LEGAL DEPARTMENT
LESBIAN GAY
BISEXUAL
TRANSGENDER &
AIDS PROJECT

ACLU
AMERICAN CIVIL LIBERTIES UNION FOUNDATION

September 26, 2014

VIA FEDEX

Office of The Surgeon General (DASG–HS–AS)
5109 Leesburg Pike
Falls Church, VA 22041–3258.

The enclosed package includes the following items submitted on behalf of Sergeant Shane Ortega, United States Army:

- DA Form 2028, *Recommended Changes to Publications and Blank Forms*, concerning Army Regulation (AR) 40-501, *Standards of Medical Fitness*, signed on September 25, 2014 by Sergeant Shane Ortega

- Additional remarks in support of Part III of DA Form 2028 (September 26, 2014 letter, signed by Joshua Block and Chase Strangio of the American Civil Liberties Union LGBT Project)

- Attachments to the additional remarks.

Very Respectfully,

/s/ Joshua A. Block

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RECOMMENDED CHANGES TO PUBLICATIONS AND BLANK FORMS For use of this form, see AR 25-30; the proponent agency is OAASA	Use Part II *(reverse)* for Repair Parts and Special Tool Lists (RPSTL) and Supply Catalogs/Supply Manuals (SC/SM).	DATE 20140925
TO: *(Forward to proponent of publication or form) (Include ZIP Code)* Office of The Surgeon General (DASG-HS-AS) 5109 Leesburg Pike Falls Church, VA 22041-3258	FROM: *(Activity and location) (Include ZIP Code)* SGT ORTEGA, SHANE A. [redacted]	

PART I - ALL PUBLICATIONS (EXCEPT RPSTL AND SC/SM) AND BLANK FORMS

PUBLICATION/FORM NUMBER	DATE	TITLE
Army Regulation 40-501	August 4, 2011	Standards of Medical Fitness

ITEM	PAGE NO.	PARA-GRAPH	LINE NO.*	FIGURE NO.	TABLE NO.	RECOMMENDED CHANGES AND REASON (Provide exact wording of recommended changes, if possible).
	15	2-27	(n)			Remove the word "transsexualism" from Paragraph 2-27 (n). Please see attachment to Part III for a fuller explanation.
	33	3-35				Remove the words "transsexual" and "gender identity" from the title of Paragraph 3-35. Please see attachment to Part III for a fuller explanation.
	33	3-35	(a)			Remove the words "transsexual, gender identity disorder to include major abnormalities or defects of the genitalia such as change of sex or a current attempt to change sex" from Paragraph 3-35(a). Please see attachment to Part III for a fuller explanation

TYPED NAME, GRADE OR TITLE	TELEPHONE EXCHANGE/AUTOVON, PLUS EXTENSION	SIGNATURE
ORTEGA, SHANE A. SGT	[redacted]	ORTEGA.SHANE.ALEJANDRO. Digitally signed by [redacted] Date: 2014.09.25 14:09:09 -10'00'

DA FORM 2028, FEB 1974 REPLACES DA FORM 2028, 1 DEC 68, WHICH WILL BE USED.

APD PE v4.02ES

TO: *(Forward direct to addressee listed in publication)*	FROM: *(Activity and location) (Include ZIP Code)*	DATE
Office of The Surgeon General (DASG-HS-AS) 5109 Leesburg Pike Falls Church, VA 22041-3258	SGT ORTEGA,SHANE A. [redacted]	20140925

PART II - REPAIR PARTS AND SPECIAL TOOL LISTS AND SUPPLY CATALOGS/SUPPLY MANUALS

PUBLICATION NUMBER	DATE	TITLE

PAGE NO.	COLM NO.	LINE NO.	NATIONAL STOCK NUMBER	REFERENCE NO.	FIGURE NO.	ITEM NO.	TOTAL NO. OF MAJOR ITEMS SUPPORTED	RECOMMENDED ACTION

PART III - REMARKS *(Any general remarks or recommendations, or suggestions for improvement of publications and blank forms. Additional blank sheets may be used if more space is needed.)*

As explained further in the attachment to this form, AR 40-51 should be revised to remove any requirement that transgender Soldiers be administratively separated. DoD Instruction 1332.38, which stated that transgender service members were subject to administrative discharge, was recently cancelled. The new DoD retention standards (DoDI 1332.18) do not require administrative separation of transgender service members, but provide simply that the individual services may determine the conditions subject to administrative discharge if -- and only if -- those conditions "interfere with assignment to or performance of duty." Being transgender or being treated for gender dysphoria does not meet this new standard. As a recent nonpartisan Commission concluded, there is no compelling medical rationale for the ban. The exclusion of transgender Soldiers is based on an outdated understanding that grouped transgender people together with people with sexual paraphilias, such as exhibitionism or voyeurism. That conflation of transgender identity and sexual paraphilias has been rejected by the medical community for decades. Moreover, there is no reason to treat Soldiers receiving medical treatment for gender dysphoria differently from Soldiers receiving treatment for other types of medical conditions, who are not automatically deemed unfit to serve. My own situation illustrates why AR 40-501 should be revised. I am a transgender Soldier. Since my transition to the male gender, I have continued to serve honorably in the Army, including a deployment to a remote FOB in Afghanistan in 2011, after I had completed my transition. I and other transgender Soldiers should not be administratively discharged without regard to our actual fitness to serve.

TYPED NAME, GRADE OR TITLE	TELEPHONE EXCHANGE/AUTOVON, PLUS EXTENSION	SIGNATURE
ORTEGA, SHANE A. SGT	[redacted]	

DA FORM 2028, FEB 1974

LEGAL DEPARTMENT
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ACLU
AMERICAN CIVIL LIBERTIES UNION FOUNDATION

September 26, 2014

Office of The Surgeon General (DASG–HS–AS)
5109 Leesburg Pike
Falls Church, VA 22041–3258.

RE Revisions to AR 40-501 Provisions Regarding Transgender Soldiers

We represent Shane Ortega, a Sergeant in the United States Army. Sergeant Ortega has served in the military since 2005 (initially with the Marine Corps) and has been on active duty in the Army since 2009. He is a transgender man, which means that he was assigned a female sex at birth but his gender identity is male.[1]

On behalf of Sergeant Ortega we respectfully request that AR 40-501 be revised as follows:

- Remove from Paragraph 2-27, the word "transsexualism"
- Remove from the title of Paragraph 3-35, the words "transsexual" and "gender identity"
- Remove from Paragraph 3-35(a), the words "transsexual, gender identity disorder to include major abnormalities or defects of the genitalia such as change of sex or a current attempt to change sex"

In addition, we respectfully request that the Surgeon General impose a moratorium on administrative separation for Sergeant Ortega and other transgender Soldiers while the foregoing revisions are being considered and implemented.

In the alternative, we request an individual waiver of the foregoing portions of AR 40-501 for Sergeant Ortega.

We explain the basis for this request further below.

Introduction

Sergeant Ortega served honorably in Iraq and Afghanistan—including on one deployment in 2011, after he had fully transitioned to living in accordance with his male gender identity. He wishes to demonstrate his continued fitness to serve. It is our understanding that, because Sergeant Ortega is transgender, the Office of the Surgeon General is currently considering whether Sergeant Ortega should be referred for administrative separation pursuant to paragraph 3-35 of the Army's retention standards in AR 40-501 (Standards of Medical Fitness). (Excerpts

[1] Transgender is an umbrella term used to describe people with a gender identity that differs from the sex they were assigned at birth. Some transgender people have been diagnosed with gender dysphoria (formerly known as "Gender Identity Disorder"), while others have not.

enclosed). This provision is generally understood to require the administrative separation of any transgender Soldier.

On behalf of Sergeant Ortega, we respectfully request that the Office of the Surgeon General review and revise the Army's retention standards as requested above. Our explanation of the basis for this request is organized as follows:

Section A explains that the Army's existing retention standards implement a previous Department of Defense Instruction (DoDI 1332.38), which instructed that transgender service members should be discharged through administrative separation. This DoD Instruction was recently cancelled. The DoD's new retention standards (found in DoDI 1332.18) no longer declare that transgender service members are deemed administratively unfit. (Copy enclosed). Instead, the regulation now delegates to the individual service branches the authority to separate service members as administratively unfit for duty if, and only if, the service branch determines that the service member has a "condition, circumstance, or defect of a developmental nature" that "interfere[s] with assignment to or performance of duty." As discussed in the subsequent sections, there is no basis under current medical science to conclude that transgender Soldiers have such a condition.

Section B explains that removing the Army's blanket policy that transgender Soldiers are automatically deemed "administratively unfit" would be consistent with the findings of a recent report by a nonpartisan commission chaired by a former U.S. Surgeon General and a former Director of Health and Safety of the U.S. Coast Guard, which found no medical justification for the current regulations. It would also align the Army's practice with the treatment of transgender individuals by the militaries of our closest allies and would be consistent with the current treatment of transgender persons by the Veterans Health Administration, the Federal Aviation Administration, and the United States Equal Employment Opportunity Commission. Section B further explains that a broad ban on transgender service in Paragraph 3-35 of AR 40-501 rests on outdated medical assumptions about transgender people, which improperly associated gender dysphoria with sexual paraphilias, such as exhibitionism or voyeurism. Those past assumptions do not have any support in today's medical science.

Section C states that concerns about fitness to serve, including in remote or austere environments, do not justify differentiating between Soldiers receiving treatment for gender dysphoria and Soldiers receiving treatment for other medical conditions. Soldiers receiving treatment for gender dysphoria should – like Soldiers with virtually every other medical condition – receive an individualized assessment of whether they are deployable under paragraph 5-14 of AR 40-501. In the vast majority of cases, Soldiers receiving treatment for gender dysphoria are fully deployable. In the unusual case in which a Soldier's treatment for gender dysphoria interferes with the ability to perform the duties of his/her office, grade, rank or rating, that Soldier should be referred to the same medical review process that determines the medical fitness for Soldiers with virtually every other medical condition. There is no reason to depart from these normal procedures and deem all Soldiers receiving treatment for gender dysphoria to be administratively unfit.

Section D summarizes Sergeant Ortega's situation. His deployment to a remote forward operating base in Afghanistan in 2011 occurred after he transitioned to living in accordance with his male gender identity. He served honorably in that assignment and has continued to serve effectively in his more recent assignments, including in his helicopter maintenance and engineering specialties, until he was removed from that assignment a few months ago. Under Paragraph 3-35 of AR 40-501, Sergeant Ortega is threatened with administrative separation without any opportunity to demonstrate his actual fitness to serve. Sergeant Ortega's situation is an excellent illustration of why the regulation providing for administrative separation of transgender Soldiers should be changed.

Finally, Section E explains how the Army can and should use existing authority to permit Sergeant Ortega and other transgender Soldiers to serve while awaiting revisions to AR 40-501. The Office of the Surgeon General has authority to provide an individual waiver of AR 40-501 paragraph 3-35 to Sergeant Ortega. But there are other transgender Soldiers who, like Sergeant Ortega, have served honorably and effectively and are fully fit to continue to serve their country as Army Soldiers. We therefore respectfully request that the Army eliminate or revise paragraph 35-5 in a manner that will afford all transgender Soldiers the same opportunity as any other Soldier who is medically fit for duty.

A. DoD Recently Cancelled Its Instruction Requiring Administrative Discharge of Transgender Service Members, and Delegated Authority to the Service Branches to Determine What Medical Conditions Should Render a Service Member Administratively Unfit.

On August 5, 2014, DoD changed its retention standards, cancelling DoDI 1332.38, *Physical Disability Evaluation*, and replaced it with DoDI 1332.18, *Disability Evaluation System (DES)*. The Army regulation that implemented DoDI 1332.38—paragraph 3-35 of AR 40-501—has not yet been updated to reflect the cancellation of that Instruction. Under the new DoD Instruction, the Army and other service branches may deem that a medical condition renders service members administratively unfit *only* if it is a "condition, circumstance, or defect of a developmental nature" that "interfere[s] with assignment to or performance of duty." Because DoD regulations no longer provide that transgender service members should be automatically separated as administratively unfit, the Office of the Surgeon General has responsibility to update AR 40-501 to eliminate the bar on continued service by transgender Soldiers.

DoDI 1332.38 provided for categorical exclusion of transgender service members. The Instruction created a framework under which potentially disqualifying conditions were divided into two tracks. Service members with most medical conditions were able to continue serving without the need for a special medical review. If the service member had a medical condition that interfered with the performance of duty, that condition was treated or was referred to evaluation by a medical review board, which made an individualized determination of whether a service member was fit for duty despite that medical condition.

In contrast, DoDI 1332.38 provided that individuals with conditions defined as "not constituting a physical disability" should be separated administratively at the commander's discretion and without the same opportunity to demonstrate fitness for duty. The list of conditions "not

constituting a physical disability" (in Enclosure 5 of DoDI 1332.38) included "Certain Mental Disorders including . . . Sexual Gender and Identity Disorders, including Sexual Dysfunctions and Paraphilias." Transgender service members were accordingly automatically referred for administrative separation and, as part of that separation, were denied the same protections afforded to service members who were referred to a medical board for other medical conditions.

Paragraph E4.1.2 of DoDI 1332.38 gave the individual services authority to "modify these guidelines to fit their particular needs" but only so long as modifications were consistent with DoD guidance. The Army promulgated its policy in paragraph 3-35 of AR 40-501, *Standards of Medical Fitness*, December 14, 2007, Revised August 4, 2011. Under this paragraph, various conditions, including "transsexual, gender identity disorder to include major defects or abnormalities of the genitalia such as change of sex or a current attempt to change sex, . . . render an individual administratively unfit . . . [and] will be dealt with through administrative channels...." Army personnel apparently read this provision to require administrative separation of all transgender Soldiers. (In addition, paragraph 2-27.n provides that "transsexualism" does not meet enlistment standards.)

DoDI 1332.18, issued in August 2014, retains the distinction between medical conditions that are referred to a medical review board and medical conditions that are subject to administrative separation. But the new regulation no longer provides an enumerated list of which conditions should lead to administrative discharge. Instead, the regulation now delegates to the individual service branches the authority to separate service members as administratively unfit if, and only if, the service branch determines that the service member has a "condition, circumstance, or defect of a developmental nature" that "interfere[s] with assignment to or performance of duty." DoDI 1332.18.

Being transgender or receiving a diagnosis of gender dysphoria does not meet this new standard. As discussed below, being transgender or receiving a diagnosis of gender dysphoria does not, by itself, interfere with a Soldier's performance of duty; and in the majority of cases, medical treatments for gender dysphoria do not interfere with performance of duty either. Revising paragraph 3-35 of AR 40-501 is therefore necessary to bring the Army's retention standards in line with the new DoD Instruction, and with today's medical science.

B. The Army's Categorical Exclusion of Transgender Soldiers Has No Basis in Modern Medical Science and Standards of Care.

This is a particularly appropriate time for the Army to reconsider its policy of administrative separation for transgender Soldiers. In March 2014, a nonpartisan commission chaired by Joycelyn Elders, MD, former Surgeon General of the United States, and Rear Admiral Alan Steinman, MD, USPHS/USCG (Ret.), former U.S. Coast Guard Director of Health and Safety, issued a comprehensive report addressing the military's policies relating to transgender persons (*Elders-Steinman Report)*. (Copy enclosed). This report concluded that there is no compelling

medical rationale for banning military service by transgender persons and that eliminating the ban would advance a number of military interests. *Elders-Steinman Report* at 3.[2]

A follow-up report by a nonpartisan group co-chaired by Major General Gale S. Pollock, USA (Ret.), former acting Army Surgeon General, and including Brigadier General Clara Adams-Ender USA (Ret.), former Head of the Army Nurse Corps (*Pollock Report*), discussed how open service by transgender service members could be effectively implemented, consistent with maintaining military readiness and adhering to core military values and principles. (Copy enclosed). These recent reports support the conclusion that paragraph 3-35 of AR 40-501 should be reexamined and the provision for administrative separation of all transgender Soldiers removed. There have been other suggestions (even within the military) that it is time to reexamine the ban on service by transgender service members. One example is the recent article by Major Mark Milhiser, *Transgender Service: The Next Social Domino for the Army*, 220 Mil. L. Rev. 191 (2014).

Revising AR 40-501 would align the Army with the militaries of the United States' closest allies in the treatment of transgender individuals. The United Kingdom, Canada, and Australia (as well as other nations) now permit transgender individuals to actively serve in their militaries. *Elders-Steinman Report* at 13. For example, a United Kingdom regulation states, "Transsexual applicants with no history of mental health problems or deliberate self-harm who meet other fitness standards should be passed as being fit to join the Armed Forces." Post-transition transgender service members from the United Kingdom and Canada have completed tours in Afghanistan. *Elders-Steinman Report* at 13-14. Revising AR 40-501 would also be timely in light of recent changes at the Veterans Health Administration (VHA), the Federal Aviation Administration (FAA), and the United States Equal Employment Opportunity Commission (EEOC). Since June 2011, the VHA has provided transgender-related health care, with the exception of gender-confirming surgery, for transgender veterans. *Elders-Steinman Report* at 20. VHA personnel have developed expertise in delivering such services. Among other things, VHA has established four Transgender E-Consultation teams to support health care providers throughout the VHA system. *Elders-Steinman Report* at 20. In 2012, the FAA eliminated onerous mental health testing requirements for transgender pilots, including those flying large commercial airlines. FAA, *Guide for Aviation Medical Examiners: Item 41. G-U System - Gender Identity Disorder.* In the same year, the EEOC found that employment discrimination against an individual because that person is transgender is covered under Title VII of the Civil Rights Act of 1964. *Macy v. Department of Justice*, EEOC Appeal No. 0120120821 (April 20, 2012).

It is unclear why the U.S. military issued regulations excluding transgender persons from service in the first place. One possible reason is that medical professionals had previously classified transgender identity as a personality disorder. Indeed, the title and text of AR 40-501 paragraph 35-5 explicitly group transgender Soldiers with Soldiers who have "[p]ersonality [disorders],

[2] A shorter version of this report was subsequently published in a peer-reviewed journal as M. Joycelyn Elders, et al, *Medical Aspects of Transgender Military Service*, Armed Forces & Society, 0095327X14545625, first published online on August 19, 2014.

psychosexual conditions, . . . exhibitionism, transvestism, voyeurism, other paraphilias, or factitious disorders" and "disorders of impulse control not elsewhere classified."

Several decades ago, the American Psychiatric Association, in its *Diagnostic and Statistical Manual* (DSM) (excerpts enclosed), also grouped "transsexualism" along with "psychosexual conditions" and "paraphilias" such as exhibitionism or voyeurism, but modern medical science has squarely rejected this conflation of gender dysphoria with sexual paraphilias (defined as conditions "involving distressing and repetitive sexual fantasies, urges, or behaviors" that "interfere[s] with everyday functioning"). Currently, in the fifth edition of the DSM (DSM-5), gender dysphoria and disorders related to sexuality are in completely separate sections, reflecting the modern medical understanding that gender identity and sexuality disorders are distinct. Even under the fourth edition (DSM-IV), Gender Identity Disorder was no longer grouped with paraphilias. *Elders-Steinman Report* at 9.[3]

Since at least the early 1980s, Army regulations have not been substantively updated to reflect these developments in medical consensus. This update should take place now. As the Elders-Steinman Report concluded, there is no compelling medical rationale for administratively separating all transgender Soldiers, regardless of their fitness to serve. *Elders-Steinman Report* at 3. The exclusion reflects past social judgments against transgender individuals, not contemporary medical science.

[3] In addition, the modern medical community no longer considers gender dysphoria (and previous names for that diagnosis) to be a mental illness or psychological disorder. This evolution is reflected in successive editions of the DSM. (Excerpts enclosed) DSM-III, issued in 1980, listed "Transsexualism" as a mental health diagnosis. The next edition (DSM-IV), issued in 1994, eliminated "Transsexualism" as a mental health diagnosis and replaced it with "Gender Identity Disorder." The most recent edition (DSM-5), published in 2013, no longer describes transgender identity as a "disorder." It replaced "Gender Identity Disorder" with "gender dysphoria," a condition diagnosed by "clinically significant distress" that may follow from the incongruence between a person's expressed or desired gender identity and the gender the person had been assigned at birth. The World Health Organization's Working Group on the Classification of Sexual Disorders and Sexual Health has recommended that the 2015 version of the *International Statistical Classification of Diseases and Related Health Problems* (ICD-11) adopt a similar view of transgender identity. (Copy of recommendation enclosed). There are now standards of care for treating gender dysphoria, and medical professionals recognize that symptoms associated with this condition typically can be alleviated by treatments that have been found in numerous peer-reviewed studies to be safe, effective, and reliable. World Professional Association for Transgender Health, *Standards of Care (SOC) for the Health of Transsexual, Transgender, and Gender Nonconforming People* (SOC-VII). (Excerpt enclosed).

C. Concerns About Fitness to Serve, Including in Remote or Austere Environments, Should Be Addressed Through the Normal Medical Review Process, Not By Automatically Deeming Transgender Soldiers Administratively Unfit.

Concerns about transgender Soldiers' deployability to remote or austere environments can and should be evaluated under the same standard that applies to virtually every other medical condition besides gender dysphoria According to Army regulations that apply to virtually every other medical condition besides gender dysphoria: "Personnel who have existing medical conditions may deploy" if deployment is unlikely to aggravate the condition, if an unexpected worsening of the condition would not pose a grave threat, if health care and medications are immediately available in theater, and if "no need for significant duty limitation is imposed by the medical condition." Department of the Army, *Personnel Policy Guidance for Overseas Contingency Operations*, 2013, at ¶ 7-9(e). In the past, the Army has permitted continued service and deployment by many Soldiers with serious medical conditions, like diabetes and other conditions that require hormone treatment, as well as mental health conditions. *Elders-Steinman Report* at 13. Enclosed is a table contrasting the different treatment of transgender Soldiers and Soldiers with a sampling of other medical conditions.

There is no good reason for treating Soldiers receiving treatment for gender dysphoria differently than Soldiers receiving treatment for any other medical diagnosis. Some transgender persons have only mild symptoms (or no symptoms) of gender dysphoria. For transgender persons who do experience gender dysphoria, that dysphoria is amendable to safe and effective treatments, and those treatments should not usually pose any barrier to service for transgender Soldiers. There are accepted standards of care for treating gender dysphoria, and the medical treatments are no longer considered experimental. *Elders-Steinman Report* at 9-15. Many transgender people do not need or want surgery (particularly genital surgery). For those who have surgery, the rate of post-surgical complications is low. The Elders-Steinman Report explains that the military already has the competency to provide care for most transgender service members; moreover, the experience of the VHA, which has treated transgender veterans for several years, demonstrates that the Army could adopt several simple tools for building knowledge in transgender care and providing resources for Army medical personnel (e.g., webinars, FAQ's and other online resources for health care providers). *Elders-Steinman Report* at 20-21. Sergeant Ortega's own experience during his post-transition deployment to Afghanistan, described in the next section, demonstrates that transgender Soldiers can receive appropriate care when assigned to remote locations.

Furthermore, the medical needs of most Soldiers receiving treatment for gender dysphoria are not materially different from those the military handles for other Soldiers, including those deployed to distant or austere environments. For example, the military provides psychological care around the globe. It also provides medications for people with diabetes and other disorders on a long-term basis and stocks various hormones in its dispensaries in the United States and abroad. *Elders-Steinman Report* at 13. Additionally, the Army deployment policy requires that "A minimum of a 180-day supply of medications for chronic conditions will be dispensed to all deploying Soldiers." Department of the Army, *Personnel Policy Guidance for Overseas Contingency Operations*, 2013 at ¶ 7-13(b)1. Indeed, according to Army regulations. "Soldiers taking medications should not automatically be disqualified for any duty assignment." AR 40-

501, ¶ 5-14(17). The military branches (including the Army) also provide leave for certain elective and reconstructive surgeries without discharging the service members who undergo those surgeries while serving. *Elders-Steinman Report* at 14.

Even in extreme cases where a particular transgender Soldier's medical care renders the Soldier ineligible for worldwide deployment, there is no reason why transgender Soldiers should be singled out for automatic discharge without an individualized inquiry into fitness. Many non-transgender service members are temporarily or permanently non-deployable, but they are not automatically discharged as a result, and military policies accommodate them within reason. *Elders-Steinman Report* at 17.

In short, transgender Soldiers receiving treatment for gender dysphoria are not inherently different from other Soldiers with treatable medical conditions. If *any* Soldier, transgender or not, has a condition requiring medication or surgery, Army medical personnel are capable of following regular standards to determine whether such condition interferes with the Soldier's performance of duty. If there are grounds to refer the Soldier to a medical review board, then transgender Soldiers should have the same opportunity afforded to every other Soldier to show they are, in fact, medically fit for service – along with the same procedural and substantive protections that Army regulations provide to all other Soldiers referred for medical evaluation.

D. Sergeant Ortega's Own Situation Illustrates Why it Makes No Sense to Discharge All Transgender Soldiers Without Allowing the Soldier to Demonstrate Fitness.

Sergeant Ortega's own service record provides a good illustration of why AR 40-501 should be revised. Sergeant Ortega has served honorably in the Marine Corps and Army since enlisting in 2005 and has successfully completed two deployments to Iraq and one to Afghanistan. The Afghanistan deployment occurred *after* his gender transition.

Sergeant Ortega enlisted in the Marine Corps in 2005. In the Marine Corps, he worked in a Military Police unit as a maintenance management specialist based at Camp Pendleton, California. He deployed twice to Iraq with Military Police units, and he earned the Marine Corps Good Conduct Medal.

Sergeant Ortega completed an inter-service transfer to the Army on July 17, 2009 and was assigned to a CH-47 Chinook helicopter flight crew in Fort Wainwright, Alaska. He has served as a mechanic and a flight engineer, and he also worked as a Human Resources Sergeant for a General Support Aviation Battalion Headquarters, supporting the operations of an S-1 section responsible for more than 700 Soldiers.

While posted to Fort Wainwright, Sergeant Ortega began the transition to live in accordance with his male gender identity. Sergeant Ortega underwent chest masculinization surgery under the care of a civilian physician, began masculinizing hormone therapy under the supervision of civilian and military physicians, and legally changed his gender marker to male and his first name to Shane. Sergeant Ortega disclosed this transition to military physicians on several occasions. He has not experienced any psychological problems. Military medical officers found him fit for duty.

Following his gender transition, Sergeant Ortega deployed to Forward Operating Base Wolverine, a remote outpost in Afghanistan. Sergeant Ortega continued to take hormone supplements under the supervision of military medical personnel while deployed in Afghanistan. Sergeant Ortega's fellow Soldiers and commanders were aware of his gender transition throughout this process.

Upon his return from Afghanistan, Sergeant Ortega served in Alaska for approximately one year before transferring to Hawaii, where he is currently based. In connection with a routine flight recertification physical, senior medical personnel in Hawaii observed that he had male hormones in his system. After Sergeant Ortega explained he was taking hormones pursuant to his transition to the male gender, his flight status was revoked, and he has been threatened with separation based on AR 40-501, despite the fact that he has no impediments to performing duties associated with helicopter maintenance positions.

Sergeant Ortega's gender transition has eliminated symptoms of gender dysphoria. He has no ongoing complications from his chest surgery, and his hormone treatment does not interfere with performance of his duties. He remains ready, willing, and able to serve as a helicopter flight crew member. We respectfully request that AR 40-501 be revised so that Sergeant Ortega can continue to serve with full flight status certification and so that he and other transgender Soldiers can continue to serve honorably.

E. Pending a Decision on Revision of AR 40-501, the Army Should Permit Sergeant Ortega and Other Transgender Soldiers to Continue to Serve.

We understand that the revision process for AR 40-501 may take time. In addition to bringing AR 40-501 in line with medical science, additional affirmative implementation strategies may be appropriate. *See generally Pollock Report.* But transgender Soldiers should not be kept in administrative limbo while the regulation is being updated. Instead, while a decision on changes to the regulation is pending, the Army Surgeon General should use existing authority to waive the regulation. The Army should publicize this action, so that Army personnel, including other transgender Soldiers, will be on notice.

Holding Sergeant Ortega in limbo, without waiver or a determination of fitness, is untenable. Sergeant Ortega's current enlistment runs through 2017, but he has been removed from flight duty and will be unable to advance in his Army career so long as AR 40-501 is on the books. He has been denied his flight certification because of the restrictions on transgender service under AR 40-501, despite the fact that he has served with honor in a flight role for several years and there have been no material changes in his ability to serve in the same capacity.

While the Army considers revision of AR 40-501, the Surgeon General has the authority to rectify this situation for Sergeant Ortega and for other transgender Soldiers. The Surgeon General should impose a moratorium on administrative separation of transgender Soldiers by waiving the regulation as it applies to active duty transgender Soldiers. The waiver would have virtually no impact on Army operations, since these Soldiers are already serving.

Request for Response

We respectfully request that AR 40-501 be revised to permit transgender Solders to continue to serve in the Army. The recent revision to DoD retention policies calls for reexamination of this issue. The medical evidence described above and in the Elders-Steinman Report, as well as Sergeant Ortega's own service record, show that the ban on continued service by transgender Soldiers is outdated and counterproductive to the Army's mission.

While the decision is pending, the Surgeon General should impose a moratorium on additional administrative separations of transgender Soldiers by waiving the application of AR 40-501 as it affects transgender Soldiers and stating explicitly that being transgender does not automatically render a Soldier administratively or physically unfit. In the alternative, we request an individual waiver for Sergeant Ortega of the portions of AR 40-501 that could be read to require administrative separation based on the fact of his transgender identity.

As discussed above, continuing to hold Sergeant Ortega in limbo creates an untenable situation that deprives him of the ability to advance in his military career. We therefore request that the Surgeon General respond formally to this request within a reasonable period of time (at least by November 30, 2014), stating whether the Army will revise the regulation and, if not, explaining the rationale.

We thank the Surgeon General and other Army officials for their attention to this matter. In addition, we respectfully request that this letter, DA Form 2028, and attachments be added to the administrative record created for the purpose of any separation proceedings initiated against Sergeant Ortega.

Very Respectfully,

/s/ Joshua A. Block

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ATTACHMENTS

The following documents (Tabs A-H) are enclosures to the September 26, 2014 letter from the American Civil Liberties Union LGBT Project to the Office of the Surgeon General (Re: Revisions to AR 40-501 Provisions Regarding Transgender Soldiers). These attachments and the letter are submitted on behalf of Sergeant Shane Ortega, United States Army, as part of his DA Form 2028 submission.

Attachments

Attachment A: Excerpts from Army Regulation 40-501, *Standards of Medical Fitness*

Attachment B: Department of Defense Instruction 1332.18

Attachment C: Elders-Steinman Report

Attachment D: Pollock-Minter Report

Attachment E: American Psychiatric Association's *Diagnostic and Statistical Manual (DSM) III, IV, and 5* Excerpts

Attachment F: World Health Organization's *International Statistical Classification of Diseases and Related Health Problems* (ICD) Recommendation

Attachment G: World Professional Association for Transgender Health's *Standards of Care* Excerpt

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BLUEPRINTS FOR SOUND PUBLIC POLICY

Dr. Joycelyn Elders, MD, former US Surgeon General, Co-Chair
RADM Alan M. Steinman, MD, USPHS/USCG (Ret.), Co-Chair

REPORT OF THE TRANSGENDER MILITARY SERVICE COMMISSION

March, 2014

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Report of the Transgender Military Service Commission

Commission co-chairs:

Dr. Joycelyn Elders, MD, former US Surgeon General
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A nonpartisan national commission, comprised of medical and psychological experts, to consider whether Pentagon policies that exclude transgender service members are based on medically sound reasons.

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The Palm Center is a research initiative of the Political Science Department of San Francisco State University.

EXECUTIVE SUMMARY

1) This commission has been convened to determine whether US military policies that ban transgender service members are based on medically sound reasons. We find that there is no compelling medical rationale for banning transgender military service, and that eliminating the ban would advance a number of military interests, including enabling commanders to better care for their service members.

2) Medical regulations requiring the discharge of all transgender personnel are inconsistent with how the military regulates medical and psychological conditions, and arbitrary in that medical conditions related to transgender identity appear to be the only gender-related conditions requiring discharge irrespective of fitness for duty.

3) The American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders 5th ed. (DSM–5)* no longer classifies gender non-conformity as a mental illness. While military regulations are updated to reflect revisions of DSM for non-transgender-related conditions, regulations have not been amended to reflect scientific consensus about gender non-conformity.

4) The prohibition on medically necessary cross-sex hormone treatment is inconsistent with the fact that many non-transgender military personnel rely on prescribed medications, including anabolic steroids, even while deployed in combat zones, and is based on inaccurate understandings of the complexity, risks and efficacy of such treatments.

5) Regulations that prohibit transgender service members from obtaining medically necessary gender-confirming surgery are harmful to the service members and inconsistent with policy concerning other reconstructive surgeries that service members are allowed to have.

6) The ban on transgender military service compromises continuity of care between the Military Health Service and Veterans Health Administration, undermining an important goal that officials from both systems have endorsed.

7) Military regulations should be stripped of enlistment disqualifications for transgender conditions, whether defined physically or mentally, as well as retention provisions that specify gender identity disorder as grounds for administrative separation. Transgender personnel should be treated in accordance with established medical standards of care, as is done with all other medical conditions.

8) Senior leaders should rely on the experiences and standards of other militaries and US federal agencies in formulating administrative policy to address fitness testing, records and identification, uniforms, housing and privacy.

1) OVERVIEW

This Commission came together with the modest goal of assessing whether US military policies that ban transgender service members are based on medically sound rationales.[1] In the process of answering this question, we came to have a deeper appreciation for the consequences of these policies, and we were troubled by what we learned. We determined not only that there is no compelling medical reason for the ban, but also that the ban itself is an expensive, damaging and unfair barrier to health care access for the approximately 15,450 transgender personnel who serve currently in the active, Guard and reserve components.[2] Medical regulations requiring the discharge of transgender personnel are inconsistent with how the military regulates all other medical and psychological conditions, and transgender-related conditions appear to be the only gender-related conditions that require discharge irrespective of fitness for duty.

Medical standards for enlistment are generally designed to ensure that applicants are free of conditions that would interfere with duty performance, endanger oneself or others, or impose undue burdens for medical care. The regulations, however, bar the enlistment of transgender individuals regardless of ability to perform or degree of medical risk. Unlike other medical disqualifications, which are based on modern medical expertise and military experience, the transgender enlistment bar is based on standards that are decades out of date.

Medical standards for retention are generally designed to identify permanent medical conditions that cannot be corrected and are likely to affect, or have already affected, performance of duty. Existing regulations, however, give commanders complete discretion to separate transgender individuals without medical review ("for the convenience of the government"), regardless of ability to perform or degree of medical risk. As with the enlistment regulations, the retention regulations are inconsistent with modern medical understanding. They include transgender conditions on a list of disqualifying, maladaptive traits assumed to be resistant to treatment and inconsistent with either fitness for duty or good order and discipline. By regulation, service members are simultaneously barred from treatment and also presumed to be unfit, despite the lack of medical evidence to support the policy.

Research shows that depriving transgender service members of medically necessary health care poses significant obstacles to their well-being.[3] According to one recent study, "Mental health, medical and substance abuse services obtained outside of the military are supposed to be communicated back to the military, so transgender people who seek these services elsewhere still risk exposure…This leads individuals to go without treatment, allowing symptoms to exacerbate, and causing some to treat symptoms with alcohol or drugs, which could lead to substance abuse or dependence."[4] Research has confirmed, as well, that policies that force individuals to conceal their identities can have significant mental health consequences.[5]

Transgender medical care should be managed in terms of the same standards that apply to all medical care, and there is no medical reason to presume transgender individuals are unfit for duty. Their medical care is no more specialized or difficult than other sophisticated medical care the military system routinely provides. Transgender service members should not be required to meet a higher standard of medical self-sufficiency than the military requires of anyone

else. Existing policies and practices are adequate for identifying rare and extreme circumstances that may affect duty performance.

Removal of the military's blanket ban on transgender service members would improve health outcomes, enable commanders to better care for their troops, and reflect the federal government's commitment to reducing disparities in health care access for transgender people. According to a 2013 resolution introduced by the United States and passed unanimously by delegates to the Pan American Health Organization, member states agree to "work to promote the delivery of health services to all people…taking into account the diversity of gender expression and gender identity" and to "give priority to promoting equal access to health services in national policies."[6]

In 2012, a federal appellate court affirmed that denying prisoners medically necessary health care for transgender-related conditions violates the 8th Amendment's prohibition against cruel treatment.[7] While acknowledging significant differences that distinguish military and prison environments, when it comes to accessing health care, US service members' dependence on the Military Health System resembles prisoners' reliance on prison medical facilities. The ban on transgender military service should be eliminated, and the health care needs of transgender personnel should be addressed in the same way that medical needs of non-transgender personnel are managed.

2) DEMOGRAPHICS

The term *transgender* is a broad, umbrella term that refers to individuals who do not identify with the physical gender that they were assigned at birth. Being transgender does not mean that one has already transitioned to a different gender, or that such a transition will occur in the future. It means recognizing that the gender one has always had does not match the physical gender that was assigned at birth. The transgender community includes people who have already transitioned to the other gender, those who have not yet transitioned but who plan to do so, those who identify with the other gender but do not wish to transition, and others.[8] Individuals assigned female at birth who identify as male are referred to as female-to-male (FTM), while individuals assigned male at birth who identify as female are referred to as male-to-female (MTF).[9] There is no single medical treatment for transgender individuals who undergo gender transition. Surgical transition refers to the use of gender-confirming surgery to change one's gender, while medical transition refers to the use of surgery and/or cross-sex hormone treatment (CSH) to do so.

Social scientists estimate that there are 700,000 transgender American adults, representing .3 percent of the nation's adult population. In addition, Dr. Gary Gates and Dr. Jody Herman estimate that 15,450 transgender service members serve currently in the US armed forces, including 8,800 in the active component and 6,650 in the National Guard and reserve components, and that 134,350 veterans are transgender. Transgender adult citizens are more than twice as likely as non-transgender Americans (2.2 percent transgender vs .9 percent non-transgender) to serve currently in the military.[10] Survey data suggest that approximately 90 percent of transgender service members are MTF transgender women.[11]

Despite their service in the armed forces, little is known about transgender service members. Almost no scholarly research has been published on transgender military service, and the available body of literature includes just seven peer-reviewed and three non-peer-reviewed studies.[12] Of those ten studies, seven offer original empirical research, including five that include data on active-duty service members and veterans and two that focus exclusively on veterans.

3) REGULATIONS

3.a) Rationale for Regulations that Ban Transgender Service Members

Four themes characterize regulations banning transgender service members. In particular, the rules are (1) binding, in that there is no option or procedure for commanders or doctors to waive rules that disqualify transgender individuals for military service, either for accession or retention; (2) decentralized, in that they are articulated in different provisions of various Department of Defense Instructions; (3) unclear, in that regulatory terminology that references transgender identity is inconsistent; and (4) regulatory, not statutory. Because policies that prohibit transgender service are spelled out in Defense Department as well as service-specific regulations, but not in congressional statute, the Commander in Chief could change policy without obtaining congressional approval. That said, provisions of the Uniform Code of Military Justice that are not specific to transgender service members, such as conduct unbecoming, have been used as the basis for discharging these service members.

US military policies that ban transgender service members do not include rationales that explain why the armed forces prohibit them from serving, although the policies are embedded in comprehensive medical and other regulations that are designed, broadly speaking, to preserve health and good order. While regulations do not offer reasons for banning transgender service members, several transgender individuals have challenged the ban's lawfulness in court, and military representatives have presented rationales via testimony and affidavit. In *Doe* v. *Alexander* (1981), a federal district court noted "evidence that transsexuals would require medical maintenance to ensure their correct hormonal balances and continued psychological treatment and that the army would have to acquire the facilities and expertise to treat the endocrinological complications which may stem from the hormone therapy. The army might well conclude that those factors could cause plaintiff to lose excessive duty time and impair her ability to serve in all corners of the globe."[13] In testimony for *Leyland* v. *Orr* (1987), an Air Force consulting physician testified that assigning individuals who had undergone a sex change operation to remote geographic areas, "would be equivalent to placing an individual with known coronary artery disease in a remote location without readily available coronary care."[14]

Finally, in *DeGroat* v. *Townsend* (2007), an Air Force consulting physician stated that,

> The known and potential complications of sex change operations are many and varied and can affect the long term health and duty performance of the individual. Additionally, many of these patients are maintained on hormone therapy which independently has potential side effects. Further, individuals undergoing male to female gender conversions may encounter prostatic diseases which are more difficult to diagnose and to manage. Air Force duties require individuals from all

> career fields to serve in a variety of locations around the globe, often changing assignments on short-term notice. Military medical providers in the field are not familiar with the problems these patients may encounter. Individuals who have undergone sex change procedures would not be qualified for world-wide service and if the Air Force assigned them even to remote domestic locations they would be without access to potentially acute specialized tertiary medical care, which would only be available at major medical centers. Overall, it is neither in the best interest of the individual patient to have their access to necessary health care limited during potential Air Force duties, nor is it in the best interest of the Air Force to have to provide the medical care that these individuals may require.[15]

Scholars have been unable to uncover any documentation on the history of the rules or the reasons why they were enacted. Hence, the trial records discussed above offer the only available official rationales for US military policies banning transgender service members.

3.b) Regulations Banning Transgender Service Members

Policies governing transgender service can be broken down into two categories: accession disqualifications and retention disqualifications.

Accession disqualification: Department of Defense Instruction (DODI) 6130.03 establishes medical standards for entry into military service.[16] The purpose of the Instruction, as explained in an introductory section, is to ensure that individuals under consideration are free of contagious diseases that could endanger the health of other personnel, free of conditions or defects that may require excessive time lost from duty or that probably would result in separation, and medically capable of completing required training, adapting to military environments without geographic limitations, and performing duties without aggravating existing conditions.[17]

Enclosure 4 of DODI 6130.03 contains a list of disqualifying physical and mental conditions that preclude applicants from joining the military, and the list includes the following conditions, some of which are transgender-related: 14f. Female genitalia: History of major abnormalities or defects of the genitalia including but not limited to change of sex, hermaphroditism, pseudohermaphroditism, or pure gonadal dysgenesis…15r. Male genitalia: History of major abnormalities or defects of the genitalia such as change of sex, hermaphroditism, pseudohermaphroditism, or pure gonadal dysgenesis…25l. Endocrine and metabolic: Male hypogonadism…29r. Learning, psychiatric and behavioral: Current or history of psychosexual conditions, including but not limited to transsexualism, exhibitionism, transvestism, voyeurism, and other paraphilias.[18]

Medical regulations generally allow for waivers of accession standards under some circumstances. Under DODI 6130.03, the services shall "Authorize the waiver of the standards [for entry] in individual cases for applicable reasons and ensure uniform waiver determinations."[19] Service-specific implementing rules affirm the possibility of accession waivers. By Army rules, for example, "Examinees initially reported as medically unacceptable by reason of medical unfitness…may request a waiver of the medical fitness standards in accordance with the basic administrative directive governing the personnel action."[20]

While accession standards allow for the possibility of waivers, they also specify that accession waivers will not be granted for conditions that would disqualify an individual for the possibility of retention: "Waivers for initial enlistment or appointment, including entrance and retention in officer procurement programs, will not be granted if the applicant does not meet the retention standards."[21] As discussed below, because some conditions related to transgender identity are grounds for discharge, and because recruiters cannot waive a condition upon enlistment that would be disqualifying for retention, transgender individuals cannot obtain medical waivers for entrance into the military. In response to a 2013 Freedom of Information Act (FOIA) request, the Pentagon disclosed that between 2008 and 2012, three individuals had been denied entry into the military for transgender-related conditions. We are unaware of any instances in which transgender-related conditions have been waived for accession.

Retention disqualification: Medical standards that apply to the retention of individuals already in military service generally are more accommodating and flexible than accession standards, due to the investment that the military makes in training. DODI 1332.38 contains rules for retiring or separating service members because of physical disability, and includes an Enclosure 4 (similar to the Enclosure 4 of DODI 6130.03 discussed above) listing medical conditions and physical and psychiatric diagnoses that require referral for physical disability evaluation.[22]

Not all medical conditions, however, are eligible for physical disability evaluation. Unlike regulations governing entry, regulations governing retention divide potentially disqualifying conditions into two tracks. Individuals with conditions deemed "physical disabilities" (Enclosure 4 conditions) are tracked into a medical system of physical disability evaluation, leading to a determination of fitness for duty or entitlement to benefits for medical separation or retirement. However, service members with conditions "not constituting a physical disability" (Enclosure 5 conditions) can be separated administratively from military service at a commander's discretion, without the same opportunity to demonstrate medical fitness for duty or eligibility for disability compensation. Enclosure 5 of DODI 1332.38 diverts service members out of the medicine-based physical disability system and into the commander-based system for administrative separation, and renders them ineligible for physical disability evaluation. Enclosure 5 lists more than twenty conditions and circumstances defined by the regulation as "not constituting a physical disability," including "Sexual Gender and Identity Disorders, including Sexual Dysfunctions and Paraphilias."[23]

DODI 1332.14 controls administrative separations for enlisted persons (DODI 1332.30 controls for officers), and the policies behind administrative separation emphasize conduct and discipline, not medical fitness.[24] A service member may be separated for the convenience of the government and at the discretion of a commander for "other designated physical or mental conditions," a category defined to include "sexual gender and identity disorders."[25] However, the regulation contains no specific guidance for determining whether, or under what circumstances, "sexual gender and identity disorders" interfere with assignment or performance of duty. The regulation appears to conclude that any of the conditions listed in DODI 1332.38 Enclosure 5 automatically meet that standard, giving commanders unguided discretion to proceed. Unlike the regulation governing physical disability evaluation, DODI 1332.14 does not offer service members the

opportunity to concede that a condition exists and then to demonstrate that it does not affect their fitness for duty.

Commanders do not of course seek out every individual with an Enclosure 5 condition and discharge them, and whether a "convenience of the government" separation will be initiated, or not, is at the discretion of the commander. But when Enclosure 5 of DODI 1332.38 lists "sexual gender and identity disorders" as conditions that are inherently maladaptive in military service, that is a strong statement about disqualification, and there is no suggestion in any of the regulations that transgender-related conditions may under some circumstances be consistent with military service. To the contrary, the regulations suggest that separations for transgender-related conditions would always be appropriate.

Some commanders do appear to believe that they have the discretion to retain transgender service members in the same way that they may retain people with other Enclosure 5 conditions if they are performing well enough. But that is not a distinction written into the regulations. In response to a recent FOIA request for discharge data, a Pentagon spokesperson said that the military does not track the number of service members who have been separated for transgender-related reasons. We are aware, however, of approximately two dozen service members who have been discharged because of their transgender identity in recent years.

In addition to the accession and retention regulations discussed above, some aspects of transgender military service are governed by other rules. For example, transgender service members may violate orders for receiving undisclosed or prohibited medical treatment if they obtain health care from non-military doctors without receiving permission from commanders.[26]

4) MEDICAL ASPECTS OF TRANSGENDER SERVICE

4.a) Mental Health

As discussed above, some regulatory provisions that prohibit transgender service emphasize psychological factors. In turn, scholars have found that some transgender service members report poor mental health. One recent study concluded that the transgender community faces, "elevated rates of suicide, risk for HIV infection, exposure to trauma, and other health challenges."[27] In a sample of 1,261 transgender respondents with prior military service, 40 percent had attempted suicide.[28] Among 70 veterans evaluated for gender identity disorder between 1987 and 2007, 4 percent "had actively harmed their genitals," 61 percent "revealed a history of serious suicidal thoughts," and 43 percent "had additional psychiatric diagnoses exclusive of [gender identity disorder]."[29]

Despite such data, arguments based on mental health are not convincing rationales for prohibiting transgender military service, and DODI 6130.03 is not consistent with modern medical understanding.[30] Indeed, scientists have abandoned psychopathological understandings of transgender identity, and no longer classify gender non-conformity as a mental illness.

"Transsexualism" was eliminated as a diagnosis by the *DSM-IV* in 1994 and replaced by gender identity disorder. Yet *DSM-IV* did not classify gender identity disorder as a paraphilia. In the

newest edition of the *Diagnostic and Statistical Manual* (*DSM-5*), gender identity disorder has been replaced with gender dysphoria, a diagnostic term that refers to an incongruence between a person's gender identity and the physical gender that they were assigned at birth, and to clinically significant distress that may follow from that incongruence.[31] While gender identity disorder was pathologized as an all-encompassing mental illness, gender dysphoria is understood as a condition that is amenable to treatment.[32] And, mental health professionals agree that not all transgender individuals suffer from dysphoria.

The World Health Organization's Working Group on the Classification of Sexual Disorders and Sexual Health (WGCSDSH) has recommended that the forthcoming version of the *International Statistical Classification of Diseases and Related Health Problems* (ICD-11), due for publication in 2015, "abandon the psychopathological model of transgender people based on 1940's conceptualizations of sexual deviance."[33] According to a recent publication by WGCSDSH members, "once-prevailing views that reject the aim of supporting transition are no longer part of the mainstream of either psychiatric or general medical thought and practice…[and] the continued linkage of gender identity diagnoses with paraphilias and diagnoses of sexual dysfunction in the classification system appears to be both outdated and inappropriate."[34]

The reclassification of transgender identity in both DSM and ICD is based, in part, on the understanding among scientists and medical practitioners that distress can be the result of prejudice and stigmatization, not mental illness, and that many individuals who do not identify with the physical gender that they were assigned at birth do not suffer from clinically significant distress, and therefore do not have a medical or psychological condition.[35] WGCSDSH members wrote recently that, "there are individuals who today present for gender reassignment who may be neither distressed nor impaired."[36] The high reported rates of distress among transgender veterans and service members have been based on clinical samples that over-represented patients requiring psychological care. And, a significant body of evidence shows that treatment can alleviate symptoms among those who do experience distress. A meta-analysis of more than 2,000 patients in 79 studies published between 1961 and 1991 found "Favorable effects of therapies that included both hormones and surgery...Most patients reported improved psychosocial outcomes, ranging between 87% for MTF patients and 97% for FTM patients."[37] Satisfaction rates have increased over time: "studies have been reporting a steady improvement in outcomes as the field becomes more advanced."[38]

Defense Department rules concerning mental health, deployment and fitness for duty do not regulate gender identity in a manner that is consistent with the management of other psychological conditions, and have the effect of singling out transgender personnel for punishment even when they are mentally healthy. For example, DODI 6130.03 prohibits individuals suffering from serious mental illnesses such as autistic, schizophrenic and delusional disorders from enlisting in the armed forces. Yet for less serious disorders, regulations strike a careful balance between admitting those whose conditions can be managed without imposing undue burdens on commanders or doctors while excluding those whose conditions would impair their service. Thus, individuals with Attention Deficit Hyperactivity Disorder are prohibited from enlisting unless they meet five criteria including documenting that they maintained a 2.0 grade point average after the age of 14. Similarly, individuals with simple phobias are banned from

enlisting unless they meet three criteria including documenting that they have not required medication for the past 24 continuous months.

Retention regulations strike a balance as well. For those who develop mood or anxiety disorders while in the military, regulations require a referral for physical disability evaluation only if their condition requires extended or recurrent hospitalization or interferes with duty performance. And, service members requiring medication for mood and anxiety disorders are not categorically barred from deployment. The determination depends on the seriousness and stability of the condition, logistical difficulties in providing medication, and the need for clinical monitoring.

Finally, empirical data suggest that many non-transgender service members continue to serve despite psychological conditions that may not be as amenable to treatment as gender dysphoria. A 2012 meta-analysis of available scholarship estimated that 5.7 percent of active-duty service members who had never been deployed suffered from major depressive disorder, and that the prevalence rate among deployed service members was approximately 12 percent.[39] In 2009, at least 15,328 service members were hospitalized for mental health disorders, and the *Los Angeles Times* reported in 2012 that, "110,000 active-duty Army troops last year were taking prescribed antidepressants, narcotics, sedatives, antipsychotics and anti-anxiety drugs."[40] According to the Congressional Research Service, "Between 2001 and 2011…[a] total of 936,283 servicemembers, or former servicemembers during their period of service, have been diagnosed with at least one mental disorder over this time period…Nearly 49% of these servicemembers were diagnosed with more than one mental disorder."[41] During manpower shortages, non-transgender individuals whose psychological well-being has not met entrance standards outlined in DODI 6130.03 have been able to obtain waivers allowing them to enlist in the military. According to the National Academy of Sciences, 1,468 of the 4,303 applicants (34 percent) who failed to meet psychiatric entrance standards from May 1, 2003, thru April 30, 2005, received waivers.[42]

Despite its legitimate need to screen out individuals suffering from mental illnesses that would impair their service, the Defense Department allows those with manageable conditions to enlist and serve. For psychological conditions that fall short of schizophrenia, autism, and other serious illnesses, military regulations strike a thoughtful balance between these two goals. In contrast, Defense Department regulations that govern service by transgender personnel, who frequently do not suffer from distress, make no such distinction, banning all transgender individuals who seek entrance into the military and requiring the automatic discharge of all transgender personnel. And, military regulations conflate transgender identity with mental illness, even though APA and WHO have abandoned psychopathological models, and even though scientists have concluded that transgender and transsexual identity do not always entail distress and that treatments are effective for alleviating symptoms among those who do experience distress.

The British regulatory provision on mental health and transgender military service may warrant consideration at this point: "Although transsexual people generally may have an increased risk of suicide, depression and self-harm, transsexual applicants should not automatically be referred to a Service Psychiatrist. Transsexual applicants with no history of mental health problems or deliberate self-harm who meet other fitness standards should be passed as being fit to join the Armed Forces."[43]

4.b) Cross-Sex Hormone Treatment

Although regulations prohibit service members from intervening surgically to modify their genitals, they are not prohibited explicitly from obtaining cross-sex hormone treatment. That said, the use of hormones to modify primary or secondary sex characteristics would almost certainly constitute evidence of having a transgender identity, which is grounds for discharge.

Many, but not all, transgender people wish to take cross-sex hormones in order to achieve feminization or masculinization of their hair and fat distribution, genitalia, and musculature, and to achieve and maintain a gender presentation consistent with their gender identity. Hormonal therapy for male-to-female (MTF) reassignment involves medications that block the production and effects of testosterone (anti-androgen therapy) and simultaneously produce feminizing effects (estrogen therapy). Several classes of medications decrease testosterone level. Spironolactone is generally safe and inexpensive and is most commonly used. Most primary care providers are familiar with its use, as it is commonly prescribed for other conditions. Spironolactone decreases libido, prostate size, erections and the growth of hair on the face and body, and causes some breast growth.

Estrogens that augment breast size and redistribute body fat are the main medications that promote feminization. Generally, feminizing effects are first noticeable in three to six months with an expected maximum effect after two to three years of treatment. That said, the degree and timing of the changes can differ from person to person. For female-to-male (FTM) patients, the main treatment for hormonal reassignment is testosterone, which can be administered through patches, gels, or injection and which usually produces satisfactory results. Masculinizing hormone therapy tends to lower the voice, produce body and facial hair, enhance upper body musculature and strength, and it also ends menses. Most effects take place beginning at eight weeks and maximize at about two years and vary depending on age and genetic make-up.

Cross-sex hormone administration is currently an off-label use of both estrogens and androgens, and entails some degree of risk, dependent on the type of medication, dose, route of administration, and patient's age, health, family history and health habits.[44] Feminizing hormones are associated with increased risk of weight gain, hypertriglyceridemia, gallstones and elevated liver enzymes. Oral estrogen may increase risk for venous thromboembolic disease and Type 2 diabetes, though this effect is attenuated for transdermal estrogen. The most serious risks of masculinizing hormones are weight gain, acne, sleep apnea, balding, and polycythemia (increased production of red blood cells).[45] For these reasons, laboratory monitoring is recommended before starting any hormone regimen. Clinical monitoring for effect is not complicated, and involves simple clinical exams and assessments of patient satisfaction. With appropriate training and/or access to expert consultation, independent duty corpsmen, physician assistants, and nurses can supervise hormone treatment initiated by a physician.

Despite the risks associated with hormone replacement, over 50 years of clinical experience have demonstrated that hormones are an effective treatment for gender dysphoria, that psychological benefits follow from cross-sex hormone administration, and that the incidence of complications is quite low.[46] Studies looking at the risk of blood clots from estrogen found an occurrence of anywhere from 0 to 142 blood clots per 10,000 people per year, with much lower rates in more

recent studies with newer estrogens and non-oral administration.[47] Clinics with a high volume of transgender patients on estrogen therapy report having "rarely seen adverse effects."[48]

While the use of hormones may entail some risk, the military consistently retains non-transgender men and women who have conditions that may require hormone replacement. For example, gynecological conditions listed in DODI 1332.38 Enclosure 4 (dysmenorrhea, endometriosis, menopausal syndrome, chronic pelvic pain, hysterectomy, or oophorectomy) require referral for evaluation only when they affect duty performance. And, the only male genitourinary conditions that require referral for evaluation involve renal or voiding dysfunctions. The need for cross-sex hormone treatment is not listed as a reason for referral for either men or women. The military also allows enlistment in some cases despite a need for hormone replacement. DODI 6130.03, for example, does not disqualify all female applicants with hormonal imbalance. Polycystic ovarian syndrome is not disqualifying unless it causes metabolic complications of diabetes, obesity, hypertension, or hypercholesterolemia. Virilizing effects, which can be treated by hormone replacement, are expressly not disqualifying.

Hormonal conditions whose remedies are biologically similar to cross-sex hormone treatment are grounds neither for discharge nor even for referral for medical evaluation if service members develop them once they join the armed forces. Male hypogonadism, for example, is a disqualifying condition for enlistment, but does not require referral for medical evaluation if a service member develops it after enlisting. Similarly, DODI 6130.03 lists "current or history of pituitary dysfunction" and various disorders of menstruation as disqualifying enlistment conditions, but personnel who develop these conditions once in service are not necessarily referred for evaluation. Conditions directly related to gender dysphoria are the only gender-related conditions that carry over from enlistment disqualification and continue to disqualify members during military service, and gender dysphoria appears to be the only gender-related condition of any kind that requires discharge irrespective of ability to perform duty.

Military policy allows service members to take a range of medications, including hormones, while deployed in combat settings. According to a comprehensive Defense Department study, 1.4 percent of all US service members (approximately 31,700 service members) reported prescription anabolic steroid use during the previous year, of whom 55.1% (approximately 17,500 service members) said that they obtained the medications from a military treatment facility. One percent of US service members exposed to high levels of combat reported using anabolic steroids during a deployment.[49] According to Defense Department deployment policy, "There are few medications that are inherently disqualifying for deployment."[50] And, Army deployment policy requires that, "A minimum of a 180-day supply of medications for chronic conditions will be dispensed to all deploying Soldiers." A former primary behavioral health officer for brigade combat teams in Iraq and Afghanistan told *Army Times* that "Any soldier can deploy on anything."[51] Although Tricare officials claimed not to have estimates of the amounts and types of medications distributed to combat personnel, Tricare data indicated that in 2008, "About 89,000 antipsychotic pills and 578,000 anti-convulsants [were] being issued to troops heading overseas."[52] The Military Health Service maintains a sophisticated and effective system for distributing prescription medications to deployed service members worldwide.[53]

Our nearest allies, Canada, the United Kingdom and Australia, have determined that the risk of deploying transgender service members on cross-sex hormone treatment is low, and post-

transition individuals from Canada and the United Kingdom have completed tours in Afghanistan. The US has deployed a post-operative transgender member of the Military Sealift Command repeatedly on Navy ships.[54]

4.c) Gender-Confirming Surgery

The consensus of the medical profession, as reflected in official policies of the American Medical Association, American Psychological Association and Endocrine Society, is that gender-confirming surgeries can be medically necessary for some transgender individuals to mitigate distress associated with gender dysphoria. Surgeries include chest reconstruction and surgeries to create testes (scrotoplasty) and penises (phalloplasty or metoidioplasty, with or without urethral lengthening) for FTM's, and facial feminization, breast augmentation and surgeries to remove testes (orchiectomy) and create vaginas (vaginoplasty) for MTF's. That said, other transgender individuals do not want or require surgery to alleviate symptoms. A recent study noted that, "As the field matured, health professionals recognized that while many individuals need both hormone therapy and surgery to alleviate their gender dysphoria, others need only one of these treatment options and some need neither. Often with the help of psychotherapy, some individuals integrate their trans- or cross-gender feelings into the gender role they were assigned at birth and do not feel the need to feminize or masculinize their body. For others, changes in gender role and expression are sufficient to alleviate gender dysphoria. Some patients may need hormones, a possible change in gender role, but not surgery; others may need a change in gender role along with surgery but not hormones."[55]

In considering the question of gender-confirming surgery among military personnel, it is important to recognize that regulations permit service members to have elective cosmetic surgeries at military medical facilities, and that some of those elective procedures risk post-operative complications that can be more serious than those of medically necessary gender-confirming surgeries.[56] For example, the LeFort osteotomy procedures and mandibular osteotomies that service members may elect to have are associated with a number of possible complications based upon the technique, surgical level, and anatomic site at which the surgery/osteotomies are performed.[57] The incidence of complications in craniofacial surgery depends upon the type of surgery and anatomic location at which the procedure is performed, and infection rates may range from approximately 1 to 3 percent.[58] Additional complications following mandibular osteotomies, such as sensory deficit, may range between 24 to 85 percent, and unfavorable fractures associated with sagittal split osteotomies may range between 3 to 23 percent.[59] Other studies cite complication rates of LeFort I osteotomies at 6.4 percent, including anatomic complications, bleeding requiring transfusion, infection, ischemic complications such as aseptic necrosis, and insufficient fixation.[60] Treatment for these complications may require additional surgical or other interventional procedures, antibiotics, and/or local wound care.

Even if the Military Health Service provided gender-confirming surgeries, however, the demand for such procedures would be low. Research on civilian employers whose insurance plans cover transition-related health care has found that very few employees submit claims for such benefits in any given year. If extrapolated to the active, Guard and reserve components of the military, the data suggest that if transgender service members were allowed to serve, and if the military covered medically necessary care related to gender transition, fewer than 2 percent of transgender service members, a total of 230 individuals, would seek gender-confirming surgery

in any particular year.[61] A recent study reported the average cost of transition-related health care at $29,929.[62]

As with any surgical procedures, gender-confirming surgeries entail a risk of short-term and chronic post-operative complications.[63] Gender-confirming procedures that pertain to the breasts and chest tend to entail low complication rates. MTFs who undergo breast augmentation as a single surgery often are discharged the same day with pain medication and antibiotics. They leave their dressings intact for three days following surgery and the steri-strips along the points of incision are left in place for another week. Patients are generally comfortable within two days and return to regular activities within two weeks, though doctors recommend that they avoid exerting themselves for a month. Surgeries involving the genitourinary system can be riskier. For MTF individuals, surgery on the external genitalia typically entails a penectomy, bilateral orchiectomy, vaginoplasty (including formation of the labia major and minora), clitoroplasty, and urethral shortening. For vaginoplasty, patients are hospitalized for six to eight days. MTFs who have this surgery will start to feel more comfortable after one to two weeks and will be asked to return to the clinic for periodic follow-up visits, though strenuous activity typically is avoided for three months.

Despite the possibility of post-operative complications, research shows that their incidence rate is low. Across 15 studies from 1986 to 2001, 2.1 percent of patients had rectal-vaginal fistula, 6.2 percent with vaginal stenosis, 5.3 percent had urethral stenosis, 1.9 percent with clitoral necrosis, and 2.7 percent with vaginal prolapse.[64] A follow-up study of 80 women who had vaginoplasties found three post-operative complications and another determined that among 89 vaginoplasties, there was one major complication.[65] If transgender service members were allowed to serve and to have gender-confirming surgery while in the military, we estimate that ongoing post-operative complications would render ten MTF service members unfit for duty each year.[66]

For FTM individuals, surgery on the genitalia can include a vaginectomy, either metoidioplasty (clitoral lengthening with or without urethral lengthening) or phalloplasty (either pedicled flap or free tissue transfer, with or without urethral lengthening), and scrotoplasty (with placement of testicular prostheses). Additionally, some individuals undergo hysterectomy and bilateral salpingo-oophorectomy. Phalloplasty is a lengthy multiple stage process, and a majority of FTM patients do not undergo any genital surgery except for a hysterectomy and the removal of the fallopian tubes and ovaries. For FTMs who desire both top (chest) and bottom (genital) surgeries, the timeline is more complex than for MTFs. The chest surgery can be completed at the same time as a hysterectomy and oophorectomy, and in most cases patients are discharged the following day. After a mastectomy, FTMs are back to their normal routines in one to two weeks but should avoid strenuous activity for four weeks. FTMs who have had a hysterectomy or oophorectomy can be required to wait four to six months until they can undergo additional genital surgeries, though hysterectomy and oophorectomy may be performed simultaneously with genital reconstruction. Those having urethral lengthening are generally hospitalized five to ten days. Phalloplasty is more complicated, and the expected hospital time can be ten to fourteen days, with a catheter required for up to three weeks.[67]

Research suggests that a minority of individuals having female-to-male genital surgery may expect long-term complications that would require ongoing care.[68] In a study of 56 FTM patients

in France who had a phalloplasty, 25 percent had complications including infection and hematoma. In the same study, 29 percent of those with a penile prosthesis had mechanical or infective complications.[69] In another study in the UK of 115 FTMs who underwent total phallic reconstruction from 1998 to 2008, 10.4 percent experienced partial skin necrosis, 4.3 percent had infection, and 2.6 percent had phalluses that were lost.[70] That said, very few FTMs have genital surgery, and out of 1,594 FTMs who responded to a recent survey, only 48 individuals (3 percent) had genital surgery, including 24 who had metoidioplasty and phalloplasty, 1 who had just phalloplasty, and 23 who had just metoidioplasty.[71] Given such low demand, even using conservative assumptions it is estimated that only 6 post-operative FTM transgender men would become unfit for duty each year as a result of ongoing, post-operative complications following genital surgery.[72]

In sum, while the risks of genital surgery are real, they are no higher than risks associated with other genitourinary procedures, and they are lower than risks that accompany some elective non-transgender-related surgeries which the military allows and which, unlike genital surgeries for transgender individuals, are cosmetic and not medically necessary. As well, the low rate of demand for genital surgeries would mean that in absolute and relative terms, allowing such procedures would place almost no burden on the military.

4.d) Deployment

In explaining the military's ban on transgender service, and as noted above, spokespersons have emphasized non-deployability, medical readiness and constraints on fitness for duty as reasons why transgender service members should not be allowed to serve. While personnel policy must of course be designed to promote deployability and medical readiness, arguments invoked to oppose transgender service on these grounds do not withstand scrutiny. With few exceptions, transgender service members are deployable and medically ready. As noted in other sections of this report, cross-sex hormone treatment and mental health considerations do not, in general, impede the deployability of transgender service members, and the public record includes instances in which transgender individuals deployed after having undergone transition.[73] With two exceptions, all transgender service members who are otherwise fit would be as deployable as their non-transgender peers. The first exception is post-operative transgender service members whose genital surgeries result in long-term complications. Using conservative assumptions, as noted earlier, an estimated 16 post-operative service members (ten MTF transgender women and six FTM transgender men) would become permanently undeployable each year as a result of ongoing post-operative medical complications following genital surgery.

The second exception would be those undergoing surgical transition while in service. But the number of service members undergoing surgical transition in any given period would be low, both in relative and absolute terms, either because they would have already transitioned prior to joining the military, would prefer to wait until the end of military service to transition, or would not want to surgically transition, regardless of the timing. As discussed above, if the military's health care program paid for transition-related coverage, fewer than 2 percent of transgender service members, a total of 230 individuals, would seek gender-confirming surgery each year. With very few exceptions, transgender service members would be deployable and medically ready on a continuous basis.

Straightforward and fair-minded regulatory options are available for managing transgender military service and deployability. According to Army regulations, which, as explained above, do not apply to transgender-related conditions, "Personnel who have existing medical conditions may deploy" if deployment is unlikely to aggravate the condition, if an unexpected worsening of the condition would not pose a grave threat, if health care and medications are immediately available in theater, and if "no need for significant duty limitation is imposed by the medical condition."[74] British military policy concerning transgender service and deployability is equally sensible: "Applicants who are about to undergo, or are still recovering from surgery to change the external appearance of their body into that of the acquired gender should be graded P8 [medically unfit], as with any other condition that is being treated or requires surgery at the time of application, until they are fully recovered from the surgery."[75]

Many non-transgender service members are temporarily or permanently non-deployable, but they are not automatically discharged as a result, and military policies accommodate them within reason. Defense Department regulations confirm that when evaluating a service member's fitness for duty, non-deployability is not grounds for a determination of unfitness: "Inability to perform the duties of his or her office, grade, rank, or rating in every geographic location and under every conceivable circumstance will not be the sole basis for a finding of unfitness."[76] Even service members who are permanently constrained by serious medical conditions and defects are allowed, under some circumstances, to remain in the military. According to DODI 1332.38, "A service member who has one or more of the listed conditions or physical defects is not automatically unfit," including systemic diseases such as tuberculosis, leprosy, lymphoma, leukemia, or Hodgkin's disease.[77] Regulations provide service members suffering from these and other serious, non-transgender-related, medical conditions with opportunities to serve in a limited capacity and to recover: "A member previously determined unfit and continued in a permanent limited duty status…may be determined fit when the member's condition has healed or improved so that the member would be capable of performing his or her duties in other than a limited duty status."[78]

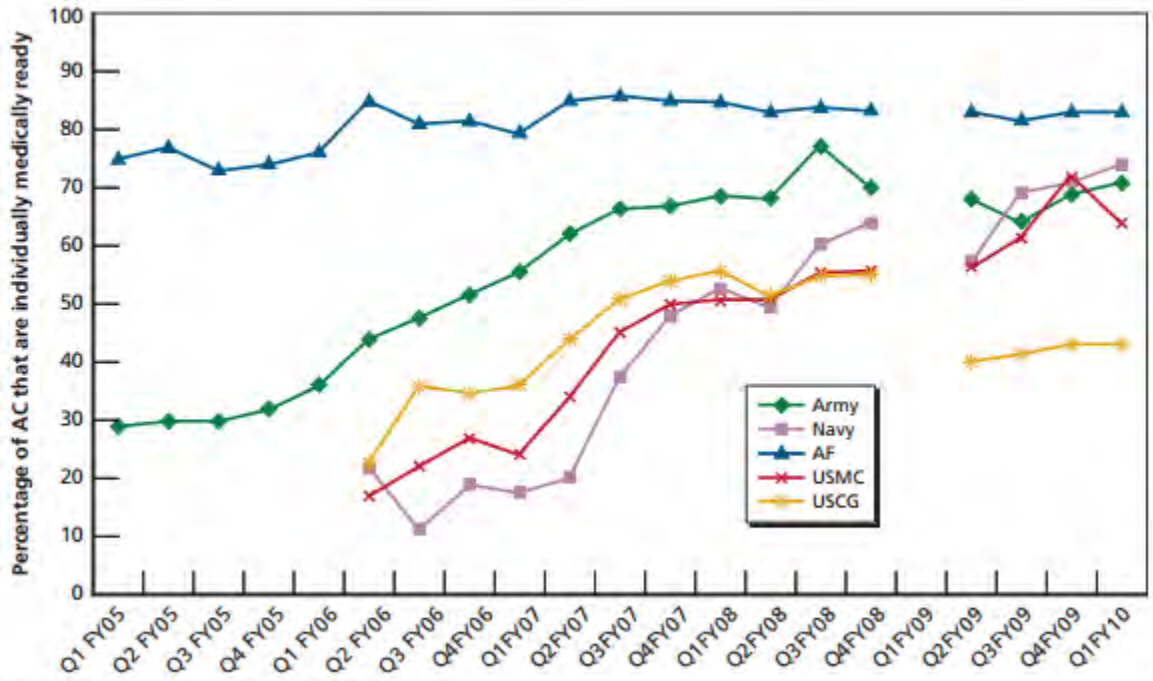
Although deployability is a crucial component of readiness, many non-transgender service members are temporarily or permanently non-deployable. According to a 2011 Defense Department study of health-related behaviors, 16.6 percent of active duty service members (244,000 service members) were unable to deploy during the twelve-month period prior to the survey's administration, including 22.5 percent of Marines. Service members who were temporarily or permanently non-deployable cited a variety of factors including injuries (31.5 percent), illness or medical problems (23.4 percent), pregnancy (9.9 percent), mental health (8.1 percent), family reasons (3.3 percent) and other unspecified reasons (29.9 percent). Another 2.2 percent of the active component returned early from a deployment during the previous year.[79]

Yet non-transgender, non-deployable service members are not automatically banned, and policies accommodate them to the extent possible. Indeed, the services have adopted leave and assignment policies that provide for prolonged absences and restrictions on duty as a result of medical conditions, as well as life choices that service members make. These include ordinary and advance leave. By law, members of the armed forces are entitled to 30 days of paid leave per year (generally referred to as "ordinary" or "annual" leave), accruing at a rate of 2½ days per month.[80] Service members need not provide any justification in order to take their annual leave. On the contrary, military commanders "shall encourage and assist all Service members to use" their

leave.[81] Leave is scheduled "consistent with operational requirements, training workloads, and the desires of the Service member," including "at least one extended leave period each year of approximately 14 consecutive days in length or longer."[82]

Service members are permitted to accumulate up to 60 days of ordinary leave under normal circumstances, and may accrue up to 120 days when deployed to certain areas or performing duties designated by the Secretary of Defense.[83] They may also be extended up to 30 days of "advance leave" after their ordinary leave has been used up.[84] While the operational needs of the service are critical considerations, existing military law and policy contemplate that members may be absent from duty for extended periods of time. On average, service members are expected to be absent one month out of every twelve, and military regulations provide for absences of up to 90 days per year without regard to medical needs or other special considerations.

Figure 2: Individual Military Readiness Rates, Active Component, 2005-2010



From *Medical Readiness of the Reserve Component*, Rand Corporation, 2012

Service members may also be granted special leave on top of their ordinary leave. This leave is in addition to the 30 days per year provided for by federal law and is not counted against the member's ordinary leave balance. Some special leave, like the 60 days allowed on graduation from service academies such as West Point, is clearly not meant to be used more than once.[85] Other special leave, however, can be used multiple times. For example: the armed forces give special leave to personnel who have children while on active duty. New mothers can take up to 42 days of maternity leave after delivery, and a service member whose spouse gives birth can take 10 days of parental leave (formerly called "paternity leave").[86] Adoptive parents are granted 21 days of special leave, which can be taken any time up to one year after the adoption is

complete.[87] The regulations do not restrict the number of times such leave can be taken. Mothers of newborn children and single parents who adopt also receive a 120-day deferment from assignments overseas where dependents are not authorized to travel typically, imminent danger or hostile fire areas.[88] Service members can elect to waive the deferment, but are not required to do so.[89]

In addition to the elective leave programs, the services provide for situations in which a member may be absent owing to a medical condition or procedure. A member unable to be present for duty due to hospitalization is excused from duty while hospitalized. The absence is not counted against the member's leave balance. Members recovering from medical procedures or illnesses can also be granted convalescent leave of up to 30 days, as directed by their unit commander or by the commander of their military hospital; this leave is likewise not charged against their ordinary leave.[90] Longer periods of convalescence may be authorized under procedures determined by each service. In the Army, for example, any period of convalescent leave exceeding 30 days requires approval by the local military hospital commander.[91]

Military convalescent leave policy does not discriminate against elective procedures such as Botox treatments and "plastic surgery for unacceptable cosmetic appearance."[92] Soldiers receiving such procedures may be expected to reimburse the service for their cost, but they "will be afforded convalescent leave and will not be required to use regular leave for their post-operative recovery."[93] Finally, the services recognize that members may on occasion have medical conditions which limit their availability to be assigned overseas. Members with such medical conditions may be deferred from reassignment for up to 12 months.[94] Personnel with more persistent medical needs are given assignment limitation codes and may be excluded from overseas service altogether, while still remaining on active duty.[95]

The concerns of the judge in the *Alexander* case notwithstanding, existing military policies and procedures are designed to ensure a capable fighting force while at the same time anticipating and providing for prolonged absences by service members based on medical conditions, elective medical procedures, personal life choices, and morale and personal welfare. Transgender service members, however, are automatically discharged, in part because of assumed constraints on their deployability and medical readiness, even though such constraints would apply to no more than a few hundred transgender service members at any one time. In contrast, non-transgender service members are given multiple opportunities to demonstrate their deployability and fitness for duty despite medical limitations, and many are retained even if they are not fully deployable or fit. Even those service members deemed permanently unfit "may be retained as an exception to the general policy rule" if their skills or experience warrant continuing service.[96]

4.e) Adaptability and Continuity of Care

While some experts have cited difficulties associated with the acquisition of competence as an argument against transgender military service, acquiring the skills necessary for providing transgender-related health care would advance military interests in a number of ways.[97] MHS's acquisition of competence would enhance the well-being of the estimated 15,450 transgender service members who serve currently. Medical research has demonstrated that "hormone therapy and surgery have been found to be medically necessary to alleviate gender dysphoria in many

people," and that treatment is effective in promoting the emotional and physical well-being of transgender individuals.[98]

MHS's acquisition of competence in the provision of transgender-related health care would promote continuity of care between the MHS and the Veterans Health Administration (VHA). Military as well as VHA officials have acknowledged the importance of continuity of care as a cost-saving measure and because continuity improves health-related outcomes.[99] And officials representing both medical systems have expressed their commitment to promoting continuity for service members transitioning from the armed forces to veteran status.[100] The regulatory requirement for the VHA to provide all transgender-related health care (aside from gender-confirming surgery) and for the military to deny it undermines continuity of care and imposes unnecessary costs on the VHA. For example, a service member whose depression could have been avoided through the provision of proper care during active service may require, upon separation from the military, significantly more interventions from VHA clinicians than would have been the case if MHS had provided appropriate and timely care.

The VHA, the largest health care system in the country, has provided all transgender-related health care except for gender-confirming surgery since the June, 2011, promulgation of VHA Directive 2011-024, "Providing Health Care for Transgender and Intersex Veterans." Since that time, VHA has disseminated its new treatment standard via internal mechanisms such as an intranet SharePoint site, and VHA's Transgender Education Workgroup has produced webinar trainings about cultural competence, mental health and cross-sex hormone treatment. VHA's Pharmacy Benefits Management Office has collaborated with LGBT Program Coordinators and experts in the Office of Health Equity to develop hormone treatment guidelines which have been distributed widely throughout the system. Permanent, recurring LGBT psychology fellowships have been established at nine VA facilities, and VHA has established four Transgender E-Consultation teams to support health care providers throughout the system. Medical systems of foreign militaries have adapted to the decision to provide transgender-related health care as well. It is clear that MHS will adapt and acquire the competence the VHA has worked to build when the ban on transgender military service is lifted.

MHS has demonstrated repeatedly that it is able to institute rapid, service-wide changes in policy and procedures when faced with new diseases, operational contingencies, legislative mandates, and economic and/or political requirements. For example, the management of battlefield injuries illustrates MHS's ability to respond to changing external realities, in this case the evolving face of wartime trauma. The Iraq and Afghanistan theaters of operation produced a large number of casualties that were managed with the most modern advancements in diagnosis, transportation and treatment. Lessons learned in all three phases were rapidly transmitted service-wide, permitting bottom-up recommendations for policy changes at the highest levels of MHS and resulting in unprecedented success in reducing morbidity and mortality. Telemedicine expertise at Landstuhl Regional Medicine Center in Germany (usually the first tertiary medical facility to receive battlefield injuries from Iraq or Afghanistan) established a system that "allow[ed] (1) rapid dissemination of lessons learned, (2) establishment of process and problem ownership, (3) rapid dissemination of policy change recommendations, (4) improved medical/surgical management efficiencies, and (5) state-of-the-art innovations in overall trauma care and

development of standardized trauma clinical practice guidelines and protocols to facilitate reductions in mortality and morbidity rates in this unique trauma population."[101]

Other examples of significant changes in MHS policies and protocols include: physical profiling of active duty members by measuring fitness capabilities;[102] development of quality assurance programs in the delivery of health care;[103] development of executive skills required for management of major military treatment facilities;[104] development and evolution of dependent medical care;[105] changing weight standards for active duty personnel;[106] and, of course, the requisite changes following the repeal of "don't ask, don't tell."[107]

5) POLICY RECOMMENDATIONS

The regulatory revisions that this commission recommends are simple, straightforward and fair. They improve care for US service members without burdening the military's pursuit of its vital missions.

Recommendation #1: Lift the ban on transgender military service. With respect to medical regulations, the Commander in Chief should order the Defense Department to eliminate bars to transgender military service by updating enlistment regulations that disqualify conditions that are defined physically ("abnormalities or defects of the genitalia such as change of sex") and mentally ("psychosexual conditions, including but not limited to transsexualism"). These blanket enlistment bars should be deleted, along with other disqualifications that may arise from medically appropriate treatment of transgender-related conditions, such as amenorrhea or hypogonadism.[108] The Commander in Chief should order the Defense Department to eliminate retention regulations that specify gender identity disorder as a condition justifying administrative separation as well.[109]

Recommendation #2: Do not write new medical regulations. Aside from these minor revisions, the Defense Department should not write new medical regulations or policies to address health care needs of transgender personnel, and should treat transgender service members in accordance with established medical practices and standards, as it does with the provision of all medical care. As we have documented throughout this report, transgender service members should be presumed to be fit. Any medical issue that interferes with an individual's performance of duty is already subject to evaluation under existing medical standards, which are sufficient for enabling doctors to make determinations of fitness and deployability for transgender personnel. Transgender service members should not be held to different standards of self-sufficiency or fitness than any other service members.

Recommendation #3: Base new administrative guidance on foreign military and US government precedents. While no new medical rules are needed, the Defense Department should formulate administrative guidance to address fitness testing, records and identification, uniforms, housing and privacy. We encourage independent scholars as well as Pentagon analysts to study foreign military experiences that could inform the policy-making process. At least 12 countries including Australia, Belgium, Canada, the Czech Republic, Denmark, Israel, the Netherlands, New Zealand, Norway, Spain, Sweden, and the United Kingdom allow transgender personnel to serve; foreign military regulations that apply to transgender military service are straightforward and sensible, offering a sound model for US military policy.

Appendix – Statement by 16 current and former military university faculty members

We write to endorse the quality of research that informs the Report of the Transgender Military Service Commission, which determined that there is no compelling medical rationale for banning transgender military service. We believe that the Commissioners who completed this study engaged in careful and well-done research, and that their conclusions are based on a reasonable assessment of available evidence.*

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Dr. Barry S. Fagin, professor, US Air Force Academy
Dr. Gregory D. Foster, professor, National Defense University
Dr. Clementine Fujimura, professor, US Naval Academy
Dr. Elizabeth L. Hillman, former instructor, US Air Force Academy
Dr. Janice H. Laurence, former professor, Naval Postgraduate School
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Professor Tammy S. Schultz, Ph.D., US Marine Corps War College

*The views expressed in this statement by current and former faculty at US Government Agencies are those of the individuals and do not necessarily reflect the official policy or position of their respective university, their Service, the Department of Defense or the US Government.

[1] We are grateful to the numerous individuals who contributed to this project including Jameson Casentini, Janelle Downing, Jacob Eleazer, Dr. Nathaniel Frank, Dr. Richard Frankenstein, Dr. Maurice Garcia, Dr. Jody Herman, Dr. Arnold Gass, Dr. Gary Gates, Dr. Louis Gooren, Dr. Jamison Green, Dr. Dan Grossman, Dr. Wylie Hembrie, Dr. Michael Kauth, Mara Keisling, Christopher Mathews, JD, Diane Mazur, JD, Dr. Christopher Neff, Paula Neira, Dr. Lealah Pollock, Kerri Ryer, Dr. Loren Schechter, Dr. Christopher Salgado, Dr. Jae Sevelius, Dr. Jillian Shipherd and Brynn Tannehill.

[2] See Gary Gates and Jody Herman (forthcoming). Transgender Military Service in the United States, Los Angeles, CA: Williams Institute. Drs. Gates and Herman are in the process of updating their calculations.

[3] Adam F. Yerke and Valory Mitchell (2013). Transgender People in the Military: Don't Ask? Don't Tell? Don't Enlist!, *Journal of Homosexuality*, 60:2-3, 436-457.

[4] Yerke and Mitchell, Transgender People in the Military, 445. Also see Jack Drescher, Peggy Cohen-Kettenis, and Sam Winter (2012), Minding the Body: Situating Gender Identity Diagnoses in the ICD-11, *International Review of Psychiatry*, 24(6), 573.

[5] Ilan H. Meyer and Mary E. Northridge, eds. (2007). *The Health of Sexual Minorities: Public Health Perspectives on Lesbian, Gay, Bisexual and Transgender Populations*. New York, NY: Springer.

[6] Nils Daulaire (November 12, 2013). A Victory for LGBT Health in the Americas. *Huffington Post*, accessed December 26, 2013 at www.huffingtonpost.com/nils-daulaire/a-victory-for-lgbt-health_b_4262367.html.

[7] See *Fields* v. *Smith*, 653 F.3d 550 (7th Cir. 2011).

[8] For example, "For many gender non-conforming people, transition as a framework has no meaning in expressing their gender – there may be no transition process at all, but rather a recognition of a gender identity that defies convention or conventional categories." Jaime M. Grant, Lisa A. Mottet and Justin Tanis (2011). Injustice at Every Turn: A Report of the National Transgender Discrimination Survey. Washington, DC: National Center for Transgender Equality and National Gay and Lesbian Task Force, 26.

[9] Cross-dressing by non-transgender individuals is beyond the scope of our analysis.

[10] Gates and Herman, Transgender Military Service. Their veteran category includes 4,650 individuals in the standby and retired reserve. At the time of writing, the active, Guard and reserve components included 2,280,875 personnel.

[11] N = 1,261. Jack Harrison-Quintana and Jody L. Herman (2013). Still Serving in Silence: Transgender Service Members and Veterans in the National Transgender Discrimination Survey. *LGBTQ Policy Journal at the Harvard Kennedy School*, 5.

[12] The peer-reviewed studies are John R. Blosnich, George R. Brown, Jillian C. Shipherd, Michael Kauth, Rebecca I. Piegari, and Robert M. Bossarte (2013). Prevalence of Gender Identity Disorder and Suicide Risk Among Transgender Veterans Utilizing Veterans Health Administration Care. *American Journal of Public Health*, 103:10, 27-32; George R. Brown (1988). Transsexuals in the Military: Flight into Hypermasculinity. *Archives of Sexual Behavior*, 17:6, 527-537; Everett McDuffie and George R. Brown (2010). Seventy U.S. Veterans with Gender Identity Disturbances: A Descriptive Study. *International Journal of Transgenderism*, 12:1, 21-30; Franklin D. Jones, Michael G. Deeken and Steven D. Eshelman (1984). Sexual Reassignment Surgery and the Military: Case Reports. *Military Medicine*, 149:5, 271-275; Matthew F. Kerrigan (2012). Transgender Discrimination in the Military, The New Don't Ask, Don't Tell. *Psychology, Public Policy, and Law*, 18:3, 500–518; Jillian C. Shipherd, Lauren Mizock, Shira Maguen and Kelly E. Green (2012). Male-to-Female Transgender Veterans and VA Health Care Utilization. *International Journal of Sexual Health*, 24:1, 78-87; and Yerke and Mitchell, Transgender People in the Military. The three non peer-reviewed studies are Harrison-Quintana and Herman, Still Serving in Silence; Bryant and Schilt (2008), Transgender People in the U.S. Military, Santa Barbara, CA: Palm Center; and Tarynn M. Witten (2007). Gender Identity and the Military: Transgender, Transsexual, and Intersex-identified Individuals in the U.S. Armed Forces. Santa Barbara, CA: Palm Center.

[13] *Doe* v. *Alexander*, 510 F. Supp. 900 (D. Minn. 1981).

[14] *Leyland* v. *Orr*, 828 F. 2d 584 (9th Cir. 1987).

[15] *DeGroat* v. *Townsend*, 495 F. Supp. 2d 845 (S.D. Ohio 2007).

[16] Department of Defense Instruction (DODI) 6130.03, *Medical Standards for Appointment, Enlistment, or Induction in the Military Services*, April 28, 2010, Incorporating Change 1, September 13, 2011.

[17] DODI 6130.03, *Medical Standards for Appointment*, at ¶ 4(c).

[18] Paraphilia is sexual arousal to an atypical object. See American Psychiatric Association (2013). *Diagnostic and Statistical Manual* (5th ed.). Arlington, VA: American Psychiatric Publishing.

[19] DODI 6130.03, *Medical Standards for Appointment*, Enclosure 2, at ¶ 3(b).
[20] AR 40-501, *Standards of Medical Fitness*, December 14, 2007, at ¶ 1-6(b).
[21] Army Reg. 40-501, *Standards of Medical Fitness*, at ¶ 1-6(h).
[22] Department of Defense Instruction 1332.38, *Physical Disability Evaluation*, November 14, 1996, Incorporating Change 2, April 10, 2013.
[23] DODI 1332.38, *Physical Disability Evaluation*, Enclosure 5, at ¶ 1.3.9.6.
[24] Department of Defense Instruction 1332.14, *Enlisted Administrative Separations*, August 28, 2008, Incorporating Change 3, September 30, 2011.
[25] DODI 1332.14, *Enlisted Administrative Separations,* Enclosure 3, at ¶ 3(a)8.
[26] See, for example, US Marine Corps MCIWEST-MCB CAMPEN ORDER 6000.1, *Reporting of Prescribed Medications and Medical Treatment Outside the Military Health System*, October 1, 2012.
[27] Jillian C. Shipherd, Lauren Mizock, Shira Maguen and Kelly E. Green (2012). Male-to-Female Transgender Veterans and VA Health Care Utilization. *International Journal of Sexual Health*, 24:1, 85.
[28] Harrison-Quintana and Herman, Still Serving in Silence, 6.
[29] Everett McDuffie and George R. Brown (2010). Seventy U.S. Veterans with Gender Identity Disturbances: A Descriptive Study. *International Journal of Transgenderism*, 12:1, 21-30.
[30] DODI 6130.03 requires a reference to diagnostic codes in the International Classification of Diseases (ICD-9), and the ICD does list diagnoses for both transsexualism and gender identity disorder. DOD translates DSM-IV diagnoses to the closest ICD code.
[31] In the World Professional Association for Transgender Health Standards of Care, dysphoria refers to the distress itself, not the incongruence between gender identity and assigned sex. See Eli Coleman et al. (2011). Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People, Version 7. *International Journal of Transgenderism*, 13, 168. Indeed, non-transgender people can experience gender dysphoria. For example, some men who are disabled in combat, especially if their injury includes genital wounds, may feel that they are no longer men because their bodies do not conform to their concept of manliness. Similarly, a woman who opposes plastic surgery, but who must undergo mastectomy because of breast cancer, may find that she requires reconstructive breast surgery in order to resolve gender dysphoria arising from the incongruence between her body without breasts and her sense of herself as a woman.
[32] Coleman et al., Standards of Care, 168.
[33] Drescher, Cohen-Kettenis, and Winter, Minding the Body, 575.
[34] Drescher, Cohen-Kettenis, and Winter, Minding the Body, 569; 574.
[35] Meyer and Northridge, *The Health of Sexual Minorities*.
[36] Drescher, Cohen-Kettenis, and Winter, Minding the Body, 573.
[37] Coleman et al., Standards of Care, 230, citing findings of Jan Eldh, Agnes Berg and Maria Gustafsson (1997). Long-Term Follow Up After Sex Reassignment Surgery. *Scandinavian Journal of Plastic and Reconstructive Surgery and Hand Surgery,* 31, 1, 39-45; Luk Gijs and Anne Brewaeys (2007). Surgical Treatment of Gender Dysphoria in Adults and Adolescents: Recent Developments, Effectiveness, and Challenges. *Annual Review of Sex Research*, 18, 1, 178-224; M.H. Murad, M.B. Elamin, M.Z Garcia, R.J. Mullan, A. Murad, P.J. Erwin and V.M. Montori (2010). Hormonal Therapy and Sex Reassignment: A Systematic Review and Meta-Analysis of Quality of Life and Psychosocial Outcomes. *Clinical Endocrinology*, *72*, 2, 214–231; F. Pfäfflin and A. Junge (1998). Sex Reassignment. Thirty Years of International Follow-up Studies After Sex Reassignment Surgery: A Comprehensive Review, 1961-1991 (Translated from German into English by Roberta B. Jacobson and Alf B. Meier), retrieved from http://web.archive.org/web/20070503090247/http://www.symposion.com/ijt/pfaefflin/1000.htm; and Richard Green and Davis Fleming (1990). Transsexual Surgery Follow-Up: Status in the 1990s. *Annual Review of Sex Research*, 1, 1, 163-174.
[38] Coleman et al., Standards of Care, 230; Murad et al., Hormonal Therapy and Sex Reassignment; G. De Cuypere, G. T'Sjoen, R. Beerten, G. Selvaggi, P. De Sutter, P. Hoebeke and R. Rubens (2005). Sexual and Physical Health after Sex Reassignment Surgery. *Archives of Sexual Behavior*, *34*, 6, 679–690; B. Kuiper and P. Cohen-Kettenis (1988). Sex Reassignment Surgery: A Study of 141 Dutch Transsexuals. *Archives of Sexual Behavior*, 17, 5, 439-457; R. N. Gorton (2011). The Costs and Benefits of Access to Treatment for Transgender People. Prepared for the San Francisco Department of Public Health, San Francisco.
[39] Anne Gaderman et al. (2012). Prevalence of DSM-IV Major Depression Among U.S. Military Personnel. *Military Medicine*, 177.
[40] Kim Murphy (April 7, 2012). A Fog of Drugs and War. *Los Angeles Times.*

[41] Katherine Blakeley and Don J. Jansen (2013). *Post-Traumatic Stress Disorder and Other Mental Health Problems in the Military: Oversight Issues for Congress*. Washington, DC: Congressional Research Service, 2, citing Mental Disorders and Mental Health Problems, Active Component, US Armed Forces, 2000-2011 (June 2012). *Medical Surveillance Monthly Report*, 19, 6, 11-17.
[42] Paul R. Sackett and Anne S. Mavor, eds. (2006). *Assessing Fitness for Military Enlistment Physical, Medical, and Mental Health Standards*. Washington, DC: The National Academies Press, 144.
[43] Ministry of Defence. *Policy for the Recruitment and Management of Transsexual Personnel in the Armed Forces*. January, 2009, London: UK.
[44] Coleman et al., Standards of Care, 189.
[45] Older MTFs, beyond the age of most service members, may risk cardiovascular disease as a consequence of hormone therapy. Testosterone may increase the risk of Type 2 diabetes, hypertension, and cardiovascular disease for older FTMs.
[46] H. Asscheman, E.J. Giltay, J.A. Megens, W.P. de Ronde, M.A. van Trotsenburg, and L.J. Gooren (2011). A Long-Term Follow-Up Study of Mortality in Transsexuals Receiving Treatment with Cross-Sex Hormones. *European journal of Endocrinology*, 164, 4, 635-42; Paul Van Kesteren et al. (1997). Mortality and Morbidity in Transsexual Subjects Treated with Cross-Sex Hormones. *Clinical Endocrinology*, 47, 3, 337-343; M. Colizzi, R. Costa, and O. Todarello (2014). Transsexual Patients' Psychiatric Comorbidity and Positive Effect of Cross-Sex Hormonal Treatment on Mental Health: Results from a Longitudinal Study. *Psychoneuroendocrinology*, 39:65-73.
[47] H. Asscheman et al. (August 14, 2013). Venous Thrombo-Embolism as a Complication of Cross-Sex Hormone Treatment of Male-to-Female Transsexual Subjects: A Review. *Andrologia*. Published online.
[48] Tom Waddell Health Center (2006). *Protocols for Hormonal Reassignment of Gender*. Accessed November 6, 2013 from: http://www.sfdph.org/dph/comupg/oservices/medSvs/hlthCtrs/TransGendprotocols122006.pdf.
[49] Department of Defense (2013), *Health Related Behaviors Survey of Active Duty Military Personnel 2011,* 119-120; 130-131; 248; 264-265.
[50] Department of Defense. *Policy Guidance for Deployment-Limiting Psychiatric Conditions and Medications*. 2006 at ¶4.2.3.
[51] Andrew Tilghman (May 17, 2010). 'Any Soldier Can Deploy on Anything': Pentagon Rules Bar Some Drugs from Combat Zone, but Oversight is Suspect. *Army Times*.
[52] Tilghman, 'Any Soldier Can Deploy on Anything'.
[53] Department of the Army. *Personnel Policy Guidance for Overseas Contingency Operations*, 2009 at ¶ 7-13(b)1.
[54]Erika Stetson, for example, served as an Army employee in Afghanistan in 2011 and 2012 under the Civilian Expeditionary Workforce program. Nicole Shounder was appointed to the rank equivalent of Lieutenant Commander in the Military Sealift Command in 2008 and subsequently deployed on four ships including the forward staging base USS Ponce. See Erika Stetson (March/April 2013). Deployed, Trans and Out. *OutServe Magazine*, 13-14; Brynn Tannehill (May/June 2013). A Life of Service. *OutServe Magazine*, 22-23; Brynn Tannehill, (April 25, 2013). Deployed While Trans: The Rachel Bolyard Story. *OutServe Magazine*, accessed at http://outservemag.com/2013/04/deployed-while-trans-the-rachel-bolyard-story/
[55] Coleman et al., Standards of Care, 170-171.
[56] For a list of 313 allowable, elective cosmetic procedures, see Tricare Management Activity, Uniform Business Office (2013). *Provider's Guide to the Elective Cosmetic Surgery Superbill*.
[57] Patel, Morris and Gassman show that these complications may include "airway, vascular, hemorrhage, vascular compromise, neurologic, infectious, skeletal, unfavorable osteotomy, tooth injury, nonunion, postoperative malocclusion, temporomandibular joint disorders, and unfavorable aesthetic results." See P. Patel, D. Morris, and A. Gassman (2007). Complications of Orthognathic Surgery. *Jounal of Craniofacial Surgery*, 18, 4, 975-985. The military allows personnel to have elective cosmetic surgeries on a space-available basis and at their own expense.
[58] Patel, Morris, and Gassman, Complications of Orthognathic Surgery; F. Kramer. C. Baethge, G. Swennen et al. (2004). Intra- and Perioperative Complications of the LeFort I Osteotomy: A Prospective Evaluation of 1000 Patients. *Journal of Craniofacial Surgery*, 15, 6, 971-977; K. Jones (2006). Le Fort II and Le Fort III Osteotomies for Midface Reconstruction and Considerations for Internal Fixation. In A. Greenberg and J. Prein, eds. *Craniomaxillofacial Reconstructive and Corrective Bone Surgery*. New York, NY: Springer, 667-668.
[59] Patel, Morris, and Gassman, Complications of Orthognathic Surgery.
[60] Kramer, Baethge, Swennen et al., Intra- and Perioperative Complications.
[61] Herman found in a recent study that the highest annualized utilization rate for large employers is 0.044 claimants per thousand employees annually (Table 8). If the military were similar to civilian firms, and given that the active, Guard and reserve components currently include 2,280,875 personnel, then one would expect 0.044x2,281=100 claimants per year if the Military Health System covered gender-confirming surgery. However, transgender people

are over-represented in the military (15,450/2,280,875 million = 0.68% military as compared to .3% of the civilian adult population.) Hence the figure of 100 claimants per year should be adjusted upward by .68/.3 = 2.3x. Hence, if the military paid for transition-related surgery, one would expect 2.3x100 = 230 claims per year. See Jody L. Herman (2013). Costs and Benefits of Providing Transition-Related Health Care Coverage in Employee Health Benefits Plans, Los Angeles, CA: Williams Institute.

[62] Herman, Costs and Benefits, 6.

[63] Short-term surgical complications can include rectal injury, infection, delayed wound healing, bleeding, venous thromboembolism, and/or urethral stream abnormalities. While many of these complications are either self-limited or may be treated with local wound care, antibiotics, or anticoagulants, some, such as rectal injury, may require additional surgical procedures such as a temporary colostomy. Long-term complications can include vaginal stenosis and unsatisfactory appearance of the surgically reconstructed genitalia, and vaginal stenosis may require additional procedures such as skin grafts or intestinal transposition.

[64] A.A. Lawrence (2006). Patient-Reported Complications and Functional Outcomes of Male-to-Female Sex Reassignment Surgery. *Archives of Sexual Behavior*, 35, 6, 717-27.

[65] Cameron Bowman and Joshua M. Goldberg (2006). Care of the Patient Undergoing Sex Reassignment Surgery. *International Journal of Transgenderism*, 9, 135-165; Miroslav L. Djordjevic, Dusan S. Stanojevic and Marta R. Bizic (2011). Rectosigmoid Vaginoplasty: Clinical Experience and Outcomes in 86 Cases. *Journal of Sexual Medicine*, 8, 12, 3487-3494; Ji-Xiang Wu, Bin Li, Wen-Zhi Li, Yong-Guang Jiang, Jie-Xiong Liang, Chen-Xi Zhong (2009). Laparoscopic Vaginal Reconstruction Using an Ileal Segment. *International Journal of Gynecology and Obstetrics*, 107, 3, 258-261; L. Jarolím, J. Sedý, M. Schmidt, O. Nanka, R. Foltán and I. Kawaciuk (2009). Gender Reassignment Surgery in Male-to-Female Transsexualism: A Retrospective 3-Month Follow-Up Study with Anatomical Remarks. *Journal of Sexual Medicine*, 6, 6, 1635-1644; S. V. Perovic, D.S. Stanojevic and M.L.J. Djordjevic (2000). Vaginoplasty in Male Transsexuals Using Penile Skin and a Urethral Flap. *BJU International*, 86, 7, 843-850.

[66] Presumably, any post-operative MTF individuals with ongoing complications would be screened out at the time of enlistment. Hence the only MTF troops who would be unfit for duty would be those experiencing ongoing post-operative complications from genital surgeries they elected to have after joining the military. As explained previously, if the Military Health Service paid for transition-related care, one would expect 230 claimants per year. Approximately 90 percent of transgender troops are MTF's, thus suggesting .9 x 230 = 207 claimants per year for MTF transition-related coverage. If 5 percent of such claims entailed ongoing post-operative complications, this would mean that 10 MTF transgender troops would become permanently unfit for duty each year.

[67] Short-term surgical complications related to the vaginectomy include bleeding, and those associated with scrotoplasty include loss of the testicular prostheses related to infection or erosion. Whether undergoing a metoidioplasty with urethral lengthening or phalloplasty, short-term complications include urethral stricture or fistulae, infection, delayed wound healing, and/or venous thromboembolism. These conditions may either be self-limited or require additional procedures such as dilation, stricture release, and/or buccal mucosal grafts, local wound care, antibiotics, or anticoagulation. Additional risks associated with phalloplasty include flap failure and delayed healing of the donor site (most commonly forearm, thigh, or back).

[68] S. Baumeister, M. Sohn, C. Domke, and K. Exner (2011). Phalloplasty in Female-to-Male Transsexuals: Experience from 259 Cases [Article in German]. *Handchir Mikrochir Plast Chir*, 43, 4, 215-21; J.E. Terrier, F. Courtois, A. Ruffion, N. Morel Journel (September 12, 2013). Surgical Outcomes and Patients' Satisfaction with Suprapubic Phalloplasty. *Journal of Sexual Medicine* [Epub ahead of print]; P.A. Sutcliffe, S. Dixon, R.L. Akehurst, A. Wilkinson, A. Shippam, S. White, R. Richards and C.M. Caddy (2009) Evaluation of Surgical Procedures for Sex Reassignment: A Systematic Review *Journal of Plastic, Reconstructive and Aesthetic Surgery*, 62, 3, 294-306; A. Leriche, M.O. Timsit, N. Morel-Journel, A. Bouillot, D. Dembele, A. Ruffion (2008). Long-Term Outcome of Forearm Flee-Flap Phalloplasty in the Treatment of Transsexualism. *BJU International*, 101, 10, 1297-1300; J.J. Hage and A.A. van Turnhout (2006). Long-Term Outcome of Metaidoioplasty in 70 Female-to -Male Transsexuals. *Annals of Plastic Surgery*, 57, 3, 312-316; M. Sengezer, S. Oztürk, M. Deveci and Z. Odabaşi (2004). Long-Term Follow-Up of Total Penile Reconstruction with Sensate Osteocutaneous Free Fibula Flap in 18 Biological Male Patients. *Plastic and Reconstructive Surgery*, 114, 2, 439-452.

[69] Albert Leriche et al. (2008). Long-Term Outcome of Forearm Flee-Flap Phalloplasty in the Treatment of Transsexualism. *BJU international*, 101, 10, 1297-1300.

[70] Giulio Garaffa, Christopher A. Nim, and David J. Ralph (2010). Total Phallic Reconstruction in Female-to-Male Transsexuals. *European Urology* 57.4, 715-722.

[71] These figures are derived from raw data that informed Grant, Mottet and Tanis, Injustice at Every Turn.

[72] Presumably, any post-operative FTM individuals with ongoing complications would be screened out at the time of enlistment. Hence the only FTM troops who, as a class, would be unfit for duty would be those experiencing ongoing post-operative complications from genital surgeries they elected to have after joining the military. As explained previously, if the Military Health Service paid for transition-related care, one would expect 230 claimants per year. However, only 10 percent of transgender troops are FTMs, thus suggesting .1x230 = 23 claimants per year for FTM transition-related coverage. If one quarter of such claims entailed ongoing post-operative complications, this would mean that 6 FTM transgender troops would become permanently unfit for duty each year.
[73]The stories of Erika Stetson, Nicole Shounder and Rachel Bolyard were referenced in a previous endnote.
[74] Department of the Army, *Personnel Policy Guidance for Overseas Contingency Operations*, 2009, at ¶ 7-9(e).
[75] Ministry of Defence, *Policy for the Recruitment and Management of Transsexual Personnel*.
[76] DODI 1332.38, *Physical Disability Evaluation,* Enclosure 3, at ¶ P3.4.1.3.
[77] DODI 1332.38, *Physical Disability Evaluation*, Enclosure 4, at ¶ 1.1.2.
[78] DODI 1332.38, *Physical Disability Evaluation,* Enclosure 3, at ¶ P3.4.3.
[79] Department of Defense. *Health Related Behaviors*.
[80] 10 U.S.C. § 701(a).
[81] Department of Defense Instruction 1327.06, *Leave and Liberty Policy and Procedures*, June 16, 2009, Incorporating Change 2, effective August 13, 2013, Enclosure 2, at ¶ 1c.
[82] DODI 1327.06, *Leave and Liberty Policy*, Enclosure 2, at ¶¶ 1j(1), 1a.
[83] 10 U.S.C. 701(b), (f).
[84] DODI 1327.06, *Leave and Liberty Policy*, Enclosure 2, at ¶ 1j(2).
[85] DODI 1327.06, *Leave and Liberty Policy*, Enclosure 2, at ¶ 1k(6).
[86] DODI 1327.06, *Leave and Liberty Policy*, Enclosure 2, at ¶¶ 1k(2), (5).
[87] DODI 1327.06, *Leave and Liberty Policy*, Enclosure 2, at ¶ 1k(4).
[88] DODI 1315.18, *Procedures for Military Personnel Assignments* (January 12, 2005), at ¶ 6.10.
[89] DODI 1315.18, *Procedures for Military Personnel Assignments,* at ¶¶ 6.10.3, 6.10.4. An alternative option for leave is the Navy's Career Intermission Pilot Program, which allows naval personnel to apply for a transfer from active service into the Individual Ready Reserve for up to three years.
[90] DODI 1327.06, *Leave and Liberty Policy,* Enclosure 2, at ¶ 1k(1).
[91] Army Regulation 600-8-10, *Leave and Passes* (August 4, 2011 revision), at ¶5-3e.
[92] Army Medical Command, OTSG/MEDCOM Policy Memo 12-076, *Revised Policy for Cosmetic Surgery Procedures and Tattoo/Brand Removal/Alteration in the Military Health System* (November 20, 2012), at ¶¶ 5e(15), 5f(2).
[93] Army Medical Command, *Revised Policy for Cosmetic Surgery*, at ¶ 5(e)(7).
[94] *See, e.g.,* Department of the Air Force Instruction 36-2110, *Assignments* (Change 2, June 8, 2012), at ¶ 2.17.1.
[95] Department of the Air Force Instruction 36-2110, *Assignments,* at ¶ 2.17.3 and Table 2.2.
[96] DODI 1332.38, *Physical Disability Evaluation*, Enclosure 3, at ¶ P7.3.
[97] Yerke and Mitchell, Transgender People in the Military,, 442.
[98] Coleman et al., Standards of Care, 170.
[99] Report of the Army Dismounted Complex Blast Injury Task Force, June 18, 2011, 31.
[100] Government Accountability Office (2012). *VA and DOD Health Care: Department-Level Actions Needed to Assess Collaboration Performance, Address Barriers, and Identify Opportunities*, GAO-12-992. Washington, DC; Government Accountability Office (2011). *DOD and VA Health Care: Action Needed to Strengthen Integration Across Care Coordination and Case Management Programs*, GAO 12-129T. Washington, DC.
[101] D.M. Lam (2007). The Trauma Continuum-of-Care Quality Forum Integration Committee System-Wide Video Teleconference. *Military Medicine* 172, 6, 611.
[102] S. Marble (2013). Origins of the Physical Profile. *Military Medicine* 178, 8, 887.
[103] E. Granger et al. (2010). Historical Evolution of Medical Quality Assurance in the Department of Defense. *Military Medicine* 175, 8, 581.
[104] B. Kerr (2007). The Joint Military Medical Executive Skills Initiative: An Impressive Response to Changing Human Resource Management Rules of Engagement. *Military Medicine* 172, 1, 49.
[105] T. Harold (2011). The Evolution of Dependent Medical Care in the U.S. Army. *Military Medicine* 176, 10, 1133.
[106] G. Bathalon (2006). The Effect of Proposed Improvements to the Army Weight Control Program on Female Soldiers. *Military Medicine* 171, 8, 800.

[107] Rapid Action Revision, September 13, 2011, to Army Regulation 601-270, OPNAVINST 1100.4C Ch-2, AFI36-2003_IP, MCO1100.75F, and COMDTINST M1100.2E, *Military Entrance Processing Station (MEPS),* http://www.apd.army.mil/jw2/xmldemo/r601_270/main.asp

[108] DODI 6130.03, *Medical Standards for Appointment*, Enclosure 4 at ¶¶ 14-15, 25, 29.

[109] DODI 1332.38, *Physical Disability Evaluation*, Enclosure 5; DODI 1332.14, *Enlisted Administrative Separations*, Enclosure 3, at ¶ 3(a)(8)(a).

Dr. M. Joycelyn Elders, MD

Joycelyn Elders, the first person in the state of Arkansas to become board certified in pediatric endocrinology, was the sixteenth Surgeon General of the United States, the first African American and only the second woman to head the US Public Health Service. Long an outspoken advocate of public health, Elders was appointed Surgeon General by President Clinton in 1993.

Born to poor farming parents in 1933, Dr. Elders grew up in a rural, segregated, poverty-stricken pocket of Arkansas. She was the eldest of eight children, and she and her siblings had to combine work in the cotton fields from age five with their education at a segregated school thirteen miles from home. They often missed school during harvest time, September to December.

After graduating from high school, she earned a scholarship to the all-black liberal arts Philander Smith College in Little Rock. While she scrubbed floors to pay for her tuition, her brothers and sisters picked extra cotton and did chores for neighbors to earn her $3.43 bus fare. In college, she enjoyed biology and chemistry, but thought that lab technician was likely her highest calling. Her ambitions changed when she heard Edith Irby Jones, the first African American to attend the University of Arkansas Medical School, speak at a college sorority. Dr. Elders—who had not even met a doctor until she was 16 years old—decided that becoming a physician was possible, and she wanted to be like Jones.

After college, Dr. Elders joined the Army and trained in physical therapy at the Brooke Army Medical Center at Fort Sam Houston, Texas. After discharge in 1956 she enrolled at the University of Arkansas Medical School on the G.I. Bill. Although the Supreme Court had declared separate but equal education unconstitutional two years earlier, Elders was still required to use a separate dining room—where the cleaning staff ate. She met her husband, Oliver Elders, while performing physical exams for the high school basketball team he managed, and they were married in 1960.

Dr. Elders did an internship in pediatrics at the University of Minnesota, and in 1961 returned to the University of Arkansas for her residency. She became chief resident in charge of the all-white, all-male residents and interns, earned her master's degree in biochemistry in 1967 and became an assistant professor of pediatrics at the university's medical achool in 1971 and full professor in 1976.

Over the next twenty years, Dr. Elders combined her clinical practice with research in pediatric endocrinology, publishing well over a hundred papers, most dealing with problems of growth and juvenile diabetes. This work led her to study of sexual behavior and her advocacy on behalf of adolescents. She saw that young women with diabetes face health risks if they become pregnant too young—including spontaneous abortion and possible congenital abnormalities in the infant. She helped her patients to control their fertility and advised them on the safest time to start a family.

Governor Bill Clinton appointed Joycelyn Elders head of the Arkansas Department of Health in 1987. As she campaigned for clinics and expanded sex education, she caused a storm of controversy among conservatives and some religious groups. Yet, largely because of her lobbying, in 1989 the Arkansas Legislature mandated a K-12 curriculum that included sex education, substance-abuse prevention, and programs to promote self-esteem. From 1987 to 1992, she nearly doubled childhood immunizations, expanded the state's prenatal care program, and increased home-care options for the chronically or terminally ill.

In 1993, President Clinton appointed Dr. Elders US Surgeon General. Despite opposition from critics, she was confirmed and sworn in on September 10, 1993. During her fifteen months in office she faced skepticism regarding her policies yet continued to bring controversial issues up for debate. As she later concluded, change can only come about when the Surgeon General can get people to listen and talk about difficult subjects.

Dr. Elders left office in 1994 and in 1995 she returned to the University of Arkansas as a faculty researcher and professor of pediatric endocrinology at the Arkansas Children's Hospital. In 1996 she wrote her autobiography, *Joycelyn Elders, M.D.: From Sharecropper's Daughter to Surgeon General of the United States of America*. Now retired from practice, she is a professor emeritus at the University of Arkansas School of Medicine, and remains active in public health education.

Professor George R, Brown, MD, DFAPA

George R. Brown, MD, DFAPA, is Associate Chairman and Professor of Psychiatry at East Tennessee State University in Johnson City, TN. He is currently serving his third term on the Board of Directors for the World Professional Association for Transgender Health, the only international organization that focuses on transgender health, where he also serves as a member of the Incarceration/Institutionalization Committee and the Standards of Care Committee. He is a coauthor on the last three versions of the Standards of Care.

Dr. Brown served as Chief of Psychiatry at Mountain Home VAMC for 18 years and served 12 years in the US Air Force as a psychiatrist. He has worked with transgender active-duty service members and with veterans during his 30 years of active clinical work in the area of gender dysphoria, and continues to evaluate and treat transgender veterans. He has assisted with the VA national workgroups tasked with educating VHA clinicians about how to deliver competent and respectful transgender health care.

Actively involved in working with legal cases on behalf of transgender persons seeking access to nondiscriminatory transgender health care in the United States, Dr. Brown has served as an expert witness in several national precedent-setting cases that have benefitted transgender persons. He has published over 135 articles and scientific abstracts, as well as 22 book chapters, many of which have been on transgender health care issues. And, he has presented his work on transgender issues at one third of the medical schools in the US as well as in seven nations.

Dr. Brown is a University of Rochester School of Medicine graduate who subsequently did residency at Wright State University as an officer in the USAF. He is board certified in General Psychiatry and a Distinguished Fellow in the American Psychiatric Association. His areas of expertise include gender identity disorders/gender dysphoria and psychopharmacology. Dr. Brown supervises resident research electives at the VA and encourages residents to develop a better understanding of the potential contributions of research on clinical practice through his example as an accomplished clinical researcher.

Professor Eli Coleman, PhD

Professor Eli Coleman is director of the Program in Human Sexuality, Department of Family Medicine and Community Health, University of Minnesota Medical School in Minneapolis, where he holds the first and only endowed academic chair in sexual health. Dr. Coleman has authored articles and books on a variety of sexual health topics, including compulsive sexual behavior, sexual orientation, and gender dysphoria.

He is founding editor of the *International Journal of Transgenderism* and founding and current editor of the *International Journal of Sexual Health*. He is past president of the Society for the Scientific Study of Sexuality, the World Professional Association for Transgender Health (formerly the Harry Benjamin International Gender Dysphoria Association), the World Association for Sexual Health, and the International Academy for Sex Research. In 2013, he was elected President of the Society for Sex Therapy and Research for a two-year term

He has been a frequent technical consultant on sexual health issues to the World Health Organization (WHO), the Pan American Health Organization (the regional office of WHO), and the Centers for Disease Control and Prevention. And, he has been the recipient of numerous awards including the US Surgeon General's Exemplary Service Award for his role as senior scientist on *Surgeon General's Call to Action to Promote Sexual Health and Responsible Sexual Behavior*, released in 2001. He was given the Distinguished Scientific Achievement Award from the Society for the Scientific Study of Sexuality and the Alfred E. Kinsey Award by the Midcontinent Region of the Society for the Scientific Study of Sexuality in 2001. In 2007, he was awarded the Gold Medal for his lifetime contributions to the field of sexual health by the World Association for Sexual Health.

In 2007, he was appointed the first endowed Chair in Sexual Health at the University of Minnesota Medical School, and in 2009 he was awarded the Masters and Johnson Award by the Society for Sex Therapy and Research. In 2011, he received the John Money Award from the Eastern Region of the Society for the Scientific Study of Sexuality.

BG Thomas A. Kolditz, PhD, USA (Ret.)

General Kolditz is Professor in the Practice of Leadership and Management and Director of the Leadership Development Program at the Yale School of Management. He has been one of the nation's leading development experts for four decades in the public, private, and social sectors. A Professor Emeritus at the US Military Academy, General Kolditz led the Department of Behavioral Sciences and Leadership at West Point for twelve years. In that role, he was responsible for teaching, research, and outreach activities in management, leader development science, psychology, and sociology.

A highly experienced global leader, General Kolditz has served for more than 26 years in leadership roles on four continents. His career has focused both on leading organizations and studying leadership and leadership policy across sectors. He served for two years as a leadership and human resources policy analyst in the Pentagon, and a year as a concept developer in the Center for Army Leadership, and was the founding director of the West Point Leadership Center. He was instrumental in the design and formation of the Thayer Leader Development Group, and is the managing member of Saxon Castle LLC, a leader development consultancy.

Professor Kolditz is an internationally recognized expert on crisis leadership and leadership in extreme contexts and in the development of programs to inculcate leadership and leader development in everything from project teams to large organizations. He has published extensively across a diverse array of academic and leadership trade journals, and serves on the editorial and advisory boards of several academic journals. He is a fellow in the American Psychological Association and is a member of the Academy of Management. In 2007, while still on active duty, General Kolditz was appointed a visiting professor at the Yale School of Management, where he designed a crisis leadership course and taught in the school's MBA curriculum for three years

His most recent book, *In Extremis Leadership: Leading as if Your Life Depended on It*, was based on more than 175 interviews conducted on the ground in Iraq during combat operations. He has been named as a leadership Thought Leader by the Leader to Leader Institute and as a Top Leader Development Professional by Leadership Excellence. In 2009, he was named to the Council of Senior Advisors, Future of Executive Development Forum.

RADM Alan M. Steinman, MD, USPHS/USCG (Ret.)

Rear Admiral Alan M. Steinman was commissioned in the United States Public Health Service as a lieutenant in July, 1972, to commence a military career of over 25 years in the United States Coast Guard and the Public Health Service. He served as senior medical officer at the USCG Support Center, Elizabeth City, NC, from July to September, 1972; as senior medical officer and flight surgeon at USCG Air Station, Cape Cod, MA, from 1973 to 1974; as senior medical officer and flight surgeon at USCG Air Station, Port Angeles, WA, from 1974 to 1976, as senior medical officer and flight surgeon at USCG Air Station, Astoria, OR, from 1976 to 1978; and as medical officer and flight surgeon at USCG Support Center, Kodiak, AK, from January to May, 1987.

During these operational assignments, Dr. Steinman flew on countless emergency medical helicopter evacuations of ill and injured seamen, fisherman, recreational boaters, loggers and military active duty personnel. His expertise in emergency medicine and in cold-weather operations, particularly in the areas of sea-survival, hypothermia and drowning, let to his initial assignment at Coast Guard Headquarters as the Chief of Special Medical Operations from 1978 to 1982.

Dr. Steinman served as Medical Advisor for search and rescue operations in the USCG HQ Search and Rescue Division of the Office of Operations from 1982 to 1984. He then attended the University of Washington in Seattle, WA, where he earned a Masters of Public Health. Following his tour of duty at Kodiak, AK, he returned to USCG HQ as the Chief of Clinical and Preventive Medicine from April, 1987, to September, 1990. Dr. Steinman next served under the US Surgeon General (Dr. C. Everett Koop) as the Deputy Director of Medical Affairs at USPHS HQ from September, 1989, to February, 1990, following which he served as Chief of the Medical Branch at USPHS HQ until February, 1991. He returned to USCG HQ as Chief of the Wellness Branch from February, 1991, to August, 1993.

RADM Steinman was selected for promotion to flag officer in August, 1993, for the position of Director of Health and Safety at USCG HQ (equivalent to both the Surgeon General and Chief of Safety Programs for the other branches of the armed forces). He retired from the Coast Guard and the Public Health Service in September, 1997. Following his retirement, Admiral Steinman was appointed to the Presidential Special Oversight Board for Department of Defense Investigations of Gulf-War Chemical and Biological Incidents, where he served under Senator Warren Rudman (R-NH) as the chief medical advisor for the Board from July, 1998, to January, 2001.

Admiral Steinman's educational degrees include a Bachelor of Science in 1966 from the Massachusetts Institute of Technology; a Doctor of Medicine in 1971 from the Stanford University School of Medicine; and a Master of Public Health in 1986 from the University of Washington. His first post-graduate year in medicine was at the Mayo Graduate School of Medicine in Rochester, MN, in 1971. Dr. Steinman also graduated from the US Navy School of Aerospace Medicine, where he earned the designation of US Navy Flight Surgeon in 1973.

Dr. Steinman is Board Certified in Occupational Medicine and is a Fellow of the American College of Preventive Medicine.

During his tenure as Director of Health and Safety, RADM Steinman managed a comprehensive health care program for over 160,000 beneficiaries with a budget of over $250 million. He also served as the Director of the Coast Guard's Safety and Environmental Health programs, overseeing the safety of all USCG personnel. He has an international reputation in cold-weather medicine, hypothermia and sea-survival, and he is widely published in these areas, including numerous articles in medical journals and chapters in textbooks of emergency medicine and cold-weather medicine. He has lectured at various national and international conferences and universities on hypothermia, sea-survival and drowning.

RADM Steinman's decorations include the Distinguished Service Medal, the Legion of Merit, the Meritorious Service Medal, two USCG Commendation medals, the USCG Achievement medal, the USPHS Commendation medal, two USPHS Unit Commendation Medals, the USPHS Surgeon General's Medallion, and the USPHS Surgeon General's Exemplary Service Medal. RADM Steinman currently serves as a consultant in cold-weather medicine and holds the position of Professional Affiliate with the Health, Leisure and Human Performance Research Institute at the University of Manitoba. He is a scientific referee for various journals of environmental and occupational medicine. He serves on the Honorary Board of Directors for the Servicemembers Legal Defense Network, and he is co-founder of the Puget Sound Chapter of the American Veterans for Equal Rights.

RADM Steinman is the most senior military officer to self-identify as gay after his retirement; he served on the Military Advisory Council for Servicemembers Legal Defense Network, as an advisor for Servicemembers United, Service Women's Action Network and the Palm Center. He is also a founding member of the Puget Sound Chapter of American Veterans for Equal Rights. He was selected to brief President-elect Obama's transition team on the issue of Don't Ask, Don't Tell; he also met with the senior members of the Pentagon's working group on gays in the military, and he was invited by the White House to attend the Presidential Signing Ceremony repealing the Don't Ask, Don't Tell law. For the past five years, RADM Steinman has lectured to college classes on Joint Base Lewis-McChord on the issue of DADT. RADM Steinman lives with his seven-year-old adopted son and his husband in Olympia, WA.

Attachment D:

Pollock-Minter Report

PALM CENTER

BLUEPRINTS FOR SOUND PUBLIC POLICY

Gale S. Pollock, Major General USA (Ret.), former acting US Army Surgeon General, Co-Chair
Shannon Minter, JD, Legal Director, National Center for Lesbian Rights, Co-Chair

REPORT OF THE PLANNING COMMISSION ON TRANSGENDER MILITARY SERVICE

August, 2014

PALM CENTER

BLUEPRINTS FOR SOUND PUBLIC POLICY

Report of the Planning Commission on Transgender Military Service

A nonpartisan national commission offering implementation guidance for the inclusion of openly-serving transgender personnel in the US military.

Commission Co-Chairs:
MG Gale S. Pollock, USA (Ret.)
Shannon Minter, JD

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BG Clara Adams-Ender, USA (Ret.)
Professor Kylar W. Broadus, JD
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Professor Tammy S. Schultz, PhD

Contents

The Palm Center is a research initiative of the Political Science Department of San Francisco State University. The views expressed are those of the authors and do not necessarily represent the views of the Department of Defense or the US Government.

Executive Summary

- An estimated 15,500 transgender personnel serve in the US armed forces, but current policy prohibits them from serving and requires separation if they are discovered.

- The US armed forces likely will, at some point, join the 18 foreign nations that allow transgender personnel to serve openly.

- In this report, we outline ideal administrative practices for adopting inclusive policy while maintaining readiness. In particular, we identify 14 relevant dimensions of policy formulation and implementation concerning transgender military service, and offer administrative guidance to help prepare the US military for the inevitable updating of current policy.

- Our central conclusion is that formulating and implementing inclusive policy is administratively feasible and neither excessively complex nor burdensome.

- Our research has been guided by seven overarching principles, beginning with the premise that preserving and promoting military readiness must be the priority of any new policy.

- Our recommendations are informed by lessons from foreign military forces that allow transgender personnel to serve openly, as well as research on, and experience with, the integration of groups previously excluded from the US military.

- In addition to careful planning and policy formulation, research shows that strong leadership throughout the chain of command will ensure successful implementation.

- While the transition to inclusive policy will require some effort and resources, the status quo policy of separating transgender personnel requires commanders, attorneys, and administrators to expend effort and resources as well.

- Inclusion of transgender personnel, however, is not primarily about administrative matters, but about core military values and principles: all military personnel should serve with honor and integrity, which means that they should not have to lie about who they are; all members of the military should be treated with respect; all persons capable of serving their country should be allowed to do so; and the military should not needlessly separate personnel who are willing and able to serve.

1) Introduction[1]

In May 2014, Secretary of Defense Chuck Hagel stated that he is open to reviewing the rules that govern service by transgender people, an estimated 15,500 of whom serve currently in the US armed forces.[2] Following his remarks, a White House spokesperson indicated that the administration supports Secretary Hagel's openness to a regulatory review. While the timing of any future policy revision is unknown, the US armed forces likely will, at some point, join the 18 foreign nations and NATO allies that allow transgender personnel to serve openly.[3] Unlike "don't ask, don't tell," the Congressional statute that for nearly two decades prohibited gay, lesbian, and bisexual people from serving openly in the armed forces, the rules and regulations governing transgender military service appear in military instructions under the authority and jurisdiction of the President and Secretary of Defense.

In March 2014, the Transgender Military Service Commission, a panel of military and medical experts including a former US Surgeon General, released a report underscoring the need for more careful deliberation in this area.[4] In particular, the Commission called for military analysts as well as outside experts to consider how to "formulate administrative guidance to address fitness testing, records and identification, uniforms, housing and privacy." The Commission also suggested that efforts to formulate inclusive policy should be informed by lessons from foreign military forces that allow transgender personnel to serve. In this report, we follow that Commission's advice by identifying all anticipated dimensions of policy formulation and implementation concerning service by transgender people and offering administrative guidance. As the Commission recommended, our conclusions are informed by lessons from foreign military forces that allow transgender personnel to serve openly, as well as research on, and experience with, the integration of groups previously excluded from the US military. As we demonstrate, formulating and implementing inclusive policy is administratively feasible and neither excessively complex nor burdensome.

Strong leadership throughout the chain of command has been the cornerstone of military culture and has led to the successful integration of other previously excluded groups throughout our military's history. Leadership by the Commander in Chief, and by senior officers and non-commissioned officers embracing the inclusion of transgender personnel, will be as vital to transgender inclusion as it was to integration based upon race, gender, and sexual orientation. As was the case with the repeal of "don't ask, don't tell," commanders will be responsible for setting a tone that takes fundamental leadership principles seriously, and setting such a tone is likely to prevent conflict and problems. For this to happen, military research notes that it is particularly important for the Commander in Chief to articulate his policy goals clearly, and for the military's top commanders to echo that message. Training modules will need to be prepared for leaders as well as for the rank and file. The literature shows consistently that organizations that demonstrate respect for members and that treat them accordingly show higher morale and performance levels. Strong leadership from the top will be the key to creating such a culture of respect.

2) Core values

We address the question of whether transgender personnel should be allowed to serve in the context of core values, including whether citizens who are able to serve their country should be

allowed to do so, absent clear and compelling reasons for exclusion. As determined by the Transgender Military Service Commission, no such reasons for exclusion exist in this case. Policy changes in complex organizations must be coordinated with deliberation, and can require periods of adjustment. Inclusive policy, however, will yield administrative efficiencies as well, as it takes time, energy, and money to maintain exclusionary policies. Thus, while the transition to inclusive policy will require some effort and resources, the status quo policy of separating transgender personnel requires military commanders, attorneys, and administrators to expend effort and resources as well. The experiences of foreign military forces as well as domestic police and fire departments in which transgender personnel serve openly show that formulating and implementing inclusive policy is neither excessively complex nor burdensome. Transgender inclusion, however, is not primarily about administrative matters. It reflects the core military values and principles that all military personnel should serve with honor and integrity, which means that they should not have to lie about who they are; all members of the military should be treated with respect; all persons capable of serving their country should be allowed to do so; and the military should not needlessly separate personnel who are willing and able to serve. Former Chairman of the Joint Chiefs of Staff Admiral Mike Mullen, while discussing the question of gay, lesbian, and bisexual people in the military, referred to the "whole issue of integrity in asking young people to come in to a military and essentially live a lie in an institution that values integrity at the highest level."[5] The same point could be made about transgender military service.

Before beginning our research, we came to agree on seven overarching principles that would guide our investigation. In formulating these principles, our concern was identifying standards that any new policy must meet in order to ensure that military readiness is enhanced at the same time that the well-being of transgender and non-transgender personnel is promoted. The seven principles we identify below should serve as benchmarks, or minimum standards, for any new policies that the Pentagon enacts.

(1) Promote military readiness. Preserving and promoting military readiness should be the priority of any new policy. As with all policies that the military adopts, the central aim of new rules concerning transgender military service should be to enhance the military's ability to accomplish its mission. Mission must always come first.
(2) Formulate unified policy. Unified and comprehensive policy concerning transgender service should be developed so that commanders and subordinates know where to turn for guidance. While the Services may wish to develop implementing regulations that follow from Defense Department instructions, a DoD–wide policy that is unified in a single document will minimize confusion.
(3) Minimize regulatory revision. The presumption should be against creating new rules that regulate transgender and non-transgender service members differently. The major exception is that new rules are required to govern gender transition, a process that is by definition temporary. There is no reason to treat transgender and non-transgender personnel differently on an ongoing basis before or after transition.
(4) Provide medically necessary health care. Transgender personnel should be provided with medically necessary health care, as is the case with all personnel whose medical conditions can be addressed sufficiently to maintain or restore their fitness for duty.

(5) Follow scientific consensus: Military medicine generally follows the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*), but current medical regulations do not reflect modern medical understandings of gender identity, and military medicine ignores standards of care applicable to the health care needs of transgender personnel. Transgender identity should be de-pathologized in military rules, and transgender service members should be treated in accordance with established medical practice, as is the case with all other personnel.
(6) Apply relevant foreign military lessons. While no two military organizations are exactly the same, the US military often studies and applies lessons learned by foreign militaries.[6] In the case of transgender military service, lessons should inform the implementation of US policy.
(7) Preserve flexibility. Because no two transgender individuals transition in exactly the same way, military regulations should be flexible enough to allow the individual service member and the unit commanding officer to fashion a transition plan that is medically appropriate for the service member and supportive of the command's mission.

3) Methods

Our research methodology consisted of careful analysis of foreign military regulations concerning transgender military service, as well as interviews with policy makers and service members from United Kingdom, Israel, Australia, Canada and New Zealand. During the course of our interviews, we sought to acquire a deep understanding of lessons learned — what worked and what did not work — when foreign military forces adopted inclusive policy. We also consulted the scholarly literature on organizational change, and paid particular attention to the recommendations of the RAND Corporation and the Pentagon's Comprehensive Review Working Group, both of which offered extensive guidance on the related question of how to allow gay, lesbian, and bisexual people to serve openly without disrupting readiness.

4) Definitions

> This background summary of relevant definitions is taken almost verbatim from the first in a series of Palm Center commission reports on transgender military policy, the March 2014 *Report of the Transgender Military Service Commission*.

Transgender is an adjective used to describe people whose "sex at birth is opposite from who they know they are on the inside. Many transgender people are prescribed hormones by their doctors to change their bodies. Some undergo surgery as well."[7] There is no single medical treatment for transgender individuals who undergo gender transition, as a wide variety of surgical and/or hormonal options is available. *Surgical transition* refers to the use of transition-related surgery to change one's gender; *medical transition* refers to the use of surgery and/or cross-sex hormone treatment (CSH) to do so; and *social transition* refers to dressing, working, and living in one's *target gender* (a term that is used by the US Office of Personnel Management to refer to the gender to which an individual intends to transition) and often includes changing one's name and gender marker in official records. The transgender community includes people

who have already transitioned to the other gender, who have not yet transitioned but who plan to do so, and who identify with the other gender but do not plan to transition.[8]

Mental health professionals have de-pathologized gender nonconformity in recent years. In the newest edition of the *Diagnostic and Statistical Manual* (*DSM-5*), gender identity disorder has been replaced with gender dysphoria, a diagnostic term that refers to clinically significant distress that may follow from an incongruence between a person's gender identity and the physical gender that they were assigned at birth.[9] Gender dysphoria is understood as a condition that is amenable to treatment,[10] and mental health professionals agree that not all transgender individuals suffer from dysphoria. The World Health Organization's Working Group on the Classification of Sexual Disorders and Sexual Health (WGCSDSH) has recommended that the forthcoming version of the *International Statistical Classification of Diseases and Related Health Problems* (*ICD-11*), due for publication in 2015, "abandon the psychopathological model of transgender people based on 1940's conceptualizations of sexual deviance."[11] According to a recent publication by WGCSDSH members, "once-prevailing views that reject the aim of supporting transition are no longer part of the mainstream of either psychiatric or general medical thought and practice…[and] the continued linkage of gender identity diagnoses with paraphilias and diagnoses of sexual dysfunction in the classification system appears to be both outdated and inappropriate."[12]

The reclassification of gender nonconformity in both *DSM* and *ICD* is based, in part, on the understanding among scientists and medical practitioners that distress can be caused by prejudice and stigmatization, not mental illness, and that many individuals who do not identify with the physical gender they were assigned at birth do not suffer from clinically significant distress, and therefore do not have a medical or psychological illness.[13] WGCSDSH members wrote recently that, "there are individuals who today present for gender reassignment who may be neither distressed nor impaired."[14]

5) Current regulations

> Portions of this background summary of military regulations are taken almost verbatim from the first in a series of Palm Center commission reports on transgender military policy, the March 2014 *Report of the Transgender Military Service Commission*.

Policies governing transgender service can be broken down into two categories: accession disqualifications and retention disqualifications.

Accession disqualification: Department of Defense Instruction (DODI) 6130.03 establishes medical standards for entry into military service.[15] Enclosure 4 of DODI 6130.03 contains a list of disqualifying physical and mental conditions that preclude applicants from joining the military, and the list includes the following conditions, some of which are transgender-related: 14f. Female genitalia: History of major abnormalities or defects of the genitalia including but not limited to change of sex …15r. Male genitalia: History of major abnormalities or defects of the genitalia such as change of sex …25l. Endocrine and metabolic: Male hypogonadism [low testosterone] …29r. Learning, psychiatric and behavioral: Current or history of psychosexual

conditions, including but not limited to transsexualism, exhibitionism, transvestism, voyeurism, and other paraphilias.[16] Thus, the accession prohibition against transgender service includes a physical component ("change of sex") and a psychological component ("transsexualism").

Medical regulations generally allow for waivers of accession standards under some circumstances.[17] Accession regulations also specify, however, that waivers will not be granted for conditions that would disqualify an individual for the possibility of retention.[18] As discussed below, because some conditions related to transgender identity are grounds for discharge, and because recruiters cannot waive a condition upon enlistment that would be disqualifying for retention, transgender individuals cannot obtain medical waivers for entrance into the military. In response to a 2013 Freedom of Information Act (FOIA) request submitted by the Palm Center, the Pentagon disclosed that between 2008 and 2012, three individuals had been denied entry into the military for transgender-related conditions.[19] We are unaware of any instances in which transgender-related conditions have been waived at the time of accession.

Retention disqualification: Less than three weeks before this report was released, the Department of Defense cancelled DODI 1332.38, *Physical Disability Evaluation*, its longstanding regulation on medical retention standards.[20] This regulation was replaced by DODI 1332.18, *Disability Evaluation System (DES)*, on August 5, 2014. One of the important changes in the new issuance was the elimination of DoD guidance on specific medical conditions that may lead to separation from the military. Instead, the new DODI 1332.18 sets only general criteria for referral for disability evaluation and defers to service-specific standards for retention. Criteria for referral include whether a medical condition prevents reasonable performance of duty, represents an obvious medical risk to self or others, or imposes unreasonable requirements on the military.[21]

Until the recent change, DoD retention disqualifications included two components, the first of which distinguished transgender identity from medical conditions that were eligible for evaluation and treatment, and the second of which designated conditions that were ineligible for evaluation and treatment as grounds for discharge. Unlike regulations governing entry, the now-cancelled DODI 1332.38 divided potentially disqualifying conditions into two tracks. Individuals with conditions deemed "physical disabilities" (both physical and psychological) were tracked into a medical system of disability evaluation, leading to a determination of fitness for duty or entitlement to benefits for medical separation or retirement. However, service members with conditions defined as "not constituting a physical disability" could be separated administratively from military service at a commander's discretion, without the same opportunity to demonstrate medical fitness for duty or eligibility for disability compensation. This system diverted some service members out of the medicine-based disability system and into the commander-based system for administrative separation, and rendered them ineligible for disability evaluation. DODI 1332.38 listed more than twenty conditions and circumstances defined by the regulation as "not constituting a physical disability," including "Sexual Gender and Identity Disorders, including Sexual Dysfunctions and Paraphilias."[22]

The new DODI 1332.18 no longer lists transgender-related conditions as grounds for administrative separation. However, the regulation permits the individual services to authorize administrative separation outside the usual medical evaluation process on the basis of "a condition, circumstance, or defect of a developmental nature, not constituting a physical

disability," which is language similar to the basis for separation of transgender personnel under the earlier regulation. DODI 1332.18 leaves it to the individual services to determine which conditions should be placed in this discretionary category, but only if the conditions in fact "interfere with assignment to or performance of duty."[23] This is a significant change from the earlier regulation, which permitted administrative separation under a variety of circumstances at the discretion of a commander, including separations of transgender personnel, but without any explicit requirement than an individual's fitness for duty was affected.

Service-specific regulations from the Army, Navy/Marine Corps, and Air Force still disqualify transgender personnel for retention,[24] and the new guidance in DODI 1332.18 does not appear to overrule those service policies. However, the service policies were instituted under a system in which DoD issued general policies governing retention for all military services, and DoD has eliminated any directive that transgender personnel should be subject to administrative separation. DODI 1332.14 controls administrative separations for enlisted persons (DODI 1332.30 controls for officers), and the policies behind administrative separation emphasize conduct and discipline, not medical fitness.[25] A service member may be separated for the convenience of the government and at the discretion of a commander for "other designated physical or mental conditions," but DoD no longer includes transgender issues within that category.[26]

In response to a recent FOIA request for discharge data submitted by the Palm Center, a Pentagon spokesperson said that the military does not track the number of service members who have been separated for transgender-related reasons. We are aware, however, of approximately two dozen service members who have been discharged because of their transgender identity in recent years.[27]

In addition to the accession and retention regulations discussed above, some aspects of transgender military service are governed by other rules. For example, transgender service members risk being held in violation of orders for receiving undisclosed or prohibited medical treatment if they obtain health care from non-military doctors without receiving permission from commanders.[28] The military health care system specifically prohibits treatment related to gender identity.[29]

6) Regulatory update

Allowing transgender personnel to serve requires only minor regulatory revisions. Defense Department as well as service regulations should be amended to eliminate bars to accession and grounds for separation. As explained above, Defense Department accession regulations automatically disqualify all transgender applicants, whether the condition is defined physically ("abnormalities or defects of the genitalia such as change of sex") or mentally ("psychosexual conditions, including but not limited to transsexualism"), regardless of ability to serve or degree of medical risk. These enlistment bars should be deleted.[30] Also as explained above, service-level retention regulations list transgender identity as a condition of presumptive unfitness justifying administrative separation, although the new DODI 1332.18 now limits such separations to circumstances preventing fitness for duty. Gender identity issues should be deleted from the list of conditions that service regulations deem ineligible for physical evaluation and treatment and

also deleted from the list of conditions that justify administrative separation. Finally, military health care rules that prohibit medical treatment related to gender identity should be deleted, giving transgender service members the same access to health care provided to non-transgender personnel.

Transgender service members should be denied enlistment or considered for separation when surgical, medical, or psychiatric conditions are unresponsive to treatment or will interfere with performance of duty, in accordance with existing regulations. That said, once the ban on transgender service is lifted, the military will not require any new medical policies to replace current prohibitions. Transgender individuals can be diagnosed and treated under existing military protocols, and current medical regulations that apply to everyone are sufficient for enabling commanders and physicians to assess transgender service members' fitness for duty. Aside from the elimination of prohibitions described above in this discussion of regulatory updating and a commitment to allowing transgender personnel to obtain medically necessary care that is consistent with the latest standards of care,[31] new medical rules for transgender personnel are unnecessary. In light of recent federal government decisions to provide transition-related coverage through Medicare and to cease prohibiting private insurance companies from providing such coverage to federal employees, as well as changes at the state and local level and among private sector employers, it is clear that the national trend is in the direction of providing medically necessary transition-related care. The military should provide such care as well.[32] The military health care system permits referral for specialty care that is not available at military treatment facilities or within its civilian provider network.[33]

Current military policy already allows service by individuals who may require hormonal treatments, including those with hormonal imbalance, dysmenorrhea, endometriosis, menopausal syndrome, chronic pelvic pain, hysterectomy, or oophorectomy, which only require special medical referral if they cause complications or impair duty performance. Non-transgender service members are allowed to take a wide range of medications, including hormones, while deployed in combat settings, and existing military policy states that "There are few medications that are inherently disqualifying for deployment."[34] As is the case with other service members taking prescription hormones, transgender personnel who are receiving cross-sex hormonal treatment should be considered fully fit for service so long as the dose of medication is stable, there are no significant side effects, and the medication does not interfere with military duty.[35] No special evaluation should be necessary.

Transition-related surgery undertaken before military service should be regarded no differently from any other surgery that potential recruits may undergo, and should only disqualify individuals from service in rare cases of serious, chronic post-operative complications. For those military members who, in consultation with physicians, determine that they need surgery after accession, the procedure should be treated in the same manner as other medically necessary procedures that may require a recovery period. In such cases, the member should be given medical leave for recovery except in rare cases when recovery requires an unusually extended period of time. There are, of course, risks of post-surgical complications which can become chronic, but the risks are no higher than risks associated with other procedures, and they are lower than risks that accompany some non-transgender-related reconstructive surgeries which are permitted.[36] According to a recent ruling by the Department of Health and Human Services,

transition-related surgery "is safe."[37] Any post-surgical complications that arise should be addressed by medical professionals on a case-by-case basis under existing medical protocols.

The fact that a medical problem is related to transgender care is much less important than the nature of the medical problem itself. Any resulting physical or mental impairment should be the focus, regardless of the cause. Medical regulations governing enlistment and retention already require fitness evaluation when surgical, medical, or psychiatric conditions are unresponsive to treatment or will interfere with performance of duty. Gender identity is not relevant to those medical determinations, and medical conditions should be evaluated under the same standards for both transgender and non-transgender personnel.

7) Administrative issues

Based on our analysis of foreign military forces that allow transgender personnel to serve, we have identified 14 administrative issues that should be addressed when military planners prepare to adopt inclusive policy. We offer guidance on each issue below.

(1) Gender marker changes
The Defense Enrollment Eligibility Reporting System (DEERS) manages the identity information used to issue identification cards (Common Access Cards) for military personnel. DEERS relies on the same documents for verifying identity that are reviewed by the US Citizenship and Immigration Services to establish civilian employment eligibility. To obtain a military identification card, applicants must present two valid and original documents "from the list of acceptable documents included in the Form I-9 'Employment Eligibility Verification.'"[38] A US passport appears first on that list as the gold standard of identification documents. We highlight the acceptance of a US passport within the DEERS procedures for managing military identity information because the State Department has already instituted a standard and efficient procedure for changing gender markers in passports.[39] Under State Department rules, applicants have two options for the timing of gender marker changes. They may obtain a ten-year passport reflecting a new gender by presenting a physician's letter stating that "the applicant has had appropriate clinical treatment for gender transition." Alternatively, they may obtain a two-year passport by presenting a physician's letter stating that "the applicant is in the process of gender transition."

Because the military already relies on the accuracy of passports for establishing identification (and, by definition, on the procedures followed by the State Department for updating gender markers), it should directly accept the same underlying documentation of gender transition once the ban on transgender service is lifted. This documentation requires only a physician's letter certifying appropriate clinical treatment, which in many cases will be provided by a doctor also serving in the military. The Commission recommends that gender markers be changed at the commencement of transition to limit instances in which a service member's identity or access will be challenged. Challenges to identity and access are a particularly important issue in a military setting because the government can control right of entry to the workplace, living accommodations, and morale, welfare, and recreational activities. The Department of Veterans Affairs follows a similar physician-based procedure for changing gender markers in VA records.[40] Reliance on a standard federal practice also avoids the inconsistency of state-level

practices for changing gender markers in identity documents.[41] Although military identification cards do not state gender on the face of the card, the Commission recommends that cards be re-issued with a new photograph when necessary. Identification that accurately reflects gender presentation and appearance is an essential component of maintaining good order and discipline. No new procedures are needed for name changes within DEERS. Any service member can change his or her name by submitting a court order documenting a new legal name.[42]

2) Confidentiality and privacy

Information related to transgender status and medical care will be subject to the same rules regulating confidentiality of medical information that protect all service members. Medical confidentiality in the military is not absolute, and information may be disclosed if necessary to ensure military readiness and fitness for duty. The military "may use and disclose the protected health information of individuals who are Armed Forces personnel for activities deemed necessary by appropriate military command authorities to assure the proper execution of the military mission."[43] Commanders should consult with transgender service members and unit leaders within the chain of command to determine the best means of fostering acceptance and understanding during the process of gender transition, which we address in greater depth in a subsequent section. Colleagues should be reminded, however, that an obligation of confidentiality still applies, and commanders must make reasonable efforts to limit the use or disclosure of protected health information to the minimum necessary to accomplish the intended purpose.[44]

(3) Grooming

Upon the beginning of transition, transgender service members should conform to service-specific regulations governing grooming, appearance, and wearing of the uniform for their gender identity.

(4) Uniforms

The US military should follow the British model by establishing a policy to issue gender-correct uniforms all at once. Upon the beginning of transition, transgender service members should be issued new, gender-correct uniforms. British policy states that, "Every effort should be made to ensure that the issue of new uniform relevant to a transsexual person's acquired gender is done in a single issue, especially for items of gender-specific kit. This avoids causing embarrassment or anxiety to the individual if repeated visits to uniform clothing stores are required."[45] In the US military, current regulations authorize payment for replacement of initial-issue uniforms that are "rendered unusable," "if the loss was not caused by any fault or negligence of the service member."[46] Although this language can be interpreted to authorize replacement of uniforms rendered unusable as a result of gender transition, the regulation should be amended to make clear that medically directed gender transition requires a new initial clothing allowance, at no cost to the service member.

(5) Cross-dressing

In several cases now more than twenty years old, the military justice system upheld criminal prosecutions for wearing the clothing of the opposite gender while off-duty, which in practical terms has always meant the wearing of women's clothing by men.[47] Cross-dressing was prosecuted as conduct that was unbecoming, service-discrediting, or prejudicial to good order

and discipline.[48] In circumstances in which uniform regulations do not apply, the end of transgender disqualification rules should eliminate any need for gender-based regulation of off-duty dress that is compatible with gender identity.[49] However, in duty-related circumstances in which uniform regulations do apply, transgender service members should continue to dress in accordance with their gender assigned at birth unless and until they commence transition under medical guidance. All service members, transgender and non-transgender, should comply with existing regulations governing suitable civilian dress, such as rules related to bodily piercings or offensive messages. No changes to the Uniform Code of Military Justice or to military regulations are needed.

(6) Housing and bathroom facilities

Management of privacy concerns in military facilities has traditionally been a matter of command judgment and discretion, and the military has extensive experience in addressing those concerns when men and women live and shower in close quarters. Similar issues that arise as a result of transgender service may require resolution on a case-by-case basis, and commanders should not be constrained by across-the-board policies. No regulatory changes are needed. When they address privacy concerns, commanders should adhere to the following guidelines: (1) Upon beginning the process of transition, transgender personnel should use the accommodations of their target gender; (2) When practical, facilities should have some private, enclosed changing areas, showers, and toilets for use by any service member who desires them; (3) Temporary, reasonable compromises may be appropriate for transitioning individuals; (4) However, transgender personnel should not be required to use separate facilities; (5) Commanders should not create separate, new bathroom facilities or living quarters for the exclusive purpose of accommodating or segregating transgender personnel, because this would have the effect of formally setting up discriminatory systems; (6) However, commanders should have the discretion to modify bathroom and shower schedules as well as berthing or billeting assignments on a case-by-case basis if necessary to maintain morale, good order, and discipline; (7) Service members should be given the opportunity to wear shower shorts and/or shirts during compulsory group showers. All members of the military should be reminded that privacy is not guaranteed and that such minimal privacy is not a bar to mission accomplishment.

(7) Physical standards

The policy underlying the military's standards of physical fitness is to "maintain physical readiness through appropriate nutrition, health, and fitness habits," including "aerobic capacity, muscular strength, muscular endurance, and desirable body fat composition."[50] Physical fitness, it should be noted, is different from job-related fitness. Physical fitness tests "assess Service-wide baseline generalized fitness levels and are not intended to represent mission or occupationally specific fitness demands."[51] Only recently has the military started a process of determining job-specific physical standards for positions that have been closed to women on the basis of sex.[52] Physical fitness standards are adjusted for both gender and age, and transgender personnel who medically transition should be required to meet fitness standards for their target gender. Current regulations already permit a temporary waiver from fitness standards for medical reasons,[53] and transgender personnel should be allowed to use this remedial opportunity, if needed, to train to the new standard. If unsuccessful, the same consequences for failure to meet the standard would apply. No regulatory changes are needed.

(8) Eligibility for gender-specific occupational specialties
The Department of Defense is currently reviewing all military occupational specialties that exclude women to determine if gender-neutral standards would be appropriate. In the interim, however, and as long as gender-based restrictions limit assignment to some positions, transgender personnel who transition should be subject to assignment rules applicable to their target gender. Service members who transition from male to female would lose eligibility to serve in positions closed to women, while service members who transition from female to male should be permitted to serve in those positions if otherwise qualified. No regulatory changes are needed.

(9) Marriage benefits
The policy of the Department of Defense is to treat all married military personnel equally. "The Department will work to make the same benefits available to all spouses, regardless of whether they are in same-sex or opposite-sex marriages, and will recognize all marriages that are valid in the place of celebration."[54] Service by transgender individuals should have no effect on this policy. The military should follow the precedent set by the Social Security Administration, which assumes that marriages remain valid for their duration even if one or both of the spouses undergoes gender transition.[55]

(10) Harassment, equal opportunity, and non-discrimination[56]
The US Equal Employment Opportunity Commission considers discrimination on the basis of gender identity to be a form of sex discrimination, and the same standard should apply in military settings. All personnel deserve to work in harassment-free environments in which discrimination, humiliation, and intimidation are not acceptable. Upon the removal of prohibitions against transgender service, leaders should emphasize that harassment of other service members will not be tolerated and will be swiftly and appropriately addressed, and Military Equal Opportunity offices should provide venues for transgender service members to report incidents of harassment or discrimination.[57] Commanders are responsible for maintaining good order and discipline, and they should establish a clear tone of respect for transgender personnel.

(11) Early separation from the armed forces
Transgender status, in and of itself, should not be considered as legitimate grounds for early separation. While a service member may request early separation for reasons of undue hardship, the military is not required to grant the request.[58] Transgender personnel who seek to separate from the armed forces should follow the same procedures as anyone else seeking premature separation.

(12) Apprehension (arrest), detention, and incarceration
While only an insignificant number of transgender military personnel may become the subject of apprehension and detention, a model policy should be developed in line with federal standards established under the Prison Rape Elimination Act and best practices from civilian police departments and prisons.[59] Military police and security personnel should be trained to ensure that detainees and inmates are treated with respect and in accordance with their gender identity to the greatest extent practical. Upon apprehension, if a bodily search is necessary, the search should be conducted under rules applicable to the gender a person identifies with and lives in, unless the

individual requests to be searched by someone of the other gender. For short-term detentions, such as custody immediately after an apprehension, safety should always be prioritized, and detaining officers should determine which facility and cell placement would provide the safest environment. For long-term incarceration, military policy should require staff to classify transgender prisoners in terms of individualized considerations, including appearance and self-identification, with the aim of minimizing risk factors that can lead to sexual victimization. Military prisons should avoid reliance on automatic, long-term isolation as the only option for safely housing transgender prisoners. Military prisons should be required to adopt best practices, such as providing transgender prisoners the option of showering at separate times, to minimize the risk of sexual assault.[60] As is done for all non-transgender prisoners, all medically necessary health care should be provided.

(13) Selective Service

All non-transgender men who are between the ages of 18 and 25 and who live in the United States must register with the Selective Service. Individuals assigned female at birth who transition to male, however, are not required to register, while individuals assigned male at birth who transition to female must remain registered, even after the completion of gender transition. Unlike other federal agencies, in other words, the Selective Service Administration considers gender transition to be irrelevant, and only recognizes gender that was assigned at birth. Thus, in the event of a return of conscription after the lifting of the military's prohibition against transgender service, transgender women would be subject to the draft while transgender men would be exempt. Given that the purpose of Selective Service registration is to facilitate filling the military's ranks if the need arises, Selective Service should amend its rules to recognize gender transition and require registration accordingly. In the case of a draft, eligibility to serve becomes obligation to serve. As long as non-transgender men are required to register, transgender men, like all other men, should be required to fulfill this obligation.

(14) Supporting transgender service members

Even with a clear recognition of their need to undergo gender transition, some transgender personnel may not necessarily be aware of how to communicate about their transition with the chain of command, how to manage issues of disclosure to colleagues, and how to anticipate issues that may arise from undergoing gender transition while on active status. The military should prepare a brief memorandum, modeled on the Australian Air Force's *Air Force Diversity Handbook: Transitioning Gender in Air Force*, to provide advice about these and other related matters to transgender personnel contemplating or undergoing transition.[61]

8) Gender transition

Medically necessary gender transition is a variable process that individuals necessarily pursue in varied ways and at different times in their lives. Some transgender individuals will have completed their transition prior to joining the military, some will need to wait until they complete their military service, some may not transition at any point in their lives, and others will need to transition during their military careers. Thus, military policy concerning transition should be designed to promote medical readiness while allowing for flexibility in the ways that different individuals undergo gender transition. Service members who need to transition during their military careers should consult with a physician to determine the most fitting medical transition

program, ideal starting date, and expected length of time that the process will require. The medical transition program should include when the individual will be ready for social transition and begin the "real life experience" of living in the other gender full time; whether hormones and/or surgeries will be involved; and when agreed-upon medical treatments should take place. Typically, hormone therapy precedes social transition and the commencement of living in the other gender, which is generally advised before surgery. The appropriate duration of living in the other gender prior to surgery should be determined on a case-by-case basis by the service member and his or her physician. In many cases this duration will be a matter of months and, for some, may be up to a year. The date when social transition commences typically should be the date when the service member will be held to the grooming standards of the target gender, begin to use the housing and other facilities of the target gender, and have the right to change gender markers in DEERS. The physician should issue a letter confirming the service member's medical need to undergo transition.

A reasonable period of time prior to the commencement of transition, the service member should notify their commander, who should consult with Military Equal Opportunity staff as discussed below in our section on "Command and Leadership Responsibilities." Commanders should consult with the transitioning individual as well as the transitioning individual's physician or mental health provider.

In light of the medical necessity of gender transition for some transgender service members, and absent a military contingency sufficiently serious as to require other service members to defer medically necessary health care, commanders should not have final say over whether and when gender transition commences. Physicians should determine, in consultation with commanders, whether the member can continue to perform current duties or should be put on limited duty or medical leave. Factors to consider should include the needs of the unit, expected time of transition, availability of appropriate housing and toileting facilities during transition, and the transitioning individual's preferences for informing colleagues. Additionally, commanders should take into account whether the individual prefers to transfer to another unit upon the completion of the process. Temporary medical waiver from physical fitness standards should be granted, if necessary, under existing rules. With the input of the transitioning individual and the physician, the commander should then approve a gender transition plan that includes the following elements:

- *Informing colleagues*: How and when unit members will be informed, and how their questions will be addressed. Australian guidance on this point, for instance, suggests that "sufficient detail should be provided to explain the facts in an appropriate manner and at a suitable level, without going into unnecessary personal or graphic detail." Information provided to colleagues, according to the Australian guidelines, could include that there will be changes to the transitioning person's appearance, that there may be behavioral changes, and that the person's personality will likely remain unchanged.[62]

- *Facilities and accommodations*: How the reassignment of facilities and accommodations will be managed. Typically, the date when social transition commences will also be the date when the service member will begin to use the housing and other facilities of the target gender. According to Australian military guidance, "Should the situation arise

where open communal same sex showers are the only showers available (i.e. field exercises/deployments), the transitioning person and their commander or manager should discuss and agree upon an appropriate arrangement to ensure the needs of all people are met. This situation would only apply prior to the transitioning person undergoing gender realignment surgery."[63]

- *Changing official records*: When name and gender markers in the DEERS system will be changed. Typically this should take place upon the commencement of social transition.

Appendix 1 to this report contains a flowchart used by the Australian military to illustrate the administrative process of gender transition.[64]

9) Training

The more leaders and service members feel capable of doing what is necessary to adapt to the new policy, the more likely it is that it will be implemented successfully. Training was critical to the success of "don't ask, don't tell" (DADT) repeal and to the Veterans Health Administration's 2011 introduction of transgender health care, and it will be an important element of transgender inclusion in the military as well. As such, we provide the following recommendations for training to help military personnel at all levels adjust to the new policy without imposing unnecessary educational requirements on members who do not need them.[65]

As was the case with training materials that DoD developed in preparation for DADT repeal, training should be accompanied by vignette examples of cases that reveal variation in social and medical experiences, because vignettes can provide service members with opportunities to think through and practice professional conduct in new situations they may face. In addition, training modules should include a set of frequently asked questions that may come from military personnel in varied roles as well as from their families. As it develops its own materials, the DoD should consult relevant training materials that other organizations have prepared, such as VA Boston Healthcare System's *Patient Care Memorandum* on the *Management of Transgender Veteran Patients*.[66]

Training materials through written, video, and face-to-face methods should precede and accompany policy implementation, revealing leadership's commitment to its swift and effective change and providing military members with the tools to comply. For example, the repeal of DADT was accompanied by training videos that included a message from Marine Corps Commandant James Amos and Sergeant Major Carlton Kent, emphasizing the commitment to the mission in the wake of the repeal. Training modules that we recommend below should address the following topics:

- Explanation of the new policy, and the rationale behind it
- Role of audience members in effective policy implementation ("What does this change mean to me?")
- Professional conduct associated with working with transgender service members
- Definitions of transgender and other related language, including distinctions between biological sex, gender identity, and sexual orientation

- Name, pronoun use, preferred terminology (included gendered formal address – when relevant) and protocols for determining this when unknown
- Policies on discrimination and harassment
- Confidentiality and privacy requirements (both with regard to disclosure of transgender identity and related medical issues)
- Resources available for transgender service members
- Accountability processes, including sanctions to enforce compliance

(1) *Military Equal Opportunity* (*MEO) Officers*: The Office of Diversity Management and Equal Opportunity should design thorough training for all military and civilian MEO personnel. Training should go into depth about the new policy, and should prepare MEO personnel to advise commanders who supervise individuals undergoing gender transition. MEO personnel should be sufficiently trained to provide one-stop shopping for commanders seeking advice about any aspect of the new policy or about gender transition.

(2) *Health care personnel*: Surgeons General of each service branch should design brief training modules, informed by materials that have been developed by the VHA, for all health care personnel, including doctors, nurses, and mental health providers.[67] The training should consist of a short video that would explain the new policy, discuss health care needs of transgender individuals, address rules and best practices concerning confidentiality and disclosure, and reinforce the point that transition plans differ from person to person.[68] Health care personnel should be provided with a summary version of the World Professional Association for Transgender Health's (WPATH) *Standards of Care (SOC) for the Health of Transsexual, Transgender, and Gender Nonconforming People*, which offers extensive information on every aspect of transgender health care.[69]

(3) *Experts*: The Office of Diversity Management and Equal Opportunity should design a brief training module for personnel responsible for administration or policy implementation, or whose occupational specialty requires them to understand the implications of policy change. At a minimum this would include judge advocates and civilian lawyers, chaplains, recruiters, personnel specialists, and military law enforcement personnel.

(4) *Leaders*: The Office of Diversity Management and Equal Opportunity should design a brief training module for personnel in leadership positions who are responsible for maintaining standards of conduct, good order and discipline, and military effectiveness. At a minimum this includes: senior leaders (general/flag officers and Senior Executive Service), commanding officers, commissioned and warrant officers, senior enlisted advisors, senior non-commissioned officers, and civilian supervisors. Rather than going into depth, the training should instruct leaders to consult with a Military Equal Opportunity officer if an individual under their command seeks to undergo transition. Training materials for leaders should emphasize leadership principles and service core values, and the expectation that if transgender personnel serve under their command, it will be their responsibility as leaders to become knowledgeable about relevant policies and guidelines, to educate members about professional conduct, and to hold them accountable for compliance.

(5) *Service members*: A brief module explaining the new policy and outlining expectations of personal conduct should be included in already-existing diversity trainings that take place from time to time. The training module should address professionalism and core values (e.g., respect, service, integrity, and honor), definitions, administrative issues (e.g., uniform regulations and physical standards), and consequences of unprofessional conduct.

10) Command and leadership responsibilities

Drawing upon policy and guidelines in use and recommended by other agencies regarding the employment of transgender personnel, this section presents command staff responsibilities that will facilitate transgender inclusion, consistent with core service values.[70] This section offers administrative guidance to help commanders know what to expect and what is expected of them when a transgender individual serving in their unit undergoes gender transition.

The RAND Corporation's 1993 and 2010 reports about sexual orientation and the military and the DoD's *Support Plan for Implementation* for the repeal of "don't ask, don't tell" thoroughly address the inclusion of gay, lesbian, and bisexual service members.[71] These reports, which include reviews of related social science research on implementation of change in complex organizations, contain lessons for the inclusion of transgender service members, as do actual experiences integrating gay, lesbian, and bisexual personnel in the US and abroad.[72] The success of DADT repeal was due, at least in part, to DoD's thoughtful and deliberate approach to implementation, which included an education and training framework emphasizing the importance of military professionalism.[73]

Scholarly analysis of transgender military service confirms the central role of leadership for policy implementation and underscores lessons learned during the integration of gay, lesbian, and bisexual personnel.[74] In particular, policy implementation requires leadership, and leadership, in turn, depends on clearly formulated policy.[75] Research suggests that in Canada, an inclusive transgender policy did not undermine readiness in the military. However, vague policy, an absence of education and training, and a failure to hold "commanders accountable for successful enforcement of the policy" did pose unnecessary and avoidable challenges to the integration of transgender personnel.[76] The Canadian case reaffirms some of the critical components of effective policy implementation, including professionalism and respect communicated through example, as well as the commitment of leadership and subsequent education and training.[77]

While having a member of one's command pursue gender transition will likely be a rare occurrence, commanders should receive basic guidance on pertinent regulations. Additionally, commanders whose units include transgender members undergoing gender transition should be required to turn to MEO officers for assistance, and MEO officers should be held responsible for developing enough in-house expertise to assist commanders, as was the case during DADT repeal. Indeed, DoD's *Support Plan for Implementation* makes clear that MEO personnel are responsible for training and for fostering environments free of harassment.

Taking into account lessons learned in the Canadian Forces, MEO officers can offer information that will assist commanders in meeting the needs of personnel undergoing gender transition

without compromising unit effectiveness.[78] More specifically, MEO officers should help commanders fulfill their responsibilities to:

- Know that advice from medical personnel should be treated with the same consideration as would be accorded to medical advice about any other physical or mental condition.
- Know what transgender means and whom it includes. This includes understanding key definitions related to sex and gender.
- Know policies on discrimination and harassment as they relate to gender identity.
- Use, and require others to use, respectful and preferred terminology (including preferred pronouns) when talking to and about transgender service members. If unsure of which language to use, ask directly how the person would like to be addressed.
- Know how policy changes related to transgender inclusion inform administrative regulations related to appearance (uniforms, grooming standards), physical standards, records, facilities, privacy, and confidentiality. Understand that these issues are managed in terms of gender identity, rather than biological sex.
- Respect transgender service members' right to privacy with regard to personal (including medical) information. This includes restricting questions about anatomy to persons with a professional need to know.
- Ensure that transgender service members who are transitioning are treated with dignity, respect, sensitivity, and confidentiality, as with anyone else managing a challenging life experience.[79]
- Proactively respond to reports of violations of these requirements.
- Work with transgender service members and other designated staff to develop a transition plan addressing the activities and logistics involved in their transition process.[80]
- Educate and train unit members on associated policies, their implementation, and related professional conduct; ensure they are prepared to comply; and enforce compliance regulations in place. This includes responding to questions and clarifying points of confusion.

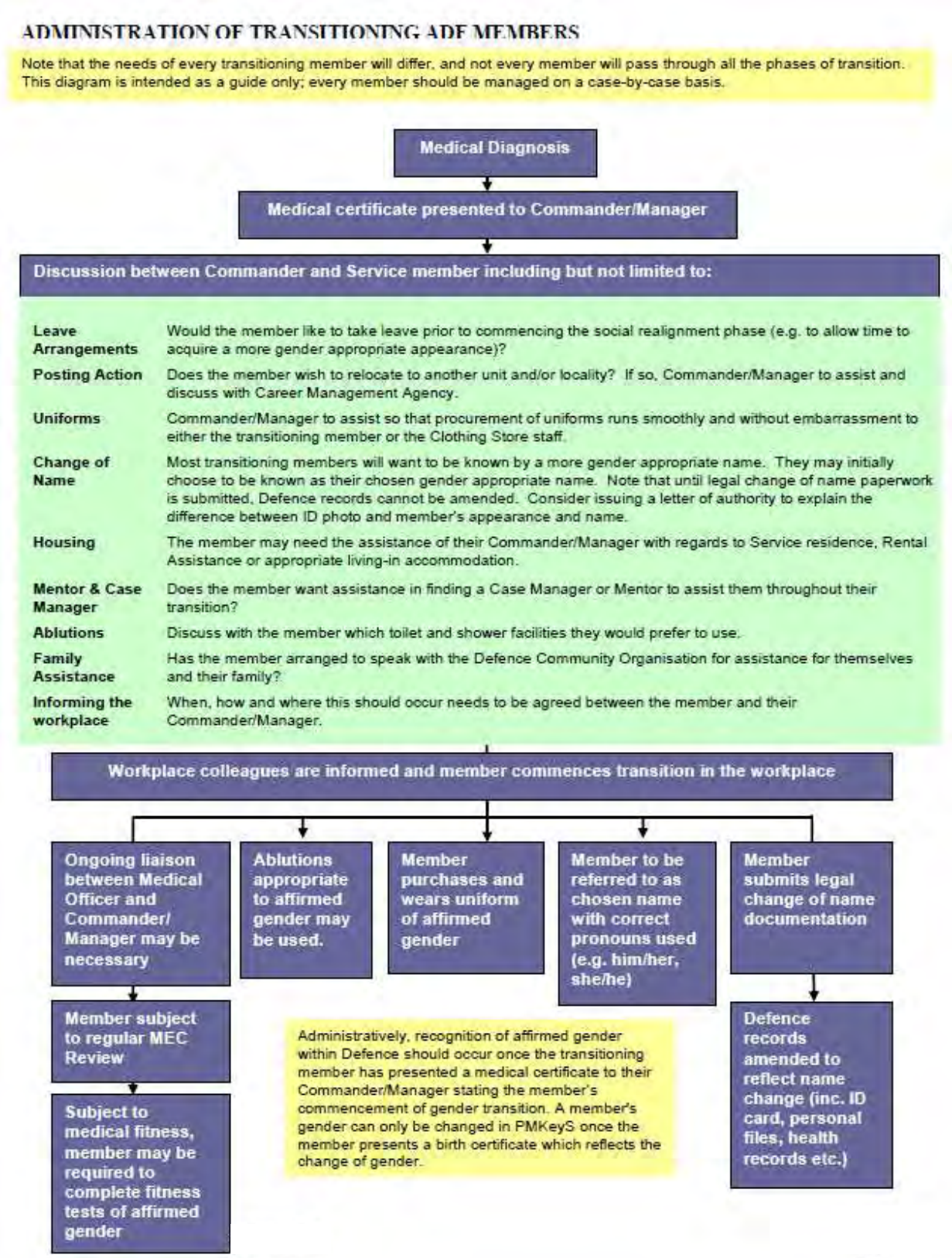
In the second appendix of this report, we re-publish a list of "Tips For Commanders From Members Who Have Transitioned Gender," which was developed by the Australian Air Force. Commanders who fulfill their responsibilities will demonstrate a commitment to the change in policy and ensure respect and privacy for both transgender and non-transgender personnel.

11) Conclusion

The decision to allow transgender personnel to serve in the military reflects the core values and principles that all military personnel should serve with honor and integrity; all persons capable of serving their country should be allowed to do so unless there is a compelling reason for prohibiting their service; and the military should not needlessly separate personnel who are willing and able to serve. As we demonstrate in this report, formulating and implementing inclusive policy is administratively feasible. Experiences of foreign military organizations that have adopted inclusive policy indicate that when the US military allows transgender personnel to

serve, commanders will be better equipped to take care of the service members under their charge, and the 15,500 transgender individuals estimated to be serving currently will have greater access to health care and be better equipped to do their jobs. While the military must prepare for the implementation of inclusive policy with deliberation and care, doing so will not be burdensome or complex. By following the recommendations outlined in this report, the US military will better live up to its ideal of reflecting the diversity of the nation it is responsible for defending.

Appendix 1 (from the Australian Department of Defence)[81]



Appendix 2 (from the Australian Air Force)[82]

TIPS FOR COMMANDERS FROM MEMBERS WHO HAVE TRANSITIONED GENDER

- Protect the member's privacy. Information management is very important.
- Become very familiar with Understanding Transitioning Gender in the Workplace.
- Seek guidance and advice from the Padre, Psychology section and Medical services. Attend medical case management meetings to ensure you are well informed on the issues surrounding your member.
- Seek guidance and advice from other Commanders & Managers who have experience with gender issues. AFWD or DEFGLIS may be able to put you in contact with other Commanders/ managers who have been through a similar management process.
- If the member has not articulated a transition plan encourage the member to develop a transition plan to include a notification plan.
- Listen to the member's wishes with respect to disclosure to the workplace and the broader community.
- Provide the member with a Mentor who the member is comfortable with.
- Be sure you understand your member's wishes with regards to their transition
- Be open with your transitioning member. Feel free to ask them questions.
- Ensure that other members in the unit know that intolerance, bullying or any other ill-behaviour towards the member transitioning will not be tolerated.

Endnotes

[1] We thank Flight Lieutenant Caroline Page (Royal Air Force), Captain Jacob Eleazer (US Army National Guard), Captain Sage Fox (US Army Reserve), Mara Keisling (National Center for Transgender Equality), Harper Jean Tobin (National Center for Transgender Equality), and Professor George R. Brown (East Tennessee State University) for helpful comments on an earlier draft of this report and Professor Jennifer Sumner (Seattle University) for outstanding research support in the preparation of this report. This report draws on policy guidance developed by the National Collegiate Athletic Association, National Center for Transgender Equality, civilian agencies of the US federal government, and foreign military forces. For other resources on this topic, see the forthcoming analysis of implementation issues by Allyson Robinson, Sue Fulton, and Brynn Tannehill of SPART*A.

[2] See Gary Gates and Jody Herman (2014), *Transgender Military Service in the United States*, Los Angeles, CA: Williams Institute, retrieved at http://williamsinstitute.law.ucla.edu/wp-content/uploads/Transgender-Military-Service-May-2014.pdf.

[3] As reported by Joycelyn Elders, Alan M. Steinman, George R. Brown, Eli Coleman, and Thomas A. Kolditz, Medical Aspects of Transgender Military Service (forthcoming in *Armed Forces and Society*), based on a private communication with the authors of Joshua Polchar, Tim Sweijs, Philipp Marten, and Jan Galdiga (2014), *LGBT Military Personnel: A Strategic Vision for Inclusion*, The Hague, The Netherlands: The Hague Centre for Strategic Studies. The 18 countries are Australia, Austria, Belgium, Bolivia, Canada, Czech Republic, Denmark, Estonia, Finland, France, Germany, Israel, Netherlands, New Zealand, Norway, Spain, Sweden, United Kingdom.

[4] Joycelyn Elders, Alan M. Steinman, George R. Brown, Eli Coleman, and Thomas A. Kolditz (2014), *Report of the Transgender Military Service Commission*, San Francisco, CA: Palm Center, accessed at http://www.palmcenter.org/files/Transgender%20Military%20Service%20Report.pdf.

[5] Comments by former Chairman of the Joint Chiefs of Staff Mike Mullen, May 28, 2010.

[6] Nathaniel Frank (2010), *Gays in Foreign Militaries 2010: A Global Primer*, Santa Barbara, CA: Palm Center, 104-133, accessed at http://www.voltairenet.org/IMG/pdf/Gays_in_Foreign_Militaries.pdf.

[7] Transgender Law Center and Basic Rights Education Fund (2013), *Healthy People. Healthy Communities*, 11.

[8] For example, "For many gender non-conforming people, transition as a framework has no meaning in expressing their gender – there may be no transition process at all, but rather a recognition of a gender identity that defies convention or conventional categories." Jaime M. Grant, Lisa A. Mottet and Justin Tanis (2011), *Injustice at Every Turn: A Report of the National Transgender Discrimination Survey*, Washington, DC: National Center for Transgender Equality and National Gay and Lesbian Task Force, 26.

[9] In the World Professional Association for Transgender Health Standards of Care, dysphoria refers to the distress itself, not the incongruence between gender identity and assigned sex. See Eli Coleman et al. (2011), Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People, Version 7, *International Journal of Transgenderism*, 13, 168. Indeed, non-transgender people can experience gender dysphoria. For example, some men who are disabled in combat, especially if their injury includes genital wounds, may feel that they are no longer men because their bodies do not conform to their concept of manliness. Similarly, a woman who opposes plastic surgery, but who must undergo mastectomy because of breast cancer, may find that she requires reconstructive breast surgery in order to resolve gender dysphoria arising from the incongruence between her body without breasts and her sense of herself as a woman.

[10] Coleman et al., Standards of Care, 168.

[11] Jack Drescher, Peggy Cohen-Kettenis , and Sam Winter (2012), Minding the Body: Situating Gender Identity Diagnoses in the ICD-11, *International Review of Psychiatry*, 24(6), 575.

[12] Drescher, Cohen-Kettenis, and Winter, Minding the Body, 569; 574.

[13] Ilan H. Meyer and Mary E. Northridge, eds. (2007), *The Health of Sexual Minorities: Public Health Perspectives on Lesbian, Gay, Bisexual and Transgender Populations*, New York, NY: Springer.

[14] Drescher, Cohen-Kettenis, and Winter, Minding the Body, 573.

[15] Department of Defense Instruction (DODI) 6130.03, *Medical Standards for Appointment, Enlistment, or Induction in the Military Services*, April 28, 2010, Incorporating Change 1, September 13, 2011.

[16] Paraphilia is sexual arousal to an atypical object. See American Psychiatric Association (2013), *Diagnostic and Statistical Manual* (5th ed.), Arlington, VA: American Psychiatric Publishing.

[17] DODI 6130.03, *Medical Standards for Appointment*, Enclosure 2, ¶ 3(b).

[18] Army Regulation 40-501, *Standards of Medical Fitness*, December 14, 2007, Revised August 4, 2011, ¶ 1-6(h).

[19] Despite the small number of rejected applicants, demographic data indicate that transgender Americans are approximately twice as likely to serve in the military as non-transgender individuals. If the Pentagon were to allow open service, many more transgender citizens would want to serve. See Gates and Herman, *Transgender Military Service in the United States*.
[20] Department of Defense Instruction 1332.38, *Physical Disability Evaluation*, November 14, 1996, Incorporating Change 2, April 10, 2013 (cancelled August 5, 2014).
[21] Department of Defense Instruction 1332.18, *Disability Evaluation System (DES)*, August 5, 2014, Appendix 1 to Enclosure 3, ¶ 2.
[22] DODI 1332.38, *Physical Disability Evaluation*, Enclosure 5, ¶ 1.3.9.6 (cancelled).
[23] DODI 1332.18, *Disability Evaluation System (DES)*, ¶ 3(i); Appendix 1 to Enclosure 3, ¶ 4(a)(1).
[24] Army Regulation 40-501, *Standards of Medical Fitness*, § 3-35(a), (b); SECNAV Instruction 1850.4E, *Department of the Navy Disability Evaluation Manual*, April 30, 2002, Enclosure 8, § 8013(a) and Attachment (b); NAVMED P-117, *U.S. Navy Manual of the Medical Department*, January 10, 2005, Chapter 18, § 18-5(3); Air Force Instruction 36-3208, *Administrative Separation of Airmen*, July 9, 2004, Incorporating Change 7, July 2, 2013, § 5.11.9.5. The only exceptions are inconsistencies within Navy regulations. In special guidelines that apply only to nuclear field duty and submarine duty, Navy regulations state that transgender status is disqualifying only if it "interfere[s] with safety and reliability or foster[s] a perception of impairment." These sections appear to permit transgender personnel to serve openly provided their gender identity does not interfere with duty performance. NAVMED P-117, Chapter 15, §§ 15-103(4)(d)(4) (Nuclear Field Duty); 15-106(4)(k)(4) (Submarine Duty) (most recently updated April 4, 2014). These sections, however, are inconsistent with general Navy guidance that categorically disqualifies transgender individuals without consideration of duty performance, as do the policies of the other services.
[25] Department of Defense Instruction 1332.14, *Enlisted Administrative Separations*, January 27, 2014.
[26] DODI 1332.14, *Enlisted Administrative Separations*, Enclosure 3, ¶ 3(a)8.
[27] See, for example, Lisa Leff, Transgender Troop Ban Faces Scrutiny, *Associated Press*, March 13, 2014; Ernesto Londoño, For Transgender Service Members, Honesty Can End Career, *Washington Post*, April 26, 2014. The figure of two dozen was communicated in informal conversations with the leadership of SPART*A, an organization of currently-serving transgender service members.
[28] See, for example, US Marine Corps MCIWEST-MCB CAMPEN ORDER 6000.1, *Reporting of Prescribed Medications and Medical Treatment Outside the Military Health System*, October 1, 2012.
[29] TRICARE Policy Manual 6010.57-M (2008), Chapter 1, § 1.2, ¶ 1.1.29.
[30] DODI 6130.03, *Medical Standards for Appointment*, Enclosure 4, §§14-15, 25(*l*), 29.
[31] Coleman et al., Standards of Care.
[32] Department of Health and Human Services, Departmental Appeals Board, Appellate Division, NCD 104.3, Transsexual Surgery, Docket No. A-13-87, Decision No. 2576, May 30, 2014; Office of Personnel Management, FEHB Program Carrier Letter, Gender Identity Disorder/Gender Dysphoria, Letter No. 2014-17, June 13, 2014; Progress on Transgender Rights and Health, *New York Times*, June 10, 2014. See also the Human Rights Campaign's Corporate Equality Index, accessed at http://www.hrc.org/campaigns/corporate-equality-index on July 30, 2014.
[33] TRICARE Operations Manual 6010.56-M (2008), Chapter 8, Section 5 (referral procedures).
[34] Department of Defense, Assistant Secretary of Defense for Health Affairs Memorandum, *Policy Guidance for Deployment-Limiting Psychiatric Conditions and Medications*, November 7, 2006, ¶ 4.2.3.
[35] UK Ministry of Defence, *Policy for the Recruitment and Management of Transsexual Personnel in the Armed Forces*, 2009DIN01-007, London, January 2009, § 42.
[36] Elders et al., *Report of the Transgender Military Service Commission*.
[37] Department of Health and Human Services, Departmental Appeals Board, Appellate Division, NCD 104.3, Transsexual Surgery, Docket No. A-13-87, Decision No. 2576, May 30, 2014.
[38] Department of Defense Manual 1000.13 (Vol. 1), DOD Identification (ID) Cards: ID Card Lifecycle, January 23, 2014, Enclosure 2, § 4(a); US Citizenship and Immigration Services, Form I-9, Employment Eligibility Verification.
[39] US Department of State, *Foreign Affairs Manual*, 7 FAM 1300 Appendix M (Gender Change), http://www.state.gov/documents/organization/143160.pdf; US Department of State, Bureau of Consular Affairs, *Gender Reassignment Applicants*, http://travel.state.gov/content/passports/english/passports/information/gender.html.
[40] Department of Veterans Affairs, Veterans Health Administration, VHA Directive 2013-003, *Providing Health Care for Transgender and Intersex Veterans*, February 8, 2013, Attachment A, §§ 20-21.

[41] The military should consider setting its policy on gender marker change to update automatically with future revisions to federal procedures in the Departments of State or Veterans Affairs.
[42] Army Regulation 600-8-104, *Army Military Human Resource Records Management,* April 7, 2014, § 5-4; Naval Military Personnel Manual, MILPERSMAN 1000-130, *Name Change of Member,* August 28, 2013; Air Force Instruction 36-2608, *Military Personnel Records System*, August 30, 2006, Certified Current as of September 17, 2010, § 5.4.
[43] Department of Defense, Assistant Secretary of Defense for Health Affairs, DoD 6025.18-R, *DoD Health Information Privacy Regulation*, January 24, 2003, § C7.11.1.1.
[44] DoD 6025.18-R, § C8.2.1.
[45] UK Ministry of Defence, *Policy for the Recruitment and Management of Transsexual Personnel,* § 68.
[46] Department of Defense Instruction 1338.18, *Armed Forces Clothing Monetary Allowance Procedures*, January 7, 1998, § 5.1.7.
[47] *United States v. Modesto*, 39 M.J. 1055 (A.C.M.R. 1994); *United States v. Guerrero*, 33 M.J. 295 (C.M.A. 1991); *United States v. Davis*, 26 M.J. 445 (C.M.A. 1988).
[48] Articles 133, 134, Uniform Code of Military Justice, 10 U.S.C. §§ 933, 934.
[49] Cross-dressing that is not related to expression of gender identity, e.g. the paraphilia of transvestic fetishism, is unrelated to open service by transgender people and remains a matter of military concern.
[50] Department of Defense Instruction 1308.3, *DOD Physical Fitness and Body Fat Programs Procedures*, November 5, 2002, § 4.
[51] DODI 1308.3, § 6.1.3.1.
[52] Chairman, Joint Chiefs of Staff, *Women in the Service Implementation Plan,* January 9, 2013 (directing the services to validate performance standards for all occupational specialties closed to women).
[53] DODI 1308.3, § 6.1.3.2.
[54] Department of Defense, Under Secretary of Defense for Personnel and Readiness, *Further Guidance on Extending Benefits to Same-Sex Spouses of Military Members,* August 13, 2013.
[55] US Social Security Administration, GN 00305.005, Determining Marital Status (March 26, 2014), https://secure.ssa.gov/apps10/poms.nsf/lnx/0200305005.
[56] Our discussion of harassment uses verbatim and adapted language from Department of Defense, *Support Plan for Implementation: Report of the Comprehensive Review of the Issues Associated with a Repeal of "Don't Ask, Don't Tell,"* November 30, 2010.
[57] The Military Equal Opportunity program provides training about equal opportunity and enforces policies that prohibit unlawful discrimination and harassment. See Department of Defense Directive 1350.2, *Department of Defense Military Equal Opportunity (MEO) Program*, August 18, 1995, Certified Current as of November 21, 2003, Incorporating Change 1, May 7, 1997.
[58] DODI 1332.14, *Enlisted Administrative Separations*, Enclosure 3, § 3(a)(3).
[59] Prison Rape Elimination Act of 2003 (PL 108-79), codified at 42 U.S.C. §§ 15601 et. seq.
[60] For the increased risk of sexual assault among transgender prisoners, see, for example, American Civil Liberties Union (2005), *Still in Danger: The Ongoing Threat of Sexual Violence against Transgender Prisoners,* Washington, DC.
[61] Royal Australian Air Force, *Air Force Diversity Handbook: Transitioning Gender in Air Force*, Canberra, April 2013, accessed at http://www.defglis.com.au/resources/GenderTransitionGuide.pdf.
[62] Australian Department of Defence, *Understanding Transitioning Gender in the Workplace*, Canberra, November 10, 2011, 5. Retrieved from http://www.defglis.com.au/resources/UnderstandingTransition.pdf.
[63] Australian Department of Defence, *Understanding Transitioning Gender*, 7.
[64] Australian Department of Defence, *Understanding Transitioning Gender*, 14.
[65] This section uses verbatim and adapted language from Department of Defense, *Support Plan for Implementation*.
[66] Department of Veterans Affairs, VA Boston Healthcare System (2011), *Management of Transgender Veteran Patients, http://www.boston.va.gov/services/images/LGBT_PATIENT_CARE_MEMO_TRANSGENDER_CARE.pdf.*
[67] On the VHA's provision of health care to transgender veterans, see Kristin Mattocks, Michael Kauth, Theo Sandfort, Alexis Matza, J. Cherry Sullivan, and Jillian Shipherd, Understanding Health-Care Needs of Sexual and Gender Minority Veterans: How Targeted Research and Policy Can Improve Health, *LGBT Health* 1, 1X, 2013.
[68] Coleman et al., Standards of Care, 166.
[69] Coleman et al., Standards of Care, 165-232.
[70] These points draw upon the following materials using both verbatim and adapted language: Department of Defense, *Support Plan for Implementation*; National Collegiate Athletic Association, *NCAA Inclusion of*

Transgender Student-Athletes, 2011; Transgender Law Center (n.d.), *Model Transgender Employment Policy: Negotiating for Inclusive Workplaces;* US Department of the Interior, Office of the Secretary, *Personnel Bulletin No: 13-03, Transgender and Other Gender Non-Conforming Employee Policy*, 2013.

[71] RAND Corporation (1993), *Sexual Orientation and U.S. Military Personnel Policy: Options and Assessment*, National Defense Research Institute, Santa Monica, CA; RAND Corporation (2010), *Sexual Orientation and U.S. Military Personnel Policy: An Update of RAND's 1993 Study*, National Defense Research Institute, Santa Monica, CA.

[72] A. Belkin, M. Ender, N. Frank, G.R. Lucas, G. Packard, T.S. Schultz, S.M. Samuels, D.R. Segal (2012), *One year out: An assessment of DADT repeal's impact on military readiness*, Palm Center: Blueprints for Sound Public Policy. Retrieved from http://www.palmcenter.org/files/One%20Year%20Out_0.pdf; A. Belkin & R.L. Evans (2000), *The effects of including gay and lesbian soldiers in the British Armed Forces: Appraising the evidence*, The Center for the Study of Sexual Minorities in the Military, University of California, Santa Barbara. Retrieved from www.palmcenter.org/publications/dadt/britsh_solider_motivation; UK Ministry of Defence, *Policy for the Recruitment and Management of Transsexual Personnel;* A.F. Yerke & V. Mitchell (2013), Transgender People in the Military: Don't ask? Don't tell? Don't enlist! *Journal of Homosexuality, 60*(2-3), 436-457.

[73] Aaron Belkin, Morten G. Ender, Nathaniel Frank, Stacie R. Furia, George Lucas, Gary Packard, Steven M. Samuels, Tammy Schultz, and David R. Segal (2012), Readiness and DADT Repeal: Has the New Policy of Open Service Undermined the Military, *Armed Forces & Society*, 39 (4), 587-601.

[74] Parco, Levy, and Spears recently concluded that: "If we had to distill this study down to a singular theme, it would be the onset of a leadership dilemma for commanders with transgender members in their units. Commanders have a choice to enforce existing policy or support their troops, with the latter requiring an abdication of duty to the former." See James Parco, Dave Levy, and S. Spears (2014), Transgender Military Personnel in the Post-DADT Repeal Era: A Phenomenological Study, *Armed Forces & Society*, 17, DOI: 10.1177/0095327X14530112.

[75] Alan Okros and Denise Scott (2014), Gender Identity in the Canadian Forces: A Review of Possible Impacts on Operational Effectiveness, *Armed Forces & Society*, 1-14, DOI:10.1177/0095327X14535371. See also J. Shipherd, L. Mizock, S. Maguen, and K. Green (2012), Male-to-Female Transgender Veterans and VA Health Care Utilization, *International Journal of Sexual Health, 24*, 78-87.

[76] Okros and Scott, Gender Identity in the Canadian Forces, 8.

[77] Okros and Scott, Gender Identity in the Canadian Forces.

[78] Okros and Scott, Gender Identity in the Canadian Forces.

[79] This guidance is taken almost verbatim from US Department of the Interior, *Personnel Bulletin No: 13-03, Transgender and Other Gender Non-Conforming Employee Policy*.

[80] This guidance is taken almost verbatim from US Department of the Interior, *Personnel Bulletin No: 13-03, Transgender and Other Gender Non-Conforming Employee Policy*.

[81] Australian Department of Defence, *Understanding Transitioning Gender*, 14.

[82] Royal Australian Air Force, *Air Force Diversity Handbook*, 21. *Understanding Transitioning Gender in the Workplace* is an Australian military document that we reference above in note 61. AFWD is Air Force Workforce Diversity. DEFGLIS is the Defence Gay, Lesbian, Bisexual, Transgender and Intersex Information Service, an organization that supports Australian LGBTI military personnel and their families.

Commission Co-Chairs

MG Gale S. Pollock, USA (Ret.), served as Acting Surgeon General of the United States Army and Commander of the US Army Medical Command, and is the first woman and first non-physician to hold those positions. Previously she served as Deputy Surgeon General of the United States Army and 22nd Chief of the Army Nurse Corps. Other assignments in her 36-year military career included serving as Commanding General, Tripler Army Medical Center, Pacific Regional Medical Command; Special Assistant to the Surgeon General for Information Management and Health Policy; Commander, Martin Army Community Hospital, Fort Benning, GA; Commander, U.S. Army Medical Department Activity, Fort Drum, New York; and Staff Officer, Strategic Initiatives Command Group for the Army Surgeon General.

Shannon Minter, JD, is Legal Director of the National Center for Lesbian Rights, one of the nation's leading advocacy organizations for lesbian, gay, bisexual, and transgender people. A graduate of Cornell University Law School, Minter has guided NCLR's litigation for over 10 years, and has been lead counsel in dozens of groundbreaking legal victories, including the landmark California marriage equality case which held that same-sex couples have the fundamental right to marry. In 2009, he was named a California Lawyer of the Year by California Lawyer.

Commission Members

BG Clara Adams-Ender, USA (Ret.), was Chief of the United States Army Nurse Corps from September 1987 to August 1991, and is the first woman to receive her master's degree in military arts and sciences from the US Army Command and General Staff College and the first African-American nurse corps officer to graduate from the US Army War College. In 1991, General Adams-Ender was selected to be Commanding General at Fort Belvoir, Virginia, and served in this capacity as well as that of Deputy Commanding General of the US Military District of Washington until her retirement in 1993. In 2013, she was recognized as a Living Legend by the American Academy of Nursing.

Professor Kylar W. Broadus, JD, is Senior Policy Counsel of the Trans Civil Rights Project, National Gay and Lesbian Task Force and founder of the Trans People of Color Coalition, the only national social justice organization promoting the interests of transgender people of color. He served as Professor of Business Law at Lincoln University and is on the board of the National Black Justice Coalition, a national black LGBT civil rights organization based in Washington, D.C. From 2007 to 2010, he served as board chair of NBJC. Broadus was the first transgender American to testify before the United States Senate and was named to the Out 100 by Out Magazine in 2013.

BG Thomas A. Kolditz, PhD, USA (Ret.), is Professor in the Practice of Leadership and Management and Director of the Leadership Development Program at Yale University's School of Management, and Professor Emeritus at the US Military Academy at West Point, where he was head of the Department of Behavioral Sciences and Leadership before joining Yale's faculty. His 34-year military career included 26 years of command and leadership experience. General Kolditz is author of *In Extremis Leadership: Leading As If Your Life Depended On It.* He is a Fellow of the American Psychological Association and a member of the Academy of Management.

Captain Lory Manning, USN (Ret.), is a Senior Fellow at SWAN, the Servicewomen's Action Network, and a Senior Fellow at the Women's Research & Education Institute, where she ran the Women in the Military Project for a number of years. She served for more than 25 years in the US Navy, and commanded the Naval Computer and Telecommunications Station, Diego Garcia, with a mixed-gender crew of over 350 people. During her final tour of active duty, she served as Deputy to the Assistant Chief of Naval Personnel for Personal Readiness and Family Support, where her responsibilities included oversight, development, and evaluation of the Navy's physical fitness standards.

Professor Diane H. Mazur, JD, is Professor of Law Emeritus at the University of Florida and former Bigelow Fellow at the University of Chicago Law School. She serves as adviser to the National Institute of Military Justice, Senior Editor for the *Journal of National Security Law and Policy* and Legal Co-Director of the Palm Center. In 2010, she published *A More Perfect Military: How the Constitution Can Make Our Military Stronger* with Oxford University Press. Previously, Professor Mazur served as an aircraft and munitions maintenance officer in the US Air Force.

Paula M. Neira, RN, CEN, Esq. (LT, USN/USNR 1985-1991), graduated with distinction from the United States Naval Academy in 1985. A qualified Surface Warfare Officer, she served at sea and ashore including mine warfare combat during Operation Desert Storm. After leaving the Navy, she became a registered nurse, certified in emergency nursing and specializing in adult emergency and trauma care. She is also an attorney and member of the Maryland bar. For more than a decade, Neira has served as one of the nation's leading experts on transgender military service.

Dr. Tammy S. Schultz is Director of the National Security and Joint Warfare Program and Professor of Strategic Studies at the U.S. Marine Corps War College, and adjunct professor at Georgetown University's Security Studies Program. In 2010, she won the Dr. Elihu Rose Award for Teaching Excellence at Marine Corps University. Previously, she was a Fellow at the Center for a New American Security, Research Fellow and Director of Research and Policy at the U.S. Army's Peacekeeping and Stability Operations Institute, and Brookings Institution Research Fellow. She is a principal in the Truman National Security Project and a member of the Council on Foreign Relations.

Attachment H:

Regulatory Comparison of the Army's Retention Standards for Various Medical Conditions

Army Standards for Retention in Military Service:
A Comparison of Medical Conditions

Medical Condition	Army Standard for Retention in Military Service
Transsexual / Gender Identity	Soldiers discovered to have any of the following conditions are subject to administrative separation, without any opportunity to demonstrate fitness for duty or duty assignment: "A history of, or current manifestations of, personality disorders, disorders of impulse control not elsewhere classified, transvestism, voyeurism, other paraphilias, or factitious disorders, psychosexual conditions, transsexual, gender identity disorder to include major abnormalities or defects of the genitalia such as change of sex or a current attempt to change sex, hermaphroditism, pseudohermaphroditism, or pure gonadal dysgenesis or dysfunctional residuals from surgical correction of these conditions render an individual administratively unfit." "These conditions render an individual administratively unfit rather than unfit because of physical illness or medical disability. These conditions will be dealt with through administrative channels." --AR 40-501, § 3-35(a), (b)
Hormone Replacement	The Army does not require medical referral for fitness evaluation based on gynecological conditions (dysmenorrhea, endometriosis, menopausal syndrome, chronic pelvic pain, hysterectomy, oophorectomy) unless they affect "satisfactory" or "successful" "performance of duty." The only male genitourinary conditions that require referral for evaluation involve renal or voiding dysfunctions. The need for hormone replacement therapy is not listed as a reason for referral for either men or women. --AR 40-501, §§ 3-17, 3-18
Diabetes	Diabetes that is well controlled by diet and exercise is not disqualifying and does not trigger physical disability evaluation. Soldiers with diabetes will be referred for evaluation when their condition cannot be controlled by lifestyle modifications, as follows: "Diabetes mellitus, unless hemoglobin A1c can be maintained at <(less than) 7% using only lifestyle modifications (diet, exercise)." --AR 40-501, § 3.11(d)

Mood and Anxiety Disorders	Soldiers with "mood" or "anxiety, somatoform, or dissociative" disorders will be referred for physical disability evaluation only when there is: "a. Persistence or recurrence of symptoms sufficient to require extended or recurrent hospitalization; or b. Persistence or recurrence of symptoms necessitating limitations of duty or duty in protected environment; or c. Persistence or recurrence of symptoms resulting in interference with effective military performance." --AR 40-501, §§ 3-32, 3-33
Traumatic Brain Injury (TBI)	TBI requires referral for medical evaluation only when residual symptoms and impairments "significantly interfere with performance of duty" despite "adequate treatment." --AR 40-501, § 3-30