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NEW DOD POLICY ON QUALIFICATION FOR MILITARY SERVICE: STANDARDS FOR GENDER TRANSITION AND ATYPICAL SEXUAL AND REPRODUCTIVE ANATOMY

On November 16, 2022, the Department of Defense revised its regulation on medical qualification for military service, DoD Instruction 6130.03, Volume 1. The new version (Change 4, replacing Change 3 dated June 6, 2022) revises standards related to gender dysphoria/gender transition and atypical sexual and reproductive anatomy.

Gender dysphoria/gender transition:

These changes are relatively minor, but they should make it easier for applicants who have transitioned gender to enlist.

A history of gender dysphoria is now disqualifying only if 1) symptomatic within the previous 18 months or 2) associated with comorbid mental health disorders. Functionally this is the same standard as before, but the change deleted language requiring a showing that "the applicant has been stable without clinically significant distress or impairment in social, occupational, or other important areas of functioning for 18 months." It's the same standard but stated in a less stigmatizing way. However, as under the earlier standard and under mental-health standards more generally, applicants who currently receive mental-health therapy for gender dysphoria will likely not qualify for military service because they would be "symptomatic."

Gender-affirming hormone use: the new standard is far more specific in defining how to assess "stability" on hormones (lab test within target range and absence of adverse symptoms/side effects), and it also reduces the waiting period to demonstrate stability from 18 months to 12 months. These assessments are made by the treating provider, not the enlistment examiner, and the new standard should help to eliminate questions about how to assess stability. The treating provider also must affirm that "no additional gender affirming treatment is anticipated, other than hormone maintenance."

The new standard also clarifies that use of any medication delivered by injectable or transdermal means (e.g., allergy, hormones, contraceptives) and requiring refrigeration is NOT disqualifying if the treating provider certifies that an alternative delivery system is available if needed during training or deployment. This is a very helpful clarification that meets concerns about hormone use in remote locations.

Gender-affirming genital surgery: the new standard retains the same 18-month waiting period following surgery and is functionally the same, but it folds the standard into a more general section for all "urogenital reconstruction or surgery," whether gender-affirming or not. Applicants are disqualified if they have genitourinary dysfunction, recurrent urinary tract infections, or any functional limitation affecting daily living or a physically active lifestyle. Applicants cannot enlist if additional surgery is contemplated. The new surgery standard also

deletes stigmatizing language designating gender-affirming surgery as a "major abnormality or defect of the genitalia."

Bottom line: the new standards for gender dysphoria and gender transition are largely consistent with the prior standards (while reducing the waiting period for stability in hormone therapy), but they remove stigmatizing language, consolidate some separate standards into standards that apply to all applicants, and provide more specific guidance for demonstrating qualification. There are small positives and no negatives.

Atypical sexual and reproductive anatomy (or differences/disorders of sexual development):

The new regulation contains major revisions to medical enlistment policy for persons with a history of atypical sexual and reproductive anatomy, converting a blanket disqualification for certain histories into a standard based on individual assessment.

The prior standard disqualified applicants with a history of certain specific diagnoses (hermaphroditism, pseudohermaphroditism, or pure gonadal dysgenesis) as part of a larger disqualification for "major abnormalities or defects of the genitalia." This disqualification had no exceptions.

The new standard disqualifies applicants with "any undiagnosed or untreated disorder of sex development." It does not include any further guidance on what any of those terms mean, but the simplicity/vagueness may be a positive. Without doubt it removes the blanket bar of the earlier standard and disqualifies only those applicants who appear for enlistment evaluation with a DSD that is "undiagnosed" or "untreated." This circumstance should be rare—very few applicants should have a history of DSD but no history of medical evaluation of that DSD.

The enlistment examination, in general, is designed to discover medical conditions that may require excessive loss of duty time for treatment, interfere with performance, or impose geographic limitations. The new standard appears intended to ensure that a history of DSD has been diagnosed, evaluated, and treated to the extent medically necessary. This judgment is for the treating provider to make, not the enlistment examiner.

There may be a good reason that the new standard is so brief and vague. The range of possible DSDs is wide, and no enlistment standard could be written to account for the tremendous complexity of possible diagnoses and treatments. The standard appears to defer to prior evaluation and medical records documenting the nature of diagnosis and treatment. There is no reason to believe that the new standard requires a certain method of treatment, or any treatment at all—certainly not medically unnecessary treatment. In other contexts, the regulation specifies when certain treatments are relevant, required, or disqualifying, and it does not do so here.

Provided the applicant has been diagnosed and evaluated, further assessment for service should default to standards that apply to all applicants. If applicants with a history of DSD cannot meet those general standards, then they will be disqualified in the same manner as non-DSD applicants. The new DSD standard appears designed to flag DSD histories without evaluation or documentation, which is reasonable. It should not be a permanent disqualification.

DoDI 6130.03 has never been a perfect model of consistency, and inconsistencies should not necessarily be taken as evidence of motivation to exclude applicants with DSD history. Sometimes updates are just poorly constructed or implemented. For example, the regulation disqualifies applicants with primary amenorrhea, which could apply to certain DSD histories but was probably not designed to flag DSD histories. Primary amenorrhea could be the result of unrelated conditions. There is a strong case to be made that if different sections of the regulation can lead to a different result, the more specifically targeted guidance should control. In this case, then, primary amenorrhea associated with a DSD should be evaluated under the specific standard for DSD, meaning that it should not be disqualifying if it has been diagnosed, explained, and treated as medically necessary (or not). (In fact, earlier versions of DoDI 6130.03 only disqualified for primary amenorrhea if it was unexplained, which makes sense.)

There is also inconsistency in that certain DSDs have always been evaluated by their own separate standards—for example, epispadias, hypospadias, and unexplained absence of testicles. The standards basically require an explanation and verification that there is no current dysfunction.

Perhaps the vaguest inconsistency that continues in the new regulation is the disqualification for history of hypogonadism. It is unclear what it means, why DoD believes the condition should be disqualifying, or whether it is intended to operate separately from the standard for DSDs. It is inconsistent with transgender service policy. One way to resolve the inconsistency is to consider hormone treatment for hypogonadism to be "gender affirming" in nature, which it is. Applicants could then qualify by demonstrating stability.

Bottom line: It is a good thing that the new DSD standard does not attempt to guide enlistment examiners through every possible DSD variation. This is a circumstance in which the examiner should be deferring to a history of evaluation and treatment, whatever that might be. If any current concern of fitness remains, it can be evaluated under generally applicable standards. The key and major improvement is that a history of any DSD is no longer automatically disqualifying. Furthermore, nothing about the specific history of, or treatment of, any DSD is automatically disqualifying. The new standard does not flag anything other than the need for evaluation at some point in time. DoD appears to have set out in good faith to remove barriers to service for applicants with history of DSD and substitute a standard based on individual assessment of ability to serve without medical limitation.

The one negative in the new regulation is that it did not resolve existing inconsistencies between the basic standard for DSDs and the standards for other conditions that may be associated with DSDs. In the past (a decade ago), DoD used to publish an annotated, "supplemental" version of DoDI 6130.03 that added additional guidance for medical examiners, essentially filling in the blanks of what the original regulation failed to explain. It may be helpful for medical examiners to receive some clarification on how to assess DSD applicants when standards seem inconsistent. The need for supplemental guidance depends on the degree to which examiners are willing to defer to the judgment of DSD treating providers, just as they already do with a host of other conditions.