, DTM 16-005 required that no later than July 1, 2017, USD P&R update DoD Instruction 6130.03, which establishes medical standards, which, if not met, are grounds for rejection for military service. Specifically, DTM 16-005 instructed USD P&R to revise DoD Instruction 6130.03 to reflect that:

(1) individuals with a history of gender dysphoria would not be disqualified from serving on that basis if a licensed medical provider certifies “the applicant has been stable without clinically significant distress or impairment in social, occupational, or other important areas of functioning for 18 months”;

(2) individuals with a history of medical treatment associated with gender transition would not be disqualified from serving on that basis if a licensed medical provider certifies “the applicant has completed all medical treatment associated with the applicant’s gender transition[,] ... has been stable in the preferred gender for 18 months,” and ... has been stable on any “cross-sex hormone therapy post-gender transition ... for 18 months”; and

(3) individuals with a history of sex reassignment or genital reconstruction surgery would not be disqualified from serving on that basis if a licensed medical service provider certifies that 18 months have elapsed since the surgery, and “no functional limitations or complications persist, nor is any additional surgery required.”

38. DTM 16-005 further ordered that effective October 1, 2016, “DoD will implement a construct by which transgender Service members may transition gender while serving in accordance with DoDI 1300.28 [In-Service Transition for Transgender Service Members].” DoDI 1300.28 established a construct by which transgender service members may transition gender while serving, proscribed procedures for changing a service member’s gender

marker in the Defense Enrollment Eligibility Reporting System (DEERS), and specified medical treatment provisions for transgender service members.

39. Through DTM 16-005, the Secretary of Defense also ordered USD P&R to “develop and promulgate education and training materials to provide relevant, useful information for transgender Service members, commander, the force, and medical professionals regarding DoD policies and procedures on transgender service” no later than October 1, 2016. Each Military Department, including the Department of the Army, was also ordered to issue implementing guidance and a written force training and education plan no later than November 1, 2016, detailing the Department’s plan and program for training and educating its assigned force, including medical professionals.

40. When Secretary Carter publicly announced the issuance of DTM 16-005 on July 1, 2016, he quoted at length the Army’s senior general and Chief of Staff, Mark Milley, to convey the principle that Americans who want to serve and can meet our standards should be afforded the opportunity to compete to do so: “The United States Army is open to all Americans who meet the standard, regardless of who they are. Embedded within our Constitution is that very principle, that all Americans are free and equal. And we as an Army are sworn to protect and defend that very principle. And we are sworn to even die for that principle. So if we in uniform are willing to die for that principle, then we in uniform should be willing to live by that principle.”

Change, Development, and Implementation of Army Policy

41. To begin implementing DTM 16-005 as applied to the Army, on July 1, 2016, I issued Army Directive 2016-30, titled “Army Policy on Military Service of Transgender Soldiers.” A true and accurate copy of Army Directive 2016-30 is attached hereto as Exhibit D.

42. Army Directive 2016-30 was effective immediately and applies to all personnel in the Active Army, U.S. Army Reserve, Army National Guard, and Army National Guard of the United States. It states that “it is Army policy to allow open Service by transgender Soldiers. The Army is open to all who can meet the standards for military service and remains committed to treating all Soldiers with dignity and respect while ensuring good order and discipline. Transgender Soldiers will be subject to the same standards as any other Soldier of the same gender. An otherwise qualified Soldier will not be involuntarily separated, discharged, or denied reenlistment or continuation of service solely on the basis of gender identity.” The Directive required the Assistant Secretary of the Army for Manpower and Reserve Affairs (the “ASA (M&RA)”) to establish, no later than July 5, 2016, a Transgender Service Implementation Group to develop policies and procedures for transgender service, as well as a Service Central Coordination Cell (SCCC), comprised of medical, legal, and military personnel experts, to serve as a resource for commanders’ inquiries and requests. By October 1, 2016, the ASA (M&RA) was directed to recommend a policy addressing service of transgender soldiers, including “a process by which transgender soldiers may transition gender while serving consistent with mission, training, operational, and readiness needs and a procedure where by a Soldier’s gender marker will be changed in [the Defense Enrollment Eligibility Reporting System (DEERS)].” In

the meantime, the Directive established a process whereby gender marker changes would be handled via Exceptions to Policy (ETPs) processed by the SCCC and ASA (MR&A), with weekly reports summarizing the ETPs to be provided to me and the Army Chief of Staff.

43. Army Directive 2016-30 also instructed the ASA (M&RA) to create a force-wide training and implementation plan no later than November 1, 2016, to be completed across the Army by July 1, 2017. By the end of 2016, the Army had completed the necessary training and education to ensure that all members of the force understood and could implement the core provisions of the Army's policy on the military service for transgender soldiers.

44. Army Directive 2016-30 also instructed that the Army would continue to provide medically necessary care to all soldiers, and that the Army would issue further guidance to its medical providers no later than 45 days following the publication of guidance from the DoD on medical care for transgender service members.

45. On October 7, 2016, I issued a further directive, Army Directive 2016-35, which "establishes policies and procedures for gender transition in the Army." A true and accurate copy of Army Directive 2016-35 is attached hereto as Exhibit E.

46. Army Directive 2016-35 provides that "a Soldier eligible for military medical care with a diagnosis from a military medical provider indicating that gender transition is medically necessary will be provided medical care and treatment for the diagnosed medical condition." The Directive provides that gender transition in the Army begins with a diagnosis that gender transition is medically necessary and ends when the Soldier's gender marker in DEERS is changed to show the Soldier's preferred gender. The Directive further states that for

policies and standards that differ according to gender, the Army will recognize a Soldier's gender based on the gender marker that appears in DEERS. It states that "the Army applies, and Soldiers are expected to meet, all standards for uniforms and grooming, body composition assessment, physical readiness testing, participation in the Military Personnel Drug Abuse Testing Program, and other military standards" according the gender marker in DEERS.

47. Army Directive 2016-35 includes detailed procedures to be followed by soldiers with a medical diagnosis indicating that gender transition is medically necessary. These procedures require consultation with the soldier's chain of command and differ depending on the soldier's duty status and eligibility for military medical care. When a soldier has completed gender transition and is stable in his or her preferred gender as confirmed by a military medical provider, the soldier may request approval of a change to their gender marker in DEERS, which must be supported by "legal documentation supporting a gender change, consisting of a certified copy of a State birth certificate, a certified copy of a court order, or a U.S. passport showing the Soldier's preferred gender."

48. Army Directive 2016-35 also provides guidance for commanders, directing that they "should approach a Soldier undergoing a gender transition in the same way they would approach a Soldier undergoing any medically necessary treatment. . . . Commanders will balance the needs of the individual transitioning Soldier and the needs of the command in a manner that is comparable to the actions available to the commander in addressing comparable medical circumstances unrelated to gender transition." The Directive instructs commanders to consider actions, such as adjusting the dates of gender transition or discussing extended leave options, in

the same manner as such actions would be considered for other medical circumstances unrelated to gender transition.

49. Army Directive 2016-35 also requires soldiers to use the billeting, bathroom, and shower facilities associated with their gender marker in DEERS. However, commanders are given discretion to employ reasonable accommodations to respect the modesty and privacy interests of soldiers, provided that no soldier is required on the basis of gender identity to use a facility not required of other soldiers with the same gender marker.

50. On September 30, 2016, the Department of Defense issued Transgender Service in the Military, An Implementation Handbook (“DoD Handbook”). A true and accurate copy of the DoD Handbook is attached hereto at Exhibit F. The DoD Handbook is intended as a practical day-to-day guide to assist all service members in understanding the Department of Defense’s policy of allowing the open service of transgender service members. To that end, the DoD Handbook instructs all service members:

The cornerstone of DoD values is treating every Service member with dignity and respect. Anyone who wants to serve their country, upholds our values, and can meet our standards, should be given the opportunity to compete to do so. Being a transgender individual, in and of itself, does not affect a Service member’s ability to perform their job.

Harms of Recent Announcements

51. In reliance on the policy changes described above, many military personnel have disclosed their transgender status to their chain of command since 2016. During my time as Secretary of the Army, I did not receive any reports that such disclosures, or the presence of transgender soldiers generally, harmed the readiness, operational effectiveness, or morale of any

Army units. To the contrary, I am aware of commanders who believed that transgender service members under their command were capable and well-qualified to serve.

52. On July 7, 2016, less than a week after Secretary Carter issued DTM 16-005, I visited Fort Jackson, South Carolina, where the Army's newest recruits received Basic Combat Training (BCT)—the introduction soldiers receive as they enter the Army. BCT takes 10 weeks to complete, and recruits undergo intensive training for 12-14 hours a day, Monday through Saturday. Fort Jackson is U.S. Army's main production center for Basic Combat Training, and it trains 50 percent of the Army's Basic Combat Training load and 60 percent of the women entering the Army each year. It also is home to the Army's Drill Sergeant School, which trains all active and Reserve component drill instructors.

53. During my visit, the Commanding General asked me if I'd like to meet a transgender drill instructor, Sergeant Ken Ochoa. Sergeant Ochoa and I met privately for nearly 30 minutes, and I inquired about his experience in the Army generally, and at Fort Jackson in particular. He told me that his experience at Fort Jackson was impressive, and although he was relieved at Secretary Carter's announcement that transgender soldiers could now serve openly, his command had already taken steps to ensure he was able to bring all of his abilities to his job and present himself authentically. His principal concern, however, was that his next post would not be as accommodating, and without formal policies to change his gender marker in DEERS, he might be forced to wear a uniform inconsistent with his gender identity.

54. 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.”

55. I am not aware of any evidence to support President Trump’s stated rationale for a total ban on transgender individuals serving in the military. Despite months of research, the members of the Working Group did not find that permitting transgender soldiers to serve would hinder any of these interests. Nor did any senior Army leaders raise these concerns with me. Because I was responsible for all Army training and readiness, such concerns would have been of great interest to me, if they existed. But they did not.

56. Based on my experience as Secretary of the Army and in other senior leadership positions within the DoD and the military departments, I believe a reversal of current DoD policy permitting open service by transgender service members would be profoundly harmful to the public interest and to our military.

57. **Loss of Qualified Personnel.** Discharging current transgender service members or prohibiting their reenlistment or continuation in service would result in the loss of highly qualified and trained personnel. Many transgender service members have specialized training or

hold leadership positions. Their training and professional development has required a significant investment of taxpayer dollars, an investment whose return depends on their continued service. In addition to losing the benefit of that investment in training and leadership development, taxpayers would bear the cost of recruiting and training replacement personnel. With an all-volunteer military, recruiting is a particular challenge, especially with a strong economy in which the military is competing for talent with the private sector.

58. **Effects of Uncertainty on Military Readiness.** The policy announced by the President unnecessarily creates uncertainty and instability for current transgender service members and their commanders. After serving openly and without incident for many months if not much longer, commanders must now deal with the prospect that key personnel may not be able to continue their service, thus impeding military readiness. This uncertainty also impacts decisions about education, training, and promotion, as commanders will be required to consider the possibility that a service member will be discharged based on a factor such as gender identity which is irrelevant to competence or fitness to serve. At the level of military policymaking, the President's action disrupts years of careful research, planning, and implementation work, reopening an issue that senior officials had already addressed comprehensively, and creating a new distraction for senior leadership at a time when our country faces unprecedented military challenges around the world.

59. **Loss of Morale and Unit Cohesion.** The President's reversal of policy is deeply harmful to morale because it impairs service members' trust in their command structure and their ability to rely on established policy.

60. Commanders have told the enlisted soldiers they command that they must treat transgender service members the same as all others. Now they are being directed by the Commander in Chief that those same soldiers are unfit to serve. The new policy reinstates discrimination with no factual basis to do so. Imposing new discriminatory standards without any justification is enormously disruptive to unit cohesion and undermines the principle of mutual respect which is essential to the military's effectiveness.

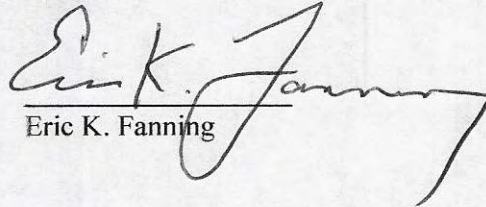
61. In addition, forcing transgender soldiers to lie and hide their transgender status to avoid separation undermines unit cohesion by eroding the bonds of trust among soldiers. It puts non-transgender soldiers in the position of having to choose between reporting fellow soldiers or violating policy. When urging Congress to repeal the ban against service by openly lesbian, gay, and bisexual service members, Admiral Mullen, the former Chairman of the Joint Chiefs, said: "No matter how I look at this issue, 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." The same is true of a policy that forces service members to lie about being transgender.

62. In the Army Directives described above, and in many other documents, the Armed Forces have told transgender service members that they may disclose their transgender status and serve openly, without fear of discharge based on their transgender status. Dramatically reversing course and now using that information as a basis for separating these

soldiers from their service is an unprecedented betrayal of the trust that is so essential to achieving the mission of all of the armed forces.

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

DATED: August 28, 2017


Eric K. Fanning

**IN THE UNITED STATES DISTRICT COURT FOR
THE DISTRICT OF COLUMBIA**

_____)	
DOE, et al.,)	
)	
<i>Plaintiffs,</i>)	
)	
v.)	Civil Action No. 17-cv-1597 (CKK)
)	
DONALD TRUMP, et al.,)	
)	
<i>Defendants.</i>)	
_____)	

**DECLARATION OF RAYMOND EDWIN MABUS, JR.
IN SUPPORT OF PLAINTIFFS’ MOTION FOR PRELIMINARY INJUNCTION**

I, Raymond Edwin Mabus, Jr., declare as follows:

Background and Experience

1. I served as the United States Secretary of the Navy from May 19, 2009 to January 20, 2017.
2. Prior to serving as Secretary of the Navy, I earned a Bachelor’s degree in English and Political Science from the University of Mississippi in 1969, a Master’s Degree in political science from Johns Hopkins University in 1970, and a J.D. from Harvard Law School in 1976. Prior to attending law school, I served from 1970 until 1972 in the Navy aboard the cruiser USS Little Rock, achieving the rank of Lieutenant, junior grade. Following law school, I worked as a law clerk in the United States Court of Appeals for the Fifth Circuit. From 1977 until 1978, I worked as legal counsel for the Cotton Subcommittee of the Agriculture Committee of the United States House of Representatives. From 1979 to 1980, I was an associate at the law firm of Fried, Frank, Harris, Shriver and Kampleman in Washington, D.C. and from 1980 to 1983, I

was Legal Counsel and Legislative Assistant to the Governor of Mississippi. From 1984 to 1988, I served as Mississippi State Auditor (an elected position), and from 1988 to 1992 as Governor of Mississippi. From 1994 to 1996 I served as the United States Ambassador to Saudi Arabia. From 1998 to 2000 I served as President of Frontline Global Services, a consulting company. From 2003-2007 I served as Chairman of Foamex, Incorporated, a public manufacturing company, and from 2006 to 2007 as Foamex's Chief Executive Officer as well.

3. As Secretary of the Navy, I functioned as the chief executive of the Department of the Navy, with the authority to conduct all of its affairs. As Secretary, I had comprehensive oversight responsibility for (i) the Department of the Navy's annual budget, (ii) overseeing the recruitment, organization, training, supplying, equipping, mobilizing, and demobilizing of Navy personnel, and (iii) overseeing the construction, outfitting, and repair of naval equipment, ships, and facilities. I was also responsible for the formulation and implementation of policies and programs that are consistent with the national security policies and objectives established by the President and the Secretary of Defense.

4. In connection with my personnel-related oversight responsibilities, I oversaw the administration of recruitment, retention, and medical policies for active duty and reserve Navy personnel. As Secretary, I performed these duties before, during, and after the end of the "Don't Ask, Don't Tell" ban on gay service members serving openly in the military in 2011.

5. Also during this period, I oversaw the Navy and the Marine Corps through the end of United States military operations in Iraq and the surge of tens of thousands of United States troops in Afghanistan. I am keenly aware that the recruitment and retention of capable and qualified service members is of critical importance to the readiness of the Navy and the Marines.

The Navy

6. The Department of the Navy comprises two uniformed Services of the United States Armed Forces: the United States Navy and the United States Marine Corps. It is one of the three military departments of the Department of Defense (“DoD”). The Navy, with an annual budget of more than \$160 billion, maintains more than 270 deployable battle force ships, operates more than 3,700 military aircraft, and employs nearly 900,000 active duty, reserve, and civilian employees.

7. The mission of the Navy is to maintain, train and equip combat-ready Naval forces capable of winning wars, deterring aggression and maintaining freedom of the seas.

Development of DoD Policy Relating to Service by Openly Transgender Persons

8. On July 28, 2015, Secretary of Defense Ashton Carter ordered Brad Carson, Acting Undersecretary of Defense for Personnel and Readiness, to convene a working group to identify and address the practical issues related to transgender Americans serving openly in the Armed Forces, and to develop an implementation plan that addressed those issues with the goal of maximizing military readiness (the “Working Group”). A true and accurate copy of this order is attached hereto as Exhibit A. The Working Group was ordered to present its findings and recommendations to the Secretary of Defense within 180 days. In the interim, pursuant to the July 28, 2015 order, no service member could “be involuntarily separated or denied reenlistment or continuation of active or reserve service on the basis of their gender identity, without the personal approval of the Under Secretary of Defense for Personnel and Readiness.”

9. As Secretary of the Navy, I was responsible for supervising the Department of the Navy’s participation in the Working Group. The Working Group met as a whole and also assigned various sub-groups to research and analyze discrete issues and report their findings. I

met multiple times per week with my deputy to the Working Group, the Navy General Counsel, who would update me on the progress of the Working Group and the Navy's positions on the issues discussed.

10. The Working Group was tasked with evaluating the hurdles, impediments, and concerns potentially raised by open service of transgender service members. They sought to identify all potential impacts on the Services and develop recommendations to address them.

11. The Working Group met and engaged in a detailed, deliberative, carefully run process. The goal was to ensure that the input of the Services would be fully considered before any changes in policy were made and that the Services were on board with those changes.

12. The Working Group conducted a comprehensive review of relevant evidence, including: research and data; information obtained from medical, personnel, and readiness experts; and information obtained from discussions with transgender service members and commanders who supervised transgender service members. The Working Group also considered the experiences of civilian employers and insurance companies.

13. The Working Group also considered a study that the DoD commissioned from the RAND Corporation. That study examined all of the available research about the healthcare needs of transgender service members, the anticipated costs of providing healthcare coverage for transition-related treatments, and the potential readiness implications of allowing transgender service members to serve openly. A true and accurate copy of the report, entitled *Assessing the Implications of Allowing Transgender Personnel to Serve Openly* ("RAND Report"), is attached as Exhibit B.

14. The RAND Report concluded that the cost of caring for the medical needs of transgender personnel would be extremely small and that there was no evidence that allowing

transgender people to serve openly would negatively impact unit cohesion, operational effectiveness, or readiness. The RAND Report also concluded that the Military Health Service could provide appropriate transition-related healthcare to transgender persons. The RAND Report also identified various DoD policies that would need to be changed to permit transgender service members to serve openly, including “transgender-specific DoD instructions that may contain unnecessarily restrictive conditions and reflect outdated terminology and assessment processes.”

15. Members of the Working Group discussed the full range of considerations relevant to assessing the potential impacts of permitting transgender service members to serve openly, including evidence relating to the costs of providing appropriate healthcare and evidence relating to the impact of service by transgender people on operational effectiveness and readiness. For example, the Working Group considered that while some transgender service members might be undeployable for short periods due to medical treatments, the overall loss of deployable time would not be significant and was consistent with the standard applied to other service members, who may take time off due to comparable medical treatments.

16. The Working Group also noted that many private and public health insurance plans now cover transition-related care and that all civilian federal employees have access to a health insurance plan that provides comprehensive coverage for such care. This was helpful to ascertain both the costs of providing such care and utilization rates, as well as to demonstrate the need for the military to keep pace with contemporary medical science and practice in the provision of healthcare to our service members.

17. The Working Group also consulted with representatives from the Armed Forces of other nations that permit openly transgender persons to serve. Those consultations confirmed

that permitting such service is not disruptive to military readiness and has not led to significantly increased costs or posed any other significant problems. The RAND Report considered the experiences of other countries as well and found no evidence of any adverse impacts. Noting the most extensive research on how a policy of open service affects readiness and unit cohesion has been conducted in Canada, the RAND Report noted that “the researchers heard from commanders that the increased diversity improved readiness.”

18. The Working Group considered that banning service by openly transgender people has numerous negative impacts, including requiring the discharge of highly trained and experienced service members, causing unexpected vacancies in operational units, and requiring the expensive and time-consuming recruitment and training of replacement personnel.

19. The Working Group also recognized that despite a ban on transgender service members, transgender persons continued to serve in the military, but were forced to lie about and hide their identities, to the detriment both of those service members and of the military as a whole. As a result, the Working Group recognized that the primary impact of the policy was to cause harms similar to those caused by “Don’t Ask, Don’t Tell.”

20. During the period in which the Working Group was in operation, the proceedings of the Working Group were reported to and reviewed by upper level Department of Defense personnel at meetings attended by the Joint Chiefs of Staff, the Chairman, the Vice Chairman, the Service Secretaries, the Secretary of Defense, and the Assistant Secretary of Defense. At these meetings, the activities of the Working Group would be shared along with their preliminary views. The meeting attendees would then discuss any comments they may have had on those views.

21. By the conclusion of its discussions and analysis, all members of the Working Group (including the senior uniformed military personnel) expressed their agreement that transgender people should be permitted to serve openly in the United States Armed Forces.

22. In or around April 2016, the Working Group communicated its view to the Secretary of Defense along with detailed recommendations regarding the full range of relevant policies and practical concerns, such as guidelines involving access to healthcare, housing and uniform standards, and when a transitioning service member should be authorized to conform to the standard of the gender to which they were transitioning.

23. On June 30, 2016, Secretary of Defense Ashton Carter accepted the recommendations of the Working Group, and issued Directive-type Memorandum (DTM) 16-005, entitled “Military Service of Transgender Service Members” (“DTM 16-005”), a true and accurate copy of which is attached as Exhibit C.

Change, Development, and Implementation of Navy Policy

24. Following the Secretary of Defense’s announcement, the Navy’s implementation of the new policy was straightforward. We focused on the administrative tasks of promulgating and implementing the appropriate processes. Having presided over the Navy during the rollout of prior policy changes such as the repeal of “Don’t Ask, Don’t Tell” and the complete integration of women into ground combat, I can confirm that the implementation of open service for transgender service members was relatively low-key, triggered fewer emotional responses, and was viewed as “no big deal.”

25. To implement DTM 16-005 as applied to the Navy, on November 4, 2016, I issued SECNAV Instruction 1000.11 concerning Service of Transgender Sailors and Marines (the “Instruction”). A true and accurate copy of the Instruction is attached hereto as Ex. D.

26. The policy and guidance in the Instruction, which was effective immediately for all Department of Navy (“DON”) personnel, established “policy for the accession and service of transgender Sailors and Marines, to include the process for transgender Service Members to transition to transgender in-service.” The policies and procedures in the Instruction “are based on the premise that open service by transgender persons who are subject to the same medical, fitness for duty, physical fitness, uniform and grooming, deployability, and retention standards and procedures is consistent with military service and readiness.” The Instruction provides that “transgender individuals shall be allowed to serve openly in the DON,” and that any “discrimination based on gender identity is a form of sex discrimination.”

27. Pursuant to the Instruction, on November 7, 2016, Chief of Naval Personnel, Vice Admiral R. P. Burke, issued interim guidance in NAVADMIN 248/16 (the “Policy”) regarding “policy, regulations and procedures related to the service of transgender Navy personnel.” The Policy, which “applies to all Navy military personnel,” remains in effect “until superseded or cancelled.” A true and accurate copy of the Policy is attached hereto as Ex. E.

28. As with the Instruction, the Policy provides that “transgender individuals shall be allowed to serve openly in the Navy. The Policy was “premised on the conclusion that transgender persons are fully qualified and are subject to the same standards and procedures as other Service Members with regard to their medical fitness for duty, physical fitness, uniform and grooming standards, deployability, and retention.” The Policy thus declares that “[n]o otherwise qualified Service Member may be involuntarily separated, discharged, or denied reenlistment or continuation of service solely on the basis of gender identity or an expressed intent to transition gender.”

29. With respect to individuals serving in the Navy or Marine Corps, the Instruction and Policy state that transgender Sailors and Marines will be responsible to meet all standards for uniforms and grooming, body composition assessment, physical readiness testing, Military Personnel Drug Abuse Testing Program participation and other military standards according to their gender marker in DEERS, subject to the approval of an Exception to Policy (“ETP”) request.

30. To allow DON commanders to address medical needs in a manner consistent with military mission and readiness, the Policy sets forth detailed procedures concerning medical treatment for transgender service members with a diagnosis from a medical military provider indicating that gender transition is medically necessary. Service members with such a diagnosis must notify their commanding officer and request commanding officer approval for the timing of medical treatment associated with gender transition. The commanding officer is the final approval authority for a transition plan. Commanding officers must respond to a gender transition request “within a framework that ensures readiness by minimizing impacts to the mission (including deployment, operational, training, exercise schedules, and critical skills availability), as well as the morale, welfare, and good order and discipline of the command.” Furthermore, the Policy provides that timing of a medical treatment plan “should consider the individual’s planned rotation date (PRD), deployment or other operational schedules, and potential impact on major career milestones, whenever possible.”

31. The Policy further provides detailed instructions regarding an in-service transition. The transition plan is considered complete once (1) a military medical provider documents that the service member has completed the care outlined in a medical treatment plan; (2) the service member obtains an appropriate document showing legal proof of gender change;

(3) the service member's commanding officer provides written permission to change the gender marker in the Navy Personnel Administrative Systems/DEERS; (4) the service member submits for the gender marker change; and (5) the gender marker is changed in the Navy Personnel Administrative Systems/DEERS.

32. As set forth in the Policy, in order to have a gender marker changed in the Navy Personnel Administrative Systems/DEERS, the service member must submit the required documentation showing legal proof of gender change and the commanding officer's written approval to Navy Personnel Command.

33. The Policy also provides that "[a]ll Service Members are world-wide assignable as their medical fitness for duty permits." "Any determination that a transgender Sailor or Marine is non-deployable at any time will be consistent with established DON standards, as applied to other Sailors and Marines whose deployability is similarly affected in comparable circumstances unrelated to gender transition."

34. Both the Instruction and Policy provide that effective July 1, 2017, the Navy and Marine Corps will begin accessing transgender applicants who meet all standards.

35. In addition, the Policy included policy changes related to: (1) privacy in berthing and showering facilities as set forth in OPNAVINST 3120.32D, Standard Organization Regulations of the U.S. Navy; (2) drug testing and urinalysis as set forth in OPNAVINST 5350.4D, Navy Alcohol and Drug Abuse Prevention and Control Program; and (3) physical fitness assessment standards as set forth in OPNAVINST 6110.1J, Physical Readiness Program.

36. On September 30, 2016, the Department of Defense issued Transgender Service in the Military, An Implementation Handbook ("DoD Handbook"). A true and accurate copy of the DoD Handbook is attached hereto at Exhibit F. The DoD Handbook is intended as a

practical day-to-day guide to assist all service members in understanding the Department of Defense's policy of allowing the open service of transgender service members. To that end, the DoD Handbook instructs all service members:

The cornerstone of DoD values is treating every Service member with dignity and respect. Anyone who wants to serve their country, upholds our values, and can meet our standards, should be given the opportunity to compete to do so. Being a transgender individual, in and of itself, does not affect a Service member's ability to perform their job.

The Impact of Reversing the Policy Permitting Service by Openly Transgender People

37. Numerous military personnel disclosed their transgender status to the military in 2016 and 2017 in reliance upon the Department of Defense's statements that it would not discharge them on that basis, as articulated in DTM 16-005 and other documents. I did not receive any reports that such disclosures harmed the operational effectiveness of any Navy units.

38. 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 due to "the tremendous medical costs and disruption that transgender in the military would entail."

39. 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."

40. President Trump's stated rationales for reversing the policy and banning military service by transgender people make no sense. They have no basis in fact and are refuted by the comprehensive analysis of relevant data and information that was carefully, thoroughly, and deliberately conducted by the Working Group.

41. As discussed above, the RAND Report concluded that any costs associated with providing appropriate healthcare to transgender service members would be "exceedingly small." In fact, the maximum financial impact estimated by the RAND Report is an amount so small it was considered to be "budget dust," hardly even a rounding error, by military leadership.

42. The claim that permitting transgender people to serve openly would be "disruptive" has no foundation. The same claim was used to oppose racial integration of the military in the 1940s, the increased recruiting of women in the 1970s, and the repeal of "Don't Ask Don't Tell." In each case, the prediction that disruption would ensue has not been borne out. Studies have shown that diversity actually improves unit cohesion. Units become closer when individual service members are respected for who they are.

43. Any evidence that permitting such service would be disruptive is entirely lacking. Since the policy permitting open service went into effect, transgender service members have been able to serve openly and have caused no disruption.

44. In addition to being contrary to the overwhelming weight of the evidence considered by the Working Group and the Secretary of Defense, a reversal of the DoD policy permitting open service and the banning of accessions by transgender people, in my assessment, based on my experience as Secretary of the Navy, disserves the public interest, for several reasons.

45. **Loss of Qualified Personnel.** First, banning transgender service members will produce vacancies in the Services, creating an immediate negative impact on readiness. The United States Armed Forces rely on an all-volunteer force, some portion of which are transgender service members. The impact of the loss of those individuals, who serve at all levels of service, is significant. Banning transgender service members will cause the loss of competent and experienced individuals, who will be difficult to replace. The Navy has invested in their education, and training. In addition to losing any return on that investment, taxpayers will bear the cost of identifying, recruiting, and training replacement personnel. Our ability to replace those individuals will also be hampered by the parallel reduction in the size of our potential recruiting pool. Artificial exclusionary barriers like this weaken the military.

46. **Unit Cohesion.** Second, banning transgender service members negatively impacts unit cohesion, a fundamental component of readiness. The only relevant qualification for the job of serving in the Armed Forces is whether an individual is capable of performing the job. Diversity in the form of nationality, religion, race, who one loves, gender, or gender identity only strengthens the force. Conversely, when the military asks people to lie about who they are in order to enlist or remain in the military, it weakens the military and has a negative impact on unit cohesion. Members of units know each other well and develop strong bonds. Unit members can tell when other unit members are lying. A policy that forces unit members to be dishonest with one another, including a ban on service by openly transgender people, weakens these bonds.

47. **Erosion of Trust in Command.** Third, arbitrary decisionmaking erodes trust in military leadership. I was dismayed by the abrupt reversal, because so much careful thought had gone into development of the policy, with consensus at the highest levels of military leadership. Furthermore, the initial directive to reverse policy through the Twitter medium was delivered

entirely outside the normal pathway of legitimate orders issued through the chain of command, and the most recent memorandum of August 25, 2017 was also issued in a highly unusual manner. It is also unprecedented to reverse policy in such an abrupt manner. I cannot recall another instance in United States military history of such a stark and unfounded reversal of policy, or of any example in our nation's history in which a minority group once permitted to serve has been excluded from the military after its members had been allowed to serve openly and honestly.

48. Even individuals who had reservations at the time the Working Group was announced trusted in the process and believed it was a fair and deliberative process that met the high standards of the military. This abrupt reversal leaves the impression among service members that military decision making is instead arbitrary and subject to political whims.

49. For transgender service members themselves, the reversal represents the ultimate mistreatment and breach of trust. In DTM-005 and in other documents issued by the Department of Defense, the military informed transgender service members that they could come forward to disclose their transgender status and serve openly, rather than facing discharge. Many transgender service members came forward based on those statements. They risked their jobs, housing, and progress towards retirement benefits in reliance on our word that we would treat their disclosures fairly and in good faith. Using that information now as a basis for separating these soldiers from their service is an unprecedented betrayal of the trust that is so essential to achieving the mission of all of the armed forces. The reversal penalizes transgender service members for doing what DoD encouraged them to do. Transgender service members, their chain of command, and their colleagues who may lose people on whom they rely, must now deal with this enormous distraction, thus detracting from military readiness.

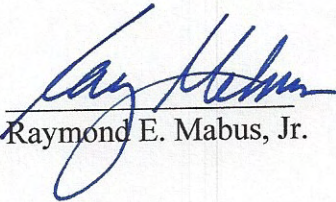
50. This sudden reversal also undermines the morale and readiness of other groups who must now deal with the stress and uncertainty created by this dangerous precedent, which represents a stark departure from the foundational principle that military policy will be based on military, not political, considerations. In 2011, the “Don’t Ask, Don’t Tell” policy prohibiting gay, lesbian, and bisexual people from openly serving in the military (Department of Defense Directive 1304.26) was repealed. More recently, DoD also removed remaining barriers for women serving in certain ground combat positions. The sudden reversal of the DoD’s policy with respect to transgender service members sets a precedent suggesting that these policies may be abruptly reversed for baseless reasons as well.

51. This sudden reversal may also have a chilling effect on the confidence of other service members that they will continue to be able to serve. Religious and ethnic minorities who have seen an increase in discrimination under the current administration may fear that the military may seek to ban them next, creating a culture of fear that is anathema to the stability and certainty that makes for an effective military.

52. This sudden reversal undermines the confidence of all service members that important military policy decisions will be made under careful review and consistent with established process. Rational decisionmaking in the adoption of and change to policy impacts the military’s ability to recruit and retain competent, high-performing people. The sudden reversal of policy makes recruitment and retention more difficult, as does the damage done to the military’s image and reputation as promoting fairness and equality and of being open to all qualified Americans. That image and reputation are critical to the military’s ability to attract talented and idealistic young people. Actions that tarnish that reputation cause real harm.

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

DATED: August 29, 2017


Raymond E. Mabus, Jr.

IN THE UNITED STATES DISTRICT COURT FOR
THE DISTRICT OF COLUMBIA

_____)	
DOE, et al.,)	
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<i>Plaintiffs,</i>)	
))	
v.)	Civil Action No. 17-cv-1597 (CKK)
))	
DONALD TRUMP, et al.,)	
))	
<i>Defendants.</i>)	
_____)	

**DECLARATION OF GEORGE RICHARD BROWN, MD, DFAPA
IN SUPPORT OF PLAINTIFFS’ MOTION FOR PRELIMINARY INJUNCTION**

I, George R. Brown, declare as follows:

1. I make this declaration based on my own personal knowledge.

PROFESSIONAL BACKGROUND

2. I am a Professor of Psychiatry and the Associate Chairman for Veterans Affairs in the Department of Psychiatry at the East Tennessee State University, Quillen College of Medicine. My responsibilities include advising the Chairman, contributing to administrative, teaching, and research missions of the Department of Psychiatry, consulting on clinical cases at the University and at Mountain Home Veterans Health Administration (“VHA”) Medical Center, where I also hold an appointment, and acting as a liaison between the VHA Medical Center and the East Tennessee State University Department of Psychiatry. The majority of my work involves research, teaching, and consulting about transgender health in military and civilian populations.

3. I also hold a teaching appointment related to my expertise with transgender healthcare and research at the University of North Texas Health Services Center (“UNTHSC”). My

responsibilities include teaching and consultation with UNTHSC and the Federal Bureau of Prisons staff regarding transgender health issues.

4. I graduated from the University of Rochester in Rochester, New York in 1979 Summa Cum Laude with a double major in biology and geology. I earned my Doctor of Medicine degree with Honors from the University of Rochester School of Medicine in 1983. From 1983-1984, I served as an intern at the United States Air Force Medical Center at Wright-Patterson Air Force Base in Ohio. From 1984-1987, I worked in and completed the United States Air Force Integrated Residency Program in Psychiatry at Wright State University and Wright-Patterson Air Force Base in Dayton, Ohio. A true and correct copy of my Curriculum Vitae is attached hereto as Exhibit A.

5. I began seeing patients in 1983, and I have been a practicing psychiatrist since 1987 when I completed my residency. Over the last 33 years, I have evaluated, treated, and/or conducted research with between 600 and 1000 individuals with gender disorders in person, and over 5100 patients with Gender Dysphoria during the course of research-related chart reviews. The vast majority of those patients have been active duty military personnel or veterans.

6. For three decades, my research and clinical practice has included extensive study of transgender health and care of transgender individuals, including three of the largest studies focused on the health-care needs of transgender service members and veterans. Throughout that time, I have done research with, taught on, and published peer-reviewed professional publications specifically addressing the needs of transgender military service members. *See* Brown Ex. A (CV).

7. I have authored or coauthored 38 papers in peer-reviewed journals and 19 book chapters on topics related to Gender Dysphoria and transgender healthcare, including the chapter

on Gender Dysphoria in Treatments of Psychiatric Disorders (3d ed. 2001), a definitive medical text published by the American Psychiatric Association.

8. In 2014, I coauthored a study along with former Surgeon General Joycelyn Elders and other military health experts, including a retired General and a retired Admiral, entitled “Medical Aspects of Transgender Military Service.” Elders J, Brown GR, Coleman E, Kolditz TA, *Medical Aspects of Transgender Military Service*. *Armed Forces and Society*, 41(2): 199-220, 2015; published online ahead of print, DOI: 10.1177/0095327X14545625 (Aug. 2014) (“2014 Report”). The study was published in the military peer-reviewed journal, *Armed Forces and Society*. A true and correct copy of that report is attached hereto as Exhibit B.

9. I have served for more than fifteen years on the Board of Directors of the World Professional Association for Transgender Health (“WPATH”), the leading international organization focused on transgender health care. WPATH has over 2,000 members throughout the world and is comprised of physicians, psychiatrists, psychologists, social workers, surgeons, and other health professionals who specialize in the diagnosis and treatment of Gender Dysphoria.

10. I was a member of the WPATH committee that authored Version 7 of the Standards of Care, published in 2011, which is the current version, and I am on the committee to revise the Standards of Care (Version 8).

11. I have been an active member of WPATH since 1987 without interruption and I have presented original research work on topics relating to Gender Dysphoria and the clinical treatment of transgender people nationally and internationally frequently over the past 3 decades. I have testified or otherwise served as an expert on transgender health issues in cases heard by numerous federal district courts and a federal tax court. I have provided and continue to provide

trainings on transgender health issues for the VHA as well as throughout the Department of Defense.

12. After the Department of Defense announced the change in policy towards transgender servicemembers in 2016, I conducted the first two large military trainings on the provision of health care to transgender service members. The first was for the Marine Corp in the spring of 2016. The second was for a tri-service meeting of several hundred active duty military clinicians and commanders in the fall of 2016. Since the issuance of Department of Defense Instruction 1300.28 in October 2016, which, among other things, implemented the policies and procedures in Directive-type Memorandum 16-005 and established a construct by which transgender service members may transition gender while serving, I have also conducted trainings for a national group of military examiners (MEPSCOM) and for Army clinicians at Fort Knox, Kentucky. I have been centrally involved in the development, writing, and review of all national directives in the VHA relating to the provision of transgender health care for veterans. Finally, I coauthored the national formulary that lists the medications provided by the VHA for the treatment of Gender Dysphoria in veterans.

GENDER DYSPHORIA

13. The term "transgender" is a term used to describe someone who experiences any significant degree of misalignment between their gender identity and their assigned sex at birth.

14. Gender identity describes a person's internalized, felt sense of who they are as male or female. For most people, their gender identity is consistent with their assigned birth sex. Most individuals assigned female at birth, grow up, develop, and manifest a gender identity typically associated with girls and women. Most individuals assigned male at birth, grow up, develop, and manifest a gender identity typically associated with boys and men. For transgender

people, that is not the case. Transgender women are individuals assigned male at birth who have a persistent gender identification associated with female identity. Transgender men are individuals assigned female at birth who have a persistent gender identification associated with male identity.

15. Experts agree that gender identity has a major biological component. Experts also agree that gender identity is set early in life, is deep-seated, and impervious to external influences. Gender identity is often referred to as a person's brain sex. This is, in part, because studies focused on determining the origins of a person's gender identity have shown that the human brain is significantly influenced by exposure to hormone levels before birth. Brain studies that correlate brain patterns of transgender individuals with non-transgender individuals who have the same gender identity further contribute to a body of research that supports a biological basis for gender identity and transgender identities.

16. The Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association ("DSM-5") (2013) is the current, generally recognized authoritative handbook on the diagnosis of mental disorders relied upon by mental health professionals in the United States, Canada, and other countries. The content of the DSM-5 reflects a science-based, peer-reviewed process by experts in the field.

17. According to the DSM-5, transgender identity is not a mental disorder. Gender dysphoria is a diagnostic term that refers to clinically significant distress associated with an incongruence or mismatch between a person's gender identity and assigned sex.

18. Gender Dysphoria is mental distress or discomfort based on the experience of discordance between the sex assigned at birth and a person's gender identity or brain sex. Because of the inflexibility of the brain sex, the experience of being transgender is sometimes

described as having, or being born in, the wrong body. The emotional distress experienced as a result of being in the wrong body is the hallmark symptom associated with Gender Dysphoria.

19. Only the subset of transgender people who have clinically significant distress or impairment qualify for a diagnosis of Gender Dysphoria.

20. Gender dysphoric persons may live for a significant period of their lives in denial of those symptoms. Some transgender people may not initially understand the emotions associated with gender dysphoria and not have the language or resources to find support for the distress as experienced as a result of them until well into adulthood. Younger people in increasing numbers have access to medical and mental health resources that help them understand their experience and allow them to obtain medical support at an earlier age.

TREATMENT FOR GENDER DYSPHORIA

21. Gender Dysphoria is understood as a condition that is amenable to treatment. Commission Report at 9; WPATH Standards of Care, Version 7; William Byne, et al., *Report of the American Psychiatric Association Task Force on Treatment of Gender Identity Disorder* (2012).¹ With appropriate treatment, individuals with a Gender Dysphoria diagnosis can be fully cured of all symptoms.

22. Treatment of Gender Dysphoria is well-established and highly effective. The protocol is set forth in the WPATH Standards of Care and in the Endocrine Society Guidelines.² The WPATH Standards of Care were first developed in 1979. Currently in their seventh version, the Standards of Care set forth the authoritative protocol for the evaluation and treatment of

¹ Available at https://www.researchgate.net/publication/228071071_Report_of_the_American_Psychiatric_Association_Task_Force_on_Treatment_of_Gender_Identity_Disorder.

² Available at <https://www.endocrine.org/guidelines-and-clinical-practice/clinical-practice-guidelines>.

Gender Dysphoria. This is the approach followed by clinicians caring for transgender veterans with Gender Dysphoria nationally in the VHA. As stated above, I was a member of the WPATH committee that authored Version 7 of the Standards of Care, published in 2011. That document is attached hereto as Exhibit C.

23. Depending on the individual, a treatment plan for persons diagnosed with Gender Dysphoria may involve psychotherapeutic, pharmacological, and surgical components. The goal in all cases for which there is a treatment plan is to enable the individual to live all aspects of one's life consistent with his or her gender identity or brain sex.

24. Pharmacological care, when needed, typically includes hormonal reassignment. Surgical care, often referred to as either sex reassignment or gender confirmation surgery, includes a range of procedures that conform the person's body to be consistent with persons of the same gender identity. There is a wide range in the treatment sought by those suffering from Gender Dysphoria. Some need both hormone therapy and surgery, while others need both or neither.

25. The care and treatment necessary for transgender individuals in the military is already provided to non-transgender individuals, whether therapy, hormonal treatments, or surgeries. Accordingly "[t]ransgender medical care should be managed in terms of the same standards that apply to all medical care, and there is no medical reason to presume transgender individuals are unfit for duty." 2014 Report at 14.

PRE-2016 MILITARY POLICY

26. Prior to 2016, military policy treated Gender Dysphoria inconsistently with other curable conditions. Department of Defense instructions contain an extensive list of physical and mental conditions that disqualify a person from enlisting in the military and which can be used as

the basis to separate someone from service. For instance, persons with autism, schizophrenia and delusional disorders (or a history of treatment for these conditions) are excluded from enlistment. Prior to 2016, that list also contained conditions relating to Gender Dysphoria, such as change of sex and transsexualism.

27. The purpose of disqualifying applicants based on certain physical and mental conditions is to ensure that service members are free of contagious diseases that endanger others, free of conditions or defects that would result in excessive duty-time lost and would probably result in separation, able to perform without aggravating existing conditions, and capable of completing training and adapting to military life.

28. Because Gender Dysphoria is a treatable and curable condition, unlike other excluded conditions, its inclusion on the list of disqualifying conditions was inappropriate. Despite having a treatable condition, persons who had a change of sex were disqualified from joining the military.

29. This was inconsistent with how persons with other curable medical conditions were treated. The result of this inconsistency was that transgender personnel were excluded or singled out for disqualification even when they were mentally and physically healthy.

30. For example, persons with certain illnesses, such as Attention Deficit Hyperactivity Disorder and simple phobias, could be admitted when their conditions could be managed without imposing undue burdens on others. Individuals with Attention Deficit Hyperactivity Disorder are prohibited from enlisting unless they meet five criteria including documenting that they maintained a 2.0 grade point average after the age of 14. Similarly, individuals with simple phobias are banned from enlisting unless they meet three criteria including documenting that they have not required medication for the past 24 continuous months. Likewise, members with

mood and anxiety disorders treated by medication were not categorically barred from deployment despite the well-known high rates of recurrence of these psychiatric disorders.

31. In short, even though the Defense Department allowed those with manageable conditions to serve, the former regulation barred transgender service without regard to its treatability and the person's ability to serve.

JUNE 2016 POLICY CHANGE

32. The military lifted the ban on open service by transgender military personnel following a June 30, 2016 announcement made by then Secretary of Defense Ashton B. Carter.

33. Under new accessions procedures – which were adopted but never put into effect – transgender individuals whose condition was stable for 18 months at the time of enlistment would be eligible to enlist. As the procedures describe, a “history of gender dysphoria” as well as a “history of medical treatment associated with gender transition” are disqualifying *unless*, as to the former, a licensed medical provider certifies that the applicant has been stable without clinically significant distress or impairment in social, occupational, or other important areas of functioning for 18 months, and as to the latter, that “the applicant has completed all medical treatment associated with the applicant's gender transition; and the applicant has been stable in the preferred gender for 18 months.” DTM-16-005 Memorandum and Attachment (June 30, 2016). Finally, for applicants presently receiving cross-sex hormone therapy post-gender transition, the individual has been stable on such hormones for 18 months. *Id.*

34. In other words, the procedures require those seeking to enlist who had any therapy or surgeries to have medical confirmation that they have been stable for the last 18 months. Similarly, those applicants taking cross-sex hormones as follow-up to their transition would also need certification that they had been stable on such hormones for 18 months.

MEDICAL JUSTIFICATIONS FOR THE TRANSGENDER BAN ARE UNFOUNDED

35. Based on my extensive research and experience treating transgender people, most of whom have served this country in uniform, my experience reviewing the medical implications of a ban on transgender service members, and my involvement in implementing the 2016 policies allowing transgender individuals to serve openly, it is my opinion that the medical objections to open service by transgender service members are wholly unsubstantiated.

36. Similarly, in a unanimous resolution published on April 29, 2015, the American Medical Association announced its support for lifting the ban on transgender service in the military.³

MENTAL HEALTH

37. Arguments based on mental health of transgender persons are completely inadequate to justify prohibiting transgender individuals from serving in the military. Being transgender is not a mental defect or disorder. Scientists have long abandoned psychopathological understandings of transgender identity, and do not classify the incongruity between a person's brain sex and one's assigned sex as a mental illness. To the extent a person's incongruity between their brain sex and their birth sex creates clinically significant distress (Gender Dysphoria), that distress is curable through appropriate medical care. The availability of a cure distinguishes Gender Dysphoria from other mental health conditions such as autism, bipolar disorder, or schizophrenia for which there are no cures. There is no reason to single out transgender personnel for separation or even limitation of service based only on the diagnosis or

³ Available at <http://archive.palmcenter.org/files/A-15%20Resoultion%20011.pdf>.

treatment of Gender Dysphoria. Rather, determinations should be made on a case-by-case basis depending on the individual's fitness to serve, as is done with other treatable conditions.

38. Moreover, the military already provides mental health evaluation services and counseling, which is the first component of treatment for Gender Dysphoria. RAND Corporation, *Assessing the Implications of Allowing Transgender Personnel to Serve Openly* ("RAND Report") at 79, attached as Exhibit D.

39. Sixty years of clinical experience have demonstrated the efficacy of treatment of the distress resulting from Gender Dysphoria. *See* 2014 Report at 6 ("a significant body of evidence shows that treatment can alleviate symptoms among those who do experience distress"). Moreover, "empirical data suggest that many non-transgender service members continue to serve despite psychological conditions that may not be as amenable to treatment as gender dysphoria." *Id.* at 7.

40. Concerns about suicide and substance abuse rates among transgender individuals are also irrelevant. At accession, all prospective military servicemembers undergo a rigorous examination to identify any pre-existing mental health diagnoses that would preclude accessions. Once someone is serving in the military, they must undergo an annual mental and physical health screen, which includes a drug screen. If one of these screenings indicates that a person suffers from a mental illness or substance abuse, then that would be the potential impediment to joining or remaining in the military. The mere fact that a person is transgender, however, does not mean that person has a mental health issue, substance abuse problem, or is suicidal.

HORMONE TREATMENT

41. The argument that cross-sex hormone treatment is too risky and complicated for military medical personnel to administer and monitor is unsubstantiated and illogical. The risks

associated with cross-sex hormone treatment are low and not any higher than for the hormones that many non-transgender personnel currently take.

42. The military has vast experience with accessing, retaining and treating non-transgender individuals who need hormone therapies or replacement. These include gynecological conditions such as dysmenorrhea, endometriosis, menopausal syndrome, chronic pelvic pain, hysterectomy or oophorectomy and genitourinary conditions like renal or voiding functions, any of which are referred for a fitness evaluation only when they affect duty performance.

43. In addition, when service members develop hormonal conditions during service whose remedies are biologically similar to cross-sex hormone treatment, those members are not discharged and may not even be referred for a medical evaluation board. Examples include male hypogonadism, menstrual disorders and current, or history of, pituitary dysfunction.

44. Military policy also allows service members to take a range of medications, including hormones, while deployed in combat settings. 2014 Report at 9. Whether anabolic steroids or antipsychotic drugs, Department of Defense policy provides “few medications are inherently disqualifying for deployment.” *Id.* (quoting Dept. of Defense, Policy Guidance for Deployment-Limiting Psychiatric Conditions and Medications, 2006 at para. 4.2.3). Access is predictable, as “[t]he Military Health Service maintains a sophisticated and effective system for distributing prescription medications to deployed service members worldwide.” *Id.* As to cross-sex hormones at least, clinical monitoring for risks and effects is not complicated, and with training and/or access to consultations, can be performed by a variety of medical personnel in the Department of Defense, just as is the case in the VHA.

45. A study done by the RAND Corporation, an independent, nonpartisan, military think tank confirms the conclusions I draw from my experience with the military and in the 2014 Report. *See* RAND Report. Specifically, the RAND Report noted that Military Health Services maintains and supports all of the medications used for treatment of Gender Dysphoria and has done so for treatment of non-transgender service members. In other words, all of the medications used by transgender service members for treatment of Gender Dysphoria are used by other service members for conditions unrelated to Gender Dysphoria. *See* RAND Report at 8 (“Both psychotherapy and hormone therapies are available and regularly provided through the military’s direct care system, though providers would need some additional continuing education to develop clinical and cultural competence for the proper care of transgender patients.”). Part of my role with the Department of Defense over the past 18 months has been to provide this continuing education.

SURGERY

46. Nor is there any basis for the argument that a transgender servicemember’s potential need for transition surgery presents unreasonable risks or burden. The risks associated with gender-confirming surgery are low.

47. Critics have also cited non-deployability, medical readiness, and constraints on fitness for duty as reasons to exclude transgender individuals from service. Such arguments are also unsubstantiated and illogical. As a general matter, transgender servicemembers are just as medically fit for service and deployable as non-transgender servicemembers.

48. Even prior to the 2016 transgender policy change, military surgeons were called upon to perform surgeries, such as those for blast victims, whose core procedures are the same as or similar to surgeries needed for transgender health. RAND Report at 8 (“Surgical procedures

quite similar to those used for gender transition are already performed within the MHS for other clinical indications.”). The RAND Report noted the benefit of military coverage of transgender surgeries because of the contribution it can make to surgical readiness and training. *Id.*

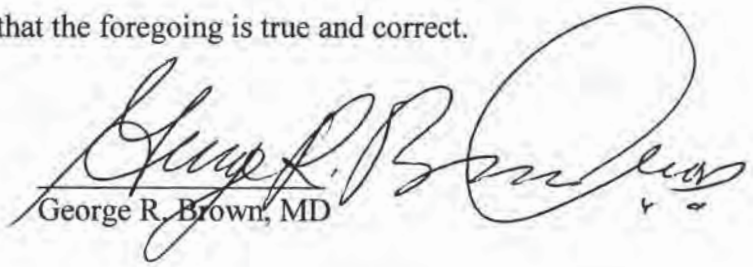
(“performing these surgeries on transgender patients may help maintain a vitally important skill required of military surgeons to effectively treat combat injuries during a period in which fewer combat injuries are sustained.”).

CONCLUSION

49. There is no evidence that being transgender alone affects military performance or readiness and there is no medical justification for the categorical exclusion of transgender individuals from the Armed Forces.

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

DATED: August 30, 2017


George R. Brown, MD

IN THE UNITED STATES DISTRICT COURT FOR
THE DISTRICT OF COLUMBIA

_____)	
DOE, et al.,)	
)	
<i>Plaintiffs,</i>)	
)	
v.)	Civil Action No. 17-cv-1597 (CKK)
)	
DONALD TRUMP, et al.,)	
)	
<i>Defendants.</i>)	
_____)	

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

I, Margaret Chamberlain Wilmoth, declare as follows:

Background and Experience

1. I served as Deputy Surgeon General for Mobilization, Readiness and Army Reserve Affairs in the Office of the Surgeon General of the United States Army from July 2014 to May 1, 2017.
2. I received a Bachelor’s degree in Nursing from the University of Maryland in 1975, followed by a Master’s Degree in Nursing from the University of Maryland in 1979. I received a Ph.D. in Nursing from the University of Pennsylvania in 1993. I received a Master’s Degree in Strategic Studies from the United States Army War College in 2001. I am a Registered Nurse.
3. My family’s history of military service dates back to the Revolutionary War. As a small child, I grew up hearing the stories of an aunt who was a nurse and a neighbor who had

served as an Army nurse during World War II. From the time I was 6 or 7 years old, I knew I wanted to be an Army nurse. When I graduated with my nursing degrees at the end of the Vietnam War, the Army was drawing down, so I went into civilian practice. I spent the first seven years of my nursing career as a teacher and researcher.

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

5. From July of 2008 through October 2011, I served as Assistant for Mobilization and Reserve Affairs in the Office of the Secretary of Defense for Health Affairs. From October 2011 through July of 2014, I served in the Control Group. In July of 2014, I was appointed Deputy Surgeon General for Mobilization and Reserve Affairs. When I received this appointment, I became the first nurse in the more than 106-year history of the Army Reserve and the first woman to serve in this position. I held this position until my retirement from the military on May 1, 2017.

6. In August of 2014, I was also appointed by the Secretary of the Army to the Army Reserve Forces Policy Committee, where I most recently served as Deputy Chair. This

congressionally-mandated committee's role includes advising the Secretary of the Army on major policy matters directly affecting the reserve components and the mobilization preparedness of the Army. I held this position until my retirement from the military on May 1, 2017.

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

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

9. Throughout my academic and research careers, my practice and research focus has been in psychosocial oncology. My research led to the development of a subspecialty in psychosexual oncology, which focuses on how surgery, chemotherapy, radiation, and immunotherapy impact body image, sexuality, and fertility. I have had more than sixty

psychosexual oncology academic papers published on topics such as comparing the effects of lumpectomy vs. mastectomy on sexual behaviors; and strategies to help nurses become comfortable with psychosexual assessments of patients.

Formation of Working Group

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

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

Working Group Process

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

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

14. **Step 2: Identifying How Medical Needs Could Be Met Within the Military Health System.** After we understood the universe of potential medical needs of transgender

service members, we focused on how the Military Health System (MHS) could meet those needs. For the large majority of medical care needs, we found that MHS was already providing the same or substantially similar services to other service members, and that there would be little, if any, additional burden on MHS from the provision of the required medical services to transgender service members.

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

16. The Working Group also examined whether there were any deployment-related obstacles to providing pharmaceutical care that requires routine doses of medication. We learned that service members with chronic conditions requiring routine medications regularly take with them enough medication to last for at least the first ninety (90) days of their deployment. Examples of such medications would include birth control, hormone replacement therapy, and medications to address low testosterone, hypertension, and osteoporosis, among other conditions. Each Combatant Command sets rules in the form of Personnel Policy Guidance that specifies any special restrictions on deployability of members to that Command, including medical restrictions. For example, a theatre that has only intermittent access to a medical supply train might require service members to bring extra medical supplies or restrict certain service members from serving in particular locations. Such issues are readily addressed in the field through the Personnel Policy

Guidance, and no unique or different issues would be raised by the pharmaceutical needs of transgender service members. The Working Group concluded that no additional burden on deployability would be created by transgender service members who required routine medication.

17. With respect to gynecological care, we learned that MHS already routinely provides this care to its service members. With transgender service members being permitted to serve openly, the concerns about confidentiality that might previously have hindered transgender service members from seeking gynecological care through MHS would no longer be an issue. Transgender service members would now be able to receive all routine medical care including gynecological services through MHS, allowing for more complete and coordinated care for the service members. The Working Group concluded that no additional burden on MHS would be created by the provision of gynecological care to transgender service members.

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

19. The Working Group also examined whether there were any deployment or readiness related obstacles associated with addressing the mental health needs of transgender

service members. The Working Group educated itself in part by consulting with our counterparts in Israel, the United Kingdom, and Australia, where open service by transgender individuals is permitted. We learned that those services have seen no reduced ability to serve from transgender service members due to mental health or other gender identity related issues. The Working Group also examined our own military's existing policies and learned that there is a rigorous screening process for all individuals applying to join the military that includes examination of mental health. The Military Entrance Processing Stations (MEPS) (enlistment processing offices) evaluate psychological stability as a component of fitness to serve. Additionally, once individuals are in active or reserve service, mental health is evaluated on an annual basis as part of the Periodic Health Assessment (PHA). The Working Group found that there was no reason to think that these pre-existing military policies, when applied to transgender service members serving openly, would not adequately protect the services from any mental health issues interfering with deployment.

20. With respect to surgical therapy, the Working Group consulted with surgical experts to determine whether there were any aspects of surgical therapy for transgender service members in which MHS did not already have the requisite expertise. We learned that MHS employs general surgeons, urologists who perform urological surgeries, and obstetrician/gynecologists who perform gynecological surgeries. Those skill sets are present in a substantial capacity within MHS, and MHS is able to address most routine surgical needs at or near the location of its service members. We learned, for instance, that surgeries for transgender service members would be relatively rare and that many of those surgeries are already routinely provided to non-transgender service members, such as hysterectomies or chest surgeries. For

surgeries requiring particular expertise, MHS maintains major medical centers that are equipped to provide a broader array of services. For surgeries requiring expertise outside of MHS's capacity, service members are typically referred out to civilian providers. The non-routine surgical needs of a transgender service member could be addressed either through training or contracting with surgeons with the appropriate expertise to MHS, or through the normal process for referring out of MHS to civilian providers. The Working Group concluded that the surgical needs of transgender service members could be addressed through either of these methods without creating additional burden on MHS.

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

22. **Step 3: Policy Development.** Throughout this educational process, the Working Group members developed a deep understanding of the medical needs of transgender service members. Next, we turned our focus to developing a policy that would address the psychological and physical needs of transgender individuals and treat those individuals fairly while keeping

readiness and deployability at the forefront. Developing the protocol was an iterative process involving multiple rounds of drafting, gathering input from the services, and redrafting.

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

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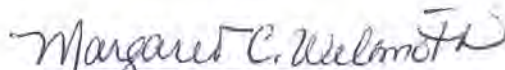
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24. The Working Group's process for developing the protocol and recommendations was deliberative and thoughtful, involved significant amounts of research and education, and in the end resulted in a policy that all services supported. We were very proud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

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

Dated: August 30, 2017


Margaret C. Wilmoth

**IN THE UNITED STATES DISTRICT COURT FOR
THE DISTRICT OF COLUMBIA**

_____)	
DOE, et al.,)	
)	
<i>Plaintiffs,</i>)	
)	
v.)	Civil Action No. 17-cv-1597 (CKK)
)	
DONALD TRUMP, et al.,)	
)	
<i>Defendants.</i>)	
_____)	

**DECLARATION OF REGAN V. KIBBY
IN SUPPORT OF PLAINTIFFS’ MOTION FOR PRELIMINARY INJUNCTION**

I, Regan Kibby, declare as follows:

1. I am a nineteen year old midshipman at the United States Naval Academy in Annapolis, Maryland. I have completed the first two years of my Naval Academy education, double majoring in English and History. I am transgender.

Early Education and Entrance to the Naval Academy

2. I was born in San Diego and lived there until the fifth grade, when I moved to North Carolina. Spending my formative years in a big military town like San Diego made the thought of serving present for me from an early age.

3. My father had served in the Navy, which ingrained in me a deep recognition of the pride and honor associated with military service. I always felt that if I could serve my country in the Armed Forces, I should. It felt like a duty.

4. In high school I enrolled in the Junior Reserve Officers’ Training Corps. My instructors recognized that I had potential and encouraged me to begin planning for my future,

including looking into the service academies. I did research, and by my junior year I was set on attending an academy.

5. I applied to the summer seminars at the United States Military Academy, the United States Air Force Academy, and the United States Naval Academy and got accepted to all of them. I attended each in consecutive weeks during the summer after my junior year of high school. At the beginning of senior year I did a candidate visit to the Coast Guard Academy.

6. I was very driven to do what it took to get into an academy. I focused hard on sports, extracurricular activities, and JROTC. I excelled at academics, took advanced classes, and never received less than A. I had strong test scores.

7. I found I was drawn to maritime service and decided to apply to the Naval and Coast Guard academies. I also applied to Norwich University and the Virginia Military Institute and was accepted to both with a full Navy Reserve Officers' Training Corps scholarship.

8. When I was accepted to the Naval Academy, I immediately decided to enroll there. My Induction Day occurred on July 1, 2015, and I joined the class of 2019. I was extremely proud to become a midshipman and knew I was where I wanted to be.

9. My first two years at the Naval Academy have been a rigorous and rewarding experience. After I graduate, I hope to perform my service as a Surface Warfare Officer aboard a Navy ship.

Transgender Identity and Coming Out at the Naval Academy

10. I always felt out of place in the social roles that were expected of me as a result of the sex assigned to me at birth. For a while I did not have the words to describe how I felt. In middle school I learned the term "transgender" and tried to learn more about it. At the time I did

not quite know why I felt so drawn to the subject, but I knew that learning about the identity and seeing the stories of transgender people made me feel inexplicably happy and right.

11. Around the same time, I was getting more serious about a future in the military. During my freshman year of high school Don't Ask Don't Tell was repealed, but transgender people were still prohibited from military service. Some part of me internalized the reality that being transgender and being in the military were not coinciding identities, and as a result I tried not to think about my gender. I stopped doing research and did not discuss it with anyone, and before long I had succeeded in burying that short span of partial realization. Unfortunately, I also buried the feelings of happiness and rightness I had briefly experienced.

12. Due to my masculine appearance and behavior, many people in school automatically perceived me as gay. Instead of openly identifying myself as transgender, even to myself, I accepted that label. Even though being labelled gay in rural North Carolina is not easy, I think I subconsciously knew that it was easier than being transgender.

13. On July 28, 2015, after I started at the Naval Academy, Secretary of Defense Ashton Carter issued an order announcing that transgender people could not be separated from the military on the basis of their gender identity.

14. Following this announcement, I started to allow myself to think more about my identity. I started being more open and honest with myself and began remembering things I had tried to ignore. After a period of self-realization, a few months into freshman year, I started to come out as transgender.

15. The first people I came out to were in Navy Spectrum, an organization for LGBT midshipmen and their allies. I also talked to my sister, with whom I am really close. I then came out to my three roommates, all of whom were very accepting. After that, I came out to the rest

of my family, and during my second semester in early 2016, I came out to my chain of command including my Company Officer.

Developing a Transition Plan to Serve Openly

16. My Company Officer was very accepting and supportive and made sure everyone treated me with respect. Because my chain of command was awaiting the conclusions of the Working Group on transgender service members that had been formed following Secretary Carter's order, no policy was yet available for them to follow.

17. In June of 2016, Secretary of Defense Ashton Carter announced that transgender people would be able to serve openly in the U.S. armed forces and that, starting on July 1, 2017, transgender people would be eligible to enlist in the military on equal terms with others.

18. I was completing summer school and summer training at the time and immediately emailed my Company Officer and asked if he had heard about the new policy or how it would be implemented at the Naval Academy. He did not have any information, but he said he would try to learn more and we scheduled a meeting for the start of the school year.

19. At that meeting, my Company Officer put me in touch with the Brigade Medical Officer (BMO) to begin the process of getting a diagnosis and a medical treatment plan.

20. In the fall of 2016, I met with the BMO. No guidelines for implementation of the new policy had been issued yet, but we knew the first step would be receiving an official diagnosis and an annotation in my medical record that transition was medically necessary. I scheduled an appointment with a psychiatrist and received both of those things.

21. Later that fall, the Navy issued a directive outlining the protocol for gender transition for service members, including midshipmen, as well as guidelines for the requirements that a transgender person would have to meet in order to be eligible to enlist. I met again with

the BMO and began discussing the rest of the process for my treatment plan. This involved many consultations with different medical professionals. I met multiple times with mental health care providers, an endocrinologist, and a plastic surgeon to develop my treatment plan.

22. The military's policy on accessions requires transgender individuals to have had eighteen months of stability in their gender identity prior to accession, meaning that everything in the treatment plan must be completed and a physician must certify that my transition is complete eighteen months before I can be commissioned. While all midshipmen are members of the military, we are still considered part of an accessions program since we do not receive our commission until graduation.

23. My treatment plan involves hormone therapy, top surgery, and real life experience. Once my doctor signs off that my treatment plan is complete, I can change the gender marker in the Defense Enrollment Eligibility Reporting System (DEERS), thus beginning the eighteen-month period of stability required for accessions.

24. Early on in the development of my treatment plan, during the winter of 2016-2017, the BMO and I started looking into how transitioning would impact my commissioning. We knew that approval and implementation of my plan would take many more months and that accessions happen immediately following graduation. Counting backward, we calculated that in order to have fully transitioned eighteen months prior to graduation (halfway through my junior year), I would need to take a year off from the academy.

25. I went through the standard medical and legal processes to request an official medical leave of absence from the Naval Academy. Working with the Transgender Care Team at Portsmouth's Naval Medical Center, we finalized the treatment plan.

26. At the end of this past school year, in May of 2017, the Commandant and Superintendent officially approved the medical transition plan and the request for a year-long medical leave of absence. I was the first midshipman to receive clearance to transition while enrolled at the Academy. Upon approval of this plan, I felt a huge sense of relief that I would not have to make a choice between two fundamental parts of my identity: being transgender and serving my country. I looked forward to graduating from the Academy and beginning my military service without having to hide who I am. Knowing that I could serve openly gave me confidence and hope for the future, and pride in our country and our Armed Forces.

27. During the month of June, I went on a regularly scheduled four-week summer training for midshipmen. Upon returning to the Naval Academy, I completed my leave paperwork. Two weeks after that I returned to North Carolina to begin my medical leave.

28. During my year of medical leave, in addition to receiving hormone therapy under the supervision of an endocrinologist, I intend to do everything I can to ensure that my return to the Naval Academy is successful and that I will be a valuable service member. I will keep in touch regularly with the Academy. I am interning at a law firm to gain professional experience. I am taking an EMT class in order to learn valuable skills, including how to save lives. I am completing a rigorous exercise and training regimen so that I will be able to meet the male fitness standards upon my return. I can already meet the male standards for push-ups and sit-ups and will be working hard on my run time. I am looking forward to returning to the Academy in the fall of 2018 and completing my education.

The July 2017 Tweet and the August 25, 2017 Memorandum

29. On July 26, 2017, the President tweeted that transgender service members would no longer be allowed to serve in the military “in any capacity.”

30. I first found out about the President's tweets through an email I received from one of my professors, offering comfort and support. Without asking what the email referred to, I Googled "transgender military." Then I saw the tweet.

31. I was devastated. The entire future I had planned for myself was crumbling around me, and I did not know what to do. To be told that you are less than, that you are not worthy, is a terrible feeling. Throughout the next few days I oscillated between anger at the unfairness of my situation and intense sadness at everything I was losing. I had a hard time focusing throughout the day. More than once I woke up crying.

32. Then, on August 25, 2017, I learned that President Trump issued a memorandum to the Secretary of Defense, directing him to reverse the policy permitting open service of transgender people.

33. When I came out as transgender I was relying on formal policies by the Navy and the Secretary of Defense that service members could no longer be separated or dismissed for being transgender, and that transgender persons would be eligible to enlist in the service provided they could demonstrate eighteen months of stability in their gender identity prior to accession. If the President's new ban means that these policies are not true, and if the new ban is permitted to stand, I will never be able to serve as a member of the Armed Forces. This causes me great distress, as the implications for my future are dire.

34. I am living in a state of uncertainty because I have not been able to obtain any assurances from my chain of command about my return to the Academy or my future military service. They have been silent because they have not known how the previously announced policies will change.

35. Now that the President has officially reversed the policy permitting open service, I am extremely concerned that I will not be permitted to remain at the Naval Academy.

36. Under the policy announced in the President's August 25, 2017 memorandum, I am ineligible to be commissioned as an officer in the Navy. If a midshipman becomes ineligible to be commissioned for any reason, they are no longer eligible to attend the Naval Academy. If that happens to me, I will suffer many different losses:

37. **Loss of Opportunity.** The Naval Academy provides incredible educational and professional development opportunities unparalleled at other institutions. We have access to travel experiences, study abroad programs, and unique internships, and of course we have the unique opportunity of beginning our professional careers by serving in the military after graduation. If I am removed from the Naval Academy, I will no longer have access to these opportunities, which cannot be replicated or even remotely approached by any civilian school.

38. **Loss of Connection to Military Network.** When one graduates with the prestigious degree that the Naval Academy provides, a connection is immediately forged to a unique network of academy alumni. From talking with fellow classmates and alumni, I understand this network is extremely valuable through the rest of your life, connecting you to others through this shared unique, intense, and rigorous experience. If I am removed from the Naval Academy, I will be deprived of access to this network of individuals of whom I long to be a part.

39. **Loss of Unique Academic and Leadership Opportunities.** The service academies are extremely selective and take less than 10% of applicants. Achieving admission is an impressive feat in and of itself. After enrollment, the courses are academically rigorous and demanding. The Naval Academy has some of the best programs in the nation in science,

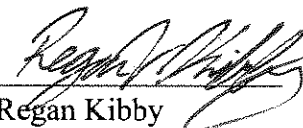
technology, engineering, mathematics, and liberal arts. The Academies also have extremely high physical fitness standards, higher even than the rest of the military. This is a point of pride for Naval Academy attendees. Graduation from the academy carries with it a recognition of unique intellectual and physical prowess, as well as a commitment to military service. I am extremely proud of my enrollment and academic success at the Naval Academy. If I am removed from the Academy, I will lose not only the benefit of my hard work and dedication, but the unique academic and leadership opportunities that no civilian university can provide.

40. **Loss of Reputation and Prestige.** The prestige associated with the service academies is widely recognized throughout the military and civilian society. The feeling of immense pride I have when I wear the midshipman uniform in public is something I deeply treasure. The idea that I may be prohibited from returning to the Naval Academy and prohibited from wearing that uniform again leaves me deeply saddened. If I am not permitted to return to the Naval Academy, as the President's new policy states, I will be forever deprived of the irreplaceable regard and esteem that benefit graduates of the Naval Academy throughout their lives.

41. **Damage to Self-Perception.** The President's statements and reversal of the policy permitting open service have changed the way I view myself. To be told that I can't serve my country even though I am willing and extremely qualified is incredibly frustrating and demoralizing, especially when there are so many others who could choose to serve but don't. When the most powerful man in the world publicly announces that I am not worthy to serve based on a factor that has nothing to do with my ability, dedication, or performance, it is deeply painful, and it is a pain I will have to bear all my life if I am not allowed to return to the Naval Academy.

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

DATED: August 28, 2017


Regan Kibby

**IN THE UNITED STATES DISTRICT COURT FOR
THE DISTRICT OF COLUMBIA**

_____)	
DOE, et al.,)	
)	
<i>Plaintiffs,</i>)	
)	
v.)	Civil Action No. 17-cv-1597 (CKK)
)	
DONALD TRUMP, et al.,)	
)	
<i>Defendants.</i>)	
_____)	

**DECLARATION OF DYLAN KOHERE
IN SUPPORT OF PLAINTIFFS’ MOTION FOR PRELIMINARY INJUNCTION**

I, Dylan Kohere, declare as follows:

1. I am eighteen years old and a first-year student the University of New Haven in West Haven, Connecticut. I am a member of the Army Reserve Officers’ Training Corps (ROTC) program at the University. I am transgender.

Early Life and Entry into Army ROTC

2. I grew up in New Jersey, where my parents still live. I have been interested in military service since I was quite young. Both of my grandfathers served in the military, and I had always been attracted to the idea of serving my country in the armed forces. My goal today is to spend my entire career in the military.

3. I considered enlisting directly after high school but eventually decided that going to college and enrolling in ROTC would be a better option for me. With ROTC, I can get a college education before I start my service and will have the career opportunities that come with being commissioned as an officer.

4. I have just started my first year of college and am living in ROTC housing. At this point in my program, we do not wear uniforms, but we have physical training three times per week and classroom instruction one day per week.

Transgender Identity and Coming Out

5. From a very young age, I was always interested in the things boys were interested in. I spent most of my time with the boys and did “guy stuff.” At that point, I did not know what being transgender meant, and I did not openly identify as a boy. I was just myself.

6. Everyone around me accepted my gender nonconformity until sometime during middle school. At that point, some people started to make fun of me for being too masculine. That was when I started to understand that there are stereotypes and expectations that people have about gender and how boys and girls are supposed to act. I started trying to conform to those stereotypes by making my appearance more feminine like the girls around me. I was depressed and really unhappy when I looked at the person in the mirror, because I knew that was not who I was.

7. When I entered high school, I became a member of the school’s Gay-Straight Alliance (“GSA”). In the GSA, our first meeting was about transgender issues, and I began to learn more about what gender identity is. During my freshman year, I began to come out as transgender, first to close friends and then to my family and others.

8. I had a good support system at my high school. My friends were very supportive, and there were also some very supportive teachers. By my senior year, I was president of the school GSA.

9. So far, everyone in the ROTC program has been very accepting of my transgender identity. My Sergeant knows I am transgender and has been supportive. I asked her whether

there are any regulations that might affect my participation in ROTC and she said she didn't know.

10. I have started working with medical professionals to begin a treatment plan for my transition. At this point, my health care is paid for by my parents' health insurance. I expect that my transition will be complete long before I graduate from college.

Effect of Changing Military Policy on Service by Transgender People

11. A big part of the reason I was comfortable coming out as transgender in the ROTC was the announcement in the summer of 2016 that transgender people would be able to serve openly in the military. I was so excited that I would be able to achieve my goal of serving while remaining true to who I am.

12. On July 26, 2017, as I was getting ready to go to college and enter ROTC, the President tweeted that transgender service members would no longer be allowed to serve in the military "in any capacity."

13. I was shocked and angry. I felt that the plans I had made for the rest of my life were being thrown out the window. I felt like I was no longer in control of my life, as if my life plans and goals were in someone else's hands.

14. On August 25, 2017, I learned that President Trump sent a memorandum to the Secretary of Defense and ordered him to reverse the policy allowing transgender people to serve openly in the military.

15. When I came out as transgender in my ROTC program, I was relying on the official policy announced in 2016 that transgender people would be able to serve openly. If the President's new ban means that the policy allowing open service is not true, and if the new ban is permitted to stand, I will never be able to serve as a member of the Armed Forces. It is

disheartening to learn that I could be denied an opportunity to serve based on something that has nothing to do with my ability or performance.

16. I am living with a great deal of uncertainty because I have not been able to obtain any information about my future military service or how it will affect my participation in ROTC. I am very concerned that I will not be allowed to complete my ROTC program or enter the military.

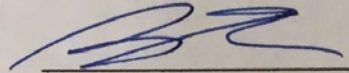
17. I will lose many things if the President's ban prevents me from serving or completing ROTC. First of all, I will lose educational and career opportunities. ROTC provides unique educational benefits and training, including extensive leadership training not available to other college students. This training is valuable in itself, but especially so because ROTC leads to a unique and very important career opportunity by allowing graduates to enter service as a military officer. If I am not allowed to enter military service or remain in ROTC, I will no longer have access to these opportunities, which is especially difficult for me since I had planned to make my entire career in military service.

18. If I am not allowed to continue in ROTC or sign a commitment to military service, I will also lose the opportunity to apply for a ROTC scholarship. I will have to pay for my own education, losing tens of thousands of dollars in tuition and living expenses that I could have earned with a scholarship.

19. The President's statements and reversal of the policy permitting open service have also affected the way I view my future prospects and life goals. To be told that I cannot serve for reasons that have nothing to do with my ability is hard to deal with, and I am frustrated by the unfairness of my situation. I want to serve in the military because I want to serve my country. To be denied that opportunity is extremely painful.

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

DATED: August 28, 2017


Dylan Kohere

CERTIFICATE OF SERVICE

I hereby certify that on September 21, 2018, I filed the foregoing Joint Appendix (Public Appendix, Volumes I-II) with the Clerk of the Court for the United States Court of Appeals for the District of Columbia Circuit by using the appellate CM/ECF system. All participants in the case are registered CM/ECF users and will be served by the appellate CM/ECF system.

s/ Tara S. Morrissey
Tara S. Morrissey