**IN THE UNITED STATES DISTRICT COURT**
**FOR THE EASTERN DISTRICT OF VIRGINIA**
**Alexandria Division**

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| NICHOLAS HARRISON; and OUTSERVE-SLDN, INC.,<br><br>Plaintiffs,<br><br>v.<br><br>PATRICK M. SHANAHAN, in his official capacity as Acting Secretary of Defense; *et al.*,<br><br>Defendants. | No. 1:18-cv-641-LMB-IDD |

**REPLY MEMORANDUM OF LAW IN SUPPORT OF OBJECTION TO MAGISTRATE JUDGE'S ORDER GRANTING PLAINTIFFS' MOTION TO COMPEL DOCUMENTS WITHHELD PURSUANT TO THE DELIBERATIVE PROCESS PRIVILEGE**

The March 14 Order is based on fundamental errors of law and fact. Initially, the decision relied on the erroneous holdings that Defendants and the military services waived the deliberative process privilege and that the withheld information was not deliberative and predecisional. Plaintiffs do not even attempt to address the error regarding waiver, and obfuscate the order's fundamental error of holding that draft revisions to policies are not deliberative. Next, the order's weighing of the *Cipollone* factors is erroneous. The order and Plaintiffs rely on the flawed premise that the documents at issue may be relevant to the Government's intent in adopting the challenged policies, and whether the Government's expressed reasons are pretextual. But there are no allegations of animus in the complaint. Rather, the Fourth Circuit applies the rational basis standard to the classification of individuals by HIV status. *See Doe v. Univ. of Md. Med. Sys. Corp.*, 50 F.3d

1261, 1267 (4th Cir. 1995). Under rational basis scrutiny, the actual motivation for a regulation is irrelevant. For this reason alone, Plaintiffs' motion to compel should have been denied in full.

## ARGUMENT

### I. Plaintiffs' Opposition Mischaracterizes The Basis Of The Magistrate Judge's Holding.

#### A. The March 14 Order Relied On Erroneous Holdings That The Government Waived Privilege And That The Documents Were Not Deliberative And Predecisional.

Although the March 14 Order states twice that waiver of the privilege is one of the two bases for requiring disclosure of the withheld documents, Dkt. 128 at 1, 3, Plaintiffs state that "[t]here is no need to address this aspect of the . . . opinion." Plfs' Opp., Dkt. 144 at 16-17. But contrary to Plaintiffs' apparent belief that this holding is mere surplusage, it is in fact one of the two bases on which the Magistrate Judge founded his decision. The Magistrate Judge's waiver determination was clearly erroneous and contrary to law because the deliberative process privilege can only be waived for individual documents by the release of that exact document. Defs.' Obj. at 22-24, Dkt. 138. Plaintiffs have, in effect, conceded that Defendants' objection to this holding is meritorious by failing to address it. *Brand v. N.C. Dep't of Crime Control & Pub. Safety*, 352 F. Supp. 2d 606, 618 (M.D.N.C. 2004) (collecting cases).

The March 14 Order also holds that "the documents withheld are not protected by the deliberative process privilege because they do not provide opinions or discussions of the military's HIV policies." Dkt. 128 at 1. Plaintiffs contend that the Magistrate Judge's opinion "did not find every document on the log non-deliberative or not predecisional." Pls.' Opp. at 14. But contrary to Plaintiffs' assertion, the plain language of the March 14 Order indicates that the Magistrate Judge's determination applies to all of the withheld or redacted documents. *See id.* at 3.[1] Instead of

[1] Plaintiffs assertion that "[t]he Magistrate Judge merely found that, '*in part*, Defendants have not demonstrated that the withheld or redacted documents are deliberative,'" is grammatically insupportable. Dkt. 144 at 14-15. The Magistrate Judge's entire statement was: "Therefore, based

meaningfully responding to the deficiencies of this holding as identified by Defendants in their Objection, Plaintiffs argue that this part of the Order does not encompass all of the withheld or redacted documents, without in any way identifying which documents they believe to be covered. Plaintiffs thus do not contradict Defendants' contention that the Magistrate Judge's blanket finding was clearly erroneous, but rather state that there is no clear error in his determination because at least *some* of the documents were not covered by the deliberative process privilege. *See id.* at 14. But that only concedes that some or perhaps most of the Defendants' withheld documents are predecisional and deliberative, and Plaintiffs make no attempt to explain in light of that concession why the Magistrate Judge's holding is not clearly erroneous. *See* Pls.' Opp. at 13 ("The Magistrate Judge did not clearly err when he determined that *at least some documents* were not predecisional or deliberative.") (emphasis added); 14 ("The Magistrate did not find every document on the log non-deliberative or not predecisional.").

Similarly, Plaintiffs fail to respond to Defendants' contention that the Magistrate Judge acted contrary to law by ordering the disclosure of privileged documents because they potentially contained some unprivileged material rather than requiring the segregation of privileged and non-privileged material through redaction. The examples provided by Plaintiffs of the Magistrate Judge's comments regarding the deliberative nature of specific statements, or items within withheld documents, illustrate why this approach was clearly erroneous and contrary to law. *See id.* at 14. Although drafts of in-process documents are a well-established example of protected predecisional and deliberative documents, the Magistrate Judge found that the privilege did not apply because

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on these examples, in part, Defendants have not demonstrated that the withheld or redacted documents are deliberative." Dkt. 128 at 2. The "in part" clearly modifies "these examples" and is in keeping with the fact that there is no indication in the Order that the holding was intended to apply only to an unidentified subgroup of documents.

specific individual comments within the drafts did not "discuss opinions and recommendations" in isolation. *See id.*; Dkt. 128 at 3. That is clear error; the documents are deliberative because they are drafts in progress, regardless of whether individual comments contained recommendations and opinions. Similarly, the Order requires the release of minutes reflecting a meeting for the purpose of deliberations concerning various Department of Defense accessions policies because the first three pages of the document list the attendees. Pls.' Opp. at 14; Dkt. 128 at 1. Again that is error because it fails to account for the plainly deliberative portion of the document. Such undifferentiated determinations clearly do not serve the purpose of the deliberative process privilege, an argument which Plaintiffs have not challenged.

Plaintiffs argue that the Magistrate Judge's errors concerning the deliberative nature of the documents and the government's alleged waiver of the privilege is harmless because the Magistrate Judge also ordered disclosure based on his balancing of the *Cipollone* factors. That alternative holding is error, as explained below. And, in any event, Plaintiffs' argument fails to grapple with the shortcomings of the Magistrate Judge's deliberative-process and wavier analysis.

**B. The Magistrate Judge's Failure To Perform An Individualized Review Of The Documents Was Erroneous And Contrary To Law.**

Plaintiffs also contend that Defendants' challenge to the procedures used by the Magistrate Judge to determine whether the deliberative process privilege applied to the withheld documents is "misguided." Plaintiffs' opposition to this objection misunderstands Defendants' argument and ignores the practical realities of assessing the privilege. Defendants challenge both the Magistrate Judge's failure to determine whether the withheld or redacted documents were predecisional or deliberative individually and the improper balancing of the *Cipollone* factors applicable to all of the withheld documents. Plaintiffs respond only that a document by document review is not necessary to properly perform the *Cipollone* balancing test. But determining the applicability of the privilege

to predecisional and deliberative documents is a necessary precondition to consideration of the balance of needs under the *Cipollone* test and the analysis is separate. *See Cipollone v. Liggett Group, Inc.,* 812 F.2d 1400, at *1-2 (4th Cir. Feb. 13, 1987) (unpublished disposition *available at* 1987 WL 36515). Other courts have held not only that "the trial court is tasked with addressing, on a document-by-document basis . . . whether the government has established that the invoked privilege applies," but that it must apply the same document by document analysis to the question of whether "the benefits of disclosure will outweigh the harms." *In re United States*, 678 F. App'x 981, 987 (Fed. Cir. 2017). Additionally, the Plaintiffs have not offered any argument or authority to challenge the practical fact that the deliberative process privilege is "*dependent upon the individual document* and the role it plays in the administrative process." *Coastal States Gas Corp. v. DOE*, 617 F.2d 854, 867 (D.C. Cir. 1980) (emphasis added); *see also City of Va. Beach v. DOC*, 995 F.2d 1247, 1254 4th Cir. 1993); *Jones v. Murphy*, 256 F.R.D. 510, 518 (D. Md. 2008). Indeed, the examples of specific phrases or parts of documents cited by Plaintiffs and the March 14 Order illustrate the necessity of examining the particular content of any document withheld to determine if the privilege is properly asserted. Plaintiffs offer nothing to explain how a blanket determination that the deliberative process privilege is inapplicable to 330 documents could reasonably be accomplished by reviewing the contents of 33 documents.[2]

[2] Defendants do not contend, as Plaintiffs suggest, that the Magistrate Judge did not review all 33 of the documents submitted for *in camera* review. Rather, Defendants challenge both the analysis as it applies to those 33 documents, and the procedure by which the Magistrate Judge extrapolated from that analysis to each and every one of the 330 withheld or redacted documents.

Plaintiffs also argue that the cases presented by the Government as examples of courts conducting a document by document analysis are distinguishable because they involve fewer documents and intent is not at issue. But the number of documents is not a principled or informative distinction and the Magistrate Judge did not rely on the question of intent to find that the deliberative process privilege was not available in this case.

Plaintiffs' attempt to rehabilitate the Magistrate Judge's methodology also fails. First, Plaintiffs' assertion that Defendants "agreed to employ" the sampling method used by the Magistrate Judge to conduct *in camera* review is misleading. Pls.' Opp. at 4. In response to the motion to compel, Defendants requested that the Court conduct an *in camera* review of all withheld documents if it declined to rely on the privilege log, and the Magistrate Judge stated at the initial hearing that he would not conduct that analysis. Dkt. 115, Feb. 1, 2019, Hearing Trans., 5:22-6:12. The parties were then ordered at that hearing and a subsequent hearing on February 8, 2019, to agree to a procedure to reduce the number of documents for review by the Court. The Government produced a sample of documents because it was directed to do so.

Second, Plaintiffs contend that the privilege logs provided by the Defendants were insufficient and caused the burden of justifying the assertions of privileged to shift onto the Court. Defendants maintain that their logs are sufficient to allow the Court to determine whether the documents were properly withheld. But even if they were insufficient, Plaintiffs should have moved for, and the Court could have granted, an order requiring a more detailed privilege log. Typically, courts in this district provide a party with multiple opportunities to update their privilege log after finding it inadequate before compelling the release of privileged documents. *See, e.g.*, *Rambus, Inc. v. Infineon Techs. AG*, 220 F.R.D. 264, 274 (E.D. Va. 2004) (providing multiple opportunities to create a "fulsome" privilege log and reviewing documents in camera, before compelling production of privileged documents due to an inadequate log); *ePlus Inc. v. Lawson Software, Inc.*, 280 F.R.D. 247, 250 (E.D. Va. 2012), *enforcement granted in part, denied in part by* No. 3:09CV620, 2012 WL 6562735 (E.D. Va. Dec. 14, 2012) (ordering multiple revisions to a privilege log before compelling production); *Asghari-Kamrani v. United Servs. Auto. Ass'n*, No. 2:15CV478, 2016 WL 8243171, at *3 (E.D. Va. Oct. 21, 2016) (finding a categorical privilege

log sufficient even when the first privilege log was deficient); *Cappetta v. GC Servs. Ltd. P'ship*, No. CIV. A. 3:08CV288, 2008 WL 5377934, at *6 (E.D. Va. Dec. 24, 2008) (ordering Defendant to "update and particularize" its claimed privileges). Instead, Plaintiffs immediately moved for disclosure of each and every withheld or redacted document regardless of its content on the ground that the deliberative process privilege is inapplicable to this case because the government's intent is allegedly at issue. Plfs.' Mot. to Compel., Dkt. 108 at 8-10. As discussed *supra*, the Magistrate Judge did not adopt that argument in reaching the challenged decision. Because Plaintiffs did not challenge the sufficiency of the privilege log in their motion to compel or ask the Court to require supplementation, they cannot raise that argument now to attempt to justify the errors in the March 14 Order.

Third, Plaintiffs contend that Defendants are not entitled to a document by document analysis because the descriptions of various documents in the privilege logs are similar. Pls.' Opp. at 16. This argument ignores the obvious fact that Plaintiffs' discovery requests covered the same subject matter areas over an extended time period and predictably produced numerous versions and revisions of similar documents. Particularly in the case of drafts, creation of those documents is iterative and different versions exist reflecting changes throughout the drafting process. Although these documents are similar, they are not identical and it is necessary to assess the content of each document to determine if it is predecisional and deliberative. And though each document may only contain minor changes, the collection of many revisions of a draft over time directly reveal the deliberations that went into the content of the document.

The March 14 Order's conclusions were erroneous and contrary to law as to whether the deliberative process privilege applies and if privilege was waived over any documents, they should be overruled.

## II. The March 14 Order's Conclusion On The *Cipollone* Factors Is Erroneous And Contrary To Law.

Additionally, the order's weighing of the *Cipollone* factors is erroneous and contrary to law. First, the magistrate judge's decision that the Government's intent is relevant is contrary to the long line of cases that hold, under rational basis scrutiny, a challenged regulation will be upheld if there is any reasonably conceivable state of facts that could provide a rational basis for it, regardless of whether the offered justification is the actual motivation for the regulation. And the Magistrate Judge's conclusions regarding the weighing of the second *Cipollone* factor was in error because the sole reason provided for weighing this factor in favor of Plaintiffs is the conclusion that the Government's subjective intent is relevant. Finally, the magistrate judge's conclusion that there would be no chilling of ongoing and future policy deliberations was erroneous.

### A. The March 14 Order's Conclusion Regarding The First *Cipollone* Factor Is Contrary To Law And Erroneous.

#### 1. Under A Rational Basis Review, The Government's Intent Is Not At Issue.

Contrary to Plaintiffs' arguments, under the rational basis standard that the Fourth Circuit applies to classification of individuals by HIV status, *Doe v. Univ. of Md. Med. Sys. Corp.*, 50 F.3d 1261, 1267 (4th Cir. 1995), the government decision and the bases for that decision stand independently from the policy making process. Plaintiffs do not require deliberative information to refute the justifications for the challenged policies. Pls. Opp. at 8, Dkt. No. 144. In fact, the Supreme Court has directed courts to uphold a challenged regulation "if there is any reasonably conceivable state of facts that could provide a rational basis" for it, regardless of whether the offered justification is the actual motivation for the regulation. *FCC v. Beach Communications, Inc.*, 508 U.S. 307, 313, 315 (1993); *cf. S.C. Educ. Ass'n v. Campbell*, 883 F.2d 1251, 1257-61 (4th

Cir. 1989) (explaining that except in certain exceptional cases, courts may not consider possible legislative motives in evaluating the constitutionality of state statutes).[3]

Further, Plaintiffs' argument that the Court should apply heightened scrutiny to this military personnel policy is contrary to Supreme Court guidance on the review of military policies. Courts "give great deference to the professional judgment of military authorities concerning the relative importance of a particular military interest." *Winter v. NRDC, Inc.*, 555 U.S. 7, 24 (2008) (quotation omitted). If the decision at issue involves "the composition, training, equipping, and control of a military force," *Gilligan v. Morgan*, 413 U.S. 1, 10 (1973), then deference to the military's policy judgments must be applied. *See Winter*, 555 U.S. at 27. Judicial review "is far more deferential than constitutional review of similar laws or regulations designed for civilian society." *Goldman v. Weinberger*, 475 U.S. 503, 507 (1986). This is so even where the policy is facially discriminatory. *Rostker v. Goldberg*, 453 U.S. 57, 69-72 (1981); *see also Doe 2 v. Shanahan*, 917 F.3d 694, 732 (D.C. Cir. 2019) (Williams, J., concurring).

The cases cited by Plaintiffs are distinguishable. Here, unlike in *Romer v. Evans*, 517 U.S. 620 (1996), and *United States v. Windsor*, 570 U.S. 744 (2013), there are no allegations of animus or other discriminatory intent in the complaint. Additionally, there is no evidence in the record that suggests the possibility of discriminatory animus. Plaintiffs do not respond to this point, even in a

[3] The reasoning in *Karnoski v. Trump* is also incorrect for this reason. Additionally, *Karnoski* was stayed by the Ninth Circuit pending that court's consideration of the Government's petition to vacate that decision. Order, *In re Trump*, No. 18-72159 (9th Cir. Sept. 17, 2018), Dkt. 36. And even assuming that the *Karnoski* decision is affirmed, that decision, like *Stone*, is distinguishable. Unlike here, the courts in *Karnoski* and *Stone* found that the challenged policies are facially discriminatory. Furthermore, as Defendants explained in the Objections, Dkt. 138 at 8 n.2, the rationale for the wide-ranging discovery permitted in *Karnoski* and *Stone* was called into question by the concurring opinions in *Doe 2 v. Shanahan*. *See* 917 F.3d 694, 706, 736-38 (D.C. Cir. 2019).

conclusory way, despite the fact that it was squarely raised in the objections and at various other points throughout the discovery process.

In sum, under the rational basis standard applied to the claims here, Plaintiffs are burdened with refuting the justifications offered to support the government decision. Those justifications are public and disclosed. *See, e.g.*, Dkt. 53-2 (2014 Report to Congress); Ex. A (2018 Report to Congress). Accordingly, the government's deliberations are not relevant to the case because they have no bearing on whether the Defendants' justifications are rationally related to the interests they claim.

**2. The Example Deliberative Documents Illustrate That The Documents Are Not Relevant To Plaintiffs' Claims.**

Examples of deliberative documents referenced in Plaintiffs' response illustrate why the deliberative materials are not relevant to plaintiffs' claims. For instance, the email, US00002429, plainly notes that the redacted information was a discussion about the forthcoming revision to the policy, not the policy that Plaintiffs challenge here, nor the application of the policy to Plaintiff Harrison. *See* Pls. Opp. at 8. Information about the Army's ongoing revision cannot be used to show any alleged animus or intent in the 2014 version of the regulation, nor does information about the Army's ongoing revision bear on the existence of any pretextual motivation at the time the Army adopted the current regulation in 2014.

Moreover, the redacted information is the personal opinion of a subordinate official. It is well-established that the privilege covers information that reflects the personal opinions of the writer rather than the policy of the agency. *Nat'l Sec. Archive v. CIA*, 859 F. Supp. 2d 65, 70 (D.D.C. 2012). Further, the redacted information cannot reflect the Army's official position because the Army has not yet decided whether it will even adopt the subordinate's conclusions. *See, e.g.*, *Access Reports v. DOJ*, 926 F.2d 1192, 1195 (D.C. Cir. 1991) ("A document from a junior

to a senior is likely to reflect his or her own subjective opinions and will clearly have no binding effect on the recipient."); *see also Ethyl Corp.v. EPA*, 25 F.3d 1241, 1249 (4th Cir. 1994). Thus, the redacted information, as well as Lieutenant Colonel Lute's personal belief, are not relevant to an inquiry into the Army's intent both because that intent only come from the senior leaders who actually decide policy, and because they are subsequent to the time of publication of the current policy. And Plaintiffs' argument that they are seeking information about the ongoing revision to get commentary on the current policy is contrary to Fourth Circuit precedent. The Fourth Circuit has cautioned courts not to engage in such semantics because "[a]gencies are, and properly should be, engaged in a continuing process of examining their policies." *City of Virginia Beach*, 995 F.2d at 1253.

**3. Plaintiffs Have Not Alleged Animus, And There Are No Viable Allegations In The Complaint That Support Their Assertion of Disparate Treatment.**

Plaintiffs also do not dispute that their argument is based entirely on the allegations of their complaint, and that there are no viable allegations in the complaint that support Plaintiffs' assertion of disparate treatment. Plaintiffs strategically chose not to allege animus in the complaint. Rather, they alleged only that Defendants' policies have not kept up with medical science. Plaintiffs cannot make the strategic decision to omit allegations of animus in one stage of litigation and then choose to rely on "coined phrases" later in the litigation about animus (without any plausible allegations or record support) in the hope of forcing the military to divulge privileged materials.

But even if there were bare allegations in the complaint, allegations alone are insufficient to overcome the deliberative process privilege. *See Alexander v. FBI*, 186 F.R.D. 154, 164 (D.D.C. 1999). Thus, Plaintiffs have failed to demonstrate "a compelling need sufficient to overcome the qualified privilege," and the Magistrate Judge conclusions to the contrary are in error. *See Scott v. PPG Industries, Inc.*, 142 F.R.D. 291, 293 (N.D. W. Va. 1992).

### B. The March 14 Order's Conclusion Regarding The Second *Cipollone* Factor Is Contrary To Law

As explained in the Objections, the Magistrate Judge's conclusions regarding the weighing of the second *Cipollone* factor was in error because the sole reason the Order provides for weighing this factor in favor of Plaintiffs is his conclusion that the Government's subjective intent is relevant. But as explained above, the Government's intent in promulgating the challenged regulations is irrelevant under rational basis scrutiny, especially in the context of a military personnel policy. For this reason, the fact that the information is in Defendants' sole possession does not cause this factor to weigh in favor of overcoming Defendants' entitlement to the privilege.

### C. The Arguments Presented In Response To The Third *Cipollone* Factor Are Not Properly Before The Court.

Defendants do not contest that they are parties to this case, which is the thrust of the third *Cipollone* factor. In their response, Plaintiffs repackage a different argument made in their motion to compel, that the deliberative process does not apply here because Defendants' intent is at issue. Pls. Opp. at 10-11. But the Magistrate Judge did not rely on this argument in the March 14 Order. Although Plaintiffs acknowledge in their opposition, twice, that the Magistrate Judge's opinion did not adopt or rely in any way on their argument that the deliberative process privilege is unavailable as a matter of law when the government's intent is at issue, they nevertheless raise this argument again to the Court. Pls.' Opp. at 9 n.4, 11, Dkt. 144. Plaintiffs had the opportunity to object to the Magistrate Judge's ruling if they believed his decision not to rule on that ground was in error and they chose not to make any objection. *See* Fed. R. Civ. P. 72(a).[4]

[4] Plaintiffs' assertion that "Defendants also fail to mention that some of the same documents they are ordered to produce in this case have been ordered to be produced in other cases," is similarly improper and also irrelevant. Plfs' Opp. at 1, Magistrate Judge Davis was aware of the parties' positions on this point prior to issuing the challenged ruling, Dkt. 125, Feb. 22, 2019 Hearing Trans. 6:6-11:23, and did not rely on it in any way in his Order. Moreover, as Plaintiffs neglect to explain, the orders to produce documents withheld under the deliberative process privilege in both *Stone v.*

### D. The March 14 Order's Conclusion Regarding The Fourth *Cipollone* Factor Is Contrary To Law And Clearly Erroneous.

The Magistrate Judge's conclusion that the order was unlikely to chill future communications within DoD because of a protective order also is in error. *See* Dkt. 128 at 3. The critical inquiry for the chilling effect of disclosure is not the limiting of dissemination of disclosure, but rather "whether protection of the materials would promote better policymaking by encouraging candor in internal deliberations." *In re United States*, 678 F. App'x at 988. Indeed, the Fourth Circuit has acknowledged "the potential damage that disclosure, even to the district court, might have on the deliberative process of an agency." *Ethyl Corp.*, 25 F.3d at 1249 (citing *EPA v. Mink*, 410 U.S. 73, 93 (1973)). A protective order can "ameliorate but cannot eliminate these threatened harms." *Perry v. Schwarzenegger*, 591 F.3d 1147, 1164 (9th Cir. 2009).

Defendants have submitted declarations from *seven* military officials that explain the likely repercussions to future and ongoing policy deliberations within DoD and the services. *See* Dkt. 111-1 (Bahdi Decl. ¶¶ 3-6); 111-2 (Beland Decl. ¶¶ 7-9); 111-3 (Ciminera Decl. ¶¶ 8-12); 111-4 (Huibregtse Decl. ¶¶ 8-10); 111-5 (Melillo Decl. ¶¶ 8-18); 111-6 (Shell Decl. ¶¶ 8-12); 116-2 (Ausprung Decl. ¶¶ 3-7). The March 14 Order makes no mention of this evidence of potential chilling effect. Nor do Plaintiffs meaningfully address these declarations, instead dismissing them as including only boilerplate language. Pls. Opp. at 12. That contention mischaracterizes the officials' declarations. The Ausprung and Bahdi declarations, for example, provide a detailed description of repercussions that may result from the disclosure of the Army's ongoing review of AR 600-110. Dkt. 111-1 (Bahdi Decl. ¶¶ 4-5); Dkt. 116-2 (Ausprung Decl. ¶¶ 5-7). Ms. Ausprung

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*Trump*, and *Karnoskiv. Trump*, have been stayed pending review of those decisions. *Stone v. Trump*, 356 F. Supp. 3d 505, 518 (D. Md. 2018) (holding all factors weigh in favor of "staying the order compelling production of these documents purportedly covered by the deliberative process privilege until the resolution of the appeal in *Karnoski*"); Order, *In re Trump*, No. 18-72159 (9th Cir. Sept. 17, 2018), Dkt. 36.

explains that disclosure of these materials could misrepresent the Army's final policy judgments, potentially confuse issues, and influence the final outcome of the review. Dkt. 116-2 (Ausprung Decl. ¶¶ 5-7). That testimony is not boilerplate, and it would be error to treat it as such.

Plaintiffs quote *Cipollone*, and argue that a protective order is sufficient. But *Cipollone* is distinguishable. There, the Government had released "all the documents underlying the 1964 Surgeon General's Report," Pls.'s Opp. at 12, but had withheld the deliberative drafts of the report and comments on those drafts. *Cipollone*, 1987 WL 36515 at *1-3. Because of the Government's release of the underlying documents, the Fourth Circuit concluded that it was unlikely that the *additional* disclosure of the drafts and comments under a protective order would chill frank discussion by future contributors. *Id.* Here, by contrast, the Army has not published a revision to AR 600-110, and the documents underlying the ongoing revision have not been released. DoD and the military service have likewise not disclosed all deliberative materials underlying the withheld documents.

Plaintiffs also contend that discussions of future revisions cannot be privileged because they would at least, in part, discuss current policy—but this makes no sense and is contrary to Fourth Circuit precedent. Taken to its logical conclusion, no deliberative discussion can be "pre-decisional" under Plaintiff's theory. This argument was squarely rejected by the Fourth Circuit in *City of Virginia Beach* when it cautioned courts to be wary of drawing the line "between predecisional documents and postdecisional documents" because "[a]gencies are, and properly should be, engaged in a continuing process of examining their policies." 995 F.2d at 1253 (citation omitted). And, as noted above, the personal opinion of a subordinate like LtCol. Lute is not relevant to the inquiry into an agency's intent, especially where, as here, the agency has not adopted the official's opinion. *See Taxation With Representation Fund v. IRS*, 646 F.2d 666, 677-78 (D.C.

Cir. 1981) (remarking that "courts have recognized little public interest in the disclosure of 'reasons supporting a policy which an agency has rejected, or reasons which might have supplied, but did not supply, the basis for a policy which was actually adopted on a different ground'").

Further, it would be fundamentally disruptive, both practically and on separation of powers grounds, for the Court to pierce the Army's ongoing deliberative process at this stage—before the Army's leaders with strategic policy making experience have fully considered the staff's recommendations. At a minimum, ordering the Army to disclose incomplete deliberations will only mislead the parties or confuse the issues. Put simply, until the Army's senior leaders have fully consider the recommendations of their staff, and apply their best military judgment to either adopt or dismiss those recommendations, Plaintiff's alleged interest in learning the opinions of those who lack decision making authority cannot outweigh the government's interest in preserving the quality of its ongoing policy development processes.

## CONCLUSION

For all the reasons stated above, in the Defendants' objection, Dkt. 138, and in Defendants' opposition to the motion to compel, Dkt. 111, this Court should sustain Defendants' objection and deny Plaintiffs' motion to compel.

DATE: April 4, 2019

Respectfully submitted,

G. ZACHARY TERWILLIGER
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*Counsel for the Government*

**CERTIFICATE OF SERVICE**

I HEREBY CERTIFY that on this date, I filed the foregoing using the Court's CM/ECF system, which will send a notification of electronic filing (NEF) to the following counsel of record:

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*Counsel for the Government*

# Exhibit A

2018 Report to Congress

**OFFICE OF THE UNDER SECRETARY OF DEFENSE**
**4000 DEFENSE PENTAGON**
**WASHINGTON, DC 20301-4000**

**PERSONNEL AND READINESS**

AUG 27 2018

The Honorable William M. "Mac" Thornberry
Chairman
Committee on Armed Services
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

This report is in response to House Report 115-200, pages 148-149, accompanying H.R. 2810, the National Defense Authorization Act for Fiscal Year 2018, which requests that the Department of Defense submit a report on its personnel policies regarding members of the Armed Forces infected with human immunodeficiency virus (HIV).

The enclosed report includes the following: (1) a description of policies addressing the enlistment or commissioning, retention, deployment, discharge, and disciplinary policies regarding individuals with this condition; (2) an update on the status of the Department of the Army's HIV policy; (3) an assessment of these policies, with reference to medical experts and literature, which includes how the policies reflect an evidence-based, medically accurate understanding of how this condition is contracted, how this condition can be transmitted to other individuals, the risk of transmission, and treatment regimens available; and (4) the feasibility of allowing an individual who is currently serving as an enlisted member of the Armed Forces to become a commissioned officer of the Armed Forces, and what restrictions are different for an officer.

Thank you for your continued support of our Service members. A similar letter is being sent to the Chairman of the Senate Committee on Armed Services.

Sincerely,

Stephanie Barna
Performing the Duties of the Under Secretary of Defense for Personnel and Readiness

Enclosure:
As stated

cc:
The Honorable Adam Smith
Ranking Member

**OFFICE OF THE UNDER SECRETARY OF DEFENSE**
**4000 DEFENSE PENTAGON**
**WASHINGTON, DC 20301-4000**

**PERSONNEL AND READINESS**

AUG 27 2018

The Honorable John McCain
Chairman
Committee on Armed Services
United States Senate
Washington, DC 20510

Dear Mr. Chairman:

This report is in response to House Report 115-200, pages 148-149, accompanying H.R. 2810, the National Defense Authorization Act for Fiscal Year 2018, which requests that the Department of Defense submit a report on its personnel policies regarding members of the Armed Forces infected with human immunodeficiency virus (HIV).

The enclosed report includes the following: (1) a description of policies addressing the enlistment or commissioning, retention, deployment, discharge, and disciplinary policies regarding individuals with this condition; (2) an update on the status of the Department of the Army's HIV policy; (3) an assessment of these policies, with reference to medical experts and literature, which includes how the policies reflect an evidence-based, medically accurate understanding of how this condition is contracted, how this condition can be transmitted to other individuals, the risk of transmission, and treatment regimens available; and (4) the feasibility of allowing an individual who is currently serving as an enlisted member of the Armed Forces to become a commissioned officer of the Armed Forces, and what restrictions are different for an officer.

Thank you for your continued support of our Service members. A similar letter is being sent to the Chairman of the House Committee on Armed Services.

Sincerely,

Stephanie Barna
Performing the Duties of the Under Secretary of Defense for Personnel and Readiness

Enclosure:
As stated

cc:
The Honorable Jack Reed
Ranking Member

# Department of Defense Personnel Policies Regarding Members of the Armed Forces Infected with Human Immunodeficiency Virus:

## Report to the Committees on the Armed Services of the Senate and House of Representatives

August 2018

The estimated cost of this report or study for the Department of Defense is approximately $18,000 for the 2018 Fiscal Year.
This includes $100 in expenses and $18,000 in DoD labor.
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## EXECUTIVE SUMMARY

**INTRODUCTION:** House Report 115-200, pages 148-149, accompanying H.R. 2810, the National Defense Authorization Act (NDAA) for Fiscal Year (FY) 2018, requested that the Department of Defense (DoD) submit a report to the Committees on Armed Services of the Senate and House of Representatives on its personnel policies regarding members of the Armed Forces infected with human immunodeficiency virus (HIV). Specifically, the Committee requested DoD provide the following in its report:

(1) A description of policies addressing the enlistment or commissioning, retention, deployment, discharge, and disciplinary policies regarding individuals with this condition.

(2) An update on the status of the Department of the Army's HIV policy, which was under review during the issuance of a 2014 report.

(3) An assessment of these policies, with reference to medical experts and literature, which includes how the policies reflect an evidence-based, medically accurate understanding of how this condition is contracted; how this condition can be transmitted to other individuals; the risk of transmission; and treatment regimens available.

(4) The feasibility of allowing an individual who is currently serving as an enlisted member of the Armed Forces to become a commissioned officer of the Armed Forces, and what restrictions are different for an officer.

**DATA COLLECTION:** This report follows the Department's interim response submitted to the Committees on Armed Services of the Senate and House of Representatives on March 19, 2018, and includes DoD- and Service-level policies and assessments addressing the requirements specified in House Report 115-200. Service-level information was obtained from each of the Military Departments at the request of the Office of the Assistant Secretary of Defense for Health Affairs (OASD(HA)).

**PERSONNEL POLICIES PERTAINING TO HIV:**

1. Enlistment and Commissioning (i.e., Accession): Grounded in statutory requirements for accessions of able-bodied and physically qualified individuals, recently reissued Department of Defense Instruction (DoDI) 6130.03, "Medical Standards for Appointment, Enlistment, or Induction into the Military Services," May 6, 2018, establishes DoD policy to ensure that individuals considered for appointment, enlistment, or induction into the Military Services are:

- Free of contagious diseases that may endanger the health of other personnel.
- Free of medical conditions or physical defects that may reasonably be expected to require excessive time lost from duty for necessary treatment or hospitalization, or may result in separation from the Military Service for medical unfitness.
- Medically capable of satisfactorily completing required training and initial period of contracted service.

- Medically adaptable to the military environment without geographical area limitations.
- Medically capable of performing duties without aggravating existing physical defects or medical conditions.

That instruction also establishes a specific policy to allow applicants who do not meet the specified physical and medical standards to be considered for a medical waiver. The instruction addresses 29 body systems, and lists for each of those a number of conditions that do not meet medical accession standards. Under the heading "Systemic Conditions," there are 19 such conditions, including presence of HIV infection. Thus, HIV infection is a disqualifying medical condition for entry into the military service. Both prior service and non-prior service applicants undergo screening for HIV prior to entrance. As with all other disqualifying medical conditions, applicants may be considered for a medical waiver.

2. Retention and Discharge: DoD and Service policies restrict involuntary separation of a Service member solely due to being HIV positive. Service members who acquire HIV after joining the military are ensured access to appropriate medical care: DoD policy requires they receive counseling and treatment consistent with the standard of care, evidence-based HIV clinical practice standards, and medical management guidelines. HIV positive Service members receive a referral for medical evaluation of fitness for continued service in the same manner as a Service member with other chronic or progressive illnesses. Service members with HIV may continue their service as long as they are able to perform their military duties, taking into account the nature of their position. If they develop a disability, HIV-positive Service members undergo evaluation of fitness for continued service by the same process as those who are HIV-negative. Active duty (AD) and Reserve Component (RC) Service members with laboratory evidence of HIV infection who are determined to be unfit for further duty undergo separation or retirement. Military Departments and Combatant Commands (CCMD) limit assignments of HIV-infected individuals based on expert medical review, determination regarding the individual's fitness for duty, and the nature and location of the duties performed, in accordance with operational requirements.

3. Deployment: DoD policy establishing deployment-limiting medical conditions sets the minimum standard for all deploying and deployed DoD personnel. Military Department policy guidance, Service-specific readiness requirements, or Combatant Commander needs may involve additional restrictions. HIV antibody positive status is a deployment-limiting medical condition precluding contingency deployment.

DoDI 6490.07, "Deployment-Limiting Medical Conditions for Service Members and DoD Civilian Employees," Enclosure 3, dated February 5, 2010, provides that individuals with a diagnosis of "human immunodeficiency virus (HIV) antibody positive with the presence of progressive [HIV related] clinical illness or immunological deficiency" shall not deploy unless a waiver is granted. All Service policies preclude HIV positive Service members from deploying to combat areas or in support of contingency operations due to the potential lack of access to needed medical care or medications in austere environments, as well as the military risks inherent in the mission assigned that could lead to illness exacerbation and compromise unit readiness and mission completion. For purposes of this report, a contingency deployment is one that is outside the continental United States (OCONUS), more than 30 days in duration, and in a

location with medical support from only non-fixed (temporary) military medical treatment facilities. A contingency deployment also includes the relocation of forces and materiel to an operational area in a situation requiring military operations in response to natural disasters, terrorists, or as otherwise directed.

All Services currently permit HIV positive Service members to deploy for purposes other than combat or a contingency operation, or to be assigned for duty in certain overseas locations, subject to receipt of a waiver. In view of this, members with HIV infection may be considered deployable with limitations. A waiver may be recommended on a case-by-case basis after review of the individual Service member's health and consideration of factors including the climate, altitude, rations, housing, nature of the duty assignment proposed, and medical services available in the location to which deployment or assignment is proposed. Further, the condition must not pose a significant risk of substantial harm to the individual or others, taking into account the condition of the deployed environment. The following table outlines the Service-specific policies for grant of a waiver to permit an HIV positive Service member to deploy for other than combat or a contingency, or to be assigned for duty in an overseas location:

| | | |
|---|---|---|
| Army | Waivable? | Yes |
| | By Whom? | Combatant Commander |
| | Under what conditions? | Soldier is determined to be fit and free of HIV-related illness. |
| | Host nation rules apply? | Yes, but deployments may be permitted ***only*** to Europe and Korea. |
| Navy/ Marine Corps | Waivable? | Yes |
| | By Whom? | Sailors: Treating HIV Evaluation and Treatment Unit (HETU), Navy Bloodborne Infection Management Center, PERS-82, and receiving command.<br>Marines: Deputy Commandant. Manpower & Reserve Affairs and receiving command. |
| | Under what conditions? | Agreement by all organizations/officials listed above and receiving command (including the CCMD, as appropriate). Sailors/Marines who have no viremia (i.e., there is no virus present in the bloodstream), do have an established history of medical compliance, and possess a professional attitude, may be considered on a case-by-case basis for large ship platform tours and OCONUS deployment/assignment. |
| | Host nation rules apply? | Yes |
| Air Force | Waivable? | Yes |
| | By Whom? | Air Force Medical Support Agency, with favorable coordination from receiving commander and CCMD approval. |
| | Under what conditions? | No HIV-related illness. |
| | Host nation rules apply? | Yes |

DoD has recently issued a new policy, DoDI 1332.45, "Retention Determinations for Non-Deployable Service Members," July 30, 2018, for implementation October 1, 2018. The overarching policy is that to maximize the lethality and readiness of the Joint Force, all Service members are expected to be deployable. Service members who are considered non-deployable for more than 12 consecutive months will be evaluated for a retention determination by their respective Military Department, and, as appropriate, referral into the Disability Evaluation System (DES) or initiation of processing for administration separation, with the normal policies and procedures, including due process procedures, of those systems continuing to apply. The Military Departments will determine the deployability status of Service members and will make retention determinations for Service members who have been non-deployable for more than 12 consecutive months. They may retain such members if determined to be in the best interest of the Military Service. Under this DoDI, "non-deployable" and "deployable with limitations" are two separate categories; the retention determination process applying to the former but not the latter. The Military Departments have authority to determine the specific dividing line between the two categories most appropriate for the operational circumstances applicable to their respective Services.

4. Disciplinary: DoD policy provides that a HIV positive status is not a punishable offense and cannot be used as a sole basis for disciplinary action against an individual. DoD policy also prohibits the use of information obtained as a result of an epidemiologic assessment interview to support any adverse personnel action against a Service member. However, Service members with laboratory evidence of HIV infection may be subject to disciplinary action if they disobey an order to inform current or potential sexual partners of their infected status or do not engage in safe sex practices.

**ARMY POLICY STATUS UPDATE:** Initiated in 2015, a working group has reviewed Army Regulation (AR) 600-110, last updated in April 2014, to assess any need for changes to reflect an evidence-based, medically accurate understanding of HIV infectivity, transmission, and treatment. This process is expected to be completed in the near future.

**MEDICAL ASSESSMENT OF PERSONNEL POLICIES:** Currently, no vaccine exists to prevent HIV infection, and no treatment exists to cure it. Broad consensus regarding published medical evidence supports the notion that people living with HIV on antiretroviral therapy (ART) who have an undetectable viral load in their blood, have a "negligible risk" of sexually transmitting HIV. Depending on the ART drugs used, it may take as long as six months for an individual's viral load to reach an undetectable level. Thus, with the advent of ART, HIV infection has evolved from a once terminal condition to a chronic illness requiring regular management and strict adherence to treatment protocol. As a result, the Department's policies have evolved over time. They currently focus not only on minimizing risks of HIV exposure, but also on providing evidence-based care and support for Service members living with HIV, with the goal to maintain a Service member's fitness for duty, optimize retention and quality of life, and help avoid disease progression of HIV-positive Service members into potential disability. Recognizing the risk factors for HIV infection and transmission, DoD- and Service-level personnel policies intend to reflect current knowledge of: how HIV is contracted and transmitted to HIV-naïve individuals; the ability of an HIV-positive individual to continue service without exacerbating his or her condition or risking the military mission; the effect of

infected personnel on commands; and the safety of military blood supplies. Medical literature pertaining to HIV medicine rapidly evolves. Subject matter experts across the Military Services are aware of and have access to all available contemporary medical literature, practice guidelines, medications, and treatment modalities based on emerging and published evidence-based studies or expert opinion.

**FEASIBILITY OF ALLOWING ENLISTED SERVICE MEMBERS TO BECOME COMMISSIONED OFFICERS AND RESTRICTIONS DIFFERENT FOR OFFICERS:** DoD policy has long maintained a difference between accession medical standards and retention medical standards. The rationale for this difference is that once a member has been fully trained and has experience in performing the duties of his or her position, whether as an enlisted member or officer, the needs of the Service incline decidedly toward allowing the member to continue to perform those duties and return the investment the Service has made in the member. At the accession stage, the needs of the Service incline toward selecting members in whom to make the training and mentoring investment who minimize any risk of inability due to medical conditions to complete an initial period of service and potentially a longer military commitment. Longstanding DoD policy under DoDI 6130.03 has also held that in the case of an enlisted member seeking appointment as a commissioned officer, the accession standards are the appropriate ones to apply because it is a new position, involving a whole new set of duties and responsibilities and new training and mentorship. The needs of the Service do not necessarily favor an officer applicant with prior enlisted service compared to one without such service, in minimizing any risk of inability to perform satisfactorily in the commissioned officer position due to medical conditions. Yet, it is appropriate to note that a review of two individual officer candidates, one with and one without prior enlisted service, requesting a medical waiver for the same condition, the candidate with prior service may well have the advantage of a record of successful military service in the enlisted ranks. However, regarding which set of standards to apply to the initial medical screening, the accession medical standards are the more appropriate standards for all applicants, including applicants for enlistment or commissioning. This is long-established DoD policy for all medical conditions; there is no special or different rule for individuals with HIV infection.

**DISCUSSION:** The Department has a responsibility to ensure the health and well-being of Service members, and through its policies, aims to minimize the risk of Service members' exposure to HIV, while ensuring that those infected with HIV have access to appropriate care and management of their illness and are able to continue service. Military unique considerations; the rapidly evolving nature of medical evidence and understanding pertaining to the nature of HIV transmission, infectivity, associated risks, and treatment; evolving mission requirements; and Service member needs pertaining to health information privacy protections, as well as opportunities for career advancement, are key factors that influence personnel policy pertaining to HIV-infected members of the Armed Forces. Current DoD- and Service-level personnel policies pertaining to HIV-infected members of the Armed Forces:

- Are established to maintain military readiness and optimize lethality of the Armed Forces.

- Are instituted to ensure military applicants can successfully complete rigorous military training and deploy to austere environments to accomplish the demanding missions of the military, including combat against enemy forces, without jeopardizing their health, the health of their unit, or the military mission, as well as to respect host Nation laws where our forces are deployed.

- Support retention of Service members infected with HIV, unless there is evidence of deteriorating health or other factors that render the individuals unable or unfit to perform their duties.

- Require the same procedures for medically evaluating Service members who develop disability due to chronic illness to determine fitness for continued service, regardless of whether the Service member is HIV-positive.

- Aim to ensure that, except for assignment limitations, HIV-infected personnel are treated no differently than other Service members.

- Ensure that a Service member infected with HIV but able to fully perform duties is not retired or involuntarily separated solely based on being infected.

- Direct the protection of health information and privacy of HIV-infected personnel.

- Reflect existing evidence and adhere to current nationally-accepted, evidence-based guidelines, and assess evolving medical evidence and scientific understanding of the nature and risk of HIV transmission, available treatment regimens, and the latest HIV management approaches and practices.

- Stipulate clinical management to be consistent with standard of care, evidence-based HIV clinical practice standards, and medical management guidelines.

**CONCLUSIONS:** DoD- and Service-level personnel policies pertaining to members of the Armed Forces infected with HIV are evidence-based in accordance with current clinical guidelines and are reviewed and updated to align with evolving medical capabilities, technologies, evidence-based practices, and current scientific understanding of the nature of HIV infection, transmission, and management. Maintaining the health of military personnel is essential for force readiness. It is a strategic objective of the Military Health System (MHS) to sustain the health of Service members and restore the health and return to duty of Service members who become ill or injured, whenever possible. Once a Service member completes training, the goal is to retain members who acquire HIV and who are still capable of performing their duties in the rigorous military environment. Personnel policies aim to balance the need of the Services (e.g., readiness, resilience, deployability, mission accomplishment, retention) with the needs of Service members infected with HIV (e.g., access to quality care, counseling, support and educational services, privacy protections, option to continue service, if desired). As such, existing DoD- and Service-level personnel policies intend to maximize the lethality, readiness, and operational effectiveness of the Armed Forces, as well as help ensure the health and well-being of Service members, while mitigating the risk of HIV transmission.

**INTRODUCTION:**

In House Report 115-200, page 148-149, to accompany H.R. 2810, NDAA for FY 2018 (Public Law 115-91), the Committee on Armed Services of the House of Representatives requested that the DoD submit a report to the Committees on the Armed Services of the Senate and House of Representatives on its personnel policies regarding members of the Armed Forces infected with HIV. Specifically, the Committee requested that DoD provide the following in its report:

(1) A description of policies addressing the enlistment or commissioning, retention, deployment, discharge, and disciplinary policies regarding individuals with this condition.

(2) An update on the status of the Department of the Army's HIV policy, which was under review during the issuance of a 2014 report.

(3) An assessment of these policies, with reference to medical experts and literature, which includes how the policies reflect an evidence-based, medically accurate understanding of how this condition is contracted; how this condition can be transmitted to other individuals; the risk of transmission; and treatment regimens available.

(4) The feasibility of allowing an individual who is currently serving as an enlisted member of the Armed Forces to become a commissioned officer of the Armed Forces, and what restrictions are different for an officer.

The Committee indicated that the Department's previous report, submitted to Congress in response to section 572 of the NDAA for FY 2014, did outline the current DoD policies; however, it failed to include how current policies reflect the evidence base and medical advances in the field of HIV. The Committee also stated the report fell short in describing the criteria guiding the implementation of these policies throughout different branches and among commanding officers.

**DATA COLLECTION:** This report follows the Department's interim response submitted to the Committees on Armed Services of the Senate and House of Representatives on March 19, 2018, and includes DoD- and Service-level policies and assessments addressing the requirements specified in House Report 115-200. Service-level information was obtained from each of the Military Departments at the request of the OASD(HA).

**PERSONNEL POLICIES PERTAINING TO HIV:**

1. Accession (Enlistment or Commissioning)

Accession standards require healthy recruits who are free of communicable diseases or medical conditions that will likely endanger the health of other personnel, require excessive time lost from duty for necessary treatment or hospitalization, or likely result in separation from service due to medical unfitness. DoDI 1304.26, "Qualification Standards for Enlistment, Appointment,

and Induction," provides basic entrance qualification standards "designed to ensure that individuals under consideration for enlistment, appointment, or induction are able to perform military duties successfully, and to select those who are the most trainable and adaptable to Service life." Recruits must also be capable of functioning in the demanding military environment without aggravation of existing medical conditions. DoDI 6130.03, "Medical Standards for Appointment, Enlistment, or Induction in the Military Services," states that individuals under consideration for appointment, enlistment, or induction into the Military Services must be:

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

DoDI 6130.03 also establishes a specific policy to allow applicants who do not meet the specified physical and medical standards to be considered for a medical waiver. This instruction addresses 29 body systems and lists for each a number of conditions that do not meet medical accession standards. Under the heading "Systemic Conditions," there are 19 such conditions, including presence of HIV infection. DoDI 6485.01, "Human Immunodeficiency Virus (HIV) in Military Service Members," June 7, 2013, reiterates that individuals with laboratory evidence of HIV infection are denied eligibility for appointment, enlistment, pre-appointment, or initial entry training for military service pursuant to DoDI 6130.03. All applicants for appointment, enlistment, or individuals being inducted into the Military Services are screened for laboratory evidence of HIV infection. Applicants do not meet accession standards if they present with HIV or serologic evidence of infection, or false-positive screening test(s) with ambiguous results on confirmatory immunologic testing. Thus, HIV infection is a disqualifying medical condition for military service, and persons infected with HIV are neither enlisted nor commissioned into military service. As with all other disqualifying medical conditions, applicants may be considered for a medical waiver pursuant to DoDI 6130.03.

Additionally, DoDI 6485.01 requires applicants to the U.S. Service Academies, the Uniformed Services University of the Health Sciences, and other officer candidate programs undergo testing for laboratory evidence of HIV within 72 hours of arrival to the program, and denies entry to the program if the test result is positive. Reserve Officer Training Corps program cadets and midshipmen must be tested for laboratory evidence of HIV no later than during their commissioning physical examination, and are denied a commission if they test positive.

Applicants for active and reserve enlisted service undergo HIV testing typically at U.S. Military Entrance Processing Command Military Entrance Processing Stations (MEPS) or other authorized locations. Applicants not tested at the MEPS undergo testing as part of the physical examination conducted prior to accession.

Service accession policies comply with DoDI 6130.03 and DoDI 6485.01. Applicable Service policies are set forth in the following: AR 600-110 and AR 40-501for the Army; Secretary of the Navy Instruction (SECNAVINST) 5300.30E for the Navy and Marine Corps; and Air Force Instruction (AFI) 48-123 for the Air Force.

DoD medical accession standards are reviewed periodically by the Accession Medical Standards Working Group (AMSWG), which evaluates and recommends updates to maintain the currency and validity of those standards. The AMSWG is co-chaired by representatives from the Office of the Assistant Secretary of Defense for Manpower and Reserve Affairs (M&RA) and OASD(HA). It includes a voting representative from each of the five Military Services, with additional support from the following DoD components/offices: Joint Staff Surgeon; Surgeons General of the Army, Navy, and Air Force; medical officers of the Coast Guard and National Guard Bureau; and personnel chiefs of the Army, Navy, Air Force, Marine Corps, Joint Staff, and National Guard Bureau. Among the functions of the AMSWG are to perform evidence-based assessments of the accession standards and provide direction in research initiatives for the Accession Medical Standards Research Activity, including evidence-based research in support of medical standards assessments.

Supported by the work of the medical and personnel experts of the AMSWG, the DoDI 6130.03 disqualification for accession for HIV infection does not reflect disagreement with the medical consensus that modern medication management of HIV infection produces very positive results. However, in the context of the extraordinary challenges of many aspects of military service, including potential mission needs under highly stressful combat conditions or in extremely austere and dangerous places worldwide, even well-managed HIV infection carries risks of complications and comorbidities, possibly with latent effects, immune system dysregulation, neurocognitive impairments (NCI) (discussed further below), disrupted medication maintenance and necessary monitoring for potential side-effects, possible military vaccination adverse effects, and potential communicability, including in circumstances of buddy-aid to a seriously injured member in combat and emergency whole blood battlefield transfusions. In view of these risks, the needs of the Service incline toward maintaining the longstanding medical standard disallowing accession of HIV infected individuals.

2. Retention/Discharge

Once a Service member completes initial training, the policy is to retain members who acquire HIV and are still capable of performing their duties in the rigorous military environment. Clinical management of an AD Service member and an RC Service member on AD for a period of more than 30 days with laboratory evidence of HIV infection is conducted consistent with standard of care, evidence-based HIV clinical practice standards, and medical management guidelines.

DoDI 6485.01 specifically addresses HIV in Service members, and prescribes procedures for the identification, surveillance, and management of members of the Military Services infected with HIV and for prevention activities to control transmission of HIV. An AD Service member with laboratory evidence of HIV infection is referred for appropriate treatment and a medical evaluation of fitness for continued service in the same manner as a Service member with other chronic or progressive illnesses, in accordance with DoDI 1332.18, "Disability Evaluation System." AD Service members with laboratory evidence of HIV infection determined to be fit for duty are allowed to serve in a manner that ensures access to appropriate medical care.

A RC Service member with laboratory evidence of HIV infection is referred for a medical evaluation of fitness for continued service in accordance with Service regulations, and in the same manner as an RC Service member with other chronic or progressive illnesses. Eligibility for AD for a period of more than 30 days is denied to those RC Service members with laboratory evidence of HIV infection (except under conditions of mobilization and on the decision of the Secretary of the Military Department concerned). RC Service members, either who are not on AD for a period of more than 30 days or who are not on full-time National Guard duty, and who show laboratory evidence of HIV infection, are transferred involuntarily to the Standby Reserve only if they cannot be used in the Selected Reserve.

In accordance with DoDI 6485.01, the privacy of a Service member with laboratory evidence of HIV infection is protected consistent with DoD 5400.11-R, "Department of Defense Privacy Program" and DoD 6025.18-R, "DoD Health Information Privacy Regulation."

A Service member infected with HIV but able to fully perform their duties is not retired or separated solely based on being infected. However, Service members, including those infected with HIV, whose condition deteriorates or otherwise interferes with their ability to perform their military occupation successfully, may be referred to the DES. The DES provides for the member to have a fair and full review to determine fitness for duty. The following DoD issuances establish policy for determining fitness for duty, and for retiring or separating Service members due to physical disability: Department of Defense Manual (DoDM) 1332.18, Vol 1, "Disability Evaluation System (DES) Manual: General Information and Legacy DES (LDES) Time Standards;" DoDM 1332.18, Vol 2, "Disability Evaluation System (DES) Manual: Integrated Disability Evaluation System (IDES);" and DoDM 1332.18, Vol 3, "Disability Evaluation System (DES) Manual: Quality Assurance Program (QAP)."

A medical evaluation is the first step in the disability evaluation process. A Medical Evaluation Board (MEB) documents a Service member's medical conditions and full clinical information. A summary of clinical information includes a medical history; appropriate physical examination; indicated medical tests and their results; medical and surgical consultations as necessary; diagnoses; ongoing or recommended treatment; and prognosis. The medical evaluation documents the medical status and duty limitations of Service members (subject to Service departmental regulations).

If the Service member cannot perform the duties of her or his military occupational specialty (MOS), the MEB refers the case to the DES. Criteria for referral of Service members into the DES include:

- Having one or more medical conditions that may, individually or collectively, prevent the Service member from reasonably performing the duties of his or her office, grade, rank, or rating, including those duties remaining on a Reserve obligation for more than one year after diagnosis;

- Having a medical condition that represents an obvious medical risk to the health of the member or to the health or safety of other members; or

- Having a medical condition that imposes unreasonable requirements on the military to maintain or protect the Service member.

A Service member is considered unfit when the evidence establishes that the member, due to physical disability, is unable to perform the duties of her or his office, grade, rank, or rating reasonably, to include duties during a remaining period of Reserve obligation. AD and RC Service members with laboratory evidence of HIV infection who, because of their disease progression, are determined to be unfit for further duty are medically separated or retired pursuant to DoDI 1332.18.

Service retention and discharge policies comply with the retention and discharge DoD policies described above.

Retention/Discharge - Army:
AR 600-110 stipulates that individuals confirmed to be HIV infected will be treated with dignity and understanding. Guidance for dealing with the psychosocial aspects of the disease may be obtained from command medical authorities and chaplains. Every effort will be made to ensure that, except for their assignment limitations, HIV infected personnel are treated no differently than other Soldiers. Commanders must ensure that information about the HIV infected Soldier's medical condition is provided only to those whose duties require knowledge of that information.

In AR 600-110, there is no medical reason for HIV-infected Soldiers' duties to change solely because of their infection (except in certain instances for health care providers). In instances where a Soldier performs duties as a member of a flight crew, or other position requiring a high degree of alertness or stability (for example, explosive ordnance disposal), a case-by-case determination is made by a MEB as to the Soldier's fitness to perform his or her duties. In the case of HIV-infected health care providers, their duties may be restricted if they present a risk of transmitting HIV to their patients. An expert medical review committee designated by the deputy commander for clinical services makes this determination. This committee makes recommendations on a case-by-case basis to the Medical and Dental Activity/United States Army Medical Center (MEDCEN)/Dental Activity commander per AR 40–68, "Clinical Quality Management," regarding the restriction of duties of HIV infected health care providers. The restriction may only apply until the risk is eliminated. In all other instances, HIV infected

Soldiers are utilized in their primary MOS, per normal utilization criteria contained in Army personnel regulations and the assignment limitations specified in AR 600-110.

Infectious disease specialists medically evaluate HIV-infected Soldiers at a participating MEDCEN supporting the health service region to determine their infection status. HIV infected Soldiers who meet medical retention standards outlined in AR 40-501, and who do not demonstrate progressive clinical illness or immunological deficiency during periodic evaluations (every six months or as directed), are not involuntarily separated solely based on HIV status.

HIV-infected RC Soldiers who wish to continue to serve in the RC must prove fitness for duty per medical retention standards of AR 40–501 and be found fit for duty. RC Soldiers are required to obtain the fit for duty medical examination from the civilian medical community at no expense to the Government. The required medical procedures are provided to the Soldier to give to his or her physician. This examination must be repeated at least annually after the initial evaluation. Medical follow-up and evaluation are conducted every six months and as directed by the infectious disease physician for all HIV infected Soldiers.

Except for those identified during the accession testing program, HIV infected AD Soldiers able to perform duties fully who do not demonstrate progressive clinical illness or immunological deficiency during periodic evaluations are not involuntarily separated solely because they are HIV infected. HIV infected Soldiers who demonstrate rapidly progressive clinical illness or immunological deficiency may not meet medical retention standards under AR 40–501, and are evaluated for physical disability processing under AR 635–40, "Disability Evaluation for Retention, Retirement, or Separation." AR 600-110 specifies procedures for officers (paragraph 6-13) and for enlisted personnel (paragraph 6-14). In accordance with AR 40-501, HIV-infected Soldiers who demonstrate progressive clinical illness or immunological deficiency are referred to a MEB. For Active Army Soldiers and RC Soldiers on AD for more than 30 days (except for training under 10 U.S.C. § 10148), a MEB must be accomplished and, if appropriate, the Soldier must be referred to a Physical Evaluation Board (PEB) under AR 635–40. For RC Soldiers not on AD for more than 30 days or on AD for training under 10 U.S.C. § 10148, referral to a PEB will be determined under AR 635–40. Records of official medical diagnoses provided by civilian medical providers 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, "Ready Reserve Screening, Qualification Records System, and Change of Address Reporting," AR 135–175, "Separation of Officers," AR 135–178, "Enlisted Administrative Separations," or AR 140–10, "Assignments, Attachments, Details, and Transfers," as appropriate. Additionally:

- Soldiers identified as HIV infected within 180 days of initial entry on AD are separated under the provisions of AR 635–200 for failure to meet accession medical fitness standards.

- HIV infected Army National Guard (ARNG) Soldiers who demonstrate progressive clinical illness or immunological deficiency, as determined by medical authorities, and who do not meet medical retention standards are processed under AR 40–501 and

National Guard Regulation (NGR) 600–200, "Enlisted Personnel Management," or NGR 635–101, "Efficiency and Physical Fitness Boards," as appropriate.

- HIV infected United States Army Reserve Soldiers who demonstrate progressive clinical illness or immunological deficiency, as determined by medical authorities, and who do not meet medical retention standards under AR 40–501 are processed in accordance with AR 135–178 (enlisted) or AR 135–175 (officer).

The Army National Guard implements guidance as prescribed by the AR 600-110 and AR 40-501 with regard to HIV positive personnel. AR 600-110 is administered by the G1 (Army Personnel) section; however, Army National Guard – Office of the Chief Surgeon (ARNG-CSG) has oversight with regard to monitoring the implementation of laboratory testing and re-testing of HIV positive Soldiers). HIV positive Soldiers are retained in current MOS/Area of Concentration, as long as medical fitness standards are maintained in accordance with AR 40-501. ARNG-CSG relies highly on the input of Army Directives, the U.S. Army Public Health Center, and the Centers for Disease Control and Prevention (CDC) when considering medical retentions.

Retention/Discharge - Navy and Marine Corps:
If an AC Sailor or Marine tests HIV antibody positive during routine screening, he or she is directed by the Chief, Bureau of Medicine and Surgery to an appropriate medical facility for evaluation and determination of fitness for duty, like all Service members with a chronic medical condition, in accordance with SECNAVINST 1850.4E, "Navy Disability Evaluation Manual," and Chapter 18 of Naval Medical Command (NAVMED) P-117, "Manual of the Medical Department," which pertains to DES. Members with HIV undergo additional evaluation in accordance with DoDI 6485.01. If found fit for full duty (i.e., physically qualified to remain on AD), they are referred, evaluated, treated, and followed by an HETU, and are subsequently retained, deployed, and returned to their unit for duty. Further, they are eligible for reenlistment following normal reenlistment procedures. RC Sailors undergo evaluation by their civilian providers, and are also evaluated for fitness for duty in the same manner as all RC members with a chronic medical condition. Marine Corps Order (MCO) 1300.8, "Marine Corps Personnel Assignment Policy," is in accordance with SECNAVINST 5300.30E regarding the referral for medical evaluation for continued service, appropriate treatment, and determination of fitness for duty.

In SECNAVINST 5300.30E, if a Sailor or Marine is found unfit for continued service, he or she is processed for medical separation through the physical disability system and discharged. Sailors and Marines who have tested HIV positive also have the option to undergo voluntary separation, and are afforded the option of requesting a voluntary discharge under honorable conditions, unless there are other factors involved. Retention or discharge decisions are based on the determination of competent medical authority regarding fitness of service. SECNAVINST 5300.30E is currently under revision.

MCO 1900.16 Chapter 1, "Separation and Retirement Manual," refers to SECNAVINST 5300.30E for voluntary separation of Marines who have tested positive for HIV. In MCO 1001R.1L, "Reserve Administration Manual," Reserve Marines identified as HIV positive and

who, although deemed medically fit for duty, are unable to fill an appropriate billet within the Selected Reserve and are placed in the Standby Reserve-Inactive Status List. Under this status, such Marines are not eligible to participate, receive pay or retirement point credit, are not eligible for promotion consideration, and are not accountable for purposes of end strength or controlled grades.

SECNAVINST 5300.30E and DoDI 6485.01 permit members of the Marine Corps Ready Reserve who are HIV positive to continue to serve within the Marine Corps Reserve, barring any medically assessed unfitting conditions, such as immunologic deficiency, neurological deficiency, progressive clinical or laboratory abnormalities associated with HIV, or diagnosis of Acquired Immune Deficiency Syndrome (AIDS)-defining conditions.

Retention/Discharge - Air Force:
AFI 44-178, "Human Immunodeficiency Virus Program," instructs that "members with laboratory evidence of HIV infection who are able to perform the duties of their office, grade, rank and/or rating, may not be separated solely on the basis of laboratory evidence of HIV infection." AFI 48-123 stipulates that HIV is potentially a cause for denying continued service and requires a retention decision through a MEB or similar review."

AFI 44-178 guides the management of AD Service members with HIV and screening protocol routinely employed by the Air Force. In accordance with AFI 44-178, all AD Airmen with asymptomatic HIV are seen annually at the Air Force HIV Medical Evaluation Unit (MEU) in San Antonio. The MEU completes a narrative summary (NARSUM) for each Airman with HIV infection, which is forwarded to the Air Force Personnel Center (AFPC) for adjudication regarding retention.

In an effort to treat every Airman equitably and with dignity and respect, the Air Force refers Airmen with asymptomatic HIV infection into the DES in the same manner and process as any other Airman with a chronic medical condition. As outlined above, current Air Force policy requires that all Airmen with HIV have a NARSUM reviewed annually by AFPC. AFPC is the only entity that can assign Airmen an Assignment Limitation Code-C (ALC-C), which restricts permanent and temporary duty assignments to areas where appropriate medical care is available to the HIV-positive Service member. The intent of the ALC-C is to protect such members from being placed in environments where adequate medical care is not available. The benefit of assigning an ALC-C is that it ensures visibility at all levels that an Airman will require a waiver for OCONUS assignment or deployment.

3. Deployment
DoDI 6490.07, "Deployment-Limiting Medical Conditions for Service Members and DoD Civilian Employees," includes HIV antibody positive diagnosis with the presence of progressive clinical illness or immunological deficiency as a medical condition that usually precludes contingency deployment. In all instances of HIV seropositivity, the policy requires that the cognizant CCMD surgeon be consulted before medical clearance for deployment. The Combatant Commander is the final approval authority for waivers. The medical standards in DoDI 6490.07 are mandatory for contingency deployments, and permissible for any other deployment, based on the commander's decision.

Medical evaluators must consider climate, altitude, rations, housing, duty assignment, and medical services available in theater when deciding whether an individual with a specific medical condition is deployable. DoD personnel with existing medical conditions may deploy based upon a medical assessment, if the following conditions are met:

(1) The condition is not of such a nature or duration that an unexpected worsening or physical trauma is likely to have a grave medical outcome or negative impact on mission execution.

(2) The condition is stable and reasonably anticipated by the pre-deployment medical evaluator not to worsen during the deployment in light of physical, physiological, psychological, and nutritional effects of the duties and location.

(3) Any required, ongoing health care or medications anticipated to be needed for the duration of the deployment are available in theater within the MHS. Medication must have no special handling, storage, or other requirements (e.g., refrigeration, cold chain, or electrical power requirements). Medication must be well tolerated within harsh environmental conditions (e.g., heat or cold stress, sunlight) and should not cause significant side effects in the setting of moderate dehydration.

(4) There is no need for routine evacuation out of theater for continuing diagnostics or other evaluations. (All such evaluations should be accomplished before deployment.)

DoDI 6490.07 sets the minimum standard for all deploying and deployed DoD personnel. Military Department policy guidance, Service-specific readiness needs, or CCMD requirements may involve additional deployment restrictions. Additionally, DoDI 6485.01 instructs compliance with host-nation requirements for screening and related matters for Service members. As outlined below, all Services currently permit HIV positive Service members to deploy for purposes other than combat or a contingency operation, or be assigned for duty in certain overseas locations, subject to receipt of a waiver. In view of this, members with HIV infection may be considered deployable with limitations.

Deployment - Army:
AR 40-501, paragraph 5-14, "Medical fitness standards for deployment and certain geographical areas," states a general rule that "all Soldiers considered medically qualified for continued military status and medically qualified to serve in all or certain areas of the continental United States (CONUS) are medically qualified to serve in similar or corresponding areas outside the continental United States (OCONUS)." However, the policy acknowledges, "because of certain medical conditions, some Soldiers may require administrative consideration when assignment to combat areas or certain geographical areas is contemplated. Such consideration of their medical conditions would ensure these Soldiers are used within their functional capabilities without undue hazard to their health and well-being as well as ensure they do not produce a hazard to the health or well-being of other Soldiers."

AR 40-501, paragraph 5-14, lists medical conditions requiring careful review prior to recommending whether the Soldier can deploy to duty in a combat zone or austere isolated area

where medical treatment may not be readily available. In accordance with AR 40-501, HIV infected Soldiers are not permitted to deploy into the combat theater of operations. Additionally, in accordance with AR 600-110 and AR 614-30, "Overseas Service," Soldiers confirmed to be HIV infected while stationed overseas are reassigned to the United States.

However, if found fit by a PEB, HIV infected Soldiers may be considered for overseas deployment to Europe or Korea (host Nation permitting), in accordance with AR 40-501. HIV infected AD Soldiers, including Active Guard and Reserve, are otherwise limited to duty within the United States (including Alaska, Guam, Hawaii, Puerto Rico, and the U.S. Virgin Islands). In the United States (including Alaska, Hawaii, Guam, Puerto Rico, and the U.S. Virgin Islands), HIV infected Soldiers are not assigned to:

- Any table of organization and equipment or modified table of organization and equipment unit. Installation commanders may reassign any HIV infected Soldier in such units to table of distribution and allowances (TDA) units on their installation, provided the Soldier has completed a normal tour in that unit (a normal tour for these purposes is three years from reporting date to the unit). After completion of a normal tour, reassignment to TDA units may be made, provided assignment can be made according to normal personnel management and assignment criteria in AR 614–100, "Officer Assignment Policies, Details, and Transfers," and AR 614–200, "Enlisted Assignments and Utilization Management." Reassignment must be to an authorized position for the Soldier's grade and primary or secondary MOS. Installation commanders unable to make appropriate reassignments report the names of HIV infected Soldiers to the Commander, Human Resource Command (HRC), Army Human Resource Command (AHRC)–EPD–I (enlisted), or Total Army Personnel Command (TAPC)–OPD–M (officer).

- Military-sponsored educational programs, regardless of length, but which would result in an additional service obligation. These programs include, but are not limited to, advanced civilian schooling, professional residency, fellowships, training with industry, and equivalent educational programs, regardless of whether the training is conducted in civilian or military organizations. HIV infected Soldiers assigned to these programs are disenrolled at the end of the academic term in which HIV infection is confirmed and may be reassigned without regard to Permanent Change of Station restrictions. Any financial support received by the Soldier may be retained through the end of the current term of enrollment and will not be subject to any recoupment. In addition, any additional service obligation incurred as a result of attendance at military sponsored educational programs is waived. Not included in this restriction are military schools required for career progression in a Soldier's MOS, branch, or functional area (such as, Noncommissioned Officer Education System schools, Captains Career Course, or intermediate level education).

- U.S. Army Recruiting Command, Cadet Command, MEPS, ARNG full time recruiting force, or ARNG full time attrition/retention force, if a Soldier's medical condition requires frequent medical follow-up (as determined by medical authorities), and if the Soldier's projected duty station is geographically isolated from an Army military treatment facility capable of providing that follow-up. These organizations report HIV-

infected Soldiers who cannot be assigned under this policy to the Commander, HRC, AHRC–EPD–I (enlisted) or TAPC–OPD–M (officer), for assignment instructions.

AR 600-110 stipulates that commanders may not change the assignment or use of HIV-infected Soldiers solely because of their infection, unless required by that regulation or the Soldier's medical condition. Grouping all HIV infected Soldiers within a command into the same subordinate unit, duty area, or living area is prohibited unless no other unrestricted units, positions, or accommodations are available.

HIV infected Service members may transfer to the Active Army from another Armed Force (inter-Service transfer), if they meet medical retention standards in AR 40–501. However, Service members who are HIV infected may not be transferred to the Army from another Armed Force, if they are required to meet accession medical standards in AR 40–501, except as specifically permitted in the Accession Testing Program, as described in AR 600-110.

Deployment - Navy/Marine Corps:
Deployment determinations for HIV-infected Service members are based on guidance articulated in DoDI 6490.07 and in CCMD Area of Responsibility specific Force Health Protection policies. SECNAVINST 5300.30E permits certain personnel on a case-by-case basis to be considered for OCONUS or large ship platform tours, in consultation with the treating HETU, Navy Bloodborne Infection Management Center, and PERS-82 (Temporary Disability Retirement List] (for Sailors), or the United States Marine Corps M&RA (for Marines). These cases apply to personnel with controlled HIV disease (as manifested by a reconstituted immune system, no viremia, an established history of medical compliance, and a history of professional attitude). This placement requires the receiving command's acceptance. These personnel are not considered for overseas individual augmentee tours, given the austere environments in which they potentially could be placed. This policy is based on the following considerations:

- There is no demonstrated risk of transmission of disease in normal daily activities.
- An investment in training of these members has been made.
- The previous policy of denying deployments has made this subset of personnel less competitive in achieving career milestones or warrior qualifications.

MCO 1300.8 is in accordance with SECNAVINST 5300.30E regarding assignment of HIV infected personnel.

Deployment - Air Force:
AFI 48-123 indicates, "conditions, which may seriously compromise the near-term well-being if an individual were to deploy, are disqualifying for mobility status or deployment duty." In accordance with DoDI 6490.07, AFI 48-123 also indicates, "medical evaluators must consider climate, altitude, rations, housing, duty assignment, and medical services available in theater when deciding whether an individual with a specific medical condition is deployable." However, AFI 48-123 also states, "in general, a member must be able to perform duty in austere environment with no special food, billeting, medical or equipment support for up to 179 days."

DoD has recently issued a new policy, DoDI 1332.45, "Retention Determinations for Non-Deployable Service Members," July 30, 2018, for implementation October 1, 2018. The overarching policy is that to maximize the lethality and readiness of the Joint Force, all Service members are expected to be deployable. Service members who are considered non-deployable for more than 12 consecutive months will be evaluated for a retention determination by their respective Military Department, and, as appropriate, referral into the DES or initiation of processing for administration separation, with the normal policies and procedures, including due process procedures, of those systems continuing to apply. The Military Departments will determine the deployability status of Service members and will make retention determinations for Service members who have been non-deployable for more than 12 consecutive months. They may retain such members if determined to be in the best interest of the Military Service. Under this DoDI, "non-deployable" and "deployable with limitations" are two separate categories; the retention determination process applying to the former but not the latter. The Military Departments have authority to determine the specific dividing line between the two categories most appropriate for the operational circumstances applicable to their respective Services.

4. Disciplinary

In and of itself, being HIV positive is not a punishable offense and cannot be used as a basis for disciplinary action against the individual. DoDI 6485.01 directs that information obtained during or primarily as a result of an epidemiologic assessment interview, (which is defined in DoDI 6485.01 as the "questioning of a Service member who has been confirmed by DoD to have laboratory evidence of HIV infection for purposes of medical treatment or counseling or for epidemiologic or statistical purposes"), cannot be used to support any adverse personnel action against the Service member, in accordance with section 705(c) of Public Law 99-661, "National Defense Authorization Act for Fiscal Year 1987," November 14, 1986. DoDI 6485.01 defines "adverse personnel action" as "a court-martial, non-judicial punishment, involuntary separation for other than medical reasons, administrative or punitive reduction in grade, denial of promotion, an unfavorable entry in a personnel record (other than an accurate entry concerning an action that is not an adverse personnel action), or a bar to reenlistment other than for medical reasons."

DoDI 6485.01 also requires aggressive disease surveillance and implementation of health education programs for Service members. A Service member with laboratory evidence of HIV infection receives training on how to prevent further transmission of HIV infection to others, and the legal consequences of exposing others to HIV infection. In compliance with this policy, the Services provide counseling and training to Service members with HIV infection regarding the prevention of disease transmission to others and the legal consequences of intentional exposure to others, or failure to disclose status to sexual partners or blood donation centers.

However, infected Service members retained on AD who fail to comply with the directives given during preventive medicine counseling are subject to appropriate disciplinary actions for their disregard or disobedience. All Services hold HIV infected members accountable under the Uniform Code of Military Justice if they ignore orders to warn and protect others whose health might be jeopardized by sexual contact or other types of high-risk exposures. Commanders may recommend that personnel who violate such guidance be considered for involuntary discharge or separation.

**STATUS UPDATE ON THE DEPARTMENT OF THE ARMY'S HIV POLICY:**
Initiated in 2015, a working group has reviewed AR 600-110, last updated in April 2014, to assess any need for changes to reflect an evidence-based, medically accurate understanding of HIV infectivity, transmission, and treatment. This process is expected to be completed in the near future.

**MEDICAL ASSESSMENT OF POLICIES:**
Currently, no vaccine exists to prevent HIV infection, and no treatment exists to cure it. As such, the Department takes every effort to protect the health and well-being of Service members to minimize the risk of exposure to HIV through regular HIV screening and surveillance efforts. DoDI 6485.01 requires that the Secretaries of the Military Departments report HIV test results to the Defense Medical Surveillance System, pursuant to Department of Defense Directive (DoDD) 6490.02E, "Comprehensive Health Surveillance," and directs health care personnel providing medical care to follow the recommendations issued by the CDC for preventing HIV transmission in health-care settings.

DoD health surveillance policy also requires that medical surveillance systems continuously capture data on occupational and environmental exposures to potential and actual health hazards, and link with medical surveillance data to monitor the health of DoD's population and identify potential risks to health. Thus, this policy enables timely implementation of interventions to prevent, treat, or control disease and injury, and reinforces the provision of optimal medical care.

*Impact of Antiretroviral Therapy on Disease Management*

Viral suppression and AIDS are two ends of the spectrum of HIV infection. Virally-suppressed HIV infection usually requires an individual to take ART, alternatively referred to as combination Antiretroviral Therapy, regularly and to see an infectious disease specialist annually. ART consists of a combination of antiretroviral (ARV) drugs to suppress the HIV virus to undetectable levels and stop HIV disease progression. AIDS is usually the result of long-term non-adherence with medications and can be associated with impairment and disability (e.g., opportunistic infections, cancer, weakness).

There is broad consensus on evidence published in the medical literature to support the notion that people living with HIV on ART with an undetectable viral load in their blood have a "negligible risk" of sexually transmitting HIV. Depending on the ART drugs used, it may take as long as six months for the viral load to become undetectable. "Continued and reliable HIV suppression requires selection of appropriate agents and excellent adherence to treatment. HIV viral suppression should be monitored to assure both personal health and public health benefits."[1]

However, it is important to emphasize that despite undetectable viral loads, HIV transmission still can occur. According to the U.S. Public Health Service Guidelines for the Management of Occupational Exposures to Human Immunodeficiency Virus and Recommendations for Postexposure Prophylaxis, "exposure to a source patient with an undetectable serum viral load does not eliminate the possibility of HIV transmission or the need for (post-exposure prophylaxis) PEP and follow-up testing. While the risk of transmission from an occupational exposure to a source patient with an undetectable serum viral load is thought to be very low, PEP

should still be offered. Plasma viral load (e.g., HIV RNA [ribonucleic acid]) reflects only the level of cell-free virus in the peripheral blood; persistence of HIV in latently infected cells, despite patient treatment with ARV drugs, has been demonstrated, and such cells might transmit infection even in the absence of viremia. HIV transmission from exposure to a source person who had an undetectable viral load has been described in cases of sexual and mother-to-child transmissions."[2] It is also important to underscore that an "undetectable" viral load that confers a "negligible risk" of HIV transmission has no application in the setting of blood transfusion or needlestick (occupational) exposures.

Thus, with the advent of ART, HIV infection has evolved from a once terminal condition to a chronic illness requiring regular management and strict adherence to treatment protocol. As a result, the Department's policies have evolved over time. They currently focus not only on minimizing risks of HIV exposure for HIV-naïve individuals, but also on providing evidence-based care and support for Service members living with HIV, with the goal to retain and maintain a Service member's fitness for duty, optimize quality of life, as well as avoid any disability that might arise as a result of HIV infectivity.

*Recent Findings Signifying Impairments Despite Viral Suppression and Asymptomatic HIV: Potential Impact on Future Policy*

Despite virological suppression, long-term treated patients may experience memory difficulties, mental slowing, attention deficits, and other neurological impairment symptoms. Moreover, neurocognitive damage can occur without HIV-infected individuals experiencing related symptoms or interference in their daily functioning. The impact of HIV-associated neurocognitive disorder and asymptomatic NCI on fitness for duty, including resilience and readiness, is currently unknown.

According to a Department of Defense Infectious Disease Clinical Research Program cross-sectional study of 200 HIV-infected and 50 HIV-uninfected military beneficiaries including AD members, retirees, or dependents, HIV positive patients diagnosed and managed early during the course of HIV infection had a low prevalence of NCI. This is comparable to matched HIV-uninfected persons.[3] Based on these data, the early recognition and management of HIV infection may be important in limiting NCI.

Yet effective ART resulting in viral suppression and asymptomatic infection does not imply absence of HIV-associated injury or impairment. Some HIV-infected, virally suppressed patients on ART will develop illnesses associated with premature aging (e.g., cardiovascular disease, osteoporosis). As the HIV-positive population ages, there is greater recognition that cerebrovascular disease risk factors such as hypertension, diabetes, and hypercholesterolemia are becoming risk factors for cognitive impairment in HIV-positive patients on ART.[4]

Common neurocognitive symptoms experienced by HIV-infected patients potentially include changes in memory, concentration, attention, and motor skills, may present challenges for accurate diagnoses and assessments of functional capacity, and often require prolonged observation or reporting.[5,6] Some patients may experience a fluctuating course of NCI over time, including symptom normalization; however, it is unknown whether these changes reflect

biologic alterations induced by responses to (or failures) of ART, or occur independently of viral load and changes to ART regimens.[7] Despite effective systemic viral suppression among HIV-positive individuals on ART, scientific studies have indicated that a small subset of individuals show neurocognitive deterioration with evidence of persistent laboratory and neuroimaging abnormalities in the central nervous system.[8] A longitudinal cohort observation study found that numerous patients with asymptomatic NCI, even with a suppressed plasma viral load, eventually developed symptomatic NCI.[9] The impact of these potential NCIs on a Service member's readiness, resilience, and/or retention is currently unknown.

As the HIV-positive population on ART ages, there is greater recognition that cerebrovascular disease risk factors such as hypertension, diabetes, and hypercholesterolemia may become risk factors for cognitive impairment.[10] The future impact of HIV as a chronic disease on readiness, resiliency, and retention, as well as treatment and management approaches, are a part of ongoing DoD health surveillance efforts.

As stipulated in DoDD 6490.02E, DoD requires comprehensive, continuous and consistent health surveillance to enable continuous capture of individual and population data, including health status, occupational exposures, disease, and medical interventions (such as immunizations, treatments and medications), in order to implement early intervention and disease control strategies and reinforce provision of optimal medical care. As such, the policy enables DoD to be well-positioned to update policies and practices to appropriately identify and manage HIV infection among Service members as the HIV-positive population on ART ages.

*Military-Unique Considerations*

According to the Military Infectious Diseases Research Program (MIDRP), HIV "remains a significant threat to Service members deployed overseas, and is a major source of regional instability in areas of US force protection."[11] Additionally, the MIDRP also recognized that infectious diseases can also impose "a significant burden on the medical logistical system for people requiring treatment" and "loss of personnel to infectious diseases reduces operational readiness and effectiveness by requiring replacement troops." Therefore, the MIDRP indicates, preventing disease is "a force multiplier by keeping people healthy and by enhancing readiness," and DoD must protect its forces from diseases that may compromise its ability to complete missions and to prevent troops from acquiring illnesses. As such, preventing disease through limiting risk of exposure to infectious disease is a key component to enhance military readiness and effectiveness.

It is important to note that DoD HIV screening policy is population-based, and accounts for unique operational military requirements. For example, protecting the safety of the U.S. military blood supply or health of potential donors and recipients (i.e., Service members) is of critical importance to DoD and therefore a central issue. Combat-related injuries, especially during mass casualty situations, require large supplies of blood for transfusions. The need for screening the blood supply is therefore critical. In certain cases, "battlefield transfusions" may be required to resuscitate casualties in life-threatening situations when the inventory of U.S. Food and Drug Administration (FDA)-compliant blood products is depleted in combat zones due to austere operating conditions and irregular resupply. In these cases, the U.S. Army Institute of Surgical

Research Joint Trauma System Clinical Practice Guideline on Fresh Whole Blood indicates that Service members may receive an emergency transfusion of fresh whole blood in life-saving or limb-sparing situations.[12] This Joint Trauma System Clinical Practice Guideline also indicates that even though fresh whole blood undergoes rapid testing for HIV to the greatest extent possible prior to transfusion, the potential risk for HIV transmission remains in battlefield circumstances. HIV infection is among a number of medical conditions that preclude blood donation. Early CDC data demonstrate that the highest risk of transmission of HIV infection is via blood transfusion (92.50 percent transmission rate, or 9250/10000 exposures).[13] Even though this data included cases involving transmission of very high viral loads as well as lower levels of viremia, it is conceivable that a unit of whole blood (as utilized used in a "walking blood bank" scenario) would pose a very high risk of transmission of HIV infection, even if from an HIV-infected Service member with an undetectable viral load.[14] To the extent possible, DoD adheres to FDA blood-borne pathogen screening guidelines requiring all donated blood products be tested for HIV types I and II.[15] DoD ensures the safety of the blood supply through policies of the Armed Services Blood Program Office and the accreditation requirements of the American Association of Blood Banks. However, in emergency battlefield circumstances it is impossible to eliminate all risk of communicability through blood transfusion.

*Service Policies*

Service policies accurately reflect current medical literature and expert opinion (consensus standards) regarding transmission and treatment of HIV. The U.S. Air Force (USAF) management of Airmen with HIV is highly structured and achieves viral load suppression in over 90 percent of patients. AFI 44-178 is the underpinning of the USAF's HIV management success. AR 600-110, "Identification, Surveillance, and Administration of Personnel Infected with Human Immunodeficiency Virus," and Headquarters, Department of the Army medical and personnel policies on HIV reflect current knowledge of the natural progression of HIV infection; the risks to the infected individual incident to military service; the risk of transmission of the disease to non-infected personnel; the overall impact of infected personnel in Army units and on readiness posture; and the safety of military blood supplies. The Assistant Secretary of the Navy (M&RA) established SECNAVINST 5300.30E to reflect current knowledge of the natural history of HIV; the risks to the infected individual incident to military service; the risk of transmission of HIV to non-infected personnel; the effect of infected personnel on commands; and the safety of military blood supplies. The Services are currently reviewing and updating several policies, to include SECNAVINST 5300.30E, AFI 44-178, AR 600-110, to reflect changes as medical capabilities, technologies, and evidence-based practices have evolved.

Medical literature pertaining to HIV medicine rapidly evolves. MHS subject matter experts are aware of and have access to all available contemporary medical literature, practice guidelines, medications, and treatment modalities based on emerging and published evidence-based studies or expert opinion, referenced in, but not limited to the following:

- "National HIV/AIDS Strategy for the United States." U.S. Department of Health & Human Services. Available at: https://www.hiv.gov.

- Panel on Antiretroviral Guidelines for Adults and Adolescents. Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents Living with HIV. Department of Health

and Human Services. Available at: http://aidsinfo.nih.gov/contentfiles/lvguidelines/AdultandAdolescentGL.pdf.

- Primary Care Guidelines for the Management of Persons Infected with HIV, issued by expert panel of the HIV Medicine Association of the Infectious Diseases Society of America. Update issued in: Aberg JA, Gallant JE, Ghanem KG, et al. Primary care guidelines for the management of persons infected with HIV: 2013 update by the HIV medicine association of the Infectious Diseases Society of America. Clin Infect Dis. 2014;58(1):e1-34. Available at: https://www.ncbi.nlm.nih.gov/pubmed/24235263/.

- CDC. "Integrated prevention services for HIV infection, viral hepatitis, sexually transmitted diseases, and tuberculosis for persons who use drugs illicitly: summary guidance from CDC and the U.S. Department of Health and Human Services." MMWR Recomm Rep. 2012;61(RR-5):1-40. Available at: https://www.cdc.gov/mmwr/preview/mmwrhtml/rr6105a1.htm.

**FEASIBILITY OF ALLOWING ENLISTED MEMBERS TO BECOME COMMISSIONED OFFICERS OF THE ARMED FORCES AND RESTRICTIONS DIFFERENT FOR OFFICERS:**

DoD policy has long maintained a difference between accession medical standards and retention medical standards. The rationale for the difference is that once a member has been fully trained to perform, and has experience in performing the duties of his or her position, whether as an enlisted member or officer, the needs of the Service incline decidedly toward allowing the member to continue to perform those duties and return the investment the Service has made in the member. At the accession stage, the needs of the Service incline toward selecting members in whom to make the training and mentoring investment, who minimize any risk of inability due to medical conditions to complete an initial period of service and potentially a longer military commitment. Longstanding DoD policy under DoDI 6130.03 has also held that in the case of an enlisted member seeking appointment as a commissioned officer, the accession standards are the appropriate ones to apply because it is a new position, involving a whole new set of duties and responsibilities and new training and mentorship. The needs of the Service do not necessarily favor an officer applicant with prior enlisted service, compared to one without such service, when it comes to minimizing any risk of inability due to medical conditions to perform satisfactorily in the commissioned officer position. However, it is appropriate to note that a review of two individual officer candidates, one with and one without prior enlisted service, requesting a medical waiver for the same condition, the candidate with prior service may well have the advantage of a record of successful military service in the enlisted ranks. However, regarding which set of standards to apply to the initial medical screening, the accession medical standards are the more appropriate standards for all applicants, including applicants for enlistment or commissioning. This is long-established DoD policy for all medical conditions; there is no special or different rule for individuals with HIV infection.

**DISCUSSION:**

The Department has a responsibility to ensure the health and well-being of Service members, and through its policies, aims to minimize the risk of Service members' exposure to HIV, while ensuring that those infected with HIV have access to appropriate care and management of their illness and are able to continue service. Military unique considerations; the rapidly evolving

nature of medical evidence and understanding pertaining to the nature of HIV transmission, infectivity, associated risks, and treatment; evolving mission requirements; and Service member needs pertaining to health information privacy protections, as well as opportunities for career advancement, are key factors that influence personnel policy pertaining to HIV-infected members of the Armed Forces.

Current DoD- and Service-level personnel policies pertaining to HIV-infected members of the Armed Forces:

- Are established to maintain military readiness and optimize lethality of the Armed Forces.
- Are instituted to ensure military applicants can successfully complete rigorous military training and deploy to austere environments to accomplish the demanding missions of the military, without jeopardizing their health, the health of their unit, or the military mission, as well as to respect host Nation laws where our forces are deployed.
- Support retention of Service members infected with HIV, unless there is evidence of deteriorating health or other factors that render the individuals unable or unfit to perform their duties.
- Require the same procedures for medically evaluating Service members who develop disability due to chronic illness to determine fitness for continued service, regardless of whether the Service member is HIV-positive.
- Aim to ensure that, except for assignment limitations, HIV-infected personnel are treated no differently than other Service members.
- Ensure that a Service member infected with HIV is not retired or involuntarily separated solely based on being infected.
- Recognize that in the unique circumstances of military combat operations, there remain significant risks that individuals with even well-controlled HIV infection may suffer adverse health effects and create additional mission risks for the military command.
- Direct the protection of health information and privacy of HIV-infected personnel.
- Reflect existing evidence and adhere to current nationally accepted, evidence-based guidelines, and assess evolving medical evidence and scientific understanding of the nature and risk of HIV transmission, available treatment regimens, and the latest HIV management approaches and practices.
- Stipulate clinical management to be consistent with standard of care, evidence-based HIV clinical practice standards, and medical management guidelines.

**CONCLUSIONS:**

DoD personnel policy for HIV-positive Service members is evidence-based, in accordance with state-of-the-art clinical guidelines, reviewed for currency, and updated accordingly as medical capabilities, technologies, and evidence-based practices evolve.

DoD accession policies align with the military's requirements to recruit healthy personnel who are able to complete demanding military training and to deploy to austere environments without exacerbating their health or compromising operational effectiveness and mission accomplishment.

For those who acquire HIV after accession, DoD policy emphasizes retention if the medical condition is stable with appropriate treatment and the Service member is found fit for duty. Service members with laboratory evidence of HIV infection who are able to perform the duties of their office, grade, rank and/or rating, cannot be separated solely based on laboratory evidence of HIV infection. Service members with medical illnesses or conditions that might limit their ability to perform military duties (including HIV infection) may undergo evaluation for either duty limitations or medical discharge.

A waiver is required for HIV-positive Service members to deploy; medical evaluators must consider climate, altitude, rations, housing, duty assignment, and available medical services in theater when deciding whether an individual is deployable. However, current Service policies do not permit HIV-infected Service members to deploy to combat theaters of operation or in support of other contingency operations, given the austere environment, potential exacerbation of illness and lack of access to needed medical care, as well as risk of compromising unit readiness and successful mission completion. Army policy currently allows deployment to Europe and Korea for HIV-infected soldiers found fit by a PEB (host Nation permitting). Navy policy currently permits case-by-case consideration for non-combat OCONUS or large ship platform tours for HIV-infected personnel with controlled HIV disease (as manifested by a reconstituted immune system, no viremia, an established history of medical compliance).

DoD policy prohibits adverse personnel actions based solely on HIV status, assuming ability to perform duties fully. However, as with any direct order, a Service member who violates the order to inform sexual partners of their HIV status or fails to use safe sexual practices, as instructed during face-to-face consultation, may be subject to disciplinary action.

Maintaining the health of military personnel is essential for force readiness. It is a strategic objective of the MHS to sustain the health of Service members, restore the health, and return to duty of Service members who become ill or injured, if possible. Once Service members complete training, the goal is to retain members who acquire HIV who are still capable of performing their duties in the rigorous military environment. Personnel policies aim to balance the need of the Services (e.g., readiness, resilience, deployability, mission accomplishment, retention) with the needs of Service members infected with HIV (access to quality care, counseling, support and educational services, privacy protections, and option to continue service, if desired). Existing personnel policies intend to maximize the lethality, readiness, and operational effectiveness of the Armed Forces, as well as to help ensure the health and well-being of Service members, while mitigating the risk of HIV transmission.

| ACRONYMS: | |
|---|---|
| **AD** | active duty |
| **AFI** | Air Force Instruction |
| **AFPC** | Air Force Personnel Center |
| **AHRC** | Army Human Resource Command |
| **AIDS** | Acquired Immune Deficiency Syndrome |
| **ALC-C** | Assignment Limitation Code-C |
| **AMSWG** | Accession Medical Standards Working Group |
| **AR** | Army Regulation |
| **ARNG** | Army National Guard |
| **ARNG-CSG** | Army National Guard – Office of the Chief Surgeon |
| **ART** | antiretroviral therapy |
| **ARV** | antiretroviral |
| **CCMD** | Combatant Command |
| **CDC** | Centers for Disease Control and Prevention |
| **CONUS** | continental United States |
| **DES** | Disability Evaluation System |
| **DoD** | Department of Defense |
| **DoDD** | Department of Defense Directive |
| **DoDI** | Department of Defense Instruction |
| **DoDM** | Department of Defense Manual |
| **FDA** | U.S. Food and Drug Administration |
| **FY** | Fiscal Year |
| **HETU** | HIV Evaluation and Treatment |
| **HIV** | human immunodeficiency virus |
| **HRC** | Human Resource Command |
| **IDES** | Integrated Disability Evaluation System |
| **IMR** | individual medical readiness |
| **LDES** | Legacy Disability Evaluation System |
| **M&RA** | Manpower and Reserve Affairs |
| **MCO** | Marine Corps Order |

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|---|---|
| **MEB** | Medical Evaluation Board |
| **MEDCEN** | United States Army Medical Center |
| **MEPS** | Military Entrance Processing Stations |
| **MEU** | Medical Evaluation Unit |
| **MHS** | Military Health System |
| **MIDRP** | Military Infectious Diseases Research Program |
| **MOS** | military occupational specialty |
| **MQA** | medical quality assurance |
| **NARSUM** | narrative summary |
| **NAVMED** | Naval Medical Command |
| **NCI** | neurocognitive impairment |
| **NDAA** | National Defense Authorization Act |
| **NGR** | National Guard Regulation |
| **OASD(HA)** | Office of the Assistant Secretary of Defense for Health Affairs |
| **OCONUS** | outside the continental United States |
| **PEB** | Physical Evaluation Board |
| **QAP** | Quality Assurance Program |
| **RC** | Reserve Component |
| **SECNAVINST** | Secretary of the Navy Instruction |
| **TAPC** | Total Army Personnel Command |
| **TDA** | table of distribution and allowances |
| **USAF** | U.S. Air Force |

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