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

RYAN KARNOSKI, *et al.*,

Plaintiffs, and

STATE OF WASHINGTON,

Plaintiff-Intervenor,

v.

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

Defendants.

Misc. No. 1:20mc16

Underlying Action: Case No. 2:17-cv-01297-MJP (W.D. Wash.)

MEMORANDUM IN SUPPORT OF DEFENDANTS' MOTION TO QUASH THIRD-PARTY SUBPOENA ISSUED TO SECRETARY OF VETERANS AFFAIRS ROBERT WILKIE JR.

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INTRODUCTION

Pursuant to Rules 26(c)(1) and 45(d)(3) of the Federal Rules of Civil Procedure, Defendants in the above-captioned action move to quash a subpoena ordering Robert Wilkie Jr., the Secretary of Veterans Affairs, to appear for a deposition on May 27, 2020 in this District. *See* Notice of Subpoena ("Wilkie Subpoena"), attached hereto as Ex. A. Secretary Wilkie is not a party to the underlying action at issue here, *Karnoski v. Trump* (*Karnoski*), No. 2:17-cv-01297-MJP (W.D. Wash.), which challenges the Department of Defense's ("DoD") policy on military service by transgender individuals and individuals with a medical condition called gender dysphoria. Plaintiffs seek to depose the Secretary to probe his thought process and reasons for recommending the challenged policy when he held the position of Under Secretary of Defense for Personnel and Readiness. Under well-established law, this subpoena should be quashed. Notably, the Ninth Circuit has issued a prior writ of mandamus limiting discovery in *Karnoski*, which weighs heavily against granting the requested deposition, and that court is presently considering a second mandamus petition concerning the scope of remaining discovery, which would further weigh against granting the deposition.

Permitting Plaintiffs' request would conflict with long-standing precedent and would be especially unwarranted in a challenge to military personnel policy. Because the Secretary is a top Executive Branch official, the Secretary's deposition is entirely inconsistent with the "apex doctrine," which protects high-ranking officials from testifying about their official decisions. The deposition is also unnecessary. Defendants have already produced all relevant, non-privileged documents necessary to litigate Plaintiffs' claims, in addition to privileged documents pursuant to court orders, and have made available several other senior DoD and Armed Forces officials with

direct personal knowledge of the challenged policy's development. For these reasons set forth further below, the Court should quash the deposition subpoena for Secretary Wilkie.

BACKGROUND

The underlying action, *Karnoski*, is one of four long-running cases challenging the constitutionality of DoD's policy concerning military service by transgender individuals and individuals with gender dysphoria. *See Stockman v. Trump*, No. 1:17-cv-6516 (C.D. Cal. Sept. 5, 2017); *Stone v. Trump*, No. 1:17-cv-02459 (D. Md. Aug. 28, 2017); *Doe v. Esper* (*Doe DC*), No. 17-cv-1597 (D.D.C. Aug. 9, 2017); *see also Doe v. Esper* (*Doe MA*), No. 1:20-cv-10530 (D. Mass. Mar. 17, 2020) (recent action for a preliminary injunction). All four cases are in discovery. The *Doe DC* Plaintiffs have also indicated their intent to depose Secretary Wilkie, and the other plaintiffs may follow suit. *See* Joint Status Report at 2, *Doe DC*, No. 17-cv-1597 (D.D.C. May 7, 2020), ECF 242.

I. DoD Policy Regarding Military Service by Transgender Individuals and Individuals with Gender Dysphoria

In February 2018, then-Secretary Mattis issued the current DoD policy regarding military service by transgender individuals and individuals with gender dysphoria. *Karnoski v. Trump*, 926 F.3d 1180, 1187–88 (9th Cir. 2019) (per curiam). For decades, the military had maintained a "categorical ban on retention of transgender service members" or their accession into—that is, their joining—the military. *Id.* The current policy permits transgender individuals to serve but presumptively disqualifies certain individuals based on a medical condition—gender dysphoria—and its treatment. As described below, the current policy, which is the product of comprehensive review by high-ranking military officials, came after several recent developments in the military's policy.

In June 2016, following a review of existing policy, then-Secretary of Defense Ashton Carter ordered the armed forces to revise their standards to permit military service by transgender individuals under certain circumstances, depending on whether an individual had been diagnosed with "gender dysphoria." Gender dysphoria is a psychological condition that "refers to the distress that may accompany the incongruence between one's experienced or expressed gender and one's assigned gender." Diagnostic and Statistical Manual of Mental Disorders Fifth Edition, DSM-5 ("DSM-5") at 451, attached hereto as Ex. B. It involves "clinically significant distress or impairment in social, occupational, or other important areas of functioning." *Doe DC v. Shanahan*, 917 F.3d 694, 710–11 (D.C. Cir. 2019) (Williams, J., concurring in result) (describing the Carter policy). The policy disqualified those with a "history of gender dysphoria" or who had undergone "gender transition" from accessing into the military unless they could demonstrate that they had "been . . . stable for 18 months." *Doe DC*, 917 F.3d at 710. Transgender persons who had already completed "gender transition" as treatment for "gender dysphoria," and demonstrated stability over the required time, could access in their "preferred biological gender." *Id.* For retention purposes, "individuals who embarked on gender transition while serving could continue to serve provided that they met the standards associated with their biological sex until their transition was 'complete' (at which point, they could serve in their preferred gender)." *Id.* at 711.

On June 30, 2017, before the Carter policy's accession standards were set to take effect, then-Secretary Mattis decided, based on the recommendations of the Secretaries of the Military Departments and the Chiefs of the Military Services and in the exercise of his discretion, that it was "necessary to defer" the Carter accession standards until January 1, 2018, so that the military could "evaluate more carefully" the effect of accessions by transgender individuals "on readiness and lethality." Memorandum from Secretary Mattis to President Trump ("Mattis Mem.") (Feb.

22, 2018) at 1, attached hereto as Ex. C; *see also Doe DC*, 917 F.3d at 713 (Williams, J., concurring in result).

While this review was ongoing, the President stated on Twitter on July 26, 2017 that the military "will not accept or allow Transgender individuals to serve in any capacity." *Doe DC*, 917 F.3d at 698 (quotation marks omitted). He then issued a memorandum in August 2017 explaining that former Secretary Carter had "failed to identify a sufficient basis to conclude that terminating the Department's longstanding policy"—which generally disqualified transgender individuals from service—"would not hinder military effectiveness and lethality, disrupt unit cohesion, or tax military resources." *Id.* (citation omitted). The President's 2017 memorandum reinstituted the military's longstanding policy disqualifying those individuals, but in doing so, made clear that the Secretary could "advise [the President] at any time, in writing, that a change to this policy is warranted." *See* Memorandum of August 25, 2017, 82 Fed. Reg. 41,319, 41,319 (Aug. 30, 2017).

Then-Secretary Mattis established a Panel of Experts (the "Panel") to "conduct an independent multi-disciplinary review and study of relevant data and information pertaining to transgender Service members." DoD Report and Recommendations on Military Service by Transgender Persons (Feb. 2018) ("DoD Report") at 17, attached hereto as Ex. D. The Panel consisted of "senior uniformed and civilian Defense Department and U.S. Coast Guard leaders." Mattis Mem. at 1. Then-Secretary Mattis designated the Under Secretary of Defense for Personnel and Readiness to chair the work of the Panel. *See* DoD Report at 18. At that time, Secretary Wilkie had not yet been appointed to that role, and so the Panel was chaired by Mr. Anthony Kurta, who was performing the duties of the Under Secretary of Defense for Personnel and Readiness at that time. Decl. of Lernes J. Hebert ("Hebert Decl.") ¶ 7, attached hereto as Ex. E. Mr. Kurta proceeded to chair the first seven of the Panel's meetings before Secretary Wilkie assumed his

duties as Under Secretary in late November 2017. *Id.* ¶ 10. After that point, Secretary Wilkie chaired the remaining six meetings of the Panel; however, he "played a limited role during the Panel's discussions and deliberations" because he had not been present for more than half of its meetings. *Id.* ¶ 11. At his first Panel meeting on November 30, 2017, Secretary Wilkie turned the meeting over to Mr. Hebert, apart from a brief introductory statement and closing remarks, and proceeded to do the same at each of the remaining five Panel meetings he attended. *Id.* He also announced at the November 30 meeting that he would remain a non-voting member of the Panel for its duration. *Id.* From that point forward, Mr. Hebert assumed the "role as facilitator," and Mr. Kurta took on the role of Special Assistant to Mr. Wilkie and an advisory role on the Panel. *Id.* ¶ 10.

Over the course of thirteen meetings over ninety days, the Panel met with commanders of transgender service members, military medical professionals, civilian medical professionals, and transgender service members. *See Karnoski*, 926 F.3d at 1191. The Panel reviewed information regarding gender dysphoria and its treatment, as well as data collected after the announcement of the Carter policy. *Id.* The Panel further received briefings from three "working groups" dedicated to specific issues involving personnel, medical treatment, and military lethality. DoD Report at 18.

The Panel ultimately developed a new policy, *see* DoD Report at 32, which then-Secretary Mattis adopted in full and which is now in effect, *see id.* at 4 (confirming that the DoD's policy is "[c]onsistent with [the Panel's] recommendations"). Because the Under Secretary had been appointed to chair the Panel, Secretary Wilkie participated in the presentation of the Panel's recommendations to then-Secretary Mattis, along with Mr. Kurta and Mr. Hebert, and signed the two-page formal memorandum to then-Secretary Mattis memorializing the Panel's agreed-upon

recommendations. Hebert Decl. ¶ 15; *see also* Memorandum from R. Wilkie to Secretary of Defense re Recommendations by the Transgender Review Panel of Experts, attached hereto as Ex. F.

Like the Carter policy before it, the Department's current policy turns on the medical condition of gender dysphoria, and its attendant psychological conditions, not on transgender status. Under each policy, transgender individuals without a history or diagnosis of gender dysphoria may serve if they meet the standards associated with their biological sex, whereas those with gender dysphoria are presumptively disqualified. *Id.* at 4–6. The main difference between the two policies is the nature of the exceptions to that presumptive disqualification. Under the current policy, individuals with a history or diagnosis of gender dysphoria may join or remain in the military if they have neither undergone gender transition nor seek to do so. *Id.* at 5. In addition, for accession into the military, such individual must show 36 months of stability (as opposed to 18 months of stability under the Carter policy) before applying, while for retention in the military, they may remain if they meet deployability standards. *Id.* By contrast, those with gender dysphoria who have undergone gender transition or seek to do so are disqualified, absent a waiver. *Id.*

Recognizing, however, that a number of individuals with gender dysphoria had "entered or remained in service following the announcement of the Carter policy," the Department included a reliance exemption in its 2018 policy. DoD Report at 43. Specifically, the exemption provides that service members "who were diagnosed with gender dysphoria by a military medical provider after the effective date of the Carter policy, but before the effective date of any new policy, may continue to receive all medically necessary treatment" as well as "serve in their preferred gender, even after the new policy commences." *Id.*

Then-Secretary Mattis conveyed the Panel's proposed policy to the President in a memorandum dated February 22, 2018 that was accompanied by DoD's Report detailing the bases for the proposal. *See* Mattis Mem. The DoD Report had been prepared by a Personnel and Readiness team that was formed by Mr. Hebert, Mr. Kurta, and Secretary Wilkie at the conclusion of the Panel process, Hebert Decl. ¶ 16, and memorialized the Panel's agreed-upon recommendations, *see* DoD Report at 17-18. Then-Secretary Mattis stated that the policy that the Panel developed was also consistent with his "professional judgment." Mattis Mem. at 2. The Secretary requested that the President "revoke" his 2017 memorandum to permit the military to adopt the new approach. *Id.* at 1. On March 23, 2018, the President revoked the 2017 memorandum, permitting the current policy to go into effect. On March 28, 2018, less than a week after the President approved DoD's policy recommendations, then-Under Secretary Wilkie was named Acting Secretary of Veterans Affairs. On March 30, 2018, he left the DoD after serving as Under Secretary of Defense for Personnel and Readiness for approximately four and a half months and had no further involvement related to the Policy. Hebert Decl. ¶ 17.

II. Underlying Litigation

Plaintiffs filed this action in August 2017 to challenge the President's 2017 Twitter announcement and 2017 memorandum. *See* Compl. for Decl. & Inj. Relief, *Karnoski*, No. 2:17-cv-01297-MJP (W.D. Wash.), ECF 1.[1] The district court preliminarily enjoined the directives in the memorandum. Order (Dec. 11, 2017), ECF 103. In April 2018, after the President revoked the directives, the *Karnoski* district court extended the injunction to DoD's current policy, stating that it "threaten[s] the very same violations." Order (Apr. 13, 2018) at 12, ECF 233.

[1] Unless otherwise indicated, all citations to the docket refer to the underlying action, *Karnoski v. Trump*, No. 2:17-cv-01297-MJP (W.D. Wash.).

Plaintiffs served broad discovery requests that sought, *inter alia*, "all documents and communications" relating to the military's deliberations on service by transgender individuals. *See* Pls.' First Set of Requests for Production of Documents to Defs. (Dec. 29, 2017) at 1, 4, ECF 246-2; Pls.' Second Set of Requests for Production of Documents to Defs. (Apr. 26, 2018) at 2–3, ECF 269-2. The Government initially submitted a partially redacted Administrative Record and produced approximately 30,000 non-privileged documents, while withholding thousands of documents protected by the deliberative process privilege. In July 2018, the district court then compelled the production of all of those documents withheld under the deliberative process privilege. Order (Jul. 27, 2018), ECF 299. In the Ninth Circuit, the Government challenged both the preliminary injunction and the discovery order.

The Ninth Circuit vacated the preliminary injunction, holding that DoD's 2018 policy "is significantly different" from the President's 2017 memorandum barring transgender individuals from serving "in both its creation and its specific provisions." *Karnoski*, 926 F.3d at 1199. It also issued a writ of mandamus vacating the district court's discovery order. *Id.* at 1203–08. The Ninth Circuit directed "careful consideration [of] executive branch privileges," concluding that "the military's interest in full and frank communication about policymaking raises serious—although not insurmountable—national defense interests." *Id.* at 1206.

Separately, in September 2019, the district court for the District of Columbia, in the related *Doe DC* litigation, concluded that the *Doe DC* plaintiffs had overcome the deliberative process privilege for documents that were used or considered by the Panel in developing DoD's current policy. *See Doe DC v. Esper*, No. 17-1597, 2019 WL 4394842, at *8–10 (D.D.C. Sept. 13, 2019). Though the Government disagreed with that order, Defendants produced an unredacted version of the Administrative Record, unredacted meeting minutes from the Panel, and all deliberative

documents and communications to, from, generated by, presented to, or reviewed by the Panel. Defs.' Notice at 1, ECF 389. That production was shared with the Plaintiffs in this action. *See* Easton Decl. ¶ 6, ECF 405-2; Stipulated Uniform Protective Order and Cross-Use Agreement, ECF 183.

Notwithstanding the above production and the Ninth Circuit's writ of mandamus, the district court in this action again ordered Defendants to produce thousands of additional documents that were never seen or considered by the Panel that developed the current policy and also ordered that witnesses at depositions must provide information protected by the deliberative process privilege. *See* Order (Dec. 18, 2019), ECF 401; Minute Entry (Feb. 3, 2020), ECF 410; Order (Feb. 7, 2020), ECF 413. Those orders are currently the subject of another pending mandamus petition before the Ninth Circuit, which has issued an administrative stay of the district court's orders in this action. *See* Order, *In re Trump*, No. 20-70365 (9th Cir. Feb. 12, 2020), ECF 415.

On May 6, 2020, Plaintiffs served Secretary Wilkie with a third-party subpoena pursuant to Rule 45 seeking his deposition testimony on May 27, 2020 in Alexandria, Virginia. *See* Wilkie Subpoena. Pursuant to Local Rule 37(E), counsel for all parties met and conferred telephonically on May 11, 2020 in a good faith effort to resolve this dispute, but were unable to do so. During the May 11, 2020 meet-and-confer, counsel for Plaintiffs and Plaintiff-Intervenor did agree, however, to stay the compliance date of the subpoena pending this Court's resolution of the instant motion to quash. The parties have also corresponded in writing regarding this issue.[2]

[2] On April 10, 2020, defense counsel informed counsel for Plaintiffs and Plaintiff-Intervenor that the Government opposes Plaintiffs' requested deposition of Secretary Wilkie, and that if Plaintiffs nevertheless seek to depose him, they must serve him with a third-party subpoena under Rule 45. Plaintiffs elected to proceed with the subpoena, and requested that the Government accept service on behalf of Secretary Wilkie, to which the Government agreed. On April 24, 2020, the Government requested that Plaintiffs provide the topics on which they intend to depose Secretary Wilkie. To date, Plaintiffs have not responded to this request.

LEGAL STANDARD

Federal Rule of Civil Procedure 45 governs subpoenas issued to non-parties. *See* Fed. R. Civ. P. 45. Under Rule 45, the Court "must quash or modify a subpoena that . . . subjects a person to undue burden," or that "requires disclosure of privileged or other protected matter, if no exception or waiver applies." Fed. R. Civ. P. 45(d)(3)(A)(iii) & (iv). Because the scope of discovery under Rule 45 tracks Rule 26, courts adjudicate motions to quash by reference to the standards for discovery under both rules. *See Singletary v. Sterling Transport Co.*, 289 F.R.D. 237, 240–41 (E.D. Va. 2012). Rule 26 grants trial courts broad discretion to "make any order which justice requires to protect a party or person from annoyance, embarrassment, oppression, or undue burden or expense," including to forbid the proposed discovery altogether. Fed. R. Civ. P. 26(c); *see also Seattle Times Co. v. Rhinehart*, 467 U.S. 20, 36 (1984). Under Rule 26(b)(2), in particular, the court "must limit the frequency or extent of discovery . . . if it determines that . . . the discovery sought is unreasonably cumulative or duplicative, or can be obtained from some other source that is more convenient, less burdensome, or less expensive." Fed. R. Civ. P. 26(b)(2)(C). Although the party moving to quash ordinarily bears the burden of persuasion, *Va. Dep't of Corrections v Jordan*, 921 F.3d 180, 189 (4th Cir. 2019), where, as discussed below, the subpoena is issued to a high-ranking government official, courts require the party seeking to depose the official to demonstrate that "extraordinary circumstances" justify the deposition. *See In re McCarthy*, 636 F. App'x 142, 143 (4th Cir. 2015); *Intelligent Verification Sys., LLC v. Microsoft Corp.*, No. 2:12-cv-525, 2014 WL 12544827, at *2 (E.D. Va. Jan. 9, 2014).

ARGUMENT

I. The Deposition of a Sitting Cabinet Secretary Should Not Be Ordered Absent Extraordinary Circumstances.

A. High-Ranking Officials Are Generally Protected from Testifying About Their Official Decisions.

Since the Supreme Court's decision in *United States v. Morgan*, 313 U.S. 409 (1941), courts have routinely held under the "apex doctrine" that high-ranking government officials should not—absent exceptional circumstances—be deposed or called to testify regarding their reasons for taking official action. *See, e.g.*, *Franklin Sav. Ass'n v. Ryan*, 922 F.2d 209, 211 (4th Cir. 1991); *Lederman v. N.Y.C. Dep't of Parks & Recreation*, 731 F.3d 199, 203–04 (2d Cir. 2013); *Bogan v. City of Boston*, 489 F.3d 417, 423 (1st Cir. 2007); *Simplex Time Recorder Co. v. Sec'y of Labor*, 766 F.2d 575, 586–87 (D.C. Cir. 1985). In *Morgan*, the Supreme Court countermanded the district court's order permitting the deposition of the Secretary of Agriculture on his process in reaching an official decision, admonishing that he "should have never been subjected to this examination" because it was improper "to probe [his] mental processes." 313 U.S. at 421–22.

Consistent with *Morgan*, the Fourth Circuit and other courts of appeals have issued the extraordinary remedy of a writ of mandamus to preclude the depositions of high-ranking Executive branch officials. *See, e.g.*, *In re McCarthy*, 636 F. App'x at 145 (EPA Administrator); *In re Commodity Future Trading Comm'n*, 941 F.3d 869, 875 (7th Cir. 2019) (CFTC chairman, commissioners, and staff); *In re Cheney*, 544 F.3d 311, 314 (D.C. Cir. 2008) (Vice President's Chief of Staff); *In re United States ("Holder")*, 197 F.3d 310, 316 (8th Cir. 1999) (Attorney General and Deputy Attorney General); *In re FDIC*, 58 F.3d 1055, 1063 (5th Cir. 1995) (members of the Board of Directors of the Federal Deposit Insurance Corporation); *In re United States ("Kessler")*, 985 F.2d 510, 513 (11th Cir. 1993) (per curiam) (FDA Commissioner). Numerous courts have upheld these protections, even after the official has left office. *See, e.g.*, *FDIC v.*

Galan-Alvarez, No. 1:15-mc-00752, 2015 WL 5602342, at *4–5 (D.D.C. Sept. 4, 2015) (former FDIC chairperson and senior deputy director); *United States v. Sensient Colors, Inc.*, 649 F. Supp. 2d 309, 316–18 (D.N.J. 2009) (former EPA Administrator); *Croddy v. FBI*, No. 00-cv-0651, 2005 WL 8168910, at *1 (D.D.C. Mar. 30, 2005) (former FBI director). Three separate rationales underlie the apex doctrine.

First, constitutional separation-of-powers principles are implicated when parties litigating against federal agencies attempt to ascertain the thoughts and mental processes by which high-ranking agency officials exercise their official discretion. *See Morgan*, 313 U.S. at 422 ("Just as a judge cannot be subjected to such a scrutiny, . . . so the integrity of the administrative process must be equally respected." (citations omitted)); *Vill. of Arlington Heights v. Metro. Hous. Dev. Corp.*, 429 U.S. 252, 268 n.18 (1977) ("[J]udicial inquiries into . . . executive motivation represent a substantial intrusion into the workings of other branches of government."). Challenges to agency policies are ordinarily resolved based on the "administrative findings that were made at the same time as the decision"—as reflected in the Administrative Record that Defendants produced in this action. *Citizens to Pres. Overton Park, Inc. v. Volpe*, 401 U.S. 402, 420 (1971). The Supreme Court has repeatedly confirmed that, absent "a strong showing of bad faith or improper behavior," discovery into "the mental processes of administrative decisionmakers" is unwarranted.[3] *Dep't of Commerce v. New York*, 139 S. Ct. 2551, 2573–74 (2019) (citation omitted); *see also In re Dep't of Commerce*, 139 S. Ct. 16 (2018) (staying the district court's order authorizing the deposition of

[3] The separation of powers concerns in this particular case are further implicated by the fact that the Under Secretary of Defense for Personnel and Readiness (subject to the authority, direction, and control of the Secretary of Defense) has been delegated specific authority from Congress to set physical and medical standards for military service. *See* 10 U.S.C. § 136; *see also* 32 C.F.R. § 66.6. Adherence to the apex doctrine to avoid probing the mental process of a former Under Secretary of Defense (and current Secretary of Veterans Affairs) in this area thus serves also to protect the interests of both political branches in policy oversight.

the Secretary of Commerce about his decision-making); *Dep't of Commerce*, 139 S. Ct. at 2574 (concluding that "the new material that the parties stipulated should have been part of the administrative record . . . largely justified such extra-record discovery as occurred (*which did not include the deposition of the Secretary himself*)" (emphasis added)).

Second, subjecting high-level government officials to depositions in civil actions involving their agency would impede the exercise of official duties. *See Lederman*, 731 F.3d at 203 (noting that, "if courts did not limit these depositions, such officials would spend 'an inordinate amount of time tending to pending litigation'" (quoting *Bogan*, 489 F.3d at 423)); *Kessler*, 985 F.2d at 512 ("High ranking government officials have greater duties and time constraints than other witnesses."). As one court explained:

> [P]ublic policy requires that the time and energies of public officials be conserved for the public's business to as great an extent as may be consistent with the ends of justice in particular cases. Considering the volume of litigation to which the government is a party, a failure to place reasonable limits upon private litigants' access to responsible governmental officials as sources of routine pre-trial discovery would result in a severe disruption of the government's primary function.

Cmty. Fed. Savings & Loan v. Fed. Home Loan Bank Bd., 96 F.R.D. 619, 621 (D.D.C. 1983).

The concern for disruption is particularly salient where, as here, Plaintiffs seek to depose a sitting Cabinet Secretary. As set forth in the declaration of Pamela J. Powers, the current Acting Deputy Department of Veterans Affairs ("VA") Secretary and Secretary Wilkie's Chief of Staff until April 1, 2020, preparing for and sitting for a deposition would "substantially interfere" with the Secretary's "exercise of his official duties." *See* Decl. of Pamela J. Powers ¶ 13, attached hereto as Ex. G. As the head of the federal government's second largest department, Secretary Wilkie is responsible for administering the largest integrated health network in the United States, with nine million enrolled veterans, in addition to overseeing the Veterans Benefits

Administration, the National Cemetery Administration, and VA's efforts to support the nation's preparedness for war, natural disasters, and other emergencies. *See id.* ¶ 8. As a member of the President's Cabinet, moreover, the Secretary must be "prepared to advise the President on any issues related to the VA that may arise at any time." *Id.* ¶ 10. On any given day, the Secretary may be called upon to attend "as many as eleven individual meetings with VA officials, external officials, and other stakeholders," many of which require "advance internal VA meetings to review the material to be discussed." *Id.* ¶ 9. The Secretary's duties also include site visits to VA facilities and medical centers across the country. *Id.*

Moreover, the "demands on Secretary Wilkie's time have increased even further since the start of the global COVID-19 pandemic." *Id.* ¶ 11. Since March 2, 2020, Secretary Wilkie has served as a member of the White House Coronavirus Task Force, and, in that capacity, "has been occupied on a daily basis with a number of pressing tasks, such as "participating in Task Force meetings, leading senior departmental leader meetings, conducting calls with state governors to offer personnel and guidance to states in need, conducting weekly conference calls with Congress and Veterans Service Organizations on VA's current COVID-19 efforts, participating in multiple daily media interviews, [and] responding to requests from the White House." *Id.* Given these responsibilities and the demands they impose on the Secretary's time and resources, Defendants have consistently opposed Plaintiffs' attempts to depose Secretary Wilkie.

Aside from imposing on high-ranking officials' time, intrusive discovery also exerts a chilling effect on their decision-making. Courts have recognized that "subjecting officials to interrogation about how they reached particular decisions would impair that decision-making process by making officials less willing to explore and discuss all available options, no matter how controversial." *Walker v. NCNB Nat'l Bank of Fla.*, 810 F. Supp. 11, 12 (D.D.C. 1993); *see also*

Sykes v. Brown, 90 F.R.D. 77, 78 (E.D. Pa. 1981) ("Should the agency head be subject to deposition in every resulting case and be repeatedly required to explain the various mental steps he took to reach his decision, the decision may be his last."). These concerns are heightened when a party requests to depose a high-ranking official about military affairs, particularly those policies affecting national security. *Cf. Karnoski*, 926 F.3d at 1206 (per curiam) (noting that "the military's interest in full and frank communication about policymaking raises serious—although not insurmountable—national defense interest.").

Third, "a contrary rule might discourage otherwise upstanding individuals from public service." *Galan-Alvarez*, 2015 WL 5602342, at *4 (citation omitted). As multiple courts have recognized, absent limits on the depositions of high-ranking officials, there is "a tremendous potential for abuse or harassment." *K.C.R. v. Cty. of Los Angeles*, No. CV 13-3806, 2014 WL 3434257, at *3 (C.D. Cal. July 11, 2014) (quotation omitted); *see In re Stone*, 986 F.2d 898, 904 (5th Cir. 1993); *United States v. Wal-Mart Stores, Inc.*, No. CIV.A. PJM–01–CV–152, 2002 WL 562301, at *4 (D. Md. 2002).

B. That Plaintiffs Seek Secretary Wilkie's Testimony Regarding His Former Role Does Not Change This Presumption.

The apex doctrine applies no less to Secretary Wilkie simply because Plaintiffs seek his testimony regarding his official actions while he served as the Under Secretary of Defense for Personnel and Readiness. Courts have recognized that "[t]he integrity of administrative proceedings and the underlying decisionmaking process of agency officials are just as important where the official to be questioned no longer serves in the same position." *Galan-Alvarez*, 2015 WL 5602342, at *3; *see also Wal-Mart Stores, Inc.*, 2002 WL 562301, at *3–4. Secretary Wilkie's appointment to a higher-ranking position does not change the apex analysis. The concerns

motivating the apex doctrine did not arbitrarily dissipate the moment Secretary Wilkie left his position as an Under Secretary at DoD to become the Secretary of VA.

In any event, should the Court consider only Secretary Wilkie's former position as the Under Secretary of Defense for Personnel and Readiness when applying the apex doctrine, the presumption against allowing his deposition would still stand. "Although no standard has been established for determining if an official is high-ranking," *Byrd v. District of Columbia*, 259 F.R.D. 1, 6 (D.D.C. 2009), the Under Secretary of Defense for Personnel and Readiness falls well within the confines of the apex doctrine. In conducting the apex analysis, courts have considered, among other things, the official's title, place in the governmental hierarchy, and job responsibilities. *See, e.g.*, *Alexander v. FBI*, 186 F.R.D. 1, 3–4 (D.D.C. 1998) (determining that three officials classified as "Assistant[s] to the President" qualified as high-ranking officials upon consideration of "the nature of their positions at the White House"); *Low v. Whitman*, 207 F.R.D. 9, 12 (D.D.C. 2002) (concluding that the EPA's Deputy Chief of Staff is a high-ranking official upon finding that, "[a]s a member of the Senior Executive Service with responsibility for budget, personnel, and resource issues, it is clear that [the Deputy Chief of Staff] is in a position of substantial authority").

The position of Under Secretary of Defense for Personnel and Readiness entails the exercise of substantial responsibilities. The Under Secretary is responsible for "serv[ing] as the senior policy advisor to the Secretary of Defense on all aspects of Total Force Management . . . for over two million uniformed personnel and nearly 750,000 DoD civilians." Hebert Decl. ¶ 7. The position also entails substantial authority. The Under Secretary represents the Secretary of Defense "on manpower and personnel matters outside of the Department" and "overs[ees] the overall state of military readiness, . . . health affairs, training, and other personnel requirements and management," including "overseeing the administration" of programs such as the "$15 billion

Defense Health Program." *Id.* ¶ 8; *see also* 10 U.S.C. § 136(b) & (d) (granting the Under Secretary responsibility "in the areas of military readiness, total force management, military and civilian personnel requirements [and] training, . . . National Guard and reserve components, and health affairs" and for "the monitoring of the operations tempo and personnel tempo of the armed forces"); DoD Directive 5124.02 (June 23, 2008), https://www.esd.whs.mil/Portals/54/Documents/DD/issuances/dodd/512402p.pdf (last visited May 20, 2020). Given the stature and those job responsibilities, the Under Secretary of Defense for Personnel and Readiness independently qualifies as a former high-ranking Government official whose deposition should only be allowed upon a showing of extraordinary circumstances.[4] Accordingly, Plaintiffs must overcome a high presumption in order to obtain Secretary Wilkie's deposition in this case, not only because he is a sitting Cabinet Secretary, but also in recognition of his senior DoD role as the Under Secretary of Defense for Personnel and Readiness.

II. Secretary Wilkie's Deposition Is Especially Inappropriate in This Case in Light of the Deference Owed by Courts to Military Judgments.

The foregoing concerns with the deposition of high-ranking officials are particularly acute in this case, where Plaintiffs seek to question and second-guess a former senior DoD official (and current Cabinet Secretary) about his decisions affecting deliberations regarding military personnel policy. As one of the "'complex, subtle, and professional decisions as to the composition . . . of a military force,' which are 'essentially professional military judgments,'" DoD's current policy is subject to a highly deferential form of review. *Winter v. NRDC*, 555 U.S. 7, 24 (2008) (citation

[4] Indeed, courts have extended the apex doctrine to preclude the depositions of officials (both current and former) of lower rank. *See, e.g.*, *Simplex Time Recorder Co.*, 766 F.2d at 586–87 (Regional Administrator of OSHA); *Sensient Colors, Inc.*, 649 F. Supp. 2d at 321 (former EPA Regional Administrator); *Low*, 207 F.R.D. at 12 (EPA Deputy Chief of Staff).

omitted). Choices about who should serve "are based on judgments concerning military operations and needs, and the deference unquestionably due the latter judgments is necessarily required in assessing the former as well." *Rostker v. Goldberg*, 453 U.S. 57, 68 (1981) (citation omitted). "Judicial deference is at its apogee" in this area because "[n]ot only are courts ill-equipped to determine the impact upon discipline that any particular intrusion upon military authority might have, but the military authorities have been charged by the Executive and Legislative Branches with carrying out our Nation's military policy." *Goldman v. Weinberger*, 475 U.S. 503, 507–08 (1986) (internal citations and alterations omitted); *see also Thomasson v. Perry*, 80 F.3d 915, 926 (4th Cir. 1996) ("Parallel to the deference owed Congressional and Presidential policies is deference to the decision-making authority of military personnel who 'have been charged by the Executive and Legislative Branches with carrying out our Nation's military policy'" (quoting *Weinberger*, 475 U.S. at 508)). The judicial inquiry into challenges to military policy is thus "highly constrained," even when evaluating a "'categorical' . . . classification that discriminate[s] on the basis of sex," *Trump v. Hawaii*, 138 S. Ct. 2392, 2419–20 (2018) (discussing *Fiallo v. Bell*, 430 U.S. 787 (1977)), or challenges under the First Amendment, *see Weinberger*, 475 U.S. at 507–08.

Even testimony that "contradict[s]" the reasons behind a military policy would be "quite beside the point," as long the policy had been "decided by the appropriate military officials" in "their considered professional judgment." *Id.* at 509. And when such discovery has occurred, the Supreme Court has "chastised the district court" for "palpably exceed[ing] its authority" in "relying on [such] testimony." *Doe DC*, 917 F.3d at 737 (Williams, J., concurring in result) (first quoting *Weinberger*, 475 U.S. at 509, then quoting *Rostker*, 453 U.S. at 81).

The rationale for the apex doctrine thus applies with particular force in the military setting. *First*, the Supreme Court has recognized that "[o]rderly government requires that the judiciary be as scrupulous not to interfere with legitimate Army matters as the Army must be scrupulous not to intervene in judicial matters." *Rostker*, 453 U.S. at 71 (quoting *Orloff v. Willoughby*, 345 U.S. 534, 540 (1953)); *see also Doe DC*, 917 F.3d at 732 (Williams, J., concurring in result) (noting, in the *Doe DC* case challenging this same policy, that, "when it comes to 'collecting evidence and drawing inferences' on questions of national security, 'the lack of competence on the part of the courts is marked'" (quoting *Hawaii*, 138 S. Ct. at 2419)); *cf. Lebron v. Rumsfeld*, 670 F.3d 540, 553 (4th Cir. 2012) (noting that the "Supreme Court has cautioned against entertaining suits that could be so 'problematic, raising the prospect of compelled depositions and trial testimony by military officers concerning the details of their military commands.'" (quoting *United States v. Stanley*, 483 U.S. 669, 683 (1987))). *Second*, as the Ninth Circuit has recognized in the underlying case, there is a substantial risk of a chilling effect, as "the military's interest in full and frank communication about policymaking raises serious . . . national defense interests." *Karnoski*, 926 F.3d at 1206. *Third*, there is no question that deterring military officials from public service by subjecting them individually to the burdens of civil litigation is an especially grave concern, where the nation relies on capable officials "to fight or be ready to fight wars should the occasion arise." *Rostker*, 453 U.S. at 70 (citation omitted). There is no proper basis here for deposing a former top DoD official (and current Cabinet Secretary) to probe his role in setting a policy regarding the "composition . . . of a military force." *Winter*, 555 U.S. at 24 (citing *Gilligan v. Morgan*, 413 U.S. 1, 10 (1973)).

III. Plaintiffs Cannot Establish that Exceptional Circumstances Require Secretary Wilkie's Deposition.

Plaintiffs cannot overcome these hurdles in seeking to depose a sitting Cabinet Secretary about his deliberations regarding a military policy. Compelling the testimony of Secretary Wilkie would result in "serious repercussions for the relationship between two coequal branches of government." *In re United States ("Jackson")*, 624 F.3d 1368, 1372 (11th Cir. 2010) (noting that "the threat to the separation of powers is more substantial" when the official is "higher-ranking"). To demonstrate extraordinary circumstances warranting Secretary Wilkie's deposition, Plaintiffs must, at minimum, demonstrate that the Secretary has additional non-privileged knowledge relevant to the underlying challenge, and that the information cannot be obtained elsewhere. *See Lederman*, 731 F.3d at 204; *Microsoft*, 2014 WL 12544827, at *2. Plaintiffs have not specified why they wish to depose Secretary Wilkie, but instead broadly assert that his testimony is "critically important" because he was "one of two military officials who chaired the Panel" and "one of the lead authors of the February 2018 Report." *See* Joint Status Report ("JSR") at 4, attached hereto as Ex. H. That is plainly insufficient, and the subpoena should be quashed for this reason alone.

A. Plaintiffs Cannot Demonstrate That the Secretary Has Unique Information Relevant to Their Claims.

Plaintiffs' principal theory on their underlying claims in this action has been that DoD's current policy merely provided "after-the-fact justification" for the President's initial Tweet and memorandum, *see* Pls.' Second Am. Compl. ¶¶ 205–07, ECF 347. But the Ninth Circuit has already rejected that theory, holding that the current policy "is significantly different" from the President's 2017 memorandum barring transgender individuals from serving "in both its creation and its specific provisions." *Karnoski*, 926 F.3d at 1199. The D.C. Circuit similarly found that "[i]t was clear error to say there was no significant change with respect to at least two aspects of

the policy recommended by Secretary of Defense James Mattis in February 2018 and approved by the President in March 2018." *Doe 2 v. Shanahan*, 755 F. App'x 19, 23 (D.C. Cir. 2019) (per curiam). Plaintiffs thus can challenge the current policy only on its own terms. There is no basis to depose Secretary Wilkie because all relevant, non-privileged information that he possesses can be (and has been) obtained from other sources.

First, Plaintiffs are mistaken in their assumptions about Secretary Wilkie's role in formulating the disputed policy and the uniqueness of any information he may possess. The assertion that Secretary Wilkie was one of two DoD officials who chaired Panel meetings and was one of the lead authors of the February 2018 Report to then-Secretary Mattis is inadequate on its face to justify his deposition.

To begin, the notion that because the Secretary was one of two officials who was formally named to chair the Panel meetings, he would have unique information about the process by which the Panel recommended the disputed policy is far too generalized and speculative to meet Plaintiffs' heavy burden of showing that the Secretary has unique information that cannot be obtained from other sources. *See Galan-Alvarez*, 2015 WL 5602342, at *5 (finding that the defendants' generalized assertions that the FDIC Chairperson "may have attended meetings and requested briefings and documents on Project Themis due to her leadership role" failed to "demonstrate that any knowledge she gained of the project was unique"); *In re United States*, 542 F. App'x 944, 949 (Fed. Cir. 2013) (refusing to permit the deposition of the Chairman of the Board of Governors for the Federal Reserve because the information sought by the plaintiff essentially amounted to a "fishing expedition").

In addition, Plaintiffs' assertion also underscores their fundamental misunderstanding of the process by which DoD developed its current policy concerning military service by transgender

individuals and gender dysphoria. In fact, Secretary Wilkie was not even appointed and confirmed to his role as Under Secretary for Personnel and Readiness until more than halfway through the Panel process; he therefore took a non-voting role on the Panel. Hebert Decl. ¶ 11. Moreover, although Secretary Wilkie signed the transmittal memorandum of the Panel's recommendations to the Secretary of Defense and briefed then-Secretary Mattis on the Panel findings along with Mr. Kurta, Mr. Hebert, and others, that memo and the DoD Report merely memorialized the Panel's agreed-upon recommendations, which were adopted by Secretary Mattis. In light of the above, Plaintiffs simply cannot show that the Secretary will have any unique, non-privileged information.

Second, Plaintiffs have not established that they are unable to obtain the non-privileged information they seek from the Secretary through other means of discovery or from other witnesses. *See In re Cheney*, 544 F.3d at 314. For starters, Defendants have produced an unredacted Administrative Record in addition to over 30,000 non-privileged documents in this case. Defendants have also produced every deliberative document sent from, received by, generated by, presented to, or considered by the Panel that formulated DoD's current policy. These include:

- Unredacted meeting minutes from the Panel;
- All documents, testimony, and data reviewed by members of the Panel and the Panel's deliberations about these materials; and
- All documents and communications related to the Panel's work that were sent from, received by, generated by, presented to, or considered by the members of the Panel.

See Defs.' Notice at 2–3, ECF 389; *Doe DC*, 2019 WL 4394842, at *8–10. Defendants have also waived the deliberative process privilege over and produced the final versions of the presentations that were given to the Deputy Secretary of Defense, the Vice Chairman of the Joint Chiefs of Staff, and Secretary Mattis regarding the Panel's recommendations. *See* Decl. of Andrew E. Carmichael

¶ 2, ECF 381 at 2–3. Accordingly, Plaintiffs already have access to all of the relevant documents necessary to litigate their claim that the policy is "not supported by any compelling, important, or even rational government interest," Pls. Second Am. Compl. ¶ 205, ECF 347, especially in light of the principles of military deference. Plaintiffs possess not only the Panel's deliberations, but also the information that the Panel presented to Secretary Mattis, and the Secretary's reasons for adopting the Panel's recommendations in full, *see* Mattis Mem; DoD Report.

Moreover, Defendants have offered several other senior DoD and armed services officials as witnesses who possess substantially similar or superior expertise and information regarding the development of the challenged policy. Most importantly, these include Anthony M. Kurta. In the fall of 2017, Mr. Kurta performed the duties of the Under Secretary of Defense for Personnel and Readiness before Secretary Wilkie was appointed, and, in that role, served as chair of the Panel until late November 2017; thereafter, unlike Secretary Wilkie, Mr. Kurta remained a voting member of the Panel. ECF 504-6 at 1. Defendants have identified Mr. Kurta as the official who presented the Panel's recommendations to the Deputy Secretary of Defense and Vice Chairman of the Joint Chiefs of Staff. ECF 504-5 at 12. Mr. Kurta acted as the Chair of the Panel for its first seven meetings and, as the Special Assistant to Secretary Wilkie, remained an advisor for the remaining six. *See* ECF 504-5 at 12; Hebert Decl. ¶ 10. Plaintiffs have indicated their intent to depose Mr. Kurta later this summer, which Defendants do not oppose. *See* ECF 504-5 at 12.

In addition, Plaintiffs have indicated they will be deposing Lernes J. Hebert, currently the Deputy Assistant Secretary of Defense for Military Personnel Policy, this summer. *See* ECF 504-5 at 12. Mr. Hebert is available to be deposed in this matter and has offered a declaration in support of this Motion. *See* Hebert Decl. As noted in Mr. Hebert's declaration, he attended Panel meetings and co-chaired the Medical Personnel Executive Steering Committee, which supported the Panel's

work. ECF 504-6 at 2. Mr. Hebert also attests that he facilitated the Panel's deliberations at each of the meetings Secretary Wilkie chaired, and that, apart from giving opening and closing remarks, Secretary Wilkie turned the balance of the Panel meetings over to Mr. Hebert. Hebert Decl. ¶ 11. Defendants have identified Mr. Hebert as the official who directly supported Mr. Kurta in his briefing to the Deputy Secretary of Defense and Vice Chairman of the Joint Chiefs of Staff on the Panel's findings. ECF 504-5 at 12.[5]

Given their personal and hands-on involvement with the Panel, these officials can provide non-privileged testimony—and, indeed, are better-situated—to answer questions Plaintiffs may have about the Panel's actions, and discuss information the Panel considered in formulating its recommendations, which then-Secretary Mattis adopted in full. At a minimum, the Court should require Plaintiffs to complete their depositions of Mr. Kurta, Mr. Hebert, Mr. Dee, Dr. Adirim, and Ms. Miller *before* requesting to depose Secretary Wilkie. *See, e.g.*, *Bogan*, 489 F.3d at 424 (holding it was "incumbent on [plaintiff] to seek information from [other officials] before turning to the Mayor").

In light of the above, Plaintiffs' proposed deposition of Secretary Wilkie is plainly unnecessary, and indeed, inappropriate. Courts have made clear that "other less burdensome

[5] Defendants have provided dates for the depositions of three additional officials. ECF 503 at 12. Mr. Thomas Dee was performing the duties of the Under Secretary of the Navy at the time the disputed policy was approved, *see* Thomas P. Dee, https://www.secnav.navy.mil/donhr/About/Senior-Executives/Biographies/Dee,%20T.pdf (last visited May 19, 2020), and served as a voting member of the Panel, ECF 503 at 12. Ms. Stephanie Miller and Dr. Terry Adirim both attended Panel meetings. ECF 503 at 12. Ms. Miller was co-chair of the Transgender Action Officer Action Working Group and chair of the Transgender Personnel Policy Working Group, and Dr. Adirim was co-chair of the Medical Personnel Executive Steering Committee with Mr. Hebert. ECF 504-6 at 2. In addition, plaintiffs in the related *Doe DC* case have already deposed representatives from the Air Force and the Army who attended Panel meetings, and Defendants are making those individuals available for a second deposition in this case.

avenues for obtaining the information" must be "exhausted" before authorizing the deposition of a high-ranking official. *Microsoft*, 2014 WL 12544827, at *2 (citation omitted); *see also Simplex*, 766 F.2d at 587 (no extraordinary circumstances exist where party failed to show information was unavailable "from published reports and available agency documents"). Courts have, moreover, refused to authorize depositions or live testimony of high-ranking officials—both current and former—if "other persons can provide the information sought." *In re Holder*, 197 F.3d at 314; *see also In re Jackson*, 624 F.3d at 1373 (granting writ of mandamus directing the district court to allow the EPA to substitute the Assistant Administrator for the EPA Administrator at a court hearing); *Galan-Alvarez*, 2015 WL 5602342, at *5 (granting motion to quash subpoena seeking testimony from the FDIC Chairperson upon finding that, among other things, the FDIC had "made available four other officials, all of whom had greater involvement in the day-to-day progress of the bank's closure").

The Court should do the same here. Not only have Plaintiffs already received all of the relevant, non-privileged documents necessary to litigate their claims, they have also obtained the deliberative material from the Panel that then-Secretary Mattis tasked with formulating the challenged policy. Further, Plaintiffs have indicated that they will be taking Mr. Kurta's and Mr. Hebert's deposition later this summer, *see* JSR at 6–7, and scheduled dates for the depositions of several other DoD officials who were involved in the Panel's work, ECF 503 at 12. Plaintiffs can offer no reason, then, why the deposition of Secretary Wilkie is necessary.

B. The Information Plaintiffs Seek from Secretary Wilkie is Protected or Privileged.

Finally, to the extent Plaintiffs seek to depose Secretary Wilkie about his thought process regarding the Panel's recommended policy, his participation in the process, or any communications that he had with then-Secretary Mattis regarding the policy or process, the Court

should quash the subpoena because that information is clearly protected or privileged. *See* Fed. R. Civ. P. 45(d)(3)(A)(iii).

Plaintiffs suggest that Secretary Wilkie's deposition is necessary to probe his thought process behind the ultimate policy proposal because he was "one of the lead authors of the February 2018 Report." JSR at 4. But even if the Secretary has unique, relevant information, discovery into his mental impressions is squarely foreclosed by the apex doctrine. *See supra* at 11-12; *see also Morgan*, 313 U.S. at 421 ("We have explicitly held in this very litigation that 'it was not the function of the court to probe the mental processes of the Secretary.'" (citation omitted)); *Franklin Savings Ass'n*, 922 F.2d at 211 ("[A]bsent 'extraordinary circumstances,' a government decision-maker will not be compelled to testify about his mental processes in reaching a decision, 'including the manner and extent of his study of the record and his consultations with subordinates.'" (quoting *Morgan*, 313 U.S. at 421–22)). Plaintiffs have no basis to overcome those protections here.[6]

Moreover, any information that Plaintiffs seek regarding deliberations outside of the Panel's development of the policy is protected by the deliberative process privilege, and Plaintiffs have no basis to overcome that privilege here. *See Cipollone v. Liggett Group, Inc.*, 812 F.2d 1400 (table) (4th Cir. 1987) (per curiam). As the *Doe DC* district court explained, the request for deliberative documents without any connection to Panel members is an improper "fishing" expedition. Tr. of Telephone Conference, *Doe DC v. Esper*, at 20:1–13 (D.D.C. Jan. 14, 2020),

[6] Plaintiffs do not allege that Secretary Wilkie harbored discriminatory intent. Nor can plaintiffs make out the "strong showing of bad faith or improper behavior" that would be required to probe Secretary Wilkie's judgment. *Dep't of Commerce*, 139 S. Ct. at 2573–74; *see also Franklin Savings Ass'n*, 922 F.2d at 211. Despite vigorous litigation across five cases over nearly three years, there is no suggestion that DoD's policy was promulgated in bad faith, or that the government behaved improperly. Accordingly, Plaintiffs have no basis to examine Secretary Wilkie's mental processes.

ECF 239; *accord Doe DC*, 917 F.3d at 737 (Williams, J., concurring in result) (noting that "the court should not bless (or invite) a futile fishing expedition into the executive's decision-making"). Given that the Panel's recommendations were the same policy adopted in the Report to Secretary Mattis and in then-Secretary Mattis's memorandum presenting the policy to the President, Plaintiffs have no need for deliberative information outside of the Panel's activities to understand if the current policy reflects the Panel's recommendations.

In fact, the Government has filed a mandamus petition in the Ninth Circuit seeking to vacate the district court's orders in the underlying action compelling the release of deliberative records never considered by the Panel, such as drafts of DoD's Report and deliberative documents relating to the Mattis memorandum. *See* Petition at 24, 25, *In re Trump*, No. 20-70365, ECF 1-2 (9th Cir. Feb. 11, 2020). That petition is currently pending. This Court should not allow Plaintiffs to circumvent the Ninth Circuit's administrative stay by compelling Secretary Wilkie to testify about the kind of privileged information contained in those documents. Indeed, the Ninth Circuit has already explained that "[d]ocuments involving the most senior executive branch officials . . . may require greater deference." *Karnoski*, 926 F.3d at 1206.

CONCLUSION

For the foregoing reasons, Defendants' Motion to Quash should be granted, and Plaintiffs should be precluded from deposing the Secretary of Veterans Affairs.

Dated: May 20, 2020

Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that on May 20, 2020, a copy of the document above was served by email to the following counsel of record for Plaintiffs and Plaintiff-Intervenor in the underlying action:

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/s/ *Dennis C. Barghaan*
DENNIS C. BARGHAAN, JR.
Deputy Chief, Civil Division
Assistant United States Attorney

Exhibit A

Wilkie Subpoena

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON
AT SEATTLE

RYAN KARNOSKI, et al., *Plaintiffs*, and STATE OF WASHINGTON, *Plaintiff-Intervenor*, v. DONALD J. TRUMP, in his official capacity as President of the United States, et al., *Defendants*.	Case No. 2:17-cv-01297-MJP Honorable Marsha J. Pechman

NOTICE OF SUBPOENA

PLEASE TAKE NOTICE that pursuant to Rule 45 of the Federal Rules of Civil Procedure, Plaintiffs, by their attorneys, will serve, on or after May 6, 2020, subpoena on Secretary Robert L. Wilkie, in the form attached hereto, for a deposition to take place at Bogorad & Richards PLLC, 209 Madison Street, Alexandria VA 22314 on May 27, 2020.

Dated: May 6, 2020

/s/ Jordan M. Heinz
LAMDBA LEGAL DEFENSE AND EDUCATION FUND, INC.
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Paul D. Castillo (admitted pro hac vice)

OUTSERVE-SLDN, INC. N/K/A MODERN MILITARY ASSOCIATION OF AMERICA
Peter Perkowski (admitted pro hac vice)

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CERTIFICATE OF SERVICE

The undersigned certifies under penalty of perjury under the laws of the United States of America and the laws of the State of Washington that on May 6, 2020, I caused a true and correct copy of the foregoing document to be served by email on the following counsel of record for Defendants:

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Counsel for Defendants

/s/ Jordan M. Heinz

AO 88A (Rev. 02/14) Subpoena to Testify at a Deposition in a Civil Action

UNITED STATES DISTRICT COURT

for the

Western District of Washington

RYAN KARNOSKI, et al.,
Plaintiff
v.
DONALD J. TRUMP, et al.,
Defendant

Civil Action No. C17-1297-MJP

SUBPOENA TO TESTIFY AT A DEPOSITION IN A CIVIL ACTION

To: Robert L. Wilkie

(Name of person to whom this subpoena is directed)

☑ *Testimony:* **YOU ARE COMMANDED** to appear at the time, date, and place set forth below to testify at a deposition to be taken in this civil action. If you are an organization, you must designate one or more officers, directors, or managing agents, or designate other persons who consent to testify on your behalf about the following matters, or those set forth in an attachment:

Place:	Date and Time:
Bogorad & Richards PLLC 209 Madison Street Alexandria VA 22314	05/27/2020 9:30 am

The deposition will be recorded by this method: Court reporter and video recording

☐ *Production:* You, or your representatives, must also bring with you to the deposition the following documents, electronically stored information, or objects, and must permit inspection, copying, testing, or sampling of the material:

The following provisions of Fed. R. Civ. P. 45 are attached – Rule 45(c), relating to the place of compliance; Rule 45(d), relating to your protection as a person subject to a subpoena; and Rule 45(e) and (g), relating to your duty to respond to this subpoena and the potential consequences of not doing so.

Date: 05/06/2020

CLERK OF COURT

OR

Signature of Clerk or Deputy Clerk

/s/ Jordan M. Heinz
Attorney's signature

The name, address, e-mail address, and telephone number of the attorney representing *(name of party)* Plaintiffs Ryan Karnoski, et al., who issues or requests this subpoena, are:

Jordan M. Heinz, 300 North LaSalle, Chicago, IL 60654, jordan.heinz@kirkland.com, 312.862.7027

Notice to the person who issues or requests this subpoena

If this subpoena commands the production of documents, electronically stored information, or tangible things before trial, a notice and a copy of the subpoena must be served on each party in this case before it is served on the person to whom it is directed. Fed. R. Civ. P. 45(a)(4).

Civil Action No. C17-1297-MJP

PROOF OF SERVICE

(This section should not be filed with the court unless required by Fed. R. Civ. P. 45.)

I received this subpoena for *(name of individual and title, if any)* _____
on *(date)* _____ .

❒ I served the subpoena by delivering a copy to the named individual as follows: _____

_____

_____ on *(date)* _____ ; or

❒ I returned the subpoena unexecuted because: _____

_____ .

Unless the subpoena was issued on behalf of the United States, or one of its officers or agents, I have also tendered to the witness the fees for one day's attendance, and the mileage allowed by law, in the amount of $ _____ .

My fees are $ _____ for travel and $ _____ for services, for a total of $ 0.00 .

I declare under penalty of perjury that this information is true.

Date: _____

_____
Server's signature

_____
Printed name and title

_____
Server's address

Additional information regarding attempted service, etc.:

Federal Rule of Civil Procedure 45 (c), (d), (e), and (g) (Effective 12/1/13)

(c) Place of Compliance.

(1) ***For a Trial, Hearing, or Deposition.*** A subpoena may command a person to attend a trial, hearing, or deposition only as follows:

(A) within 100 miles of where the person resides, is employed, or regularly transacts business in person; or

(B) within the state where the person resides, is employed, or regularly transacts business in person, if the person

(i) is a party or a party's officer; or

(ii) is commanded to attend a trial and would not incur substantial expense.

(2) ***For Other Discovery.*** A subpoena may command:

(A) production of documents, electronically stored information, or tangible things at a place within 100 miles of where the person resides, is employed, or regularly transacts business in person; and

(B) inspection of premises at the premises to be inspected.

(d) Protecting a Person Subject to a Subpoena; Enforcement.

(1) ***Avoiding Undue Burden or Expense; Sanctions.*** A party or attorney responsible for issuing and serving a subpoena must take reasonable steps to avoid imposing undue burden or expense on a person subject to the subpoena. The court for the district where compliance is required must enforce this duty and impose an appropriate sanction—which may include lost earnings and reasonable attorney's fees—on a party or attorney who fails to comply.

(2) ***Command to Produce Materials or Permit Inspection.***

(A) *Appearance Not Required.* A person commanded to produce documents, electronically stored information, or tangible things, or to permit the inspection of premises, need not appear in person at the place of production or inspection unless also commanded to appear for a deposition, hearing, or trial.

(B) *Objections.* A person commanded to produce documents or tangible things or to permit inspection may serve on the party or attorney designated in the subpoena a written objection to inspecting, copying, testing, or sampling any or all of the materials or to inspecting the premises—or to producing electronically stored information in the form or forms requested. The objection must be served before the earlier of the time specified for compliance or 14 days after the subpoena is served. If an objection is made, the following rules apply:

(i) At any time, on notice to the commanded person, the serving party may move the court for the district where compliance is required for an order compelling production or inspection.

(ii) These acts may be required only as directed in the order, and the order must protect a person who is neither a party nor a party's officer from significant expense resulting from compliance.

(3) ***Quashing or Modifying a Subpoena.***

(A) *When Required.* On timely motion, the court for the district where compliance is required must quash or modify a subpoena that:

(i) fails to allow a reasonable time to comply;

(ii) requires a person to comply beyond the geographical limits specified in Rule 45(c);

(iii) requires disclosure of privileged or other protected matter, if no exception or waiver applies; or

(iv) subjects a person to undue burden.

(B) *When Permitted.* To protect a person subject to or affected by a subpoena, the court for the district where compliance is required may, on motion, quash or modify the subpoena if it requires:

(i) disclosing a trade secret or other confidential research, development, or commercial information; or

(ii) disclosing an unretained expert's opinion or information that does not describe specific occurrences in dispute and results from the expert's study that was not requested by a party.

(C) *Specifying Conditions as an Alternative.* In the circumstances described in Rule 45(d)(3)(B), the court may, instead of quashing or modifying a subpoena, order appearance or production under specified conditions if the serving party:

(i) shows a substantial need for the testimony or material that cannot be otherwise met without undue hardship; and

(ii) ensures that the subpoenaed person will be reasonably compensated.

(e) Duties in Responding to a Subpoena.

(1) ***Producing Documents or Electronically Stored Information.*** These procedures apply to producing documents or electronically stored information:

(A) *Documents.* A person responding to a subpoena to produce documents must produce them as they are kept in the ordinary course of business or must organize and label them to correspond to the categories in the demand.

(B) *Form for Producing Electronically Stored Information Not Specified.* If a subpoena does not specify a form for producing electronically stored information, the person responding must produce it in a form or forms in which it is ordinarily maintained or in a reasonably usable form or forms.

(C) *Electronically Stored Information Produced in Only One Form.* The person responding need not produce the same electronically stored information in more than one form.

(D) *Inaccessible Electronically Stored Information.* The person responding need not provide discovery of electronically stored information from sources that the person identifies as not reasonably accessible because of undue burden or cost. On motion to compel discovery or for a protective order, the person responding must show that the information is not reasonably accessible because of undue burden or cost. If that showing is made, the court may nonetheless order discovery from such sources if the requesting party shows good cause, considering the limitations of Rule 26(b)(2)(C). The court may specify conditions for the discovery.

(2) ***Claiming Privilege or Protection.***

(A) *Information Withheld.* A person withholding subpoenaed information under a claim that it is privileged or subject to protection as trial-preparation material must:

(i) expressly make the claim; and

(ii) describe the nature of the withheld documents, communications, or tangible things in a manner that, without revealing information itself privileged or protected, will enable the parties to assess the claim.

(B) *Information Produced.* If information produced in response to a subpoena is subject to a claim of privilege or of protection as trial-preparation material, the person making the claim may notify any party that received the information of the claim and the basis for it. After being notified, a party must promptly return, sequester, or destroy the specified information and any copies it has; must not use or disclose the information until the claim is resolved; must take reasonable steps to retrieve the information if the party disclosed it before being notified; and may promptly present the information under seal to the court for the district where compliance is required for a determination of the claim. The person who produced the information must preserve the information until the claim is resolved.

(g) Contempt.

The court for the district where compliance is required—and also, after a motion is transferred, the issuing court—may hold in contempt a person who, having been served, fails without adequate excuse to obey the subpoena or an order related to it.

For access to subpoena materials, see Fed. R. Civ. P. 45(a) Committee Note (2013).

Exhibit B

Diagnostic and Statistical Manual of Mental Disorders 5th Edition, DSM-5

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FIFTH EDITION

DSM-5™

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Gender Dysphoria

In this chapter, there is one overarching diagnosis of gender dysphoria, with separate developmentally appropriate criteria sets for children and for adolescents and adults. The area of sex and gender is highly controversial and has led to a proliferation of terms whose meanings vary over time and within and between disciplines. An additional source of confusion is that in English "sex" connotes both male/female and sexuality. This chapter employs constructs and terms as they are widely used by clinicians from various disciplines with specialization in this area. In this chapter, *sex* and *sexual* refer to the biological indicators of male and female (understood in the context of reproductive capacity), such as in sex chromosomes, gonads, sex hormones, and nonambiguous internal and external genitalia. Disorders of sex development denote conditions of inborn somatic deviations of the reproductive tract from the norm and/or discrepancies among the biological indicators of male and female. *Cross-sex* hormone treatment denotes the use of feminizing hormones in an individual assigned male at birth based on traditional biological indicators or the use of masculinizing hormones in an individual assigned female at birth.

The need to introduce the term *gender* arose with the realization that for individuals with conflicting or ambiguous biological indicators of sex (i.e., "intersex"), the lived role in society and/or the identification as male or female could not be uniformly associated with or predicted from the biological indicators and, later, that some individuals develop an identity as female or male at variance with their uniform set of classical biological indicators. Thus, *gender* is used to denote the public (and usually legally recognized) lived role as boy or girl, man or woman, but, in contrast to certain social constructionist theories, biological factors are seen as contributing, in interaction with social and psychological factors, to gender development. *Gender assignment* refers to the initial assignment as male or female. This occurs usually at birth and, thereby, yields the "natal gender." *Gender-atypical* refers to somatic features or behaviors that are not typical (in a statistical sense) of individuals with the same assigned gender in a given society and historical era; for behavior, *gender-nonconforming* is an alternative descriptive term. *Gender reassignment* denotes an official (and usually legal) change of gender. *Gender identity* is a category of social identity and refers to an individual's identification as male, female, or, occasionally, some category other than male or female. *Gender dysphoria* as a general descriptive term refers to an individual's affective/cognitive discontent with the assigned gender but is more specifically defined when used as a diagnostic category. *Transgender* refers to the broad spectrum of individuals who transiently or persistently identify with a gender different from their natal gender. *Transsexual* denotes an individual who seeks, or has undergone, a social transition from male to female or female to male, which in many, but not all, cases also involves a somatic transition by cross-sex hormone treatment and genital surgery (*sex reassignment surgery*).

Gender dysphoria refers to the distress that may accompany the incongruence between one's experienced or expressed gender and one's assigned gender. Although not all individuals will experience distress as a result of such incongruence, many are distressed if the desired physical interventions by means of hormones and/or surgery are not available. The current term is more descriptive than the previous DSM-IV term *gender identity disorder* and focuses on dysphoria as the clinical problem, not identity per se.

Gender Dysphoria

Diagnostic Criteria

Gender Dysphoria in Children 302.6 (F64.2)

A. A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months' duration, as manifested by at least six of the following (one of which must be Criterion A1):

1. A strong desire to be of the other gender or an insistence that one is the other gender (or some alternative gender different from one's assigned gender).
2. In boys (assigned gender), a strong preference for cross-dressing or simulating female attire; or in girls (assigned gender), a strong preference for wearing only typical masculine clothing and a strong resistance to the wearing of typical feminine clothing.
3. A strong preference for cross-gender roles in make-believe play or fantasy play.
4. A strong preference for the toys, games, or activities stereotypically used or engaged in by the other gender.
5. A strong preference for playmates of the other gender.
6. In boys (assigned gender), a strong rejection of typically masculine toys, games, and activities and a strong avoidance of rough-and-tumble play; or in girls (assigned gender), a strong rejection of typically feminine toys, games, and activities.
7. A strong dislike of one's sexual anatomy.
8. A strong desire for the primary and/or secondary sex characteristics that match one's experienced gender.

B. The condition is associated with clinically significant distress or impairment in social, school, or other important areas of functioning.

Specify if:

With a disorder of sex development (e.g., a congenital adrenogenital disorder such as 255.2 [E25.0] congenital adrenal hyperplasia or 259.50 [E34.50] androgen insensitivity syndrome).

Coding note: Code the disorder of sex development as well as gender dysphoria.

Gender Dysphoria in Adolescents and Adults 302.85 (F64.1)

A. A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months' duration, as manifested by at least two of the following:

1. A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics).
2. A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender (or in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics).
3. A strong desire for the primary and/or secondary sex characteristics of the other gender.
4. A strong desire to be of the other gender (or some alternative gender different from one's assigned gender).
5. A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender).
6. A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender).

B. The condition is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Specify if:

With a disorder of sex development (e.g., a congenital adrenogenital disorder such as 255.2 [E25.0] congenital adrenal hyperplasia or 259.50 [E34.50] androgen insensitivity syndrome).

Coding note: Code the disorder of sex development as well as gender dysphoria.

Specify if:

Posttransition: The individual has transitioned to full-time living in the desired gender (with or without legalization of gender change) and has undergone (or is preparing to have) at least one cross-sex medical procedure or treatment regimen—namely, regular cross-sex hormone treatment or gender reassignment surgery confirming the desired gender (e.g., penectomy, vaginoplasty in a natal male; mastectomy or phalloplasty in a natal female).

Specifiers

The posttransition specifier may be used in the context of continuing treatment procedures that serve to support the new gender assignment.

Diagnostic Features

Individuals with gender dysphoria have a marked incongruence between the gender they have been assigned to (usually at birth, referred to as *natal gender*) and their experienced/expressed gender. This discrepancy is the core component of the diagnosis. There must also be evidence of distress about this incongruence. Experienced gender may include alternative gender identities beyond binary stereotypes. Consequently, the distress is not limited to a desire to simply be of the other gender, but may include a desire to be of an alternative gender, provided that it differs from the individual's assigned gender.

Gender dysphoria manifests itself differently in different age groups. Prepubertal natal girls with gender dysphoria may express the wish to be a boy, assert they are a boy, or assert they will grow up to be a man. They prefer boys' clothing and hairstyles, are often perceived by strangers as boys, and may ask to be called by a boy's name. Usually, they display intense negative reactions to parental attempts to have them wear dresses or other feminine attire. Some may refuse to attend school or social events where such clothes are required. These girls may demonstrate marked cross-gender identification in role-playing, dreams, and fantasies. Contact sports, rough-and-tumble play, traditional boyhood games, and boys as playmates are most often preferred. They show little interest in stereotypically feminine toys (e.g., dolls) or activities (e.g., feminine dress-up or role-play). Occasionally, they refuse to urinate in a sitting position. Some natal girls may express a desire to have a penis or claim to have a penis or that they will grow one when older. They may also state that they do not want to develop breasts or menstruate.

Prepubertal natal boys with gender dysphoria may express the wish to be a girl or assert they are a girl or that they will grow up to be a woman. They have a preference for dressing in girls' or women's clothes or may improvise clothing from available materials (e.g., using towels, aprons, and scarves for long hair or skirts). These children may role-play female figures (e.g., playing "mother") and often are intensely interested in female fantasy figures. Traditional feminine activities, stereotypical games, and pastimes (e.g., "playing house"; drawing feminine pictures; watching television or videos of favorite female characters) are most often preferred. Stereotypical female-type dolls (e.g., Barbie) are often favorite toys, and girls are their preferred playmates. They avoid rough-and-tumble play and competitive sports and have little interest in stereotypically masculine toys (e.g., cars, trucks). Some may pretend not to have a penis and insist on sitting to urinate. More

rarely, they may state that they find their penis or testes disgusting, that they wish them removed, or that they have, or wish to have, a vagina.

In young adolescents with gender dysphoria, clinical features may resemble those of children or adults with the condition, depending on developmental level. As secondary sex characteristics of young adolescents are not yet fully developed, these individuals may not state dislike of them, but they are concerned about imminent physical changes.

In adults with gender dysphoria, the discrepancy between experienced gender and physical sex characteristics is often, but not always, accompanied by a desire to be rid of primary and/or secondary sex characteristics and/or a strong desire to acquire some primary and/or secondary sex characteristics of the other gender. To varying degrees, adults with gender dysphoria may adopt the behavior, clothing, and mannerisms of the experienced gender. They feel uncomfortable being regarded by others, or functioning in society, as members of their assigned gender. Some adults may have a strong desire to be of a different gender and treated as such, and they may have an inner certainty to feel and respond as the experienced gender without seeking medical treatment to alter body characteristics. They may find other ways to resolve the incongruence between experienced/expressed and assigned gender by partially living in the desired role or by adopting a gender role neither conventionally male nor conventionally female.

Associated Features Supporting Diagnosis

When visible signs of puberty develop, natal boys may shave their legs at the first signs of hair growth. They sometimes bind their genitals to make erections less visible. Girls may bind their breasts, walk with a stoop, or use loose sweaters to make breasts less visible. Increasingly, adolescents request, or may obtain without medical prescription and supervision, hormonal suppressors ("blockers") of gonadal steroids (e.g., gonadotropin-releasing hormone [GnRH] analog, spironolactone). Clinically referred adolescents often want hormone treatment and many also wish for gender reassignment surgery. Adolescents living in an accepting environment may openly express the desire to be and be treated as the experienced gender and dress partly or completely as the experienced gender, have a hairstyle typical of the experienced gender, preferentially seek friendships with peers of the other gender, and/or adopt a new first name consistent with the experienced gender. Older adolescents, when sexually active, usually do not show or allow partners to touch their sexual organs. For adults with an aversion toward their genitals, sexual activity is constrained by the preference that their genitals not be seen or touched by their partners. Some adults may seek hormone treatment (sometimes without medical prescription and supervision) and gender reassignment surgery. Others are satisfied with either hormone treatment or surgery alone.

Adolescents and adults with gender dysphoria before gender reassignment are at increased risk for suicidal ideation, suicide attempts, and suicides. After gender reassignment, adjustment may vary, and suicide risk may persist.

Prevalence

For natal adult males, prevalence ranges from 0.005% to 0.014%, and for natal females, from 0.002% to 0.003%. Since not all adults seeking hormone treatment and surgical reassignment attend specialty clinics, these rates are likely modest underestimates. Sex differences in rate of referrals to specialty clinics vary by age group. In children, sex ratios of natal boys to girls range from 2:1 to 4.5:1. In adolescents, the sex ratio is close to parity; in adults, the sex ratio favors natal males, with ratios ranging from 1:1 to 6.1:1. In two countries, the sex ratio appears to favor natal females (Japan: 2.2:1; Poland: 3.4:1).

Development and Course

Because expression of gender dysphoria varies with age, there are separate criteria sets for children versus adolescents and adults. Criteria for children are defined in a more con-

crete, behavioral manner than those for adolescents and adults. Many of the core criteria draw on well-documented behavioral gender differences between typically developing boys and girls. Young children are less likely than older children, adolescents, and adults to express extreme and persistent anatomic dysphoria. In adolescents and adults, incongruence between experienced gender and somatic sex is a central feature of the diagnosis. Factors related to distress and impairment also vary with age. A very young child may show signs of distress (e.g., intense crying) only when parents tell the child that he or she is "really" not a member of the other gender but only "desires" to be. Distress may not be manifest in social environments supportive of the child's desire to live in the role of the other gender and may emerge only if the desire is interfered with. In adolescents and adults, distress may manifest because of strong incongruence between experienced gender and somatic sex. Such distress may, however, be mitigated by supportive environments and knowledge that biomedical treatments exist to reduce incongruence. Impairment (e.g., school refusal, development of depression, anxiety, and substance abuse) may be a consequence of gender dysphoria.

Gender dysphoria without a disorder of sex development. For clinic-referred children, onset of cross-gender behaviors is usually between ages 2 and 4 years. This corresponds to the developmental time period in which most typically developing children begin expressing gendered behaviors and interests. For some preschool-age children, both pervasive cross-gender behaviors and the expressed desire to be the other gender may be present, or, more rarely, labeling oneself as a member of the other gender may occur. In some cases, the expressed desire to be the other gender appears later, usually at entry into elementary school. A small minority of children express discomfort with their sexual anatomy or will state the desire to have a sexual anatomy corresponding to the experienced gender ("anatomic dysphoria"). Expressions of anatomic dysphoria become more common as children with gender dysphoria approach and anticipate puberty.

Rates of persistence of gender dysphoria from childhood into adolescence or adulthood vary. In natal males, persistence has ranged from 2.2% to 30%. In natal females, persistence has ranged from 12% to 50%. Persistence of gender dysphoria is modestly correlated with dimensional measures of severity ascertained at the time of a childhood baseline assessment. In one sample of natal males, lower socioeconomic background was also modestly correlated with persistence. It is unclear if particular therapeutic approaches to gender dysphoria in children are related to rates of long-term persistence. Extant follow-up samples consisted of children receiving no formal therapeutic intervention or receiving therapeutic interventions of various types, ranging from active efforts to reduce gender dysphoria to a more neutral, "watchful waiting" approach. It is unclear if children "encouraged" or supported to live socially in the desired gender will show higher rates of persistence, since such children have not yet been followed longitudinally in a systematic manner. For both natal male and female children showing persistence, almost all are sexually attracted to individuals of their natal sex. For natal male children whose gender dysphoria does not persist, the majority are *androphilic* (sexually attracted to males) and often self-identify as gay or homosexual (ranging from 63% to 100%). In natal female children whose gender dysphoria does not persist, the percentage who are *gynephilic* (sexually attracted to females) and self-identify as lesbian is lower (ranging from 32% to 50%).

In both adolescent and adult natal males, there are two broad trajectories for development of gender dysphoria: early onset and late onset. *Early-onset gender dysphoria* starts in childhood and continues into adolescence and adulthood; or, there is an intermittent period in which the gender dysphoria desists and these individuals self-identify as gay or homosexual, followed by recurrence of gender dysphoria. *Late-onset gender dysphoria* occurs around puberty or much later in life. Some of these individuals report having had a desire to be of the other gender in childhood that was not expressed verbally to others. Others do not recall any signs of childhood gender dysphoria. For adolescent males with late-onset gender dysphoria, parents often report surprise because they did not see signs of gender

dysphoria during childhood. Expressions of anatomic dysphoria are more common and salient in adolescents and adults once secondary sex characteristics have developed.

Adolescent and adult natal males with early-onset gender dysphoria are almost always sexually attracted to men (androphilic). Adolescents and adults with late-onset gender dysphoria frequently engage in transvestic behavior with sexual excitement. The majority of these individuals are gynephilic or sexually attracted to other posttransition natal males with late-onset gender dysphoria. A substantial percentage of adult males with late-onset gender dysphoria cohabit with or are married to natal females. After gender transition, many self-identify as lesbian. Among adult natal males with gender dysphoria, the early-onset group seeks out clinical care for hormone treatment and reassignment surgery at an earlier age than does the late-onset group. The late-onset group may have more fluctuations in the degree of gender dysphoria and be more ambivalent about and less likely satisfied after gender reassignment surgery.

In both adolescent and adult natal females, the most common course is the early-onset form of gender dysphoria. The late-onset form is much less common in natal females compared with natal males. As in natal males with gender dysphoria, there may have been a period in which the gender dysphoria desisted and these individuals self-identified as lesbian; however, with recurrence of gender dysphoria, clinical consultation is sought, often with the desire for hormone treatment and reassignment surgery. Parents of natal adolescent females with the late-onset form also report surprise, as no signs of childhood gender dysphoria were evident. Expressions of anatomic dysphoria are much more common and salient in adolescents and adults than in children.

Adolescent and adult natal females with early-onset gender dysphoria are almost always gynephilic. Adolescents and adults with the late-onset form of gender dysphoria are usually androphilic and after gender transition self-identify as gay men. Natal females with the late-onset form do not have co-occurring transvestic behavior with sexual excitement.

Gender dysphoria in association with a disorder of sex development. Most individuals with a disorder of sex development who develop gender dysphoria have already come to medical attention at an early age. For many, starting at birth, issues of gender assignment were raised by physicians and parents. Moreover, as infertility is quite common for this group, physicians are more willing to perform cross-sex hormone treatments and genital surgery before adulthood.

Disorders of sex development in general are frequently associated with gender-atypical behavior starting in early childhood. However, in the majority of cases, this does not lead to gender dysphoria. As individuals with a disorder of sex development become aware of their medical history and condition, many experience uncertainty about their gender, as opposed to developing a firm conviction that they are another gender. However, most do not progress to gender transition. Gender dysphoria and gender transition may vary considerably as a function of a disorder of sex development, its severity, and assigned gender.

Risk and Prognostic Factors

Temperamental. For individuals with gender dysphoria without a disorder of sex development, atypical gender behavior among individuals with early-onset gender dysphoria develops in early preschool age, and it is possible that a high degree of atypicality makes the development of gender dysphoria and its persistence into adolescence and adulthood more likely.

Environmental. Among individuals with gender dysphoria without a disorder of sex development, males with gender dysphoria (in both childhood and adolescence) more commonly have older brothers than do males without the condition. Additional predisposing

factors under consideration, especially in individuals with late-onset gender dysphoria (adolescence, adulthood), include habitual fetishistic transvestism developing into autogynephilia (i.e., sexual arousal associated with the thought or image of oneself as a woman) and other forms of more general social, psychological, or developmental problems.

Genetic and physiological. For individuals with gender dysphoria without a disorder of sex development, some genetic contribution is suggested by evidence for (weak) familiality of transsexualism among nontwin siblings, increased concordance for transsexualism in monozygotic compared with dizygotic same-sex twins, and some degree of heritability of gender dysphoria. As to endocrine findings, no endogenous systemic abnormalities in sex-hormone levels have been found in 46,XY individuals, whereas there appear to be increased androgen levels (in the range found in hirsute women but far below normal male levels) in 46,XX individuals. Overall, current evidence is insufficient to label gender dysphoria without a disorder of sex development as a form of intersexuality limited to the central nervous system.

In gender dysphoria associated with a disorder of sex development, the likelihood of later gender dysphoria is increased if prenatal production and utilization (via receptor sensitivity) of androgens are grossly atypical relative to what is usually seen in individuals with the same assigned gender. Examples include 46,XY individuals with a history of normal male prenatal hormone milieu but inborn nonhormonal genital defects (as in cloacal bladder exstrophy or penile agenesis) and who have been assigned to the female gender. The likelihood of gender dysphoria is further enhanced by additional, prolonged, highly gender-atypical postnatal androgen exposure with somatic virilization as may occur in female-raised and noncastrated 46,XY individuals with 5-alpha reductase-2 deficiency or 17-beta-hydroxysteroid dehydrogenase-3 deficiency or in female-raised 46,XX individuals with classical congenital adrenal hyperplasia with prolonged periods of non-adherence to glucocorticoid replacement therapy. However, the prenatal androgen milieu is more closely related to gendered behavior than to gender identity. Many individuals with disorders of sex development and markedly gender-atypical behavior do not develop gender dysphoria. Thus, gender-atypical behavior by itself should not be interpreted as an indicator of current or future gender dysphoria. There appears to be a higher rate of gender dysphoria and patient-initiated gender change from assigned female to male than from assigned male to female in 46,XY individuals with a disorder of sex development.

Culture-Related Diagnostic Issues

Individuals with gender dysphoria have been reported across many countries and cultures. The equivalent of gender dysphoria has also been reported in individuals living in cultures with institutionalized gender categories other than male or female. It is unclear whether with these individuals the diagnostic criteria for gender dysphoria would be met.

Diagnostic Markers

Individuals with a somatic disorder of sex development show some correlation of final gender identity outcome with the degree of prenatal androgen production and utilization. However, the correlation is not robust enough for the biological factor, where ascertainable, to replace a detailed and comprehensive diagnostic interview evaluation for gender dysphoria.

Functional Consequences of Gender Dysphoria

Preoccupation with cross-gender wishes may develop at all ages after the first 2–3 years of childhood and often interfere with daily activities. In older children, failure to develop age-typical same-sex peer relationships and skills may lead to isolation from peer groups and to distress. Some children may refuse to attend school because of teasing and harass-

ment or pressure to dress in attire associated with their assigned sex. Also in adolescents and adults, preoccupation with cross-gender wishes often interferes with daily activities. Relationship difficulties, including sexual relationship problems, are common, and functioning at school or at work may be impaired. Gender dysphoria, along with atypical gender expression, is associated with high levels of stigmatization, discrimination, and victimization, leading to negative self-concept, increased rates of mental disorder comorbidity, school dropout, and economic marginalization, including unemployment, with attendant social and mental health risks, especially in individuals from resource-poor family backgrounds. In addition, these individuals' access to health services and mental health services may be impeded by structural barriers, such as institutional discomfort or inexperience in working with this patient population.

Differential Diagnosis

Nonconformity to gender roles. Gender dysphoria should be distinguished from simple nonconformity to stereotypical gender role behavior by the strong desire to be of another gender than the assigned one and by the extent and pervasiveness of gender-variant activities and interests. The diagnosis is not meant to merely describe nonconformity to stereotypical gender role behavior (e.g., "tomboyism" in girls, "girly-boy" behavior in boys, occasional cross-dressing in adult men). Given the increased openness of atypical gender expressions by individuals across the entire range of the transgender spectrum, it is important that the clinical diagnosis be limited to those individuals whose distress and impairment meet the specified criteria.

Transvestic disorder. Transvestic disorder occurs in heterosexual (or bisexual) adolescent and adult males (rarely in females) for whom cross-dressing behavior generates sexual excitement and causes distress and/or impairment without drawing their primary gender into question. It is occasionally accompanied by gender dysphoria. An individual with transvestic disorder who also has clinically significant gender dysphoria can be given both diagnoses. In many cases of late-onset gender dysphoria in gynephilic natal males, transvestic behavior with sexual excitement is a precursor.

Body dysmorphic disorder. An individual with body dysmorphic disorder focuses on the alteration or removal of a specific body part because it is perceived as abnormally formed, not because it represents a repudiated assigned gender. When an individual's presentation meets criteria for both gender dysphoria and body dysmorphic disorder, both diagnoses can be given. Individuals wishing to have a healthy limb amputated (termed by some *body integrity identity disorder*) because it makes them feel more "complete" usually do not wish to change gender, but rather desire to live as an amputee or a disabled person.

Schizophrenia and other psychotic disorders. In schizophrenia, there may rarely be delusions of belonging to some other gender. In the absence of psychotic symptoms, insistence by an individual with gender dysphoria that he or she is of some other gender is not considered a delusion. Schizophrenia (or other psychotic disorders) and gender dysphoria may co-occur.

Other clinical presentations. Some individuals with an emasculinization desire who develop an alternative, nonmale/nonfemale gender identity do have a presentation that meets criteria for gender dysphoria. However, some males seek castration and/or penectomy for aesthetic reasons or to remove psychological effects of androgens without changing male identity; in these cases, the criteria for gender dysphoria are not met.

Comorbidity

Clinically referred children with gender dysphoria show elevated levels of emotional and behavioral problems—most commonly, anxiety, disruptive and impulse-control, and de-

pressive disorders. In prepubertal children, increasing age is associated with having more behavioral or emotional problems; this is related to the increasing non-acceptance of gender-variant behavior by others. In older children, gender-variant behavior often leads to peer ostracism, which may lead to more behavioral problems. The prevalence of mental health problems differs among cultures; these differences may also be related to differences in attitudes toward gender variance in children. However, also in some non-Western cultures, anxiety has been found to be relatively common in individuals with gender dysphoria, even in cultures with accepting attitudes toward gender-variant behavior. Autism spectrum disorder is more prevalent in clinically referred children with gender dysphoria than in the general population. Clinically referred adolescents with gender dysphoria appear to have comorbid mental disorders, with anxiety and depressive disorders being the most common. As in children, autism spectrum disorder is more prevalent in clinically referred adolescents with gender dysphoria than in the general population. Clinically referred adults with gender dysphoria may have coexisting mental health problems, most commonly anxiety and depressive disorders.

Other Specified Gender Dysphoria

302.6 (F64.8)

This category applies to presentations in which symptoms characteristic of gender dysphoria that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning predominate but do not meet the full criteria for gender dysphoria. The other specified gender dysphoria category is used in situations in which the clinician chooses to communicate the specific reason that the presentation does not meet the criteria for gender dysphoria. This is done by recording "other specified gender dysphoria" followed by the specific reason (e.g., "brief gender dysphoria").

An example of a presentation that can be specified using the "other specified" designation is the following:

The current disturbance meets symptom criteria for gender dysphoria, but the duration is less than 6 months.

Unspecified Gender Dysphoria

302.6 (F64.9)

This category applies to presentations in which symptoms characteristic of gender dysphoria that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning predominate but do not meet the full criteria for gender dysphoria. The unspecified gender dysphoria category is used in situations in which the clinician chooses *not* to specify the reason that the criteria are not met for gender dysphoria, and includes presentations in which there is insufficient information to make a more specific diagnosis.

Exhibit C

Mattis Memorandum

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

FEB 22 2018

MEMORANDUM FOR THE PRESIDENT

SUBJECT: Military Service by Transgender Individuals

"Transgender" is a term describing those persons whose gender identity differs from their biological sex. A subset of transgender persons diagnosed with gender dysphoria experience discomfort with their biological sex, resulting in significant distress or difficulty functioning. Persons diagnosed with gender dysphoria often seek to transition their gender through prescribed medical treatments intended to relieve the distress and impaired functioning associated with their diagnosis.

Prior to your election, the previous administration adopted a policy that allowed for the accession and retention in the Armed Forces of transgender persons who had a history or diagnosis of gender dysphoria. The policy also created a procedure by which such Service members could change their gender. This policy was a departure from decades-long military personnel policy. On June 30, 2017, before the new accession standards were set to take effect, I approved the recommendation of the Services to delay for an additional six months the implementation of these standards to evaluate more carefully their impact on readiness and lethality. To that end, I established a study group that included the representatives of the Service Secretaries and senior military officers, many with combat experience, to conduct the review.

While this review was ongoing, on August 25, 2017, you sent me and the Secretary of Homeland Security a memorandum expressing your concern that the previous administration's new policy "failed to identify a sufficient basis" for changing longstanding policy and that "further study is needed to ensure that continued implementation of last year's policy change would not have ... negative effects." You then directed the Department of Defense and the Department of Homeland Security to reinstate the preexisting policy concerning accession of transgender individuals "until such time as a sufficient basis exists upon which to conclude that terminating that policy" would not "hinder military effectiveness and lethality, disrupt unit cohesion, or tax military resources." You made clear that we could advise you "at any time, in writing, that a change to this policy is warranted."

I created a Panel of Experts comprised of senior uniformed and civilian Defense Department and U.S. Coast Guard leaders and directed them to consider this issue and develop policy proposals based on data, as well as their professional military judgment, that would enhance the readiness, lethality, and effectiveness of our military. This Panel included combat veterans to ensure that our military purpose remained the foremost consideration. I charged the Panel to provide its best military advice, based on increasing the lethality and readiness of America's armed forces, without regard to any external factors.

The Panel met with and received input from transgender Service members, commanders of transgender Service members, military medical professionals, and civilian medical

professionals with experience in the care and treatment of individuals with gender dysphoria. The Panel also reviewed available information on gender dysphoria, the treatment of gender dysphoria, and the effects of currently serving individuals with gender dysphoria on military effectiveness, unit cohesion, and resources. Unlike previous reviews on military service by transgender individuals, the Panel's analysis was informed by the Department's own data obtained since the new policy began to take effect last year.

Based on the work of the Panel and the Department's best military judgment, the Department of Defense concludes that there are substantial risks associated with allowing the accession and retention of individuals with a history or diagnosis of gender dysphoria and require, or have already undertaken, a course of treatment to change their gender. Furthermore, the Department also finds that exempting such persons from well-established mental health, physical health, and sex-based standards, which apply to all Service members, including transgender Service members without gender dysphoria, could undermine readiness, disrupt unit cohesion, and impose an unreasonable burden on the military that is not conducive to military effectiveness and lethality.

The prior administration largely based its policy on a study prepared by the RAND National Defense Research Institute; however, that study contained significant shortcomings. It referred to limited and heavily caveated data to support its conclusions, glossed over the impacts of healthcare costs, readiness, and unit cohesion, and erroneously relied on the selective experiences of foreign militaries with different operational requirements than our own. In short, this policy issue has proven more complex than the prior administration or RAND assumed.

I firmly believe that compelling behavioral health reasons require the Department to proceed with caution before compounding the significant challenges inherent in treating gender dysphoria with the unique, highly stressful circumstances of military training and combat operations. Preservation of unit cohesion, absolutely essential to military effectiveness and lethality, also reaffirms this conclusion.

Therefore, in light of the Panel's professional military judgment and my own professional judgment, the Department should adopt the following policies:

- Transgender persons with a history or diagnosis of gender dysphoria are disqualified from military service, except under the following limited circumstances: (1) if they have been stable for 36 consecutive months in their biological sex prior to accession; (2) Service members diagnosed with gender dysphoria after entering into service may be retained if they do not require a change of gender and remain deployable within applicable retention standards; and (3) currently serving Service members who have been diagnosed with gender dysphoria since the previous administration's policy took effect and prior to the effective date of this new policy, may continue to serve in their preferred gender and receive medically necessary treatment for gender dysphoria.

- Transgender persons who require or have undergone gender transition are disqualified from military service.

- Transgender persons without a history or diagnosis of gender dysphoria, who are otherwise qualified for service, may serve, like all other Service members, in their biological sex.

I have consulted with the Secretary of Homeland Security, and she agrees with these proposed policies.

By its very nature, military service requires sacrifice. The men and women who serve voluntarily accept limitations on their personal liberties – freedom of speech, political activity, freedom of movement - in order to provide the military lethality and readiness necessary to ensure American citizens enjoy their personal freedoms to the fullest extent. Further, personal characteristics, including age, mental acuity, and physical fitness – among others – matter to field a lethal and ready force.

In my professional judgment, these policies will place the Department of Defense in the strongest position to protect the American people, to fight and win America's wars, and to ensure the survival and success of our Service members around the world. The attached report provided by the Under Secretary of Defense for Personnel and Readiness includes a detailed analysis of the factors and considerations forming the basis of the Department's policy proposals.

I therefore respectfully recommend you revoke your memorandum of August 25, 2017, regarding Military Service by Transgender Individuals, thus allowing me and the Secretary of Homeland Security with respect to the U.S. Coast Guard, to implement appropriate policies concerning military service by transgender persons.

Attachment:
As stated

cc:
Secretary of Homeland Security

Exhibit D

Department of Defense Report and Recommendations on Military Service by Transgender Persons (Feb. 2018)

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

FEBRUARY 2018

Table of Contents

Executive Summary

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

History of Policies Concerning Transgender Persons

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

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

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

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

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

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

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

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

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

Transgender Policy Prior to the Carter Policy

A. Accession Medical Standards

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

Accession medical standards are based on the operational needs of the Department and are designed to ensure that individuals are physically and psychologically "qualified, effective, and able-bodied persons"[1] capable of performing military duties. Military effectiveness requires that the Armed Forces manage an integrated set of unique medical standards and qualifications because all military personnel must be available for worldwide duty 24 hours a day without

[1] 10 U.S.C. § 505(a).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

B. Retention Standards

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

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

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

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

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

The Carter Policy

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

A. Changes to the DSM

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

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

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

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

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

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

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

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

B. The Department Begins Review of Transgender Policy

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

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

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

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

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

C. New Standards for Transgender Persons

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

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

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

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

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

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

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

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

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

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

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

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

Panel of Experts Recommendation

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

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

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

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

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

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

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

To fulfill its mandate, the Panel addressed three questions:

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

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

Recommended Policy

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

The Carter policy assumed that transgender persons were generally qualified for service and that their accession and retention would not negatively impact military effectiveness. As noted earlier, Secretary Carter directed the TSRWG, the group charged with evaluating, and making recommendations on, transgender service, to "start with the presumption that transgender persons can serve openly without adverse impact on military effectiveness and readiness, unless and except where objective practical impediments are identified."[50] Where necessary, standards were adjusted or relaxed to accommodate service by transgender persons. The following analysis makes no assumptions but instead applies the relevant standards applicable to everyone to determine the extent to which transgender persons are qualified for military duty.

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

Discussion of Standards

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

A. Mental Health Standards

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

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

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

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

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

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

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

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

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

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

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

[58] DSM-5 at 452.

[59] DSM-5 at 453.

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

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

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

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

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

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

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

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

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

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

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

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

[68] RAND Study at 73.

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

[70] Id. at 3885-3888.

[71] Id.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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[84] Id.

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

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

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

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

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

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

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

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

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

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

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

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

B. Physical Health Standards

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

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

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

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

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

C. Sex-Based Standards

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

New Transgender Policy

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[140] See *supra* note 109.

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

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

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

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

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

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

[142] See *supra* note 108.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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[155] Id. at 45.

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

[157] Id. at 9.

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

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

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

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

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

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

[159] Minutes, Transgender Review Panel (Nov. 21, 2017).

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

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

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

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

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

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

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

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

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[165] DSM-5 at 455.

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

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

Conclusion

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

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

Exhibit E

Declaration of Lernes J. Hebert

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

RYAN KARNOSKI, *et al.*,

Plaintiffs, and

STATE OF WASHINGTON,

Plaintiff-Intervenor,

v.

DONALD J. TRUMP, *et al.*,

Defendants.

Misc. Action No. _____

Underlying Action: Civil Action No. 2:17-cv-01297-MJP

DECLARATION OF LERNES J. HEBERT

I, Lernes J. Hebert, do hereby declare as follows:

1. I am currently the Deputy Assistant Secretary of Defense for Military Personnel Policy, in the Office of the Under Secretary of Defense for Personnel and Readiness. I was selected for this position in November 2019, after having served in an acting capacity since January 2017.

2. Between September 2012 and January 2017, I served as the Principal Director for Military Personnel Policy in the Office of the Deputy Assistant Secretary of Defense for Military Personnel Policy and have served in Military Personnel Policy since August 2003. During that time, I led the Department of Defense ("Department" or "DoD") through a number of major personnel initiatives and policy changes.

3. Prior to my retirement from the United States Air Force in the rank of Colonel after

24 years of active service, I served at every level of the field of personnel management including key assignments in the Office of the Secretary of Defense, the Air Staff, at the Air Force Personnel Center, and with Air Combat Command. I hold a Master of Science degree in National Security Strategy from the National War College, a Master of Arts degree in Management and Computer Resource Management from Webster University, and a Bachelor of Science degree in Management from the University of Louisiana.

4. In the exercise of my official duties, I have been made aware of the above-captioned lawsuit, as well as four additional suits pending in other jurisdictions that all challenge DoD's policy on military service by transgender individuals and individuals with gender dysphoria. I submit this declaration in support of Defendants' Motion to Quash the third-party subpoena issued in the above-captioned case to Robert Wilkie Jr., the Secretary of Veterans Affairs.

5. Before becoming the Secretary of Veterans Affairs, Mr. Wilkie served briefly as the Under Secretary of Defense for Personnel and Readiness from November 2017 to March 2018. The purpose of this declaration is to provide the Court with general information regarding Secretary Wilkie's duties when he was at DoD and, in particular, his involvement in formulating the policy that is at issue in this case and in the four other related lawsuits. The statements made herein are based on my personal knowledge and information available to me in the course of my official duties.

6. Section 136 of Title 10 of the United States Code creates the position of Under Secretary of Defense for Personnel and Readiness. By statute, the Under Secretary of Defense for Personnel and Readiness is appointed by the President with the advice and consent of the Senate. Mr. Wilkie was confirmed by the Senate as the Under Secretary on November 16, 2017 and assumed his duties at the Pentagon shortly thereafter.

7. As the Under Secretary of Defense for Personnel and Readiness, Mr. Wilkie served as the senior policy advisor to the Secretary of Defense on all aspects of Total Force Management, including recruitment, career development, and pay and benefits for over two million uniformed personnel and nearly 750,000 DoD civilians. In that capacity, he represented the Secretary of Defense on manpower and personnel matters outside the Department.

8. The Under Secretary is also responsible for overseeing the overall state of military readiness, National Guard and Reserve component affairs, health affairs, training, and other personnel requirements and management, including equal opportunity, morale, welfare, recreation, and quality of life for military families. This includes overseeing the administration of the $15 billion Defense Health Program, the Defense Commissaries and Exchanges, and the Defense Education Activity.

9. Prior to Mr. Wilkie's appointment and confirmation, then-Secretary of Defense James Mattis directed the creation of a Panel of Experts ("Panel") on September 14, 2017, to propose DoD policy, standards, and procedures for military service by transgender individuals and individuals with gender dysphoria that was consistent with military effectiveness and lethality, budget constraints, and applicable law. At that time, I was the Acting Deputy Assistant Secretary of Defense for Military Personnel Policy. In that capacity, I co-chaired DoD's Medical and Personnel Executive Steering Committee, which supported the work of the Panel, and I attended all Panel meetings.

10. Secretary Mattis designated the Under Secretary of Defense for Personnel and Readiness to chair the work of the Panel. Because Mr. Anthony Kurta was performing the duties of the Under Secretary of Defense for Personnel and Readiness when the Panel was created, he chaired the Panel's first seven meetings held between October 13 and November 21,

2017. After Mr. Wilkie assumed his duties as the Under Secretary in late November 2017, he took over the role of chairing the Panel for the remaining six meetings. Mr. Kurta then became Special Assistant to Mr. Wilkie and assumed an advisory role to the Panel and I assumed his former role as facilitator for the remaining meetings.

11. At his first Panel meeting on November 30, 2017, Mr. Wilkie announced that he would not be a voting member of the Panel because he had not attended the first seven meetings, and turned the balance of the meeting over to me to facilitate a discussion of the process the Panel would follow in deliberating and voting on the various policy alternatives. Thereafter, discussions, deliberations, and voting began. While Mr. Wilkie expressed great interest in getting "up to speed" quickly on the issues, he played a limited role during the Panel's discussions and deliberations. Aside from opening each meeting and giving introductory and concluding remarks, he turned over the balance of each of the six meetings he attended to me to facilitate the Panel's discussions and deliberations.

12. During the ninth Panel meeting on December 7, 2017, for example, Mr. Wilkie opened the meeting, reiterated that he would not be voting on any of the proposals, reminded the Panel that Secretary Mattis was seeking their best military assessment and advice, and turned the balance of the meeting over to me to provide additional data to the Panel and to facilitate continued discussion, deliberation, and voting.

13. During the tenth Panel meeting on December 13, 2017, I led the Panel in reviewing the briefing to be given to the Deputy Secretary of Defense and Vice Chairman of the Joint Chiefs of Staff regarding the Panel's recommendations. On December 15, 2017, Mr. Wilkie participated, with Mr. Kurta and me, in making that presentation.

14. At the final three Panel meetings on December 22, 2017, January 11 and January

18, 2018, Mr. Wilkie opened the meetings as the Chair, made introductory remarks, and turned the balance of the meetings over to me. As I recall, at the December 22, 2017 meeting, I facilitated a Panel discussion regarding an alternative proposal by one of the Services and questions for future research that had been offered during the Panel process. The January 4 and January 11, 2018 meetings consisted largely in me facilitating the Panel's final discussions of policy proposals and reviewing the upcoming brief to Secretary Mattis.

15. On January 11, 2018, Mr. Wilkie signed the formal memo to Secretary Mattis, which memorialized the Panel's agreed-upon recommendations regarding military service by transgender individuals and individuals with gender dysphoria. And, on January 17, 2017, Mr. Wilkie, Mr. Kurta and I, along with others, briefed then-Secretary Mattis on the Panel's recommendations.

16. At the conclusion of the Panel process, Mr. Wilkie, Mr. Kurta, and I formed the Personnel and Readiness team that was given primary responsibility for preparing the Department's Report and Recommendations on Military Service by Transgender Persons. This Report contained the same recommendations that were in the January 11, 2018 memo from Mr. Wilkie to the Secretary. The Report was approved by Secretary Mattis in February 2018 and was presented to the President in March 2018.

17. On March 28, 2018, shortly after the President approved DoD's policy recommendations, Mr. Wilkie was named Acting Secretary of Veterans Affairs. On March 30, 2018, he left the Department of Defense after serving as Under Secretary for Personnel and Readiness for approximately four and a half months. I am not aware of Mr. Wilkie having any further involvement in formulating or implementing DoD's policy regarding military service by transgender individuals or individuals with gender dysphoria after March 30, 2018.

Pursuant to 28 U.S.C. § 1746(2), I declare under the penalty of perjury that the foregoing is true and correct.

Executed on this 20 day of May 2020, in Arlington, Virginia.

Lernes J. Hebert
Deputy Assistant Secretary of Defense for Military Personnel Policy
Office of the Under Secretary of Defense for Personnel and Readiness

Exhibit F

Memorandum from R. Wilkie to Secretary of Defense re Recommendations by the Transgender Review Panel of Experts

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

PERSONNEL AND READINESS

ACTION MEMO

JAN 11 2018

TO: SECRETARY OF DEFENSE

THROUGH: DEPUTY SECRETARY OF DEFENSE
VICE CHAIRMAN OF THE JOINT CHIEFS OF STAFF

FROM: Robert Wilkie, Under Secretary of Defense for Personnel and Readiness

SUBJECT: Recommendations by the Transgender Review Panel of Experts

- On September 14, 2017, you directed the establishment of a Panel of Experts to review and recommend changes to Department of Defense policies regarding the service of transgender individuals (Tab A), in accordance with direction from the President on August 25, 2017 (Tab B).
- The Panel, which I chaired, comprised the officials performing the duties of the Under Secretaries of the Military Departments, the Uniformed Services' Vice Chiefs, and Senior Enlisted Advisors.
- You directed the Panel to conduct its review and render recommendations consistent with military readiness, lethality, deployability, budgetary constraints, and applicable law.
- The Panel was informed by testimony from commanders with transgender troops, currently-serving transgender Service members, military physicians, and other health experts.
- The Panel considered available DoD data and information on currently-serving transgender personnel and relevant external research and studies.
- Based on the individual and collective experience leading warfighters and their expertise in military operational and institutional effectiveness, the Panel makes the following recommendations:
    - Transgender individuals should be allowed to enter the military in their biological sex, subject to meeting all applicable accession standards. A diagnosis of gender dysphoria is disqualifying for accessions unless medical documentation establishes stability in his/her biological sex for no less than 36 consecutive months—as determined by a qualified Department of Defense medical provider—at the time of application. [*Gender Dysphoria*: a medical diagnosis involving significant distress or problems functioning resulting from a difference between the gender with which an individual identifies and the individual's biological sex]

- Transgender Service members should be permitted to serve openly, but only in their biological sex and without receiving cross-sex hormone therapy or surgical transition support.
- In order to keep faith with those transgender Service members who receive a diagnosis of gender dysphoria from a qualified military medical provider prior to the implementation of a revised DoD policy in 2018, they should be authorized all medically necessary and appropriate care and treatment, including cross-sex hormone therapy and medically necessary surgery. Such care and treatment should be authorized and provided at government expense even if it is determined to be necessary and appropriate only after the implementation of a revised policy in 2018.
- Transgender Service members should be subject to the same retention standards applicable to all other Service members.

- To ensure consistent application of the policies, procedures, and guidance currently in effect with regard to the accession[1] and in-service transition[2] of transgender individuals, I intend to issue a memorandum clarifying existing guidance regarding privacy concerns that may arise.

RECOMMENDATION: As discussed, based on your review of these recommendations, and other information and input you elect to consider, we will develop a writing by which you would advise the President of your conclusions and recommendations in this matter.

COORDINATION: TAB C

Attachments:
As stated

[1] As required by court order.
[2] As authorized by DoDI 1300.28, *In-Service, Transition for Transgender Service members*, dated July 1, 2016.

Exhibit G

Declaration of Pamela J. Powers

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

RYAN KARNOSKI, *et al.*,

Plaintiffs, and

STATE OF WASHINGTON,

Plaintiff-Intervenor,

v.

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

Defendants.

Misc. No. _____

Underlying Action: Case No. 2:17-cv-01297-MJP (W.D. Wash.)

DECLARATION OF PAMELA J. POWERS, ACTING DEPUTY SECRETARY OF VETERANS AFFAIRS

I, Pamela J. Powers, do hereby declare as follows:

1. I am currently the Acting Deputy Secretary of the U.S. Department of Veterans Affairs ("VA"). I have held this position since April 2, 2020. I previously served as the Chief of Staff for U.S. Secretary of Veterans Affairs Robert Wilkie Jr. from August 10, 2018 to April 1, 2020.

2. As the Acting Deputy Secretary, I serve as second in command to, and chief operating officer for, Secretary Wilkie. I am responsible for directing the policy and operations of the VA and providing broad direction to the VA's staff offices, ensuring coordinated action and conformance with the Secretary's directives.

3. While serving as Secretary Wilkie's Chief of Staff, I was the principal advisor to the Secretary and the Deputy Secretary on the development and implementation of Department-

wide policies and programs and on the internal management and operations of the VA. In my capacity as Chief of Staff, I also represented the Secretary in high-level negotiations involving top VA officials as well as top officials external to the VA, and facilitated the development of partnerships and collaborations with various stakeholders, including representatives of the White House, Congress, the media, other federal agencies, Veterans Service Organizations, and state and local governments. Accordingly, I am well-acquainted with the duties of the office of the VA Secretary and, in particular, with Secretary Wilkie's day-to-day schedule.

4. In the exercise of my official duties, I have been made aware of the above-captioned lawsuit. I submit this declaration in support of Defendants' Motion to Quash the third-party subpoena issued to Secretary Wilkie, seeking his deposition testimony in the above-captioned case. I make the following statements based on my personal knowledge and upon information furnished to me in the course of my official duties.

5. Secretary Wilkie currently serves as the Secretary of Veterans Affairs. He was nominated by President Donald J. Trump to serve in this position on June 20, 2018, and he was confirmed by the United States Senate on July 23, 2018 and sworn in and appointed on July 30, 2018. Prior to his appointment, Secretary Wilkie served as the Acting VA Secretary from March 28, 2018 to May 28, 2018.

6. In addition to leading the VA, Secretary Wilkie has served in the United States Air Force Reserve since 2008, and currently holds the rank of Colonel.

7. VA is a federal cabinet-level agency created to serve America's veterans and their families with dignity and compassion and to be their principal advocate in ensuring that they receive medical care, benefits, social support, and lasting memorials. VA is the federal

government's second largest department after the Department of Defense and employs approximately 400,000 people.

8. As the head of the VA, Secretary Wilkie is responsible for a wide array of matters related to veterans affairs and sets policies governing the Department's operations. For example, the Secretary manages the VA's Veterans Health Administration – the largest integrated health care network in the United States, with 1,255 health care facilities serving 9 million enrolled veterans each year. He also oversees the Veterans Benefits Administration, which helps service members transition out of military service and assists with, among other things, their education, home loans, and life insurance. Secretary Wilkie also supervises the National Cemetery Administration, which provides dignified burial services for veterans and eligible family members at 142 cemeteries maintained by the VA. And he leads the Department's efforts to assist the nation's preparedness for response to war, terrorism, national emergencies, and natural disasters by developing plans and taking actions to ensure continued service to veterans, and by supporting national, state, and local emergency management, public health, safety, and homeland security efforts. Finally, Secretary Wilkie is responsible for maintaining favorable relations with organizations, groups, and individuals interested in veterans affairs.

9. In light of Secretary Willkie's official duties, he has many competing demands on his time. On a daily basis, the Secretary is scheduled to attend as many as eleven individual meetings with VA officials, external officials, and other stakeholders, many of which require advance preparation. For instance, conference calls with lawmakers and veterans groups take at least one hour each and require advance internal VA meetings to review the material to be discussed. In addition, the Secretary's duties include site visits, which require him to travel to VA facilities and medical centers across the country.

10. As the Secretary of VA, Secretary Wilkie is also a member of President Trump's Cabinet, serving as the President's Chief Advisor on Veterans Affairs. In that capacity, the Secretary must be prepared to advise the President on any issues related to the VA that may arise at any time. Currently, the Secretary plays an important role in advising the President on the federal government's response to the COVID-19 pandemic.

11. The demands on Secretary Wilkie's time have increased even further since the start of the COVID-19 pandemic. The Secretary was asked to join the White House Coronavirus Task Force ("the Task Force") on March 2, 2020, and, in that role, provides advice on the effects of the COVID-19 pandemic on the veteran community, VA Hospitals, and VA Healthcare Centers.

12. Since becoming a member of the Task Force, Secretary Wilkie has been occupied on a daily basis with a number of pressing tasks, such as participating in Task Force meetings, leading senior departmental leader meetings, conducting calls with governors to offer personnel and guidance to states in need, conducting weekly conference calls with Congress and Veterans Service Organizations on VA's current COVID-19 efforts, participating in multiple daily media interviews, responding to requests from the White House, and ensuring the VA remains ready and able to serve veterans and the general public during the pandemic. These meetings have intensified in recent weeks and are expected to continue for the foreseeable future. Task Force meetings, in particular, require advance internal VA meetings to review updated information on employee and veteran COVID-19 data. And these meetings can take between one and two hours each depending on the agenda set by the Vice President.

13. It is my understanding that Plaintiffs in the above-captioned action seek to depose Secretary Wilkie about his official actions while he served as the Under Secretary of Defense for

Personnel and Readiness. In light of the Secretary's many responsibilities and pressing duties, described above, the time it would take the Secretary to prepare for, and sit for, a deposition would substantially interfere with the exercise of his official duties.

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

EXECUTED this 20th day of May 2020, United States Department of Veterans Affairs Central Office, Washington, DC

PAMELA J. POWERS
Acting Deputy Secretary
U.S. Department of Veterans Affairs

Exhibit H

Joint Status Report for
May 13, 2020 Status Conference

The Honorable Marsha J. Pechman

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON
AT SEATTLE

RYAN KARNOSKI, et al.,

Plaintiffs, and

STATE OF WASHINGTON,

Plaintiff-Intervenor,

v.

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

Defendants.

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

JOINT STATUS REPORT FOR MAY 13, 2020 STATUS CONFERENCE

In advance of the May 13, 2020 status hearing, the parties respectfully submit the following Joint Status Report.

PLAINTIFFS AND PLAINTIFF-INTERVENOR'S STATEMENT

In this Joint Status Report, Plaintiffs provide the Court an update regarding the following issues:

1. Proposed adjustments to the current May 29 fact discovery cutoff necessitated by delays in completing fact discovery;
2. Deposition scheduling;
3. Scheduling issues arising from the depositions of Plaintiffs' hybrid fact and expert witnesses, former Secretary of the Air Force, Deborah James, and former Secretary of the Navy, Ray Mabus; and
4. Overview of pending discovery motions.

A. Fact Discovery Deadline and Case Schedule

Plaintiffs continue to face roadblocks in completing fact discovery by the current May 29, 2020 deadline. Most of those roadblocks are of the Government's making—filing a mandamus petition and refusing to produce tens of thousands of documents on grounds of deliberative process privilege; extensive objections to Plaintiffs' Rule 30(b)(6) Notice; threatened motions to quash subpoenas directed to military decision-makers at the center of this dispute; and preemptively stating it will refuse to permit witnesses to answer questions at depositions over deliberative process privilege objections. Other roadblocks and delays have resulted from the COVID-19 pandemic. Plaintiffs respectfully request that the Court lift the May 29 fact discovery deadline and order the parties to report on the progress of discovery at the next status conference in June. The reasons for this request are as follows.

First, the Government continues to withhold tens of thousands of documents concerning the decision to impose the Ban, and the circumstances that led to that decision, pursuant to the deliberative process privilege. While the parties await a ruling by the Ninth Circuit on the Government's mandamus petition and motion to stay, Plaintiffs recently filed a LCR 37 motion proposing a framework by which the Special Master would review a random sample of

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documents withheld by the Government pursuant to the deliberative process privilege in order to determine whether the Government has been properly invoking the privilege in the first place, and if not, recommend guidance to the Government as to the types and/or categories of documents to which the privilege does not apply. (*See* Dkt. 497.) The Plaintiffs proposed that the Court would then review the documents and the Special Master's recommendations and, as to any documents it deems the privilege was properly invoked, determine whether the privilege has been overcome, applying the *Warner* factors. If this review confirms that the Government has been improperly invoking the privilege as to documents to which the privilege does not apply, the Court's orders could provide a basis for a further motion (and order) that the Government promptly review its privilege claims as to the remaining documents withheld on the grounds of deliberative process privilege in light of the Court's rulings and, on a rolling basis, produce any documents as to which the privilege is no longer claimed, with the Special Master to conduct an *in camera* review, again on a rolling basis, of any documents as to which the Government continues to claim the privilege. Should the Court decide this process is beneficial in resolving the parties' long-standing dispute over the Government's deliberative process privilege assertions, such further reviews and rolling productions will take time to complete. However, Plaintiffs believe that such a review is likely to result in the production of documents that are highly relevant to their constitutional challenge to the Ban, including the Government's claims that the Ban was unrelated to the ban announced by the President via Twitter on July 27, 2017 and formalized in the August 25, 2017 Presidential Memorandum.

Second, the Government recently informed Plaintiffs that it intends to move to quash Plaintiffs' deposition subpoenas directed to four critical witnesses: former Secretary of Defense James Mattis; former Vice Chairman of the Joint Chiefs of Staff Paul Selva; former Under Secretary of Defense for Personnel and Readiness Robert Wilkie; and former Admiral William Moran. These witnesses are critically important to Plaintiffs' case. The proposed Ban was sent to President Trump under Secretary Mattis' signature, and Defendants maintain that Mattis was personally involved in and responsible for the Ban (which they call the "Mattis policy"), and that it represents his personal and independent military judgment. (*See, e.g.*, Defs.' Pet. to S. Ct. for

Cert. Before Judgment, *Trump v. Karnoski*, No. 18-676, 2018 WL 6169245, at *8–9 (Nov. 23, 2018) (Ban "reflected 'the exercise of Secretary Mattis's independent judgment"); *18 (seeking "a prompt resolution of the validity of Secretary Mattis's proposed policy"); *24–25 (Ban "reflects the exercise of Secretary Mattis's 'independent judgment'").) Former Vice Chairman of the Joint Chiefs of Staff, Paul Selva, in turn was one of two senior DoD officials that Mattis directed "to lead" DoD "in developing an Implementation Plan on military service by transgender individuals, to effect the policy and directives" in the President's August 25, 2017 Memorandum, and, supported by the "Panel of Experts," to recommend to Mattis the policy that would effect the President's directives (what Defendants call the "Mattis policy"). (*See* 9/14/2017 Terms of Reference, Ex. 1.) Wilkie was one of two military officials who chaired the Panel, and according to Defendants, one of the lead authors of the February 2018 Report. And, Moran was a very senior and active member of the Panel who was an author or recipient of a number of the more relevant communications concerning the Panel produced by Defendants. Although Plaintiffs informed the Government on March 2, 2020 that they intended to depose Mattis, Selva, and Wilkie, and on March 27, 2020 requested the deposition of Moran, the Government did not inform Plaintiffs until April 10, 2020 that it will move to quash the subpoenas directed to these four witnesses, all of whom are former Department of Defense officials. Since that time, Plaintiffs determined where these witnesses currently live and work in order to ascertain where the depositions can take place, and identified locations near those localities at which the depositions can be taken. Plaintiffs recently served these subpoenas, but do not expect motion practice concerning the subpoenas to conclude until July at the earliest, given that motion practice will necessarily occur in at least two different jurisdictions (E.D. Va. and M.D.N.C.).

Third, the Government has lodged extensive objections to Plaintiffs' Rule 30(b)(6) Notice, causing delay in scheduling this deposition, which Plaintiffs had noticed as their first deposition in order to obtain information concerning a number of key subject matters that would help them develop and focus their examination of subsequent deponents. While Plaintiffs served the Government with their Rule 30(b)(6) Notice on March 9, 2020, it was not until nearly six weeks

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later, on April 17, 2020, that the Government served a 22-page letter of objections, which are now the subject of Defendants' forthcoming LCR 37 motion for protective order. One common objection across many of the Rule 30(b)(6) topics, which is raised by Defendants' motion, is the Government's intention to instruct witnesses not to answer questions that it believes call for information subject to the deliberative process privilege. This is notwithstanding that the Court already ruled at the February 3, 2020 status conference that "if there is an objection based upon deliberative process, the objection is made, then the question is answered, and you seal the deposition. And if we have to, we will go over line-by-line as to what comes in and what doesn't in terms of public testimony." (2/3/2020 Hr'g Tr., Dkt. No. 412, at 64:14–24.) The Government contends this Order was somehow stayed by the Ninth Circuit's subsequent administrative stay, despite the fact that the Order is nowhere referenced in the Government's mandamus petition. The Government has also asserted numerous other objections that likewise have no basis in law—such as the bizarre proposition that a party cannot take a Rule 30(b)(6) deposition on issues that are also the subject of interrogatories and document requests—all of which must be resolved by this Court and have delayed the Rule 30(b)(6) deposition.

Finally, the COVID-19 pandemic has caused certain depositions of Government witnesses to be delayed into the summer. Plaintiffs had at least five depositions scheduled in March and April that had to be canceled due to the pandemic. Even after the Court urged the parties to use teleconferencing resources to conduct depositions, scheduling depositions in April and May became untenable, in part because of the witnesses' own duties to respond to COVID-19. The parties have confirmed dates for depositions to take place in June should the Court approve extension of the discovery deadline, but some key witnesses may be unavailable for longer than that. For example, the Government has notified Plaintiffs that Colonel Mary Krueger is the Hospital Commander of the Tripler Army Medical Center, which is tasked with leading the military medicine response to COVID-19 in Hawaii. Due to these responsibilities, the Government has advised that it is unable to provide dates for her deposition until the pandemic has stabilized. At the same time, Plaintiff-Intervenor's state agencies are overloaded with requirements in response to the pandemic while other programs are closed or significantly

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inaccessible at this time.

In sum, due to the above delays in completing discovery, Plaintiffs request the May 29, 2020 fact discovery deadline be lifted, and that the parties be ordered to update the Court on the status of discovery at another status conference in early June. Plaintiffs believe these issues are so integral to this case that a further delay of fact discovery is worth the likely impact to the October 2020 trial setting. Plaintiffs are committed to ensuring ensuring that the Court and any reviewing court have the benefit of a full record at trial, even if it requires a later trial date.

B. Deposition Scheduling

The parties have confirmed the following depositions:

- **June 3: Dr. Terry Adirim**, former Principal Deputy Assistant Secretary of Defense Health Affairs
- **June 4: Stephanie Miller**, Director of Military Accession Policy
- **June 10: Kevin Cron**, Defendants' hybrid fact/expert witness, Preventive Medicine Officer for United States Central Command
- **June 11: Thomas Dee**, Panel member and Undersecretary of the Navy
- **June 12: Martha Soper**, Assistant Deputy for Health Policy Office of the Deputy Assistant Secretary of the Air Force, Reserve Affairs & Airman Readiness
- **June 17: Christopher Meyering**, Defendants' hybrid fact/expert witness, Command Surgeon and the Waiver Surgeon, U.S. Army Recruiting Command
- **June 23: Dr. George Brown**, Plaintiffs' expert witness
- **June 24: Stephen Pflanz**, Defendants' hybrid fact/expert witness, Director of Psychological Health, Air Force Medical Support Agency

Plaintiffs have also requested the depositions of former Secretary of Defense James Mattis, former Vice Chair of the Joint Chiefs Paul Selva, former Undersecretary Robert Wilkie, Admiral William Moran, former Undersecretary Anthony Kurta, Commander Mary Krueger, William Bushman, and Assistant Secretary Lernes Hebert. As described above, the Government is moving to quash the subpoenas issued to Mattis, Selva, Wilkie, and Moran, and is deferring setting a date for Krueger given her pandemic response duties. The parties had previously set

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dates for Kurta and Hebert, but given the above delays, Plaintiffs wish to defer those depositions until later in the summer, along with the Bushman deposition, to permit the Ninth Circuit additional time to rule on the pending mandamus petition and the Special Master to review withheld documents, if so ordered.

C. Depositions of Plaintiffs' Expert Witnesses Mabus AND James

In their Joint Status Report and during the February 3, 2020 hearing, Plaintiffs flagged that one issue resulting from the Government's refusal to produce Carter Working Group documents was the Government's attempt to impugn the conclusions of, and the process used by, the Carter Working Group during the depositions of Plaintiffs' experts General Margaret Wilmoth and former Acting Under Secretary of Defense Brad Carson, without having first provided all relevant Carter Working Group documents. (*See, e.g.*, Dkt. No. 408 at 4–5; 2/3/2020 Hr'g Tr., Dkt. No. 412, at 27:2–41:25.) Plaintiffs expressed concern that the Government would again attempt to undermine the Carter Working Group during the depositions of former Secretary of the U.S. Navy Raymond Mabus and former Secretary of the U.S. Air Force Deborah James, both of whom have submitted expert reports on behalf of Plaintiffs. (2/3/2020 Hr'g Tr., Dkt. No. 412, at 28:3–7 ("Your Honor, it's just fairness. We can't respond to these arguments attacking the credibility of the Carter working group that came to the opposite conclusion than the panel did just two years before, unless they give us the documents.").) After hearing the parties' arguments regarding whether these depositions may proceed before all ordered Carter Working Group documents are produced, the Court stated:

> [Defendants] can decide that you're not going to take the deposition. But if you're going to take the deposition and talk to them about what they remember, or say that's not what this document says, you've got to give them a full set of documents so that they can prepare.

(*Id*. at 36:15–19.) On February 5, 2020, counsel for the Government sent an email memorializing the Government's understanding of the Court's order:

> During a hearing this past Monday in Karnoski, the court stated that Defendants would not be permitted to take further depositions of Plaintiffs' witnesses in that case until Defendants had produced certain additional deliberative materials related to the development of the Carter policy. As a result, and to avoid having to depose Mr. Mabus more than once, we will need

> to reschedule his deposition . . . .

Thereafter, the Government sought mandamus review by the Ninth Circuit of this Court's orders to produce Carter Working Group documents, and also requested an administrative stay of the Court's Order, which the Ninth Circuit granted. By requesting a stay of the production of Carter Working Group documents, and in turn having its request for an administrative stay granted, the Government necessarily delayed its ability to take the depositions of Secretaries Mabus and James until the Ninth Circuit has ruled, and, if the Government's mandamus petition is denied, the Carter Working Group documents are produced.

Undeterred, on April 20, 2020, counsel for the Government requested that Plaintiffs make Secretaries Mabus and James available for a deposition prior to the Ninth Circuit's decision on the mandamus petition:

> [P]lease let us know Plaintiffs' position on whether Defendants can take the depositions of Secretary Mabus and Secretary James without disclosing the Carter policy documents that are currently subject to the mandamus petition pending with the Ninth Circuit. Defendants' position is that the Ninth Circuit has stayed the district court's February 3, 2020 Order in its entirety, including the order that Defendants may not take further depositions prior to production of additional Carter policy deliberative documents. *See* ECF No. 415. If Plaintiffs disagree, please let us know so we can raise this issue with the district court and then possibly with the Ninth Circuit.

The Government therefore appears to be arguing that although its mandamus petition and motion to stay only requested relief with respect to the Court's Orders to produce certain documents (RFP Nos. 15 and 29), the Ninth Circuit administratively stayed ***all*** orders and directives made by this Court at the February 3, 2020 status conference, including the Order regarding the depositions of Plaintiffs' experts Mabus and James. Plaintiffs respectfully disagree, and contend that the depositions of Secretaries Mabus and James should be deferred until the Ninth Circuit decides Defendants' mandamus petition, and if that petition is denied, the Government produces the Carter Working Group documents.

D. Pending Discovery Motions

For the Court's convenience, Plaintiffs provide the following summary of pending discovery motions:

a. the Government's motion to extend time to respond to this Court's Order regarding Plaintiffs' RFP 44 (Dkt. No. 485);

b. Plaintiffs and Plaintiff-Intervenor's LCR 37 motion to extend the deadline to file discovery-related motions (Dkt. No. 490);

c. Plaintiffs' LCR 37 motion requesting review of the Government's deliberative process privilege claims (Dkt. No. 497); and

d. the Government's forthcoming LCR 37 motion for protective order regarding Plaintiffs' 30(b)(6) Notice.

DEFENDANTS' STATEMENT

I. Discovery Motions

As Plaintiffs point out, there are several discovery motions currently pending before the Court. *See* Dkts. 485, 490, 497. Defendants also anticipate filing this week an LCR 37 motion for protective order related to Plaintiffs' proposed Rule 30(b)(6) deposition of the Department of Defense. Defendants respectfully refer the Court to Defendants' briefing on these motions for statements of Defendants' positions and arguments.

In addition, Defendants anticipate filing motions to quash the depositions of current Secretary of Veterans Affairs Robert Wilkie,[1] former Secretary of Defense James Mattis, former Vice Chief of Naval Operations William Moran, and former Vice Chairman of the Joint Chiefs of Staff Paul Selva. Defendants disagree with Plaintiffs' assertion that these individuals are "critical witnesses" or that it is proper to depose such high-ranking current and former government officials. However, because these witnesses are not located in the Western District of Washington, Defendants anticipate filing motions to quash in other districts and this Court need not address these issues. *See* Fed. R. Civ. P. 45 (d)(3)(A) (authorizing "the court for the district where compliance is required" to "quash or modify a subpoena").

II. Currently Scheduled Depositions

Many of Plaintiffs' and Defendants' witnesses in this case are also witnesses in the related

[1] Plaintiffs describe Mr. Wilkie as the "former Under Secretary of Defense for Personnel and Readiness," Pls.' Statement 2, but that is not his current position. He is now a Cabinet Secretary.

cases around the country. Accordingly, in an effort to prevent witnesses from unnecessarily facing multiple depositions, Defendants have coordinated with the Plaintiffs across all four related cases in scheduling depositions.[2] Using this process, Defendants have scheduled the following depositions.

- **June 3: Dr. Terry Adirim**, former Principal Deputy Assistant Secretary of Defense Health Affairs
- **June 4: Stephanie Miller**, Director of Military Accession Policy
- **June 10: Kevin Cron**, Defendants' hybrid fact/expert witness
- **June 11: Thomas Dee**, Panel member and Undersecretary of the Navy
- **June 12: Martha Soper**, Assistant Deputy for Health Policy Office of the Deputy Assistant Secretary of the Air Force, Reserve Affairs & Airman Readiness
- **June 17: Christopher Meyering**, Defendants' hybrid fact/expert witness,
- **June 23: Dr. George Brown**, Plaintiffs' expert witness
- **June 24: Stephen Pflanz**, Defendants' hybrid fact/expert witness

In addition, within the past few weeks the parties in the various cases scheduled depositions of Anthony Kurta, formerly performing the duties of Deputy Under Secretary of Defense (Personnel & Readiness), and Lernes Hebert, Deputy Assistant Secretary of Defense for Military Personnel Policy, to take place on June 5 and June 8, respectively. However, Plaintiffs now state that they do not intend to proceed with these scheduled depositions. It is unclear what has changed. Plaintiffs state that they would like to first see whether they can obtain further deliberative documents in light of the mandamus petition and the special master's appointment. But Plaintiffs were aware of both the mandamus petition and the special master when they scheduled these depositions just a few weeks ago. Moreover, Plaintiffs have already received every deliberative document in the possession of Panel of Experts members that relate to the Panel's deliberations, including Mr. Kurta's documents. It is unclear why Plaintiffs now think they cannot proceed with Mr. Kurta's deposition at least.

[2] Defendants have not coordinated depositions with the Plaintiff in the newly filed case in the District of Massachusetts, *Doe v. Esper*, No. 20-cv-10530 (D. Mass.), because that case is not in discovery.

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Finally, as Defendants stated during the April 2, 2020 hearing, Colonel Mary Krueger is unable to provide dates for a deposition during the current COVID-19 crisis. (4/2/2020 Hr'g Tr. 31:5–13.) Colonel Krueger is Hospital Commander of the Tripler Army Medical Center, and is tasked with leading the military medicine response to COVID-19 in the state of Hawaii. Colonel Krueger has in fact already been deposed in these cases, in April 2018. However, Defendants have agreed that she may sit for an additional deposition, once she is available.

III. Depositions of Plaintiffs' Witnesses

During the February 3, 2020 status conference, the Court issued an oral ruling that Defendants were required to produce certain deliberative material responsive to Plaintiffs' RFP 15 related to the development of the Carter policy. (2/3/2020 Hr'g Tr. 40:8–11.) The Court then ruled further: "And I suggest that they [Defendants] don't get to take anybody's deposition further until they do turn over the material." (*Id.* at 40:8–10.)

Defendants subsequently filed a petition for a writ of mandamus with the Ninth Circuit, and the Ninth Circuit issued an order staying the "[t]he district court's December 18, 2019, February 3, 2020, and February 7, 2020 orders challenged in this petition." Order, Dkt. 415. Plaintiffs now split hairs by arguing that the mandamus petition challenged only the Court's February 3 order to produce Carter-era deliberative documents, and not the February 3 order to refrain from further depositions until those documents are produced. But those oral rulings are inextricably linked: a ruling to refrain from taking depositions until Defendants complete a production makes little sense unless Defendants are also required to complete the production. Moreover, under Plaintiffs' interpretation, Defendants would not be permitted to take *any* depositions until the mandamus petition is resolved—seemingly at odds with the Court's recent instruction to proceed with depositions "right away" and by videoconference if necessary. (4/2/2020 Hr'g Tr. 30:12–13.)

As a way forward, Defendants propose the following: If Plaintiffs wish to defer depositions of certain witnesses who served as government officials during the development of the Carter policy—such as the depositions of former Secretaries Mabus and James—until after the Ninth Circuit rules on the mandamus petition, Plaintiffs should be permitted to do so. In the

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meantime, however, Defendants should be permitted to move forward with depositions of other witnesses who were not involved in the development of the Carter policy, such as Plaintiffs' experts Dr. George Brown and Dr. Jody Herman. Dr. Brown's deposition is already scheduled for June 24. And on April 10, 2020, Defendants requested that Washington provide dates when Dr. Herman is available for deposition, but Washington has not done so.[3]

IV. Case Schedule

Plaintiffs' request for an indefinite extension of all fact discovery should be rejected. While Defendants would consent to a limited extension of time to complete currently scheduled depositions (including motion practice related to those depositions), Plaintiffs provide no compelling reason why additional time to serve written discovery is required, nor have they identified any further written discovery they intend to propound.

Since Plaintiffs filed their complaint in August 2017, Plaintiffs and Washington have served over 100 requests for production and dozens of interrogatories. Defendants have produced tens of thousands of documents and timely served detailed interrogatory objections and responses.[4] Plaintiffs have not explained why these many written discovery requests are insufficient, nor have they identified what additional discovery requests they contend they still need to serve.

Plaintiffs also fail to explain why they could not have served any additional written discovery requests during the more than two and a half years this lawsuit has been pending. The individual Plaintiffs sporadically served discovery requests during these years, and Washington did not serve any discovery at all until July 2019, nearly two years after this case was filed. *See*

[3] It is possible that, due to case schedules in the related cases, Defendants may have to move forward with depositions of former Secretaries Mabus and James in the related cases prior to the Ninth Circuit's ruling on the mandamus petition. In that circumstance, Defendants would notice the depositions in the related cases, but not in this case, and may subsequently have to notice additional depositions of Secretaries Mabus and James in this case once the Ninth Circuit has ruled.

[4] In addition, because of the cross-use agreement, Defendants have produced to Plaintiffs and Washington documents responsive to the numerous discovery requests that have been served by plaintiffs in the related cases, as well as documents responsive to court orders issued in other cases. See Dkt. 183. Most notably, in response to an order issued by the court in the related Doe v. Esper case in the District of Columbia, Defendants produced to all of the plaintiffs in the related cases a complete, unredacted Administrative Record of the documents, testimony, and data relied on or considered by the Panel of Experts charged with developing the challenged policy, along with the Panel's deliberations on those materials, as well as communications to or from members of the Panel relating to their development of the policy. See Decl. of Robert Easton ¶¶ 4–6 (Jan. 24, 2020), Dkt. 405-2.

ECF Nos. 483-1, 483-2. Notably, when Plaintiffs moved for summary judgment in February 2018, and Defendants requested an opportunity to take discovery pursuant to Rule 56(d), Dkt. 178, Plaintiffs opposed Defendants' request, arguing that Defendants "have failed to exercise reasonable diligence to pursue any of the discovery they suddenly claim they need." Dkt. 185 at 1. The Court agreed and denied Defendants' request to take discovery, noting that "[t]his case has been pending for nearly six months," and finding that Defendants "have failed to show that they were diligent in seeking the discovery they now claim to need." Dkt. 189 at 4. More than two years after the Court found the Defendants "failed to show that they were diligent," Plaintiffs are now moving for more time, the very position they opposed initially. Plaintiffs cannot have it both ways.

Moreover, Plaintiffs' argument that the Government is to blame for delays in this case is unpersuasive. If permitted, Defendants are prepared now to have this case proceed to summary judgment so that their policy may be "evaluated on the record supporting that decision and with the appropriate deference due to a proffered military decision." *Karnoski v. Trump*, 926 F.3d 1180, 1207 (9th Cir. 2019). Discovery is only still proceeding due to Plaintiffs' strategic decisions to delay for years taking any depositions and their refusal to grapple with the Ninth Circuit's prior holdings in this case.

For more than two and a half years, Plaintiffs and Washington steadfastly refused to take even a single deposition until the deliberative process privilege was set aside as to all documents in the Government's production. This position had no merit to begin with, and certainly has not had merit for the nearly one year since the Ninth Circuit granted the Government's initial petition for a writ of mandamus. In the face of that ruling, it was misguided for Plaintiffs again to insist on an order overruling all of Defendants' deliberative process privilege assertions *en masse*, *see* Dkt. 365 at 5, or an order overruling the deliberative process privilege as to all documents "related" to the formation of DoD's 2018 policy and the Carter policy. *See* Dkt 408 at 2-6. Yet Plaintiffs sought just that, and the Government, accordingly, was forced to file a second petition for writ of mandamus. Dkt. 414-1. Thereafter, the Ninth Circuit recognized that the Government's second petition "raises issues that warrant an answer[,]" *see* Dkt. 416, and granted

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the Government's request for a "temporary administrative stay[,]" Dkt. 415, which is still in place. Plaintiffs' actual grievance is with the Ninth Circuit—both for granting the original writ of mandamus and for issuing the current administrative stay. But both Defendants and Plaintiffs are bound by these decisions even if Plaintiffs find them incompatible with their chosen case strategy.

Similarly, Plaintiffs cannot seriously hold Defendants responsible for not acquiescing to their attempt to circumvent the Ninth Circuit's review of Defendants' mandamus petition, as well as the Ninth Circuit's administrative stay, through a Rule 30(b)(6) deposition seeking the same privileged information through testimony that is currently at issue before the Ninth Circuit. The weakness of Plaintiffs' position is highlighted by their request to have the district court—rather than the Ninth Circuit—adjudicate the bounds of the Ninth Circuit's own stay order.

Perhaps most fundamentally, Plaintiffs have delayed this case because they refuse to accept that the role of this Court is not to "substitute its 'own evaluation of evidence for a reasonable evaluation' by the military," but to test whether the decision the military made, in light of the evidence that it actually considered, is justifiable, *Karnoski*, 926 F.3d at 1202 (quoting *Rostker v. Goldberg*, 453 U.S. 57, 68 (1981)). Instead, Plaintiffs have repeatedly insisted on overbroad and intrusive discovery that has no precedent in a case involving the military, and little, if any, relation to the core questions before the Court. Indeed, discovery recently has been sidetracked into such far-flung topics as outlook "delivery notifications" and "journaling reports," Dkt. 455, and confidential service member medical information that was never even considered by Government decisionmakers, Dkt. 485. And Plaintiffs now insist that even the October 2020 trial date may have to be moved in service of their improper approach to discovery, even though that trial date was set just a few months ago. These are delays of Plaintiffs' making, not Defendants'.

In short, while Defendants would consent to a limited extension of time to conduct currently scheduled depositions (including motions related to those depositions), Plaintiffs' request for an indefinite extension of all discovery should be rejected.

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Respectfully submitted, May 6, 2020

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CERTIFICATE OF SERVICE

The undersigned certifies under penalty of perjury under the laws of the United States of America and the laws of the State of Washington that all participants in the case are registered CM/ECF users and that service of the foregoing documents will be accomplished by the CM/ECF system on May 6, 2020.

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