IN THE UNITED STATES DISTRICT COURT FOR THE DISTRICT OF COLUMBIA

DOE, et al.,	)	
	)	
Plaintiffs,	)	
	)	
v.	)	Civil Action No. 17-cv-1597 (CKK)
	)	
DONALD TRUMP, et al.,	)	
	)	
Defendants.	)	

DECLARATION OF MARGARET C. WILMOTH IN SUPPORT OF PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION

I, Margaret Chamberlain Wilmoth, declare as follows:

Background and Experience

1. I served as Deputy Surgeon General for Mobilization, Readiness and Army Reserve Affairs in the Office of the Surgeon General of the United States Army from July 2014 to May 1, 2017.

2. I received a Bachelor's degree in Nursing from the University of Maryland in 1975, followed by a Master's Degree in Nursing from the University of Maryland in 1979. I received a Ph.D. in Nursing from the University of Pennsylvania in 1993. I received a Master's Degree in Strategic Studies from the United States Army War College in 2001. I am a Registered Nurse.

3. My family's history of military service dates back to the Revolutionary War. As a small child, I grew up hearing the stories of an aunt who was a nurse and a neighbor who had

served as an Army nurse during World War II. From the time I was 6 or 7 years old, I knew I wanted to be an Army nurse. When I graduated with my nursing degrees at the end of the Vietnam War, the Army was drawing down, so I went into civilian practice. I spent the first seven years of my nursing career as a teacher and researcher.

4. While I was teaching at the University of Delaware, my father, who had joined the Air Force Reserve after serving as a pilot, encouraged me to pursue my dream of serving as an Army nurse by joining the United States Army Reserve (U.S.A.R.). I joined the U.S.A.R. in 1981 and served in various capacities during over thirty-five years in service, achieving the ranks of Captain, Major, Lieutenant Colonel, Colonel, Brigadier General, and Major General, before my retirement from the military on May 1, 2017. When I was promoted to Brigadier General in 2005, I became the first nurse and first woman to command a medical brigade as a general officer. When I was promoted to Major General, I became only the third nurse from the Army Reserve ever to achieve that rank.

5. From July of 2008 through October 2011, I served as Assistant for Mobilization and Reserve Affairs in the Office of the Secretary of Defense for Health Affairs. From October 2011 through July of 2014, I served in the Control Group. In July of 2014, I was appointed Deputy Surgeon General for Mobilization and Reserve Affairs. When I received this appointment, I became the first nurse in the more than 106-year history of the Army Reserve and the first woman to serve in this position. I held this position until my retirement from the military on May 1, 2017.

6. In August of 2014, I was also appointed by the Secretary of the Army to the Army Reserve Forces Policy Committee, where I most recently served as Deputy Chair. This

congressionally-mandated committee's role includes advising the Secretary of the Army on major policy matters directly affecting the reserve components and the mobilization preparedness of the Army. I held this position until my retirement from the military on May 1, 2017.

7. In my more than three-and-a-half decades of service, I received many decorations, including the Distinguished Service Medal, Defense Superior Service Medal, the Legion of Merit Medal, the Meritorious Service Medal, the Army Commendation Medal, and the Army Achievement Medal. I also hold the Expert Field Medical Badge and was awarded the 9A proficiency designation in medical surgical nursing by the Surgeon General, U.S. Army. I am a member of the Order of Military Medical Merit.

8. My civilian professional experience includes academic appointments at Central Missouri State University, University of Kansas, University of North Carolina at Charlotte, and Georgia State University. At Georgia State, I served as Dean of and Professor at the Byrdine F. Lewis School of Nursing and Health Professions at Georgia State University. I also served as a Health Policy Fellow at the Robert Wood Johnson Foundation. I am also a Fellow of the American Academy of Nursing, where I have served as Co-Chair of the Military/Veterans Expert Panel. In August of 2017, I joined the University of North Carolina School of Nursing as the Executive Dean and Associate Dean for Academic Affairs.

9. Throughout my academic and research careers, my practice and research focus has been in psychosocial oncology. My research led to the development of a subspecialty in psychosexual oncology, which focuses on how surgery, chemotherapy, radiation, and immunotherapy impact body image, sexuality, and fertility. I have had more than sixty

psychosexual oncology academic papers published on topics such as comparing the effects of lumpectomy vs. mastectomy on sexual behaviors; and strategies to help nurses become comfortable with psychosexual assessments of patients.

Formation of Working Group

10. On July 28, 2015, Secretary of Defense Ashton Carter directed Brad Carson, Acting Undersecretary of Defense for Personnel and Readiness, to convene a working group (the "Working Group") to study the policy and readiness implications allowing transgender persons to serve openly in the Armed Forces. The Working Group was asked to determine whether there were any objective, evidence-based impediments to permitting transgender people to serve openly and, if not, to develop an implementation plan for changing the policy to permit open service with the goal of maximizing military readiness. A true and accurate copy of this directive is attached hereto as Exhibit A.

11. When Secretary Carter directed the formation of the Working Group, I was serving as Deputy Surgeon General for Mobilization, Readiness, and Army Reserve Affairs. I was asked by Surgeon General, United States Army to serve as that office's representative to the Working Group. At the Working Group, I was able to provide the benefit of my medical expertise, my academic research, and my knowledge of the workings of the Military Health System and the Defense Health Agency. I participated in the meetings of the Working Group from its initial meeting in the summer of 2015 though the final meeting in late spring of 2016.

Working Group Process

12. The Working Group addressed many topics, one of which was determining how the medical needs of transgender service members could be met by the military. With respect to that topic, our process involved three steps: (1) Understanding the medical needs of transgender service members; (2) identifying how those needs could be met within the Military Health System; and (3) developing policies and protocols to ensure transgender service members could serve openly and have their medical needs met. The Working Group focused on ensuring that transgender service members' medical needs would be treated in the same manner and under the same framework as the medical needs of other service members, unless that proved unworkable.

13. **Step 1: Understanding Medical Needs.** The first step for the members of the Working Group was to establish a baseline level of knowledge among all Working Group members about the medical needs of transgender service members. We educated ourselves by meeting with experts from the civilian sector so we could begin to understand what being transgender means. We wanted to learn about the full range of medical treatment that might be required for a transgender service member. We sought to understand how an individual might go through a transition process and what the medical components of that process might be. We spoke to internal medicine experts, psychologists, endocrinologists, and surgeons who educated the Working Group regarding all aspects of transgender care including mental health treatment, pharmaceutical treatment, and surgical treatment.

14. **Step 2: Identifying How Medical Needs Could Be Met Within the Military Health System**. After we understood the universe of potential medical needs of transgender

service members, we focused on how the Military Health System (MHS) could meet those needs. For the large majority of medical care needs, we found that MHS was already providing the same or substantially similar services to other service members, and that there would be little, if any, additional burden on MHS from the provision of the required medical services to transgender service members.

15. With respect to hormonal therapy, we learned that MHS already provides this service to service members. Women frequently receive hormonal therapy, as do other service members who have adrenal or pituitary deficiencies that require hormone replacement therapy. The Working Group concluded that providing similar care for transgender individuals from a pharmaceutical perspective would not be a complicating issue or an additional burden.

16. The Working Group also examined whether there were any deployment-related obstacles to providing pharmaceutical care that requires routine doses of medication. We learned that service members with chronic conditions requiring routine medications regularly take with them enough medication to last for at least the first ninety (90) days of their deployment. Examples of such medications would include birth control, hormone replacement therapy, and medications to address low testosterone, hypertension, and osteoporosis, among other conditions. Each Combatant Command sets rules in the form of Personnel Policy Guidance that specifies any special restrictions on deployability of members to that Command, including medical restrictions. For example, a theatre that has only intermittent access to a medical supply train might require service members to bring extra medical supplies or restrict certain service members from serving in particular locations. Such issues are readily addressed in the field through the Personnel Policy

Guidance, and no unique or different issues would be raised by the pharmaceutical needs of transgender service members. The Working Group concluded that no additional burden on deployability would be created by transgender service members who required routine medication.

17. With respect to gynecological care, we learned that MHS already routinely provides this care to its service members. With transgender service members being permitted to serve openly, the concerns about confidentiality that might previously have hindered transgender service members from seeking gynecological care through MHS would no longer be an issue. Transgender service members would now be able to receive all routine medical care including gynecological services through MHS, allowing for more complete and coordinated care for the service members. The Working Group concluded that no additional burden on MHS would be created by the provision of gynecological care to transgender service members.

18. With respect to mental health care, we learned that MHS already routinely provides this care to its service members. With transgender service members being permitted to serve openly, the concerns about confidentiality that might previously have inhibited transgender service members from seeking mental health care through MHS would no longer be an issue. Because transgender service members would now be able to seek such care, if needed, openly through MHS, the Working Group expected that the service members would benefit from more complete and coordinated care. The Working Group concluded that no additional burden on MHS would be created by the provision of mental health care to transgender service members.

19. The Working Group also examined whether there were any deployment or readiness related obstacles associated with addressing the mental health needs of transgender

service members. The Working Group educated itself in part by consulting with our counterparts in Israel, the United Kingdom, and Australia, where open service by transgender individuals is permitted. We learned that those services have seen no reduced ability to serve from transgender service members due to mental health or other gender identity related issues. The Working Group also examined our own military's existing policies and learned that there is a rigorous screening process for all individuals applying to join the military that includes examination of mental health. The Military Entrance Processing Stations (MEPS) (enlistment processing offices) evaluate psychological stability as a component of fitness to serve. Additionally, once individuals are in active or reserve service, mental health is evaluated on an annual basis as part of the Periodic Health Assessment (PHA). The Working Group found that there was no reason to think that these pre-existing military policies, when applied to transgender service members serving openly, would not adequately protect the services from any mental health issues interfering with deployment.

20. With respect to surgical therapy, the Working Group consulted with surgical experts to determine whether there were any aspects of surgical therapy for transgender service members in which MHS did not already have the requisite expertise. We learned that MHS employs general surgeons, urologists who perform urological surgeries, and obstetrician/gynecologists who perform gynecological surgeries. Those skill sets are present in a substantial capacity within MHS, and MHS is able to address most routine surgical needs at or near the location of its service members. We learned, for instance, that surgeries for transgender service members would be relatively rare and that many of those surgeries are already routinely provided to non-transgender service members, such as hysterectomies or chest surgeries. For

surgeries requiring particular expertise, MHS maintains major medical centers that are equipped to provide a broader array of services. For surgeries requiring expertise outside of MHS's capacity, service members are typically referred out to civilian providers. The non-routine surgical needs of a transgender service member could be addressed either though training or contracting with surgeons with the appropriate expertise to MHS, or through the normal process for referring out of MHS to civilian providers. The Working Group concluded that the surgical needs of transgender service members could be addressed through either of these methods without creating additional burden on MHS.

21. The Working Group also learned that the development of gynecology/genitourinary (GYN/GU) surgical expertise within MHS could have an added benefit for MHS beyond the provision of surgical care to transgender service members. MHS struggles with ensuring that their medical providers acquire and retain the skills they need to serve in a wartime scenario. Having surgeons engage in training in the surgical techniques needed to perform sex-reassignment surgery would provide analogous surgical skills required to address, for instance, blast injuries in wartime scenarios. Having the expertise to address genital mutilation from a blast would be a benefit for MHS and all service members.

22. **Step 3: Policy Development**. Throughout this educational process, the Working Group members developed a deep understanding of the medical needs of transgender service members. Next, we turned our focus to developing a policy that would address the psychological and physical needs of transgender individuals and treat those individuals fairly while keeping

readiness and deployability at the forefront. Developing the protocol was an iterative process involving multiple rounds of drafting, gathering input from the services, and redrafting.

23. The Working Group concluded that there were no barriers that should prevent transgender service members from serving openly in the military. Open service by transgender service members would not impose any significant burdens on readiness, deployability, or unit cohesion. For those seeking to join the military, the Working Group recommended that the medical standards for accession into the Military Services by transgender persons be based upon the same standards applied to persons with other medical conditions, which seek to ensure that those entering service are free of medical conditions or physical defects that may require excessive time lost from duty. Based upon that standard, the Working Group recommended that the new accessions policy permit enlistment so long as an applicant with a history of gender dysphoria or of treatment for gender dysphoria has completed all medical treatment associated with the applicant's medical condition and has been stable in the preferred gender for a sufficient period of time.

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24. The Working Group's process for developing the protocol and recommendations was deliberative and thoughtful, involved significant amounts of research and education, and in the end resulted in a policy that all services supported. We were very proud to have developed a policy that treats transgender service members as the equal of their fellow service members, and as soldiers, sailors, marines, cuttermen, and airmen first.

I declare under the penalty of perjury that the foregoing is true and correct.

Dated: August 30, 2017

Margaret C. Wilmoth

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