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By Diane H. Mazur

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Arbitrary and Capricious: Six Inconsistencies Distinguishing Military Medical Policies for Transgender and Non-Transgender Personnel

By Diane H. Mazur

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EXECUTIVE SUMMARY

- The March 2014 *Report of the Transgender Military Service Commission* concluded "there is no compelling medical rationale for banning transgender military service." The Commission, chaired by former U.S. Surgeon General Joycelyn Elders, M.D., and retired Rear Admiral Alan M. Steinman, M.D., found that the military did not have medically sound reasons for refusing enlistment to or requiring discharge of transgender individuals.

- This study builds on the Commission's findings by comparing military regulations governing four sets of representative medical conditions with regulations governing service by transgender individuals. It finds that medical regulations affecting transgender personnel are inconsistent with the regulation of medical conditions in general:

  (1) Two different standards can apply to comparable medical care, or even the same medical care, depending on whether the service member is transgender or not.

  (2) Medical regulations governing non-transgender-related conditions strike a careful balance in retaining service members whose medical conditions do not significantly impair fitness for duty while avoiding undue burden on doctors, commanders, and the military healthcare system. In contrast, rules that apply to transgender personnel make no attempt to balance these aims and instead require the exclusion of all transgender service members, regardless of fitness for duty or burden of care.

  (3) Medical regulations governing non-transgender-related conditions assess medical risk based on individual medical evaluation and generally rely on ability to perform military duty in making retention decisions. In contrast, military regulations governing gender identity presume all transgender personnel are unfit and render their duty performance irrelevant.

  (4) Medical regulations governing non-transgender-related conditions are designed to maintain and restore health. They refer service members for fitness evaluation and possible separation only after medical treatment and a reasonable period of time for recovery. In contrast, regulations governing gender identity prohibit military doctors from providing safe, effective, and medically necessary treatment and require separation without an opportunity to demonstrate fitness.

  (5) Medical regulations governing non-transgender-related conditions are updated on a regular basis to reflect current scientific consensus and best medical practices. In contrast, military rules governing gender identity are decades out of date and reflect assumptions that were repudiated a generation ago.

(6) Medical regulations governing non-transgender-related conditions do not stigmatize personnel who have those conditions. In contrast, transgender personnel are stigmatized by medical regulations that classify transgender identity within a category of "inherent defects" that includes sexual deviance and mental illness.

- Inconsistencies in military regulations between medical treatment of transgender and non-transgender personnel remain unexplained. For example, the military has defended its transgender policies in court by contending that assignment of transgender personnel to remote geographic areas "would be equivalent to placing an individual with known coronary artery disease in a remote location without readily available coronary care." However, military medical guidance expressly permits deployment by individuals who have had heart attacks or coronary artery bypass grafts, provided the cardiac events occurred at least a year before deployment. Similarly, the military contends that hormone replacement treatment requires a level of monitoring and expertise beyond the capability of deployed medical facilities, yet it permits deployment by diabetic personnel who require much more intensive monitoring.

INTRODUCTION: SIX INCONSISTENCIES

The March 2014 *Report of the Transgender Military Service Commission*[1] concluded "there is no compelling medical rationale for banning transgender military service." The Commission, chaired by former U.S. Surgeon General Joycelyn Elders, M.D., and retired Rear Admiral Alan M. Steinman, M.D., found that the military did not have medically sound reasons for refusing enlistment to or requiring discharge of transgender individuals. In response to stated rationales that included the difficulty of providing hormone treatment and the risk of complications from gender-transition surgery, the commission reported that the military routinely provides hormone treatment for non-transgender personnel and also authorizes other reconstructive surgeries that pose greater health risks, even when the procedures are medically unnecessary and performed solely for cosmetic reasons.

The August 2014 *Report of the Planning Commission on Transgender Military Service*[2] outlined ideal administrative practices for adopting transgender-inclusive policy while maintaining military readiness. This second commission, which included several General Officers and was led by retired Major General Gale S. Pollock, former acting Surgeon General of the Army, concluded that formulating and implementing inclusive policy is feasible and not excessively complex or burdensome.

This study is the third in a series of Palm Center reports on military service by transgender individuals. It expands on one of the medical issues discussed in the Elders-Steinman *Report of the Transgender Military Service Commission*. One of the Elders-Steinman Commission's principal findings was that military medical regulations affecting transgender personnel are inconsistent with regulations that govern medical and psychological conditions more generally. However, its report did not discuss the comparison in depth.

The purpose of this study is to illustrate in more detail how military regulations governing comparable medical conditions in non-transgender personnel differ from the standards that apply to gender identity. It does not compare military medical judgments to civilian judgments or directly assess the validity of military medical policy, but instead compares the military's own stated rationales across different medical conditions and determines whether the military is taking a medically consistent approach in opposing service by transgender persons. This study identifies six major inconsistencies in military regulations between the medical treatment of transgender and non-transgender personnel:

> (1) Two different standards can apply to comparable medical care, or even the same medical care, depending on whether the service member is transgender or not.
>
> (2) Medical regulations governing non-transgender-related conditions strike a careful balance in retaining service members whose medical conditions do not significantly impair fitness for duty while avoiding undue burden on doctors, commanders, and the military healthcare system. In contrast, rules that apply to

transgender personnel make no attempt to balance these aims and instead require the exclusion of all transgender service members, regardless of fitness for duty or burden of care.

(3) Medical regulations governing non-transgender-related conditions assess medical risk based on individual medical evaluation and generally rely on ability to perform military duty in making retention decisions. In contrast, military regulations governing gender identity presume all transgender personnel are unfit and render their duty performance irrelevant.

(4) Medical regulations governing non-transgender-related conditions are designed to maintain and restore health. They refer service members for fitness evaluation and possible separation only after medical treatment and a reasonable period of time for recovery. In contrast, regulations governing gender identity prohibit military doctors from providing safe, effective, and medically necessary treatment and require separation without an opportunity to demonstrate fitness.

(5) Medical regulations governing non-transgender-related conditions are updated on a regular basis to reflect current scientific consensus and best medical practices. In contrast, military rules governing gender identity are decades out of date and reflect assumptions that were repudiated a generation ago.

(6) Medical regulations governing non-transgender-related conditions do not stigmatize personnel who have those conditions. In contrast, transgender personnel are stigmatized by medical regulations that classify transgender identity within a category of "inherent defects" that includes sexual deviance and mental illness.

Following short introductions to the regulatory systems governing enlistment and retention, basic medical guidelines for deployment, and the military's transgender policy, this study reviews the medical standards that govern four representative physical or mental conditions as points for comparison. Both Department of Defense (DOD) and service-specific regulations from the Departments of the Army, Navy, and Air Force are included (Marines are governed by Navy medical guidance), although they are largely consistent with one another.[3]

Each of the four sections discusses the common DOD standard for initial enlistment and then standards for retention in the military, which vary slightly across the services. Standards for retention are generally more accommodating and flexible than rules for initial entry, reflecting the military's investment in training and the value of experience. The rules governing transgender personnel, however, do not follow this general principle and are equally unforgiving regardless of length of service or fitness for duty.

The first comparison, and the most direct, is between the rules governing transgender individuals and the rules for medical evaluation of other conditions that are also gender-related or may require hormone replacement. The military contends that hormone therapy

would impose an undue burden on the medical system and limit the ability of transgender personnel to deploy, but the military permits similar hormone treatments for non-transgender personnel. Gender-related conditions are generally not disqualifying for retention in military service, with the exception of transgender identity, which is categorically disqualifying.

The second comparison addresses regulations on the treatment of mood and anxiety disorders. One of the military's justifications for the transgender ban has been the assumption that transgender personnel require continuing mental health care, although the Elders-Steinman Commission Report found that many transgender individuals do not experience significant distress and that treatment can alleviate symptoms in those who do experience distress. Furthermore, the military's flexible standards for both enlistment and retention of individuals with mental health concerns unrelated to gender identity are inconsistent with the across-the-board ban on transgender personnel.

The third comparison discusses military medical policy for diabetic personnel. The military makes individualized decisions whether to retain and deploy service members with diabetes despite the need for continuous care and monitoring of the condition. In contrast, transgender personnel are deemed automatically unfit on the basis of medical monitoring that would be far more infrequent.

The fourth and final comparison concerns the military's evaluation of head injuries and concussions. The military recognizes the individualized nature of head injuries and their consequences. It does not refer individuals for possible medical separation unless medical treatment proves ineffective over a significant period of time and continues to impair duty performance. The military tolerates medical risk based on individual medical assessment and avoids blanket assumptions about fitness for duty. In contrast, the military presumes that transgender personnel pose an unacceptable medical risk to themselves and an unacceptable burden on the military health care system, and it does so without assessing medical need, providing treatment, or evaluating fitness for duty. Furthermore, the military's comprehensive response to novel issues presented by traumatic brain injury undermines its position that the military is unable to adapt to new medical concerns arising from transgender-inclusive service.

MEDICAL STANDARDS FOR ENTRY INTO MILITARY SERVICE

Department of Defense Instruction 6130.03, *Medical Standards for Appointment, Enlistment, or Induction in the Military Services*, establishes medical standards for entry into military service. Enclosure 4 of DODI 6130.03 contains a list of disqualifying physical and mental conditions. The regulation also provides the following general policy guidance for evaluating medical conditions:

> It is DOD policy to:
>
> Ensure that individuals under consideration for appointment, enlistment, or induction into the Military Services are:
> (1) Free of contagious diseases that probably will endanger the health of other personnel.
> (2) 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 the Service for medical unfitness.
> (3) Medically capable of satisfactorily completing required training.
> (4) Medically adaptable to the military environment without the necessity of geographical area limitations.
> (5) Medically capable of performing duties without aggravation of existing physical defects or medical conditions.[4]

DODI 6130.03 does not require applicants to be free of all medical conditions or ongoing medical care at the time of enlistment. The regulation does not necessarily disqualify individuals who are taking medication for a chronic condition, provided the medication is effective in controlling the condition. For example, the military permits enlistment by persons with gastro-esophageal reflux disease (if controlled by medication) or with high cholesterol (if controlled by taking only one statin medication).[5]

The individual services (the Army, Air Force, Navy, and Marine Corps) are required to follow the medical guidelines of DODI 6130.03 and may not set their own medical standards for enlistment, with limited exceptions. The only authorized medical differences among the services at the time of entry are for vision requirements; height, weight, and body fat standards; and "special programs" such as aviation duty.[6] While medical entry standards are largely common across the services, the Department of Defense permits individual services to develop particularized standards governing retention of their own personnel and the circumstances under which they are allowed to deploy away from the United States or to remote locations. The following sections explain both DOD and service policies on retention and deployment.

Finally, it is also DOD policy to "eliminate inconsistencies and inequities based on race, sex, or location of examination in the application of these standards by the Military Services."[7] An automatic disqualification of transgender applicants, without

consideration of fitness for duty, would appear to be inconsistent with the military's stated goal of eliminating inequitable treatment on the basis of sex. The Equal Employment Opportunity Commission has ruled that intentional discrimination against transgender individuals constitutes unlawful discrimination on the basis of sex under Title VII of the Civil Rights Act of 1964,[8] but the EEOC has no jurisdiction over military personnel.[9]

MEDICAL STANDARDS FOR RETENTION IN MILITARY SERVICE

Different medical standards apply to the retention of individuals already in military service. Retention standards are generally more accommodating and flexible than entry standards, taking into account the military's investment in training and the value of a service member's experience.

The Department of Defense establishes general guidelines for determining when service members should be referred for medical evaluation of fitness for duty and retention in service. The guidelines focus on ability to perform military duties, medical risk to the service member and others, and requirements for continuing care, but decisions to refer are made only after medical treatment and a reasonable period of time for recovery:

> When the course of further recovery is relatively predictable or within 1 year of diagnosis, whichever is sooner, medical authorities will refer eligible Service members into the DES [Disability Evaluation System] who:
>
> (1) Have one or more medical conditions that may, individually or collectively, prevent the Service member from reasonably performing the duties of their office, grade, rank, or rating including those duties remaining on a Reserve obligation for more than 1 year after diagnosis;
>
> (2) Have a medical condition that represents an obvious medical risk to the health of the member or to the health or safety of other members; or
>
> (3) Have a medical condition that imposes unreasonable requirements on the military to maintain or protect the Service member.[10]

The following considerations are relevant in determining whether a service member can reasonably perform military duties, although none is alone determinative of fitness: whether the individual can 1) perform common military tasks such as firing a weapon or wearing load-bearing equipment; 2) take a physical fitness test; 3) deploy to any vessel or location; and 4) perform specialized or alternative duties.[11]

Referral for evaluation of medical fitness for continued service does not necessarily mean that an individual will be medically separated from the military. The purpose of disability evaluation is to determine the fitness of service members with medical impairments to perform their military duties, and for those members found to be unfit, their entitlement to compensation upon separation or retirement.[12] The military service involved "must cite objective evidence in the record, as distinguished from personal opinion, speculation, or conjecture, to determine a Service member is unfit because of disability."[13] Fitness or unfitness is determined based on the preponderance of the evidence, and service members have the opportunity to demonstrate their capacity to perform duty.[14]

Some service members, however, are ineligible for referral for evaluation of medical fitness and are instead subject to administrative separation without the protections of the medical review process. If an individual has what the regulation describes as "a condition, circumstance, or defect of a developmental nature, not constituting a physical disability, . . . that interferes with assignment to or performance of duty," he or she is subject to separation without an opportunity to demonstrate medical fitness.[15] The military uses the phrase "physical disability" as a term of art. It includes both mental and physical conditions, but it specifically excludes what the military considers "inherent defects" or "developmental or behavioral disorders."[16] By the authority of regulation, such physical or mental conditions become "not physical disabilities" and are diverted outside the medical disability system.

Until very recently, the Department of Defense also issued specific lists of medical conditions in both categories: conditions requiring referral for medical fitness evaluation, and conditions "not constituting a physical disability" that led to administrative separation. These lists served as default policies throughout the military departments, and their content was generally adopted by the services with minor modifications and amplifications.

As of August 5, 2014, however, DOD no longer specifies which medical conditions should be referred for either medical evaluation or administrative separation. It establishes only the most general principles governing fitness for service and grants authority to the services to decide which specific medical conditions should be disqualifying for retention. Because of the importance of this fundamental regulatory shift, this section describes retention policy both before and after August 5, 2014, the date of the regulatory change.

Before August 5, 2014

Now-cancelled Department of Defense Instruction 1332.38, *Physical Disability Evaluation*, contained an Enclosure 4 (similar to the Enclosure 4 of DODI 6130.03 discussed in the section on Entry Into Military Service) listing the specific medical conditions and diagnoses that required referral for medical evaluation of fitness for continued service. The Department of Defense permitted the individual services to modify Enclosure 4 guidelines to fit their particular needs, but only if the modifications were "consistent with this Instruction."[17]

DODI 1332.38 also identified certain medical conditions as ineligible for disability evaluation and listed them separately in an Enclosure 5. Service members with physical and mental conditions the regulation defined as "not constituting a physical disability" were placed on a track for administrative separation for "the convenience of the government," without the procedural protections of the usual medical evaluation process.[18] "Sexual gender and identity disorders" were among these Enclosure 5 conditions, and the effect of this classification was to deny transgender individuals the opportunity to demonstrate fitness for duty despite their gender identity.

Enclosure 5 comprised a list of more than twenty conditions that appeared to be linked only by the military's assumption that they were "developmental" in nature, not caused or aggravated by military service, resistant to treatment, and inherently dysfunctional in a military setting. In addition to transgender identity, they included enuresis,* sleepwalking, learning disorders, stuttering, motion sickness, personality disorders, "mental retardation" (the military's term), obesity, shaving infections, certain allergies, "unsanitary habits including repeated venereal disease infections," and homosexuality. (It is unclear why the last item remained after the repeal of "don't ask, don't tell" [DADT] made sexual orientation a neutral matter for all service members.) These conditions were deemed not to constitute a physical disability even though the same conditions were subject to medical evaluation at the time of entry into military service under DODI 6130.03.

Each of the military services has regulations containing a similar list of administratively disqualifying conditions that was derived in whole or in part from the former Enclosure 5 of DODI 1332.38.[19]

After August 5, 2014

On August 5, 2014, the Department of Defense cancelled DODI 1332.38 and substituted the new DODI 1332.18, *Disability Evaluation System (DES)*, in its place. While retaining the two-track system of medically and administratively disqualifying conditions, the new regulation eliminates both Enclosure 4 and Enclosure 5 entirely and no longer takes a position on which conditions should be disqualifying in either category. Instead, the new DODI 1332.18 grants authority to the services to decide when they should refer individuals for medical fitness evaluation.[20] It also grants authority to the services to determine which "congenital or developmental defects," if any, should be administratively disqualifying and ineligible for medical fitness evaluation.[21]

Under DODI 1332.18, DOD defers to the judgment of the services and allows them to make their own decisions, within general guidelines, concerning retention of personnel. The new regulation, however, introduces a new limitation on administrative separation of personnel who have what used to be called "Enclosure 5" conditions. DODI 1332.18 states that the services can authorize administrative separation for designated conditions outside the medical review process only if the conditions "interfere with assignment to or performance of duty."[22] Under the old guidance, DOD simply "designated" certain conditions as disqualifying and the services followed suit, without any explicit medical finding that the conditions impair performance or limit assignment. Now that the regulation has been revised, services have the obligation to determine whether their own regulations, legacies of Enclosure 5, do in fact comply with the revised guidance in DODI 1332.18. As of this date of this study, no service-level retention regulation has been revised.

* Involuntary urination.

MEDICAL STANDARDS FOR DEPLOYMENT

Department of Defense Instruction 6490.07, *Deployment-Limiting Medical Conditions for Service Members and DOD Civilian Employees*, establishes policy for ensuring that personnel "are medically able to accomplish their duties in deployed environments."[23] It serves as a minimum medical standard across DOD, but is not intended to displace more restrictive standards that individual services may choose to impose.[24] In Enclosure 3, it lists a number of medical conditions that are normally disqualifying for deployment, although waivers can be granted after medical assessment. Medical conditions that can prevent deployment generally present one of the following issues:

Protection of self or others (inability to wear protective gear or receive immunizations)
Impairment of duty performance
Need for frequent clinical care, specialty treatment not readily available, or surgery
Failure to respond to adequate treatment; unresolved illness or injury
Requirement for durable medical appliances
Risk of sudden incapacitation or loss of consciousness
Infectious disease
Severe cardiac disease
Severe mental disorders

Despite these potentially disqualifying factors, DODI 6490.07 expressly permits deployment, without need for a waiver, for a number of medical conditions that present a significant health risk in a deployed environment. For example, hypertension is not disqualifying if controlled by medication, and heart attacks or coronary artery bypass grafts are not disqualifying if they occur more than a year preceding deployment. Service members may deploy with psychiatric disorders if they demonstrate stability under treatment for at least three months.[25]

ARMY STANDARDS FOR DEPLOYMENT

Army Regulation 40-501, *Standards of Medical Fitness*, is the Army's rulebook for determining overall medical fitness for duty, but it also provides special standards for deployment and assignment to certain geographical areas. The regulation emphasizes flexibility in accommodating medical needs in deployed areas and generally does not require any automatic disqualification from deployment:

> All Soldiers considered medically qualified for continued military status and medically qualified to serve in all or certain areas of the continental United States (CONUS) are medically qualified to serve in similar or corresponding areas outside the continental United States (OCONUS).
>
> Because of certain medical conditions, some Soldiers may require administrative consideration when assignment to combat areas or certain

> geographical areas is contemplated. Such consideration of their medical conditions would ensure these Soldiers are used within their functional capabilities without undue hazard to their health and well-being as well as ensure they do not produce a hazard to the health or well-being of other Soldiers.
>
> The final decision to deploy a Soldier with certain medical conditions is a command decision, based on the health care provider's (HCP's) recommendations and taking into account the geographical and environmental conditions the Soldier will be subject to and the mission requirements the Soldier will be assigned…. When HCPs and unit commanders disagree on the deployability status of a Soldier, the decision will be raised to the first general officer in the Soldier's chain of command, who will review the case and make the final decision.[26]

The deployment section of AR 40-501 also contains more specific guidelines for determining whether, or under which circumstances, it is appropriate to deploy individuals with certain conditions requiring medication and/or clinical monitoring. These conditions include diabetes, cardiovascular conditions, neurological conditions, asthma, sleep apnea, musculoskeletal conditions, psychiatric conditions, history of heat illnesses, pregnancy [the only categorical bar on the list], history of cancer, chronic infectious diseases [personnel may deploy to Europe or Korea, but not to a combat theatre], abnormal cervical cytology, malignant hyperthermia, and contact lenses.

AR 40-501 also offers guidance on the use of medications while deployed. Medications that are prescribed for "serious and/or complex medical conditions" are "not usually suitable for extended deployments." There are no automatic disqualifications, and the regulation advises pre-deployment screening and evaluation for individuals requiring certain listed medications. Hormone therapy, however, is not listed as one of the medications requiring special evaluation.

> *Medications.* Soldiers taking medications should not automatically be disqualified for any duty assignment. Medications used for serious and/or complex medical conditions are not usually suitable for extended deployments. The medications on the list below are most likely to be used for serious and/or complex medical conditions that could likely result in adverse health consequences. This is not an all-inclusive listing of medications that may render an individual non-deployable but is provided as a guideline to be used during pre-deployment medical screening. Because some medications are used for multiple reasons, any medical screening should take into account whether the drug is being used for a serious and/or complex medical condition or another use that might be appropriate for a deploying Soldier.[27]

NAVY/MARINE CORPS STANDARDS FOR DEPLOYMENT

Navy Bureau of Medicine and Surgery (BUMED) Instruction 1300.2A, *Suitability Screening, Medical Assignment Screening, and Exceptional Family Member Program (EFMP) Identification and Enrollment*, sets standards of medical fitness for Navy and Marine Corps personnel deploying to overseas, remote duty, or worldwide operational assignments.[28] This guidance is designed to ensure that service members do not deploy with medical conditions that are "beyond the treatment capability of the operational unit."[29]

The Navy and Marine Corps, like the Army, emphasize the importance of individual medical consideration of each service member prior to deployment:

> The underlying principle of suitability screening is to screen each service and family member as a specific individual for a specific location at a specific time. A service or family member may be suitable for one location or platform, but unsuitable for another; or suitable at one time and unsuitable at another. Two individuals with the same diagnosis may have different medical requirements; or a duty location may have a capability at one time, but not another.[30]

BUMED Instruction 1300.2A is far less specific, directive, and comprehensive than Army guidance when discussing medical conditions that are potentially disqualifying, but it highlights for closer evaluation several categories of conditions that may interfere with successful completion of an operational tour of sea duty: orthopedic injuries, cardiac or respiratory ailments, pregnancy, and psychological problems. Conditions that require frequent medical visits, ongoing medication, or specialized medical expertise should also be reviewed during the screening evaluation.[31] Except for pregnancy, however, none of these factors is necessarily dispositive. For example, service members may obtain a 180-day supply of required medication in advance if it is not normally stocked at overseas, remote duty, or operational locations.[32]

The bottom line is that communication and individual assessments are key:

> Screening supports readiness by ensuring the service member can execute his or her military duties associated with the military occupation and assignment. Communication and collaboration among and between the transferring and gaining commands and the screening and gaining military treatment facilities (MTF) during the transfer process is essential to ensure successful assignments.[33]

AIR FORCE STANDARDS FOR DEPLOYMENT

Air Force Instruction 48-123, *Medical Examinations and Standards*, defers to general Department of Defense guidance in defining deployment-disqualifying medical

conditions. It offers no additional service-specific guidelines on particular medical conditions and provides only the most general guidance on fitness to deploy:

> In general, a member must be able to perform duty in austere environment with no special food, billeting, medical or equipment support for up to 179 days. See DODI 6490.07, *Deployment-Limiting Medical Conditions for Service Members and DOD Civilian Employees* for medical standards not consistent with deployment.[34]

The Air Force also follows DOD guidance in expressly permitting waiver of deployment-disqualifying conditions. Airmen who have "Assignment Limitation Codes" based on disqualifying medical conditions may still be deployed outside the United States with the approval of the gaining command, provided the condition is stable and unlikely to worsen; medical care and medications are available without routine evacuation; and duty performance is not impaired.[35]

The Air Force administers a process for consideration and waiver of deployment-disqualifying medical conditions that appears very similar to the discretionary process used by the Navy and Marine Corps (with capitalization in the original):

> The [Assignment Limitation Code] is NOT designed to limit deployment and/or overseas assignments. It is designed to ensure that members with medical conditions are assigned and/or deployed to the appropriate location where care is available. This requires that waiver coordination between the losing base and the medical waiver approval authority occur in a timely manner.[36]

THE TRANSGENDER BAN AND ITS MILITARY RATIONALES

As explained in earlier sections on Entry and Retention, enlistment standards for all military services are governed by Department of Defense policy, but retention standards for personnel already serving in the military are governed by separate rules issued by each of the services. These service standards, however, were established under a system in which DOD issued a default set of medical retention standards and the services used them as a starting point for their own policies. As of August 5, 2014, DOD no longer takes a position on which specific conditions or circumstances should disqualify someone from retention in the military, and therefore the policies of the individual services are the current controlling authorities.

DOD STANDARDS FOR ENTRY INTO MILITARY SERVICE

Department of Defense Instruction 6130.03, *Medical Standards for Appointment, Enlistment, or Induction in the Military Services*, contains several sections that make transgender applicants ineligible for military service. (Additional guidance and commentary from the U.S. Military Entrance Processing Command [USMEPCOM] appear in italics after the corresponding regulatory sections.)

The following conditions do not meet the standard for enlistment and are disqualifying for military service:

> Female Genitalia: History of major abnormalities or defects of the genitalia including but not limited to change of sex….[37]
>
> Male Genitalia: History of major abnormalities or defects of the genitalia such as change of sex….[38]
>
> Current or history of psychosexual conditions, including but not limited to transsexualism, exhibitionism, transvestism, voyeurism, and other paraphilias.
> *This item is not a contradiction of the repeal of "Don't Ask, Don't Tell." Homosexuality was removed from the DSM classification of psychosexual conditions in 1973.*[39]

DODI 6130.03 grounds transgender identity in both physical conditions ("change of sex") and psychological conditions ("transsexualism," "transvestism," or "other paraphilias"), and being transgender under either definition is disqualifying. The references to gender identity within DODI 6130.03, however, are inconsistent with modern medical understanding. First, transgender identity is not considered a paraphilia and has no connection to paraphilic disorders that cause harm to others, such as exhibitionism or voyeurism.[40] Second, "transsexualism" was eliminated as a diagnosis 20 years ago when the *Diagnostic and Statistical Manual of Mental Disorders (DSM)* was

updated from the third (*DSM-III*)[41] to the fourth edition (*DSM-IV*).[42] Third, "transvestism" is an even more outdated term that was discarded in the 1980s.[43] As there are no modern *DSM* criteria for diagnoses of either "transsexualism" or "transvestism" in relation to gender identity, it is unclear how the military determines whether applicants have these conditions.

The military medical system purports to rely on the *DSM* as the authoritative diagnostic guide for psychiatric conditions,[44] but gender identity appears to be an exception to this practice. The military has not updated its enlistment regulations in decades to acknowledge developments in medical understanding of gender identity, despite publication of two new editions of the *DSM* in the interim. The most current version of the *DSM* (*DSM-5* in 2013,[45] abandoning roman numeral designators) replaced the *DSM-IV* discussion of "gender identity disorder" with new criteria for diagnosing what is now classified as gender dysphoria, or the distress that may follow from incongruence between gender assigned at birth and gender identity. The change was made to remove definitively any suggestion that transgender identity itself is a mental disorder,[46] although even under *DSM-IV*, gender identity was specifically distinguished from paraphilic disorders such as exhibitionism and voyeurism. Decades later, the military continues to confuse and conflate transgender identity with dysfunctional paraphilic disorders.

The USMEPCOM supplemental guidance on psychosexual conditions also anticipates that examiners may not properly understand and distinguish between sexual orientation and gender identity. ("This item is not a contradiction of the repeal of 'Don't Ask, Don't Tell.'") It is unclear why this enlistment guidance emphasizes the consistency of military policy (after repeal) with medical consensus from the *DSM* in the case of gay applicants, but fails to recognize the medical obsolescence of its policy in the case of transgender applicants.

DOD STANDARDS FOR RETENTION IN MILITARY SERVICE

Before August 5, 2014

The now-cancelled DODI 1332.38, *Physical Disability Evaluation*, was superficially more current in its references to gender identity because it followed the terminology used in the 1994 *DSM-IV* instead of the 1980 *DSM-III*.[47] (The regulation was not revised to incorporate 2013 developments from *DSM-5* before it was cancelled in 2014.) In other words, prior to August 5, 2014, the DOD retention rules referred to transgender diagnoses that were one *DSM* edition out of date, and the DOD enlistment rules referred to diagnoses that were two editions out of date. More importantly, neither one recognized the substantive shift in medical understanding of gender identity that had taken place over the last three decades. Although DODI 1332.38 revised the terminology it used to refer to transgender servicemembers to be consistent with *DSM-IV*, it retained its medically inaccurate view of transgender identity as pathological or deviant.

DODI 1332.38 stated that certain psychiatric disorders rendered individuals administratively unable to perform duty under Enclosure 5 rather than medically unable under Enclosure 4:

> Personality, Sexual, or Factitious Disorders, Disorders of impulse control not elsewhere classified, Adjustment Disorders (with the exception of Chronic Adjustment Disorders), Substance-related Disorders, Mental Retardation (primary), or Learning Disabilities are conditions that may render an individual administratively unable to perform duties rather than medically unable, and may become the basis for administrative separation. These conditions do not constitute a physical disability despite the fact they may render a member unable to perform his or her duties.[48]

Enclosure 5 of DODI 1332.38 contained a comprehensive list of these administratively disqualifying conditions. One category of conditions on the list was "sexual gender and identity disorders, including sexual dysfunctions and paraphilias,"[49] without further elaboration or explanation beyond those ten words. This phrase referred to a full chapter in *DSM-IV* and therefore included a wide variety of conditions related to gender or sexual behavior, ranging from premature ejaculation to pedophilia. "Gender Identity Disorders" was one sub-topic within this *DSM-IV* chapter, separate and distinct from other sub-topics addressing sexual dysfunctions or paraphilias. DODI 1332.38 itself contained no further guidance, but it appeared the Department of Defense applied this disqualification selectively and had no intention of separating service members for the full range of conditions within this category. For example, it would have been shocking if the military separated service members for inadequate sexual performance, although DODI 1332.38 would have given the military latitude to do so.

The Defense Department's regulatory classification of transgender status as "not constituting a physical disability" under Enclosure 5 stigmatized transgender individuals. Gender identity concerns were presumed to be resistant to treatment and inherently dysfunctional in a military setting, all without opportunity to rebut. Transgender service members were denied the dignity of a medical evaluation process that permitted non-transgender members to receive medical care and then demonstrate fitness for duty. Instead, Enclosure 5 grouped transgender individuals together with service members deemed beyond saving: the deviant, the bed-wetter, the fearful, the addict, the mentally disordered, the obese, and the unsanitary. All were subject, under Department-wide rules, to administrative separation for the convenience of the government and at a commander's discretion.

After August 5, 2014

The replacement of DODI 1332.38 with the new DODI 1332.18 on August 5, 2014 ushered in a new era of military medical retention guidelines. The Department of Defense transferred authority to the individual services to decide which conditions or circumstances should lead to administrative separation and would no longer establish any

specific position as a default. As a result, DOD no longer requires the services to separate transgender service members, but the legacy of the prior system of DOD control leaves all services with similar or identical policies that disqualify transgender personnel from remaining in the military, regardless of fitness for duty or need for medical care. Each service has a linked set of medical and administrative regulations designed to achieve two results: 1) A medical regulation that declares personnel with certain conditions or circumstances, including transgender identity, to be ineligible for the protections of the medical evaluation system; and 2) An administrative regulation that designates the same conditions or circumstances as grounds for administrative separation for the convenience of the government.[50]

One could make the case that current service-level lists of administratively disqualifying conditions (all derived from the former Enclosure 5) are arbitrary as a whole because they allow commanders to make decisions about fitness for duty without the protections of the medical evaluation process. If these conditions were handled in the same way as other potentially disqualifying medical conditions, affected service members would at least have the opportunity to make their case for fitness after receiving appropriate treatment, even if a finding of unfitness did not require disability compensation. However, this study considers only the narrower claim that designating transgender identity as an administratively disqualifying condition is particularly arbitrary and clearly distinguishable from other listed conditions. Many "Enclosure 5" conditions can be problematic in a military setting, for reasons that are apparent. To the extent they are pre-existing to service and also resistant to medical intervention, commanders may be as able as medical professionals to evaluate continued fitness for duty. In contrast, there is no medical reason to assume that transgender identity poses a similar risk to duty performance or health. Commanders have no basis for making medical judgments of unfitness, and medical treatments are safe and effective.

The transgender disqualification is also distinguishable from other "Enclosure 5" disqualifications in the way it is applied. For example, commanders do not separate every service member who stutters while speaking, even though stuttering is listed as an administratively disqualifying condition. Commanders would presumably take action only if the condition seriously interfered with communication to a degree that impacted duty performance. Likewise, it would be shocking if commanders denied medical treatment to service members seeking relief for conditions such as incontinence, motion sickness, or shaving infection, under the justification that Enclosure 5 made them automatically ineligible for care or retention. Unlike other conditions that can lead to administrative separation, however, being transgender is considered a sweeping disqualification for both necessary medical treatment and continued service.[51]

ARMY STANDARDS FOR RETENTION IN MILITARY SERVICE

Army medical retention standards in Army Regulation 40-501, *Standards of Medical Fitness*, state that soldiers should be administratively separated if they are discovered to have any of the following conditions:

> A history of, or current manifestations of, personality disorders, disorders of impulse control not elsewhere classified, transvestism, voyeurism, other paraphilias, or factitious disorders, psychosexual conditions, transsexual, gender identity disorder to include major abnormalities or defects of the genitalia such as change of sex or a current attempt to change sex, hermaphroditism, pseudohermaphroditism, or pure gonadal dysgenesis or dysfunctional residuals from surgical correction of these conditions render an individual administratively unfit.
>
> These conditions render an individual administratively unfit rather than unfit because of physical illness or medical disability. These conditions will be dealt with through administrative channels….[52]

The Army's corresponding guidance on administrative separation contains its service-level version of the now-cancelled DODI 1332.38 Enclosure 5. Army Regulation 635-200, *Active Duty Enlisted Administrative Separations*, lists "transsexualism/gender transformation" as one of the "physical or mental conditions not amounting to disability" justifying administrative separation. Other conditions on this nonexclusive list include airsickness, seasickness, enuresis, sleepwalking, dyslexia, nightmares, claustrophobia, and "other disorders manifesting disturbances of perception, thinking, emotional control or behavior sufficiently severe that the Soldier's ability to effectively perform military duties is significantly impaired."[53]

These regulations make reference to a variety of outdated terms related to transgender identity culled from various versions of the *DSM* over several decades: "transvestism," "transsexualism," and "gender identity disorder." Like the now-cancelled DODI 1332.38, the Army associates transgender identity with paraphilia and other dysfunctional disorders. The choice of terms, however, has not affected the consequences of the transgender ban. For example, the Army National Guard and Army Reserve version of *Enlisted Administrative Separations* reissued on March 18, 2014 is apparently the first military regulation at any level to add the correct *DSM-5* terminology of gender dysphoria to the mix, but this semantic addition did not change the substance of the policy or acknowledge the medical consensus of the current *DSM*. Transgender identity remains grounds for administrative separation, consistent with general Army guidance:

> Such conditions may include, but are not limited to, chronic airsickness or seasickness, enuresis, sleepwalking, dyslexia, severe nightmares, claustrophobia, personality disorder, transvestism, gender identity disorder or gender dysphoria, and other related conditions in accordance with AR 40-501, paragraph 3-35. Transsexualism/gender transformation in accordance with AR 40-501, and other disorders manifesting disturbances or perception, thinking, emotional control or behavior sufficiently severe that the Soldier's ability to perform military duties effectively is significantly impaired.[54] [Incomplete sentence is in the original.]

NAVY/MARINE CORPS STANDARDS FOR RETENTION IN MILITARY SERVICE

Navy/Marine Corps standards for retention were copied from DODI 1332.38 Enclosure 5 and contain the full complement of "developmental defects" justifying administrative separation. "Sexual gender and identity disorders and paraphilias" (and, oddly, "homosexuality") are included as conditions that "should be referred for appropriate administrative action."[55] The corresponding administrative regulation, *Separation By Reason of Convenience of the Government—Physical or Mental Conditions*, provides for administrative separation of personnel with disqualifying conditions, including transgender personnel.[56] Interestingly, this regulation requires that affected service members be notified in writing that "You are being afforded any and all medical assistance as required by your medical condition,"[57] although in the case of transgender personnel that statement cannot be accurate. Other regulations specifically prohibit the military medical system from providing transgender-related medical care.[58]

However, Navy standards depart from the standards of other services in one unusual and unexplained way. In discussing special qualifications for naval nuclear field duty (nuclear propulsion and/or nuclear weapons) and submarine duty, Navy regulations offer the following additional guidance for both prospective and current personnel (emphasis added):

> Psychological and Cognitive. Psychological fitness for nuclear field [or submarine] duty must be carefully and continuously evaluated in all nuclear field [or submarine] personnel. It is imperative that individuals working in these programs have a very high degree of reliability, alertness, and good judgment. Disorders italicized below refer to diagnoses or categories described in the DSM-IV-TR.
> …
>
> Disorders usually first diagnosed in infancy, childhood, or adolescence, sleep disorders, *and sexual and gender identity disorders are disqualifying if they interfere with safety and reliability or foster a perception of impairment*.[59]

These sections appear to permit personnel with a "gender identity disorder" (the military's outdated reference) to serve in the naval nuclear field or in submarine duty provided the condition does not interfere with safety and reliability or foster a perception of impairment. If these sections did in fact permit enlistment and retention of transgender personnel in these elite career fields, the result would be inconsistent with more general Navy guidance that categorically bans transgender personnel. The discrepancy seems unintended because special standards for nuclear or submarine duty would normally be more restrictive than general service standards, not less. However, these specific sections were reviewed and reissued by the Navy without change to the gender identity provisions as recently as April 4, 2014, when Change 147 was issued.

AIR FORCE STANDARDS FOR RETENTION IN MILITARY SERVICE

The Air Force's *Medical Standards Directory* refers to administratively disqualifying conditions only by general reference to the conditions that were listed in the now-cancelled DODI 1332.38: "A list of unsuiting disorders are location [located] in DODI 1332.38 Enclosure 5."[60] This DOD regulation no longer exists, and so the Air Force will need to revise its *Medical Standards Directory* to identify those conditions it considers "unsuiting." It can be assumed, however, that its current medical standards intend to disqualify transgender airmen for retention because other Air Force regulations specifically permit their separation for the convenience of the government. Air Force Instruction 36-3208, *Administrative Separation of Airmen*, includes "transsexualism or gender identity disorders" among the "mental disorders" and "conditions that interfere with military service" that are grounds for involuntary separation.[61]

Although an unlikely circumstance, if the Air Force discovers that a service member has undergone a surgical change of sex either before enlistment or during military service, that physical "change of sex" is separately and specifically disqualifying for retention.[62]

MILITARY RATIONALES FOR THE TRANSGENDER BAN

The military has rarely been asked to justify or explain its exclusions based on gender identity. Some of the few official statements on record date to the 1980s. At first glance, these earlier statements may seem dated or even irrelevant, but they were made in defense of the same regulatory exclusion that remains in effect today. Regardless of when these rationales were offered, they are valid evidence of the reasoning that underlies this longstanding policy. Furthermore, the military reaffirmed some of these justifications in 2014 following publication of the Elders-Steinman Commission Report.

The most comprehensive statement supporting a categorical exclusion of transgender individuals from service appears in a 1981 court declaration filed in response to a former service member's legal challenge to the policy.[63] General Frank F. Ledford, Jr., a physician and Chief of Medical Corps Affairs in the Army's Office of the Surgeon General, cited four medical justifications for the military's exclusion of persons who, like the plaintiff seeking to re-enlist, have had gender-transition surgery:

1. Lack of medical competence in hormone replacement therapy and limited availability of medication:

> Hence, determination and adjustment of hormone dosage levels in the case of post-operative transsexuals are matters which are outside the competence of general medical officers. The general medical officer normally is also not qualified to diagnose and treat endocrinological aberrations that may appear in the course of hormone therapy associated with change of sex operations. Further, hormones which are essential to

> maintenance of the post-operative transsexual may not be available at remote installations and would not be among the medications available in wartime medical facilities.

2. Potential surgical complications:

> Medical officers in the field cannot be expected to be able to recognize all post-surgical complications with ease, or, having diagnosed such complications, to be able to treat them with full knowledge of what they may entail.

3. Risk of mental disorder and disproportionate need for mental health care:

> The state of mind of a person who decides to undergo such surgery is not the norm, and is not likely to become normal upon completion of such a procedure. Postsurgical psychological treatment is expected and psychiatric therapy may be necessary for an indefinite period. The medical literature indicates that transsexuals do not handle interpersonal and social relationships well and experience difficulty with internal self-concept.

4. The need for specialized medical care and facilities, with limits on deployment:

> In order to anticipate and provide for all of the medical and psychological problems which the transsexual may experience in service, more specialized treatment facilities and more specialized personnel would have to be made available to the transsexual soldier than are available at many military installations…. Furthermore, specialized treatment facilities and personnel are not found in remote areas of the world where military personnel currently serve or where military requirements may require their assignment in the future. To limit the assignment of transsexuals to areas where treatment facilities adequate for their potential needs exist would so limit their assignment availability as to preclude their effective deployment where and when the needs of the military dictate.[64]

In a 1987 court case, the Air Force defended its transgender policies by contending that assignment of transgender service members to remote geographic areas "would be equivalent to placing an individual with known coronary artery disease in a remote location without readily available coronary care."[65] Ironically, however, Department of Defense policy does not automatically prohibit deployment by personnel with coronary artery disease. For example, hypertension is not disqualifying if controlled by medication, and heart attacks or coronary artery bypass grafts are not disqualifying if they occur more than a year preceding deployment.[66] If the two situations were genuinely regarded as equivalent, the military would not consider transgender personnel automatically unsuitable for deployment.

In general, the most common justification raised over the last thirty years is the assumption that transgender service members require specialized medical care that can only be provided in major medical facilities and ideally in the United States. As a result, the military contends that transgender individuals must be categorically excluded from service because they cannot be deployed as the needs of the military may direct. In 2007, the Air Force relied on this rationale in successfully defending a legal challenge against the categorical transgender ban:

> Air Force duties require individuals from all career fields to serve in a variety of locations around the globe, often changing assignments on short-term notice. Military medical providers in the field are not familiar with the problems these patients may encounter. Individuals who have undergone sex change procedures would not be qualified for world-wide service and if the Air Force assigned them even to remote domestic locations they would be without access to potentially acute specialized tertiary medical care, which would only be available at major medical centers.[67]

Following publication of the Elders-Steinman Commission Report in March 2014 and increased attention to the medical basis for the policy, the military reaffirmed its position that transgender individuals present medical concerns beyond the military's capacity to manage. The operative words in recent official military statements have been "austere" and "untenable."

> In doing these reviews, the department considers that service members must serve in austere environments, many of which make necessary and ongoing treatments related to sex reassignment and many other conditions untenable.[68]

> Policies on military personnel and health care regarding transgender members are intended to meet the needs of the services, which include the ability to deploy to and serve in austere environments with limited (and perhaps no) access to medical care for prolonged periods on little or no notice.… Service members must serve in austere environments, many of which make necessary and ongoing treatments related to sex reassignment and many other conditions untenable.[69]

COMPARISON 1:
CONDITIONS THAT ARE GENDER-RELATED OR MAY REQUIRE HORMONE REPLACEMENT

The military's medical standards for conditions that are gender-related or may require hormone replacement were chosen as representative comparisons to the transgender medical ban because the nature of medically necessary care in each instance will be similar and sometimes identical. The comparison is also helpful in illustrating how the military typically determines if gender-related conditions impair fitness for duty.

Non-transgender individuals who have conditions that are gender-related or may require hormone replacement are not necessarily disqualified for enlistment, and retention regulations do not require referral for possible medical separation unless the condition interferes with duty performance. Medical regulations strike a careful balance in retaining service members whose medical conditions do not significantly impair fitness for duty while avoiding undue burden on doctors, commanders, and the military healthcare system.

In contrast, medical rules that apply to transgender personnel make no attempt to balance these aims and instead require the exclusion of all transgender service members, regardless of fitness for duty or burden of care. Transgender individuals are medically disqualified for enlistment and administratively ineligible for retention, and the ban is categorical. Within the military's universe of conditions that relate in some way to gender or gender-related hormones, being transgender is uniquely disqualifying.

DOD STANDARDS FOR ENTRY INTO MILITARY SERVICE

Department of Defense Instruction 6130.03, *Medical Standards for Appointment, Enlistment, or Induction in the Military Services*, contains some standards that are gender-related and therefore apply only to men or to women. (Additional guidance and commentary from the U.S. Military Entrance Processing Command [USMEPCOM] appear in italics after the corresponding regulatory sections.)

For example, the following gynecological conditions do not meet the standard for enlistment and are disqualifying for military service:

> Current or history of abnormal menstruation unresponsive to medical management within the last 12 months …
>
> Primary amenorrhea, or current unexplained secondary amenorrhea. *Amenorrhea secondary to contraceptive use (i.e. Depo Provera, Seasonale) meets the standard.*

> Current dysmenorrhea that is unresponsive to medical therapy and is incapacitating to a degree recurrently requiring absences of more than a few hours from routine activities.
>
> Endometriosis that is unresponsive to medical therapy.
>
> Polycystic ovarian syndrome with metabolic complications.
> *Metabolic complications are diabetes, obesity, hypertension, and hypercholesterolemia. The following are not metabolic complications: virilization, menstrual cycle changes, infertility, and acne. Applicants with suspected polycystic ovarian syndrome (PCOS) are referred to their primary care provider for evaluation. Confirmed PCOS meets the standard if the applicant's primary care provider has evaluated and ruled out metabolic complications in the last two years.*[70]

For men, the following conditions do not meet the standard for enlistment and are disqualifying for military service:

> Absence of one or both testicles, congenital or undescended.
> *A missing testicle from any cause does not meet the standard. Undescended testicle surgically placed into the scrotum meets the standard.*
>
> Male hypogonadism [low testosterone].[71]

Under DODI 6130.03, it appears that the Defense Department is stricter in its evaluation of men with hormone deficiency or need for hormone replacement than it is with women. The regulation disqualifies all male applicants with testosterone deficiency (male hypogonadism). However, it does not disqualify all female applicants with hormonal imbalance. Polycystic ovarian syndrome (PCOS) is not disqualifying unless it causes metabolic complications of diabetes, obesity, hypertension, or hypercholesterolemia. Virilization[*] in non-transgender women with PCOS, which can be treated by hormone replacement, is expressly not disqualifying for enlistment.

DODI 6130.03 therefore permits enlistment by non-transgender women who are receiving medically effective hormone treatments to control virilization, but it categorically disqualifies transgender women who are receiving hormone treatments for the same reason. The circumstance of applicants with polycystic ovarian syndrome is an example of how the identical medical treatment, used for the same purpose, can be either permitted or disqualifying depending on whether the individual receiving the treatment is transgender or not.

Various menstrual disorders ("abnormal menstruation," dysmenorrhea, or endometriosis) are disqualifying for enlistment only if the condition is "unresponsive to medical management" or "unresponsive to medical therapy."[72] The regulation permits women to

[*] Virilization is the masculinization of the body.

enlist despite these conditions, provided a medically effective treatment is available. DODI 6130.03 does not place any restrictions on the medications used to manage these conditions, and therefore effective treatments can include hormone therapy. In contrast, a similar need for hormone therapy is one of the military's rationales for banning all transgender individuals from military service, even though gender dysphoria is similarly responsive to medical management and can be treated effectively with hormones. Once again, the same form of medical treatment can be either permitted or disqualifying for enlistment, depending on whether the individual receiving the treatment is transgender or not.

ARMY STANDARDS FOR RETENTION IN MILITARY SERVICE

Army medical regulations do not refer gender-related conditions to a medical retention board unless they significantly affect duty performance and are not responsive to medical treatment. Ability to perform is the benchmark. For example, the Army does not refer individuals with gynecological conditions (dysmenorrhea, endometriosis, menopausal syndrome, chronic pelvic pain, hysterectomy, oophorectomy) for fitness evaluation unless the conditions affect duty performance. The only male genitourinary conditions that require referral for fitness evaluation involve renal or voiding dysfunctions. Use of gender-related hormones is not listed as a reason for referral for either men or women.[73]

The only gender-related conditions that carry over from enlistment disqualification and continue to disqualify members categorically during military service are conditions directly related to gender identity. There is only one gender-related medical condition or status that leads to separation regardless of fitness for duty and regardless of medical risk, and that is being transgender.

NAVY/MARINE CORPS STANDARDS FOR RETENTION IN MILITARY SERVICE

Consistent with Army standards, Navy/Marine Corps regulations do not refer gender-related medical conditions to a medical retention board unless they significantly affect duty performance or are not responsive to treatment, and the only gender-related conditions that carry over from enlistment disqualification and continue to disqualify members categorically during military service are conditions directly related to gender identity.[74]

AIR FORCE STANDARDS FOR RETENTION IN MILITARY SERVICE

Air Force standards similarly focus on whether a gender-related condition impairs duty performance or is not responsive to treatment. For example, gynecological conditions are referred for fitness evaluation only under these circumstances:

> Endometriosis, ovarian cysts, or any other type of chronic pelvic pain, when it results in an inability to perform duties, frequent absences from duty, or the need for ongoing specialty follow-up more than annually.
>
> Dysmenorrhea, menopausal, premenstrual symptoms, and/or abnormal uterine bleeding leading to inability to perform duties, frequent absences from duty, or the need for ongoing specialty follow-up more than annually.[75]

For men, absence of testicles or hypogonadism are not disqualifying for retention.[76] Use of gender-related hormones is not disqualifying for either men or women.

COMPARISON 2
MOOD AND ANXIETY DISORDERS

The military's medical standards for mood and anxiety disorders were chosen as a representative comparison to the transgender medical ban because military enlistment and retention regulations characterize both as psychiatric problems that can interfere with military service. For example, DODI 6130.03, *Medical Standards for Appointment, Enlistment, or Induction in the Military Services*, classifies mood and anxiety disorders under the same heading as the outdated terms of "transsexualism" and "transvestism."

This is, however, where the similarity ends. Mood and anxiety disorders are not automatically disqualifying for enlistment or retention in military service. Service members diagnosed with such disorders receive medical treatment and obtain relief in accordance with best medical practices. Mood and anxiety disorders lead to separation only if they significantly interfere with duty performance and also remain resistant to treatment. In contrast, transgender individuals are categorically disqualified for enlistment without consideration of actual risk. Transgender individuals already in military service are not eligible to receive medical care that is safe, effective, and medically necessary, and they can be separated without an opportunity to demonstrate fitness for duty.

DOD STANDARDS FOR ENTRY INTO MILITARY SERVICE

A history of mood or anxiety disorders is not automatically disqualifying for enlistment. The condition is assessed for seriousness and stability, and examiners are given guidance in weighing whether an applicant's psychiatric history presents a significant risk. The following conditions do not meet the standard for entry:

> History of depressive disorders, including but not limited to major depression, dysthymic disorder, and cyclothymic disorder requiring outpatient care for longer than 12 months by a physician or other mental health professional, or any inpatient treatment in a hospital or residential facility.
>
> Depressive disorder not otherwise specified, or unspecified mood disorder, UNLESS:
>
> (1) Outpatient care was not required for longer than 24 months (cumulative) by a physician or other mental health professional.
> (2) The applicant has been stable without treatment for the past 36 continuous months.
> (3) The applicant did not require any inpatient treatment in a hospital or residential facility.
>
> History of anxiety disorders, anxiety disorder not otherwise specified,

> panic disorder, agoraphobia, social phobia, simple phobias, other acute reactions to stress UNLESS:
>
> (1) The applicant did not require any treatment in an inpatient or residential facility.
>
> (2) Outpatient care was not required for longer than 12 months (cumulative) by a physician or other mental health professional.
>
> (3) The applicant has not required treatment (including medication) for the past 24 continuous months.
>
> (4) The applicant has been stable without loss of time from normal pursuits for repeated periods even if of brief duration; and without symptoms or behavior of a repeated nature that impaired social, school, or work efficiency for the past 24 continuous months.[77]

Near the end of the section on learning, psychiatric, and behavioral disqualifications in DODI 6130.03, there is also a "catch all" provision permitting examiners to reject applicants with "current or history of other mental disorders that, in the opinion of the civilian or military medical examiner, shall interfere with or prevent satisfactory performance of military duty."[78] This discretionary disqualification confirms the general policy and purpose behind the enlistment standards in DODI 6130.03: to identify physical or mental conditions that interfere with satisfactory performance of military duty. Ironically, however, the across-the-board disqualification of transgender applicants prevents any consideration of whether an individual's gender identity actually would interfere with satisfactory performance of military duty. Given that modern medical understanding holds that transgender identity is not itself a mental disorder, the inconsistency is particularly difficult to explain.

DOD STANDARDS FOR DEPLOYMENT

As of August 5, 2014, the Department of Defense no longer specifies which medical conditions should be disqualifying for retention in military service, giving the services discretion to make those decisions within general guidelines. However, DOD does issue standards for deployment of personnel with psychiatric conditions or prescriptions for psychotropic medications. These standards permit deployment in most circumstances despite the condition or need for medication. *Policy Guidance for Deployment-Limiting Psychiatric Conditions and Medications* begins with the twin principles that mental health disorders can and should be treated, and that service members should be given a reasonable period of time—up to a year—to determine if treatment is effective:

> Recovery, amelioration of symptoms, and reduction of behavioral impairment are always goals associated with military mental health treatment, as psychiatric disorders, including posttraumatic stress disorder, are treatable. Diagnosed conditions that are not amenable or anticipated not amenable to treatment and restoration to full functioning within one year of onset of treatment should generally be considered unfitting or

> unsuitable for military duty and referred to a medical evaluation board or to the personnel system.[79]

"The personnel system" is a reference to the procedures for administrative separation that are also used to separate transgender personnel. The difference is that regulations governing gender identity place service members on a track to separation that prohibits medically necessary and effective treatment, offers no opportunity for recovery or amelioration of symptoms, and makes demonstration of fitness for duty irrelevant. In contrast, non-transgender personnel "should be actively encouraged to seek treatment for mental health concerns."[80]

In general, service members with psychiatric conditions who demonstrate behavioral stability are permitted to deploy.[81] Psychotic and bipolar disorders are the only psychiatric conditions that are categorically disqualifying for deployment. The Department of Defense also recognizes that many service members with psychiatric conditions require medication and directs that only a few prescriptions are inherently disqualifying for deployment, primarily those used to treat disorders that are already disqualifying (psychotic and bipolar disorders). Otherwise, decisions can be made on a case-by-case basis.[82] News reports and investigations indicate, however, that even the small handful of deployment restrictions on psychotropic medications are routinely waived or violated.[83]

The Department of Defense and the individual services have adopted medical standards designed to identify applicants whose mental health history presents undue risk for successful military service. However, Army research recently published in *JAMA Psychiatry*, a peer-reviewed journal of the American Medical Association, has concluded that this informal and largely honor-system enlistment screening is less than effective. Army enlistees entered military service with significantly higher rates of post-traumatic stress disorder, panic disorder, and attention deficit and hyperactivity disorder than civilian peers. More than 8% of soldiers entered the Army with intermittent explosive disorder, nearly six times the civilian rate. Overall, nearly one in five soldiers had a common mental illness prior to enlistment.[84] A bill passed in May 2014 by the U.S. House of Representatives as an amendment to the National Defense Authorization Act for FY 2015 directs the National Institutes of Health (NIH) to develop better screening tools for military entrance examiners.[85]

The observation that the military lacks an effective screening mechanism for mental conditions should not be taken as a call for less screening in circumstances that require it. Better screening tools could be used to individually assess the mental health history of all applicants, including transgender applicants. However, the present lack of rigor in mental health screening undermines the military's insistence that transgender personnel must be categorically banned, without individual evaluation, for reasons that include mental health status. Furthermore, if the pressure to meet enlistment quotas has created an incentive to look the other way on mental health risks, it makes little sense to turn people away based on assumptions about gender identity that have been discredited by mental health professionals.

ARMY STANDARDS FOR RETENTION IN MILITARY SERVICE

The medical standard for retention of service members with mood and anxiety disorders is far less strict than the standard in place at the time of enlistment. In general, the condition must be severe and resistant to effective treatment before the Army considers referring an individual for a formal medical proceeding that could lead to separation. Soldiers with mood or anxiety disorders are referred for disability evaluation only if the condition requires "extended or recurrent" hospitalization or interferes with duty performance.

> The causes for referral to an MEB [Medical Evaluation Board] 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.[86]

Army Regulation 40-501, *Standards of Medical Fitness*, contains detailed guidance for worldwide deployment of service members with psychiatric conditions that closely tracks DOD's *Policy Guidance for Deployment-Limiting Psychiatric Conditions and Medications*. Soldiers requiring medication for mood and anxiety disorders are not categorically barred from deployment. The determination depends on the seriousness and stability of the condition, logistical difficulties in providing medication, and the need for clinical monitoring.[87]

NAVY/MARINE CORPS STANDARDS FOR RETENTION IN MILITARY SERVICE

Navy/Marine Corps standards for retention are similar. The standard is generous to the service member and favors retention. Mood and anxiety disorders that require medication or even hospitalization (as long as the hospitalization is not "extended or recurrent") are not disqualifying and do not require referral for disability evaluation.[88]

Rules for deployment overseas do not mandate any automatic disqualifications. An individual evaluation is required under the following circumstances, but the regulation does not direct a particular result:

> An episode of inpatient psychiatric treatment occurred in the past year.
>
> An exacerbation occurred, which did not result in hospitalization, but resulted in the inability to perform military or civilian work duties or to attend school for a period lasting longer than 3 days.

> Currently undergoing evaluation or treatment for mental disorder, as defined by the DSM-IV.
>
> Two or more significant outpatient interventions were required in the past year.[89]

AIR FORCE STANDARDS FOR RETENTION IN MILITARY SERVICE

The Air Force takes a similarly long-term view to the treatment and management of personnel with mood and anxiety disorders. They are not referred for possible medical separation unless their condition impairs duty performance for more than one year even with medical treatment. Retention standards from the Air Force's *Medical Standards Directory* require that individuals with mood or anxiety disorders be referred to a medical board under the following circumstances:

> Mental Health conditions causing persistent duty impairment or requiring recurrent duty limitations, or conditions resulting in interference with effective military performance for more than 1 year.
>
> Conditions which require continuing psychiatric support (e.g. weekly psychotherapy in order to function) beyond one year.
>
> Conditions requiring use of lithium, anticonvulsants, or antipsychotics for mood stabilization.
>
> Anxiety disorders, recurrent or chronic, requiring more than SSRIs[*] or other first-line CPG[**] directed medication, or requiring hospitalization.
>
> Depression or depressive disorders, chronic or recurrent, that impair duty performance or worldwide duty, or that do not resolve with SSRIs or other first-line therapy per CPG.[90]

These guidelines follow a consistent principle of patience in allowing effective medical treatment to take its course. Only when treatment is ineffective and duty performance is impaired for significant periods of time does the Air Force evaluate whether to retain an individual in service. For transgender personnel, however, the future possibility of duty limitation for periods far shorter than one year is used as a justification for separating them without treatment and without an opportunity to demonstrate fitness.

The *Medical Standards Directory* underscores the difference in how the Air Force responds to mood and anxiety disorders as compared to transgender identity. In the section that permits a full year for treatment and resolution of psychiatric conditions, and

[*] Selective Serotonin Reuptake Inhibitors
[**] Clinical Practice Guidelines

also limits referral for separation to circumstances of impaired duty performance, the regulation appends a note that reads, "Unless condition listed as 'unsuiting' per DODI 1332.38, Enclosure 5."[91] As a result, non-transgender service members with a confirmed mental impairment are provided medical treatment and as much as a year to recover, but transgender service members who may have no mental impairment are nonetheless subject to administrative separation without delay.

The Air Force *Medical Standards Directory* is the only service-level medical retention regulation to undergo a major revision and reissuance since the publication of *DSM-5* in May 2013, but it is unclear how comprehensively the Air Force has incorporated developments from *DSM-5*. At least some changes, however, seem connected to *DSM-5*. For example, the *Medical Standards Directory* includes a new *DSM-5* gender-related depressive disorder as potentially disqualifying for retention: Premenstrual Dysphoric Disorder (PMDD).[92]

Like other gender-related conditions (with the exception of having a transgender identity), the regulation refers military women with *DSM-5* PMDD for possible medical separation only if the condition significantly interferes with duty performance. In contrast, it continues to categorically disqualify transgender airmen for retention by deferring to the now-cancelled DODI 1332.38 Enclosure 5, even after the publication of *DSM-5* and its stance that transgender identity is not itself a mental disorder.

COMPARISON 3
DIABETES

The military's medical standards for diabetes were chosen as a representative comparison to the transgender medical ban because both involve conditions that require some degree of medical care and monitoring on an ongoing basis. There may also be significant variation among individuals in each group as to the degree of medical attention required. The comparison offers an opportunity to consider how the military manages chronic conditions that may (or may not) require specialized care, particularly in deployed environments. Diabetes may present one of the most extreme medical requirements for monitoring. Awareness of physical condition is necessary on a daily and even hourly basis, and lack of attention can quickly lead to rapid physical deterioration.

Newspaper reporting on two military medical cases, one involving a soldier diagnosed with diabetes and the other involving a sailor discovered to be transgender, highlights the significant differences in medical management of the two situations and serves as an introduction to and illustration of military regulations governing diabetes.

Mark Thompson, an Army non-commissioned officer, was diagnosed with Type 1 diabetes after four years of military service.[93] He immediately received medical treatment, including a $5,000 belt-mounted insulin pump to manage his medication. No immediate decisions were made about his military future, and the Army approved his assignment to a professional development course necessary for promotion. More than eighteen months after diagnosis, a medical evaluation board approved Sgt. Thompson's request to stay in the Army. When his unit received orders to deploy to Iraq, he was permitted to deploy because insulin was available and could be stored in a portable refrigerator. He obtained syringes and cool packs for emergencies, and they were used when his insulin pump was broken. His military doctor was initially skeptical, but said that Thompson "showed me that he had a comprehensive knowledge of his body, his diet, his insulin needs, and that he also had an in-depth trouble-shooting plan."[94]

Thompson became a spokesperson for the American Diabetes Association while continuing to serve. The Army had sent his story to the organization as part of its outreach on how the Army handles soldiers with diabetes.[95] The ADA sold a uniformed teddy bear, the "Staff Sergeant Thompson Bear," to raise funds for diabetes research.[96] Thompson also appeared in a short film about his military career aired in November 2012.[97]

In contrast, the treatment of transgender personnel by the military medical system can be decidedly more abrupt and stigmatizing. Petty Officer Landon Wilson was discovered to be transgender while deployed to Afghanistan as a Navy cryptologic technician.[98] Within six hours of revealing his gender identity, he was removed from duty and put on a plane back to the United States. It did not matter to the military that no one was immediately available to take his place conducting intelligence interception and analysis. Within weeks, Petty Officer Wilson was administratively separated from the Navy without

medical evaluation, without receiving medically necessary treatment, and without being afforded an opportunity to demonstrate fitness for duty.

In response to an inquiry, a Pentagon spokesperson stated that the department had no plans to change the policy, citing the claim that service by transgender personnel is medically untenable:

> In doing these reviews, the department considers that service members must serve in austere environments, many of which make necessary and ongoing treatments related to sex reassignment and many other conditions untenable.[99]

DOD STANDARDS FOR ENTRY INTO MILITARY SERVICE

The enlistment disqualification for diabetes and related conditions is as strict and as categorical as the disqualification for transgender identity. The following conditions do not meet the standard for entry:

> Diabetes mellitus disorders, including:
>
> (1) Current or history of diabetes mellitus.
>
> (2) Current or history of pre-diabetes mellitus defined as fasting plasma glucose 110-125 milligrams per deciliter (mg/dL) and glycosylated hemoglobin greater than 5.7 percent.
>
> (3) History of gestational diabetes mellitus.
>
> (4) Current persistent glycosuria, when associated with impaired glucose tolerance or renal tubular defects.[100]

DOD STANDARDS FOR DEPLOYMENT

As of August 5, 2014, the Department of Defense no longer specifies which medical conditions should be disqualifying for retention in military service, giving the services discretion to make those decisions within general guidelines. However, DOD does issue standards for deployment of personnel with certain medical conditions. The Department of Defense lists diabetes treated with insulin or oral hypoglycemics as a medical condition usually precluding contingency deployment, unless a waiver is granted after individual medical assessment.[101] "Consideration should be made for the nature of the disability and if it would put the individual at increased risk of injury or illness, or if the condition is likely to significantly worsen in a deployed environment."[102]

ARMY STANDARDS FOR RETENTION IN MILITARY SERVICE

Diabetes that is well controlled by diet and exercise is not disqualifying and does not trigger disability evaluation. Soldiers with diabetes are referred for evaluation only when their condition cannot be controlled by lifestyle modifications, as follows:

> Diabetes mellitus, unless hemoglobin A1c can be maintained at <(less than) 7% using only lifestyle modifications (diet, exercise).[103]

Apparently soldiers with diabetes whose condition *cannot* be controlled by diet and exercise are frequently found fit for duty and retained after disability evaluation, because the Army issues detailed guidance on when soldiers requiring insulin or oral medication may be deployed overseas:

> Diabetes requiring insulin:
> This requires a [physical evaluation board]. If found fit for duty, the Soldier should not deploy to areas where insulin cannot be properly stored (stored above freezing level but at less than 86 degrees Fahrenheit) or appropriate medical support cannot be reasonably assured. Deployment should only follow predeployment review and recommendation by an endocrinologist.
>
> Diabetes requiring oral medication for control:
> This requires a [physical evaluation board]. If found fit for duty by a PEB, the Soldier may or may not be worldwide deployable (see table 5–1 for medical qualifications).[104]

Eligibility for deployment depends on the seriousness of diabetes-related conditions, the ability of the soldier to comply with medical direction, availability of appropriate medical support, and the presence of significant co-morbidities. The guidance permits deployment by soldiers taking insulin or oral hypoglycemics even though they would require daily blood sugar monitoring and periodic lab monitoring.

Table 5-1 of AR 40-501 (reproduced on the following page) provides a detailed checklist of standards for deployment eligibility:

Table 5–1
Guidance on deployment of Soldiers with diabetes

Factor	OK to Deploy	Should Not Be Deployed
Hgb A1C (for patient)	At target	Not at target
Monofilament discrimination	Present	Absent
Autonomic neuropathy	Absent	Present
Knowledge of sick day rules	Sufficient	Insufficient
Proliferative diabetic retinopathy	Absent	Present
Macular edema	Absent	Present
Severe hypoglycemia (an episode requiring another person's assistance)	Infrequent	Frequent
History of diabetic ketoacidosis in previous 6 mos.	No	Yes
Self-management skills	Good	Poor
Hypoglycemia unawareness	Absent	Present
Parameters of permanent profile can be followed	Yes	No
Significant co-morbidities (for example, congestive heart failure, chronic kidney disease, significant coronary artery disease, poorly controlled hypertension) requiring intensive management	Absent	Present
Risk of hypoglycemia is high if meals are missed or delayed	No	Yes
Duty will place the Soldier in an OCONUS-Isolated area where appropriate medical care and means to monitor and support him/her are not available	No	Yes

NAVY/MARINE CORPS STANDARDS FOR RETENTION IN MILITARY SERVICE

Navy/Marine Corps standards for retention are slightly less restrictive than Army standards. Cases requiring oral hypoglycemics are not referred for disability evaluation if control is adequate.[105]

Diabetes is not necessarily deployment-limiting. Regulations governing deployment do not specifically rule in or rule out diabetes, but instead require doctors to consider the medical expertise and ancillary capability (laboratory, pharmacy) available to the service member when deployed.[106]

Naval personnel in the more austere and challenging fields of special operations duty or submarine duty may obtain waivers to serve with diabetes under limited circumstances, depending on the type of medication required and the presence or absence of organ damage.

> Special Operations (SO) duty takes place in every part of the world under harsh conditions at the extremes of human physical capabilities. Medical austerity and the presence of armed opposition are common. SO personnel, depending on service and warfare community, may engage the most high-risk operations including parachuting, static line rappelling, high-speed boat operations, employment of a variety of weapons, and

> diving. As such, SO is the most physically and mentally demanding duty in the U.S. military. Only the most physically and mentally qualified personnel should be selected, and those who are or may be reasonably expected to become unfit or unreliable must be excluded.
>
> Submarine duty is characterized by isolation, medical austerity, need for reliability, prolonged subsistence in enclosed spaces, exposure to atmosphere contaminants, and psychological stress. The purpose of the submarine duty standards is to maximize mission capability by ensuring the mental and physical readiness of the Submarine Force.[107]

The rules for retention in special operations duty are as follows:

> Diabetes mellitus is disqualifying.
>
> Diabetes mellitus requiring insulin or long-acting sulfonylurea hypoglycemic medication (such as chlorpropamide or glyburide) shall not be considered for a waiver.
>
> Diabetes mellitus controlled without the use of insulin or long-acting sulfonylurea medication may be considered for a waiver. Waiver requests must include documentation of current medications, current hemoglobin A1C level, and documentation of the presence or absence of any end organ damage.[108]

Similar guidance applies to submarine duty:

> Diabetes mellitus is disqualifying.
>
> Diabetes mellitus requiring insulin shall not be considered for a waiver.
>
> Diabetes mellitus controlled without the use of insulin may be considered for a waiver. Waiver requests must include documentation of current medications, current hemoglobin A1C level, and documentation of the presence or absence of any end organ damage.[109]

AIR FORCE STANDARDS FOR RETENTION IN MILITARY SERVICE

Air Force standards are the most restrictive of the services. All airmen diagnosed with diabetes, whether controlled by diet or requiring insulin or oral hypoglycemics, must be referred to a medical board to evaluate fitness for continued service.[110] It is important to note, however, that referral for medical fitness evaluation does not automatically lead to separation from service. The purpose of medical referral is to make an individualized assessment of fitness for duty.

COMPARISON 4
HEAD INJURY/CONCUSSION

Head injuries and concussions serve as a useful comparison to transgender medical care because they demonstrate the military's ability to adapt to new medical concerns. An Army report published in 2012, *Army 2020: Generating Health & Discipline in the Force Ahead of the Strategic Reset*, highlighted the rapid progress made by military medicine in identifying and treating concussive brain injuries, unexpectedly the signature injury of service members wounded in Iraq and Afghanistan.[111] Military medical policy on brain injuries applies the most advanced medical practices available to relieve suffering, heal injury, avoid recurrence, and return service members to effective duty performance and normal life activities.

The military's policies on head injuries also demonstrate its willingness to tolerate medical risk based on individual medical evaluation. Enlistment standards exclude applicants only if they have experienced very significant head injuries, and they appear to disregard milder, though serious, injuries typically associated with sports. For members of the military already serving, retention decisions are guided entirely by individual medical judgment about degree of impairment and capacity for improvement and recovery.

In 2012, the Department of Defense issued DODI 6490.11, *DOD Policy Guidance for Management of Mild Traumatic Brain Injury/Concussion in the Deployed Setting*. Its purpose was to standardize military procedures, leadership actions, and medical management of brain injuries in deployed environments.[112] The regulation stays up-to-date by directing commanders and medical personnel to information posted at the website for the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury.[113] "All deployed medical personnel must use, and commanders support, the most current clinical practice guidance for the deployed environment when possible."[114] The number of concussions sustained within a year is a key factor in treatment protocol.

Obviously the number of service members treated for head injuries will far exceed the number treated for gender dysphoria in a military that permits service by transgender persons. The Army reported a total of more than 125,000 diagnosed cases of traumatic brain injury for the decade 2000-2010.[115] The intent here is not to suggest that the military needs to devote a similarly massive effort to the treatment of gender dysphoria. Instead, the comparison invites a lesson closer to the reverse: that relatively simple medical interventions, even if seemingly novel and unfamiliar at the outset, can enhance the health and well being of military personnel and assist them in remaining fit for duty.

The military's response to the sudden rise in hidden brain injury demonstrates that military medicine is more than capable of adapting to unanticipated medical concerns and new treatment practices, even when medical knowledge about brain injury is developing quickly and subject to change. It undermines the claim that it would be beyond the military's capacity to develop expertise in the medical treatment of transgender

personnel. The military's insistence on the most up-to-the-minute medical practices in treating brain injuries also makes its 30-year delay in updating medical treatment of gender identity all the more unexplainable.

DOD STANDARDS FOR ENTRY INTO MILITARY SERVICE

Enlistment standards for applicants with a history of head injury are based on a detailed series of factors, primarily the severity of symptoms at the time of the injury, the length of time since the injury, and the persistence of residual effects from the injury. Given the magnitude of the military's problem with traumatic brain injury, a restrictive enlistment standard for history of head injury or concussion might be expected, but this is not the case. The regulation appears to assume that a history of concussive injuries does not unduly increase risk for later brain injury, provided a certain period of time has passed and symptoms have dissipated—even when the initial injury was serious enough to cause a significant period of unconsciousness (hours) or amnesia/disorientation (days).

Department of Defense standards disqualify applicants with a history of head injury only if the incident is far more serious than the sports-related concussions now receiving closer attention and monitoring. The regulation divides head injuries into three categories: "head injury" (the most serious category), "moderate head injury," and "mild head injury."[116]

The most serious category disqualifies an applicant whose head injury is associated with any of the following:

- Seizures occurring more than 30 minutes after injury
- Persistent motor, sensory, vestibular, visual, or other neurological defect
- Persistent impairment of cognitive function
- Persistent alteration of personality or behavior
- Unconsciousness of 24 hours or more post-injury
- Amnesia or disorientation of 7 days duration or longer
- Cerebral hematoma (only disqualifying until resolved and 12 months have elapsed)
- Abscess or meningitis
- Cerebrospinal fluid rhinorrhea [nose] or otorrhea [ear] persisting more than 7 days
- Penetrating brain injury

Moderate head injuries cause unconsciousness of more than 30 minutes but less than 24 hours, amnesia or disorientation of more than 24 hours but less than 7 days, or linear skull fracture. Moderate injuries are not disqualifying for enlistment if 12 months have passed and neurological examination shows no residual dysfunction or complication.

Mild head injuries are defined as those causing unconsciousness of less than 30 minutes post-injury, or causing amnesia or disorientation of less than 24 hours. They are not disqualifying for enlistment if one month has passed and neurological examination shows no residual dysfunction or complications.

A history of *persistent* post-concussive symptoms for more than one month is separately disqualifying, including headache, vomiting, disorientation, spatial disequilibrium, impaired memory, poor mental concentration, shortened attention span, dizziness, or altered sleep patterns.

ARMY STANDARDS FOR RETENTION IN MILITARY SERVICE

Army medical standards offer only general guidelines for retention of soldiers with brain injuries, which is not surprising given the inherently individualized nature of the injuries, their consequences, and appropriate medical treatment. One unifying principle within the guidelines is successful duty performance. Brain injury requires referral for medical evaluation when residual symptoms and impairments "significantly interfere with performance of duty" despite "adequate treatment":

> Any other neurologic conditions, Traumatic Brain Injury (TBI) or other 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.[117]

The emphasis on residual effects means that referral is necessary only when treatment is ineffective and the injury continues to significantly impair duty performance. Individual assessment is key, and the regulation determines whether to refer individuals to a medical board based on the presence or absence of severe and persistent complications from an injury, not on the nature of the injury itself.

NAVY/MARINE CORPS STANDARDS FOR RETENTION IN MILITARY SERVICE

Navy/Marine Corps standards are far less specific than Army standards, offering no markers or guidelines for retention of service members with brain injuries. "Traumatic brain injuries, residuals" are cause for referral into the disability evaluation system.[118] Like Army standards, the focus on "residuals" of a medical condition assumes three things: the service member receives medically necessary treatment; the treatment is to some degree ineffective; and duty performance remains significantly impaired.

AIR FORCE STANDARDS FOR RETENTION IN MILITARY SERVICE

Air Force standards are nearly identical to Army standards and require referral for fitness evaluation when the residual effects of brain injury are severe and unresponsive to medical treatment:

> Traumatic brain injury when after adequate treatment, there remain persistent post-traumatic sequelae [residual effects from a condition] including but not limited to: focal neurological signs, headache, vomiting, weakness or paralysis of important muscle groups, deformity, incoordination, pain or sensory disturbance, disturbance of consciousness, speech disturbance, disorientation, spatial disequilibrium, impaired memory, poor mental concentration, shortened attention span, dizziness, altered sleep patterns, any other findings consistent with encephalopathy, or personality changes of such a degree as to definitely interfere with the performance of duty.[119]

Each of these service-level policies recognizes the individualized nature of brain injury, the variety of symptoms or complications that may or may not result, and the possibility that medical treatment may or may not be effective. The military decides whether to refer a service member for fitness evaluation, a process that may lead to separation, only after medical treatment has proven ineffective, and only when symptoms or complications persist and significantly affect duty performance. The policies reflect the military's willingness to tolerate medical risk based on individual medical evaluation. In the case of transgender service members, however, the presumption is reversed. All transgender personnel are disqualified for retention based on a presumption that medically necessary treatment will render them unfit for duty.

CONCLUSION

Comparison of medical regulations governing gender identity and four representative medical conditions illustrates that the military's transgender policies are significant outliers in the context of its overall medical policies. This study identifies six major inconsistencies in military regulations between the medical treatment of transgender and non-transgender personnel:

(1) Two different standards can apply to comparable medical care, or even the same medical care, depending on whether the service member is transgender or not.

(2) Medical regulations governing non-transgender-related conditions strike a careful balance in retaining service members whose medical conditions do not significantly impair fitness for duty while avoiding undue burden on doctors, commanders, and the military healthcare system. In contrast, rules that apply to transgender personnel make no attempt to balance these aims and instead require the exclusion of all transgender service members, regardless of fitness for duty or burden of care.

(3) Medical regulations governing non-transgender-related conditions assess medical risk based on individual medical evaluation and generally rely on ability to perform military duty in making retention decisions. In contrast, military regulations governing gender identity presume all transgender personnel are unfit and render their duty performance irrelevant.

(4) Medical regulations governing non-transgender-related conditions are designed to maintain and restore health. They refer service members for fitness evaluation and possible separation only after medical treatment and a reasonable period of time for recovery. In contrast, regulations governing gender identity prohibit military doctors from providing safe, effective, and medically necessary treatment and require separation without an opportunity to demonstrate fitness.

(5) Medical regulations governing non-transgender-related conditions are updated on a regular basis to reflect current scientific consensus and best medical practices. In contrast, military rules governing gender identity are decades out of date and reflect assumptions that were repudiated a generation ago.

(6) Medical regulations governing non-transgender-related conditions do not stigmatize personnel who have those conditions. In contrast, transgender personnel are stigmatized by medical regulations that classify transgender identity within a category of "inherent defects" that includes sexual deviance and mental illness.

Most gender-related medical conditions, even those that may be treated with hormones, are not disqualifying for enlistment. It would be extremely unusual for a service member to be separated for any gender-related condition unless it significantly impaired duty performance. For medical conditions in general, service members are usually not referred to a medical board for fitness evaluation and possible separation unless medical treatment for that condition has been ineffective and their duty performance remains significantly impaired. Ability to perform duty satisfactorily and safely is the touchstone. Referral is also not appropriate unless a reasonable amount of time, up to a year, is allowed for recovery. Medical conditions are subject to few categorical rules. In almost all cases, military personnel have an opportunity to demonstrate they are fit to perform duty. The military cannot rely on speculation or conjecture in determining unfitness; objective evidence is necessary. Medical regulations are updated when necessary to reflect modern medical understanding and best practices.

All of these principles fall away in the case of military medical policies for transgender personnel. These policies prohibit treatment when the same or similar treatment would be provided to non-transgender personnel. They create gender-based disqualification in a system that has few gender-based disqualifications. They impose categorical disqualifications in a system that usually relies on individual assessment. They make duty performance irrelevant in a system that usually makes performance an important factor. They encourage arbitrary and rushed decisions although medical evaluation is normally deliberate and patient. They fail to value modern medical expertise and consensus. Finally, they stigmatize transgender service members by mistakenly associating them with sexual deviants and the mentally ill.

The Department of Defense's recent grant of authority to the individual services to set their own standards for retention of personnel offers an opportunity to reconsider the inconsistency and arbitrariness of transgender policy in the context of military medical policies in general.

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[3] The Air Force's medical standards for retention were removed from public access as part of a November 2013 revision to AFI 48-123, Medical Examinations and Standards. The regulation now refers readers to a non-public *AF Medical Standards Directory* for information about the standards themselves. The medical standards for retention in the other services remain available to the public at Army- and Navy-sponsored web sites.
[4] DODI 6130.03, Medical Standards for Appointment, Enlistment, or Induction in the Military Services, § 4(c).
[5] DODI 6130.03, Enclosure 4, §§ 13(a), 25(i).
[6] DODI 6130.03, Enclosure 2, § 3. Service-specific regulations and enlistment processing rules reflect the same understanding. USMEPCOM Regulation 40-1, Medical Services: Medical Processing and Examinations, § 5.1(b); AR 40-501, Standards of Medical Fitness, § 2-2(d); NAVMED P-117, U.S. Navy Manual of the Medical Department, Chapter 15, § 15-1(4); AFI 48-123, Medical Examinations and Standards, § 4.1.
[7] DODI 6130.03, § 4(a).
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[21] DODI 1332.18, § 3(i).
[22] DODI 1332.18, § 3(i).
[23] DODI 6490.07, Deployment-Limiting Medical Conditions for Service Members and DOD Civilian Employees, § 1.
[24] DODI 6490.07, § 2(c)(3).
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[26] AR 40-501, Standards of Medical Fitness, § 5-14(a), (b), (d).
[27] AR 40-501, § 5-14(f)(17).

[28] BUMED Instruction 1300.2A, Suitability Screening, Medical Assignment Screening, and Exceptional Family Member Program (EFMP) Identification and Enrollment, § 1(c).
[29] BUMED Instruction 1300.2A, § 3(b).
[30] BUMED Instruction 1300.2A, Enclosure 2, § 1(c).
[31] BUMED Instruction 1300.2A, Enclosure 2, § 3(a)–(c).
[32] BUMED Instruction 1300.2A, Enclosure 2, § 10(r).
[33] BUMED Instruction 1300.2A, § 3(c).
[34] AFI 48-123, Medical Examinations and Standards, § 11.1.
[35] AFI 48-123, § 11.2.
[36] AFI 41-210, TRICARE Operations and Patient Administration Functions, § 4.76.3 and Attachment 17.
[37] DODI 6130.03, Medical Standards for Appointment, Enlistment, or Induction in the Military Services, Enclosure 4, § 14(f).
[38] DODI 6130.03, Enclosure 4, § 15(r).
[39] DODI 6130.03, Enclosure 4, § 29(r).
[40] A paraphilic disorder is an atypical sexual interest that causes distress to self or harm to others. American Psychiatric Association, Paraphilic Disorders Fact Sheet (2013), *http://www.dsm5.org/Documents/Paraphilic%20Disorders%20Fact%20Sheet.pdf*.
[41] American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* (3rd ed. 1980).
[42] American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* (4th ed. 1994), 789.
[43] Under the 1980 *DSM-III*, the paraphilia of transvestism meant the wearing of women's clothing by heterosexual men for purposes of sexual excitement. It had nothing to do with gender identity. *Diagnostic and Statistical Manual* (3rd ed. 1980), 269–70. This paraphilia is now referred to as transvestic disorder. See note 40.
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[46] American Psychiatric Association, Gender Dysphoria Fact Sheet (2013), *http://www.dsm5.org/documents/gender%20dysphoria%20fact%20sheet.pdf*.
[47] DODI 1332.38, Physical Disability Evaluation, Enclosure 4, § E.4.13.1.1 (cancelled August 5, 2014).
[48] DODI 1332.38, Enclosure 4, § E4.13.1.4 (cancelled August 5, 2014).
[49] DODI 1332.38 mistakenly transposed the correct *DSM* language "sexual and gender identity disorders," further confusing its obsolete use of language and reference to outdated diagnoses.
[50] AR 40-501, Standards of Medical Fitness, § 3-35(a), (b); AR 635-200, Active Duty Enlisted Administrative Separations, §§ 5-13, 5-17; SECNAV Instruction 1850.4E, Department of the Navy Disability Evaluation Manual, Enclosure 8, Attachment (b), § 3(i)(7); NAVMED P-117, U.S. Navy Manual of the Medical Department, Chapter 18, § 18-5(3); MILPERSMAN 1910-120, Separation by Reason of Convenience of the Government—Physical or Mental Conditions, § 2; AF Medical Standards Directory (referring to "unsuiting" conditions under the former Enclosure 5 throughout); AFI 36-3208, Administrative Separation of Airmen, § 5.11.9.5.
[51] The military health care system (TRICARE) also excludes from coverage all medical treatments related to gender identity. TRICARE Policy Manual 6010.57-M (2008), Chapter 1, § 1.2, ¶ 1.1.29.
[52] AR 40-501, Standards of Medical Fitness, § 3-35(a), (b).
[53] AR 635-200, Active Duty Enlisted Administrative Separations, § 5-17.
[54] AR 135-178, Army National Guard and Army Reserve Enlisted Administrative Separations, § 6-7(a).
[55] SECNAV Instruction 1850.4E, Enclosure 8, Attachment (b), § 3(i)(7) and NAVMED P-117, U.S. Navy Manual of the Medical Department, Chapter 18, § 18-5(3).
[56] MILPERSMAN 1910-120, Separation By Reason of Convenience of the Government—Physical or Mental Conditions, § 2(a)(13).
[57] MILPERSMAN 1910-120, Exhibit 1.
[58] TRICARE Policy Manual 6010.57-M (2008), Chapter 1, § 1.2, ¶ 1.1.29.
[59] NAVMED P-117, Chapter 15, §§ 15-103(4)(d) and subsection (4) (Nuclear Field Duty); 15-106(4)(k) and subsection (4) (Submarine Duty).
[60] *AF Medical Standards Directory*, 66.

[61] AFI 36-3208, Administrative Separation of Airmen, § 5.11.9.5. See also AFI 36-3206, Administrative Discharge Procedures for Commissioned Officers, § 2.3.7.5.
[62] *AF Medical Standards Directory*, § J57.
[63] Declaration of General Frank F. Ledford, Jr., Feb. 9, 1981, filed in *Doe v. Alexander*, 510 F. Supp. 900 (D. Minn. 1981).
[64] In addition to the medical rationales stated in his Declaration, General Ledford also cited "peer considerations" in support of the ban on transgender personnel: "The presence of a transsexual in a military unit, especially when deployed in circumstances requiring close living conditions, would have an adverse impact upon the morale and the consequential combat effectiveness of a military unit."
[65] *Leyland v. Orr*, 828 F.2d 584, 585-86 (9th Cir. 1987).
[66] DODI 6490.07, Deployment-Limiting Medical Conditions for Service Members and DOD Civilian Employees, Enclosure 3.
[67] *DeGroat v. Townsend*, 495 F. Supp. 2d 845, 851 (S.D. Ohio 2007).
[68] Ernesto Londoño, When Honesty Can End a Career, Washington Post, Apr. 27, 2014.
[69] Nathaniel Frank, Why Has the Pentagon Turned Into a Robot When Asked to Explain Its Trans Ban, Slate, May 1, 2014, *http://www.slate.com/blogs/outward/2014/05/01/pentagon_ban_on_transgender_service_there_s_no_good_reason_to_exclude_trans.html*.
[70] DODI 6130.03, Medical Standards for Appointment, Enlistment, or Induction in the Military Services, Enclosure 4, § 14(a)–(e), (h). Polycystic ovarian syndrome with metabolic complications is a new disqualifying condition added by Change 1 to DODI 6130.03 (Sept. 13, 2011).
[71] DODI 6130.03, Enclosure 4, §§ 15(a), 25(l). Male hypogonadism is a new disqualifying condition added by Change 1 to DODI 6130.03 (Sept. 13, 2011).
[72] DODI 6130.03, Enclosure 4, §§ 14 (a), (d), (e).
[73] AR 40-501, Standards of Medical Fitness, §§ 3-17, 3-18.
[74] SECNAV Instruction 1850.4E, Department of the Navy Disability Evaluation Manual, Enclosure 8, § 8008.
[75] *AF Medical Standards Directory*, §§ J60, J64.
[76] *AF Medical Standards Directory*, § J51.
[77] DODI 6130.03, Medical Standards for Appointment, Enlistment, or Induction in the Military Services, Enclosure 4, §§ 29(f), (g), (p).
[78] DODI 6130.03, Enclosure 4, § 29(t).
[79] Assistant Secretary of Defense for Health Affairs, Policy Guidance for Deployment-Limiting Psychiatric Conditions and Medications, Nov. 7, 2006, § 4.1.1.
[80] Policy Guidance for Deployment-Limiting Psychiatric Conditions, § 4.1.2.
[81] Policy Guidance for Deployment-Limiting Psychiatric Conditions, § 4.1.3.
[82] Policy Guidance for Deployment-Limiting Psychiatric Conditions, § 4.2.
[83] Andrew Tilghman, 'Any Soldier Can Deploy on Anything': Pentagon Rules Bar Some Drugs From Combat Zone, But Oversight Is Suspect, Army Times, Mar. 17, 2010, *http://www.armytimes.com/article/20100317/NEWS/3170310/-8216-Any-soldier-can-deploy-on-anything-*; Kim Murphy, A Fog of Drugs and War, Los Angeles Times, Apr. 7, 2012, *http://articles.latimes.com/print/2012/apr/07/nation/la-na-army-medication-20120408*.
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[86] AR 40-501, Standards of Medical Fitness, §§ 3-32, 3-33.
[87] AR 40-501, § 5-14(f)(8).
[88] SECNAV Instruction 1850.4E, Department of the Navy Disability Evaluation Manual, Enclosure 8, § 8013(c), (d).

[89] BUMED Instruction 1300.2A, Suitability Screening, Medical Assignment Screening, and Exceptional Family Member Program (EFMP) Identification and Enrollment, Enclosure 2, § 10(n).
[90] *AF Medical Standards Directory*, §§ Q6, Q8, Q9, Q13, Q14.
[91] *AF Medical Standards Directory*, § Q6.
[92] *AF Medical Standards Directory*, § Q31; American Psychiatric Association, Highlights of Changes from DSM-IV-TR to DSM-5 (2013), 4, *http://www.dsm5.org/Documents/changes%20from%20dsm-iv-tr%20to%20dsm-5.pdf*.
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[102] DODI 6490.07, Enclosure 2, § 2(a).
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[109] NAVMED P-117, Chapter 15, § 15-106(4)(i).
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