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DoD's Accession Disqualifications Related to Sexual and Reproductive Anatomy Are Unrelated to Fitness and Inconsistent with Other Standards

July 12, 2021 *(incorporating updated list of endorsements, September 12, 2022)*

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The following organizations concur with the recommended revised language proposing an accession standard that enables the military to evaluate conditions related to sexual or reproductive anatomy in a manner that is consistent across all candidates and also consistent with the purpose of medical accession standards.

Accord Alliance
American Society for Reproductive Medicine
Center for American Progress
Differences of Sex Development Translational Research Network
Endocrine Society
GLBTQ Legal Advocates & Defenders (GLAD)
GLMA: Health Professionals Advancing LGBTQ Equality
Human Rights Campaign
interACT
InterConnect
Lambda Legal
Modern Military Association of America
National Center for Lesbian Rights
National Center for Transgender Equality
North American Society for Pediatric and Adolescent Gynecology
Out in National Security
Pediatric Endocrine Society
Societies for Pediatric Urology
Society of Pediatric Psychology
SPARTA
Transgender American Veterans Association

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DOD'S ACCESSION DISQUALIFICATIONS RELATED TO SEXUAL AND REPRODUCTIVE ANATOMY ARE UNRELATED TO FITNESS AND INCONSISTENT WITH OTHER STANDARDS

Medical standards for entry ("accession") into military service exclude some applicants with atypical sexual or reproductive anatomy. This is not because they are transgender, because policy reinstated under the Biden administration permits military service by individuals who have transitioned gender. These medical enlistment standards affect individuals with congenital conditions called "differences of sex development" or intersex traits. Despite the term "intersex," this is not about identifying as non-binary in gender. Under regulations governing accession, men and women can be disqualified from military service solely for having sexual or reproductive anatomy that is not typical in comparison to other men and women, even if their congenital condition has no effect on fitness for service.

This policy memorandum conducts an extensive review of military accession standards since 1961 and explains why disqualifications based on sexual or reproductive anatomy are inconsistent with standards applied to other applicants with similar medical histories but not considered to have "abnormalities or defects" that make them ineligible for service. It closes with a proposed amendment to accession regulations that would enable the military to evaluate conditions related to sexual or reproductive anatomy in a manner that is consistent across all candidates and also consistent with the purpose of medical accession standards.

1. How Military Accession Standards Work

Department of Defense Instruction 6130.03 establishes standards of medical qualification for military service.[1] The regulation begins with a statement of purpose, which is to:

> *Ensure that individuals considered for appointment, enlistment, or induction into the Military Services are:*
>
> *(1) Free of contagious diseases that may endanger the health of other personnel.*
>
> *(2) Free of medical conditions or physical defects that may reasonably be expected to require excessive time lost from duty for necessary treatment or hospitalization, or may result in separation from the Military Service for medical unfitness.*
>
> *(3) Medically capable of satisfactorily completing required training and initial period of contracted service.*

[1] DoDI 6130.03, Volume 1, Medical Standards for Military Service: Appointment, Enlistment, or Induction, April 30, 2021 (Change 2). We thank the Michael D. Palm Center for Research Translation and Public Policy at San Francisco State University for supporting this research.

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

(5) Medically capable of performing duties without aggravating existing physical defects or medical conditions.[2]

(Block quotes from regulations will appear in italic throughout.)

Medical standards for entry into military service are rules of disqualification, not qualification. In other words, they are written in the negative—what will keep you out of military service, not what will get you in. In 30 categories organized by body system, the standards list medical conditions or medical histories that are disqualifying for military service, although disqualified applicants may be considered for a medical waiver.

The standards generally distinguish three types of medical histories. Some conditions (such as colds or typical childhood diseases) are never disqualifying. Some conditions (such as malignant tumors) are always disqualifying. And some conditions (such as attention deficit hyperactivity disorder or ADHD) are sometimes disqualifying, depending on severity and stability.

The first type of condition (never disqualifying) would not be mentioned in medical standards at all because it isn't relevant to standards written in the negative, while the second type (always disqualifying) can be listed with little elaboration or commentary. The third type of condition (sometimes disqualifying) is included in the regulation along with "if" or "unless" conditional qualifications that guide the medical examiner in determining whether the condition is resolved (or minor and stable) and therefore unlikely to interfere with military service. It can be confusing because "if" qualifications focus on evidence of instability or limitation as a means of separating fit and unfit candidates, while "unless" qualifications do the opposite and focus on evidence that a condition is resolved (or minor and stable) and not limiting. But the idea behind both is the same: to identify specific objective factors that indicate whether a condition is likely to interfere with success in military service.

For example, ADHD is an "if" disqualification.[3] A history of ADHD is disqualifying for enlistment only if any one of the following applies: school or work accommodations after the age of 14; a history of comorbid mental disorders; prescription of ADHD medication in the previous 24 months; or documentation of adverse performance in school or at work. "If" factors like this allow the applicant to overcome a presumption of disqualification by proving a negative—that none of the listed indicators of a continuing problem apply—and lead to a reasonable estimate of risk. If an applicant has had success in school or work over a significant period of time, without accommodation, medication, or associated mental disorder, then ADHD is not likely to be a problem in military service.

In contrast, an "unless" standard starts with a potentially disqualifying condition and then enumerates the positive case for when the disqualification does not apply. For example, the body system standard for "Heart" states, in part, that a history of myocarditis or pericarditis is

[2] DoDI 6130.03, Volume 1, April 30, 2021 (Change 2), ¶ 1.2.
[3] DoDI 6130.03, Volume 1, April 30, 2021 (Change 2), ¶ 5.28.

disqualifying for service "unless" the applicant "is free of all cardiac symptoms, does not require medical therapy, and has normal echocardiography for at least 1 year after the event."[4] The military has made a judgment that if these factors are true, then this history of a heart condition is unlikely to interfere with military service. The factors provide evidence that the condition is resolved.

2. History of Accession Standards Related to Sexual or Reproductive Anatomy

1961 Standards

The earliest accession standards directly related to sexual or reproductive anatomy that we were able to find are from Army Regulation 40-501, *Standards of Medical Fitness* (February 10, 1961). This version includes the following disqualifications:

> *Hermaphroditism.*
>
> *Major abnormalities and defects of the genitalia such as a change of sex, a history thereof, or complications (adhesions, disfiguring scars, etc.) residual to surgical correction of these conditions.*
>
> *Epispadias or hypospadias when accompanied by evidence of infection of the urinary tract or if clothing is soiled when voiding.*[5]

The one-word disqualification for hermaphroditism[6]—an historical term for ambiguous genitalia considered outdated and pejorative today—did not reveal any reason why the military considered it relevant to fitness for service. It lacked any functional standard under which examiners could determine military fitness despite that medical history. In contrast, the other two standards focused examiner attention on functional limitations for service. "Major abnormalities and defects of the genitalia" were disqualifying only if there were continuing "complications"; epispadias and hypospadias[7] (apparently considered "minor" defects of the genitalia) were disqualifying only if accompanied by urinary infection or dysfunction.

It should be noted that the "major abnormalities" disqualification is internally inconsistent in one respect. It disqualified applicants for "a history thereof" but also for "complications" arising from surgical correction. If mere "history" of a condition was disqualifying in and of itself, it wouldn't be necessary to evaluate how it was treated or to check for current complications or

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[4] DoDI 6130.03, Volume 1, April 30, 2021 (Change 2), ¶ 5.11(p).
[5] Army Regulation 40-501, *Standards of Medical Fitness* (February 10, 1961), ¶¶ 2-14(e)(s), 2-15(d).
[6] According to the International Classification of Diseases (ICD-10), "hermaphroditism" is "a rare condition characterized by the unequivocal presence of both testicular and ovarian tissues in an individual. It is usually manifested with ambiguous external genitalia." 2021 ICD-10 Diagnosis Code Q56.0, Hermaphroditism, Not Elsewhere Classified, https://www.icd10data.com/ICD10CM/Codes/Q00-Q99/Q50-Q56/Q56-/Q56.0.
[7] "In boys with epispadias, the urethra generally opens on the top or side of the penis rather than the tip." Johns Hopkins Medicine, https://www.hopkinsmedicine.org/health/conditions-and-diseases/epispadias. "Hypospadias is a congenital defect noted in boys. The location of the meatus (outlet for urine on the penis) is located on the undersurface of the penis rather than on the tip of the penis." Johns Hopkins Medicine, https://www.hopkinsmedicine.org/health/conditions-and-diseases/hypospadias.

functional limitations. The more reasonable interpretation is to read the rule to require an assessment of present function *because* a history of the condition is *not* necessarily disqualifying. The purpose of the standard is to determine whether an applicant has a current functional limitation that could affect military service.

These three disqualifications remained the same for the next 25 years, without any elaboration, until March 31, 1986. There is no indication these standards were studied or tested during that time.

1986 Standards

Responsibility for enlistment regulations shifted from the Army to the Department of Defense in 1986, and DoD issued a very similar regulation to govern medical standards.[8] The new DoD standard made a minor change to one of the disqualifications related to sexual or reproductive anatomy—major abnormalities and defects of the genitalia—emphasizing that "residuals" must also be "dysfunctional" in order to be disqualifying:

> *Major abnormalities and defects of the genitalia, such as a change of sex, a history thereof, or dysfunctional residuals from surgical correction of these conditions.*[9]

This change appeared to clarify, for example, that the "disfiguring scars" of the 1961 standard were not disqualifying unless they were also dysfunctional in terms of fitness for military service. The amendment helped to clarify that the military intended it to be a functional standard, meaning that applicants with this medical history should be permitted to serve provided they had no current functional impairment. But it did not delete the phrase "a history thereof" or explain its purpose within an otherwise functional standard, leaving some ambiguity in place.

2005 Standards

Another 19 years passed before DoD revised enlistment standards related to sexual or reproductive anatomy.[10] One of the revisions was substantial and established a standard that remains mostly in place today.

The single-word hermaphroditism disqualification was combined with the disqualification for "major abnormalities and defects of the genitalia," which converted hermaphroditism from a stand-alone disqualification to being just one example (within an expanded list of examples) of "major abnormalities or defects of the genitalia." In addition, DoD also removed all functional assessment from the new combined section. Departing from a rule in place for the prior 44 years, a history of "major abnormalities or defects of the genitalia" became disqualifying in and of itself, and enlistment examiners were no longer asked to evaluate whether applicants had any current limitation or dysfunction as a result. Under the 2005 amendment, having a medical

[8] DoD Directive 6130.3, *Physical Standards for Enlistment, Appointment, and Induction*, March 31, 1986.
[9] DoD Directive 6130.3, March 31, 1986, ¶ 2-14(s).
[10] DoD Instruction 6130.4, *Medical Standards for Appointment, Enlistment, and Induction in the Armed Forces*, January 18, 2005.

history of atypical genitalia was disqualifying regardless of current status or whether that history affected fitness for service:

> *History of major abnormalities or defects of the genitalia such as change of sex (P64.5), hermaphroditism, pseudohermaphroditism, or pure gonadal dysgenesis (752.7) is disqualifying.*[11]

(The numbers in parentheses refer to International Classification of Diseases (ICD) codes.)

"Pseudohermaphroditism" and "pure gonadal dysgenesis" were added as examples of "major abnormalities or defects of the genitalia." DoD's use of ICD-9 code 752.7 for all of them helps to specify the intended scope of the disqualification and translates to current ICD-10 codes for "pseudohermaphroditism" or "indeterminant sex."[12] The expanded list of examples appears intended to identify applicants whose physiology does not "match" a strictly male or female model. Under ICD-10, pseudohermaphroditism is "an historical term for a variety of abnormalities in sex development that lead to anomalies in the reproductive tract and /or external genitalia."[13] "Indeterminant sex" means that "external genitalia do not have the typical appearance of a male's or female's genitalia."[14] "Pure gonadal dysgenesis" describes a 46XY (chromosomally male-typical) individual with underdeveloped gonads (testes/testicles) but a female-typical external genital appearance.[15]

A second revision also made in the 2005 standards was insignificant and largely a matter of word choice. DoD edited the standard for epispadias and hypospadias, but like the standard from 1961, the new version disqualified applicants only if they had a current limitation or dysfunction as a result of the condition. It's possible that DoD believed it was more modern or medical in tone to say "voiding dysfunction" rather than "if clothing is soiled when voiding":

> *Current epispadias (752.62) or hypospadias (752.61), when accompanied by evidence of urinary tract infection, urethral stricture, or voiding dysfunction, is disqualifying.*[16]

The 2005 amendments created, for the first time, a fundamental distinction between 1) applicants with atypical genital development deemed a "major" abnormality or defect and 2) applicants with apparently "minor" genital deviations such as epispadias and hypospadias. In the first category, atypical genital development was across-the-board disqualifying; in the second, atypical genital appearance was a problem only if it was actually a functional problem. The regulations did not suggest why disqualifications for "major" forms of atypical sexual or reproductive anatomy existed at all, or why function and fitness became irrelevant in assessing

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[11] DoD Instruction 6130.4, January 18, 2005, ¶¶ E1.12.5, E1.13.10.
[12] Convert ICD-9-CM Diagnosis 752.7 to ICD-10-CM, https://www.icd10data.com/Convert/752.7.
[13] 2021 ICD-10 Diagnosis Code Q56.3, https://www.icd10data.com/ICD10CM/Codes/Q00-Q99/Q50-Q56/Q56-/Q56.3.
[14] 2021 ICD-10 Diagnosis Code Q56.4, https://www.icd10data.com/ICD10CM/Codes/Q00-Q99/Q50-Q56/Q56-/Q56.4.
[15] Columbia University Department of Urology, Disorders of Sex Development, https://www.columbiaurology.org/staywell/disorders-sex-development.
[16] DoD Instruction 6130.4, January 18, 2005, ¶ E1.13.2.

applicants, but DoD appeared to conclude that typically male or female sexual and reproductive anatomy was required for military service.

2011 Standards

The next relevant update to medical enlistment standards was issued on September 13, 2011[17] and included significant refinement to disqualifications for hypospadias and epispadias. The standard now varied depending on more precise descriptions of disqualifying conditions and the nature of any treatment:

> *Current or history of epispadias (752.62).*
> *Current or history of surgery for proximal hypospadias (752.61).*
> *Distal (coronal) hypospadias without history of surgery DOES meet the standard.*
> *Distal (coronal) hypospadias treated with surgery when accompanied by evidence of urinary tract infection, urethral stricture, or voiding dysfunction.*[18]

The 2011 amendments suggest an effort to distinguish between different medical histories related to these genital conditions and how they might differently affect prospects for success in military service. The contrast to one-word, unexplained disqualifications such as "hermaphroditism" is stark.

2018 Standards

Despite the reevaluation of epispadias and hypospadias that changed standards in 2011, on May 6, 2018, DoD reverted back to a rule based on existing complications or limitations. It was very similar to the standard in place prior to 2011, except for an added clarification that surgical intervention could take place at any time, even as an adult, and meet the standard provided two years has passed prior to enlistment. With this reversal, DoD completed a full circle back to a functional standard of assessment for some conditions of atypical genitalia:

> *History of epispadias or hypospadias when accompanied by history of urinary tract infection, urethral stricture, urinary incontinence, symptomatic chordee, or voiding dysfunction or surgical intervention for these issues within the past 24 months.*[19]

A small but extremely noteworthy change was also made to the disqualification for "major abnormalities or defects of the genitalia" in order to remove any reference, inclusionary or exclusionary, to transgender accession standards. The 2018 standards were issued during a time of policy uncertainty caused by the Trump administration's push to reverse the inclusive transgender service policy implemented by the Obama administration almost two years earlier, on June 30, 2016. Rather than wait for final resolution of court injunctions preventing the Trump ban from taking effect (it would eventually take effect in April 2019), the topic of transgender

[17] DoD Instruction 6130.03, *Medical Standards for Appointment, Enlistment, or Induction in the Military Services*, April 28, 2010 (Change 1, September 13, 2011).
[18] DoD Instruction 6130.03, Change 1, September 13, 2011, ¶ 15(b)-(e).
[19] DoD Instruction 6130.03, Medical Standards for Appointment, Enlistment, or Induction into the Military Services, May 6, 2018, ¶ 5.14(b).

accession policy was excised from the regulation. DoD removed exactly three words in the effort to separate transgender policy from accession policy in general: "change of sex."

> *History of major abnormalities or defects of the genitalia, such as ~~change of sex,~~ hermaphroditism, pseudohermaphroditism, or pure gonadal dysgenesis.*[20]

The most remarkable aspect of deleting "change of sex" in response to transgender service policy is that, when "change of sex" first appeared in medical enlistment regulations in 1961, the phrase almost certainly did not intend to refer to what we think of today as surgical treatment associated with gender transition in adults. In fact, the standard for "change of sex" was likely a response, at least in part, to the first wave of research in the 1950s on surgical "correction" of ambiguous genitalia in infants and reassignment of the sex in which they would be reared.[21]

First, it seems unlikely that the military would have developed an enlistment standard by 1961 for surgical gender transition in adults, an intervention so uncommon in the 1950s that it was tabloid spectacle.[22] Second, it seems doubly unlikely that such a standard would be written in functional terms to permit enlistment by people who had surgically transitioned gender as adults, provided they had no continuing complications or residuals from the surgery.

This did not stop the military from contending in the 1980s, as transgender individuals began to challenge exclusion from military service, that the 1961 "change of sex" standard was always meant to exclude transgender individuals who had undergone surgical treatment as part of their gender transition. DoD was forced to reverse engineer a ban out of the "change of sex" language because at the time the military had no disqualification targeted at mental states such as gender dysphoria or gender identity. "Change of sex" was the only option available, and it succeeded against court challenges.[23] It became conventional wisdom that the military had consistently maintained a ban on transgender service from at least as early as 1961. Therefore, in order to remove transgender service policy from the 2018 regulation, DoD had to remove the "change of sex" language.

But the manner in which this change was made—removing only the three words—left behind a disqualification that was disconnected from any purpose or justification. What remains in military accession policy today is an unexplained, unexamined ban on individuals with atypical sexual or reproductive anatomy. A vague and arbitrary category of disqualifying conditions related to "hermaphroditism" has persisted in military policy for 60 years without any rigorous examination of what it accomplishes. Any of the reasons one might imagine could justify a ban on individuals with atypical sexual or reproductive anatomy are either covered by other accession disqualifications or are inconsistent with inclusive transgender policy.

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[20] DoD Instruction 6130.03, May 6, 2018, ¶¶ 5.13(f), 5.14(m).
[21] John William Money, 84, Sexual Identity Researcher, Dies, New York Times, July 11, 2006.
[22] From GI Joe to GI Jane: Christine Jorgensen's Story, The National WWII Museum New Orleans, June 30, 2020, https://www.nationalww2museum.org/war/articles/christine-jorgensen.
[23] Doe v. Alexander, 510 F. Supp. 900 (D. Minn. 1981). In this case, a senior Army Medical Corps officer, Brigadier General Frank F. Ledford, Jr., affirmed under oath that he was familiar with the "change of sex" disqualification and "the rationale within the Department of the Army for that provision's prohibition of the enlistment of persons who have undergone sex reassignment surgery."

In 2015, decades after "change of sex" first appeared, the Accession Medical Standards Analysis and Research Activity (AMSARA), the research arm of military accession standards, undertook a study of transgender accession policy.[24] It conceded that the disqualification for "change of sex" was not a very good metric for identifying rejected transgender applicants, because change of sex "may have a more general use than specifically identifying operations for sex transformation." It meant, without specifically saying, that change of sex historically referred to surgical "correction" of ambiguous genitalia in infants, and there was no way to go back in time and separate the two definitions.

The removal of the three words was not the only change made in 2018 connected to the unresolved legal controversy over transgender policy. The 2018 edition of DoDI 6130.03 was also amended to shore up some of the inconsistencies in accession regulation that were making it uncomfortably difficult to defend discriminatory policies affecting transgender applicants and service members. For example, prior to 2018, DoD did not have a clear policy to disqualify military applicants with a history of taking masculinizing or feminizing hormones. The 2011 accession standard expressly approved qualification of women who used feminizing hormones to manage gynecological conditions such as abnormal menstruation or dysmenorrhea.[25] "Male hypogonadism" was only added as a disqualification in 2011, without specifying whether successful hormone supplementation would also be disqualifying.[26] Use of estrogen/progestin-based contraception—similar or identical to the dosing used to treat differences of sex development—has never been disqualifying for military service.

In 2018, however, DoD ramped up accession disqualification for hormone treatment for both men and women, and we believe the changes were in response to the difficulty of defending inconsistent disqualifications in court. DoD removed all approving references to use of hormones in treating gynecological conditions (previously referred to as "medical therapy") and added a comprehensive hormone disqualification for both men and women, one that remains in effect today:

> *History of hypogonadism that is congenital, treated with hormonal supplementation, or of unexplained etiology.*[27]

It was probably not one of the underlying motivations, but an additional effect of this change was to provide yet another basis for disqualifying applicants with conditions involving atypical sexual or reproductive anatomy.

But like the original 1961 accession standard for "major abnormalities and defects of the genitalia," this change is also internally inconsistent. If a history of hypogonadism is congenital and treated with hormone supplementation, it very likely has an etiology that is "explained." This

[24] Accession Medical Standards Analysis and Research Activity, Annual Report 2015, 18-23.
[25] DoD Instruction 6130.03, *Medical Standards for Appointment, Enlistment, or Induction in the Military Services*, April 28, 2010 (Change 1, September 13, 2011), ¶ 14(a), (d).
[26] DoD Instruction 6130.03, Change 1, September 13, 2011, ¶ 25(l). [This subsection is lower case L, not the number 1.]
[27] DoD Instruction 6130.03, Medical Standards for Appointment, Enlistment, or Induction into the Military Services, May 6, 2018, ¶ 5.24(q).

disqualification should not be wrapped in a concern about "unexplained etiology" when that is unlikely to be the case.

3. Accession Disqualifications for "Hermaphroditism, Pseudohermaphroditism, or Pure Gonadal Dysgenesis" are Inconsistent with Transgender Service Policy

We believe that the remaining disqualifications for atypical sexual or reproductive anatomy were originally motivated by discomfort with atypical genital appearance and cannot be justified today by any military purpose.

Military accession policy for transgender individuals was written in "unless" format to address medical concerns related to diagnosis of gender dysphoria, treatment for gender dysphoria, and fitness for service. The advantage of "unless" and "if" formats in qualification standards is that they are transparent about the reasons for the requirements, they educate prospective applicants on what actions they can take to ensure fitness for service and, most importantly, they avoid unnecessarily broad exclusion of people who would otherwise meet military standards.

Inclusive transgender accession policy in DoDI 6130.03 reflects three concerns about the medical and mental-health consequences of gender dysphoria and treatment for gender dysphoria. First, if an individual's gender transition involves surgical treatment (including genital reconstruction), the standard requires a post-surgical waiting period of 18 months prior to enlistment and certification by a medical provider that no functional limitations or complications persist. Second, the policy anticipates the possibility of hormone therapy and requires a showing of stability on hormones, if taken, for 18 months prior to enlistment. Finally, a mental-health provider must certify that applicants with a history of gender dysphoria have been stable, without clinically significant distress or impairment, for 18 months prior to enlistment—in other words, that the applicant is no longer gender dysphoric.

Current transgender accession policy under the 2021 reinstatement of open service follows the usual design of leading with the potential disqualification and then explaining the circumstances under which the disqualification will *not* apply:

> *History of major abnormalities or defects of the genitalia including, but not limited to:*
> *(1) Hermaphroditism, pseudohermaphroditism, or pure gonadal dysgenesis.*
> *(2) A history of sex reassignment or genital reconstruction surgery is disqualifying unless all of the following conditions are met, as certified by a licensed medical provider:*
> *(a) A period of 18 months has elapsed since the date of the most recent of any such surgery.*
> *(b) No functional limitations or complications persist, and no additional surgery is required.*
>
> *History of cross-sex hormone therapy associated with gender transition is disqualifying unless the individual has been stable on such hormones for 18 months or no longer requires such hormones, as certified by a licensed medical provider.*

> *History of gender dysphoria is disqualifying unless, as certified by a licensed mental health provider, the applicant has been stable without clinically significant distress or impairment in social, occupational, or other important areas of functioning for 18 months.*[28]

In practical terms, 2021 transgender accession policy makes several clear judgments:

1. Gender identity in military service does not need to be the same as sex presumed at birth.

2. A medical history of surgical treatments affecting sexual and reproductive anatomy is no longer automatically disqualifying.

3. A medical history of masculinizing or feminizing hormone treatment is no longer automatically disqualifying.

4. Gender transition is an individualized process and does not require any particular course of treatment. As a result, a typical male or female body appearance is no longer required for military service.

5. Fertility is not a requirement for military service.

6. Capacity to menstruate is not a requirement for women in military service.

7. Having a typical combination of sexual and reproductive anatomy is not a requirement for military service.

The carefully detailed approach that accession regulation now takes with transgender applicants is a stark contrast with the decade-after-decade carryover of unexamined, arbitrary, and poorly defined exclusions of persons whose medical histories are comparable in every militarily relevant respect. It is difficult to imagine what reasons could support continued exclusion of persons medically defined by body features that do not match typical notions of male or female.

Outward appearance can't be the issue (although it was likely the original justification), because transgender applicants need not have typical sexual anatomy. Use of masculinizing or feminizing hormones can't be the issue, because transgender applicants only need to demonstrate stability of hormone treatment. Having undergone genital surgery as an infant can't be the issue, because even genital surgery as an adult is no longer disqualifying—and epispadias/hypospadias surgery has not been disqualifying for much of the last 60 years. Concerns about bone density or urinary dysfunction can't be the issue, because medical accession standards already disqualify any applicant with osteopenia, osteoporosis, incontinence, or recurrent infection.

Current accession policy invites completely arbitrary decision-making when it applies a one-line set of labels like "hermaphroditism, pseudohermaphroditism, or pure gonadal dysgenesis." A male applicant can enlist with a history of hypospadias treated with surgery, but not if the

[28] DoD Instruction 6130.03, Volume 1, Medical Standards for Military Service: Appointment, Enlistment, or Induction, April 30, 2021 (Change 2), ¶¶ 5.13(f), 5.14(m), 5.24(t), 5.28(t).

examiner concludes that his hypospadias condition suggests a history of pseudohermaphroditism. A female transgender applicant can enlist after demonstrating stability on feminizing hormones, but a female applicant who is not transgender, but who takes feminizing hormones because she was born without ovaries, will be disqualified. The same principles ought to apply consistently to all prospective members of the military. A standard that reaches different and arbitrary conclusions based on whether an applicant's history is labeled with "hermaphroditism" or with something else is simply not an effective standard in terms of measuring military fitness.

This is not a hypothetical exercise. One personal account[29] tells the story of a young woman rejected for military service when she revealed she had never had a menstrual period. She was a female with 46XY chromosomes, born without a uterus or ovaries. She was disqualified as having major abnormalities and defects of the genitalia—perhaps one of the options (unspecified) from the list of hermaphroditism, pseudohermaphroditism, or pure gonadal dysgenesis. This account took place in 2014, prior to the beginning of inclusive transgender policy in 2016, but if had happened today, she would have been rejected for service even though a transgender woman in similar circumstances (lacking uterus and ovaries) would not.

This young woman could also have been disqualified for a different reason, one that is probably not intentionally related to exclusions for atypical sexual or reproductive anatomy. Going back to 1961, accession standards have included a disqualification related to amenorrhea, or the absence of menstrual periods. Amenorrhea can be either secondary, which means cessation of periods after periods have begun, or primary, meaning periods have never started. The target of the standard, however, traditionally was *unexplained* amenorrhea. The point was to confirm whether amenorrhea was a symptom of another condition or circumstance[30] that would separately raise questions about fitness for service. Early accession regulations—generally less medically precise than regulations today—disqualified applicants with amenorrhea unless the condition was the result of either natural or artificial menopause. In other words, amenorrhea was not an issue if there was a benign explanation.

In 1994, the principle was more clearly spelled out: amenorrhea (specifically including both primary or secondary forms) was only disqualifying "if unexplained or otherwise disqualifying."[31] If the reason for absence of periods was known, and that reason was not separately disqualifying, then lack of menstruation wasn't a problem for military fitness.[32]

Not until 2011 did accession rules separate secondary amenorrhea (acceptable if explained) from primary amenorrhea (disqualifying whether explained or not). The regulation offers no clue as to

[29] InterACT, Transgender Military Ban or Not, Intersex People Like Me Still Can't Serve, https://interactadvocates.org/transgender-military-ban-intersex/.
[30] David A. Klein et al., Amenorrhea: A Systematic Approach to Diagnosis and Management, *Am Fam Physician* 100(1):39-48, July 1, 2019. Lt. Col. Klein is an Air Force doctor who specializes in family and adolescent medicine and is an expert in reproductive health. Uniformed Services University, David A. Klein, MD, MPH, https://medschool.usuhs.edu/profile/david-klein-md-mph.
[31] DoD Directive 6130.3, Physical Standards for Appointment, Enlistment, and Induction, May 2, 1994, ¶ L(2).
[32] The current DoDI 6130.03, ¶ 5.14 (April 30, 2021) on "Male Genital System" approaches testicular issues in an analogous way. In cases of apparent congenital absence of one testicle, the standard requires the absence be verified by surgical exploration. Without that surgical exploration, the "unknown" is disqualifying. With an explanation, it is not disqualifying.

the reason policy became more restrictive. Applicants without periods due to use of certain forms of contraception, for example, could enlist in the military. Applicants without periods due to congenital absence of a uterus could not, both because the explanation was irrelevant under the standard and because an examiner could conclude, as in the personal account above, that they had "major abnormalities or defects of the genitalia."

4. Transgender policy is a model for more nuanced evaluation of sexual and reproductive anatomy

It would be a simple matter to retain accession evaluation of differences of sexual development but include "unless" factors to guide examiners in determining current fitness in light of that medical history. Transgender accession policy serves as a helpful model in anticipating common concerns, although differences of sexual development do not involve a mental-health diagnosis. If the two standards were combined into a single section, the requirements could even be streamlined. First, the current version:

> *History of major abnormalities or defects of the genitalia including, but not limited to:*
> *(1) Hermaphroditism, pseudohermaphroditism, or pure gonadal dysgenesis.*
> *(2) A history of sex reassignment or genital reconstruction surgery is disqualifying unless all of the following conditions are met, as certified by a licensed medical provider:*
> *(a) A period of 18 months has elapsed since the date of the most recent of any such surgery.*
> *(b) No functional limitations or complications persist, and no additional surgery is required.*
>
> *History of cross-sex hormone therapy associated with gender transition is disqualifying unless the individual has been stable on such hormones for 18 months or no longer requires such hormones, as certified by a licensed medical provider.*[33]

A revised combined, consistent standard might look like this:

> *History of sex reassignment or genital reconstruction surgery is disqualifying unless all of the following conditions are met, as certified by a licensed medical provider:*
> *(a) A period of 18 months has elapsed since the date of the most recent of any such surgery.*
> *(b) No functional limitations or complications persist, and no additional surgery is required.*
>
> *History of hormone therapy associated with gender transition or congenital differences in sex development is disqualifying unless the individual has been stable on such hormones for 18 months or no longer requires such hormones, as certified by a licensed medical provider.*

[33] DoD Instruction 6130.03, Volume 1, Medical Standards for Military Service: Appointment, Enlistment, or Induction, April 30, 2021 (Change 2), ¶¶ 5.13(f), 5.14(m), 5.24(t).

This proposed new standard removes the phrases “major abnormalities or defects of the genitalia” and “hermaphroditism, pseudohermaphroditism, and pure gonadal dysgenesis.” They don’t add anything to the effectiveness of the standard, and they are outdated and pejorative as well. Calling a condition an “abnormality” or a “defect” does not help in evaluating whether an applicant is fit for service.

What matters most is understanding how variations in genital or reproductive anatomy may affect body systems in ways relevant to military fitness. If there are concerns, they should be transparent and rigorously tested by “unless” factors that accession examiners have experience in applying. While such a policy would be new, the task for examiners would not be new. They do not need to be experts in sexual or reproductive development. Under current accession standards, examiners frequently evaluate waiting periods, stability, and function in the same body systems. This would be no different.

5. Conclusion

Secretary of Defense Lloyd Austin issued a memorandum on March 12, 2021, to senior Pentagon leadership, commanders of combatant commands, and all defense agency and DoD activity directors entitled, *Promoting and Protecting the Human Rights of Lesbian, Gay, Bisexual, Transgender, Queer, and Intersex Persons Around the World*. The focus of the memorandum was on actions abroad, but it stated that it was the policy of DoD to end discrimination on the basis of “sex characteristics.” It directed that all DoD components “review and, as appropriate and consistent with applicable law, take steps to rescind any directives, orders, regulations, policies, or guidance inconsistent with the President’s Memorandum.”

DoD would be well-served to undertake a long-overdue review of accession policies that exclude individuals from the military solely based on sex characteristics that the department deems to be disqualifying “major abnormalities or defects of genitalia,” without regard to fitness for service. We call on DoD to adopt policy that treats those individuals consistently with other applicants with comparable medical histories.