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BLUEPRINTS FOR SOUND PUBLIC POLICY

UNINTENDED CONSEQUENCES IN CRAFTING NEW POLICY FOR TRANSGENDER MILITARY PERSONNEL

July 2015

Context: After Defense Secretary Ash Carter announced in 2015 that the Pentagon would study how to lift the ban on military service by transgender troops, the Palm Center sent this memo to officials in charge of the study and repeal process. We outlined six general principles for inclusive policy on gender identity that would avoid double standards and allow transgender personnel to serve under existing rules and practices. While the officials had considerable experience formulating military personnel policy, they had not engaged deeply with questions concerning gender identity, and they turned to us repeatedly for input. The Pentagon's eventual policy of inclusion successfully avoided most of the pitfalls we identified in the memo.

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The following unintended consequences should be avoiding in crafting new rules of inclusion based on gender identity.

1. Gender dysphoria should not be equated with unfitness for duty.

The American Psychiatric Association (APA) has concluded that "gender nonconformity is not itself a mental disorder."[1] Some transgender persons, however, may experience gender dysphoria, which is the distress that can result from the difference between gender identity and gender assigned at birth. The APA retained the diagnostic option of gender dysphoria in *DSM-5* to ensure transgender individuals could obtain insurance coverage for medically necessary care, not to judge their fitness for any task. In our medical system, without a medical diagnosis, there is no access to medical care.[2]

All of the hundreds of mental health diagnoses in *DSM-5* are based on a generic diagnostic criterion, usually worded as a condition that "causes clinically significant distress or impairment." The military permits enlistment and retention of individuals with a variety of mental health diagnoses—without waivers or medical retention boards—and so a *DSM-5* diagnosis of "distress or impairment" is clearly not an indication of unfitness for duty. Only the most serious conditions, or conditions resistant to treatment, are disqualifying for military service. Treatments for gender dysphoria are safe, effective, and reliable.[3]

2. Transgender individuals should not be required to obtain enlistment waivers or prove fitness to a medical retention board just because they are transgender or have gender dysphoria.

The vast majority of transgender personnel are medically fit the vast majority of the time. Enlistment waivers and medical retention boards are designed for medical conditions that typically render individuals unfit to perform duty and are also not amenable to treatment. These procedures serve as safety valves and allow individuals to prove they are exceptions to the usual case. But there is no scientifically valid reason for presuming transgender individuals to be unfit, including those who have been diagnosed with gender dysphoria or who have had or may require gender transition surgery. A former US Surgeon General and retired General and Flag Officers found that gender-transition surgeries are medically necessary for only a small percentage of transgender individuals and are unlikely to result in complications.[4]

When members of an identified group are as fit as other applicants if all are assessed under the same standard, there is no justification for singling out that group for the uphill process of overturning a presumption of unfitness through a waiver or medical retention board process. Enlistment and retention bans on transgender individuals should be eliminated and not replaced by extra hurdles that constitute a ban in another form.

3. Evaluate transgender individuals under the same standards that apply to all.

Potential reasons for unfitness are not specific to transgender personnel, and so special medical standards that categorize people based on gender identity are unnecessary. Transgender identity is itself medically neutral and not a mental disorder. For persons diagnosed with gender dysphoria, or who have a history of gender dysphoria, every possible symptom is covered by other existing medical standards. If the concern is that transgender individuals are more likely to experience depressive or anxiety disorders, enlistment and retention regulations already provide standards for assessment. If the concern is that transgender individuals as a group are at greater risk for suicide, regulations already address that risk for everyone. If the concern is that surgical complications may persist, current standards governing surgical recovery in general are sufficient. There is nothing about the medical fitness of transgender individuals that is unique to transgender individuals, and existing standards are enough to ensure fitness for duty.

4. Don't repeat the "status/conduct" mistake of "don't ask, don't tell."

It would be disingenuous to establish a policy that permitted individuals with a transgender "status" or identity to serve, but disqualified them if they experienced the natural consequences of that status, such as a medical need to obtain treatment or to transition gender. Such an artificial distinction would be reminiscent of "don't ask, don't tell," which made the untenable distinction between the permissible "status" of sexual orientation and the impermissible "conduct" of speaking to another person about being gay or forming personal relationships. Given the evidence that transgender identity, gender dysphoria, and gender transition are not themselves indicative of unfitness, status/conduct distinctions are unnecessary and counterproductive. A Planning Commission led by a former acting Surgeon General of the Army and including several retired General Officers concluded that formulating and implementing transgender-inclusive policy is feasible and would not be excessively complex or burdensome.[5]

5. Minimize regulatory revision.

The same Planning Commission recommended a presumption against creating new rules that regulate transgender and non-transgender service members differently, and concluded that transgender-inclusive service requires comparatively minor regulatory revision.[6] Specific enlistment and retention bans must be deleted, as well as military health care rules that prohibit medical treatment related to gender identity. Little else is needed, because most current administrative policies are already gender-identity neutral, including regulations governing name and gender marker changes (they rely on federal

passport rules), uniforms and grooming, and physical standards. Individuals who transition gender will be required to comply with standards for the gender in which they live. Management of privacy concerns will continue to be a matter of command judgment and discretion, in the same way commanders now manage those concerns for men and women.

The major exception to that general principle is that new rules are required to govern gender transition for those with a medical need, a process that by definition is temporary. But there is no reason to treat transgender and non-transgender personnel differently on an ongoing basis before or after transition.

6. Make an affirmative statement of inclusion.

In order to ensure the success of policy change, the end of the ban on service by transgender individuals should be accompanied by an affirmative statement of inclusion similar to the statements made in recent revisions to Military Equal Opportunity policy. The military should make clear that all service members, including transgender service members, are evaluated "only on individual merit, fitness, capability, and performance" and "are afforded equal opportunity in an environment free from harassment and unlawful discrimination."[7]

[1] American Psychiatric Association, Gender Dysphoria Fact Sheet (2013), http://www.dsm5.org/documents/gender%20dysphoria%20fact%20sheet.pdf.

[2] "Persons experiencing gender dysphoria need a diagnostic term that protects their access to care and won't be used against them in social, occupational, or legal areas. … To get insurance coverage for the medical treatments, individuals need a diagnosis. The Sexual and Gender Identity Disorders Work Group was concerned that removing the condition as a psychiatric diagnosis—as some had suggested—would jeopardize access to care." Gender Dysphoria Fact Sheet.

[3] M. Joycelyn Elders, George R. Brown, Eli Coleman, Thomas A. Kolditz, and Alan M. Steinman (2015). Medical Aspects of Transgender Military Service, *Armed Forces & Society*, 41(2): 199-220 (hormone replacement therapy); Department of Health and Human Services, Departmental Appeals Board, Appellate Division, NCD 104.3, Transsexual Surgery, Docket No. A-13-87, Decision No. 2576, May 30, 2014 (surgical procedures).

[4] Elders et al., 208-10.

[5] Major General Gale S. Pollock & Shannon Minter, Report of the Planning Commission on Transgender Military Service (Palm Center 2014), *http://www.palmcenter.org/files/Report%20of%20Planning%20Commission%20on%20Transgender%20Military%20Service.pdf*.

[6] Report of the Planning Commission on Transgender Military Service.

[7] DODD 1020.02E, Diversity Management and Equal Opportunity in the DoD, June 8, 2015, Enclosure 2, ¶ 2(a), (b)(1).