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Transgender Personnel Policy Working Group

Kickoff Meeting – October 02, 2017

Agenda

Introductions

Guidance

Deliverables

Timeline

Questions

Introductions

Guidance

POTUS memo to the SECDEF, 25 AUG 17

SECDEF Interim Guidance, 14 SEP 17

SECDEF Terms of Reference, 14 SEP 17

Guidance

lieve any individual who meets the physical and mental standards,

is worldwide deployable and is currently serving, should be afforde

pportunity to continue to serve."

General Joseph F. Dunford
Chairman, Joint Chiefs of Staff
Testimony given to the SASC
September 26, 2017

Deliverables

ansgender accessions policy (MEDPERS)

ulti-Disciplinary review and study of relevant data (MEDPERS)

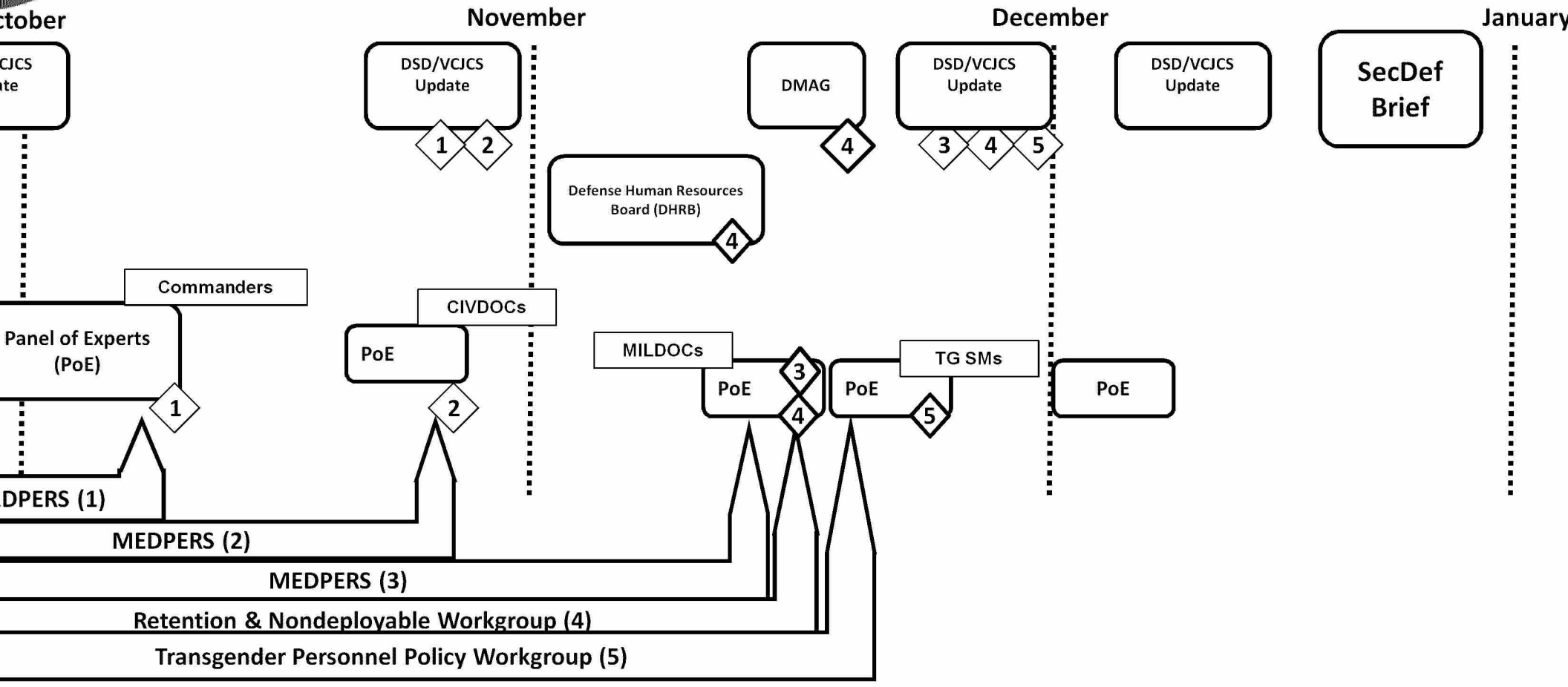
uthorized gender dysphoria medical procedures policy (MEDPERS)

niversal deployability retention standards (Ret & Non-Dep WG)

ngle policy document for current transgender service members (Personn

olicy WG)

Timeline



Deliverables/Milestones

cessions policy

disciplinary review and study of relevant data

rized GD medical procedures policy

rsal deployability retention standards

policy document for current transgender service
ers

Meeting Frequency

- DSD update: Monthly
- DHRB/DMAG: 8 Nov (DHRB), 15 Nov (DMAG)
- Panel of Experts; meetings the week of 30 Oct-3 Nov, 13-18 Nov, 20-24 Nov, 4-8 Dec
- Medical Personnel Executive Steering Committee (MEDPERS): Week of 16-20 Oct, 30 Oct– 3 Nov
- Retention & Nondeployable WG: Weekly
- Transgender Personnel Policy WG: Weekly

Beyond Dec

Final po
recommendati
White Hou
Februa

Working Groups	Panel	DSD/VC JCS	SD

Timeline Matrix

	MEDPERS	R&N WG	TG Pers Policy WG	Panel of Experts	DSD/VC
		Weekly meeting to develop universal ret and Nondep standard (Del #4).	**Weekly meeting, begin work on DoDI (Del #5) Email: 27 SEP 17**		Receive inbrief from approve process
		Weekly meeting to develop #4.	**2 OCT: Kickoff meeting; Review DoDI 1300.28 – Sections 1 and 2**	Introductory meeting Review DoDI Accessions language	
		Weekly meeting to develop #4.	**Friday, 13 OCT: Review DoDI 1300.28 – Sections 1 and 2**		
	Meet to discuss Del #1 and #2. Prepare to brief findings	Weekly meeting to develop #4.	**16 OCT: Review DoDI 1300.28 – Sections 1 and 2**		
		Weekly meeting to develop #4.	**Tuesday, 24 OCT @1000: Review DoDI 1300.28 – Section 3**	Receive MEDPERS brief on 1 & 2; app progress / provide guidance	
		Weekly meeting to develop #4.	**30 OCT: Review DoDI 1300.28 – Section 3**		Receive briefing on D
	Meet to discuss Del #3. Prepare to brief findings	Weekly meeting to develop #4.	**6 NOV: Review DoDI 1300.28 – Section 3**		
		15 NOV: Brief DMAG universal ret and Nondep standard (4); brief PoE upon completion.	**13 NOV: Finalize DoDI 1300.28 –**	Receive brief from MEDPERS on 3, R&N WG on 4; approve progress and provide guidance	
			TBD: Brief PoE on Deliverable #5	Receive brief from TG WG on 5; app progress/provide guidance	
					Receive briefing on D
				Receive pre-brief on SECDEF briefing	
					Receive pre-brief on briefing

bles:
olicy
ry review and study of relevant data
nedical procedures policy

4 – Universal deployability and retention standards
5 – Single policy document for current TG
Service members

SecDef Brief: 22 December

Navy_00040991
USDOE00063231

Questions?

Review of Last WG Product

Policy Guidance

fter consultation with my Generals and military experts, please be advised
at the United States Government will not accept or allow Transgender
ividuals to serve in any capacity in the U.S. Military. Our military must be
cused on decisive and overwhelming victory and cannot be burdened with th
mendous medical costs and disruption that transgender in the military woul
tail. Thank you."

President Donald Trump

26 July 2017

DoD Definition of Transgender SM

Transgender Service Member Per DoDI 1300.28: A Service member who has received a medical diagnosis indicating that gender transition is medically necessary, including any Service member who intends to begin transition, is undergoing transition, or has completed transition and is stable in the preferred gender.

Military Transgender population as of 26 Jul 17 ~ 994

Gender transition process: Gender transition in the military begins when the Service member receives a diagnosis from a military medical provider indicating that the members gender transition is medically necessary, and concludes when the Service member's gender marker in DEERS is changed and the member is recognized in the preferred gender.

Assumptions

Deliberative Process Privilege

Courses of Action

Deliberative Process Privilege

Deliberative Process Privilege

Deliberative Process Privilege

Deliberative Process Privilege

Deliberative Process Privilege

COAs

How

When

Medically Nec
Care

Deliberative Process Privilege

Deliberative Process Privilege

Deliberative Process Privilege

Deliberative Process Privilege

Deliberative Process Privilege

Courses of Action

COAs	How	When	Medically Nec Care

Deliberative Process Privilege

Deliberative Process Privilege

Deliberative Process Privilege

Deliberative Process Privilege

Deliberative Process Privilege

Deliberative Process Privilege

Deliberative Process Privilege

Deliberative Process Privilege

Courses of Action

COAs	How	When	Medically Nec Care

Deliberative Process Privilege

Deliberative Process Privilege

Deliberative Process Privilege

Deliberative Process Privilege

Deliberative Process Privilege

Deliberative Process Privilege

Deliberative Process Privilege

Deliberative Process Privilege

Courses of Action

COAs	How	When	Medically Nec Care

Deliberative Process Privilege

Service Academy / ROTC Populations

Deliberative Process Privilege

Questions?

AA

From: Franzos, Marc Alaric CAPT USN BUMED FCH VA (US)
To: Calloway, Margaret CAPT CNRC MILLINGTON, TN
CC: Palacios, Cindi L LCDR USN ASSTSECNAV MRA DC (US)
Sent: 10/20/2017 8:37:14 PM
Subject: Gender Dysphoria within the 6130.03
Attachments: MEDPERS Charter 2012.pdf; October 12, 2017 MEDPERS Meeting Agenda V1 2017.10.05-Final.docx; TG - Accession Medical Standards Policy Review - MEDPERS V1 2017.10.04-....pptx

CAPT Calloway,

Attached is the MEDPERS brief from 12 Oct 2017 meeting within which the body unanimously recommended adoption of this Change 1 to the yet unpublished DODI 6130.03. Navy Medicine was represented by RADM Gillingham and Navy Personnel was represented by RADM Nowell. This recommendation was forwarded to the Transgender Panel of Experts. LTC Brown indicated that the POE also unanimously recommended adoption and forwarded to the SECDEF and White House for decision.

Per the discussion in MEDPERS on 12 Oct 2017, we are voting on the proposed DODI 6130.03 with the knowledge that the Gender Dysphoria changes recommended in the MEDPERS meeting are pending.

This circuitous decision making process was required because of transgender decision-making consolidated at the highest levels.

We are concurring with comment with reference to this comment.

Call anytime with questions.

Very respectfully,

Alaric

Marc Alaric Franzos, MD, MPH, FACP
Captain, MC (FS/FMF), USN
Director of Medical Readiness (M34)
US Navy Bureau of Medicine and Surgery (BUMED)
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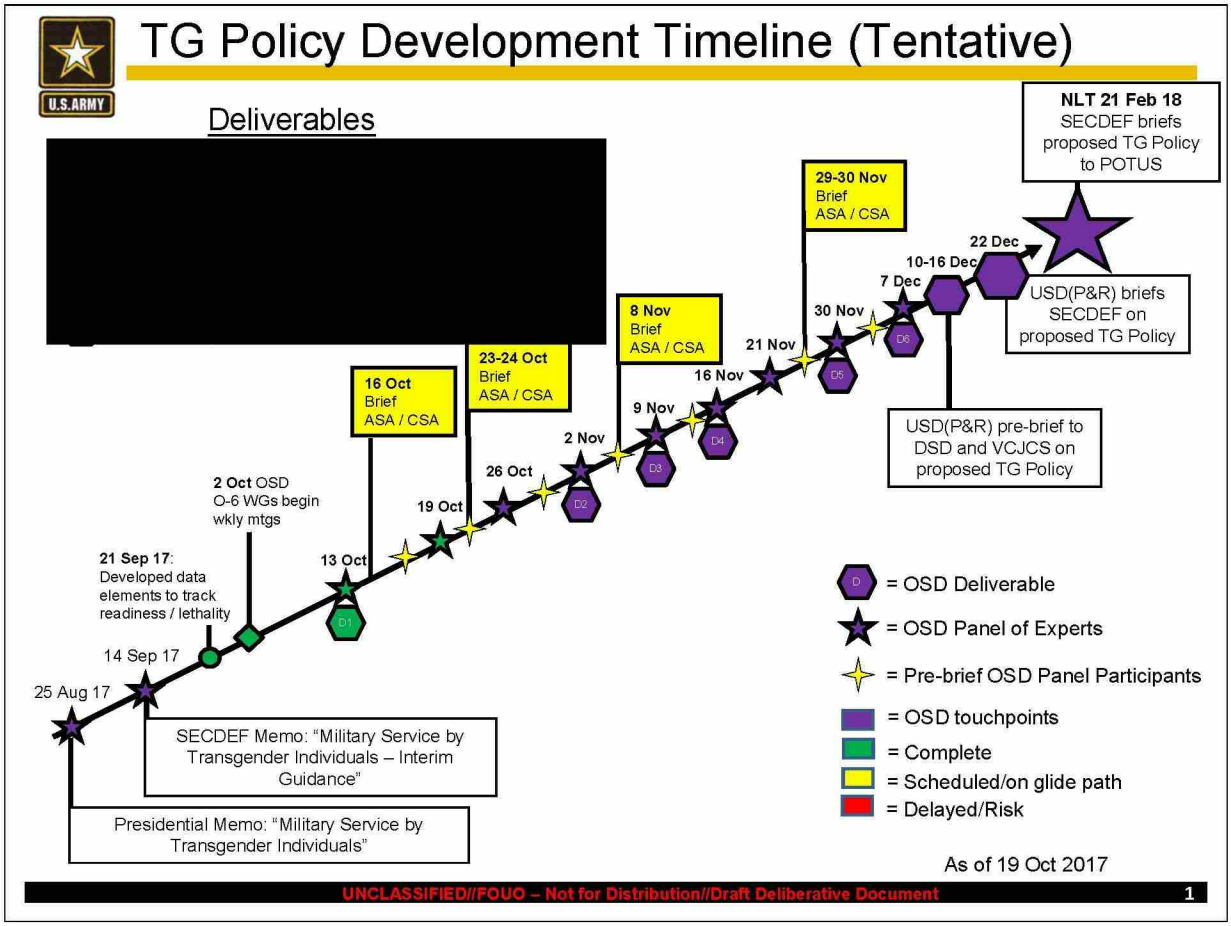
TG Policy Development Timeline (Tentative)
U.S.ARMY
Deliverables
[redacted]
NLT 21 Feb 18
SECDEF briefs proposed TG Policy to POTUS
29-30 Nov
Brief
ASA / CSA
22 Dec
10-16 Dec
7 Dec
30 Nov
21 Nov
16 Nov
9 Nov
2 Nov
26 Oct
19 Oct
13 Oct
8 Nov
Brief
ASA / CSA
23-24 Oct
Brief
ASA / CSA
16 Oct
Brief
ASA / CSA
USD(P&R) briefs SECDEF on proposed TG Policy
USD(P&R) pre-brief to DSD and VCJCS on proposed TG Policy
2 Oct OSD O-6 WGs begin wkly mtgs
21 Sep 17: Developed data elements to track readiness / lethality
14 Sep 17
25 Aug 17
SECDEF Memo: "Military Service by Transgender Individuals – Interim Guidance"
Presidential Memo: "Military Service by Transgender Individuals"
D1
D2
D3
D4
D5
D6
= OSD Deliverable
= OSD Panel of Experts
= Pre-brief OSD Panel Participants
= OSD touchpoints
= Complete
= Scheduled/on glide path
= Delayed/Risk
As of 19 Oct 2017
UNCLASSIFIED//FOUO – Not for Distribution//Draft Deliberative Document
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Updates

Panel of Experts (19 Oct 17)

- Next Panel of Experts 26 Oct 17 (Topic: Military Medical Providers)

OSD Evidence on TG Population

- 2016 Workplace and Gender Relations Survey of Active Duty Members
  - Estimate: 8,980 TG AD SMs
  - Designed to evaluate sexual assault/harassment; not gender ID
  - Small sample size data extrapolated across the force
- Assessing Implications of TG Service: RAND
  - Estimated population, impact on readiness
  - Population: 3,960 TG SMs across the force
    - Data extrapolated from 3 surveys of civilian populations
  - Minimal readiness impact
    - Attributed zero non-deployable time to hormone use; experience shows 6 – 12 months non-deployable when initiating hormone therapy

Service Evidence on TG Population

- Service Central Coordination Cells
  - Army: 121
  - Air Force: 175
  - Navy: 240
  - Total: 536
  - Limited to population with medical treatment plan and/or approved gender marker change
- Military Health System:
  - Total number of Soldiers with gender dysphoria dx
  - Army: 405 (89%)
  - Limitation: fails to capture visits for civilian sector: USAR

Personnel Data Collection

Medical Data Collection

- Detailed analysis pending from OEMA
- Profiles (September 2017):
  - Deployable percentage: 72%
  - Temporary profiles: 26%
- Treatment Plans:
  - Approved treatment plan: 90/121 (74%)
  - Psychotherapy as part of treatment plan: 86/90 (96%)
  - Hormones as part of treatment plan: 86/90 (96%)
  - Surgery planned as part of treatment plan: 65/90 (72%)
  - Surgery planned across the population: 65/121 (54%)
- IDES:
  - Enrolled in IDES: 5/121 (4%)

BACKUP

CC

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

PERSONNEL AND READINESS

ACTION MEMO JAN 11 2018

TO: SECRETARY OF DEFENSE

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

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

SUBJECT: Recommendations by the Transgender Review Panel of Experts

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

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

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

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

COORDINATION: TAB C

Attachments:
As stated

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

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

9/14/17

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

SUBJECT: Military Service by Transgender Individuals - Interim Guidance

The Department of Defense ("DoD") has received the Presidential Memorandum, *Military Service by Transgender Individuals*, dated August 25, 2017 ("Presidential Memorandum"). DoD will carry out the President's policy and directives in consultation with the Department of Homeland Security ("DHS") with respect to the U.S. Coast Guard. Not later than February 21, 2018, I will present the President with a plan to implement the policy and directives in the Presidential Memorandum. Consistent with military effectiveness and lethality, budgetary constraints, and applicable law, the implementation plan will establish the policy, standards and procedures for transgender individuals serving in the military. The Deputy Secretary of Defense and the Vice Chairman of the Joint Chiefs of Staff, supported by a panel of experts ("Panel"), shall propose for my consideration recommendations supported by appropriate evidence and information.

To comply with the Presidential Memorandum, ensure the continued combat readiness of the force, and maximize flexibility in the development of the implementation plan, the attached Interim Guidance takes effect immediately and will remain in effect until I promulgate DoD's final policy in this matter. By agreement with the Acting Secretary of Homeland Security, this Interim Guidance also applies to the U.S. Coast Guard.

Attachment:
As stated

James Mattis

cc:
Secretary of Homeland Security

Interim Guidance

First and foremost, we will continue to treat every Service member with dignity and respect.

Accessions: The procedures set forth in Department of Defense Instruction (DoDI) 6130.03, *Medical Standards for Appointment, Enlistment, or Induction in the Military Services*, dated April 28, 2010 (Change 1), which generally prohibit the accession of transgender individuals into the Military Services, remain in effect because current or history of gender dysphoria or gender transition does not meet medical standards, subject to the normal waiver process.

Medical Care and Treatment: Service members who receive a gender dysphoria diagnosis from a military medical provider will be provided treatment for the diagnosed medical condition. As directed by the Memorandum, no new sex reassignment surgical procedures for military personnel will be permitted after March 22, 2018, except to the extent necessary to protect the health of an individual who has already begun a course of treatment to reassign his or her sex.

In-Service Transition for Transgender Service Members: The policies and procedures set forth in DoDI 1300.28, *In-Service Transition for Transgender Service Members*, dated July 1, 2016, remain in effect until I promulgate DoD's final guidance in this matter.

Separation and Retention of Transgender Service members:

Service members who have completed their gender transition process and whose gender marker has been changed in DEERS will continue to serve in their preferred gender while this Interim Guidance remains in effect.

An otherwise qualified transgender Service member whose term of service expires while this Interim Guidance remains in effect, *may*, at the Service member's request, be re-enlisted in service under existing procedures.

As directed by the Memorandum, no action may be taken to involuntarily separate or discharge an otherwise qualified Service member solely on the basis of a gender dysphoria diagnosis or transgender status. Transgender Service members are subject to the same standards as any other Service member of the same gender; they may be separated or discharged under existing bases and processes, but not on the basis of a gender dysphoria diagnosis or transgender status.

Reestablishment of the Office of the Under Secretary of Defense for Personnel and Readiness (OUSD(P&R)) Central Coordination Cell: The OUSD(P&R) will reestablish the Central Coordination Cell (CCC) to provide expert advice and assistance to the Military Departments and Services and to commanders with regard to this Interim Guidance. The CCC may be reached at https://ra.sp.pentagon.mil/DoDCCC/SitePages/HomePage.aspx.

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

9/14/17

MEMORANDUM FOR SECRETARIES OF THE MILITARY DEPARTMENTS
CHAIRMAN OF THE JOINT CHIEFS OF STAFF
UNDER SECRETARIES OF DEFENSE
COMMANDANT, U.S. COAST GUARD
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DIRECTOR OF NET ASSESSMENT
DIRECTOR, STRATEGIC CAPABILITIES OFFICE
DIRECTORS OF DEFENSE AGENCIES
DIRECTORS OF DOD FIELD ACTIVITIES

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

Reference: Military Service by Transgender Individuals – Interim Guidance

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

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

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

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

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

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

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

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

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

cc:
Secretary of Homeland Security

THE WHITE HOUSE

WASHINGTON

August 25, 2017

MEMORANDUM FOR THE SECRETARY OF DEFENSE
THE SECRETARY OF HOMELAND SECURITY

SUBJECT: Military Service by Transgender Individuals

Section 1. Policy. (a) Until June 2016, the Department of Defense (DoD) and the Department of Homeland Security (DHS) (collectively, the Departments) generally prohibited openly transgender individuals from accession into the United States military and authorized the discharge of such individuals. Shortly before President Obama left office, however, his Administration dismantled the Departments' established framework by permitting transgender individuals to serve openly in the military, authorizing the use of the Departments' resources to fund sex-reassignment surgical procedures, and permitting accession of such individuals after July 1, 2017. The Secretary of Defense and the Secretary of Homeland Security have since extended the deadline to alter the currently effective accession policy to January 1, 2018, while the Departments continue to study the issue.

In my judgment, the previous Administration failed to identify a sufficient basis to conclude that terminating the Departments' longstanding policy and practice would not hinder military effectiveness and lethality, disrupt unit cohesion, or tax military resources, and there remain meaningful concerns that further study is needed to ensure that continued implementation of last year's policy change would not have those negative effects.

(b) Accordingly, by the authority vested in me as President and as Commander in Chief of the Armed Forces of the United States under the Constitution and the laws of the United States of America, including Article II of the Constitution, I am directing the Secretary of Defense, and the Secretary of Homeland Security with respect to the U.S. Coast Guard, to return to the longstanding policy and practice on military service by transgender individuals that was in place prior to June 2016 until such time as a sufficient basis exists

upon which to conclude that terminating that policy and practice would not have the negative effects discussed above. The Secretary of Defense, after consulting with the Secretary of Homeland Security, may advise me at any time, in writing, that a change to this policy is warranted.

Sec. 2. Directives. The Secretary of Defense, and the Secretary of Homeland Security with respect to the U.S. Coast Guard, shall:

(a) maintain the currently effective policy regarding accession of transgender individuals into military service beyond January 1, 2018, until such time as the Secretary of Defense, after consulting with the Secretary of Homeland Security, provides a recommendation to the contrary that I find convincing; and

(b) halt all use of DoD or DHS resources to fund sex-reassignment surgical procedures for military personnel, except to the extent necessary to protect the health of an individual who has already begun a course of treatment to reassign his or her sex.

Sec. 3. Effective Dates and Implementation. Section 2(a) of this memorandum shall take effect on January 1, 2018. Sections 1(b) and 2(b) of this memorandum shall take effect on March 23, 2018. By February 21, 2018, the Secretary of Defense, in consultation with the Secretary of Homeland Security, shall submit to me a plan for implementing both the general policy set forth in section 1(b) of this memorandum and the specific directives set forth in section 2 of this memorandum. The implementation plan shall adhere to the determinations of the Secretary of Defense, made in consultation with the Secretary of Homeland Security, as to what steps are appropriate and consistent with military effectiveness and lethality, budgetary constraints, and applicable law. As part of the implementation plan, the Secretary of Defense, in consultation with the Secretary of Homeland Security, shall determine how to address transgender individuals currently serving in the United States military. Until the Secretary has made that determination, no action may be taken against such individuals under the policy set forth in section 1(b) of this memorandum.

Sec. 4. Severability. If any provision of this memorandum, or the application of any provision of this memorandum, is held to be invalid, the remainder of this

memorandum and other dissimilar applications of the provision shall not be affected.

Sec. 5. General Provisions. (a) Nothing in this memorandum shall be construed to impair or otherwise affect:

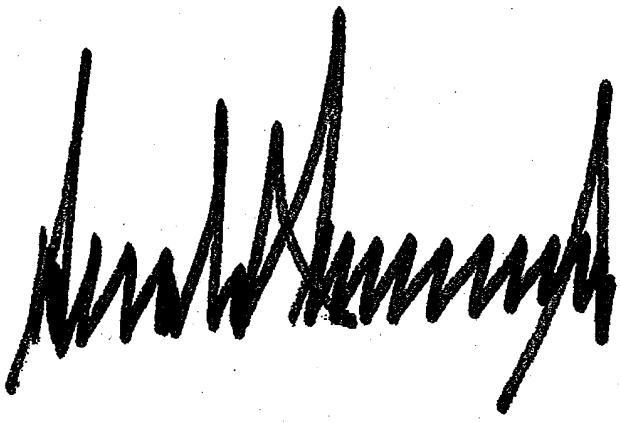
(i) the authority granted by law to an executive department or agency, or the head thereof; or

(ii) the functions of the Director of the Office of Management and Budget relating to budgetary, administrative, or legislative proposals.

(b) This memorandum shall be implemented consistent with applicable law and subject to the availability of appropriations.

(c) This memorandum is not intended to, and does not, create any right or benefit, substantive or procedural, enforceable at law or in equity by any party against the United States, its departments, agencies, or entities, its officers, employees, or agents, or any other person.

(d) The Secretary of Defense is authorized and directed to publish this memorandum in the *Federal Register*.



Hormone Therapy Issues in Transgender Service Members

Cross-sex hormone therapy (CSHT) is a treatment for individuals who are transgender with gender dysphoria (GD), which facilitates their transition from birth gender to desired gender. Though data is limited in cross-sex hormone therapy, the long-term monitoring requirements, adverse outcomes, and deployment opportunities are similar to other common hormone-based therapies. In the case of the female to male CSHT, the transition requires simply the administration of testosterone. In the case of the male to female CSHT, the transition requires blocking the production of testosterone and the administration of estrogens.

For the management of GD, the MHS policy is based on the clinical practice guidelines proposed by the Endocrine Society in their 2017 paper, *Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline*. This document provides guidelines for the diagnosis, mental health, hormonal and surgical treatment for GD. It includes hormone dosing and monitoring recommendations as well as recommended criteria for surgery

HORMONES FOR TRANSITION

	Transgender Female (M to F)	**Transgender Male (F to M)**
Medications	Anti-androgens (block testosterone) Estrogen Oral Transdermal patch Parental (IM injections)	Testosterone Parenteral (IM or SQ injections) Transdermal patch
Routes	Oral, parenteral or transdermal preparations	Parenteral or transdermal preparations
Comments	More complex than the transgender male regimen (F to M)	Follows the general principle of hormone replacement treatment for male hypogonadism
Selected Results	Breast development is generally maximal at 2 years after initiating hormones. Over a long period of time, the prostate gland and testicles will undergo atrophy.	Results in cessation of menses, increased muscle mass and decreased fat mass, increased facial hair and acne, male pattern baldness in those genetically predisposed, and increased sexual desire

MONITORING TESTS

The tests associated with monitoring hormone therapy for GD include:
1. Complete Blood Count (CBC)
2. Electrolytes (Sodium, Potassium, Chloride and Bicarbonate)
3. Liver Function Tests (LFTs) and Lipids (LFTs - Liver transaminases (AST or SGOT and ALT or SGPT), albumin and bilirubin)
4. Estradiol
5. Prolactin
6. Total Testosterone

Hormone Therapy Issues in Transgender Service Members

Monitoring of Transgender Persons on Gender-Affirming Hormone Therapy 2017 Endocrine Society Recommendations							
Transgender Male (F to M)				**Transgender Female (M to F)**			
		Initial	Follow up			Initially	Follow up
Bloodwork	Testosterone	Every 3 months until reaches normal physiologic male range	1 – 2 times per year	**Bloodwork**	Testosterone	Every 3 months	1 – 2 times per year
	Hematocrit & Hemoglobin	Every 3 months for first year	1 - 2 time per year		Estradiol	Every 3 months	1 – 2 times per year
	Lipids	Regular intervals			Electrolytes (K)	Every 3 months for first year	Yearly
					Prolactin	Annually during transition	Every 2 years when stable
Physical Exam		Every 3 months for first year	1 - 2 times per year	**Physical Exam**		Every 3 months for first year	1 - 2 times per year
Other	Screening for osteoporosis		Yearly if indicated	**Other**	Routine Cancer screening		Yearly as indicated
	Female cancer screening as appropriate		Yearly if indicated		Osteoporosis		Begin at age 60
	Cardiovascular Risks		Yearly if indicated		Cardiovascular Risks		Yearly if indicated

For deployability, a change in the type of estrogen or testosterone administration from injections to oral or patch usually requires 2 to 3 months of monitoring to ensure stability.

MHS TESTING LOCATIONS

All of the listed tests can be obtained in all CONUS facilities. Larger MTFs usually have capability to perform these tests in-house. Smaller MTFs can either mail specimens to larger MTFs in the same geographic location or send to them to commercial labs for specimen processing. Anything not done in house is referred to a civilian commercial network with no issue.

OCONUS fixed facilities (Landstuhl, Tripler, Okinawa, Rota, Guam etc.) all have capability to perform CBCs, Electrolytes and LFTs. Larger OCONUS fixed facilities such as Landstuhl and Tripler, have capability to perform Estradiol, Total Testosterone and Prolactin (i.e. hormone levels). Landstuhl and Tripler serve as regional testing centers for smaller OCONUS fixed facilities in AFRICOM/EUCOM, CENTCOM and PACOM. Specimens are flown on a regular basis from smaller MTFs to the regional testing centers.

Deployed/mobilized facilities can provide basic blood work to include CBCs, Electrolytes and LFTs, but not hormone levels. Larger Role 3 facilities in Bagram, Kandahar and Kuwait can successfully ship specimens to Landstuhl within 1-5 days. Forward Role 2 bases and smaller units have difficulty with reliable shipping for hormone levels. It may take up to 16 days for a specimen to make it to the referring clinical site and the ability to keep samples frozen throughout that time period is problematic.

There is capability on some ships to perform CBCs, LFTs, and electrolytes. There is no capability to perform hormone levels. There are multiple shipping, turn-around time, and IT connectivity issues with samples that need to be shipped out, depending on the location of the ship. For ships in port with a MTF in close proximity, specimens can be sent to the MTF for processing. Deployed ships must depend on the mail system for shipping specimens out for processing. Mail services are usually available during replenishment at sea, but there is no guarantee that mail services will be available during every replenishment. And there can be two to three weeks between replenishments. As with Role 2 and smaller deployed facilities, the ability to keep a specimen frozen from the time it is drawn to the time it reaches the referral clinical site is problematic.

SPECIMEN PROCESSING

Typically, a specimen is good for 30 days or longer while frozen and as long as the frozen chain is not broken. Specimens are packed on dry ice for shipping where capability to do so exists. There is limited time before the dry ice evaporates and the sample is lost. The amount of dry ice used for transport usually will typically provide for 3-5 days of transit. In a mobilized/deployed environment, however there is limited to no dry ice availability and units must rely on frozen packs for transport. Frozen packs may be able to keep a specimen frozen for up to 48 hours.

Large Role 3 bases (i.e. Bagram, Kandahar, Kuwait) can successfully ship to Landstuhl within 1-5 days. Role 2 and more forward bases experience difficulty with reliable weekly ground or air transport to the ship out point.

Shipment requirements to Landstuhl are generally as follows:

Estradiol: refrigerated 48 hrs., frozen >48 hrs.
Total Testosterone: refrigerated 24 hrs., frozen >24 hrs.
Prolactin: refrigerated 48 hrs., frozen >24 hrs.

Specimen stability requirements for two civilian commercial labs are shown in the table below.

Commercial Requirements for Specimens – Specimen Stability					
TEST	Specimen	Commercial Labs			
		MAYO		QUEST	
		Refrigerated	Frozen	Refrigerated	Frozen
Testosterone	Serum	14 days	60 days	7 days	21 days
Estradiol	Serum	28 days	28 days	7 days	6 months

RISKS OF STOPPING HORMONES

We are unable to find any data in the scientific literature regarding the risks or effects of Transgender individuals stopping cross-sex hormones, or any references to any concerns specific to this.

Anecdotally, there are a number of instances of transgender men (natal female) who have stopped testosterone in order to produce oocytes for pregnancy with no references to any type of "withdrawal syndrome". Also transgender women (natal male) routinely stop estrogens prior to vaginoplasty and for several weeks post-surgery. Some of these transgender women have reported emotional effects from stopping estrogen, but that is not a universal finding.

There are abundant literature references and internet blogs regarding the consequences of abrupt withdrawal of testosterone in natal males taking testosterone for "Low T", hypogonadism and physical effects (body/strength enhancement). Many of these reports concern men with normal testosterone levels taking high doses of testosterone for the physical effects. Common symptoms reported include anxiety, mild depression, fatigue, headaches, muscle loss and low libido, among others. Most reports state withdrawal symptoms are relatively mild and usually resolve in a matter of weeks to months. The length of time the symptoms persist is highly dependent on the length of time the individual has been taking testosterone and the dose or amount of testosterone taken, with higher doses taken for a long period of time resulting in a longer period of symptoms.

Similarly, there is abundant literature on the effects of loss of estrogen in natal females, the most common reason being menopause.

Hormone Therapy Issues in Transgender Service Members

In their June 17, 2016 publication "*Guidelines for the Primary and Gender Affirming Care of Transgender and Gender Nonbinary People*" authors at the University of California, San Francisco (UCSF) Center of Excellence for Transgender Health discuss the effects of stopping cross-sex hormones in older transgender individuals:

Older transgender women: Since the mean age of menopause in the U.S. is 49, it is reasonable in transgender women who have undergone gonadectomy to consider stopping hormone therapy around age 50. Expected effects of this may be similar to non-transgender women experiencing menopause. Transgender women who retain their gonads but withdraw hormone therapy may experience return of virilization. (Section 9 - Overview of feminizing hormone therapy)

Older transgender men: Older transgender men: No upper age limit exists for testosterone replacement in non-transgender men. As such, there is no age recommendation for the termination of testosterone therapy in transgender men. It is reasonable to consider discontinuing hormone therapy at or around age 50, the age at which non-transgender women undergo menopause. Regardless of the presence of gonads at this age, withdrawal of testosterone will result in reduced muscle mass, body hair and libido. (Section 10- Overview of masculinizing hormone therapy)

NON-TRANSGENDER MEDICAL CONDITIONS REQUIRING REGULAR MONITORING

An MDR data pull was performed to identify ADSMs with two conditions that require regular laboratory monitoring, diabetes and hypothyroidism.

Diabetics on oral hypoglycemic medications require frequent Hemoglobin A1c testing to adjust the dosage, monitor the response to therapy and determine stability on treatment. The American Diabetes Association recommends:
A1C testing should be performed routinely in all patients with diabetes at initial assessment and as part of continuing care. Measurement approximately every 3 months determines whether patients' glycemic targets have been reached and maintained. The frequency of A1C testing should depend on the clinical situation, the treatment regimen, and the clinician's judgment. The use of point-of-care A1C testing may provide an opportunity for more timely treatment changes during encounters between patients and providers. Patients with type 2 diabetes with stable glycemia well within target may do well with A1C testing only twice per year. Unstable or intensively managed patients (e.g., pregnant women with type 1 diabetes) may require testing more frequently than every 3 months (Glycemic Targets: Standards of Medical Care in Diabetes – 2018; Diabetes Care 2018;41(Suppl.1):S55–S64)

Likewise, individuals with hypothyroidism require regular laboratory testing to ensure adequate blood levels of thyroid hormone and stability on their treatment regimen. The American Thyroid Association in collaboration with the American Association of Endocrinologists recommends:

Patients being treated for established hypothyroidism should have serum TSH measurements done at 4-8 weeks after initiating treatment or after a change in dose. Once an adequate

replacement dose has been determined, periodic TSH measurements should be done after 6 months and then at 12-month intervals, or more frequently if the clinical situation dictates otherwise (Clinical Practice Guidelines for Hypothyroidism in Adults: Cosponsored by the American Association of Clinical Endocrinologists and The American Thyroid Association; Ata/Aace Guidelines for Hypothyroidism in Adults, *Endocr Pract.* 2012;18(No. 6))

Service members with Type 2 diabetes and hypothyroidism who are stable on oral treatment regimens for at least one year are deployable. The following table shows the results of the MDR data pull including the number of service members with ICDM-10 codes for one of the two diagnoses, the number on oral medications and the number deployed over the previous 2 year period.

Number of Active Duty and Activated Guard/Reserve with a Primary Diagnosis of Interest - FY2016-17

Condition	# w Diagnosis	# w Diagnosis and on RX	# Deployed 2016-2017 after Dx	# Deployed 2016-2017 after Dx and RX	Testing Frequency
AD with a diagnosis of **diabetes**?	5,945	2,334	528	108	Every 3 months until stable, then every 6 months
AD with a diagnosis of **hypothyroidism**	10,473	6,136	992	620	Measurements done at 4-8 weeks after initiating treatment or after a change in dose; then periodic TSH measurements should be done after 6 months and then at 12-month intervals

Examples of other diagnoses that require periodic blood testing include HIV, malignancy, gout and anemia. Many of these conditions, including diabetes and hypothyroidism, fall under Service categories for assignment limitations and may require COCOM approval for deployment.

Hormone Therapy Issues in Transgender Service Members

There are also non-transgender ADSMs who have ICDM-10 codes for low testosterone and low estrogen conditions who are receiving testosterone and estrogen therapy. Individuals who are stable on their regimens are deployable. The following table shows the results of the MDR data pull including the number of service members with ICDM-10 codes for one of the two diagnoses, the number on oral medications and the number deployed over the previous 2 year period.

Number of Active Duty and Activated Guard/Reserve with a Primary Diagnosis of Interest - FY2016-17					
Condition	**# w Diagnosis**	**# w Diagnosis and on Rx**	**# Deployed 2016-2017 after Dx**	**# Deployed 2016-2017 after Dx and Rx**	**Testing Frequency**
AD men with a diagnosis of "**Low Testosterone**", "Hypogonadism" and/or "Hypogonadotropic hypogonadism"	9,547	4,176	813	352	Every 3 months until stable, then every 6–12 months
AD women with a diagnosis of **estrogen deficiency** such as menopause, perimenopause, hypoestrogenism due to hypogonadism, castration or primary ovarian failure, polycystic ovarian syndrome or prevention of osteoporosis	2,952	544	180	19	Every 3 months for first year, then annually

SPECIMEN PROCESSING FOR DIABETES AND HYPOTHYROIDISM MONITORING

The same issues discussed above in regards to specimen processing for testosterone and estradiol apply to HgBA1c and TSH testing.

Shipment requirements to Landstuhl are generally as follows:

HGB A1c: refrigerated
TSH, Free T3, Free T4: refrigerated 48 hrs., frozen >48 hrs.

Specimen stability requirements for two civilian commercial labs are shown in the table below.

Commercial Requirements for Specimens – Specimen Stability					
TEST	Specimen	Commercial Labs			
		MAYO		QUEST	
		Refrigerated	Frozen	Refrigerated	Frozen
HgBA1c	Whole blood	7 days	None given	7 days	6 months
TSH	Serum	7 days	30 days	7 days	28 days

OTHER CONSIDERATIONS

Forward deployed service members on hormonal therapy could be evacuated back to larger in-theater MTFs for periodic blood draws to mitigate the challenges with specimen processing. The dollar costs associated with such a medivac as well as the cost to unit readiness and mission accomplishment would need to be determined. Also the risk of movement would need to be factored in.

Case-by-case deployment waivers may be provided by COCOM for a Service member on injectable medications for certain medical conditions when that Service member is in a critical mission essential role and is collocated with a larger medical unit.

Until such time as the MHS has amassed sufficient experience and data to develop guidelines specific to the military setting, MHS policy for the treatment of gender dysphoria is based on the 2017 Endocrine Society guidelines. The Endocrine Society guidelines are recommendations for the care of gender dysphoria in the civilian sector and may not be fully applicable to the military setting. While the Endocrine Society guidelines recommend 12 months of lab work and exams for monitoring initial stabilization, many military endocrinologists are reporting achieving stability in Service members with gender dysphoria in 6 to 9 months.

Prepared by [redacted]

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

FEB 22 2018

MEMORANDUM FOR THE PRESIDENT

SUBJECT: Military Service by Transgender Individuals

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Attachment:
As stated

cc:
Secretary of Homeland Security

EE

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

FEBRUARY 2018

Table of Contents

Executive Summary

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

History of Policies Concerning Transgender Persons

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

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

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

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

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

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

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

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

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

Transgender Policy Prior to the Carter Policy

A. Accession Medical Standards

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

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

[1] 10 U.S.C. § 505(a).

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

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

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

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

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

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

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

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

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

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

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

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[14] See, e.g., id. at 47.

[15] The accession standards for applicants with HIV are not waivable absent a waiver from both the accessing Service and the Under Secretary of Defense for Personnel and Readiness. See Department of Defense Instruction 6485.01, *Human Immunodeficiency Virus (HIV) in Military Service Members* (Jun. 7, 2013).

[16] DoDI 6130.03 at 48.

[17] American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders (DSM-III)*, pp. 261-264 (3rd ed. 1980).

[18] American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders (DSM-III-R)*, pp. 76-77 (3rd ed. revised 1987).

[19] American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)*, pp. 532-538 (4th ed. 1994).

[20] DoDI 6130.03 at 18.

[21] Id. at 25-27.

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

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

B. Retention Standards

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

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

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

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

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

The Carter Policy

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

A. Changes to the DSM

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

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

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

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

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

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

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

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

B. The Department Begins Review of Transgender Policy

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

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

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

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

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

C. New Standards for Transgender Persons

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

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

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

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

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

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

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

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

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

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

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

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

Panel of Experts Recommendation

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

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

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

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

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

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

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

To fulfill its mandate, the Panel addressed three questions:

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

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

Recommended Policy

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

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

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

Discussion of Standards

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

A. Mental Health Standards

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

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

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

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

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

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

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

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

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

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

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

[58] DSM-5 at 452.

[59] DSM-5 at 453.

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

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

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

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

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

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

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

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

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

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

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

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

[68] RAND Study at 73.

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

[70] Id. at 3885-3888.

[71] Id.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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[84] Id.

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

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

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

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

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

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

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

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

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

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

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

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

B. Physical Health Standards

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

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

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

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

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

C. Sex-Based Standards

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

New Transgender Policy

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[140] See *supra* note 109.

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

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

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

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

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

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

[142] See *supra* note 108.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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[155] Id. at 45.

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

[157] Id. at 9.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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[165] DSM-5 at 455.

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

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

Conclusion

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

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

FF

THE WHITE HOUSE

WASHINGTON

March 23, 2018

MEMORANDUM FOR THE SECRETARY OF DEFENSE
THE SECRETARY OF HOMELAND SECURITY

SUBJECT: Military Service by Transgender Individuals

Pursuant to my memorandum of August 25, 2017, "Military Service by Transgender Individuals," the Secretary of Defense, in consultation with the Secretary of Homeland Security, submitted to me a memorandum and report concerning military service by transgender individuals.

These documents set forth the policies on this issue that the Secretary of Defense, in the exercise of his independent judgment, has concluded should be adopted by the Department of Defense. The Secretary of Homeland Security concurs with these policies with respect to the U.S. Coast Guard.

Among other things, the policies set forth by the Secretary of Defense state that transgender persons with a history or diagnosis of gender dysphoria -- individuals who the policies state may require substantial medical treatment, including medications and surgery -- are disqualified from military service except under certain limited circumstances.

By the authority vested in me as President by the Constitution and the laws of the United States of America, I hereby order as follows:

Section 1. I hereby revoke my memorandum of August 25, 2017, "Military Service by Transgender Individuals," and any other directive I may have made with respect to military service by transgender individuals.

Sec. 2. The Secretary of Defense, and the Secretary of Homeland Security, with respect to the U.S. Coast Guard, may exercise their authority to implement any appropriate policies concerning military service by transgender individuals.

Sec. 3. (a) Nothing in this memorandum shall be construed to impair or otherwise affect:

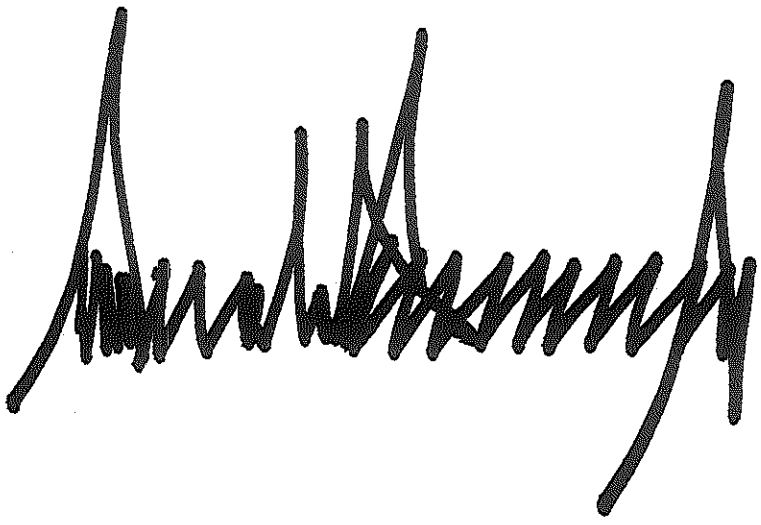
(i) the authority granted by law to an executive department or agency, or the head thereof; or

(ii) the functions of the Director of the Office of Management and Budget relating to budgetary, administrative, or legislative proposals.

(b) This memorandum shall be implemented consistent with applicable law and subject to the availability of appropriations.

(c) This memorandum is not intended to, and does not, create any right or benefit, substantive or procedural, enforceable at law or in equity by any party against the United States, its departments, agencies, or entities, its officers, employees, or agents, or any other person.

(d) The Secretary of Defense is authorized and directed to publish this memorandum in the *Federal Register*.



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AMERICAN PSYCHOLOGICAL ASSOCIATION

March 26, 2018

APA Statement Regarding Transgender Individuals Serving in Military

WASHINGTON — Following is a statement by Arthur C. Evans Jr., PhD, regarding President Trump's placing new limits on transgender individuals serving in the military:

"The American Psychological Association is alarmed by the administration's misuse of psychological science to stigmatize transgender Americans and justify limiting their ability to serve in uniform and access medically necessary health care."

"Substantial psychological research shows that gender dysphoria is a treatable condition, and does not, by itself, limit the ability of individuals to function well and excel in their work, including in military service. The science is clear that individuals who are adequately treated for gender dysphoria should not be considered mentally unstable. Additionally, the incidence of gender dysphoria is extremely low."

"No scientific evidence has shown that allowing transgender people to serve in the armed forces has an adverse impact on readiness or unit cohesion. What research does show is that discrimination and stigma undermine morale and readiness by creating a significant source of stress for sexual minorities that can harm their health and well-being."

APA's governing Council of Representatives adopted a resolution (http://www.apa.org/about/policy/chapter-12b.aspx#transgender) in 2008 supporting full equality for transgender and gender-variant people and calling for legal and social recognition of transgender individuals.

The American Psychological Association, in Washington, D.C., is the largest scientific and professional organization representing psychology in the United States. APA's membership includes nearly 115,700 researchers, educators, clinicians, consultants and students. Through its divisions in 54 subfields of psychology and affiliations with 60 state, territorial and Canadian provincial associations, APA works to advance the creation, communication and application of psychological knowledge to benefit society and improve people's lives.

Find this article at:
http://www.apa.org/news/press/releases/2018/03/transgender-military.aspx

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AMA
AMERICAN MEDICAL ASSOCIATION

JAMES L. MADARA, MD
EXECUTIVE VICE PRESIDENT, CEO

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April 3, 2018

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

Dear Secretary Mattis:

On behalf of the physician and medical student members of the American Medical Association (AMA), I am writing to express our concern about the new policy recently approved by President Trump imposing limits on transgender individuals serving in the military. This new policy, based on recommendations you made in February to President Trump, states that "transgender persons with a history or diagnosis of gender dysphoria—individuals who the policies state may require substantial medical treatment, including medications and surgery—are disqualified from military service except under certain limited circumstances" (Presidential Memorandum for the Secretary of Defense and the Secretary of Homeland Security Regarding Military Service by Transgender Individuals, May 23, 2018).

We believe there is no medically valid reason—including a diagnosis of gender dysphoria—to exclude transgender individuals from military service. Transgender individuals have served, and continue to serve, our country with honor, and we believe they should be allowed to continue doing so. We share the concerns recently expressed by former Surgeons General M. Joycelyn Elders and David Satcher that the Defense Department's February 22, 2018, Memorandum for the President mischaracterized and rejected the wide body of peer-reviewed research on the effectiveness of transgender medical care. This research, demonstrating that medical care for gender dysphoria is effective, was the rationale for the AMA's adoption of policy by our House of Delegates in 2015, that there is no medically valid reason to exclude transgender individuals from military service.

The AMA also supports public and private health insurance coverage for treatment of gender dysphoria as recommended by the patient's physician. We support the finding of the RAND study conducted for the Department of Defense on the impact of transgender individuals in the military that the financial cost is negligible and a rounding error in the defense budget. It should not be used as a reason to deny patriotic Americans an opportunity to serve their country. We should be honoring their service.

Sincerely,

James L. Madara, MD

II

DoD INSTRUCTION 6130.03

MEDICAL STANDARDS FOR APPOINTMENT, ENLISTMENT, OR INDUCTION INTO THE MILITARY SERVICES

Originating Component:	Office of the Under Secretary of Defense for Personnel and Readiness
Effective:	May 6, 2018
Releasability:	Cleared for public release. Available on the Directives Division Website at http://www.esd.whs.mil/DD/.
Reissues and Cancels:	DoD Instruction 6130.03, "Medical Standards for Appointment, Enlistment, or Induction in the Military Services," April 28, 2010, as amended
Approved by:	Robert L. Wilkie, Under Secretary of Defense for Personnel and Readiness

Purpose: This issuance, in accordance with the authority in DoD Directive 5124.02, establishes policy, assigns responsibilities, and prescribes procedures for physical and medical standards for appointment, enlistment, or induction into the Military Services. It was approved by Mr. Wilkie on March 30, 2018, and will take effect 30 days after publication on the Directives Division Website.

TABLE OF CONTENTS

SECTION 1: GENERAL ISSUANCE INFORMATION

1.1. APPLICABILITY.

a. This issuance applies to:

(1) OSD, the Military Departments (including the Coast Guard at all times, including when it is a Service in the Department of Homeland Security by agreement with that Department), the Office of the Chairman of the Joint Chiefs of Staff and the Joint Staff, the Combatant Commands, the Office of the Inspector General of the Department of Defense, the Defense Agencies, the DoD Field Activities, and all other organizational entities within the DoD.

(2) The Reserve Components, which include the Army and the Air National Guards of the United States, in accordance with Title 10, United States Code (U.S.C.).

(3) The United States Merchant Marine Academy in accordance with Section 310.56 of Title 46, Code of Federal Regulations.

b. The entities in Paragraphs 1.1.a.(1) through 1.1.a.(3) are referred to collectively in this issuance as the "DoD Components."

c. This issuance does not apply to any medical issue associated with gender dysphoria or gender transition; such medical accession standards are addressed in separate guidance. Any questions regarding such medical accessions standards or procedures should be directed to the Commander, U.S. Military Entrance Processing Command (USMEPCOM).

1.2. POLICY.

It is DoD policy to:

a. Use the guidance in this issuance for appointment, enlistment, or induction of personnel into the Military Services.

b. Use common medical standards for appointment, enlistment, or induction of personnel into the Military Services and eliminate inconsistencies and inequities in the DoD Components based on race, sex, or location of examination when applying these standards.

c. Ensure that individuals considered for appointment, enlistment, or induction into the Military Services are:

(1) Free of contagious diseases that may endanger the health of other personnel.

(2) Free of medical conditions or physical defects that may reasonably be expected to require excessive time lost from duty for necessary treatment or hospitalization, or may result in separation from the Military Service for medical unfitness.

(3) Medically capable of satisfactorily completing required training and initial period of contracted service.

(4) Medically adaptable to the military environment without geographical area limitations.

(5) Medically capable of performing duties without aggravating existing physical defects or medical conditions.

d. Allow applicants who do not meet the physical and medical standards in this issuance to be considered for a medical waiver.

1.3. INFORMATION COLLECTIONS. DD Form 2807-1, "Report of Medical History;" DD Form 2807-2, "Accessions Medical Prescreen Report;" DD Form 2808, "Report of Medical Examination;" and the supplemental health documents referred to in Paragraph 2.3.d. of this issuance have been assigned Office of Management and Budget control number 0704-0413 in accordance with the procedures in Volume 2 of DoD Manual 8910.01. The expiration date of this information collection is listed on the DoD Information Collections System at https://apps.sp.pentagon.mil/sites/dodiic/Pages/default.aspx.

SECTION 2: RESPONSIBILITIES

2.1. UNDER SECRETARY OF DEFENSE FOR PERSONNEL AND READINESS (USD(P&R)). The USD(P&R):

a. Ensures that the standards in Section 5 are implemented throughout the DoD Components.

b. Eliminates inconsistencies and inequities based on race, sex, or location of examination in DoD Component application of these standards.

c. Maintains and convenes the chartered Medical and Personnel Executive Steering Committee (MEDPERS).

2.2. ASSISTANT SECRETARY OF DEFENSE FOR HEALTH AFFAIRS (ASD(HA)). Under the authority, direction, and control of the USD(P&R), the ASD(HA):

a. Reviews, approves, and issues technical modifications to the standards in Section 5 to the Secretaries of the Military Departments.

b. Provides guidance to the DoD Medical Examination Review Board to implement the standards in Section 5.

2.3. SECRETARIES OF THE MILITARY DEPARTMENTS AND COMMANDANT, UNITED STATES COAST GUARD. The Secretaries of the Military Departments and the Commandant, United States Coast Guard:

a. Direct their respective Military Services to apply and uniformly implement the standards contained in this issuance.

b. Authorize the medical waiver of the standards in individual cases for applicable reasons and ensure uniform waiver determinations.

c. Ensure that accurate International Classification of Diseases codes are assigned to all medical conditions resulting in a personnel action, such as separation, waiver, or assignment limitation, and that such codes are included in all records of such actions.

d. Ensure that medical information for “Existed Prior to Service” discharges is provided to the USMEPCOM by Service training centers conducting basic military training. This information will include:

(1) A copy of the trainee’s medical discharge summary and related medical documents.

(2) Copies of DD Forms 2807-2, 2807-1, and 2808, including supplemental behavioral health screening documents.

(3) Consultation reports or other medical documentation used in the enlistment process and qualification decision.

e. Eliminate inconsistencies and inequities based on race, sex, or examination location in the application of these standards by the DoD Components.

2.4. SECRETARY OF THE NAVY. In addition to the responsibilities in Paragraph 2.3., the Secretary of the Navy will direct the medical processing for applicants seeking entry into the Military Services from Guam and environs while applying and uniformly implementing the standards contained within this issuance.

SECTION 3: MEDPERS

3.1. ORGANIZATION. The MEDPERS convenes at least twice a year under the joint guidance of the Deputy Assistant Secretary of Defense for Military Personnel Policy and the Deputy Assistant Secretary of Defense for Health Services Policy and Oversight and in accordance with the MEDPERS charter.

3.2. AGENDA. The MEDPERS:

a. Provides the Accession Medical Standards Working Group with guidance and oversight on setting standards for accession medical and physical processes.

b. Directs research and studies as necessary to produce evidence-based accession standards using the Accession Medical Standards Analysis and Research Activity.

c. Ensures medical and personnel community coordination when changing policies that affect each community and other relevant DoD Components.

SECTION 4: MEDICAL STANDARDS FOR APPOINTMENT, ENLISTMENT, OR INDUCTION

4.1. APPLICABILITY. The medical standards in Section 5 apply to:

a. Applicants for appointment as commissioned or warrant officers in the Active and Reserve Components.

b. Applicants for enlistment in the Military Services. For medical conditions or defects that predate the current enlistment and were not aggravated in the line of duty during the current enlistment, these standards apply to enlistees during the first 6 months of the current period of active duty.

c. Applicants for accession in the Reserve Components and federally recognized units or organizations of the National Guard. For medical conditions or defects that predate the original term of service and were not aggravated in the line of duty during such term of service, these standards apply during the applicant's initial period of active duty for training until their return to the Reserve Components.

d. Applicants for re-accession in Regular and Reserve Components and in federally recognized units or organizations of the National Guard after a period of more than 12 months have elapsed since the separation physical.

e. Applicants for the Service academies, Reserve Officer Training Corps, Uniformed Services University of the Health Sciences, and all other DoD Component special officer personnel procurement programs.

f. Cadets and midshipmen at the Service academies and students enrolled in Reserve Officer Training Corps scholarship programs applying for retention in their respective programs.

g. Individuals on the Temporary Disability Retired List who have been found fit when reevaluated by the Disability Evaluation System and who elect to return to active duty or to active status in the Reserve Components within the time standards prescribed by Service regulations. These individuals are exempt from the procedures in this issuance only for the conditions for which they were found fit on reevaluation by the Disability Evaluation System. Applicants must meet all other medical standards contained in this section with the exception of the medical condition for which they were placed on the Temporary Disability Retired List.

h. All individuals being inducted into the Military Services.

4.2. PROCEDURES.

a. Applicants for appointment, enlistment, or induction into the Military Services will:

(1) Fully disclose all medical history.

(2) Submit all medical documentation related to medical history as requested to the USMEPCOM and DoD Medical Examination Review Board, including the names of their medical insurer and past medical providers.

(3) Provide authorization for the DoD Components to request and obtain their medical records.

(a) Authorize the DoD to request medical or behavioral health data holders (e.g. healthcare providers, clinics, hospitals, insurance companies, pharmacy benefit managers, pharmacies, health information exchanges, and federal and State agencies) release complete transcripts of health data to the DoD medical authority for the processing of their application for military service.

(b) Authorize holders of their health data to report to the DoD whether any data they hold or have held about them has been amended or restricted.

(4) Acknowledge that information provided constitutes an official statement, and that any persons making false statements could face fines, penalties, and imprisonments pursuant to Section 1001 of Title 18, U.S.C. If the applicant is selected for enlistment, commission, or entrance into a commissioning program based on a false statement, the applicant can be tried by court-martial or meet an administrative board for discharge and could receive a less than honorable discharge.

b. The USMEPCOM and DoD Medical Examination Review Board will:

(1) Render medical qualification decisions by using standard medical terminology to describe a medical condition, rather than International Classification of Disease codes.

(2) Use coding to document personnel actions in order to collect information to enable research, analyses, and support for evidence-based medical standards.

c. The DoD Components:

(1) May initiate and request a medical waiver. Each DoD Component's waiver authority for medical conditions will make a determination based on all available information regarding the issue or condition, as well as the specific needs of the Military Service.

(2) Will specify any medical condition which causes a personnel action, such as separation, medical waiver, or assignment limitation, by utilizing standard medical terminology, the International Classification of Diseases, Current Procedural Terminology, or the Healthcare Common Procedure Coding System for data collection and analysis in support of evidence based standards.

SECTION 5: DISQUALIFYING CONDITIONS

5.1. MEDICAL STANDARDS. Unless otherwise stipulated, the conditions listed in this section are those that do **not** meet the standard by virtue of current diagnosis, or for which the candidate has a verified past medical history. The medical standards for appointment, enlistment, or induction into the Military Services are classified into general systems in Paragraphs 5.2. through 5.30.

5.2. HEAD.

a. Deformities of the skull, face, or mandible of a degree that may reasonably be expected to prevent the individual from properly wearing a protective mask or military headgear.

b. Loss, or absence of the bony substance of the skull not successfully corrected by reconstructive materials, or leaving any residual defect in excess of 1 square inch (6.45 square centimeters), or the size of a U.S. quarter coin.

5.3. EYES.

a. Lids.

(1) Current symptomatic blepharitis.

(2) Current blepharospasm.

(3) Current dacryocystitis, acute or chronic.

(4) Defect or deformity of the lids or other disorders affecting eyelid function, including ptosis, sufficient to interfere with vision, require head posturing, or impair protection of the eye from exposure.

(5) Current growths or tumors of the eyelid, other than small, non-progressive, asymptomatic, benign lesions.

b. Conjunctiva.

(1) Current acute or chronic conjunctivitis excluding seasonal allergic conjunctivitis.

(2) Current pterygium if condition encroaches on the cornea in excess of 3 millimeters (mm), is symptomatic, interferes with vision, or is progressive.

(3) History of pterygium recurrence after any prior surgical removal.

c. Cornea.

(1) Corneal dystrophy or degeneration of any type, including but not limited to keratoconus of any degree.

(2) History of any incisional corneal surgery including, but not limited to, partial or full thickness corneal transplant, radial keratotomy, astigmatic keratotomy, or corneal implants (e.g., Intacs®).

(3) Corneal refractive surgery performed with an excimer or femtosecond laser, including but not limited to photorefractive keratectomy, laser epithelial keratomileusis, laser-assisted in situ keratomileusis, and small incision lenticule extraction, if any of the following conditions are met:

(a) Pre-surgical refractive error in either eye exceeded a spherical equivalent of +8.00 or -8.00 diopters.

(b) Pre-surgical astigmatism exceeded 3.00 diopters.

(c) Within 180 days of accession medical examination.

(d) Complications, ongoing medications, ophthalmic solutions, or any other therapeutic interventions required beyond 180 days of procedure.

(e) Post-surgical refraction in each eye is not stable as demonstrated by at least two separate refractions at least 1 month apart, with initial refraction at least 90 days post-procedure, and the most recent of which demonstrates either more than +/- 0.50 diopters difference for spherical vision or more than +/- 0.50 diopters for cylinder vision.

(4) Current or recurrent keratitis.

(5) History of herpes simplex virus keratitis.

(6) Current corneal neovascularization, unspecified, or corneal opacification from any cause that is progressive or reduces vision.

(7) Any history of uveitis or iridocyclitis.

d. Retina. Any history of any abnormality of the retina, choroid, or vitreous.

e. Optic Nerve.

(1) Any history of optic nerve disease, including but not limited to optic nerve inflammation, optic nerve swelling, or optic nerve atrophy.

(2) Any optic nerve anomaly.

f. Lens.

(1) Current aphakia, history of lens implant to include implantable collamer lens, or any history of dislocation of a lens.

(2) Any history of opacities of the lens, including cataract.

g. Ocular Mobility and Motility.

(1) Current or recurrent diplopia.

(2) Current nystagmus other than physiologic "end-point nystagmus."

(3) Esotropia, exotropia, and hypertropia.

(4) History of restrictive ophthalmopathies.

h. Miscellaneous Defects and Diseases.

(1) History of abnormal visual fields.

(2) Absence of an eye.

(3) History of disorders of globe.

(4) Current unilateral or bilateral exophthalmoses.

(5) History of glaucoma, ocular hypertension, pre-glaucoma, or glaucoma suspect.

(6) Any abnormal pupillary reaction to light or accommodation.

(7) Asymmetry of pupil size greater than 2 mm.

(8) Current night blindness.

(9) History of intraocular foreign body, or current corneal foreign body.

(10) History of ocular tumors.

(11) History of any abnormality of the eye or adnexa, not specified in Paragraphs 5.3.h.(1)-(10), which threatens vision or visual function.

5.4. VISION.

a. Current distant visual acuity of any degree that does not correct with spectacle lenses to at least 20/40 in each eye.

b. For entrance into Service academies and officer programs, the individual DoD Components may set additional requirements. The DoD Components will determine special administrative criteria for assignment to certain specialties.

c. Current near visual acuity of any degree that does not correct to 20/40 in the better eye.

d. Current refractive error (hyperopia, myopia, astigmatism) in excess of -8.00 or +8.00 diopters spherical equivalent or astigmatism in excess of 3.00 diopters.

e. Any condition that specifically requires contact lenses for adequate correction of vision, such as corneal scars and opacities and irregular astigmatism.

f. Color vision requirements will be set by the individual DoD Components.

5.5. EARS.

a. Current defect that would require either recurrent evaluation or treatment or that may reasonably be expected to prevent or interfere with the proper wearing or use of military equipment (including hearing protection) to include atresia of the external ear or severe microtia, congenital or acquired stenosis, chronic otitis externa, or severe external ear deformity.

b. Any history of Ménière's Syndrome or other chronic diseases of the vestibular system.

c. History of any surgically implanted hearing device.

d. History of cholesteatoma.

e. History of any inner or middle ear surgery.

f. Current perforation of the tympanic membrane or history of surgery to correct perforation during the preceding 180 days.

g. Chronic Eustachian tube dysfunction within the last 3 years as evidenced by retracted tympanic membrane, or recurrent otitis media, or the need for pressure-equalization tube.

5.6. HEARING.

a. Audiometric hearing levels are measured by audiometers calibrated to the standards in American National Standards Institute S3.6-2010 and will be used to test the hearing of all applicants.

b. Current hearing threshold level in either ear that exceeds:

(1) Pure tone at 500, 1000, and 2000 cycles per second for each ear of more than 25 decibels (dB) on the average with any individual level greater than 30 dB at those frequencies.

(2) Pure tone level more than 35 dB at 3000 cycles per second or 45 dB at 4000 cycles per second for each ear.

(3) There is no standard for 6000 cycles per second.

c. History of using hearing aids.

5.7. NOSE, SINUSES, MOUTH, AND LARYNX.

a. Current cleft lip or palate defects not satisfactorily repaired by surgery or that prevent drinking from a straw or that may reasonably be expected to interfere with using or wearing military equipment.

b. Current ulceration of oral mucosa or tongue, excluding aphthous ulcers.

c. Symptomatic vocal cord dysfunction to include but not limited to vocal cord paralysis, paradoxical vocal cord movement, spasmodic dysphonia, non-benign polyps, chronic hoarseness, or chronic laryngitis (lasting longer than 21 days). History of vocal cord dysfunction with respiratory symptoms or exercise intolerance.

d. Current olfactory deficit.

e. Recurrent, unexplained epistaxis requiring medical intervention within the last 2 years.

f. Current chronic sinusitis, current nasal polyp or polypoid mass(es) or history of sinus surgery within the last 2 years, excluding antralchoanal polyp or sinus mucosal retention cyst.

g. Current symptomatic perforation of nasal septum.

h. History of deformities, or conditions or anomalies of the upper alimentary tract, mouth, tongue, palate, throat, pharynx, larynx, and nose, that interfered with chewing, swallowing, speech, or breathing.

5.8. DENTAL.

a. Current diseases or pathology of the jaws or associated tissues that prevent the jaws' normal functioning. A minimum of 6 months healing time must elapse for any individual who completes surgical treatment of any maxillofacial pathology lesions.

b. Temporomandibular disorders or myofascial pain that has been symptomatic or required treatment within the last 12 months.

c. Current severe malocclusion, which interferes with normal chewing or requires immediate and protracted treatment, or a relationship between the mandible and maxilla that prevents satisfactory future prosthodontic replacement.

d. Eight or more grossly (visually) cavitated or carious teeth. Applicants who are edentulous must have functioning dentures. Lack of a serviceable prosthesis that prevents adequate biting and chewing of a normal diet. Individuals undergoing endodontic care are acceptable for entry into the Delayed Entry Program only if a civilian or military dentist or endodontist provides documentation that active endodontic treatment will be completed prior to being sworn to active duty.

e. Current orthodontic appliances (mounted or removable, e.g., Invisalign®) for continued active treatment unless:

(1) The appliance is permanent or removable retainer(s); or

(2) An orthodontist (civilian or military) provides documentation that:

(a) Active orthodontic treatment will be completed before being sworn in to active duty; or

(b) All orthodontic treatment will be completed before beginning active duty.

5.9. NECK.

a. Current symptomatic cervical ribs.

b. Current congenital mass, including cyst(s) of branchial cleft origin or those developing from the remnants of the thyroglossal duct or history of surgical correction, within 12 months.

c. Current contraction of the muscles of the neck, spastic or non-spastic, or cicatricial contracture of the neck to the extent that it may reasonably be expected to interfere with properly wearing a uniform or military equipment, or is so disfiguring as to reasonably be expected to interfere with or prevent satisfactorily performing military duty.

5.10. LUNGS, CHEST WALL, PLEURA, AND MEDIASTINUM.

a. Any abnormal findings on imaging or other examination of body structure, such as the lungs, diaphragm, or other thoracic or abdominal organs, unless the findings have been evaluated and further surveillance or treatment is not required.

b. Current abscess of the lung or mediastinum.

c. Infectious pneumonia within the last 3 months.

d. History of recurrent (2 or more episodes within an 18 month period) infectious pneumonia after the 13th birthday.

e. History of airway hyper responsiveness including asthma, reactive airway disease, exercise-induced bronchospasm or asthmatic bronchitis, after the 13th birthday.

(1) Symptoms suggestive of airway hyper responsiveness include but are not limited to cough, wheeze, chest tightness, dyspnea or functional exercise limitations after the 13th birthday.

(2) History of prescription or use of medication (including but not limited to inhaled or oral corticosteroids, leukotriene receptor antagonists, or any beta agonists) for airway hyper responsiveness after the 13th birthday.

f. Chronic obstructive pulmonary disease including but not limited to bullous or generalized pulmonary emphysema or chronic bronchitis.

g. Bronchiectasis (after the 1st birthday).

h. Bronchopleural fistula, unless resolved with no sequelae.

i. Current chest wall malformation, including but not limited to pectus excavatum or pectus carinatum which has been symptomatic, interfered with vigorous physical exertion, has been recommended for surgery, or may interfere with wearing military equipment.

j. History of empyema unless resolved with no sequelae.

k. Interstitial lung disease including pulmonary fibrosis.

l. Current foreign body in lung, trachea, or bronchus.

m. History of thoracic surgery including open and endoscopic procedures.

n. Pleurisy or pleural effusion within the previous 3 months.

o. History of spontaneous pneumothorax occurring within the past 2 years, or pneumothorax due to trauma or surgery occurring within the past year.

p. Recurrent spontaneous pneumothorax.

q. History of chest wall surgery, including breast, during the preceding 6 months, or with persistent functional limitations.

r. Tuberculosis:

(1) History of active pulmonary or extra-pulmonary tuberculosis in the previous 2 years or history of active pulmonary or extra-pulmonary tuberculosis without reliable documentation of adequate treatment, or

(2) History of latent tuberculosis infection, as defined by current Centers for Disease Control and Prevention guidelines, unless documentation of completion of appropriate treatment.

s. History of pulmonary or systemic embolus.

t. History of other disorders, including but not limited to cystic fibrosis or porphyria, that prevent satisfactorily performing duty, or require frequent or prolonged treatment.

u. History of nocturnal ventilation support, respiratory failure, pulmonary hypertension, or any requirement for chronic supplemental oxygen use.

5.11. HEART.

a. History of valvular repair or replacement.

b. History of the following valvular conditions as listed in the current American College of Cardiology and American Heart Association guidelines and evidenced by echocardiogram within the last 12 months:

(1) Moderate or severe pulmonic regurgitation.

(2) Moderate or severe tricuspid regurgitation.

(3) Moderate or severe mitral regurgitation.

(4) Mild, moderate, or severe aortic regurgitation.

(5) Mitral valve prolapse associated with:

(a) Mild or greater mitral regurgitation.

(b) Cardiopulmonary symptoms.

(c) Medical therapy specifically for this condition.

c. Bicuspid aortic valve with any degree of stenosis or regurgitation or aortic dilatation.

d. All valvular stenosis.

e. History of atherosclerotic coronary artery disease.

f. History of pacemaker or defibrillator implantation.

g. History of supraventricular tachycardia if:

(1) History of atrial fibrillation or flutter.

(2) Any atrioventricular nodal reentrant tachycardia or atrioventricular reentrant tachycardia (e.g., Wolff-Parkinson-White syndrome) unless successfully treated with ablative therapy, no recurrence of symptoms after 3 months, and documentation of normal electrocardiograph.

h. Premature atrial or ventricular contractions sufficiently symptomatic to require treatment, or result in physical or psychological impairment.

i. The following abnormal electrocardiograph patterns:

(1) Long QT.

(2) Brugada pattern.

(3) Pre-excitation pattern, unless it is asymptomatic and associated with low-risk accessory pathway by appropriate diagnostic testing.

j. History of ventricular arrhythmias including ventricular fibrillation, tachycardia, or multifocal premature ventricular contractions other than occasional asymptomatic unifocal premature ventricular contractions.

k. History of conduction disorders, including but not limited to disorders of sinus arrest, asystole, Mobitz type II second-degree atrioventricular (AV) block, and third-degree AV block.

l. Any conductive disorder, if symptomatic, including but not limited to:

(1) Sinus arrhythmia.

(2) First degree AV block.

(3) Left axis deviation of less than -45 degrees.

(4) Early repolarization.

(5) Incomplete right bundle branch block.

(6) Wandering atrial pacemaker or ectopic atrial rhythm.

(7) Sinus bradycardia.

(8) Mobitz type I second-degree AV block.

m. History of conduction disturbances, including right bundle branch block, unless it is asymptomatic with a normal echocardiogram.

n. All left bundle branch block, left anterior/posterior hemiblock.

o. History of myocardial infarction, cardiomyopathy, cardiomegaly, hypertrophy (defined as septal wall thickness of 15 mm or greater), or congestive heart failure.

p. History of myocarditis or pericarditis unless the individual is free of all cardiac symptoms, does not require medical therapy, and has normal echocardiography for at least 1 year after the event.

q. History of recurrent myocarditis or pericarditis.

r. Current persistent tachycardia (as evidenced by an average heart rate of 100 beats per minute or greater over a 24-hour period of continuous monitoring).

s. History of congenital anomalies of the heart and great vessels other than the following conditions. Excepted conditions require an otherwise normal current echocardiogram within the last 12 months.

(1) Dextrocardia with situs inversus without any other anomalies.

(2) Ligated or occluded patent ductus arteriosus.

(3) Corrected atrial septal defect without residua.

(4) Patent foramen ovale.

(5) Corrected ventricular septal defect without residua.

t. History of recurrent syncope or presyncope, including black out, fainting, loss or alteration of level of consciousness (excludes single episode of vasovagal reaction with identified trigger such as venipuncture) unless it has not recurred during the preceding 2 years while off all medication for treatment of this condition.

u. Unexplained ongoing or recurring cardiopulmonary symptoms (to include but not limited to syncope, presyncope, chest pain, palpitations, and dyspnea on exertion).

v. History of Postural Orthostatic Tachycardia Syndrome.

w. History of rheumatic fever if associated with rheumatic heart disease or indication for ongoing prophylactic medication.

5.12. ABDOMINAL ORGANS AND GASTROINTESTINAL SYSTEM.

a. Esophageal Disease.

(1) History of Gastro-Esophageal Reflux Disease, with complications, including, but not limited to:

(a) Stricture.

(b) Dysphagia.

(c) Recurrent symptoms or esophagitis despite maintenance medication.

(d) Barrett's esophagus.

(e) Extraesophageal complications such as: reactive airway disease; recurrent sinusitis or dental complications; unresponsive to acid suppression.

(2) History of surgical correction (e.g., fundoplication) for Gastro-Esophageal Reflux Disease within 6 months or with complications.

(3) History of dysmotility disorders to include but not limited to diffuse esophageal spasm, nutcracker esophagus, and achalasia.

(4) History of eosinophilic esophagitis.

(5) History of other esophageal strictures (e.g., from ingesting lye).

(6) History of esophageal disease not specified above; including but not limited to neoplasia, ulceration, varices, or fistula.

b. Stomach and Duodenum.

(1) Current dyspepsia, gastritis, or duodenitis despite medication (over the counter or prescription).

(2) Current gastric or duodenal ulcers, including but not limited to peptic ulcers and gastrojejunal ulcers:

(a) History of a treated ulcer within the last 3 months.

(b) Recurrent or complicated by bleeding, obstruction, or perforation within the previous 5 years.

(3) History of surgery for peptic ulceration or perforated ulcer.

(4) History of gastroparesis of greater than 6 week's duration, confirmed by scintigraphy or equivalent test.

(5) History of bariatric surgery of any type (e.g., lap-band or gastric bypass surgery for weight loss).

(6) History of gastric varices.

c. Small and Large Intestine.

(1) History of inflammatory bowel disease, including but not limited to Crohn's disease, ulcerative colitis, ulcerative proctitis, or indeterminate colitis.

(2) Current infectious colitis.

(3) History of intestinal malabsorption syndromes, including but not limited to celiac sprue, pancreatic insufficiency, post-surgical and idiopathic.

(4) Dietary intolerances that may interfere with military duty or consuming military rations. Lactase deficiency does not meet the standard only if of sufficient severity to require frequent intervention, or to interfere with military duties.

(5) History of gastrointestinal functional or motility disorders including but not limited to volvulus within the past 24 months, or any history of pseudo-obstruction or megacolon.

(6) Current chronic constipation, requiring prescription medication or medical interventions (e.g., pelvic floor physical therapy, biofeedback therapy).

(7) History of diarrhea of greater than 6 weeks duration, regardless of cause, persisting or symptomatic in the past 2 years.

(8) History of gastrointestinal bleeding, including positive occult blood, if the cause requires treatment and has not been corrected.

(9) History of irritable bowel syndrome of sufficient severity to require frequent intervention or prescription medication or that may reasonably be expected to interfere with military duty.

(10) History of symptomatic diverticular disease of the intestine.

(11) Personal or family history of familial adenomatous polyposis syndrome or hereditary non-polyposis colon cancer (Lynch syndrome).

d. Hepatic-Biliary Tract.

(1) History of chronic Hepatitis B unless successfully treated and the cure is documented. A documented cure for Hepatitis B is viral clearance manifested by Hepatitis B surface antigen negative/Hepatitis B surface antibody positive/Hepatitis B core antibody positive.

(2) History of chronic Hepatitis C, unless successfully treated and with documentation of a cure 12 weeks after completion of a full course of therapy.

(3) Other acute hepatitis in the preceding 6 months, or persistence of symptoms or abnormal serum aminotransferases after 6 months, or objective evidence of impairment of liver function.

(4) History of cirrhosis, hepatic abscess, or complications of chronic liver disease.

(5) History of symptomatic gallstones or gallbladder disease unless successfully treated.

(6) History of sphincter of Oddi dysfunction.

(7) History of choledochal cyst.

(8) History of primary biliary cirrhosis or primary sclerosing cholangitis.

(9) History of metabolic liver disease, excluding Gilbert's syndrome. This includes but is not limited to hemochromatosis, Wilson's disease, or alpha-1 anti-trypsin deficiency.

(10) History of alcoholic or non-alcoholic fatty liver disease if there is evidence of chronic liver disease, manifested as impairment of liver function or hepatic fibrosis.

(11) History of traumatic injury to the liver within the preceding 6 months.

e. Pancreas. History of:

(1) Pancreatic insufficiency.

(2) Acute pancreatitis, unless due to cholelithiasis successfully treated by cholecystectomy.

(3) Chronic pancreatitis.

(4) Pancreatic cyst or pseudocyst.

(5) Pancreatic surgery.

f. Anorectal.

(1) Current anal fissure or anal fistula.

(2) History of rectal prolapse or stricture within the last 2 years.

(3) History of fecal incontinence after the 13th birthday.

(4) Current hemorrhoid (internal or external), if symptomatic or requiring medical intervention within the last 60 days.

g. Abdominal Wall.

(1) Current abdominal wall hernia other than small (less than 2 centimeters (cm) in size), asymptomatic inguinal or umbilical hernias.

(2) History of open or laparoscopic abdominal surgery during the preceding 3 months.

(3) The presence of any ostomy (gastrointestinal or urinary).

5.13. FEMALE GENITAL SYSTEM.

a. Abnormal uterine bleeding (period greater than 7 days, or more frequent than 21 days or greater than 35 days, or soaking more than one pad per hour for several hours) within the last 12 months.

b. Primary amenorrhea.

c. Current unexplained secondary amenorrhea.

d. Dysmenorrhea resulting in recurrent absences or activity modification within the last 6 months.

e. History of symptomatic endometriosis.

f. History of major abnormalities or defects of the genitalia, such as hermaphroditism, pseudohermaphroditism, or pure gonadal dysgenesis.

g. Current ovarian cyst(s) greater than 5 cm.

h. Polycystic ovarian syndrome unless no evidence of metabolic complications as specified by National Heart, Lung, and Blood Institute and American Heart Association Guidelines.

i. Pelvic inflammatory disease within the preceding 6 months.

j. History of chronic pelvic pain (6 months or longer) within the last 24 months.

k. Pregnancy through 6 months after the completion of the pregnancy.

l. Uterine enlargement due to any cause.

m. History of genital infection or ulceration, including but not limited to herpes genitalis or condyloma acuminatum, if any of the following apply:

(1) Current lesions are present.

(2) Use of chronic suppressive therapy is needed.

(3) There have been three or more outbreaks per year.

(4) Any outbreak in the past 12 months that interfered with normal life activities.

(5) After the initial outbreak, treatment that included hospitalization or intravenous therapy.

n. Abnormal gynecologic cytology within the preceding 3 years, including but not limited to unspecified abnormalities of the Papanicolaou smear of the cervix, excluding atypical squamous cells of undetermined significance without human papillomavirus and confirmed low-grade squamous intraepithelial lesion. For the purposes of this issuance, confirmation is by colposcopy or repeat cytology.

o. History of abnormal cervical, vaginal, or vulvar cytology or pathology to include atypical squamous cells that cannot exclude high grade squamous intraepithelial lesions, low-grade squamous intraepithelial lesions, high-grade squamous intraepithelial lesions, cervical intraepithelial neoplasia grades 2 or 3, vaginal intraepithelial neoplasia grades 2 or 3, vulvar intraepithelial neoplasia grades 2 or 3 without demonstrated resolution in accordance with American Society for Colposcopy and Cervical Pathology guidelines.

p. History of abnormal endometrial pathology within the last 3 years (e.g., simple or complex hyperplasia with or without atypia) without demonstrated resolution in accordance with American Society for Colposcopy and Cervical Pathology guidelines.

5.14. MALE GENITAL SYSTEM.

a. Absence of both testicles, current undescended testicle, or congenital absence of one testicle not verified by surgical exploration.

b. History of epispadias or hypospadias when accompanied by history of urinary tract infection, urethral stricture, urinary incontinence, symptomatic chordee, or voiding dysfunction or surgical intervention for these issues within the past 24 months.

c. Current enlargement or mass of testicle, epididymis, or spermatic cord, in addition to those described elsewhere in Paragraph 5.14.

d. Current hydrocele or spermatocele associated with pain or which precludes a complete exam of the scrotal contents.

e. Current varicocele, unless it is:

(1) On the left side only.

(2) Asymptomatic and smaller than the testes.

(3) Reducible.

(4) Without associated testicular atrophy.

f. Current or history of recurrent orchitis or epididymitis.

g. History of penis amputation.

h. Current penile curvature if associated with pain.

i. History of genital infection or ulceration, including but not limited to herpes genitalis or condyloma acuminatum, if:

(1) Current lesions are present;

(2) Use of chronic suppressive therapy is needed;

(3) There are three or more outbreaks per year;

(4) Any outbreak in the past 12 months interfered with normal activities; or

(5) After the initial outbreak, treatment included hospitalization or intravenous therapy.

j. History of urethral condyloma acuminatum.

k. History of acute prostatitis within the last 24 months, history of chronic prostatitis, or history of chronic pelvic pain syndrome.

l. History of chronic or recurrent scrotal pain or unspecified symptoms associated with male genital organs.

m. History of major abnormalities or defects of the genitalia such as hermaphroditism, pseudohermaphroditism, or pure gonadal dysgenesis.

5.15. URINARY SYSTEM.

a. History of interstitial cystitis or painful bladder syndrome.

b. Lower urinary tract infection (cystitis):

(1) For males, any cystitis not related to an indwelling catheter during a hospitalization.

(2) For females, current cystitis or recurrent cystitis of greater than two episodes per year, or requiring daily suppressive antibiotics, or non-responsive to antibiotics for 10 days.

c. Current urethritis.

d. History or treatment of the following voiding symptoms within the previous 12 months in the absence of a urinary tract infection:

(1) Urinary frequency or urgency more than every 2 hours on a daily basis.

(2) Nocturia more than two episodes during sleep period.

(3) Enuresis.

(4) Incontinence of urine, such as urge or stress.

(5) Urinary retention.

(6) Dysuria.

e. History of neurogenic bladder or other functional disorder of the bladder that requires urinary catheterization with intermittent or indwelling catheter for any period greater than 2 weeks.

f. History of bladder augmentation, urinary diversion, or urinary tract reconstruction.

g. History of abnormal urinary findings in the absence of urinary tract infection:

(1) Gross hematuria.

(2) Persistent microscopic hematuria (3 or more red blood cells per high-powered field on properly collected urinalyses, unless urology evaluation determines benign essential hematuria).

(3) Pyuria (6 or more white blood cells per high-powered field in 2 of 3 properly collected urinalyses).

h. Current or recurrent urethral or ureteral stricture or fistula involving the urinary tract.

i. Absence of one kidney, congenital or acquired.

j. Asymmetry in size or function of kidneys.

k. History of renal transplant.

l. Chronic or recurrent pyelonephritis or any other unspecified infections of the kidney.

m. History of polycystic kidney.

n. History of horseshoe kidney.

o. Hydronephrosis on most recent imaging not related to pregnancy.

p. History of acute nephritis or chronic kidney disease of any type as evidenced by 3 months or longer of:

(1) Estimated glomerular filtration rate of less than 60cc per minute per 1.73 square meter of body surface area or abnormal renal imaging;

(2) Casturia; or

(3) Abnormal renal biopsy.

q. History of acute kidney injury requiring dialysis.

r. History of proteinuria with a protein-to-creatinine ratio greater than 0.2 in a random urine sample, more than 48 hours after strenuous activity, excluding benign orthostatic proteinuria.

s. Urolithiasis if any of the following apply:

(1) Current stone of 3 mm or greater.

(2) Current multiple stones of any size.

(3) History of symptomatic urolithiasis within the preceding 12 months.

(4) History of nephrocalcinosis, bilateral renal calculi, or recurrent urolithiasis at any time.

(5) History of urolithiasis requiring a procedure.

5.16. SPINE AND SACROILIAC JOINT CONDITIONS.

a. Ankylosing spondylitis or other inflammatory spondylopathies.

b. History of any condition, in the last 2 years, or any recurrence, including but not limited to the spine or sacroiliac joints, with or without objective signs, if:

(1) It prevents the individual from successfully following a physically active avocation in civilian life, or is associated with local or radicular pain, muscular spasms, postural deformities, or limitation in motion;

(2) It requires external support;

(3) It requires limitation of physical activity or frequent treatment; or

(4) It requires the applicant to use medication for more than 6 weeks.

(5) It causes one or more episodes of back pain lasting greater than 6 weeks requiring treatment other than self-care.

c. Current deviation or curvature of the spine from normal alignment, structure, or function if:

(1) It prevents the individual from following a physically active avocation in civilian life;

(2) It can reasonably be expected to interfere with the proper wearing of military uniform or equipment;

(3) It is symptomatic; or

(4) There is lumbar or thoracic scoliosis greater than 30 degrees, or thoracic kyphosis greater than 50 degrees when measured by the Cobb Method.

d. History of congenital fusion involving more than 2 vertebral bodies or any surgical fusion of spinal vertebrae.

e. Current dislocation of the vertebra.

f. Vertebral fractures including but not limited to:

(1) Any cervical spine fracture.

(2) History of fracture of lumbar or thoracic vertebral body that exceeds 25 percent of the height of a single vertebra or that has occurred within the last 12 months or is symptomatic.

(3) A history of fractures of the transverse or spinous process if currently symptomatic.

g. History of juvenile epiphysitis with any degree of residual change indicated by X-ray or Scheuermann’s kyphosis.

h. History of uncorrected herniated nucleus pulposus associated with any treatment, symptoms, or activity limitations.

i. History of surgery to correct herniated nucleus pulposus other than a single-level lumbar or thoracic diskectomy that is currently asymptomatic with full resumption of unrestricted activity for at least 12 months.

j. Spinal dysraphisms other than spina bifida occulta.

k. History of spondylolysis or spondylolisthesis, congenital or acquired.

5.17. UPPER EXTREMITY CONDITIONS.

a. Limitation of Motion. Current active joint ranges of motion less than:

(1) Shoulder.

(a) Forward elevation to 130 degrees.

(b) 130 degrees abduction.

(c) 60 degrees external and internal rotation at 90 degrees abduction.

(d) Cross body reaching 115 degrees adduction.

(2) Elbow.

(a) Flexion to 130 degrees.

(b) Extension to 30 degrees.

(3) Wrist. A total range of 60 degrees (extension plus flexion), or radial and ulnar deviation combined are 30 degrees.

(4) Hand.

(a) Pronation to 45 degrees.

(b) Supination to 45 degrees.

(5) Fingers and Thumb. Inability to clench fist, pick up a pin, grasp an object, or touch tips of at least three fingers with thumb.

b. Hand and Fingers.

(1) Absence of the distal phalanx of either thumb.

(2) Absence of any portion of the index finger.

(3) Absence of 2 or more distal and middle phalanges of the middle, ring, or small finger of either hand.

(4) Absence of 2 or more distal phalanges of any finger on either hand.

(5) Absence of hand or any portion thereof, except for specific absence of fingers as noted in Paragraphs 5.17.b.(1)-(4).

(6) Current polydactyly or syndactyly.

(7) Intrinsic paralysis or weakness of upper limbs, including but not limited to nerve paralysis, carpal tunnel, and cubital syndromes, lesion of ulnar, median, or radial nerve, sufficient to produce physical findings in the hand such as muscle atrophy and weakness.

c. Residual Weakness and Pain. Current disease, injury, or congenital condition with residual weakness, pain, sensory disturbance, or other symptoms that may reasonably be expected to prevent satisfactory performance of duty, including but not limited to chronic joint pain associated with the shoulder, the upper arm, the forearm, and the hand; or chronic joint pain as a late effect of fracture of the upper extremities, as a late effect of sprains without mention of injury, and as late effects of tendon injury.

5.18. LOWER EXTREMITY CONDITIONS.

a. General.

(1) Current deformities, disease, or chronic joint pain of pelvic region, thigh, lower leg, knee, ankle or foot that prevent the individual from following a physically active avocation in civilian life, or that may reasonably be expected to interfere with walking, running, weight bearing, or with satisfactorily completing training or military duty.

(2) Current discrepancy in leg-length that causes a limp.

b. Limitation of Motion. Current active joint ranges of motion less than:

(1) Hip.

(a) Flexion to 90 degrees.

(b) No demonstrable flexion contracture.

(c) Extension to 10 degrees (beyond 0 degrees).

(d) Abduction to 45 degrees.

(e) Rotation of 60 degrees (internal and external combined).

(2) Knee.

(a) Full extension to 0 degrees.

(b) Flexion to 110 degrees.

(3) Ankle.

(a) Dorsiflexion to 10 degrees.

(b) Planter flexion to 30 degrees.

(c) Subtalar eversion and inversion totaling 5 degrees.

c. Foot and Ankle.

(1) Current absence of a foot or any portion thereof, other than absence of a single lesser toe that is asymptomatic and does not impair function of the foot.

(2) Deformity of the toes that may reasonably be expected to prevent properly wearing military footwear or impair walking, marching, running, maintaining balance, or jumping.

(3) Symptomatic deformity of the toes (acquired or congenital), including but not limited to conditions such as hallux valgus, hallux varus, hallux rigidus, hammer toe(s), claw toe(s), or overriding toe(s).

(4) Clubfoot or pes cavus that may reasonably be expected to properly wearing military footwear or causes symptoms when walking, marching, running, or jumping.

(5) Rigid or symptomatic pes planus (acquired or congenital).

(6) Current ingrown toenails, if infected or symptomatic.

(7) Current or recurrent plantar fasciitis.

(8) Symptomatic neuroma.

d. Leg, Knee, Thigh, and Hip.

(1) Current loose or foreign body in the knee joint.

(2) History of uncorrected anterior or posterior cruciate ligament injury.

(3) History of surgical reconstruction of knee ligaments within the last 12 months, or which is symptomatic or unstable or shows signs of thigh or calf atrophy.

(4) Recurrent anterior cruciate ligament reconstruction.

(5) Current medial or lateral meniscal injury with symptoms or limitation of activity.

(6) Surgical meniscal repair, within the last 6 months or with residual symptoms or limitation of activity.

(7) Surgical partial meniscectomy within the last 3 months or with residual symptoms or limitation of activity.

(8) Meniscal transplant.

(9) Symptomatic medial and lateral collateral ligament instability.

(10) History of developmental dysplasia (congenital dislocation) of the hip, osteochondritis of the hip (Legg-Calve-Perthes Disease), or slipped capital femoral epiphysis of the hip.

(11) History of hip dislocation.

(12) Symptomatic osteochondritis of the tibial tuberosity (Osgood-Schlatter Disease) within the past 12 months.

(13) Stress fractures, either recurrent or a single episode occurring during the past 12 months.

5.19. MISCELLANEOUS CONDITIONS OF THE EXTREMITIES.

a. History of chondromalacia, including but not limited to chronic patello-femoral pain syndrome and retro-patellar pain syndrome, osteoarthritis, or traumatic arthritis.

b. Dislocation of patella if two or more episodes, or any occurring within the last 12 months.

c. History of any dislocation, subluxation, or instability of the hip, knee, ankle, subtalar joint, foot, shoulder, wrist, elbow except for “nursemaid’s elbow” or dislocated finger.

d Acromioclavicular separation within the last 12 months or if symptomatic.

e. History of osteoarthritis or traumatic arthritis of isolated joints that has interfered with a physically active lifestyle, or that may reasonably be expected to prevent satisfactorily performing military duty.

f. Fractures, if:

(1) Current malunion or non-union of any fracture (except asymptomatic ulnar styloid process fracture).

(2) Current retained hardware (including plates, pins, rods, wires, or screws) used for fixation that is symptomatic or may reasonably be expected to interfere with properly wearing military equipment or uniforms. Retained hardware is not disqualifying if fractures are healed, ligaments are stable, and there is no pain.

g. Current orthopedic implants or devices to correct congenital or post-traumatic orthopedic abnormalities except for bone anchor and hardware as allowed in accordance with Paragraph 5.19.f.(2).

h. History of contusion of bone or joint if:

(1) The injury is of more than a minor nature with or without fracture, nerve injury, open wound, crush, or dislocation which occurred within the last 6 months;

(2) Recovery has not been sufficiently completed or rehabilitation has not been sufficiently resolved;

(3) The injury may reasonably be expected to interfere with or prevent performance of military duty; or

(4) The contusion requires frequent or prolonged treatment.

i. History of joint replacement or resurfacing of any site.

j. History of hip arthroscopy or femoral acetabular impingement.

k. History of neuromuscular paralysis, weakness, contracture, or atrophy not completely resolved and of sufficient degree to reasonably be expected to interfere with or prevent satisfactory performing military duty.

l. Current symptomatic osteochondroma or history of two or more osteocartilaginous exostoses.

m. History of atraumatic fractures or bone mineral density below the expected range for age with risk factors for low bone density.

n. Osteopenia, osteoporosis, or history of fragility fracture.

o. History of osteomyelitis within the past 12 months, or history of recurrent osteomyelitis.

p. History of osteochondral defect, formerly known as osteochondritis dissecans.

q. History of cartilage surgery, including but not limited to cartilage debridement or chondroplasty for Grade III or greater chondromalacia, microfracture, or cartilage transplant procedure.

r. History of any post-traumatic or exercise-induced compartment syndrome.

s. History of osteonecrosis of any bone.

t. History of recurrent tendon disorder, including but not limited to tendonitis, tendonopathy, tenosynovitis.

5.20. VASCULAR SYSTEM.

a. History of abnormalities of the arteries, including but not limited to aneurysms, arteriovenous malformations, atherosclerosis, or arteritis (e.g., Kawasaki's disease).

b. Current or medically-managed hypertension. Hypertension is defined as systolic pressure greater than 140 millimeters of mercury (mmHg) or diastolic pressure greater than 90 mmHg confirmed by manual blood pressure cuff averaged over two or more properly measured, seated, blood pressure readings on separate days within a 5-day period (isolated, single-day blood pressure elevation is not disqualifying unless confirmed on 2 separate days within a 5-day period).

c. History of peripheral vascular disease, including but not limited to diseases such as Raynaud's Disease and vasculitides.

d. History of venous diseases, including but not limited to recurrent thrombophlebitis, thrombophlebitis during the preceding year, or evidence of venous incompetence, such as edema, skin ulceration, or symptomatic varicose veins that would reasonably be expected to limit duty or properly wearing military uniform or equipment.

e. History of deep venous thrombosis.

f. History of operation or endovascular procedure on the arterial or venous systems, including but not limited to vena cava filter, angioplasty, venoplasty, thrombolysis, or stent placement.

g. History of Marfan's Syndrome, Loey-Dietz, or Ehlers Danlos IV.

5.21. SKIN AND SOFT TISSUE CONDITIONS.

a. Applicants under treatment with systemic retinoids, including, but not limited to isotretinoin (e.g. Accutane®), do not meet the standard until 4 weeks after completing therapy.

b. Severe nodulocystic acne, on or off antibiotics.

c. History of dissecting scalp cellulitis, acne inversa, or hidradenitis suppurativa.

d. History of atopic dermatitis or eczema after the 12th birthday. History of residual or recurrent lesions in characteristic areas (face, neck, antecubital or popliteal fossae, occasionally wrists and hands).

e. History of recurrent or chronic non-specific dermatitis within the past 2 years to include contact (irritant or allergic) or dyshidrotic dermatitis requiring more than treatment with topical corticosteroid.

f. Cysts, if:

(1) The current cyst (other than pilonidal cyst) is of such a size or location as to reasonably be expected to interfere with properly wearing military equipment.

(2) The current pilonidal cyst is associated with a tumor mass or discharging sinus, or is a surgically resected pilonidal cyst that is symptomatic, unhealed, or less than 6 months post-operative. A pilonidal cyst that has been simply incised and drained does not meet the military accession medical entrance standard.

g. History of bullous dermatoses, including but not limited to dermatitis herpetiformis, pemphigus, and epidermolysis bullosa.

h. Current or chronic lymphedema.

i. History of furunculosis or carbuncle if extensive, recurrent, or chronic.

j. History of severe hyperhidrosis of hands or feet unless controlled by topical medications.

k. History of congenital or acquired anomalies of the skin, such as nevi or vascular tumors that may interfere with military duties or cause constant irritation.

l. History of severe keloid formation.

m. History of pseudofolliculitis barbae or keloidalis nuchae, severe enough to prevent daily shaving or would reasonably be expected to interfere with wearing military equipment.

n. Current lichen planus (either cutaneous or oral).

o. History of oculocutaneous albinism, Neurofibromatosis I (Von Recklinghausen's Disease), Neurofibromatosis II, and tuberous sclerosis.

p. History of photosensitivity, including but not limited to any primary sun-sensitive condition, such as polymorphous light eruption or solar urticaria, or any dermatosis aggravated by sunlight, such as lupus erythematosus, porphyria, and xeroderma pigmentosa.

q. History of psoriasis excluding non-recurrent childhood guttate psoriasis.

r. History of chronic radiation dermatitis (radiodermatitis).

s. History of scleroderma.

t. History of chronic urticaria lasting longer than 6 weeks even, if it is asymptomatic when controlled by daily maintenance therapy.

u. Current symptomatic plantar wart(s).

v. Current scars that can reasonably be expected to interfere with properly wearing military clothing or equipment, or to interfere with satisfactorily performing military duty due to pain or decreased range of motion, strength, or agility.

w. Prior burn injury involving 18 percent or more body surface area (including graft sites), or resulting in functional impairment to such a degree, due to scarring, as to interfere with satisfactorily performing military duty due to pain or decreased range of motion, strength, temperature regulation, or agility.

x. Current localized fungal infections, if they can be reasonably expected to interfere with properly wearing military equipment or performing military duties. For systemic fungal infections, refer to Paragraph 5.23.s.

y. History of any medical condition severe enough to warrant use of systemic steroids for greater than 2 months, or any use of other systemic immunosuppressant medications.

z. Conditions with malignant potential in the skin including but not limited to basal cell nevus syndrome, oculocutaneous albinism, xeroderma pigmentosum, Muir-Torre Syndrome, Dyskeratosis Congenita, Gardner Syndrome, Peutz-Jeghers Syndrome, Cowden Syndrome, Multiple Endocrine Neoplasia, Familial Atypical Multiple Mole Melanoma Syndrome, and Birt-Hogg-Dube Syndrome.

aa. History of cutaneous malignancy before the 25th birthday including but not limited to basal cell carcinoma and squamous cell carcinoma. History of the following skin cancers at any age: malignant melanoma, Merkel cell carcinoma, sebaceous carcinoma, Paget's disease, extramammary Paget's disease, microcystic adnexal carcinoma, other adnexal neoplasms, and cutaneous lymphoma including mycosis fungoides.

ab. History of lupus erythematosus.

ac. History of congential disorders of cornification including but not limited to ichthyosis vulgaris, x-linked ichthyosis, lamellar ichthyosis, Darier's Disease, Epidermal Nevus Syndrome, and any palmo-plantar keratoderma.

ad. History of congenitalal disorder of the hair and nails including but not limited to pachyonychia congenita or ectodermal dysplasia.

ae. History of dermatomyositis.

5.22. BLOOD AND BLOOD FORMING SYSTEM.

a. Current hereditary or acquired anemia.

b. History of coagulation defects.

c. Any history of chronic, or recurrent thrombocytopenia.

d. History of deep venous thrombosis or pulmonary embolism.

e. History of chronic or recurrent agranulocytosis or leukopenia.

f. History of chronic polycythemia, chronic leukocytosis or chronic thrombocytosis.

g. Disorders of the spleen including:

(1) Current splenomegaly.

(2) History of splenectomy.

5.23. SYSTEMIC CONDITIONS.

a. History of disorders involving the immune mechanism, including immunodeficiencies.

b. Presence of human immunodeficiency virus or laboratory evidence of infection or false-positive screening test(s) with ambiguous results by supplemental confirmation test(s).

c. Tuberculosis.

(1) History of active pulmonary or extra pulmonary tuberculosis in the previous 2 years or history of active pulmonary or extra-pulmonary tuberculosis without reliable documentation of adequate treatment.

(2) History of latent tuberculosis infection, as defined by current Centers for Disease Control guidelines, unless documentation of completion of appropriate treatment.

d. History of syphilis without appropriate documentation of treatment and cure.

e. History of anaphylaxis. Anaphylaxis is highly likely when any one of the following three criteria are fulfilled:

(1) Acute onset of an illness (minutes to several hours) with involvement of the skin, mucosal tissue, or both (e.g., generalized hives, pruritus or flushing, swollen lips-tongue-uvula) and at least one of the following:

(a) Respiratory compromise (e.g., dyspnea, wheeze-bronchospasm, stridor, reduced peak expiratory flow, hypoxemia); or

(b) Reduced blood pressure (BP) or associated symptoms of end-organ dysfunction (e.g., hypotonia [collapse], syncope, incontinence).

(2) Two or more of the following that occur rapidly after exposure to a likely allergen for that patient (minutes to several hours):

(a) Involvement of the skin-mucosal tissue (e.g., generalized hives, itch-flush, swollen lips-tongue-uvula).

(b) Respiratory compromise (e.g., dyspnea, wheeze-bronchospasm, stridor, reduced peak expiratory flow, hypoxemia).

(c) Reduced BP or associated symptoms (e.g., hypotonia [collapse], syncope, incontinence).

(d) Persistent gastrointestinal symptoms (e.g., crampy, abdominal pain, vomiting).

(3) Reduced blood pressure after exposure to known allergen for that patient (minutes to several hours):

(a) Infants and Children: Low systolic BP (less than 70 mmHg from 1 month to 1 year, less than (70 mmHg + [2×age]) from 1 to 10 years, and less than 90 mm Hg from 11 to 17 years) or greater than 30 percent decrease in systolic blood pressure.

(b) Adults: Systolic BP of less than 90 mmHg or greater than 30 percent decrease from that person's baseline.

f. History of systemic allergic reaction to biting or stinging insects, unless it was limited to a large local reaction, a cutaneous only reaction (including hives) occurring under the age of 16, or unless there is documentation of 3-5 years of maintenance venom immunotherapy.

g. History of acute allergic reaction to fish, shellfish, peanuts, or tree nuts including the presence of a food-specific immunoglobulin E antibody if accompanied by a correlating clinical history.

h. History of cold urticaria.

i. History of malignant hyperthermia.

j. History of industrial solvent or other chemical intoxication with sequelae.

k. History of motion sickness resulting in recurrent incapacitating symptoms.

l. History of rheumatic fever if associated with rheumatic heart disease or indication for ongoing prophylactic medication.

m. History of muscular dystrophies or myopathies.

n. History of amyloidosis.

o. History of eosinophilic granuloma and all other forms of histiocytosis except for healed eosinophilic granuloma, when occurring as a single localized bony lesion and not associated with soft tissue or other involvement.

p. History of polymyositis or dermatomyositis complex with or without skin involvement.

q. History of rhabdomyolysis.

r. History of sarcoidosis.

s. Current active systemic fungus infections or ongoing treatment for systemic fungal infection. History of systemic fungal infection unless resolved or treated without sequelae.

5.24. ENDOCRINE AND METABOLIC CONDITIONS.

a. Current adrenal dysfunction or any history of adrenal dysfunction requiring treatment or hormone replacement.

b. Diabetic disorders, including:

(1) History of diabetes mellitus.

(2) History of unresolved pre-diabetes mellitus (as defined by the American Diabetes Association) within the last 2 years.

(3) History of gestational diabetes mellitus.

(4) Current persistent glycosuria, when associated with impaired glucose metabolism or renal tubular defects.

c. History of pituitary dysfunction except for resolved growth hormone deficiency.

d. History of pituitary tumor unless proven non-functional, less than 1 cm and stable in size for the last 12 months.

e. History of diabetes insipidus.

f. History of primary hyperparathyroidism unless surgically corrected.

g. History of hypoparathyroidism.

h. Current goiter.

i. Thyroid nodule unless a solitary thyroid nodule less than 5 mm or less than 3 cm with benign histology or cytology, and that does not require ongoing surveillance.

j. History of complex thyroid cyst or simple thyroid cyst greater than 2 cm.

k. Current hypothyroidism unless asymptomatic and demonstrated euthyroid by normal thyroid stimulating hormone testing within the preceding 12 months.

l. History of hyperthyroidism unless treated successfully with surgery or radioactive iodine.

m. Current nutritional deficiency diseases, including but not limited to beriberi, pellagra, and scurvy.

n. Dyslipidemia with low-density lipoprotein greater than 200 milligrams per deciliter (mg/dL) or triglycerides greater than 400 mg/dL. Dyslipidemia requiring more than one medication or low-density lipoprotein greater than 190 mg/dL on therapy. All those on medical management must have demonstrated no medication side effects (e.g., myositis, myalgias, or transaminitis) for a period of 6 months.

o. Metabolic syndrome, as defined in accordance with the 2005 National Heart, Lung, and Blood Institute and American Heart Association Scientific Statement as any three of the following:

(1) Medically-controlled hypertension or elevated blood pressure of greater than 130 mmHg systolic or greater than 85 mmHg diastolic.

(2) Waist circumference greater than 35 inches for women and greater than 40 inches for men.

(3) Medically controlled dyslipidemia or triglycerides greater than 150 mg/dL.

(4) Medically controlled dyslipidemia or high-density lipoprotein less than 40 mg/dL in men or less than 50 mg/dL in women.

(5) Fasting glucose greater than 100 mg/dL.

p. Metabolic bone disease including but not limited to:

(1) Osteopenia, osteoporosis, or low bone mass with history of fragility fracture.

(2) Paget's disease.

(3) Osteomalacia.

(4) Osteogenesis imperfecta.

q. History of hypogonadism that is congenital, treated with hormonal supplementation, or of unexplained etiology.

r. History of islet-cell tumors, nesideoblastosis, or hypoglycemia.

s. History of gout.

5.25. RHEUMATOLOGIC CONDITIONS.

a. History of mixed connective tissue disease variant or systemic lupus erythematosus.

b. History of progressive systemic sclerosis, including calcinosis, Raynaud's phenomenon, esophageal dysmotility, scleroderma, or telangiectasia syndrome.

c. History of reactive arthritis (formerly known as Reiter's disease).

d. History of rheumatoid arthritis.

e. History of Sjögren's syndrome.

f. History of vasculitis, including but not limited to polyarteritis nodosa, arteritis, Behçet's, Takayasu's arteritis, and Anti Neutrophil Cytoplasmic Antibody associated vasculitis.

g. History of Henoch-Schonlein Purpura occurring after the 19th birthday or within the last 2 years.

h. History of non-inflammatory myopathy including but not limited to metabolic myopathy such as glycogen storage disease, lipid storage disease, and mitochondrial myopathy.

i. History of fibromyalgia or myofascial pain syndrome.

j. History of chronic wide-spread pain requiring prescription medication for greater than 6 weeks within the last 2 years.

k. History of chronic fatigue syndrome, systemic exertion intolerance disease, or chronic multisystem illness.

l. History of spondyloarthritis including but not limited to ankylosing spondyloarthritis, psoriatic arthritis, reactive arthritis, or spondyloarthritis associated with inflammatory bowel disease.

m. History of joint hypermobility syndrome (formerly Ehler's Danlos syndrome, Type III).

n. Any history of connective tissue disease including but not limited to Ehlers-Danlos syndrome, Marfan syndrome, Pseudoxanthoma Elasticum, and osteogenesis imperfecta.

o. History of scleroderma.

p. History of IgG-4 related disease.

q. History of polymyositis or dermatomyositis complex, with or without skin involvement.

5.26. NEUROLOGIC CONDITIONS.

a. History of cerebrovascular conditions, including but not limited to subarachnoid or intracerebral hemorrhage, vascular stenosis, aneurysm, stroke, transient ischemic attack or arteriovenous malformation.

b. History of congenital or acquired anomalies of the central nervous system or meningocele.

c. History of disorders of meninges, including but not limited to cysts except for asymptomatic incidental arachnoid cysts demonstrated to be stable by neurological imaging over a 6-month or longer time period.

d. History of neurodegenerative disorders, including but not limited to those disorders affecting the cerebrum, basal ganglia, cerebellum, spinal cord, peripheral nerves, or muscles.

e. History of headaches, including but not limited to, migraines and tension headaches that:

(1) Are severe enough to disrupt normal activities (e.g., loss of time from school or work) more than twice per year in the past 2 years;

(2) Require prescription medications more than twice per year within the last 2 years; or

(3) Are associated with neurological deficit other than scotoma.

f. Cluster headaches.

g. History of moderate or severe brain injury if associated with:

(1) Post-traumatic seizure(s) occurring more than 30 minutes after injury;

(2) Persistent motor, sensory, vestibular, visual, or any other focal neurological deficit;

(3) Persistent impairment of cognitive function;

(4) Persistent alteration of personality or behavior;

(5) Cerebral traumatic findings, including but not limited to epidural, subdural, subarachnoid, or intracerebral hematoma on neurological imaging;

(6) Associated abscess or meningitis;

(7) Cerebrospinal fluid rhinorrhea or otorrhea persisting more than 7 days;

(8) Penetrating head trauma to include radiographic evidence of retained foreign body or bony fragments secondary to the trauma, or operative procedure in the brain; or

(9) Any skull fracture.

h. History of mild brain injury if:

(1) The injury occurred within the past month;

(2) Neurological evaluation shows residual symptoms, dysfunction or activity limitations, or complications;

(3) Two episodes of mild brain injury occurred with or without loss of consciousness within the last 12 months; or

(4) Three or more episodes of mild brain injury.

i. History of persistent post-concussive symptoms that interfere with normal activities or have duration of more than 1 month. Symptoms include but are not limited to headache, vomiting, disorientation, spatial disequilibrium, impaired memory, poor mental concentration, shortened attention span, dizziness, or altered sleep patterns.

j. History of infectious processes of the central nervous system, including but not limited to encephalitis, neurosyphilis, or brain abscess.

k. History of meningitis within the last 12 months or with persistent neurologic defects.

l. History of paralysis, weakness, lack of coordination, chronic pain syndrome (including but not limited to complex regional pain syndrome or neuralgias), or sensory disturbance or other specified paralytic syndromes, including but not limited to Guillain-Barre Syndrome.

m. Any atraumatic seizure occurring after the 6th birthday, unless the applicant has been free of seizures for a period of 5 years while taking no medication for seizure control, and has a normal sleep-deprived electroencephalogram and normal neurology evaluation while taking no medications for seizure control.

n. Chronic nervous system disorders, including but not limited to myasthenia gravis, multiple sclerosis, tremor, and tic disorders (e.g., Tourette's Syndrome).

o. History of central nervous system shunts of all kinds including endoscopic third ventriculocisternostomy.

p. Syncope or atraumatic loss of consciousness. History of recurrent syncope or presyncope, including blackout, fainting, loss or alteration of level of consciousness (excludes single episode of vasovagal reaction with identified trigger such as venipuncture), unless there has been no recurrence during the preceding 2 years while off all medication for treatment of this condition.

q. History of muscular dystrophies or myopathies.

5.27. SLEEP DISORDERS.

a. Chronic insomnia as defined by the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, or the use of medications or other substances to promote sleep 15 or more times over the past year.

b. Current diagnosis or treatment of sleep-related breathing disorders, including but not limited to sleep apnea.

c. History of narcolepsy, cataplexy, or other hypersomnia disorders.

d. Circadian rhythm disorders requiring treatment or special accommodation.

e. History of parasomnia, including but not limited to sleepwalking, or night terrors, after the 13th birthday.

f. Current diagnosis or treatment of sleep-related movement disorders to include but not limited to restless leg syndrome (i.e., Willis-Ekbom Disease) for which prescription medication is recommended.

5.28. LEARNING, PSYCHIATRIC, AND BEHAVIORAL DISORDERS.

a. Attention Deficit Hyperactivity Disorder, if with:

(1) A recommended or prescribed Individualized Education Program, 504 Plan, or work accommodations after the 14th birthday;

(2) A history of comorbid mental disorders;

(3) Prescribed medication in the previous 24 months; or

(4) Documentation of adverse academic, occupational, or work performance.

b. History of learning disorders after the 14th birthday, including but not limited to dyslexia, if any of the following apply:

(1) With a recommended or prescribed Individualized Education Program, 504 Plan, or work accommodations after the 14th birthday;

(2) With a history of comorbid mental disorders; or

(3) With documentation of adverse academic, occupational, or work performance.

c. Autism spectrum disorders.

d. History of disorders with psychotic features such as schizophrenic disorders, delusional disorders, or other unspecified psychoses or mood disorders with psychotic features.

e. History of bipolar and related disorders (formerly identified as mood disorders not otherwise specified) including but not limited to cyclothymic disorders and affective psychoses.

f. Depressive disorder if:

(1) Outpatient care including counseling required for longer than 12 cumulative months;

(2) Symptoms or treatment within the last 36 months;

(3) The applicant required any inpatient treatment in a hospital or residential facility;

(4) Any recurrence; or

(5) Any suicidality (in accordance with Paragraph 5.28.m.).

g. History of a single adjustment disorder if treated or symptomatic within the previous 6 months, or any history of chronic (lasting longer than 6 months) or recurrent episodes of adjustment disorders.

h. History of disruptive, impulse control and conduct disorder to include but not limited to oppositional defiant and other behavior disorders.

i. Any personality disorder including unspecified personality disorder or maladaptive personality traits demonstrated by:

(1) Repeated inability to maintain reasonable adjustment in school, with employers or fellow workers, other social groups, or psychological testing revealing that the degree of immaturity, instability, of personality inadequacy, impulsiveness, or dependency may reasonably be expected to interfere with their adjustment to the Military Services;

(2) Recurrent encounters with law enforcement agencies (excluding minor traffic violations) or antisocial behaviors are tangible evidence of impaired capacity to adapt to military service; or

(3) Any behavioral health issues that have led to incarceration for any period.

j. Encopresis after 13th birthday.

k. History of any feeding or eating disorder.

l. Any current communication disorder that significantly interferes with producing speech or repeating commands.

m. Suicidality, including suicidal ideation with a plan, suicidal gesture(s), or attempt(s).

n. History of self-mutilation.

o. History of obsessive-compulsive disorder.

p. History of post-traumatic stress disorder.

q. History of anxiety disorders if:

(1) Outpatient care including counseling was required for longer than 12 cumulative months.

(2) Symptomatic or treatment within the last 36 months.

(3) The applicant required any inpatient treatment in a hospital or residential facility.

(4) Any recurrence.

(5) Any suicidality (in accordance with Paragraph 5.28.m.).

r. History of dissociative disorders.

s. History of somatic symptoms and related disorders.

t. History of paraphilic disorders.

u. Any history of substance-related and addictive disorders (except using caffeine or tobacco).

v. History of other mental disorders that may reasonably be expected to interfere with or prevent satisfactory performance of military duty.

w. Prior psychiatric hospitalization for any cause.

5.29. TUMORS AND MALIGNANCIES.

a. Current benign tumors or conditions that would reasonably be expected to interfere with function, to prevent properly wearing the uniform or protective equipment, or would require frequent specialized attention.

b. History of malignancy.

c. History of cutaneous malignancy, meeting criteria in Paragraph 5.21.aa.

5.30. MISCELLANEOUS CONDITIONS.

a. Any current acute pathological condition, including but not limited to communicable, infectious, parasitic, or tropical diseases, until recovery has occurred without relapse or sequelae.

b. History of porphyria.

c. History of cold-related disorders, including but not limited to frostbite, chilblain, and immersion foot.

d. History of angioedema, including hereditary angioedema.

e. History of receiving organ or tissue transplantation other than dental.

f. History of pulmonary or systemic embolism.

g. History of untreated acute or chronic metallic poisoning (including but not limited to lead, arsenic, silver, beryllium, or manganese), or current complications or residual symptoms of such poisoning.

h. History of heatstroke, or heat injury with evidence of organ or muscle damage, or recurrent heat exhaustion.

i. History of any condition that may reasonably be expected to interfere with the successful performance of military duty or training or limit geographical assignment.

j. History of any medical condition severe enough to warrant use of systemic steroids for greater than 2 months, or any use of other systemic immunosuppressant medications.

GLOSSARY

G.1. ACRONYMS.

ASD(HA)	Assistant Secretary of Defense for Health Affairs
AV	atrioventricular
BP	blood pressure
cm	centimeters
dB	decibel
MEDPERS	Medical and Personnel Executive Steering Committee
mg/dL	milligrams per deciliter
mm	millimeters
mmHg	millimeters of mercury
U.S.C.	United States Code
USD(P&R)	Under Secretary of Defense for Personnel and Readiness
USMEPCOM	United States Military Entrance Processing Command

G.2. DEFINITIONS. Unless otherwise noted, these terms and their definitions are for the purpose of this issuance.

504 Plan. The 504 Plan is a plan developed to ensure that a child who has a disability identified under Section 504 of the Rehabilitation Act of 1973 as amended and codified at Section 701 of Title 29, U.S.C. and is attending an elementary or secondary educational institution, receives accommodations that will ensure their academic success and access to the learning environment.

accession. An enlistment that increases the incremental strength of the Regular or Reserve Components of the Military Services. Personnel enlisted under the Delayed Entry Program are not involved in this category.

existed prior to Service. A term used to signify there is clear and unmistakable evidence that the disease or injury, or the underlying condition producing the disease or injury, existed prior to the individual's entry into military service.

induction. Transition from civilian to military status for a period of definite military obligation under Chapter 49 of Title 50, U.S.C. also known as the "Military Selective Service Act."

medical waiver. A formal request to consider the suitability for service of an applicant who, because of current or past medical conditions, does not meet medical standards. Upon the completion of a thorough review, the applicant may be considered for a waiver. The applicant must have displayed sufficient mitigating circumstances/provided medical documentation that

clearly justify waiver consideration. The Secretaries of the Military Departments may delegate the final approval authority for all waivers.

mild head injury. Unconsciousness of less than 30 minutes post-injury, or amnesia or disorientation of person, place, or time, alone or in combination, of less than 24 hours post-injury.

MEDPERS. Includes leaders from the medical and personnel communities to develop, discuss, and make decisions about common medical issues that require resolution. The primary focus is the nexus of medical and personnel systems that impact the total force to include those seeking entry into the armed forces and those who must depart prior to completion of an enlistment or career.

Military Department. Defined in the DoD Dictionary of Military and Associated Terms.

moderate brain injury. Unconsciousness of more than 30 minutes but less than 24 hours, or amnesia, or disorientation of person, place or time, alone or in combination, lasting more than 24 hours but less than 7 days after the injury.

National Heart, Lung, and Blood Institute. An agency within the National Institutes of Health that provides global leadership for a research, training, and education program to promote the prevention and treatment of heart, lung, and blood diseases and enhance the health of all individuals so that they can live longer and more fulfilling lives.

severe brain injuries. Unconsciousness of 24 hours or more post injury, or amnesia or disorientation of person, place or time longer than 7 days after the-injury.

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[1] Available at https://catalog.ama-assn.org/Catalog/cpt/cpt_home.jsp

[2] Available for purchase at http://www.ansi.org/

[3] Available at http://www.cdc.gov/nchs/icd/icd10cm.htm#icd2016.

JJ

Stenographic Transcript
Before the

COMMITTEE ON
ARMED SERVICES

UNITED STATES SENATE

HEARING TO RECEIVE TESTIMONY ON
THE POSTURE OF
THE DEPARTMENT OF THE AIR FORCE
IN REVIEW OF THE DEFENSE AUTHORIZATION REQUEST
FOR FISCAL YEAR 2019 AND
THE FUTURE YEARS DEFENSE PROGRAM

Tuesday, April 24, 2018

Washington, D.C.

ALDERSON COURT REPORTING
1155 CONNECTICUT AVENUE, N.W.
SUITE 200
WASHINGTON, D.C. 20036
(202) 289-2260
www.aldersonreporting.com

General Neller, and Admiral Richardson have told me that they have seen zero reports of issues of cohesion, discipline, and morale, as a result of open transgender service in their respective service branches. Are you aware of any specific issues of unit cohesion, disciplinary problems, or issues of morale resulting from open transgender service members in the Air Force?

General Goldfein: Not the way you have presented the question, ma'am, I am not. I will tell you that I have talked commanders in the field, first sergeants, senior NCOs, and I am committed to ensure that they have the right levels of guidance to understand these very personal issues that they are dealing with. And so we continue to move forward to ensure that we understand the issues.

Senator Gillibrand: And have you personally met with transgender service members?

General Goldfein: Yes, ma'am, I have.

Senator Gillibrand: And what did you learn from those meetings?

General Goldfein: A combination of, one, commitment to serve by each of them, and then number two, how individual each particular case is. It is not a one-size-fits-all approach. It is very personal to each individual. And that is why I go back to we have an obligation to ensure that we understand this medically and that we can provide our

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Stenographic Transcript
Before the

COMMITTEE ON
ARMED SERVICES

UNITED STATES SENATE

HEARING TO
RECEIVE TESTIMONY ON THE POSTURE OF THE DEPARTMENT OF THE NAVY IN REVIEW OF THE DEFENSE AUTHORIZATION REQUEST FOR FISCAL YEAR 2019 AND THE FUTURE YEARS DEFENSE PROGRAM

Thursday, April 19, 2018

Washington, D.C.

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told me, last week, that there were, quote, "precisely zero reports of issues of cohesion, discipline, morale, and all sorts of things in the Army as a result of open transgender service." Are you aware of any issue of unit cohesion, disciplinary problems, or issues with morale resulting from open transgender service?

Admiral Richardson: Senator, I'll go first on that. You know, by virtue of being a Navy sailor, we treat every one of those sailors, regardless, with dignity and respect that is warranted by wearing the uniform of the United States Navy. By virtue of that approach, I am not aware of any issues.

Senator Gillibrand: General Neller?

General Neller: Senator, by reporting, those marines that have come forward -- there's 27 marines that have identified as transgender, one sailor serving -- I am not aware of any issues in those areas. The only issues I have heard of is, in some cases, because of the medical requirements of some of these individuals, that there is a burden on the commands to handle all their medical stuff. But, discipline, cohesion of the force, no.

Senator Gillibrand: Can you amplify what burdens on the command are related to medical issues?

General Neller: Some of these individuals -- and, you know, they've resolved whatever it was that -- as they went

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Stenographic Transcript
Before the

COMMITTEE ON
ARMED SERVICES

UNITED STATES SENATE

HEARING TO RECEIVE TESTIMONY ON THE POSTURE OF THE DEPARTMENT OF THE ARMY IN REVIEW OF THE DEFENSE AUTHORIZATION REQUEST FOR FISCAL YEAR 2019 AND THE FUTURE YEARS DEFENSE PROGRAM

Thursday, April 12, 2018

Washington, D.C.

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and want to make sure that they are, in fact, treated with dignity and respect. And no, I have received precisely zero reports --

Senator Gillibrand: Okay.

General Milley: -- of issues of cohesion, discipline, morale, and all those sorts of things. No.

Senator Gillibrand: That's good news.

I know that the Secretary spoke with transgender soldiers recently. Of all the ones that you have personally spoke with of the Active Duty transgender soldiers, were you concerned by any of them continuing to serve?

Dr. Esper: Well, I actually met with them in the first 30 days on the job, Senator. And no, nothing came up that would cause me concern. I was, you know, impressed by what I heard.

Senator Gillibrand: And have either of you spoken to any transgender servicemembers since this set of recommendations was released by the administration in March? And, if you have, what did you hear?

Dr. Esper: No, ma'am.

General Milley: I have not. I did before. I have not. But, let -- you know, the case, as you are well aware, is in litigation. It's in four different courts. So, the -- we're limited in, actually, what we should or could say right this minute, because it could, either one way or the

MM

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

PERSONNEL AND READINESS

FEB 14 2018

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

SUBJECT: DoD Retention Policy for Non-Deployable Service Members

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

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

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

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

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

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

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

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

Robert L. Wilkie

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

NN

DoD Press Guidance

RTQ AFTER INTERIM GUIDANCE IS GIVEN

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

1. What Interim Guidance has the Secretary issued?
1A. The Secretary's Interim Guidance primarily addresses three areas: accessions, medical treatment for transgender service members, and policy and procedures for transgender individuals currently serving in the military.

2. Will transgender individuals be allowed to join the armed forces?
2A. As directed by the President's memorandum of August 25, 2017, the current policy and procedures, which generally prohibit the accession of transgender individuals into the military, will remain in effect.

3. Will transgender individuals currently serving in the military continue to receive medical treatment?
3A. Current transgender service members will continue to receive medically necessary treatment as prescribed by their medical treatment provider in accordance with the Military Health System guidance.

4. Will transgender service members be allowed to receive sex reassignment surgeries?
4A. As directed by the Presidential Memorandum, no new sex reassignment surgical procedures for military personnel will be permitted after March 22, 2018, except to the extent necessary to protect the health of an individual who has already begun a course of treatment to reassign his or her sex.

5. Will transgender individuals currently serving in the military be allowed to remain?
5A. As directed by the President's August 25, 2017 memorandum, the Secretary will make Implementation Plan recommendations to the President, which will include addressing transgender persons currently serving. While the Interim Guidance is in effect, current policies and procedures concerning transgender service members will remain in place.

6. Will transgender service members be able to re-enlist during the interim time period?
6A. Transgender service members whose term of service expires while the Interim Guidance is in effect, may, at the service member's request, be re-enlisted in service under existing procedures.

7. The Secretary's August 29, 2017 statement said that "Pending the approval of that implementation plan, current policy will remain in place, subject to any necessary interim adjustments to procedures." What procedures will be adjusted?

7A. At this time, current policy and procedures will remain in place. If in the formulation of the Implementation Plan, or in implementation of current policy, certain interim adjustments prove necessary, the Department will publish further guidance to existing procedures.

8. The Secretary's August 29, 2017 statement said he would establish a panel of experts serving within the Departments of Defense and Homeland Security to provide advice and recommendations on the implementation of the President's direction. Who will be on the panel of experts?

8A. The Deputy Secretary of Defense and the Vice Chairman of the Joint Chiefs of Staff, supported by a panel of experts, will provide recommendations to the Secretary that are supported by appropriate evidence and information. The panel will be comprised of the Military Department Under Secretaries, Service Vice Chiefs, and Service Senior Enlisted Advisors. The Deputy Secretary and the Vice Chairman will also designate personnel to support the panel's work to ensure panel recommendations reflect senior civilian experience, combat experience, and expertise in military operational effectiveness. The panel will be chaired by the Under Secretary of Defense for Personnel and Readiness.

9. What will the panel of experts study?

9A. The Panel will conduct an independent multi-disciplinary review of relevant data and information pertaining to transgender service members. The review and recommendations will address aspects of medical care and treatment, personnel management, general policies and practices, and other matters, including the effects of the service of transgender persons on military readiness and lethality. The Panel will provide recommendations on three areas: accessions, medical care, and standards and procedures for transgender members currently serving in the armed forces.

10. Will the Panel receive input from persons outside DoD?

10A. The Panel may obtain advice from outside experts on an individual basis. Input from outside experts will be at the discretion of the Deputy Secretary and the Vice Chairman.

11. How long does the Interim Guidance remain in effect?

11A. The Interim Guidance takes effect immediately and will remain in effect until the Secretary promulgates DoD's final policy concerning the military service by transgender individuals.

12. How long will the Panel have to develop the Implementation Plan?

12A. As directed in the President's August 25, 2017 memorandum, DoD will submit its recommended Implementation Plan to the President no later than February 21, 2018.

OO

Medical Services

Standards of Medical Fitness

Headquarters
Department of the Army
Washington, DC
29 August 2003

UNCLASSIFIED

SUMMARY of CHANGE

AR 40–501
Standards of Medical Fitness

This revision, dated 29 August 2003--

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

This administrative revision dated 30 September 2002--

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

This revision (dated 28 March 2002)--

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

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

Headquarters
Department of the Army
Washington, DC
29 August 2003

*Army Regulation 40–501

Effective 29 September 2003

Medical Services

Standards of Medical Fitness

By order of the Secretary of the Army:

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

Official:

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

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

Summary. This regulation provides information on medical fitness standards for induction, enlistment, appointment, retention, and related policies and procedures. This publication implements DOD Directive 6130.3, Physical Standards for Appointment, Enlistment, and Induction, December 15, 2000, and DOD Instruction 6130.4, Criteria and Procedure Requirements for Physical Standards for Appointment, Enlistment, or Induction in the Armed Forces, December 14, 2000.

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

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

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

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

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

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

Contents (Listed by paragraph and page number)

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

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Contents—Continued

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Contents—Continued

Figure List

Glossary

Table 2–2
Military acceptable weight (in pounds) as related to age and height for females—Initial Army procurement[1, 2]—Continued

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

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

Notes:
[1] If a female exceeds these weights, percent body fat will be measured by the method described in AR 600–9.
[2] If a female also exceeds this body fat, she will be rejected for service.

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

3–1. General
This chapter gives the various medical conditions and physical defects which may render a soldier unfit for further military service and which fall below the standards required for the individuals in paragraph 3–2 below.

3–2. Application
These standards apply to the following individuals (see chaps 4 and 5 for other standards that apply to specific specialties):

a. All commissioned and warrant officers of the Active Army, ARNGUS, and USAR.

b. All enlisted soldiers of the Active Army, ARNGUS, and USAR.

c. Students already enrolled in the HPSP and USUHS programs.

d. Enlisted soldiers of the ARNGUS or USAR who apply for enlistment in the regular Army.

e. Commissioned and warrant officers of the ARNGUS or USAR who apply for appointment in the Active Army.

f. Soldiers of the ARNGUS or USAR who re-enter active duty under the "split-training option." (However, the weight standards of tables 2–1 and 2–2 apply to split option trainees.)

g. Retired soldiers recalled to active duty.

3–3. Disposition
Soldiers with conditions listed in this chapter who do not meet the required medical standards will be evaluated by an MEB as defined in AR 40–400 and will be referred to a PEB as defined in AR 635–40 with the following caveats:

a. USAR or ARNGUS soldiers not on active duty, whose medical condition was not incurred or aggravated during an active duty period, will be processed in accordance with chapter 9 and chapter 10 of this regulation.

b. Soldiers pending separation in accordance with provisions of AR 635–200 or AR 600–8–24 authorizing separation under other than honorable conditions who do not meet medical retention standards will be referred to an MEB. In the case of enlisted soldiers, the physical disability processing and the administrative separation processing will be conducted in accordance with the provisions of AR 635–200 and AR 635–40. In the case of commissioned or warrant officers, the physical disability processing and the administrative separation processing will be conducted in accordance with the provisions of AR 600–8–24 and AR 635–40.

c. A soldier will not be referred to an MEB or a PEB because of impairments that were known to exist at the time of acceptance in the Army and that have remained essentially the same in degree of severity and have not interfered with successful performance of duty.

d. Physicians who identify soldiers with medical conditions listed in this chapter should initiate an MEB at the time of identification. Physicians should not defer initiating the MEB until the soldier is being processed for nondisability

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

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

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

3–4. General policy

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

3–5. Abdominal and gastrointestinal defects and diseases

The causes for referral to an MEB are as follows:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3–6. Gastrointestinal and abdominal surgery

The causes for referral to an MEB are as follows:

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

b. Colostomy, when permanent.

c. Enterostomy, when permanent.

d. Gastrectomy, total.

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

f. Gastrostomy, when permanent.

g. Ileostomy, when permanent.

h. Pancreatectomy.

i. Pancreaticoduodenostomy, pancreaticogastrostomy, or pancreaticojejunostomy, followed by more than mild symptoms of digestive disturbance, or requiring insulin.

j. Proctectomy.

k. Proctopexy, proctoplasty, proctorrhaphy, or proctotomy, if fecal incontinence remains after an appropriate treatment period.

3–7. Blood and blood-forming tissue diseases

The causes for referral to an MEB are as follows:

a. Anemia, hereditary, acquired, aplastic, or unspecified, when response to therapy is unsatisfactory, or when therapy is such as to require prolonged, intensive medical supervision.

b. Hemolytic crisis, chronic and symptomatic.

c. Leukopenia, chronic, when response to therapy is unsatisfactory, or when therapy is such as to require prolonged, intensive medical supervision.

d. Hypogammaglobulinemia with objective evidence of function deficiency and severe symptoms not controlled with treatment.

e. Purpura and other bleeding diseases, when response to therapy is unsatisfactory, or when therapy is such as to require prolonged, intensive medical supervision.

f. Thromboembolic disease when response to therapy is unsatisfactory, or when therapy is such as to require prolonged, intensive medical supervision.

g. Splenomegaly, chronic.

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

3–8. Dental diseases and abnormalities of the jaws

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

3–9. Ears

The causes for referral to an MEB are as follows:

a. Infections of the external auditory canal when chronic and severe, resulting in thickening and excoriation of the canal or chronic secondary infection requiring frequent and prolonged medical treatment and hospitalization.

b. Malfunction of the acoustic nerve. (Evaluate functional impairment of hearing under para 3–10.)

c. Mastoiditis, chronic, with constant drainage from the mastoid cavity, requiring frequent and prolonged medical care.

d. Mastoiditis, chronic, following mastoidectomy, with constant drainage from the mastoid cavity, requiring frequent and prolonged medical care or hospitalization.

e. Meniere's syndrome or any peripheral imbalance, syndrome or labyrinthine disorder with recurrent attacks of sufficient frequency and severity as to interfere with the satisfactory performance of duty or requiring frequent or prolonged medical care or hospitalization.

f. Otitis media, moderate, chronic, suppurative, resistant to treatment, and necessitating frequent and prolonged medical care or hospitalization.

3–10. Hearing

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

3–11. Endocrine and metabolic disorders

The causes for referral to an MEB are as follows:

a. Acromegaly with severe function impairment.

b. Adrenal dysfunction that does not respond to therapy satisfactorily or where replacement therapy presents serious problems in management.

c. Diabetes insipidus unless mild and the patient shows good response to treatment.

d. Diabetes mellitus when proven to require insulin or oral medications for control.

e. Goiter causing breathing obstruction.

f. Gout in advanced cases with frequent acute exacerbations and severe bone, joint, or kidney damage.

g. Hyperinsulinism when caused by a tumor or when the condition is not readily controlled.

h. Hyperparathyroidism when residuals or complications of surgical correction such as renal disease or bony deformities preclude the reasonable performance of military duty.

i. Hypofunction, adrenal cortex requiring medication for control.

j. Osteomalacia with residuals after therapy of such nature or degree as to preclude the satisfactory performance of duty.

3–12. Upper extremities

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

a. Amputation of part or parts of an upper extremity equal to or greater than—

(1) A thumb proximal to the interphalangeal joint.

(2) Two fingers of one hand, other than the little finger, at the proximal interphalangeal joints.

(3) One finger, other than the little finger, at the metacarpophalangeal joint and the thumb of the same hand at the interphalangeal joint.

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

(1) Shoulder—forward elevation to 90 degrees, or abduction to 90 degrees.

(2) Elbow—flexion to 100 degrees, or extension to 60 degrees.

(3) Wrist—a total range extension plus flexion of 15 degrees.

(4) Hand (for this purpose, combined joint motion is the arithmetic sum of the motion at each of the three finger joints (TC 8–640))—an active flexor value of combined joint motions of 135 degrees in each of two or more fingers of the same hand, or an active extensor value of combined joint motions of 75 degrees in each of the same two or more fingers, or limitation of motion of the thumb that precludes opposition to at least two finger tips.

c. Recurrent dislocations of the shoulder, when not repairable or surgery is contraindicated.

3–13. Lower extremities

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

a. Amputations.

(1) Loss of toes that precludes the abilities to run or walk without a perceptible limp and to engage in fairly strenuous jobs.

(2) Any loss greater than that specified above to include foot, ankle, below the knee, above the knee, femur, hip.

b. Feet.

(1) Hallux valgus when moderately severe, with exostosis or rigidity and pronounced symptoms; or severe with arthritic changes.

(2) Pes planus, when symptomatic, more than moderate, with pronation on weight bearing which prevents the wearing of military footwear, or when associated with vascular changes.

(3) Pes cavus when moderately severe, with moderate discomfort on prolonged standing and walking, metatarsalgia, and which prevents the wearing of military footwear.

(4) Neuroma that is refractory to medical treatment, refractory to surgical treatment, and interferes with the satisfactory performance of military duties.

(5) Plantar fascitis or heel spur syndrome that is refractory to medical or surgical treatment, interferes with the satisfactory performance of military duties, or prevents the wearing of military footwear.

(6) Hammertoes, severe, that precludes the wearing of appropriate military footwear, refractory to surgery, or interferes with satisfactory performance of duty.

(7) Hallux limitus, hallux rigidus.

c. Internal derangement of the knee.

(1) Residual instability following remedial measures, if more than moderate in degree.

(2) If complicated by arthritis, see paragraph 3–14*a*.

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

(1) Hip—flexion to 90 degrees or extension to 0 degree.

(2) Knee—flexion to 90 degrees or extension to 15 degrees.

(3) Ankle—dorsiflexion to 10 degrees or planter flexion to 10 degrees.

e. Shortening of an extremity that exceeds 2 inches.

f. Recurrent dislocations of the patella.

3–14. Miscellaneous conditions of the extremities

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

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

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

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

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

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

f. Fractures.

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

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

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

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

g. Joints.

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

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

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

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

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

h. Muscles.

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

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

i. Myotonia congenita.

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

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

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

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

3–15. Eyes

The causes for referral to an MEB are as follows:

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

b. Aphakia, bilateral.

c. Atrophy of the optic nerve due to disease.

d. Glaucoma, if resistant to treatment or affecting visual fields as in a above, or if side effects of required medication are functionally incapacitating.

e. Degenerations, when vision does not meet the standards of paragraph 3–16*e*, or when vision is correctable only by the use of contact lenses or other special corrective devices (telescopic lenses, etc.).

f. Diseases and infections of the eye, when chronic, more than mildly symptomatic, progressive, and resistant to treatment after a reasonable period. This includes intractable allergic conjunctivitis inadequately controlled by medications and immunotherapy.

g. Residuals or complications of injury or disease, when progressive or when reduced visual acuity does not meet the criteria stated in paragraph 3–16*e*.

h. Unilateral detachment of retina if any of the following exists:

(1) Visual acuity does not meet the standard stated in paragraph 3–16*e*.

(2) The visual field in the better eye is constricted to less than 20 degrees.

(3) Uncorrectable diplopia exists.

(4) Detachment results from organic progressive disease or new growth, regardless of the condition of the better eye.

i. Bilateral detachment of retina, regardless of etiology or results of corrective surgery.

3–16. Vision

The causes for referral to an MEB are as follows:

a. Aniseikonia, with subjective eye discomfort, neurologic symptoms, sensations of motion sickness and other gastrointestinal disturbances, functional disturbances and difficulties in form sense, and not corrected by iseikonica lenses.

b. Binocular diplopia, not correctable by surgery, that is severe, constant, and in a zone less than 20 degrees from the primary position.

c. Hemianopsia, of any type if bilateral, permanent, and based on an organic defect. Those due to a functional neurosis and those due to transitory conditions, such as periodic migraine, are not considered to fall below required standards.

d. Night blindness, of such a degree that the soldier requires assistance in any travel at night.

e. Visual acuity.

(1) Vision that cannot be corrected with ordinary spectacle lenses (contact lenses or other special corrective devices (telescopic lenses, etc.) are unacceptable) to at least: 20/60 in one eye and 20/60 in the other eye, or 20/50 in one eye and 20/80 in the other eye, or 20/40 in one eye and 20/100 in the other eye, or 20/20 in one eye and 20/800 in the other eye; or

(2) An eye has been enucleated.

f. Visual field with bilateral concentric constriction to less than 20 degrees.

3–17. Genitourinary system

The causes for referral to an MEB are as follows:

a. Cystitis, when complications or residuals of treatment themselves preclude satisfactory performance of duty.

b. Dysmenorrhea, when symptomatic, irregular cycle, not amenable to treatment, and of such severity as to necessitate recurrent absences of more than 1 day.

c. Endometriosis, symptomatic and incapacitating to a degree that necessitates recurrent absences of more than 1 day.

d. Hypospadias, when accompanied by evidence of chronic infection of the genitourinary tract or instances where the urine is voided in such a manner as to soil clothes or surroundings and the condition is not amenable to treatment.

e. Incontinence of urine, due to disease or defect not amenable to treatment and of such severity as to necessitate recurrent absence from duty.

f. Kidney.

(1) Calculus in kidney, when bilateral, resulting in frequent or recurring infections, or when there is evidence of obstructive uropathy not responding to medical or surgical treatment.

(2) Congenital anomaly, when bilateral, resulting in frequent or recurring infections, or when there is evidence of obstructive uropathy not responding to medical or surgical treatment.

(3) Cystic kidney (polycystic kidney), when symptomatic and renal function is impaired or is the focus of frequent infection.

(4) Glomerulonephritis, when chronic.

(5) Hydronephrosis, when more than mild, bilateral, and causing continuous or frequent symptoms.

(6) Hypoplasia of the kidney, when symptomatic and associated with elevated blood pressure or frequent infections and not controlled by surgery.

(7) Nephritis, when chronic.

(8) Nephrosis.

(9) Perirenal abscess, with residuals of a degree that precludes the satisfactory performance of duty.

(10) Pyelonephritis or pyelitis, when chronic, that has not responded to medical or surgical treatment, with evidence of hypertension, eye–ground changes, cardiac abnormalities.

(11) Pyonephrosis, when not responding to treatment.

g. Menopausal syndrome, physiologic or artificial, when symptoms are not amenable to treatment and preclude successful performance of duty.

h. Chronic pelvic pain with or without demonstrative pathology that has not responded to medical or surgical treatment and of such severity to necessitate recurrent absence from duty.

i. Strictures of the urethra or ureter, when severe and not amenable to treatment.

j. Urethritis, chronic, when not responsive to treatment and necessitating frequent absences from duty.

3–18. Genitourinary and gynecological surgery

The causes for referral to an MEB are as follows:

a. Cystectomy.

b. Cystoplasty, if reconstruction is unsatisfactory or if residual urine persists in excess of 50 cubic centimeters (cc) or if refractory symptomatic infection persists.

c. Hysterectomy, when residual symptoms or complications preclude the satisfactory performance of duty.

d. Nephrectomy, when after treatment, there is infection or pathology in the remaining kidney.

e. Nephrostomy, if drainage persists.

f. Oophorectomy, when complications or residual symptoms are not amenable to treatment and preclude successful performance of duty.

g. Pyelostomy, if drainage persists.

h. Ureterocolostomy.

i. Ureterocystostomy, when both ureters are markedly dilated with irreversible changes.

j. Ureteroileostomy cutaneous.

k. Ureteroplasty.

(1) When unilateral procedure is unsuccessful and nephrectomy is necessary, consider it on the basis of the standard for a nephrectomy; or

(2) When bilateral, evaluate residual obstruction or hydronephrosis and consider it on the basis of the residuals involved.

l. Ureterosigmoidostomy.

m. Ureterostomy, external or cutaneous.

n. Urethrostomy, if there is complete amputation of the penis or when a satisfactory urethra cannot be restored.

o. Kidney transplant recipient.

3–19. Head

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

3–20. Neck

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

3–21. Heart

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

a. Coronary heart disease associated with—

(1) Myocardial infarction, angina pectoris, or congestive heart failure due to fixed obstructive coronary artery disease or coronary artery spasm. The policies for trial of duty, profiling, and referral to an MEB and a PEB (as outlined in para 3–25) apply. The trial of duty will be for 120 days.

(2) Myocardial infarction with normal coronary artery anatomy. The policies for trial of duty, profiling, and referral to an MEB and a PEB (as outlined in para 3–25) apply. The trial of duty will be for 120 days.

(3) Angina pectoris in association with objective evidence of myocardial ischemia in the presence of normal coronary artery anatomy.

(4) Fixed obstructive coronary artery disease, asymptomatic but with objective evidence of myocardial ischemia.

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

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

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

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

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

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

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

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

i. Pericarditis as follows:

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

(2) Chronic serous pericarditis.

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

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

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

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

3–22. Vascular system

The causes for referral to an MEB are as follows:

a. Arteriosclerosis obliterans when any of the following pertain:

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

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

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

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

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

d. Periarteritis nodosa with definite evidence of functional impairment.

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

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

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

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

i. Varicose veins that are severe and symptomatic despite therapy.

j. Cold injury. (See paragraph 3–46).

3–23. Miscellaneous cardiovascular conditions

The causes for referral to an MEB are as follows:

a. Hypertensive cardiovascular disease and hypertensive vascular disease. Diastolic pressure consistently more than 110 mmHg following an adequate period of therapy in an ambulatory status.

b. Rheumatic fever, active, with heart damage. Recurrent attacks.

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

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

a. Permanent prosthetic valve implantation.

b. Implantation of permanent pacemakers, antitachycardia and defibrillator devices, and similar newly developed devices.

c. Reconstructive cardiovascular surgery employing exogenous grafting material.

d. Vascular reconstruction, after a period of 90 days trial of duty when medically advisable, that results in the individual's inability to perform satisfactory duty. The policies for trial of duty, profiling, and referral to an MEB and a PEB (as outlined in para 3–25) apply.

e. Coronary artery revascularization, with the option of a 120-day trial of duty based upon physician recommendation when the individual is asymptomatic, without objective evidence of myocardial ischemia, and when other functional assessment (such as exercise testing and newly developed techniques) indicates that it is medically advisable. Any individual undergoing median sternotomy for surgery will be restricted from lifting 25 pounds or more, performing pullups and pushups, or as otherwise prescribed by a physician for a period of 90 days from the date of surgery on DA Form 3349 (Physical Profile). The policies for trial of duty, profiling, and referral to an MEB and a PEB (as outlined in para 3–25) apply.

f. Heart or heart-lung transplantation.

g. Coronary or valvular angioplasty procedures, with the option of a 180-day trial of duty based upon physician recommendation when the individual is asymptomatic, without objective evidence of myocardial ischemia, and when other functional assessment (such as cardiac catheterization, exercise testing, and newly developed techniques) indicates that it is medically advisable. The policies for trial of duty, profiling, and referral to an MEB and a PEB (as outlined in para 3–25) apply.

h. Cardiac arrhythmia ablation procedures, with the option of a 180-day trial of duty based upon physician recommendation when asymptomatic, and no evidence of any unfitting arrhythmia as noted in paragraph 3–21. The policies for trial of duty, MEB, and physical profile (as outlined in para 3–25) apply.

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

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

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

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

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

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

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

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

3–26. Tuberculosis, pulmonary

The cause for referral to an MEB for pulmonary tuberculosis—

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

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

3–27. Miscellaneous respiratory disorders

The causes for referral to an MEB are as follows:

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

(1) Definitions/diagnostic criteria are as follows.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

f. Diaphragm, congenital defect. Symptomatic.

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

h. Histoplasmosis. Chronic and not responding to treatment.

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

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

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

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

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

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

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

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

3–28. Surgery of the lungs

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

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

The causes for referral to an MEB are as follows:

a. Esophagus.

(1) Achalasia, unless controlled by medical therapy.

(2) Esophagitis, persistent and severe.

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

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

b. Larynx.

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

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

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

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

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

f. Trachea. Stenosis of trachea.

3–30. Neurological disorders

The causes for referral to an MEB are as follows:

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

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

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

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

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

f. Stroke, including both the effects of ischemia and hemorrhage, when residuals affect performance.

g. Migraine, tension, or cluster headaches, when manifested by frequent incapacitating attacks.

h. Narcolepsy, sleep apnea syndrome, or similar disorders. (See para 3–41.)

i. Seizure disorders and epilepsy. Seizures by themselves are not disqualifying unless they are manifestations of epilepsy. However, they may be considered along with other disabilities in judging fitness. In general, epilepsy is disqualifying unless the soldier can be maintained free of clinical seizures of all types by nontoxic doses of medications. The following guidance applies when determining whether a soldier will be referred to an MEB/PEB.

(1) All active duty soldiers with suspected epilepsy must be evaluated by a neurologist who will determine whether epilepsy exists and whether the soldier should be given a trial of therapy on active duty or referred directly to an MEB for referral to a PEB. In making the determination, the neurologist may consider the underlying cause, EEG findings, type of seizure, duration of epilepsy, family history, soldier's likelihood of compliance with therapeutic program, absence of substance abuse, or any other clinical factor influencing the probability of control or the soldier's ability to perform duty during the trial of treatment.

(2) If a trial of duty on treatment is elected by the neurologist, the soldier will be given a temporary P–3 profile with as few restrictions as possible.

(3) Once the soldier has been seizure free for 1 year, the profile may be reduced to a P–2 profile with restrictions specifying no assignment to an area where medical treatment is not available.

(4) If seizures recur beyond 6 months after the initiation of treatment, the soldier will be referred to an MEB.

(5) Should seizures recur during a later attempt to withdraw medications or during transient illness, referral to a PEB is at the discretion of the physician or MEB.

(6) If the soldier has remained seizure free for 36 months, he or she may be removed from profile restrictions.

(7) Recurrent pseudoseizures are disqualifying under the same rules as epilepsy.

j. Any other neurologic conditions, regardless of etiology, when after adequate treatment there remains residual symptoms and impairments such as persistent severe headaches, uncontrolled seizures, weakness, paralysis, or atrophy of important muscle groups, deformity, uncoordination, tremor, pain, or sensory disturbance, alteration of consciousness, speech, personality, or mental function of such a degree as to significantly interfere with performance of duty.

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

3–31. Disorders with psychotic features

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

3–32. Mood disorders

The causes for referral to an MEB are as follows:

a. Persistence or recurrence of symptoms sufficient to require extended or recurrent hospitalization; or

b. Persistence or recurrence of symptoms necessitating limitations of duty or duty in protected environment; or

c. Persistence or recurrence of symptoms resulting in interference with effective military performance.

3–33. Anxiety, somatoform, or dissociative disorders

The causes for referral to an MEB are as follows:

a. Persistence or recurrence of symptoms sufficient to require extended or recurrent hospitalization; or

b. Persistence or recurrence of symptoms necessitating limitations of duty or duty in protected environment; or

c. Persistence or recurrence of symptoms resulting in interference with effective military performance.

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

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

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

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

3–36. Adjustment disorders

Situational maladjustments due to acute or chronic situational stress do not render an individual unfit because of physical disability, but may be the basis for administrative separation if recurrent and causing interference with military duty.

3–37. Eating disorders

The causes for referral to an MEB are eating disorders that are unresponsive to treatment or that interfere with the satisfactory performance of duty.

3–38. Skin and cellular tissues

The causes for referral to an MEB are as follows:

a. Acne. Severe, unresponsive to treatment, and interfering with the satisfactory performance of duty or wearing of the uniform or other military equipment.

b. Atopic dermatitis. More than moderate and after hospitalization interfering with performance of duty.

c. Amyloidosis. Generalized.

d. Cysts and tumors. (See paras 3–42 and 3–43.)

e. Dermatitis herpetiformis. Not responsive to therapy.

f. Dermatomyositis.

g. Dermographism. Interfering with the performance of duty.

h. Eczema, chronic. Regardless of type, when there is more than minimal involvement and the condition is unresponsive to treatment and interferes with the satisfactory performance of duty.

i. Elephantiasis or chronic lymphedema. Not responsive to treatment.

j. Epidermolysis bullosa.

k. Erythema multiforme. More than moderate and recurrent or chronic.

l. Exfoliative dermatitis. Chronic.

m. Fungus infections, superficial or systemic types. If not responsive to therapy and interfering with the satisfactory performance of duty.

n. Hidradenitis suppurative and/or folliculitis decalvans (dissecting cellulitis of the scalp).

o. Hyperhidrosis. On the hands or feet, when severe or complicated by a dermatitis or infection, either fungal or bacterial and not amenable to treatment.

p. Leukemia cutis or mycosis fungoides or cutaneous T–Cell lymphoma. (See also para 3–42.)

q. Lichen planus. Generalized and not responsive to treatment.

r. Lupus erythematosus. Cutaneous or mucous membranes involvement that is unresponsive to therapy and interferes with the satisfactory performance of duty.

s. Neurofibromatosis. When interfering with the satisfactory performance of duty.

t. Panniculitis. Relapsing, febrile, nodular.

u. Parapsoriasis. Extensive and not controlled by treatment.

v. Pemphigus. Not responsive to treatment and with moderate constitutional or systemic symptoms, or interfering with the satisfactory performance of duty.

w. Psoriasis. Extensive and not controllable by treatment.

x. Radiodermatitis. If resulting in malignant degeneration at a site not amenable to treatment.

y. Scars and keloids. So extensive or adherent that they seriously interfere with the function of an extremity or interfere with the performance of duty.

z. Scleroderma. Generalized or of the linear type that seriously interferes with the function of an extremity.

aa. Tuberculosis of the skin. (See paragraph 3–40.)

ab. Ulcers of the skin. Not responsive to treatment after an appropriate period of time if interfering with the satisfactory performance of duty.

ac. Urticaria/Angioedema. Chronic, severe, and not responsive to treatment.

ad. Xanthoma. Regardless of type, but only when interfering with the satisfactory performance of duty.

ae. Intractable plantar keratosis, chronic. Requires frequent medical/surgical care or that interferes with the satisfactory performance of duty.

af. Other skin disorders. If chronic or of a nature that requires frequent medical care, or interferes with the satisfactory performance of military duty.

3–39. Spine, scapulae, ribs, and sacroiliac joints

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

a. Dislocation. Congenital, of hip.

b. Spina bifida. Demonstrable signs and moderate symptoms of root or cord involvement.

c. Spondylolysis or spondylolisthesis. More than mild symptoms resulting in repeated outpatient visits, or repeated hospitalization or limitations effecting performance of duty.

d. Coxa vara. More than moderate with pain, deformity, and arthritic changes.

e. Herniation of nucleus pulposus. More than mild symptoms following appropriate treatment or remedial measures, with sufficient objective findings to demonstrate interference with the satisfactory performance of duty.

f. Kyphosis. More than moderate, interfering with military duties.

g. Scoliosis. Severe deformity with over 2 inches deviation of tips of spinous process from the midline, or of lesser degree if recurrently symptomatic and interfering with military duties.

h. Nonradicular pain involving the cervical, thoracic, lumbosacral, or coccygeal spine, whether idiopathic or secondary to degenerative disc or joint disease, that fails to respond to adequate conservative treatment and necessitates significant limitation of physical activity.

3–40. Systemic diseases

The causes for referral to an MEB are as follows:

a. Amyloidosis.

b. Blastomycosis.

c. Brucellosis. Chronic with substantiated, recurring febrile episodes, severe fatigue, lassitude, depression, or general malaise.

d. Leprosy. Any type that seriously interferes with performance of duty or is not completely responsive to appropriate treatment.

e. Myasthenia gravis.

f. Mycosis. Active, not responsive to therapy or requiring prolonged treatment, or when complicated by residuals that themselves are unfitting.

g. Panniculitis. Relapsing, febrile, nodular.

h. Porphyria, cutanea tarda.

i. Sarcoidosis. Progressive with severe or multiple organ involvement and not responsive to therapy.

j. Tuberculosis.

(1) Meningitis, tuberculous.

(2) Pulmonary tuberculosis (see para 3–26), tuberculous empyema, and tuberculous pleurisy.

(3) Tuberculosis of the male genitalia. Involvement of the prostate or seminal vesicles and other instances not corrected by surgical excision, or when residuals are more than minimal, or are symptomatic.

(4) Tuberculosis of the female genitalia.

(5) Tuberculosis of the kidney.

(6) Tuberculosis of the larynx.

(7) Tuberculosis of the lymph nodes, skin, bone, joints, eyes, intestines, and peritoneum or mesentery. These will be evaluated on an individual basis, considering the associated involvement, residuals, and complications.

k. Rheumatoid arthritis that interferes with successful performance of duty or requires geographic assignment limitations or requires medication for control that requires frequent monitoring by a physician due to debilitating or serious side effects.

l. Spondyloarthropathies. Chronic or recurring episodes of arthritis causing functional impairment interfering with successful performance of duty supported by objective, subjective, and radiographic findings, or requires medication for control that requires frequent monitoring by a physician due to debilitating or serious side effects.

(1) Ankylosingpondylitis.

(2) Reiter's syndrome.

(3) Psoriatic arthritis.

(4) Arthritis associated with inflammatory bowel disease.

(5) Whipple's disease.

m. Systemic lupus erythematosus that interferes with successful performance of duty or requires geographic assignment limitations or requires medication for control that requires frequent monitoring by a physician due to debilitating or serious side effects.

n. Sjogren's syndrome. When chronic, more than mildly symptomatic and resistant to treatment after a reasonable period of time.

o. Progressive systemic sclerosis, diffuse and limited disease that interferes with successful performance of duty or requires geographic assignment limitations or requires medication for control that requires frequent monitoring by a physician due to debilitating or serious side effects.

p. Myopathy, to include inflammatory, metabolic or inherited, that interferes with successful performance of duty or requires geographic assignment limitations or requires medication for control that requires frequent monitoring by a physician due to debilitating or serious side effects.

q. Systemic vasculitis involving major organ systems, chronic, that interferes with successful performance of duty or requires geographic assignment limitations or requires medication for control that requires frequent monitoring by a physician due to debilitating or serious side effects.

r. Hypersensitivity angiitis when chronic or having recurring episodes that are more than mildly symptomatic or show definite evidence of functional impairment which is resistant to treatment after a reasonable period of time.

s. Behcet's syndrome that interferes with successful performance of duty or requires geographic assignment limitations or requires medication for control that requires frequent monitoring by a physician due to debilitating or serious side effects.

t. Adult onset Still's disease that interferes with successful performance of duty or requires geographic assignment limitations or requires medication for control that requires frequent monitoring by a physician due to debilitating or serious side effects.

u. Mixed connective tissue disease and other overlap syndromes that interfere with successful performance of duty or require geographic assignment limitations or require medication for control that requires frequent monitoring by a physician due to debilitating or serious side effects.

v. Any chronic or recurrent systemic inflammatory disease or arthritis not listed above that interferes with successful performance of duty or requires geographic assignment limitations, or requires medication for control that requires frequent monitoring by a physician due to debilitating or serious side effects.

3–41. General and miscellaneous conditions and defects

The causes for referral to an MEB are as follows:

a. Allergic manifestations.

(1) Allergic rhinitis, chronic, severe, and not responsive to treatment. (See also paras 3–29*d* and 3–29*e*.)

(2) Asthma. (See para 3–27*a*.)

(3) Allergic dermatoses. (See para 3–38.)

b. Cold injury/heat injury. (See paras 3–45 and 3–46.)

c. Sleep apnea. Obstructive sleep apnea or sleep-disordered breathing that causes daytime hypersomnolence or snoring that interferes with the sleep of others and that cannot be corrected with medical therapy, surgery, or oral prosthesis. The diagnosis must be based upon a nocturnal polysomnogram and the evaluation of a pulmonologist, neurologist, or a provider with expertise in sleep medicine. A 12-month trial of therapy with nasal continuous positive air pressure may be attempted to assist in weight reduction or other interventions, during which time the individual will be profiled as T3. Long-term therapy with nasal continuous positive air pressure requires referral to an MEB.

d. Fibromyalgia, when severe enough to prevent successful performance of duty. Diagnosis will include evaluation by a rheumatologist.

e. Miscellaneous conditions and defects. Conditions and defects not mentioned elsewhere in this chapter are causes for referral to an MEB, if—

(1) The conditions (individually or in combination) result in interference with satisfactory performance of duty as substantiated by the individual's commander or supervisor.

(2) The individual's health or well-being would be compromised if he or she were to remain in the military service.

(3) In view of the soldier's condition, his or her retention in the military service would prejudice the best interests of the Government (for example, a carrier of communicable disease who poses a health threat to others). Questionable cases, including those involving latent impairment, will be referred to PEBs.

3–42. Malignant neoplasms

The causes for referral to an MEB are as follows:

a. Malignant neoplasms that are unresponsive to therapy, or when the residuals of treatment are in themselves unfitting under other provisions of this chapter.

b. Neoplastic conditions of the lymphoid and blood-forming tissues that are unresponsive to therapy, or when the residuals of treatment are in themselves unfitting under other provisions of this chapter.

c. Malignant neoplasms, when on evaluation for administrative separation or retirement, the observation period subsequent to treatment is deemed inadequate in accordance with accepted medical principles.

d. The above definitions of malignancy or malignant disease exclude basal cell carcinoma of the skin.

3–43. Benign neoplasms

The causes for referral to an MEB are as follows:

a. Benign tumors if their condition precludes the satisfactory performance of military duty.

b. Ganglioneuroma.

c. Meningeal fibroblastoma, when the brain is involved.

d. Pigmented villonodular synovitis when severe enough to prevent successful performance of duty.

3–44. Sexually transmitted diseases

The causes for referral to an MEB are as follows:

a. Symptomatic neurosyphilis in any form.

b. Complications or residuals of a sexually transmitted disease of such chronicity or degree that the individual is incapable of performing useful duty.

3–45. Heat illness and injury

The causes for referral to an MEB are as follows:

a. Heat exhaustion.

(1) Heat exhaustion is defined as collapse, including syncope, occurring during or immediately following exercise–heat stress without evidence of organ damage or systemic inflammatory activation.

(2) Individual episodes of heat exhaustion are not cause for MEB referral. However, soldiers suffering from recurrent episodes of heat exhaustion (three or more in less than 24 months) should be referred for complete medical evaluation for contributing factors.

(3) If no remediable factor causing recurrent heat exhaustion is identified, then the soldier will be referred to an MEB.

b. Heat stroke.

(1) The definitions of heat stroke are as follows.

(a) Heat stroke: A syndrome of hyperpyrexia, collapse, and encephalopathy with evidence of organ damage and/or systemic inflammatory activation occurring in the setting of environmental heat stress.

(b) Exertional rhabdomyolysis: Rhabdomyolysis with myoglobinuria occurring with exercise–heat stress but without the encephalopathy of heat stroke.

(2) Soldiers will be referred to an MEB after an episode of heat stroke or exertional rhabdomyolysis. If the soldier has had full clinical recovery, and particularly if a circumstantial contributing factor to the episode can be identified, the MEB may recommend a trial of duty with a P–3 (T) profile. The profile will restrict the soldier from performing vigorous physical exercise for periods longer than 15 minutes. Maximal efforts, such as the APFT 2-mile run are not permitted. If, after 3 months, the soldier has not manifested any heat intolerance, the profile may be modified to P–2 (T) and normal unrestricted work permitted. Maximal exertion and significant heat exposure (such as wearing Mission Oriented Protective Posture (MOPP) IV) are still restricted. If the soldier manifests no heat intolerance, including a season of significant environmental heat stress, normal activities can be resumed and the soldier may be returned to duty without a PEB. Any evidence of significant heat intolerance, either during the period of the profile or subsequently, requires a referral to a PEB. (A description of the heat intolerance should be included in the MEB narrative summary.)

3–46. Cold injury

The causes for referral to an MEB are as follows:

a. Frostbite (freezing cold injury).

(1) The definition of frostbite is the consequence of freezing of tissue. First degree frostbite is manifested by superficial injury without blistering. Second degree frostbite is manifested by superficial injury with clear blisters with only epidermal tissue loss. Third degree and fourth degree frostbite are manifested by significant subepidermal tissue loss.

(2) Soldiers with first degree frostbite after clinical healing will be given a permanent P–2 profile permitting the use of extra cold weather protective clothing, including nonregulation items, to be worn under authorized outer garments.

(3) Soldiers with frostbite more than first degree will be given a P–3 profile, renewed as appropriate, for the duration of the cold season restricting them from any exposure to temperatures below 0 degrees C (32 degrees F) and from any activities limited by the remainder of the season. After the cold season, soldiers will be reevaluated and, if appropriate, given the P–2 profile described in (2) above.

(4) Soldiers will be referred to an MEB for recurrent cold injury, recurrent or persistent cold sensitivity despite the P–2 profile, vascular or neuropathic symptoms, or disability due to tissue lost from cold injury.

b. Trench foot (nonfreezing cold injury).

(1) The definition of trench foot is the consequence of prolonged cold immersion of an extremity. It is manifested by maceration of tissue and neurovascular injury.

(2) Soldiers with residual symptoms or significant tissue loss after healing will be referred to an MEB.

c. Accidental hypothermia.

(1) The definition of accidental hypothermia is clinically significant depression of body temperature due to environmental cold exposure.

(2) Soldiers with significant symptoms of cold intolerance or a recurrence of hypothermia after an episode of accidental hypothermia will be referred to an MEB.

Table 3–1
Methods of assessing cardiovascular disability

Class	New York Heart Association Functional Classification	Canadian Cardiovascular Society Functional Classification	Specific activity scale (Goldstein et al: Circulation 64:1227, 1981)	New York Heart Association Functional Classification (Revised)
I.	Patient with cardiac disease but without resulting limitations of physical activity. Ordinary physical activity does not cause undue fatigue, palpitations, dyspnea, or anginal pain.	Ordinary physical activity, such as walking and climbing, stairs, does not cause angina. Angina with strenuous or rapid or prolonged exertion at work or recreation.	Patients can perform to completion any activity requiring 7 metabolic equivalents: for example, can carry 24 lbs up eight steps, carry objects that weigh 80 lbs, do outdoor work. (shovel snow, spade soil), do recreational activities (skiing, basketball, handball, jog, and walk 5 mph).	Cardiac status uncompromised.
II.	Patients with cardiac disease resulting in slight limitation of physical activity. They are comfortable at rest. Ordinary physical activity results in fatigue, palpitation, dyspnea, or anginal pain	Slight limitations of ordinary activity. Walking or climbing stairs rapidly, walking uphill, walking or stair climbing after meals, in cold, in wind, or when under emotional stress, or only during the few hours after awakening. Walking more than 2 blocks on the level and climbing more than one flight of ordinary stairs at a normal pace and in normal conditions.	Patient can perform to completion any activity requiring ≥5 metabolic equivalents, but cannot and does not perform to completion activities requiring metabolic equivalents: for example, have sexual intercourse without stopping, garden, rake, weed, roller skate, dance fox trot, walk at 4 mph on level ground.	Slightly compromised.
III.	Patients with cardiac disease resulting in marked limitation of physical activity. They are comfortable at rest. Less than ordinary physical activity causes fatigue, palpitation, dyspnea, or anginal pain.	Marked limitation of ordinary physical activity. Walking one to two blocks on the level and climbing more than one flight in normal conditions.	Patient can perform to completion any activity requiring ≥2 metabolic equivalents but cannot and does not perform to completion activities requiring ≥5 metabolic equivalents: for example, shower without stopping, strip and make bed, clean windows, walk 2.5 mph, bowl, play golf, dress without stopping.	Moderately compromised.
IV.	Patient with cardiac disease resulting in inability to carry on any physical activity without discomfort. Symptoms of cardiac insufficiency or of the anginal syndrome may be present even at rest. If any physical activity is undertaken, discomfort is increased.	Inability to carry on any physical activity without discomfort—anginal syndrome may be present at rest.	Patient cannot or does not perform to completion activities requiring ≥2 metabolic equivalents. Cannot carry activities listed above (specify activity scale, Class III).	Severely compromised.

New York Heart Association Therapeutic Classification

Therapeutic Classification		Revised classification (prognosis)
Class A–	Patients with cardiac disease whose physical activity need not be restricted	Class I—Good.
Class B–	Patients with cardiac disease whose ordinary activity need not be restricted, but who should be advised against severe or competitive physical efforts.	Class II—Good with therapy.
Class C–	Patients with cardiac disease whose ordinary physical activity should be moderately restricted, and whose more strenuous efforts should be discontinued.	Class III—Fair with therapy.
Class D–	Patients with cardiac disease who should be at complete rest, confined to bed or chair.	Class IV—Guarded despite therapy.

METS Equivalents (Required for PEB adjudication)

Table 3–1
Methods of assessing cardiovascular disability—Continued

Class	New York Heart Association Functional Classification	Canadian Cardiovascular Society Functional Classification	Specific activity scale (Goldstein et al: Circulation 64:1227, 1981)	New York Heart Association Functional Classification (Revised)
Class I=8 METS or greater Class II=5–8 METS Class III=3–5 METS Class IV=Less than 3 METS				

Chapter 4
Medical Fitness Standards For Flying Duty

4–1. General

a. In this regulation, the term "flying duty" is synonymous with "flight status" and "aviation service." The term "aircrew" or "aircrew member" applies to rated and non–rated personnel in aviation service and air traffic control. All provisions apply to the USAR and the ARNGUS.

b. The Aviation Medicine Consultant (AMC) to TSG will recommend to TSG a senior specialist in aerospace medicine to be placed on orders for designation as the Aeromedical Review Authority. Responsibilities will include all administrative actions and medical fitness standards for flying duty for all active and RC Army aviators. The Aeromedical Review Authority is located at Building 301, Dustoff Avenue, Fort Rucker, AL 36362–5333.

c. Provisions in this chapter are subject to NATO Standardization Agreement (STANAG) 3526, which applies to allied nation aircrews serving with U.S. Forces or attending U.S. Army training programs, and to U.S. aircrews serving with foreign forces.

d. This chapter lists medical conditions and physical defects that are causes for rejection in selection, training, and retention of—

(1) Army aviators.

(2) DA civilian (DAC) pilots and contract civilian pilots who are employed by firms under contract to DA.

(3) Flight surgeons (FSs) (MOS 61N) and aeromedical physician assistants (APAs).

(4) Military, DAC, and DA contract air traffic controllers (ATCs).

(5) Individuals ordered by competent authority to participate in regular flights as nonrated aircrew.

(6) Applicants for special flight training programs directed by DA or National Guard Bureau (NGB), such as Army ROTC or USMA flight training programs.

(7) Aircrew of allied host nations or U.S. Government agencies other than DA who are flying Army aircraft, unless superseded by agreements with that nation or agency.

e. A failure to meet medical standards for flying duties remains disqualifying for flying duties until reviewed by the Aeromedical Review Authority. The Aeromedical Review Authority may recommend qualified, qualified with waiver, or medical suspension from aviation service. The Aeromedical Review Authority issues Aeromedical Policy Letters (APLs) and Aeromedical Technical Bulletins (ATBs) that provide detailed recommendations for specific, common disqualifications. Refer all questionable cases to the Aeromedical Review Authority, Fort Rucker, AL 36362–5333.

4–2. Classes of medical standards for flying and applicability

The classes of medical fitness standards for flying duties are as follows:

a. Class 1 (warrant officer candidate) or Class 1A (commissioned officer or cadet) standards apply to—

(1) Applicants for aviator training. (See also AR 611–85 and AR 611–110.)

(2) Applicants for special flight training programs directed by DA or NGB, such as Army ROTC or USMA flight training programs.

(3) Other non-U.S. Army personnel selected for training until the beginning of training at aircraft controls, or as determined by Chief, Army Aviation Branch.

b. Class 2 standards apply to—

(1) Student aviators after beginning training at aircraft controls or as determined by Chief, Army Aviation Branch.

(2) Rated Army aviators (AR 600–105).

(3) DAC pilots and contract civilian pilots who are employed by firms under contract to the DA that conduct flight operations or training, utilizing Army aircraft or aircraft leased by the Army. (See para 4–31.)

(4) Army aviators considered for return to aviation service.

(5) Senior career officers. When directed by DA or NGB under special procurement programs for initial Army aviation flight training, selected senior officers of the Army may be medically qualified under Army Class 2 medical standards.

PP

Summary of Changes

USMEPCOM Regulation 40-1
Medical Qualification Program

Immediate revisions have been made to this regulation and are formatted in red text; information that is obsolete and will be deleted is formatted in red text with strikethrough. It is highly recommended that this regulation be reviewed in its entirety to have a clear understanding of all revisions.

Incorporating changes effective July 24, 2017

- Paragraph 2-3e(1): Redefines "Processing Authorized (PA)" to include MEPS profilers authorizing medical examinations for applicants disqualified during the medical prescreening process because there is the possibility for a Service medical waiver after the medical examination is complete.
- Paragraph 2-3e(2): Clarifies the definition of "Processing Requested by SMWRA (PRW)" for those instances when the SMWRAs request an applicant disqualified during the medical prescreening process be allowed to come to the MEPS for a medical examination.
- Paragraph 11-1d(59): clarifies that either a T or O in the profile signifies that the PULHES is not complete and therefore should not be signed (bottom-lined) by the profiling provider.

DEPARTMENT OF DEFENSE
HEADQUARTERS, UNITED STATES MILITARY ENTRANCE PROCESSING COMMAND
2834 GREEN BAY ROAD, NORTH CHICAGO, ILLINOIS 60064-3091

*USMEPCOM Regulation
No. 40-1

July 24, 2017

Effective date: July 24, 2017

Medical Qualification Program

FOR THE COMMANDER

OFFICIAL:

D.R. O'Brien
Deputy Commander/Chief of Staff

R. D. Wesler
Chief, Services Division

DISTRIBUTION:
A (Electronic only publication)

Executive Summary. This regulation prescribes policy and procedures for administration of the United States Military Entrance Processing Command (HQUSMEPCOM) Medical Qualification Program.

Applicability. This regulation applies to all elements of USMEPCOM and to the recruiting and liaison personnel of all military components insofar as their duties relate to all aspects of applicant medical processing required under this and related regulations.

Supplementation. Supplementation of this regulation is prohibited without prior approval from Headquarters, United States Military Entrance Processing Command (HQ USMEPCOM), ATTN: J-7/MEMD, 2834 Green Bay Road, North Chicago, IL 60064-3091.

Suggested Improvements. The proponent agency of this regulation is HQ USMEPCOM, [J-7/MEMD]. Users are invited to send comments and suggested improvements on Department of the Army (DA) Form 2028, Recommended Changes to Publications and Blank Forms, or memorandum, to HQ USMEPCOM, ATTN: J-7/MEMD, 2834 Green Bay Road, North Chicago, IL 60064-3091.

Internal Control Process. This regulation contains internal control provisions and provides an internal control evaluation checklist, in Appendix B, for use in conducting internal controls.

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* This regulation supersedes USMEPCOM Regulation 40-1, February 27, 2017

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Chapter 1
General

1-1. Purpose
The purpose of this regulation is to establish policies and procedural guidance for the USMEPCOM Medical Qualification Program of the USMEPCOM Medical Program. The Medical Qualification Program is executed at USMEPCOM locations such as Military Entrance Processing Stations (MEPS) and remote processing sites and is applicable to all applicants medically processing for accession into the Military Services and other federal organizations as approved by higher authority. The Medical Qualification Program consists of performing medical services including performing medical prescreening; performing medical examinations which consist of medical history interviews, physical screening examinations, medical tests, specimen collections, determining whether medical processing is warranted, determining additional medical information and consultative services required; and determining medical qualification. Medical qualification decisions include determining if an applicant does or does not meet Department of Defense (DoD) accession medical standards and when requested by the Services and approved by USMEPCOM, Service specific medical standards. USMEPCOM designated physicians are the DoD medical authority for applicants processing with USMEPCOM for determining if an applicant medically meets the requirements of Title 10 to be qualified, effective, and able-bodied prior to enlistment. USMEPCOM provides medical services support to other federal organizations approved by Accession Policy; services provided are determined through a memorandum of agreement arrangement with the organization requesting medical services.

1-2. References
References are listed in Appendix A.

1-3. Abbreviations and Terms
Abbreviations and terms used in this regulation are explained in Appendix C, Glossary.

1-4. Responsibilities

a. **J-7/Medical Plans and Policy, (J-7/MEMD) Director will:**

(1) Exercise primary staff responsibility and develop policies and procedures for applicant medical processing and related matters for the USMEPCOM Medical Qualification Program.

(2) Ensure the execution and quality of the USMEPCOM Medical Qualification Program in accordance with (IAW) DoD and Commander, USMEPCOM policies.

(3) Provide a single point of contact for all applicant daily medical processing issues to facilitate standardized applicant medical processing, services and decisions.

b. **J-7/MEMD, Deputy Director will:**

(1) Formulate and manage policy concerning the USMEPCOM Medical Qualification Program.

(2) Ensure policies set forth in this regulation are complied with across the Command.

(3) Be responsible for daily applicant medical processing mission support.

(4) Manage systematic feedback and support to Sector and Battalion Commanders on the USMEPCOM Medical Qualification Program.

(5) Provide supervision of personnel assigned to J-7/MEMD divisions including the Clinical Operations Division (J-7/MEMP-COD) consisting of a division chief, HIV/DAT Program Office (J-7/MEMD-COD-HPO), ~~Battalion Support~~ Accession Medicine Branches (J-7/MEMD-COD-BD, J-7/MEMD-COD-BL, and J-7/MEMD-COD-BR); and the Clinical Quality Division (J-7/MEMD-QD) consisting of the division Chief, Medical Informatics Officer, and Medical Program Business Manager; Quality and Requirements Branch (J-7/MEMD-QD-QDO); Clinical Management Branch (J-7/MEMD-QD-QDM) and Programs Branch (J-7/MEMD-QD-QDP).

c. **J-7/MEMD, Clinical Operations Division Chief will:**

(1) Ensure the MEPS comply with the policies and guidance set forth in this regulation.

(2) Manage the applicant Human Immunodeficiency Virus (HIV) testing program, the drug and alcohol testing (DAT) programs.

(3) Manage J-7/MEMD applicant daily medical support for MEPS medical processing issues through the Operations Center (MOC) ticket system.

(4) Formulate medical policies and procedures for applicant HIV testing program, DAT testing program, and medical operational aspects of the USMEPCOM Medical Qualification Program.

(5) Develop and provide training for Command personnel on medical policies and procedures for HIV testing program, DAT testing program, and medical operational aspects of the USMEPCOM Medical Qualification Program.

(6) Ensure collaboration by Clinical Operations Division personnel with Clinical Quality Division personnel. Participate in Quality Medical Assessment Teams, when assigned.

(7) Provide oversight of Clinical Operations Division continuous performance improvement efforts for the USMEPCOM Medical Program balanced scorecard, trend analysis, and metrics planning and execution.

(8) Provide supervision of the HIV/DAT Program Office and ~~Battalion Support~~ Accession Medicine Branches.

(9) Develop the curriculum for the annual medical training seminar for MEPS medical leadership including Chief Medical Officers (CMOs), Assistant CMOs (ACMOs), Assistant Medical Officers (AMOs) and MEPS medical department paraprofessional staff.

d. **J-7/MEMD, HIV/DAT Program Officer will:**

(1) Manage the USMEPCOM Applicant Drug and Alcohol and Human Immunodeficiency Virus (HIV) Programs in accordance with (IAW) USMEPCOM Regulation (UMR) 40-8 (Department of Defense (DoD) Drug and Alcohol Testing (DAT) Program and Human Immunodeficiency Virus (HIV) Testing Program.

(2) Respond to HIV/DAT MOC tickets in support of daily applicant medical processing.

(3) Collaborate with the USMEPCOM Contracting Officer Representative (COR) for the HIV contract to ensure USMEPCOM compliance with contract requirements.

e. **J-7/MEMD, ~~Battalion Support~~ Accession Medicine Branch ~~(BSB)~~ Chiefs will:**

(1) Formulate medical policies and procedures for medical operational aspects of the USMEPCOM Medical Qualification Program as a fully qualified accessions medical officers.

(2) Execute the J-7/MEMD clinical operational aspects of the USMEPCOM Medical Qualification Program ensuring collaboration for quality aspects of the program with the Clinical Quality Division for adherence to DoD medical standards and USMEPCOM policies and guidelines.

(3) Ensure the MEPS comply with the policies and guidance set forth in this regulation.

(4) Respond to MOC tickets and other inquiries (congressional, inspector general, special action, etc.) requiring physician input in support of applicant medical processing.

(5) Engage Service Medical Waiver Review Authorities (SMWRAs) as appropriate to facilitate applicant medical processing while authorizing use of medical funds effectively.

(6) Provide medical provider evaluation visits and quality medical assessment team support and visits to the MEPS including evaluation and assessment of USMEPCOM regulatory medical policy in USMEPCOM Regulations (UMRs) 40-1, 40-2, 40-8, and 40-9.

(7) Provide clinical support for business process reengineering efforts, assigned medical projects and continuous performance improvement efforts for the USMEPCOM Medical Program balanced scorecard, trend analysis, and metrics planning and execution.

(8) Develop and provide training/training guides for MEPS medical providers on current and pending medical processes to facilitate consistent implementation of medical policies and procedures.

(9) Perform applicant medical examinations at MEPS when required.

(10) Provide feedback to MEPS CMOs on Existed Prior to Service (EPTS) cases received from the training bases.

(11) Provide supervision of the Medical Management Analysts (MMAs).

f. **J-7/MEMD, ~~BSB~~ Accession Medicine Branch MMAs will:**

(1) Be responsible for the medical paraprofessional staff aspects of the USMEPCOM Medical Qualification Program as fully qualified accessions medical specialists.

(2) Provide staff assistance visits (SAVs), individual training visits (ITVs), and medical reassessment visits (MRVs) to MEPS including evaluation and assessment of USMEPCOM regulatory medical policy in USMEPCOM regulations and policies.

(3) Ensure completion of MOC tickets applicable to the USMEPCOM Medical Qualification Program.

(4) Review and recommend updates to USMEPCOM regulations and policies.

(5) Provide medical technical support for business process reengineering efforts, assigned medical projects and continuous performance improvement efforts for the USMEPCOM Medical Program balanced scorecard, trend analysis, and metrics planning and execution.

(6) Provide medical technical coding support for the EPTS program.

(7) Manage the Command-wide participation in the College of American Pathology/Clinical Laboratory Improvement Program (CAP/CLIP).

(8) Provide management analyst support to the HIV/DAT programs.

g. **J-7/MEMD, Clinical Quality Division (QD) Chief will:**

(1) Formulate medical policies and procedures for medical quality/performance improvement and contract management aspects of the USMEPCOM Medical Qualification Program.

(2) Manage the business needs of the USMEPCOM Medical Qualification Program.

(3) Manage USMEPCOM medical contracts associated with the USMEPCOM Medical Qualification Program. Provide contracting officer representative (COR) and alternate COR (ACOR) personnel for managing completion of workload associated with medical contracts.

(4) Manage the medical aspects of USMEPCOM special programs as assigned.

(5) Coordinate with the J-7/MEMD staff on the medical aspects of future initiatives including requirements definition and studies.

(6) Manage United States Military Entrance Processing Command Integrated Resource System (USMIRS) medical changes and manage user acceptance of these changes. Provide technical expertise in support of future technical initiatives impacting the Medical Qualification Program.

(7) Provide supervision for the medical informatics officer, medical program business manager, Quality and Requirements Branch, Quality Management Branch, and Programs Branch.

h. **MEPS Commanders will:**

(1) Ensure MEPS personnel comply with this regulation.

(2) Hire the chief medical officer (CMO), assistant CMO (ACMO), and assistant medical officer (AMO) including physician assistants (PAs) and Certified Nurse Practitioners (CNPs) through the local servicing civilian personnel activity IAW USMEPCOM (UMR) Regulation 40-2.

(3) Ensure Fee Basis Provider (FBP) training and administrative requirements are met IAW UMR 40-2 before allowing an FBP to conduct aspects of the USMEPCOM Medical Program.

(4) Ensure any deviation from USMEPCOM policy in this regulation has an approved exception to policy (ETP) signed by the J-7/MEMD Director (or designated representative) prior to implementation.

i. **MEPS Operations Officers (OPSOs) will:**

(1) Responsible for monitoring applicant flow through the MEPS and the Medical Department.

(2) Keep the MEPS Commander abreast of applicant flow and current processing concerns.

(3) Ensure medical processing is complete and an applicant is medically qualified to "ship" per the MEPS CMO (or CMO designated medical lead) during Quality Review Program (QRP).

(4) Ensure USMIRS is updated with medical data in a timely and accurate manner.

(5) Ensure reconciliation between the medical process results and medical processing departments USMEPCOM Form (UMF) 727-E is accomplished.

j. **MEPS CMOs will:**

(1) Supervise and manage the MEPS Medical Department and the execution of the Medical Qualification Program at the local MEPS level to ensure program quality.

(2) Supervise and provide written evaluations on ACMOs and MEPS Medical NCOICs/ SUP MTs.

(3) Serve as the principal MEPS medical officer and local authority in all accession medicine decisions, including but not limited to, requesting laboratory studies, radiographic procedures, ancillary services, and specialty consultations; requesting and reviewing applicants' medical documents; counseling applicants with regard to medical problems discovered during their MEPS evaluation, qualification/disqualification decisions, and recommendations for medical waivers. MEPS Commanders and other non-medical personnel cannot reverse the professional accession medicine decisions of CMOs/ACMOs and contract physicians working as Fee Basis-CMOs (FB-CMOs).

(4) Establish a professional working relationship with the Medical Non-Commissioned Officers in Charge (Medical NCOIC)/Supervisory Medical Technician (SUP MT) and provide them the support to execute CMO decisions and medical policies.

(5) Ensure medical staff (government and contract medical providers and paraprofessional staff) is fully trained in conducting all aspects of the USMEPCOM Medical Qualification Program.

(6) Ensure assigned requirements associated with USMEPCOM medical contracts are executed at the local MEPS level including documentation of issues where contract providers are not providing quality medical services.

(7) Ensure applicant's medical documents are appropriately reviewed for completeness and accuracy.

(8) Prepare and conduct quarterly training and inspection of the entire medical department.

(9) Ensure Occupational Safety and Health Administration (OSHA) requirements are met for all medical personnel.

(10) Respond to Dial-A-Doc/Email-A-Doc questions promptly.

(11) Ensure MEPS medical personnel training requirements are met.

(12) Act as the appointed Lab Director.

k. **MEPS Medical Non-Commissioned Officers in Charge/Supervisory Medical Technicians will:**

(1) Establish a professional working relationship with the CMO as well as the rest of the medical department.

(2) Support and follow through with CMO-directed medical decisions and policies.

(3) Supervise and provide written evaluations on all medical technicians to ensure the quality of the USMEPCOM Medical Qualification Program.

(4) Ensure each medical station is properly staffed for an efficient applicant flow through the medical department processes.

(5) Serve as the government point of contact for USMEPCOM medical contracts and ensure compliance with COR assigned responsibilities.

(6) Ensure quality control of medical packets with complete and legible entries.

(7) Act as the primary trainer for the medical department and ensure technicians are thoroughly trained and capable in all phases of the Medical Qualification Program.

(8) Responsible for the daily checks, calibration, periodic maintenance, and timely repairs of medical equipment to optimize functionality.

(9) Coordinate scheduling of annual biomedical equipment maintenance.

(10) Ensure daily organization, professional appearance, and cleanliness of the MEPS medical department.

(11) Coordinate with the other MEPS departments and Service Liaisons on medical matters impacting applicant flow.

(12) Ensure disruptive applicants are managed appropriately.

(13) Aid the Commander and the CMO in the requirements of UMR 40-1, 40-2, 40-8, and 40-9 to include ensuring contract providers only provide medical services appropriate to their Designated Provider Category (DPC).

(14) Ensure quality review process (QRP) of projected applicants' medical packets is accomplished at least two working days before the applicant processes at the MEPS.

(15) Ensure weekly and quarterly departmental and CMO-directed training is accomplished.

(16) Ensure OSHA requirements are met for all medical personnel.

(17) Establish verification and validation procedures for invoice reconciliation to ensure data accuracy for all medical contracts.

(18) Complete all required taskings within the established time period.

(19) Ensure accuracy of USMIRS data entry.

l. **MEPS Lead Medical Technicians will:**

(1) Establish a professional working relationship with the CMO and Medical NCOIC/SUP MT as well as the rest of the medical department.

(2) Support and follow through with CMO and Medical NCOIC/SUP MT-directed medical decisions and policies.

(3) Lead all medical technicians to ensure the quality of the USMEPCOM Medical Qualification Program in the absence of a Medical NCOIC/SUP MT.

(4) Assist the Medical NCOIC/SUP MT with the duties outlined in the preceding section.

(5) Ensure accuracy of USMIRS data entry.

m. **MEPS Medical Technicians will:**

(1) Establish a professional working relationship with the CMO and NCOIC/SUP MT.

(2) Support and follow through with CMO and NCOIC/SUP MT/Lead Medical Technician-directed medical decisions and policies.

(3) Perform quality checks accurately and daily.

(4) Accurately execute applicant vision and hearing testing, specimen collections, and other assigned medical services.

(5) Perform accurate and daily USMIRS, FBP, and Invoice Reconciliation Program (IRP) application entries.

(6) Complete the technician portion of the USMIRS and Training Standardization Job Task Sheets (TSJTS) within 90 working days after arrival.

(7) Ensure that documents and Department of Defense (DD) Form 2807-2 are completed accurately and timely and are tracked accordingly.

(8) Ensure QRP of projected applicants' medical packets is accomplished at least two working days before the applicant processes at the MEPS.

(9) Comply with all training requirements for all phases of the Medical Qualification Program as well as additional USMEPCOM training as established by NCOIC/SUP MT.

(10) Ensure accuracy of USMIRS data entry.

n. **FBP responsibilities.** FBPs will conduct accession medical services at the MEPS according to established guidance and the individual Service directives.

o. **J-4/Facilities and Acquisition Directorate will:**

(1) Provide medical logistics support to the USMEPCOM Medical Qualification Program.

(2) Provide acquisition support for medical contracts associated with the USMEPCOM Medical Qualification Program.

1-5. General Policy

a. **Medical Services Execution.** All personnel performing medical services for USMEPCOM will adhere to current version of DoD Instruction (DoDI) 6130.03 (Medical Standards for Appointment, Enlistment, or Induction in the Armed Forces), this regulation, UMR 40-2, UMR 40-8, and UMR 40-9.

b. **Applicant Medical Qualification Decisions**. Profiling is a critical part of applicant processing. Profiling duties are done by USMEPCOM medical providers with a DPC Level of 3 or higher. The accuracy of the final applicant profile is the responsibility of the CMO. When profiling proficiency has been demonstrated by an FBP to the satisfaction of the CMO, a modification of DPC level to allow profiling can be requested (DPC Level 3). An FBP will not profile unless specifically assigned by the J-7/MEMD Director (or designated J-7/MEMD representative). An FBP will not be designated as FB-CMO if not assigned to DPC Level 4 which includes the ability to profile.

c. **Designation of FB-CMO.** If the CMO is absent from the MEPS or if the MEPS has a CMO vacancy, MEPS with ACMOs will have the ACMO be administratively in charge of the medical department and perform any required CMO duties as designated by the MEPS Commander. If there is no ACMO, then a FB-CMO can be requested from the contractor. Only FBPs assigned to DPC Level 4 will be designated as the FB-CMO. FB-CMOs will conduct applicant accession medical services including medical prescreening and examinations and are clinically responsible for the MEPS medical department and will respond to requests from the MEPS Commander to attend meetings and provide technical advice and medical guidance to the medical department. Medical processing questions that cannot be resolved at the local level will be referred to J-7/MEMD via MOC ticket.

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1-6. Use of Reserve Component and National Guard Practitioners

MEPS Commanders will contact J-7/MEMD for guidance when there are requests for Armed Forces Reserve and National Guard (NG) practitioners in drill status or on active duty for training (ADT) for duty at the MEPS. When working in a MEPS as FBPs, reserve component providers cannot be paid through the contract if they are in a duty status. Providers must meet the requirements in UMR 40-2 to have their initial credentials reviewed by J-7/MEMD, before performing medical examinations or associated MEPS duties.

1-7. MEPS Communication with J-7/ MEMD

a. The USMEPCOM MOC ticket system will be used for applicant medical processing issues. If immediate help is needed after submitting a MOC ticket, contact the appropriate J-7/MEMD personnel using the contact list provided on the USMEPCOM intranet, Sharing, Policy, Experience and Resources (SPEAR), on the J-7/MEMD home page.

b. Use the following address for mailing information to J-7/MEMD

HQ USMEPCOM
ATTN: J-7/MEMD (position or person who should receive the mail)
2834 Green Bay Road
North Chicago, IL 60064-3091

c. Use the following facsimile number for faxing information to J-7/MEMD. If faxing personal or medical information, call J-7/MEMD first and verify someone is available to immediately retrieve the fax from the machine.

FAX: (847) 688-2453

d. J-7/MEMD has group email addresses for a number of areas. These addresses are in the USMEPCOM global address list and are listed on the J-7/MEMD SPEAR page. Emails containing personal and medical information must always be sent encrypted.

QQ

IN THE UNITED STATES DISTRICT COURT FOR THE DISTRICT OF COLUMBIA

DOE, et al.,	)	
Plaintiffs,	)	
v.	)	Civil Action No. 17-cv-1597 (CKK)
DONALD TRUMP, et al.,	)	
Defendants.	)	

DECLARATION OF GEORGE RICHARD BROWN, MD, DFAPA IN SUPPORT OF OPPOSTION TO DEFENDANTS' MOTION TO DISMISS AND MOTION TO DISSOLVE THE PRELIMINARY INJUNCTION

1. I, George R. Brown, have been retained by counsel for Plaintiffs as an expert in connection with the above-captioned litigation.

2. My professional background and qualifications are set forth in my previous declaration in this case dated August 30, 2017. *See* Dkt. Nos. 13-11 & 13-12. A copy of that declaration is attached as Exhibit A.

3. The purpose of this supplemental declaration is to offer my expert opinion on the "Department of Defense Report and Recommendations of Military Service By Transgender Persons," which I refer to in this declaration as the "Implementation Report."

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

5. As noted in my previous declaration, I am being compensated at an hourly rate for actual time devoted, at the rate of $400 per hour for work that does not involve depositions or court testimony (e.g., review of materials, emails, preparing reports); $500 per hour for

depositions (there is a half-day fee for depositions); $600 per hour for in-court testimony; and $4000 per full day spent out of the office for depositions and $4800 per full day out of the office for trial testimony. Travel days necessary for work are billed at half the "work day" rate plus expenses. My compensation does not depend on the outcome of this litigation, the opinions I express, or the testimony I provide.

THE IMPLEMENTATION REPORT REJECTS THE OVERWHELMING MEDICAL CONSENSUS REGARDING TRANSGENDER IDENTITY AND TREATMENT FOR GENDER DYSPHORIA

6. Although the Implementation Report refers to a study conducted by a "Panel of Experts," the referenced panel does not appear to have included any experts in treating gender dysphoria or any medical experts at all. The Implementation Report indicates that the panel consulted with such experts, but the Implementation Report appears to have consistently disregarded what those experts say. *See* Implementation Report at 17.

7. As a result, the Implementation Report relies on notions of gender dysphoria and transgender identity that have no basis in fact, science, or medicine and that have been rejected by the mainstream medical community.

8. In my previous declaration, I explained that arguments that the mental health of transgender persons could justify prohibiting such individuals from serving in the military are wholly unfounded and unsupported in medical science. *See* Exhibit A, August 30, 2017 Brown Decl. ¶37. Being transgender—and living in accordance with one's gender identity—is not a mental defect or disorder. To the extent the misalignment between gender identity and assigned birth sex creates clinically significant distress (gender dysphoria), that distress is curable through appropriate medical care that allows the individual to live consistently with their gender identity.

As a class, transgender individuals have suffered, and continue to suffer, severe persecution and discrimination. Being transgender does not limit one's ability to contribute to society.

9. Only a subset of transgender people have gender dysphoria. If a transgender person is able to live in accordance with their gender identity from an early age, they may never develop gender dysphoria as an adult. If a transgender person develops gender dysphoria, they can receive appropriate transition-related care that resolves the clinically significant distress. For transgender people who have resolved symptoms of gender dysphoria, the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (2013) ("DSM-5") provides a separate "post-transition" diagnostic subtype to reflect that the gender dysphoria is in remission and that the person may only need a maintenance dose of cross-sex hormones.

10. The Implementation Report turns this understanding on its head by requiring transgender people to live in accordance with the sex assigned to them at birth. The Implementation Report conceives of a transgender person without gender dysphoria as someone who comfortably lives and functions according to the sex assigned to them at birth without suffering any distress from the incongruence with their gender identity. That hypothetical person is likely not someone who is transgender.

11. The Implementation Report directly contradicts the medical consensus about the nature of gender dysphoria by treating every transgender person who lives according to the person's gender as having a disabling mental health condition even when the person no longer experiences gender dysphoria. The medical community has definitively rejected that view. In response to the Implementation Report, the American Psychological Association stated that it "is alarmed by the administration's misuse of psychological science to stigmatize transgender Americans and justify limiting their ability to serve in uniform and access medically necessary

health care." *See* Exhibit C, APA Statement Regarding Transgender Individuals Serving in Military. The American Medical Association released a similar statement reaffirming that "there is no medically valid reason—including a diagnosis of gender dysphoria—to exclude transgender individuals from military service" and expressing concern that the Implementation Report "mischaracterized and rejected the wide body of peer-reviewed research on the effectiveness of transgender medical care." *See* Exhibit D, AMA Letter to Secretary James Mattis. The American Psychiatric Association also released a statement denouncing the Implementation Report and reiterating that "[t]ransgender people do not have a mental disorder; thus, they suffer no impairment whatsoever in their judgment or ability to work." *See* Exhibit E, APA Statement.

12. Decades of research have demonstrated that attempting to treat gender dysphoria by forcing transgender people to live in accordance with their sex assigned at birth—to "convert" them out of being transgender—is ineffective, unethical, and dangerous. The mainstream medical community overwhelmingly condemns this "conversion therapy."

13. The Implementation Report appears to dispute the consensus of the mainstream medical community that gender dysphoria is amenable to treatment through social and medical transition. The American Medical Association, the Endocrine Society, the American Psychiatric Association, and the American Psychological Association all agree that medical treatment for gender dysphoria is medically necessary and effective. *See* American Medical Association, Resolution 122 (A-08) (2008); American Psychiatric Association, Position Statement on Discrimination Against Transgender & Gender Variant Individuals (2012); Endocrine Treatment of Transsexual Persons: An Endocrine Society Clinical Practice Guideline (2017); American

Psychological Association Policy Statement on Transgender, Gender Identity and Gender Expression Nondiscrimination (2009). *See* Exhibit A, August 30, 2017 Brown Decl. ¶¶ 21-25.

14. Sixty years of clinical experience and data have demonstrated the efficacy of treatment for the distress resulting from gender dysphoria (*see*, for example, the recently published multi-country, long-term follow up study: Tim C. van de Grift et al., Effects of Medical Interventions on Gender Dysphoria and Body Image: A Follow-Up Study, 79 Psychosomatic Med. 815 (Sept. 2017)). The Implementation Report asserts that this evidence is unreliable because there are no "double-blind" scientific studies regarding the efficacy of surgical care for gender dysphoria. But medical standards of care are not determined solely by double-blind studies, especially in the context of surgery. Double-blind studies with "sham" surgeries are often impossible or unethical to conduct.

14. If the military limited all medical care to surgical procedures supported by prospective, controlled, double-blind studies, then only a very few medical conditions would ever be treated. For example, one of the most common surgical procedures performed in the United States is a tonsillectomy, with over 530,000 cases completed a year, using multiple, competing surgical techniques. However, a review of the evidence base for this very common procedure, including when to apply it and the best surgical techniques to utilize, is not supported by "double blind" controlled studies in spite of the common use of this treatment over centuries. *See* Reginald F. Baugh et al., *Clinical Practice Guideline: Tonsillectomy in Children*, 144 Otolaryngology–Head and Neck Surgery S1 (2011)). Baugh and coauthors noted: "While there is a body of literature from which the guidelines were drawn, significant gaps remain in knowledge about preoperative, intraoperative, and postoperative care in children who undergo tonsillectomy." Id. at S22.

15. Similarly, acute appendicitis is one of the most common causes of acute abdominal pain in the United States. However, it remains unclear whether the common approach of appendectomy is superior to nonsurgical treatment with antibiotics in many patients. A recent Cochrane review was inconclusive: "We could not conclude whether antibiotic treatment is or is not inferior to appendectomy. Because of the low to moderate quality of the trials, appendectomy remains the standard treatment for acute appendicitis." *See* Ingrid M. H.A. Wilms et al., *Appendectomy Versus Antibiotic Treatment for Acute Appendicitis*, Cochrane Database of Systematic Rev. (2011). In other words, the prevailing standard of care, in spite of the "low quality" of evidence in support of surgery over a nonsurgical alternative, remains the accepted standard.

16. By insisting that treatment for gender dysphoria—unlike treatment for virtually every other medical condition—be supported by "double blind" studies, the Implementation Report holds the robust medical consensus surrounding treatment for gender dysphoria to an impossible standard—and a standard that few if any medical conditions are required to meet.

17. The Implementation Report also mischaracterizes a recent decision by the U.S. Department of Health & Human Services Center for Medicare and Medicaid Services ("CMS"). *See* Implementation Report at 24–26. In 2014, an impartial adjudicative board in the Department of Health & Human Services concluded, based on decades of studies, that surgical care to treat gender dysphoria is safe, effective, and not experimental. *See* Exhibit F, NCD 140.3, Transsexual Surgery. The decision specifically noted that, regardless of whether the studies were randomized double-blind trials, there was sufficient evidence to prove "a consensus among researchers and mainstream medical organizations that transsexual surgery is an effective, safe and medically necessary treatment for [gender dysphoria]." *Id.* at 20. Ever since the

adjudicative board's decision, Medicare has provided coverage for transition-related surgery based on patients' individual needs.

18. In the document referenced by the Implementation Report, CMS decided to continue covering surgery based on patients' individual needs and refrain from issuing national standards regarding how to determine medical necessity in individualized cases. *See* CMS Report. The Implementation Report incorrectly states that CMS "found insufficient scientific evidence to conclude that such surgeries improve health outcomes for persons with gender dysphoria." Implementation Report at 24 n.82. In fact, the decision specifically clarified that "GRS [gender reassignment surgery] may be a reasonable and necessary service for certain beneficiaries with gender dysphoria," but "[t]he current scientific information is not complete for CMS to make a [national coverage determination] that identifies the precise patient population for whom the service would be reasonable and necessary." CMS Report at 54 (emphasis added). In particular, CMS expressed concern that the Medicare population includes "older adults [who] may respond to health care treatments differently than younger adults." Id. at 57. These differences can be due to, for example, multiple health conditions or co-morbidities, longer duration needed for healing, metabolic variances, and impact of reduced mobility." Id. The CMS memorandum concluded that the appropriateness of surgical care for this population should be determined on an individualized basis. Indeed, most medical and surgical care provided to patients should be individualized, taking into account each patient's unique clinical circumstances.

INDIVIDUALS WHO HAVE UNDERGONE GENDER TRANSITION ARE MEDICALLY FIT TO ENLIST

19. To justify prohibiting transgender people from serving even if they have resolved the distress associated with gender dysphoria, the Implementation Report attempts to use a

transgender person's history of gender dysphoria as a proxy for other mental health conditions such as anxiety, depression, and suicidal behavior.

20. Statistically, transgender people as a group are at greater risk of experiencing those conditions as a result of the stressors inherent in being prevented from transitioning or obtaining medical care throughout all, or much, of their lives. Some studies have documented that these health disparities can persist even after transition-related treatment because of the continuing effects of discrimination and the reality that gender dysphoria-specific treatments are not panaceas for all problems that a person may experience in their life (nor were these treatments designed to be). *See*, e.g., Implementation Report at 25 (citing Cecilia Dhejne et al., Long-Term Follow-Up of Transsexual Persons Undergoing Sex Reassignment Surgery: Cohort Study in Sweden, 6 PloS One, 6 (2011)). Transgender people as a group represent a very small subset of society and lack the sort of political power other groups might harness to protect themselves from discrimination.

21. But there is no evidence to support the notion that every individual transgender person is at risk of developing one of these conditions, particularly for those who have been treated early in their lives, as opposed to those who never received treatment or who may have come to treatment much later in life, such as the transgender veterans studied by my research group and cited in the Implementation Report at 21 n.60 (citing George R. Brown & Kenneth T. Jones, Mental Health and Medical Health Disparities in 5135 Transgender Veterans Receiving Healthcare in the Veterans Health Administration: A Case-Control Study, 3 LGBT Health 128 (2016)).

21. Under the Open Service policy, all prospective military service members must undergo a rigorous examination to identify any pre-existing mental health diagnoses that would

preclude enlistment. There is no reason to use a person's transgender status as a proxy for depression, anxiety, or suicidal ideation because the military directly screens for those conditions. Anyone with a history of suicidal behavior—whether transgender or not—is categorically barred from enlisting. *See* DODI 6130.03, Enclosure 4 § 29(n). Anyone with a history of anxiety or depression—whether transgender or not—is barred from enlisting unless, inter alia, they have been stable and without medical treatment for 24 consecutive months or 36 consecutive months respectively. *See id*. §§ 29(f), (p). As a result, any transgender individual who actually has one of those conditions is already screened out without a need for a categorical ban.

22. There is no medical basis for using a transgender person's history of gender dysphoria as a proxy for other medical conditions that the person does not actually have. This approach is akin to assuming non-transgender female applicants are, or should be considered, clinically depressed, as it is well known that depressive disorders are about twice as common in non-transgender females than in non-transgender males. *See* Paul R. Albert, Why Is Depression More Prevalent in Women? 40 J. of Psychiatry & Neuroscience 219-21 (2015). Women are twice as likely as men to have anxiety disorders, but the military does not bar women from military service. Depression, anxiety, and suicide are more common among white people than black people, but the military does not bar white people from military service. One study of California school children shows that children of service members are more than 50 percent more likely to have attempted suicide than the general population. *See* Exhibit B, Vice Admiral Donald C. Arthur, USN (Ret.), Former Surgeon General of the U.S. Navy, et al., *DoD's Rationale for Reinstating the Transgender Ban is Contradicted by Evidence*, Palm Center (April 2018). Yet the military does not bar individuals in this highrisk group from entry. If a

transgender individual who seeks to enlist in the military has already transitioned, no longer experiences gender dysphoria, and has been screened for other mental health conditions (including depression, anxiety, and suicidal ideation) there is no reason to conclude that individual is at elevated risk of developing one of these comorbidities in the future.

23. The Implementation Report distorts my own work by citing a recent study in which I documented that some transgender veterans who have received treatment after years of living in the shadows continue to have health disparities even after their gender dysphoria is resolved through treatment. *See* Implementation Report at 21 n.60. The veterans in my study were untreated veterans for a long period of time and survived—but did not thrive—while living an inauthentic life in the shadows on active duty. Many of the transgender veterans included in this large study had never received treatment for gender dysphoria. Clearly, the population group of transgender individuals in that study is not comparable to the population group of people who have already received medical care, resolved their gender dysphoria, and are coming to the military openly stating they are transgender.

24. The Implementation Report also states that data regarding existing service members has called into question assumptions about the mental health of transgender service members. *See* Implementation Report 21. I have reviewed USDOE 2633-2664, which appears to be a slide-show presentation of the data on which the Implementation Report relies. *See* Exhibit H, USDOE 2633-2664 (produced by Defendants as USDOE 2633-2664 (AF_00007405-7436) and filed as Docket No. 139-27 in the related matter of Stone, et al. v. Trump, et al, No. 17-CV-02459-MJG (D. Md.)). It should be noted that my career as an academic research psychiatrist, including conducting extensive research within the Department of Defense and the

Department of Veterans Affairs for many years, enables me to critically assess research design, methodology, and outcomes.

25. As an initial matter, none of the data relates to service members who have completed transition and are enlisting for the first time—the group of people who meet the Open Service standards and began the process of enlisting on or after January 1, 2018. The data are exclusively from service members who were diagnosed with gender dysphoria while already serving, in some cases well before any guidance was provided by DOD for treatment. Again, this means that the data reflects a group of people who were serving in the shadows for years before they were allowed to serve openly.

26. Even with respect to these service members, the data is fundamentally flawed and presented in a grossly misleading manner. The study period for the data was for the 22-month period from October 1, 2015 to July 26, 2017. But Secretary Carter's Open Service Directive was not issued until June 30, 2016, and the military did not issue force-wide treatment protocols for gender dysphoria until October 1, 2016. As a result, for 12 out of the 22 months in the study, the service members were, with few exceptions, not serving openly and not receiving DOD-sanctioned treatments for gender dysphoria.

27. If the purpose of the study is to draw conclusions about the health of transgender service members under the Open Service policy, it is fundamentally illegitimate to include data from before that policy went into effect and before those service members were allowed to receive health care under DOD guidelines to treat their gender dysphoria.

28. For example, the Implementation Report cites data from the study for the proposition that transgender service members had an average of 28.1 mental health encounters over a 22-month period. *See* Implementation Report at 24; Exhibit H, USDOE 2633-2664 at 8.

But it is impossible to determine whether these mental health encounters occurred before or after the Open Service policy went into effect. If the utilization rate dropped once service members started receiving care for gender dysphoria, then the data would actually support the efficacy of the Open Service policy.

29. The Implementation Report also ignores the critical fact that service members were required to meet with mental health providers numerous times to document their gender dysphoria as a precondition for receiving health care for gender dysphoria, and for continued access to cross-sex hormones. It is unknown how many of these visits were mandated/required, as opposed to visits voluntarily requested by service members for mental health care. As a result, without more specific data, there is no reason to conclude that mental health visits by transgender service members who are initiating transition-related care are a sign of co-morbid mental health conditions. The report is quite misleading is this regard, as it implies that all mental health visits by transgender service members were initiated for the treatment of mental illnesses, when this is far from the truth.

30. Similarly, the Implementation Report cites data from the study for the proposition that service members with gender dysphoria are "eight times more likely to attempt suicide than Service members as a whole." Implementation Report at 12. In fact, the underlying data refer to "suicidal ideation," not actual suicide attempts. Exhibit H, USDOE 2633-2664 at 9. Moreover, with respect to suicidal ideation, the data does not reveal whether the suicidal ideation was reported before or after the service member was allowed to serve openly and receive treatment. Given the fundamental flaws with the study methodology and the low number of observed events, the data presented on this, and other, mental health questions are not interpretable in any meaningful way.

31. In short, transgender individuals should be screened and evaluated for mental health conditions the same way every other person is screened and evaluated. There is no medical basis to using a transgender individual's history of gender dysphoria as a proxy for other mental health conditions that they do not have.

TRANSGENDER SERVICE MEMBERS WHO HAVE TRANSITIONED ARE PHYSICALLY FIT TO ENLIST AND DEPLOY

32. The argument that cross-sex hormone treatment should be a bar to service for transgender individuals is not supported by medical science or current military medical protocols. Experts in the endocrine treatment of transgender people have previously advised military medical providers that cross-sex hormone treatments can be accomplished without difficulty, both before accession and after service has begun. *See* WPATH Timeline Guide for United States Armed Service Members Going Through Transgender Hormonal or Surgical Transition (Jan. 2017), https://www.wpath.org/newsroom/policies (attached as Exhibit I).

33. The military allows people with a history of other medical conditions to enlist even when the condition is currently being managed by medication. Individuals with abnormal menstruation, dysmenorrhea, and endometriosis may enlist if their conditions are adequately managed through hormone medication. *See* DODI 6130.03, Enclosure 4 §§ 14(a), (d), (e). Individuals with Gastro-Esophageal Reflux Disease or high cholesterol may enlist if they are taking medication with no relevant side effects. *Id*. §§ 13(a), 25(i).

34. The Implementation Report asserts that transgender service members receiving cross-sex hormone therapy would risk having their treatment disrupted if they are deployed. But the same concerns about interruptions apply to every service member who is deployed while taking medication. These concerns have not been a barrier to deployment for service members

who require hormones for other medical conditions or who require medications for other mental health conditions that allow for deployment.

35. Military policy also allows service members to take a range of medications, including hormones, while deployed in combat settings. Access to medication is predictable, as "[t]he Military Health Service maintains a sophisticated and effective system for distributing prescription medications to deployed service members worldwide." *See* M. Joycelyn Elders et al., Medical Aspects of Transgender Military Service, 41 Armed Forces & Soc'y 199, 207 (Aug. 2014) (the "Elders Commission Report").

36. Hormone therapy is neither too risky nor too complicated for military medical personnel to administer and monitor. The risks associated with use of cross-sex hormone therapy to treat gender dysphoria are low and not any higher than for the hormones that many non-transgender active duty military personnel currently take. The medications do not have to be refrigerated, and alternatives to injectables are readily available, further simplifying treatment plans. Clinical monitoring for risks and effects is not complicated and, with training and/or access to consultations, can be performed by a variety of medical personnel in the DOD, just as is the case in the VHA. This is the military services' current practice in support of the limited medical needs of their transgender troops in CONUS (Continental United States) and in deployment stations worldwide. Guidance on this issue was provided in January 2017 to military medical providers who care for transgender service members and shows that stable, transitioned troops require only yearly laboratory monitoring for cross-sex hormone treatment (which is consistent with the yearly, routine laboratory health screenings that all active duty troops receive). *See* Exhibit I, WPATH Timeline Guide.

37. Transgender service members—including service members who receive hormone medication—are just as capable of deploying as service members who are not transgender. DOD rules expressly permit deployment, without need for a waiver, for a number of medical conditions that present a much more significant degree of risk in a harsh environment than simply being transgender. For example, hypertension is not disqualifying if controlled by medication, despite the inherent risks in becoming dehydrated in desert deployment situations. Heart attacks experienced while on active duty or treatment with coronary artery bypass grafts are also not disqualifying, if they occur more than a year preceding deployment. These are very serious, life-threatening medical conditions with a high rate of recurrence, yet these service members with cardiac disease are nonetheless allowed to stay on active duty and deploy under prescribed conditions.

38. Under the Department of Defense's generally applicable policies, service members may deploy with certain psychiatric conditions, if they demonstrate stability under treatment for at least three months. *See* DODI 6490.07, Enclosure 3 § h(2); Dep't of Defense, Clinical Practice Guidance for Deployment-Limiting Mental Disorders and Psychotropic Medications (2013). Army regulations specifically provide that "[a] psychiatric condition controlled by medication should not automatically lead to non-deployment." *See* AR 40-501 § 5-14(8)(a).

39. Instead of discussing these medical conditions, the Implementation Report compares cross-sex hormone therapy for gender dysphoria with other medical conditions that are plainly not comparable. For example, the Implementation Report states that "[a]ny DSM-5 psychiatric disorder with residual symptoms or medication side effects, which impair social or occupational performance, require a waiver for the Service member to deploy." Implementation

Report at 34. As I previously explained, gender dysphoria is a treatable and curable condition. With medically appropriate care, it is possible for transgender service members to resolve the clinically significant gender dysphoria without any residual symptoms or impairment. Comparisons made to schizophrenia and bipolar disorder in the Implementation Report are inappropriate, as these two conditions constitute serious mental illnesses for which treatments are often ineffective and for which the notion of "cure" is nonsensical.

40. In any case, the military recently adopted universal deployment standards that already mandate the discharge of service members who are nondeployable "for more than 12 consecutive months, for any reason." Exhibit G, Memorandum for Secretaries of Military Departments, "DoD Retention Policy for Non-Deployable Service Members," February 14, 2018.

SERVICE MEMBERS WHO TRANSITION WHILE IN SERVICE CAN MEET THE SAME RETENTION STANDARDS THAT APPLY TO NON-TRANSGENDER SERVICE MEMBERS

41. Service members who are diagnosed with gender dysphoria after already enlisting can transition while in service and still meet the same retention standards that apply to non-transgender service members. The military has generally applicable standards for determining whether a service member may continue to serve despite periods of limited non-deployability. If a transgender service member's limited period of non-deployability complies with those generally applicable standards, there is no reason why the service member should be automatically discharged simply because they were receiving surgery for gender dysphoria as opposed to a different medical condition. A determination of non-deployability must be based on the status of the individual and not on arbitrary, non-evidence based determinations. There is some evidence that the latter is occurring, based on the widely disparate between-service data

reported on days of limited duty for service members receiving treatment for gender dysphoria as reported by the various services. *See* Exhibit H, USDOE 2633-2664 at 17. This DOD data strongly suggests that non-medical factors are playing an outsized role in determination of days spent in other than full-duty capacities for transgender service members on service-level treatment plans.

42. Although the Implementation Report states that one commander predicted that transgender service members beginning a course of hormone therapy will be non-deployable for as long as two-and-a-half years, the Implementation Report does not cite any data to support that assertion. Implementation Report at 33–34. To the contrary, the presentation of the data states that service members initiating hormone therapy were non-deployable for 3–6 months in the Navy and for an average of 5–6 months in the Army and Air Force. Exhibit H, USDOE 2633-2664 at 17. There is no medical basis for the Implementation Reports suggestion that cross-sex hormone therapy could render a transgender service member non-deployable for a full twelve months. Implementation Report at 23. In fact, expert guidance on this very issue was provided to military medical providers by WPATH in January 2017, as previously noted.

43. There is also no basis to presume that surgical care for gender dysphoria will render transgender service members non-deployable for extended periods of time. The recovery time for non-genital surgeries, which are the most common procedures performed, is only 2–8 weeks. Exhibit H, USDOE 2633-2664 at 19.

44. Moreover, transgender service members can schedule medical procedures to ensure that they do not interfere with deployment. This approach is routinely done for other medically necessary procedures, such as orthopedic surgeries that allow for flexibility in the timing of the surgery. As the Implementation Report acknowledges, "[t]his conclusion was

echoed by some experts in endocrinology who found no harm in stopping or adjusting hormone therapy treatment to accommodate deployment during the first year of hormone use." Implementation Report at 34.

45. To be sure, there may be some transgender service members whose individualized medical needs make it impossible to transition while satisfying the military's generally applicable standards for deployment and retention. But those determinations can and should be made on a case-by-case basis depending on the individual's fitness to serve, as is done with other treatable conditions. There is no medical basis to conclude that all, or even most, service members undergoing treatment for gender dysphoria are categorically unfit to serve.

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

Executed this 11th day of May, 2018

George R. Brown, M.D.

RR

IN THE UNITED STATES DISTRICT COURT FOR THE DISTRICT OF COLUMBIA

DOE, et al., *Plaintiffs*,	)	
v.	)	Civil Action No. 17-cv-1597 (CKK)
DONALD TRUMP, et al., *Defendants*.	)	

DECLARATION OF BRAD R. CARSON IN SUPPORT OF PLAINTIFFS' JOINT OPPOSITION TO MOTION TO DISSOLVE THE PRELIMINARY INJUNCTION

1. I, Brad R. Carson, have been retained by counsel for Plaintiffs as an expert in connection with the above-captioned litigation.

2. My professional background and qualifications are set forth in my previous declaration dated August 28, 2017. *See* Dkt. No. 13-3. A copy of that declaration is attached as Exhibit A.

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

4. The purpose of this supplemental declaration is to respond to the "Department of Defense Report and Recommendations of Military Service By Transgender Persons," which I refer to in this declaration as the "Implementation Report."

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

THE WORKING GROUP'S MANDATE

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

7. Secretary Carter's order directed the Working Group to "start with the presumption that transgender persons can serve openly without adverse impact on military effectiveness and readiness, unless and except where objective practical impediments are identified." Memorandum from Ashton Carter, Secretary of Defense, "Transgender Service Members" (July 28, 2015). That mandate did not mean, as the Implementation Report insinuates, that "standards were adjusted or relaxed to accommodate service by transgender persons." Implementation Report at 19. Rather, instead of simply assuming that the medical needs of transgender service members were inconsistent with generally applicable standards for fitness or deployability, we conducted an evidence-based assessment to determine whether those prior assumptions were actually true.

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

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

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

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

ADHERENCE TO MILITARY STANDARDS AND READINESS

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

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

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

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

FITNESS AND DEPLOYABILITY

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

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

17. Avoiding an increase in the number of non-deployable service members was a priority for the Working Group. This led to the development of a policy on gender transition by

existing service members that minimized any impact on deployability. Under the policy we developed, a service member could not begin a treatment plan for gender transition without prior consultation with his or her commander. The service member was required to work with his or her commander and military medical provider to develop a transition plan that would not impact deployability. Depending on the individual's medical needs and the timing of any planned deployment, this might mean delaying the commencement of hormone replacement therapy or postponing planned surgeries.

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

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

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

21. In addition, the Working Group discussed that while some transgender service members might not be deployable for short periods of time due to their treatment, temporary periods of non-deployability are not unusual. It is common for service members to be non-

deployable for periods of time due to medical conditions such as pregnancy, orthopedic injuries, obstructive sleep apnea, appendicitis, gall bladder disease, infectious disease, and myriad other conditions. The Implementation Report does not provide any indication that the temporary non-deployability of some transgender service members raises unique logistical concerns.

COSTS

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

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

PRIVACY AND UNIT COHESION

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

25. To begin with, for most service members, shower and toilet facilities are a secondary consideration at best compared to the other challenges and demands of military

deployment. In addition, even in relatively harsh conditions, some privacy is usually available in showers and other facilities.

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

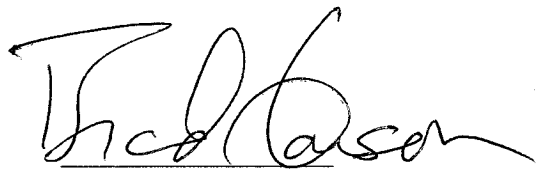
27. Similar concerns about privacy and unit cohesion were raised preceding policy changes permitting open service by gay and lesbian personnel and allowing women to serve in ground combat positions. In both cases, those concerns proved to be unfounded. The Implementation Report offers no evidence that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

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

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

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

Executed this 17th day of April, 2018



Brad R. Carson

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IN THE UNITED STATES DISTRICT COURT FOR THE DISTRICT OF COLUMBIA

DOE, et al.,	)	
	)	
Plaintiffs,	)	
	)	
v.	)	Civil Action No. 17-cv-1597 (CKK)
	)	
DONALD TRUMP, et al.,	)	
	)	
Defendants.	)	

DECLARATION OF JOSHUA D. SAFER, MD, FACP IN SUPPORT OF PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION

I, Joshua D. Safer, declare as follows:

1. I make this declaration based on my own personal knowledge.

PROFESSIONAL BACKGROUND

2. I am a Staff Physician in the Department of Medicine at the Mount Sinai Hospital and Mount Sinai Beth Israel Medical Center in New York, NY. I serve as Executive Director of the Center for Transgender Medicine and Surgery at Mount Sinai. I also hold an academic appointment as Senior Faculty in Mount Sinai's Icahn School of Medicine. A true and correct copy of my CV is attached hereto as Exhibit A.

3. I am Board Certified in Endocrinology, Diabetes and Metabolism by the American Board of Internal Medicine, and I have been since 1997.

4. I graduated from the University of Wisconsin in Madison with a Bachelor of Science in 1986. I earned my Doctor of Medicine degree from the University of Wisconsin in 1990. I completed intern and resident training at Mount Sinai School of Medicine, Beth Israel Medical Center in New York, New York from 1990 to 1993. From 1993 to 1994, I was a Clinical Fellow

in Endocrinology at Harvard Medical School and Beth Israel Deaconess Medical Center in Boston, Massachusetts. I stayed at the same institution, serving as a Clinical and Research Fellow in Endocrinology under Fredric Wondisford, from 1994 to 1996.

5. Since 1997, I have evaluated and treated patients along with conducting research in endocrinology. Since 2004, the patient care and research has been the medicine/science specific to transgender individuals. I have led several other programs either in transgender medicine or in general endocrinology. In particular, I served as Medical Director of the Center for Transgender Medicine and Surgery, Boston Medical Center, Boston, MA (2016-2018); as Director of the Medical Education, Endocrinology Section, Boston University School of Medicine, Boston, MA (2007-2018); as Program Director of the Endocrinology Fellowship Training, Boston University Medical Center, Boston, MA (2007-2018); and as Director of the Thyroid Clinic, Boston Medical Center, Boston, MA (1999-2003).

6. I have authored or coauthored 71 papers in peer-reviewed journals, including many critical reviews; textbook chapters; and case reports in endocrinology and transgender medicine.

7. I have served as a Transgender Medicine Guidelines Drafting Group Member for the International Olympic Committee ("IOC") since 2017.

8. I currently serve as the President of the United States Professional Association for Transgender Health (USPATH). I am also Secretary and Co-Chair of the Steering Committee of TransNet, the International Consortium for Transgender Medicine and Health Research. I have served in several other leadership roles in professional societies related to endocrinology and transgender health. These societies include the Alliance of Academic Internal Medicine, the American College of Physicians Council of Subspecialty Societies, the American Board of

Internal Medicine, the Association of Program Directors in Endocrinology and Metabolism, and the American Thyroid Association.

9. Since 2014, I have held various roles as a member of the World Professional Association for Transgender Health ("WPATH"), the leading international organization focused on transgender health care. WPATH has over 1,000 members throughout the world and is comprised of physicians, psychiatrists, psychologists, social workers, surgeons, and other health professionals who specialize in the diagnosis and treatment of transgender individuals. From 2016 to the present I have served on the Writing Committee for Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People.

10. I have served in various roles as a member of the Endocrine Society since 2014. I served as a Task Force member to develop the Endocrine Treatment of Transgender Persons Clinical Practice Guideline from 2014 to 2017. As part of this task force of nine experts, a methodologist, and a medical writer, I contributed to the "Endocrine Treatment of Gender-Dysphoria/Gender Incongruent Persons: An Endocrine Society Clinical Practice Guideline," ("Endocrine Society Guidelines").[1] These were an update to the "Endocrine Treatment of Transsexual Persons: An Endocrine Society Clinical Practice Guideline," published by the Endocrine Society in 2009.

11. I served in the Wisconsin Army Reserve National Guard from 1987 to 1990 and remained in the Army Reserve until 1995. This service made me sympathetic to the unique needs of servicemembers and reflected my support for the military as an institution. Since then, I

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

have continued to devote a significant part of my career to assisting people in the military and veterans, including from 2001 to 2006 when I served as a Staff Physician at the Veterans Administration Boston Health Care System in Boston, Massachusetts.

CONSULTING FOR THE DEPARTMENT OF DEFENSE WORKING GROUP BEFORE RELEASE OF THE OPEN SERVICE POLICY

12. In 2014 and 2015, the Department of Defense ("DOD") began a review of whether transgender people should be permitted to serve openly in the Armed Forces. In July 2015, then-Secretary of Defense Ashton Carter issued an order establishing a Working Group to carry out the analysis of this issue. It is my understanding that the Working Group met to discuss issues relating to military service by transgender people over the course of about a year, consulting personnel, training, readiness, and medical specialists from across the Department of Defense. The Working Group also consulted civilian medical professionals of which I was one. To assist the Working Group, I went to the Pentagon to advise the Working Group, answered questions from military and civilian leadership, and provided advice on endocrinology and transgender health.

CONSULTING FOR THE DEPARTMENT OF DEFENSE PANEL OF EXPERTS

13. Following his July announcement to the public over Twitter, President Donald Trump released a memorandum ("August 25 Memorandum") containing a formal directive to the current Secretary of Defense, Secretary James N. Mattis, and the Secretary of Homeland Security that, among other things, required the Secretary of Defense, in consultation with the Secretary of Homeland Security, to "submit to [the President] a plan for implementing" the ban on service by transgender people within six months.

14. Secretary Mattis, in turn, set up a process for "developing an Implementation Plan on military service by transgender individuals, in which the Deputy Secretary of Defense and the

Vice Chairman of the Joint Chiefs of Staff would be "supported by a panel of experts." ("Review Panel").

15. I reprised my earlier role as an advisor to the Working Group by serving as one of the outside expert consultants for the Review Panel. On November 9, 2017, Dr. Jillian Shipherd, a Clinical Psychologist and Director of the LGBT Health Program at the Veterans Health Administration; Dr. Loren Schechter, Visiting Clinical Professor of Surgery at the University of Illinois in Chicago and Director of the Center for Gender Confirmation Surgery at Weiss Memorial Hospital in Chicago; and I met with the Review Panel. About 15 to 20 people were present. Some of them were the same people who were on the Working Group conducted under Secretary of Defense Ashton Carter.

A. COSTS

16. After some preliminary discussion, costs of medical care for transgender service members did not appear to be a big concern for the Review Panel because the cost figures associated with transgender military health services were so low relative to the costs of other health conditions and to the overall military health budget.

B. DEPLOYABILITY

17. The Review Panel's main focus was deployability, and in particular, the impact of hormone treatment on deployability. The Review Panel members also wanted information regarding how long an already-serving member of the Armed Forces would have to be on leave, nondeployable, or on limited duty as a result of initiating or being on hormone therapy as part of transgender medical treatment. In response to questions and in discussions, I stated that based on current research, I believe that the initiation of hormone therapy or being on hormone therapy would not prevent a servicemember from carrying out their military duties.

18. Secretary Mattis's February 22 Memorandum to the President cites the Endocrine Society Guidelines that I worked to develop to say that a person needs blood work to be done by a laboratory every 90 days for the first year of hormone therapy.[2] This is a misrepresentation of what my colleagues and I wrote in the Endocrine Society Guidelines. The Endocrine Society Guidelines suggest that clinicians measure hormone levels during treatment to ensure that "administered sex steroids are maintained in the normal physiologic range for the affirmed gender."[3] They also state, "We suggest regular clinical evaluation for physical changes and potential adverse changes in response to sex steroid hormones and laboratory monitoring of sex steroid hormone levels every 3 months during the first year of hormone therapy for transgender males and females and then once or twice yearly."[4]

19. The language we used made clear this was just a *suggestion*, not a requirement. The 3-month schedule is one that facilitates a relatively rapid dose advancement regimen within medically accepted standards. But that is not to say that a slower regimen would be less safe or not medically acceptable.

20. The Guidelines were written to aid endocrinologists in providing care for transgender patients. They do not state mandatory or essential treatment protocols.

21. When it is not practicable to perform quarterly blood work in the first year of hormone therapy, the patient's medication may simply be maintained at the prescribed level. The quarterly blood work is not necessary care. A doctor should check blood work after changing a

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[2] Pages 22 and 33.

[3] Para. 3.3

[4] Para. 4.1.

patient's dose, but if a deployed service member cannot have a doctor check blood work, a patient can be maintained at the last known safe does with no negative health consequences and no impact on readiness.

22. When I met with the Review Panel, I explained that while hormone therapy is necessary medical treatment for some transgender patients, temporarily (even for up to a 12 month deployment period where laboratory monitoring was not available) freezing the level of hormones a service member receives does not risk any provision of inadequate treatment; nor does it pose any medical or mental health risks *per se*.

23. The February 22 Memorandum is not consistent with the statements and recommendations I made when I met with the Review Panel.

24. There is no genuine issue regarding whether hormones can be taken into the field just as other medications are. Hormone therapies do not generally require special care or treatment such as refrigeration. There are versions that are stable and transportable.

25. A person receiving hormone therapy is in a steady state with hormones within weeks. There are no negative mental health consequences associated with not changing those levels for an extended period of time once a person's levels are in steady state.

26. The February 22 Memorandum states that "the available information indicates that there is inconclusive scientific evidence that the serious problems associated with gender dysphoria can be fully remedied through transition-related treatment and that, even if it could, most persons requiring transition-related treatment could be non-deployable for a potentially significant amount of time."[5] As an expert in the field of endocrinology and transgender health, I

[5] Page 35.

do not agree with this statement. My remarks to the Review Panel are not consistent with that conclusion.

C. LETHALITY

27. The Review Panel was also interested in lethality. I believe, and so stated, that there is no known correlation between hormone levels and lethality.

CONCLUSION

28. The February 22 Memorandum does not reflect the recommendations that I made to the Review Panel. As an expert qualified in the field of endocrinology and transgender health, it is my opinion that the February 22 Memorandum does not reflect the established scientific literature in this area. Based on my understanding of current data, statements that transgender people will be limited in their readiness to deploy based on hormone therapy needs are incorrect.

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

DATED: April 30, 2018

/s/
Joshua D. Safer, M.D.

EXHIBIT A

CURRICULUM VITAE

Joshua D. Safer, MD, FACP
March 1, 2018
Office Address: 17 E. 102nd Street, Room D-240
New York, NY 10128
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Academic Training

1990 MD	University of Wisconsin School of Medicine, Madison, WI
1986 BS	University of Wisconsin, Madison, WI, Economics

Postdoctoral Training

1994-1996	Clinical and Research Fellow, Endocrinology, under Fredric Wondisford, Harvard Medical School and Beth Israel Deaconess Medical Center, Boston, MA
1993-1994	Clinical Fellow, Endocrinology, Harvard Medical School and Beth Israel Deaconess Medical Center, Boston, MA
1990-1993	Intern and Resident, Department of Medicine, The Mount Sinai School of Medicine, Beth Israel Medical Center, New York City, NY

Academic Appointments

2018-present	Senior Faculty, Icahn School of Medicine at Mount Sinai, New York, NY
2006-2018	Associate Professor of Medicine and Molecular Medicine, Boston University School of Medicine
1999-2006	Assistant Professor of Medicine, Boston University School of Medicine
1996-1999	Instructor in Medicine, Harvard Medical School
1993-1996	Fellow in Medicine, Harvard Medical School

Hospital Appointments

2018-present	Staff Physician, Department of Medicine, The Mount Sinai Hospital, New York City, NY
2018-present	Staff Physician, Department of Medicine, Mount Sinai Beth Israel Medical Center, New York City, NY
1999-2018	Staff Physician, Department of Medicine, Boston University Medical Center, Boston, MA
2001-2006	Staff Physician, Veterans Administration Boston Health Care System, Boston, MA
1996-1999	Staff Physician, Department of Medicine, Beth Israel Deaconess Medical Center, Boston, MA
1990-1993	House Staff, Department of Medicine, Beth Israel Medical Center, New York City, NY

Other Medical Staff Appointments

2004-2013	Staff Physician, Massachusetts Institute of Technology Medical Center, Cambridge, MA
1994-1999	Physician, Adult Urgent Care, Harvard Vanguard Medical A1ssociates, Boston, MA
1987-1996	Captain, United States Army Reserve, Medical Corps

Honors:

2017	Lesbian, Gay, Bisexual and Transgender Health Award, Massachusetts Medical Society
2012	Outstanding Service Award, Association of Program Directors in Endocrinology and Metabolism
2007	Fellow, American College of Physicians
2004	Boston University School of Medicine Outstanding Student Mentor Award
2001	Abbott Thyroid Research Advisory Council Award
1996	Knoll Thyroid Research Clinical Fellowship Award, Endocrine Society
1995	Trainee Investigator Award for Excellence in Scientific Research, American Federation for Clinical Research (AFCR)
1994	Trainee Investigator Award for Excellence in Scientific Research, AFCR
1990	The University of Wisconsin Medical Alumni Association Award
1988-1990	Senior Class President, University of Wisconsin, School of Medicine

Licensure and Certification

1997	Board Certification in Endocrinology, Diabetes and Metabolism, American Board of Internal Medicine, recertified 2007, 2017
1994	Board Certification in Internal Medicine, American Board of Internal Medicine, recertified 2007
1993	MA License Registration #77459
1990	New York License Registration #187263-1

Departmental and University Committees

Boston Medical Center

2016-2018	Physician Satisfaction Task Force, Department of Medicine
2016-2018	Transgender Patient Task Force
2006-2017	Pharmacy and Therapeutics Committee, Health Net Plan

Boston University School of Medicine

2009-2018	Admissions Committee
2005	Review Committee, Department of Medicine Pilot Project Grants
2000	Residency and Fellowship Core Curriculum Committee,
2000-2018	Internship Selection Committee, Residency Program in Medicine

Boston University Goldman School of Dental Medicine

2003-2018	Course Directors Committee, Goldman School of Dental Medicine

Teaching Experience and Responsibilities

Tufts University School of Medicine

2016-2018	Lecturer in Endocrinology, Second-year Pathophysiology Course

Boston University School of Medicine

2003-2018	Course Director, Disease and Therapy - Endocrinology Section
1999-2018	Regular lectures to medical students, residents, and fellows on thyroid disease, diabetes insipidus, and transgender medicine

Boston University Goldman School of Dental Medicine

2002-2018	Course Director, General Medicine and Dental Correlations
2002-2018	Course Director, Medical Concerns in the Dental Patient

Major Mentoring Activities

Physician Career/Peer Advising

Year	Mentee	Most Recent Title
1995-present	**Cohen, Ron, MD** Ongoing career guidance	▪ Associate Professor of Medicine and Interim Chief, Division of Endocrinology, University of Chicago School of Medicine
1999-present	**Tangpricha, Vin, MD, PhD** Ongoing career guidance	▪ Associate Professor of Medicine and Program Director, Endocrinology Fellowship, Emory University School of Medicine
2003-present	**McDonnell, Marie, MD** Ongoing career guidance	▪ Director, Inpatient Diabetes Service, Brigham and Women's Hospital
2003-present	**Arum, Seth, MD** Ongoing career guidance.	▪ Faculty, Endocrinology Section, University of Massachusetts Medical Center
2004-present	**Ananthakrishnan, Sonia, MD** Ongoing career guidance	▪ Evans Educator, Endocrinology Section, Boston University Medical Center
2007-present	**Vimalananda, Varsha, MD** Ongoing career guidance	▪ Faculty, Endocrinology Section, Boston University Medical Center and Boston VA Hospital
2008-present	**Port, Ava, MD** Ongoing career guidance	▪ Faculty, Endocrinology Section, University of Maryland Medical Center
2009-2013	**Choong, Karen, MD** Ongoing career guidance	▪ Private Practice, MA
2009-2010	**Kannan, Subramanian, MD** Ongoing career guidance	▪ Completed Endocrinology Fellowship Cleveland Clinic
2010-present	**Spitzer, Matthew, MD** Ongoing career guidance	▪ Private Practice, Amherst, MA
2011-present	**Steenkamp, Devin, MD** Ongoing career guidance	▪ Faculty, Endocrinology Section, Boston University Medical Center
2014-present	**Thomas, Dylan, MD** Ongoing career guidance	▪ Endocrinology Fellow, Department of Medicine, Boston University Medical Center
2017-present	**Korpaisarn, Sira, MD** Ongoing career guidance	▪ Endocrinology Fellow, Department of Medicine, Boston University Medical Center

Student Research Mentor and/or Thesis Advisor

Year	Mentee	Most Recent Title
1996-1997	**Martin, Andrew** Used DNA manipulation and tissue culture techniques to analyze *in vitro* functional impact of thyroid hormone resistance mutations.	▪ Matriculated University of Virginia September, 1997
1998	**Wong, Jenny** Used DNA manipulation and tissue culture techniques to analyze *in vitro* functional impact of thyroid hormone resistance mutations.	▪ Matriculated Harvard College September, 1998
1998	**Song, Hyang Yeon** Used DNA manipulation and tissue culture techniques to analyze *in vitro* functional impact of thyroid hormone resistance mutations.	▪ Graduated Mount Holyoke College
1999-2001	**Fraser, Lisa** Used DNA manipulation and tissue culture techniques to analyze *in vitro* functional impact of thyroid hormone resistance mutations. Learned and performed tissue culture assays in order to assess thyroid hormone action on skin cell lines. Assisted in design and implementation of experiments to assess thyroid hormone action on the skin of animals.	▪ Working in biotechnology
2000	**Hoa, Michael** Learned and performed tissue culture assays in order to assess thyroid hormone action on skin cell lines. Assisted in design and implementation of experiments to assess thyroid hormone action on the skin of animals.	▪ Matriculated Boston University School of Medicine September, 2000
2001-2004	**Crawford, Tara** Learned and performed tissue culture/gene expression/protein expression assays in order to assess thyroid hormone action on skin cell lines. Assisted in design and implementation of experiments to assess thyroid hormone action on the skin of animals.	▪ Works in recruitment for Ross Medical School
2003-2004	**Vaghasia, Pramil** Learned and performed tissue culture/gene expression/protein expression assays in order to assess thyroid hormone action on skin cell lines	▪ Graduated Boston University, 2004
2003	**Ladhani, Anil** Learned and performed tissue culture/gene expression/protein expression assays in order to assess thyroid hormone action on skin cell lines.	▪ Graduated Boston University, 2004
2003	**Belardo, Sheila** Learned and performed tissue culture/gene expression/protein expression assays in order to assess thyroid hormone action on skin cell lines.	▪ Graduated Boston University, 2005

Year	Mentee	Most Recent Title
2004	**Mohan, Shaulnie** Learned and performed tissue culture/gene expression/protein expression assays in order to assess thyroid hormone action on skin cell lines.	▪ Graduated Boston University, 2005; matriculated Boston University School of Medicine
2004	**Patel, Nathan** Learned and performed tissue culture/gene expression/protein expression assays in order to assess thyroid hormone action on skin cell lines.	▪ Graduated Boston University, 2005
2004	**Sharma, Aman** Learned and performed tissue culture/gene expression/protein expression assays in order to assess thyroid hormone action on skin cell lines.	▪ Graduated Boston University, 2005; matriculated SUNY-Downstate School of Medicine
2006-2007	**Holland (now Rogers), Kathryn** Learned and performed tissue culture/gene expression/protein expression assays in order to assess thyroid hormone action on skin cell lines. Assisted in design and implementation of experiments to assess thyroid hormone action on the skin of animals. Learned and performed in vivo methodologies with mice. Coauthored a publication from the data.	▪ Graduated Boston University, 2005; working as a school teacher
2006-2008	**Huang, Max** Learned and performed tissue culture/gene expression/protein expression assays in order to assess thyroid hormone action on skin cell lines. Assisted in design and implementation of experiments to assess thyroid hormone action on the skin of animals. Learned and performed in vivo methodologies with mice. First authored a poster presented at a national meeting. First authored a publication from the data.	▪ MS from Boston University; matriculated medical school
2006-2008	**Mehta, Meetal** Learned and performed tissue culture/gene expression/protein expression assays in order to assess thyroid hormone action on skin cell lines. Coauthored a publication from the data.	▪ MS from Boston University; matriculated medical school
2006-2007	**O'Mara, Rosemary** Learned and performed tissue culture/gene expression/protein expression assays in order to assess thyroid hormone action on skin cell lines. Assisted in design and implementation of experiments to assess thyroid hormone action on the skin of animals. Learned and performed in vivo methodologies with mice. Coauthored a publication from the data.	▪ BA from Boston University

Year	Mentee	Most Recent Title
2007	**Abuzahra, Hilal** Assisted in design and implementation of experiments to assess thyroid hormone action on the skin of animals. Learned and performed in vivo methodologies with mice. Coauthored a publication from the data.	▪ MS from Boston University; matriculated Boston University School of Medicine
2007	**Tannenbaum, Andrew** Assisted in design and implementation of experiments to assess thyroid hormone action on the skin of animals. Learned and performed in vivo methodologies with mice. Coauthored a publication from the data.	▪ MS from Boston University; matriculated Boston University School of Medicine
2007-2008	**Yoo, David** Learned and performed tissue culture/gene expression/protein expression assays in order to assess thyroid hormone action on skin cell lines.	▪ MS from Boston University
2007-2008	**Pagano, Joe** Learned and performed tissue culture/gene expression/protein expression assays in order to assess thyroid hormone action on skin cell lines.	▪ MS from Boston University
2007-2009	**Bhakit, Mena** Learned and performed tissue culture/gene expression/protein expression assays in order to assess thyroid hormone action on skin cell lines. Assisted in design and implementation of experiments to assess thyroid hormone action on the skin of animals. Learned and performed in vivo methodologies with mice. Coauthored a publication from the data.	▪ MS from Boston University; matriculated medical school
2007-2008	**Chan, Yvonne** Learned and performed tissue culture/gene expression/protein expression assays in order to assess thyroid hormone action on skin cell lines.	▪ MS from Boston University; matriculated graduate school
2007-2008	**Lee, Monica** Learned and performed tissue culture/gene expression/protein expression assays in order to assess thyroid hormone action on skin cell lines.	▪ MS from Boston University
2007-2008	**Grasso, Victoria** Learned and performed tissue culture/gene expression/protein expression assays in order to assess thyroid hormone action on skin cell lines.	▪ MS from Boston University
2007-2008	**Bokhari, Matthew** Learned and performed tissue culture/gene expression/protein expression assays in order to assess thyroid hormone action on skin cell lines.	▪ BA from Boston University

Year	Mentee	Most Recent Title
2008-2010	**Watto, Matthew** Career guidance.	▪ Matriculated Temple University Internal Medicine Residency Program
2008-2011	**Agee, Erin** Master's Thesis Advisor. Learned and performed tissue culture/gene expression/protein expression assays in order to assess thyroid hormone action on skin cell lines.	▪ MS from Boston University
2009-2010	**Wang, Yun** Master's Research and Thesis Advisor. Learned and performed tissue culture/gene expression/protein expression assays in order to assess thyroid hormone action on skin cell lines.	▪ MS from Boston University
2009-2011	**Nishtala, Arvind** Research Advisor. Learned and performed tissue culture/gene expression/protein expression assays in order to assess thyroid hormone action on skin cell lines.	▪ Matriculated Medical School, Boston University
2009-2010	**Chen, Bridgett** Master's Research Project and Thesis Advisor. Learned and performed tissue culture/gene expression/protein expression assays in order to assess thyroid hormone action on skin cell lines.	▪ Matriculated Medical School, Albany Medical College
2009	**Esochaghi, Sorochi** Master's Research Project and Thesis Advisor. Learned and performed tissue culture/gene expression/protein expression assays in order to assess thyroid hormone action on skin cell lines.	▪ MS from Boston University
2009-2011	**Kim, Kyeonghee** Master's Research and Thesis Advisor. Learned and performed tissue culture/gene expression/protein expression assays in order to assess thyroid hormone action on skin cell lines.	▪ MS from Boston University
2010-2011	**Faruqi, Adnan** Master's Research Project and Thesis Advisor. Learned and performed tissue culture/gene expression/protein expression assays in order to assess thyroid hormone action on skin cell lines.	▪ MS from Boston University
2010-2011	**Fink, Kyle** Master's Research Project and Thesis Advisor. Learned and performed tissue culture/gene expression/protein expression assays in order to assess thyroid hormone action on skin cell lines.	▪ Matriculated Medical School at New York Medical College

Year	Mentee	Most Recent Title
2010-2011	**Heath, Alyson** Master's Thesis Advisor. Learned and performed tissue culture/gene expression/protein expression assays in order to assess thyroid hormone action on skin cell lines.	▪ MS from Boston University
2010-2011	**Mouchati, Alex** Master's Research and Thesis Advisor. Learned and performed tissue culture/gene expression/protein expression assays in order to assess thyroid hormone action on skin cell lines. First authored an abstract at a local meeting.	▪ MS from Boston University
2010-2011	**Porter, Drew** Learned and performed tissue culture/gene expression/protein expression assays in order to assess thyroid hormone action on skin cell lines.	▪ BS from Boston University
2010	**Rosenbaum, Lucy** Learned and performed tissue culture/gene expression/protein expression assays in order to assess thyroid hormone action on skin cell lines.	▪ Matriculated Boston University School of Medicine
2011-2012	**Stratton, Michael** Master's Research and Thesis Advisor. Learned and performed tissue culture/gene expression/protein expression assays in order to assess thyroid hormone action on skin cell lines.	▪ Matriculated Boston University School of Medicine
2011-2012	**Feeley, Brigid** Master's Research and Thesis Advisor. Learned and performed tissue culture/gene expression/protein expression assays in order to assess thyroid hormone action on skin cell lines.	▪ MS from Boston University
2011-2012	**Gonzales, Christopher** Master's Research and Thesis Advisor. Learned and performed tissue culture/gene expression/protein expression assays in order to assess thyroid hormone action on skin cell lines.	▪ MS from Boston University
2011-2012	**Mahmood, Sundis** Master's Research and Thesis Advisor. Learned and performed tissue culture/gene expression/protein expression assays in order to assess thyroid hormone action on skin cell lines.	▪ MS from Boston University

Year	Mentee	Most Recent Title
2011-2012	**Berman, Reena** Research and undergraduate thesis advisor. Assisted in design and implementation of experiments to assess thyroid hormone action on the skin of animals. Learned and performed in vivo methodologies with mice. First authored a poster presentation at a local meeting from the data.	▪ BA from Boston University
2011-2012	**Dwivedi, Sashank** Research advisor. Learned and performed tissue culture/gene expression/protein expression assays in order to assess thyroid hormone action on skin cell lines.	▪ BA from Boston University
2012-2013	**Carey, Katelyn** Learned and performed tissue culture/gene expression/protein expression assays in order to assess thyroid hormone action on skin cell lines.	▪ MS from Boston University
2012-2013	**Moroney, James** Learned and performed tissue culture/gene expression/protein expression assays in order to assess thyroid hormone action on skin cell lines.	▪ MS from Boston University
2012-2013	**Sayeed, Sabina** Learned and performed tissue culture/gene expression/protein expression assays in order to assess thyroid hormone action on skin cell lines.	▪ MS from Boston University
2012-present	**Meyers, Steven** Developed and analyzed clinical data sets for quality projects and research projects in Transgender Medicine. First author of two publications.	▪ BS from Hampshire College
2012-present	**Gardner, Ivy** Learned and performed tissue culture/gene expression/protein expression assays in order to assess androgen action on endometrial cell lines. First author of data presented at two meetings. First author of publication.	▪ MD from Boston University; matriculated general surgery residency
2012-2013	**Bonzagni, Anthony** Developed and analyzed data for research projects in Transgender Medicine.	▪ MS from Boston University
2012-2014	**Ma, Peter** Developed and analyzed data for research projects in Transgender Medicine.	▪ BS from Boston University
2013-present	**Fong, Elias** Developed and analyzed data for research projects in Transgender Medicine.	▪ BS from Boston University

Year	Mentee	Most Recent Title
2013-present	**Weinand, Jamie** Developed and analyzed data for research projects in Transgender Medicine. First author of data presented at two meetings. First author of publication.	▪ MD from Boston University; matriculated family medicine residency
2014-present	**Eriksson, Sven** Developed and analyzed data for research projects in Transgender Medicine. First author of publication.	▪ MS from Boston University; matriculated medical school
2015-present	**Liang, Jennifer** Developed and analyzed data for research projects in Transgender Medicine. First author of two publications	▪ Medical Student at Boston University
2015-present	**Lu, Simon** Developed and analyzed data for research projects in Transgender Medicine. Publication co-author	▪ MD from Boston University; matriculated obstetrics-gynecology residency
2015-present	**Qian, Ray** Developed and analyzed data for research projects in Transgender Medicine. First author of publication.	▪ Medical Resident at Boston University Medical Center
2016-present	**Kailas, Maya** Developed and analyzed data for research projects in Transgender Medicine. First author of publication.	▪ Medical Student at Boston University
2016-present	**Jolly, Divya** Developed and analyzed data for research projects in Transgender Medicine. Manuscript in progress	▪ Medical Anthropology Graduate Student at Boston University
2016-present	**Chan, Kelly** Developed and analyzed data for research projects in Transgender Medicine. Manuscript in progress	▪ Masters Student at Harvard University
2017-present	**Park, Jason** Developed and analyzed data for research projects in Transgender Medicine. Manuscript in progress	▪ Medical Student at Boston University
2017-present	**Bisson, Jason** Developed and analyzed data for research projects in Transgender Medicine. Manuscript in progress	▪ College Student at Northeastern University

Major Administrative Responsibilities

2018-present	Executive Director, Center for Transgender Medicine and Surgery, Mount Sinai Health System, New York City, NY
2016-2018	Medical Director, Center for Transgender Medicine and Surgery, Boston Medical Center, Boston, MA
2007-2018	Director, Medical Education, Endocrinology Section, Boston University School of Medicine, Boston, MA
2007-2018	Program Director, Endocrinology Fellowship Training, Boston University Medical Center, Boston, MA
1999-2003	Director, Thyroid Clinic, Boston Medical Center, Boston, MA

Other Professional Activities

Professional Societies: Memberships

2016-present	United States Professional Association for Transgender Health (USPATH)
2014-present	World Professional Association for Transgender Health (WPATH)
2007-present	Association of Program Directors in Endocrinology and Metabolism (APDEM)
2007-present	Association of Specialty Professors (ASP), Alliance of Academic Internal Medicine (AAIM)
1999-present	American Association of Clinical Endocrinologists
1998-present	American Thyroid Association
1995-present	Endocrine Society
1994-present	American College of Physicians
1994-1996	American Federation for Medical Research
1993-present	MA Medical Society

Professional Societies: Offices Held and Committee Assignments

International

International Olympic Committee (IOC)

2017-present	Drafting Group Member, Medical Guidelines, International Olympic Committee

World Professional Association for Transgender Health (WPATH)

2016-present	Writing Committee Member, Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People
2016-present	Co-Chair, Scientific Committee, International Meeting, Buenos Aires - 2018
2015-2016	Chair, Scientific Committee, International Meeting, Amsterdam - 2016
2015-present	Task Force Member, Global Education Initiative
2015-present	Media Liaison

TransNet – International Consortium for Transgender Medicine and Health Research

2014-present	Secretary and Co-Chair, Steering Committee

National

United States Professional Association for Transgender Health (USPATH)
2018-present President

Alliance of Academic Internal Medicine
2016-present Chair, Compliance Committee
2016-2017 Committee member, Compensation
2015-2016 President, Association of Specialty Professors (ASP)
2014-2017 Council member
2014-present Task Force member, Program Planning
2014-present Work Group member, Survey Center
2013-2015 Chair, Program Planning Committee, ASP
2012-2017 Council member, ASP
2012-2013 Chair, Membership Services Committee, ASP
2010-2015 Chair, Program Directors Site Visit Training Seminar, ASP
2007-2013 Committee member, Membership Services, ASP

American College of Physicians
2016-present Council of Subspecialty Societies member

Endocrine Society
2017-present Advisory Board member, Transgender/Disorders of Sex Development
2017-present Committee member, Clinical Endocrine Education
2014-present Media Liaison for Transgender Medicine
2014-2017 Task Force member, Endocrine Treatment of Transgender Persons Clinical Practice Guideline

American Board of Internal Medicine
2013-present Task Force member, Endocrinology Procedures
2013 Task Force member, ASP/AAIM/ACGME/ABIM Joint Next Accreditation System Internal Medicine Subspecialty Milestones

Association of Program Directors in Endocrinology and Metabolism
2017-present Secretary-Treasurer
2012-present Task Force member, Next Accreditation System Endocrinology Milestones
2011-2012 Task Force member, Procedures Accreditation
2010-2012 Council member
2009-2016 Chair, Site Visit/Curriculum Web-Toolbox Committee

American Thyroid Association
2006-2009 Publications Committee member
2004 Program Committee member

Editorships and Editorial Boards

2018-present Associate Editor, *Transgender Health*
2017-present Editorial Advisory Board, *Endocrine News*

2016-present	Transgender Section Co-Editor, *UpToDate*
2015-present	Editorial Board, *Transgender Health*
2015-present	Editorial Board, *International Journal of Transgenderism*
2013-present	Associate Editor, *Journal of Clinical & Translational Endocrinology*
2007-present	Editorial Board, *Endocrine Practice*

External Medical Advising and Consulting

International

2016-present	International transgender athlete guidelines, Medical and Scientific Commission, International Olympic Committee

National

2017-present	Transgender medical and surgical treatment, National Collegiate Athletic Association,
2017-present	Safety for transgender medical treatment, Food and Drug Administration, United States
2015-present	Transgender workforce and military readiness, Department of Defense, United States
2014	Transgender prison population health, Federal Bureau of Prisons, United States

Regional

2011-present	Transgender prison population health, Massachusetts Department of Correction

Past Other Support

2015-2016	R13 HD084267, **Multi-PI: Joshua D. Safer**, TransNet: Developing a Research Agenda in Transgender Health and Medicine
2014-2015	Boston Foundation, Equality Fund, **PI: Joshua D. Safer**, Pilot Program to Educate Physicians in Transgender Medicine
2013-2014	Evans Foundation, **PI: Joshua D. Safer**, A Pilot Curriculum in Transgender Medicine
2001-2003	Thyroid Research Advisory Council, **PI: Joshua D. Safer**, Thyroid Hormone Action on Skin
2001-2002	Evans Foundation, **PI: Joshua D. Safer**, Thyroid Hormone Action on Skin
1996-2001	K08 DK02423, **PI: Joshua D. Safer**, Characterization of Central Resistance to Thyroid Hormone

Conferences Organized

International Conferences

World Professional Association for Transgender Health (WPATH)

June, 2018 Bi-annual meeting, Scientific Co-Chair, Buenos Aires, Argentina (scheduled)

June, 2016 Bi-annual meeting, Scientific Co-Chair, Amsterdam, Netherlands

November, 2015 Global Education Initiative, inaugural conference, Chicago, IL

TransNet – International Consortium for Transgender Health and Medicine Research

May, 2016 International meeting to set transgender medicine research priorities, Amsterdam, Netherlands

May, 2015 NIH conference to set transgender medicine research priorities, Bethesda, MD

June, 2014 Inaugural meeting, Chicago, IL

National Conferences

April, 2018 Live Surgery Course for Gender Affirmation Procedures, Mount Sinai Hospital and WPATH, New York City, NY (scheduled)

January, 2017 United States Professional Association for Transgender Health (USPATH) bi-annual meeting, Los Angeles, CA

November, 2015 NIH/Alliance for Academic Internal Medicine - Physician Researcher Workforce Taskforce Meeting, Washington, DC

October, 2015 National Internal Medicine Subspecialty Summit, Atlanta, GA

June, 2013 Special Symposium: "Transgender Medicine – What Every Physician Should Know" Annual Meeting of the Endocrine Society, San Francisco, CA

April, 2011 2011 ASP Accreditation Seminar "Meeting the ACGME and RRC-IM Standards for Successful Fellowship Programs" Arlington, VA

Alliance for Academic Internal Medicine

April, 2015 2015 ASP Accreditation Seminar "Moving Your Fellowship Program Forward" Spring Meeting, Houston, TX

April, 2014 2014 ASP Accreditation Seminar "NAS for Medical Subspecialties Is Almost Here" Spring Meeting, Nashville, TN

May, 2013 2013 ASP Accreditation Seminar "A Changing Landscape in Subspecialty Fellowship Education" Spring Meeting, Lake Buena Vista, FL

April, 2012 2012 ASP Accreditation Seminar "Meeting ACGME and RRC-IM Standards for Successful Fellowship Programs" Spring Meeting, Atlanta, GA

Invited Lectures and Presentations

International

February, 2017 "A 21st-Century Framework to for Transgender Medical Care" Sheba Hospital, Tel Aviv, Israel

October, 2016 "A 21st-Century Approach to Hormone Treatment of Transgender Individuals" EndoBridge, Antalya, Turkey

May, 2016 "Transgender Women" International Olympic Committee Headquarters, Lausanne, Switzerland

October, 2015 "Workshop on Guidelines for Transgender Health Care" Canadian Professional Association for Transgender Health, Halifax, NS

March, 2015 "Endocrinology - Hormone Induced Changes" Transgender Health Care in Europe, European Professional Association for Transgender Health, Ghent, Belgium

June, 2014 "What to Know to Feel Safe Providing Hormone Therapy for Transgender Patients" International Congress of Endocrinology, Chicago, IL

September, 2011 "Transgender Therapy – The Endocrine Society Guidelines" World Professional Association for Transgender Health, Atlanta, GA

February, 2007 "Treating skin disease by manipulating thyroid hormone action" Grand Rounds, Meier Hospital, Kfar Saba, Israel

March, 2004 "New Directions in Thyroid Hormone Action: Skin and Hair" Grand Rounds, Meier Hospital, Kfar Saba, Israel

National

October, 2018 "Transgender Therapy – The Endocrine Society Guidelines" Endocrine Society: Clinical Endocrinology Update, Anaheim, CA

September, 2018 "Transgender Therapy – The Endocrine Society Guidelines" Endocrine Society: Clinical Endocrinology Update, Miami, FL

September, 2018 "Current Guidelines and Strategy for Hormone Treatment of Transgender Individuals" Minnesota-Midwest Chapter - American Association of Clinical Endocrinologists Annual Meeting, Minneapolis, MN (scheduled)

July, 2018 "Current Guidelines and Strategy for Hormone Treatment of Transgender Individuals" Upper Ohio Valley Chapter - American Association of Clinical Endocrinologists Annual Meeting, Indianapolis, IN (scheduled)

May, 2018 "A 21st-Century Strategy for Hormone Treatment of Transgender Individuals" American Association of Clinical Endocrinologists Annual Meeting, Boston, MA (scheduled)

March, 2018 "21st-Century Strategies for Transgender Hormone Care" New Jersey Chapter - American Association of Clinical Endocrinologists Meeting, Morristown, NJ

February, 2018 "A Strategy for the Medical Care of Transgender Individuals" Keynote Address for the International Society for Clinical Densitometry Annual Meeting, Boston, MA

November, 2017 "A 21st-Century Strategy for Hormone Treatment of Transgender Individuals" National Transgender Health Summit, Oakland, CA

September, 2017 "Transgender Therapy – The Endocrine Society Guidelines" Endocrine Society: Clinical Endocrinology Update, Chicago, IL

May, 2017 "Transgender Medicine – a 21st Century Strategy for Patient Care" University of Arizona College of Medicine, Tucson, AR

April, 2017 "Transgender Care Across the Age Continuum" Annual Meeting of the Endocrine Society, Orlando, FL

March, 2017 "A 21st-Century Approach to Hormone Treatment of Transgender Individuals" Brown University School of Medicine, Providence, RI

March, 2017 "What to Know: A 21st-Century Approach to Transgender Medical Care" United States Food and Drug Administration (FDA), Washington, DC

February, 2017 "A 21st-Century Approach to Transgender Medical Care" United States Professional Association for Transgender Health, Los Angeles, CA

February, 2017 "A 21st-Century Approach to Hormone Treatment of Transgender Individuals" Southern States American Association of Clinical Endocrinologists Annual Meeting, Memphis, TN

December, 2016 "Transgender Medical Care in the United States Armed Forces" Global Education Initiative, World Professional Association for Transgender Health, Arlington, VA

December, 2016 "Foundations in Hormone Treatment" Global Education Initiative, World Professional Association for Transgender Health, Arlington, VA

November, 2016 "Developing a Transgender/Gender-Identity Curriculum for Medical Students" Association of American Medical Colleges National Meeting, Seattle, WA

September, 2016 "A 21st-Century Approach to Hormone Treatment of Transgender Individuals" Endocrine Society: Clinical Endocrinology Update, Seattle, WA

August, 2016 "A 21st-Century Approach to Hormone Treatment of Transgender Individuals" Oregon Health and Science University Ashland Endocrine Conference, Ashland, OR

March, 2016 "State-of-the-Art: Use of Hormones in Transgender Individuals" Annual Meeting of the Endocrine Society, Boston, MA

October, 2015 "What Every Endocrinologist Should Know to Feel Safe Providing Hormone Therapy for Transgender Patients" University of Utah School of Medicine, Salt Lake City, UT

April, 2015 "What to Know –to Feel Safe Providing Hormone Therapy for Transgender Patients" Pritzker School of Medicine, University of Chicago, Chicago, IL

March, 2015 "What to Know –to Feel Safe with Hormone Therapy for Transgender Patients" Annual Transgender Health Symposium, Medical College of Wisconsin, Milwaukee, WI

May, 2014 "Transgendocrinology" Annual Meeting of the American Association of Clinical Endocrinologists, Las Vegas, NV

May, 2013 "Transgender Therapy – Hormone Action and Nuance" National Transgender Health Summit, Oakland, CA

April, 2013 "Transgender Therapy – What Every Provider Needs to Know" Empire Conference: Transgender Health and Wellness, Albany, NY

April, 2013 "Transgender Therapy – What Every Endocrinologist Needs to Know" University of Maryland School of Medicine, Baltimore, MD

November, 2012 "Transgender Therapy – What Every Endocrinologist Should Know" New York University School of Medicine, New York, NY

May, 2010 "Transgender Treatment: What Every Endocrinologist Needs to Know" Brown University School of Medicine, Providence, RI

November, 2009 "New Directions in Thyroid Hormone Action: Skin and Hair" Emory University School of Medicine, Atlanta, GA

November, 2009 "Primary Care Update in the Treatment of Thyroid Disorders" Emory University School of Medicine, Atlanta, GA

October, 2008 "Topical Iopanoic Acid Stimulates Epidermal Proliferation through Inhibition of the Type 3 Thyroid Hormone Deiodinase" Annual Meeting of the American Thyroid Association, Chicago, IL

February, 2005 "New Directions in Thyroid Hormone Action: Skin and Hair" Endocrinology Grand Rounds, University of Minnesota, Minneapolis, MN

February, 2005 "Thyroid Hormone Action on Skin and Hair: What We Thought We Knew" Dermatology Grand Rounds, University of Minnesota, Minneapolis, MN

December, 2004 "Transgender Therapy: The Role of the Endocrinologist" Endocrinology Grand Rounds, Brown Medical Center, Providence, RI

November, 2003 "New Directions in Thyroid Hormone Action: Skin and Hair" Endocrinology Grand Rounds, Dartmouth Medical Center, Hanover, NH

Regional

February, 2018 "Transgender Medicine – 21st Century Strategies for Patient Care" Medicine Rounds, Newton-Wellesley Hospital, Newton, MA (scheduled)

October, 2017 "Transgender Medicine – 21st Century Strategies for Patient Care" Medicine Rounds, Beth Israel-Milton Hospital, Milton, MA

September, 2017 "Transgender Medicine – 21st Century Strategies for Patient Care" Obstetrics-Gynecology Grand Rounds, Brigham and Women's Hospital, Boston, MA

June, 2017 "State-of-the-Art: Hormone Therapy for Transgender Patients" Reproductive Endocrinology Rounds, Massachusetts General Hospital, Boston, MA

May, 2017 "A 21st-Century Strategy for Medical Treatment of Transgender Individuals" Boston Medical Center and Boston University School of Medicine, Boston, MA

March, 2017 "A 21st-Century Strategy for Medical Treatment of Transgender Individuals" Tufts Medicine Grand Rounds, Boston, MA

January, 2017 "What to Know: A 21st-Century Approach to Transgender Medical Care" Internal Medicine Rounds, Brigham and Women's Hospital, Boston, MA

March, 2016 "State-of-the-Art: Hormone Therapy for Transgender Patients" Obstetrics-Gynecology Rounds, Brigham and Women's Hospital, Boston, MA

November, 2015 "What Every Endocrinologist Should Know to Feel Safe Providing Hormone Therapy for Transgender Patients" Endocrinology Rounds, Tufts Medical Center, Boston, MA

May, 2015 "What Every Endocrinologist Should Know to Feel Safe Providing Hormone Therapy for Transgender Patients" Endocrinology Rounds, Massachusetts General Hospital, Boston, MA

December, 2014 "What to Know to Feel Safe Providing Hormone Therapy for Transgender Patients" Endocrinology Rounds, Beth Israel Deaconess Medical Center, Boston, MA

November, 2013 "Transgender Therapy – What Every Physician Should Know" Medicine Grand Rounds, Boston Veterans Administration Hospital, Boston, MA

May, 2005 "Transgender Therapy: The Role of the Endocrinologist", Endocrinology Rounds, Tufts-New England Medical Center, Boston, MA

January, 2004 "New Directions in Thyroid Hormone Action: Skin and Hair", Endocrinology Rounds, Brigham and Women's Hospital, Boston, MA

October, 1999 "The Many Faces of Hypothyroidism", Medicine Grand Rounds, Bedford Veterans Administration Hospital, Bedford, MA

Institutional, Icahn School of Medicine at Mount Sinai, New York, NY

April, 2018 "State of the Art Hormone Therapy for Transgender Patients", Section of Infectious Disease

Institutional, Boston University School of Medicine, Boston, MA

March, 2017 "State of the Art Hormone Therapy for Transgender Patients", Section of Infectious Disease

January, 2017 "What you need to know – to supervise care for our transgender patients at BMC", Section of Endocrinology

February, 2016 "State of the Art Hormone Therapy for Transgender Patients", Department of Medicine

November, 2015 "What the Family Medicine Physician Should Know to Feel Safe Providing Hormone Therapy for Transgender Patients", Department of Family Medicine

November, 2014 "What the Anesthesiologist Should Know to Feel Safe Providing Hormone Therapy for Transgender Patients", Department of Anesthesia

January, 2014 "Update on the Current Guidelines for Transgender Hormone Therapy", Section of Endocrinology

October, 2011 "Transgender Therapy – What Every Physician Should Know", Department of Medicine

February, 2011 "Current Guidelines for Transgender Hormone Therapy: What Every Endocrinologist Should Know", Section of Endocrinology

November, 2005 "Thyroiditis and Other Insults to Thyroid Function" Core Curriculum in Adult Primary Care Medicine

November, 2005 "Interpretation of Thyroid Function Tests Made Easy" Core Curriculum in Adult Primary Care Medicine

January, 2005 "Transgender Therapy: The Role of the Endocrinologist" Endocrinology Grand Rounds

December, 2004 "Update in Endocrinology: Thyroid" Medicine Grand Rounds

January, 2004 "New Directions in Thyroid Hormone Action: Skin and Hair" Medicine Grand Rounds

March, 2003 "Thyroid Hormone Action on Hair and Skin" Endocrinology Grand Rounds

November, 1999 "Central Resistance to Thyroid Hormone – From Bedside to Bench" Endocrinology Grand Rounds

Curriculum development with external dissemination

2014-present Web site for Association of Program Directors of Endocrinology and Metabolism (APDEM), which serves as ***the primary resource for endocrinology fellowship program directors throughout the United States and Canada***.

- Sample curricula
- Streaming lectures to support specific curricular needs to feel programmatic gaps at certain programs
- New assessment forms that map skills to milestones that conform to Next Accreditation System (NAS) standards of the Accreditation Council for Graduate Medical Education (ACGME)

2013-present Dissemination of Transgender Medicine Curriculum with local modification to institutions in the United States and Canada

Curriculum adopted

Johns Hopkins School of Nursing (sample video: http://vimeo.com/jhunursing/review/97477269/abbcf6d33a)
Ohio State University College of Medicine
University of British Columbia, Faculty of Medicine
University of Central Florida College of Medicine
Tufts University School of Medicine

Curriculum in development

Dartmouth School of Medicine
University of Vermont College of Medicine

Work in progress in preparation for sharing transgender curriculum

Albany Medical College
Emory School of Medicine
George Washington University Medical School
Hofstra School of Medicine
University of California – San Diego School of Medicine
University of Kentucky College of Medicine
University of Louisville School of Medicine
University of Michigan Medical School
University of Minnesota Medical School
University of Nebraska School of Medicine
University of Pennsylvania School of Medicine
Washington University School of Medicine

2013-2015 Co-author of the ***Medical Subspecialty Reporting Milestones used for evaluation of Internal Medicine subspecialty medicine fellowship programs throughout the Unites States*** by the Accreditation Council for Graduate Medical Education (ACGME).

https://www.acgme.org/acgmeweb/Portals/0/PDFs/Milestones/InternalMedicineSubspecialtyMilestones.pdf

2011-2014 Web site content expert for APDEM, which served as ***the primary resource for endocrinology fellowship Program directors throughout the United States and Canada***. Materials included sample curricula, streaming lectures to support specific curricular needs to feel programmatic gaps at certain programs, and guidance dealing with ACGME site-visits

Other curriculum development

2016-present Curricular Content to teach transgender hormone therapy in the LGBT elective at Harvard Medical School

2016-present Curricular Content to teach transgender hormone therapy at Tufts University School of Medicine.

2011-present Fully revised curriculum for the Boston University Medical Center Fellowship Training Program in Endocrinology, Diabetes and Nutrition.

2010-present Curricula to teach transgender hormone therapy at Boston University School of Medicine.

2006-2014 Written examination in endocrinology to complement the multiple choice examination for medical students — validation relative to success later in medical school is in progress.

Bibliography: (ORCID # 0000 0003 2497 8401)

Names of mentees are underlined throughout the bibliography section

**5 currently most influential papers are noted with double asterisks

Original, Peer-Reviewed Articles

1. **Safer JD**, Langlois MF, Cohen R, Monden T, John-Hope D, Madura J, Hollenberg AN, Wondisford FE. Isoform variable action among thyroid hormone receptor mutants provides insight into pituitary resistance to thyroid hormone. *Mol Endocrinol* 1997;11(1):16-26. PMID 8994184

2. Langlois MF, Zanger K, Monden T, **Safer JD**, Hollenberg AN, Wondisford FE. A unique role of the beta-2 thyroid hormone receptor isoform in negative regulation by thyroid hormone - mapping of a novel amino-terminal domain important for ligand-independent activation. *J Biol Chem* 1997;272(40):24927-24933. PMID 9312095

3. **Safer JD**, Cohen RN, Hollenberg AN, Wondisford, FE. Defective release of corepressor by hinge mutants of the thyroid hormone receptor found in patients with resistance to thyroid hormone. *J Biol Chem* 1998;273(46):30175-30182. PMID 9804773

4. **Safer JD**, O'Connor MG, Colan SD, Srinivasan S, Tollin SR, Wondisford FE. The TR-beta gene mutation R383H is associated with isolated central resistance to thyroid hormone. *J Clin Endocrinol Metab* 1999;84(9):3099-3109. PMID 10487671

5. **Safer JD**, Fraser LM, Ray S, Holick MF. Topically applied triiodothyronine stimulates epidermal proliferation, dermal thickening, and hair growth in mice and rats. *Thyroid* 2001;1(8):717-724. PMID 11525263

6. Tangpricha V, Chen BJ, Swan NC, Sweeney AT, de las Morenas A, **Safer JD**. Twenty-one gauge needles provide more cellular samples than twenty-five gauge needles in fine needle aspiration biopsy of the thyroid. *Thyroid* 2001;11(10):973-976. PMID 11716046

7. **Safer JD**, Crawford TM, Fraser LM, Hoa M, Ray S, Chen TC, Persons K, Holick MF. Thyroid hormone action on skin: diverging effects of topical versus intraperitoneal administration. *Thyroid* 2003;13(2):159-165. PMID 12699590

8. Santini F, Ceccarini G, Montanelli L, Rosellini V, Mammoli C, Macchia P, Gatti G, Pucci E, Marsili A, Chopra IJ, Chiovato L, Vitto P, **Safer JD**, Braverman LE, Martino E, Pinchera A. Role for inner ring deiodination preventing transcutaneous passage of thyroxine. *J Clin Endocrinol Metab* 2003;88(6):2825-2830. PMID 12788895

9. **Safer JD**, Crawford TM, Holick MF. A role for thyroid hormone in wound healing through keratin gene expression. *Endocrinology* 2004;145(5):2357-2361. PMID 14736740

10. **Safer JD**, Crawford TM, Holick MF. Topical thyroid hormone accelerates wound healing in mice. *Endocrinology* 2005;146(10):4425-4430. PMID 15976059

11. Saha AK, Persons K, **Safer JD**, Luo Z, Holick MF, Ruderman NB. AMPK regulation of the growth of cultured human keratinocytes. *Biochem Biophys Res Co* 2006;349(2):519-24. PMID 16949049

12. **Safer JD**, Ray S, Holick MF. A topical PTH/PTHrP receptor antagonist stimulates hair growth in mice. *Endocrinology* 2007;148(3):1167-1170. PMID 17170098

13. **Safer JD**, Persons K, Holick MF. A thyroid hormone deiodinase inhibitor can decrease cutaneous cell proliferation in vitro. *Thyroid* 2009;19(2):181-185. PMID 19191748

14. Ariza MA, Loken WM, Pearce EN, **Safer JD**. Male sex, African-American race/ethnicity, and T3 levels at diagnosis are predictors of weight gain following medication and radioactive iodine treatment for hyperthyroidism. *Endocr Pract* 2010;16(4):609-616. PMID 20350916

15. Abraham TM, de las Morenas A, Lee SL, **Safer JD**. In thyroid fine needle aspiration, use of bedside-prepared slides significantly increased diagnostic adequacy and specimen cellularity relative to solution-based samples. *Thyroid* 2011;21(3):237-242. PMID 21323589

16. Huang MP, Rodgers KA, O'Mara R, Mehta M, Abuzahra HS, Tannenbaum AD, Persons K, Holick MF, **Safer JD**. The thyroid hormone degrading Dio3 is the primary deiodinase active in murine epidermis. *Thyroid* 2011;21(11):1263-1268. PMID 21936673

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18**. **Safer JD**, Pearce EN. A simple curriculum content change increased medical student comfort with transgender medicine. *Endocr Pract* 2013;19(4):633-637. PMID 23425656
- First ever demonstration of the effectiveness of an evidence-based approach to teaching transgender medicine to medical students

19**. Thomas DD, **Safer JD**. A simple intervention raised resident-physician willingness to assist transgender patients seeking hormone therapy. *Endocr Pract* 2015;21(10):1134-42. PMID 26151424
- First ever demonstration of the effectiveness of an evidence-based approach to teaching transgender medicine to physician trainees

20. Mundluru SN, **Safer JD**, Larson, AR. Unforeseen ethical challenges for isotretinoin treatment in transgender patients. *Int J of Womens Dermatol* 2016;2(2):46-48. PMID 28492004

21. Eriksson SES, **Safer JD**. Evidence-based curricular content improves student knowledge and changes attitudes towards transgender medicine. *Endocr Pract* 2016;22(7):837-841. PMID 27042742

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23. Myers SC, **Safer JD**. Increased rates of smoking cessation observed among transgender women receiving hormone treatment. *Endocr Pract* 2017;23(1):32-36. PMID 27682351

24. Berli J, Knudson G, Fraser L, Tangpricha V, Ettner R, Ettner F, **Safer JD**, Graham j, Monstrey S, Schecter L. Gender confirmation surgery: What surgeons need to know when providing care for transgender individuals. *JAMA Surgery* 2017;152(4):394-400. PMID 28196182

25. Kailas M, Lu HMS, Rothman EF, **Safer JD**. Prevalence and types of gender-affirming surgery among a sample of transgender endocrinology patients prior to state expansion of insurance coverage. *Endocr Pract* 2017;23(7):780-786. PMID 28448757

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27. Park JA, **Safer JD**. Clinical exposure to transgender medicine improves students' preparedness above levels seen with didactic teaching alone: A key addition to the Boston University model for teaching transgender health care. *Transgender Health* 2018;3(1),10-16. PMID 29344576

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29. Chan KJ, Jolly D, Liang JJ, Weinand JD, **Safer JD**. Estrogen levels do not rise with testosterone treatment for transgender men. *Endocr Pract* 2018; In Press. PMID

Case Reports, Reviews, Chapters:

Editorials and Critical Reviews:

30. **Safer JD**, Colan SD, Fraser LM, Wondisford FE. A pituitary tumor in a patient with thyroid hormone resistance: A diagnostic dilemma. *Thyroid* 2001;11(3):281-291. PMID 11327621

31. **Safer JD**, Hennessey JV, Braverman LE. Substituting brand name levothyroxine preparations with generics would increase treatment cost. *Ann Intern Med* 2005; on-line available at http://www.annals.org/cgi/eletters/142/11/891#1882

32. Pietras SM, **Safer JD**. A spurious elevation of both total thyroid hormone and thyroid hormone uptake measurements in the setting of autoantibodies may result in diagnostic confusion: A case report and review of the related literature. *Endocr Pract* 2008;14(6):738-742. PMID 18996795

33. **Safer JD**, Tangpricha V. Out of the Shadows: It is time to mainstream treatment for transgender patients. *Endocr Pract* 2008;14(2):248-50. PMID 18308667

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35. Bhasin S, **Safer JD**, Tangpricha V. The Hormone Foundation's patient guide to the endocrine treatment of transsexual persons. *J Clin Endocrinol Metab* 2009;94(9).

36. **Safer JD**. Thyroid hormone action on skin. *Dermatoendocrinol* 2011;3(3):1-5. PMID 22110782

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38. **Safer JD**. Thyroid hormone action on skin. *Curr Opin Endocrinol Diabetes Obes* 2012;19(5):388-293. PMID 22914563

39. **Safer JD**. Thyroid hormone and wound healing. *J Thyroid Res* 2013;doi:10.1155/2013/124538. PMID 23577275

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43**. Saraswat A, Weinand JD, **Safer JD**. Evidence supporting the biological nature of gender identity. *Endocr Pract* 2015; 21(2):199-204. PMID 25667367
- Review of the biological nature of transgender identity most referenced by popular media (Google)

44**. Weinand JD, **Safer JD**. Hormone therapy in transgender adults is safe with provider supervision; A review of hormone therapy sequelae for transgender individuals. *J Clin Transl Endocr* 2015; 2:55-60. PMID 28090436
- The most comprehensive recent review of the relative safety of transgender hormone therapy

45. Boh B, **Safer JD**. State-of-the-art: Use of hormones in transgender individuals. *Endocrine Society* 2016; on-line available at http://dx.doi.org/10.1210/MTP5.9781943550043.ch55

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- The most current review of barriers to delivery of transgender healthcare in the United States in the medical system, medical curriculum, and medical culture

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50. **Safer JD**. The large gaps in transgender medical knowledge among providers must be measured and addressed. *Endocr Pract* 2016;22(7):902-903. PMID 27214166

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- The most respected guideline for hormone treatment of transgender individuals

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Textbook Chapters:

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Case Reports:

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Dissemination Through Lay Press and Social Media

Mass Audience Programming:

"Transgender Health AMA" Reddit. July 24, 2017. Expert responses to questions about transgender medicine.
https://www.reddit.com/r/science/comments/6p7uhb/transgender_health_ama_series_im_joshua_safer/
over 150,000 views, over 4200 comments

"Gender Revolution with Katie Couric" National Geographic Channel. Kouric, Katie. February 6, 2017.
Extended interview with Katie Couric threaded into a 2-hour television special. Trailer:
https://www.youtube.com/watch?v=y93MsRaC6Zw
broadcast in 143 countries

"Is gender identity biologically hard-wired?" Judd, Jackie. PBS NewsHour. May 13, 2015.
Extended interview for Jackie Judd http://www.pbs.org/newshour/bb/biology-gender-identity-children/
estimated just over 1,000,000 viewers per Nielsen

Innovation	**Significance/impact**
Development and leadership of the Transgender Medicine Clinical Center at Boston Medical Center	• The Center for Transgender Medicine and Surgery at BMC is the first comprehensive center for transgender medical care in New England • The Center is one of only several such centers in North America that are housed in academic teaching hospitals where care can be integrated • The Center is a model for such care delivery in North America.
Development and dissemination of the seminal reviews that are most widely cited in the lay press that explain the concept that gender identity is a biological phenomenon (see bibliography section above, e.g. PMID: 25667367).	• The concept that gender identity is a biological phenomenon has been a key component of the recent culture change in favor of mainstream medical care for transgender individuals (see media section above)
Development and dissemination of new and influential curricular content to teach the biology of gender identity in conventional medical education (see curriculum section above)	The teaching of evidence-based approaches to transgender medical care to: • Medical students (see bibliography section above, e.g. PMID 23425656 and PMID 27042742) • Physician trainees (see bibliography section above, e.g. PMID 26151424) • Practicing physicians (see invited lectures section above) serves as a crucial component to the gained credence given to care for transgender individuals in conventional medical settings.
Development and dissemination of seminal reviews supporting the safety of transgender hormone treatment regimens (see invited lectures section above)	• Once mainstream medical providers learn of the biology underlying gender identity, their biggest concern is the relative safety of the medical interventions relative to the benefit. • The development and dissemination of the seminal reviews and lectures supporting the safety of current treatment regimens serves as a further crucial component to the culture change among conventional medical providers in favor of routine medical care for transgender individuals