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20 UNITED STATES DISTRICT COURT
21 CENTRAL DISTRICT OF CALIFORNIA

22 AIDEN STOCKMAN; NICOLAS
TALBOTT; TAMASYN REEVES;
23 JAQUICE TATE; JOHN DOES 1-2;
24 JANE DOE; and EQUALITY
CALIFORNIA,

25 Plaintiffs,

26 v.

27 DONALD J. TRUMP, et al.

28 Defendants.

CASE NO. 5:17-cv-01799-JGB-KKx

**DECLARATION OF GEORGE
RICHARD BROWN, MD, DFAPA
IN SUPPORT OF PLAINTIFFS'
MOTION FOR PRELIMINARY
INJUNCTION**

1 I also hold an appointment; and acting as a liaison between the VHA Medical
2 Center and the East Tennessee State University Department of Psychiatry. The
3 majority of my work involves researching, teaching, and consulting about health
4 care in the military and civilian transgender populations.

5 6. I also hold a teaching appointment related to my expertise with health
6 care for transgender individuals and research at the University of North Texas
7 Health Services Center (“UNTHSC”). My responsibilities include teaching and
8 consultation with UNTHSC and the Carswell Federal Bureau of Prisons facility
9 staff regarding health issues for transgender individuals.

10 7. In 1979, I graduated *Summa Cum Laude* with a double major in
11 biology and geology from the University of Rochester in Rochester, New York. I
12 earned my Doctor of Medicine degree with Honors from the University of
13 Rochester School of Medicine in 1983. From 1983-1984, I served as an intern at
14 the United States Air Force Medical Center at Wright-Patterson Air Force Base in
15 Ohio. From 1984-1987, I worked in and completed the United States Air Force
16 Integrated Residency Program in Psychiatry at Wright State University and
17 Wright-Patterson Air Force Base in Dayton, Ohio. A true and correct copy of my
18 Curriculum Vitae is attached hereto as Exhibit A.

19 8. I first began seeing patients in 1983. I have been a practicing
20 psychiatrist since 1987, when I completed my residency. From 1987-1991, I
21 served as one of the few U.S. Air Force teaching psychiatrists. In this capacity, I
22 performed over 200 military disability evaluations and served as an officer on
23 medical evaluation boards (“MEBs”) at the largest hospital in the Air Force.

24 9. Over the last 33 years, I have evaluated, treated, and/or conducted
25 research in person with 600-1000 individuals with gender disorders, and during the
26 course of research-related chart reviews with over 5100 patients with gender
27 dysphoria. The vast majority of these patients have been active duty military
28 personnel or veterans.

1 10. For three decades, my research and clinical practice has included
2 extensive study of the health care for transgender individuals, including three of
3 the largest studies focused on the health care needs of transgender service members
4 and veterans. Throughout that time, I have done research with, taught on, and
5 published peer-reviewed professional publications specifically addressing the
6 needs of transgender military service members. *See* Brown Exhibit A (CV).

7 11. I have authored or coauthored 38 papers in peer-reviewed journals and
8 19 book chapters on topics related to gender dysphoria and health care for
9 transgender individuals, including the chapter concerning gender dysphoria in
10 *Treatments of Psychiatric Disorders* (3d ed. 2001), a definitive medical text
11 published by the American Psychiatric Association.

12 12. In 2014, I coauthored a study along with former Surgeon General
13 Joycelyn Elders and other military health experts, including a retired General and a
14 retired Admiral. The study was entitled “*Medical Aspects of Transgender Military*
15 *Service.*” *See* Elders J, Brown GR, Coleman E, Kolditz TA, *Medical Aspects of*
16 *Transgender Military Service. Armed Forces and Society*, 41(2): 199-220, 2015;
17 published online ahead of print, DOI: 10.1177/0095327X14545625 (Aug. 2014)
18 (the “Elders Commission Report”). The military peer-reviewed journal, *Armed*
19 *Forces and Society*, published the Elders Commission Report. A true and correct
20 copy of that report is attached hereto as Exhibit B.

21 13. I have served for more than 15 years on the Board of Directors of the
22 World Professional Association for Transgender Health (“WPATH”), the leading
23 international organization focused on health care for transgender individuals.
24 WPATH has over 2000 members throughout the world and is comprised of
25 physicians, psychiatrists, psychologists, social workers, surgeons, and other health
26 professionals who specialize in the diagnosis and treatment of gender dysphoria.

27 14. I was a member of the WPATH committee that authored and
28 published in 2011 the current version of the WPATH Standards of Care (“SoC”)

1 (Version 7). The SoC are the operative collection of evidence-based treatment
2 protocols for addressing the health care needs of transgender individuals. I will
3 also be serving as a Chapter Co-Leader on the WPATH committee that will author
4 and publish the next edition of the Standards of Care (Version 8).

5 15. Without interruption, I have been an active member of WPATH since
6 1987. Over the past three decades, I have frequently presented original research
7 work on topics relating to gender dysphoria and the clinical treatment of
8 transgender people at the national and international levels.

9 16. I have testified or otherwise served as an expert on the health issues of
10 transgender individuals in numerous cases heard by several federal district and tax
11 courts. A true and correct list of federal court cases in which I have served as an
12 expert is contained in the “Forensic Psychiatry Activities” section of my
13 Curriculum Vitae, which is attached hereto as Exhibit A.

14 17. I have conducted and continue to provide trainings on transgender
15 health issues for the VHA as well as throughout the Department of Defense
16 (“DoD”). After the DoD announced the policy that allowed for transgender
17 individuals to serve openly in the Armed Forces in 2016, I conducted the initial
18 two large military trainings on the provision of health care to transgender service
19 members. The first training in Spring 2016 was for the Marine Corps. The second
20 training in Fall 2016 was for a tri-service meeting of several hundred active duty
21 military clinicians, commanders, and Flag officers.

22 18. Since the issuance of DoD Instruction (“DoDI”) 1300.28 in October
23 2016, I have led trainings for a national group of military examiners
24 (USMEPCOM) in San Antonio, Texas and for Army clinicians at Fort Knox,
25 Kentucky. Among other things, DoDI 1300.28 implemented the policies and
26 procedures in Directive-type Memorandum 16-005, established a construct by
27 which transgender service members may transition gender while serving, and
28 required certain trainings for the military. I received a letter of appreciation for my

1 role in making the national USMEPCOM event a success from the Commander of
2 the United States Military Entrance Processing Command, David S. Kemp,
3 Captain, U.S. Navy.

4 19. I have been centrally involved in the development, writing, and
5 review of all national directives in the VHA relating to the provision of health care
6 for transgender veterans. I also coauthored the national medication formulary that
7 lists the medications provided by the VHA for the treatment of gender dysphoria in
8 veterans. Finally, I regularly consult with VHA leadership regarding the training
9 of VHA clinicians on transgender clinical care of veterans nationally.

10 **GENDER DYSPHORIA**

11 20. The term “transgender” is used to describe someone who experiences
12 any significant degree of misalignment between their gender identity and their
13 assigned sex at birth.

14 21. Gender identity describes a person’s internalized, inherent sense of
15 who they are as a particular gender (i.e, male or female). Everyone has a gender
16 identity. For most people, their gender identity is consistent with their assigned
17 birth sex. Most individuals assigned female at birth grow up, develop, and
18 manifest a gender identity typically associated with girls and women. Most
19 individuals assigned male at birth grow up, develop, and manifest a gender identity
20 typically associated with boys and men. For transgender people, that is not the
21 case. Transgender women are individuals assigned male at birth who have a
22 persistent female identity. Transgender men are individuals assigned female at
23 birth who have a persistent male identity.

24 22. Experts agree that gender identity has a biological component,
25 meaning that each person’s gender identity (transgender and non-transgender
26 individuals alike) is the result of biological factors, and not just social, cultural, and
27 behavioral ones.

28

1 23. Regardless of the precise origins of a person’s gender identity, there is
2 a medical consensus that gender identity is deep-seated, set early in life, and
3 impervious to external influences.

4 24. The American Psychiatric Association’s Diagnostic and Statistical
5 Manual of Mental Disorders (2013) (“DSM-5”) is the current, authoritative
6 handbook on the diagnosis of mental disorders. Mental health professionals in the
7 United States, Canada, and other countries throughout the world rely upon the
8 DSM-5. The content of the DSM-5 reflects a science-based, peer-reviewed,
9 consensus process by experts in the field.

10 25. Being transgender is not a mental disorder. *See* DSM-5. Men and
11 women who are transgender have no impairment in judgment, stability, reliability,
12 or general social or vocational capabilities solely because of their transgender
13 status.

14 26. Gender dysphoria is the diagnostic term in the DSM-5 for the
15 condition that can manifest when a person suffers from clinically significant
16 distress or impairment associated with an incongruence or mismatch between a
17 person’s gender identity and assigned sex at birth.

18 27. The clinically significant emotional distress experienced as a result of
19 the incongruence of one’s gender with their assigned sex and the physiological
20 developments associated with that sex is the hallmark symptom associated with
21 gender dysphoria.

22 28. Only the subset of transgender people who have clinically significant
23 distress or impairment qualify for a diagnosis of gender dysphoria.

24 29. Individuals with gender dysphoria may live for a significant period of
25 their lives in denial of these symptoms. Some transgender people may not initially
26 understand the emotions associated with gender dysphoria and may not have the
27 language or resources for their distress to find support until well into adulthood.

28

1 Endocrine Treatment of Transsexual Persons: An Endocrine Society Clinical
2 Practice Guideline (2009; 2017); American Psychological Association Policy
3 Statement on Transgender, Gender Identity and Gender Expression
4 Nondiscrimination (2009). Additional organizations that have made similar
5 statements include the American Academy of Child & Adolescent Psychiatry,
6 American Academy of Family Physicians, American Academy of Nursing,
7 American College of Nurse Midwives, American College of Obstetrics and
8 Gynecology, American College of Physicians, American Medical Student
9 Association, American Nurses Association, American Public Health Association,
10 National Association of Social Workers, and National Commission on Correctional
11 Health Care.

12 35. The protocol for treatment of gender dysphoria is set forth in the
13 WPATH SoC and in the recently updated Endocrine Society Guidelines.² First
14 developed in 1979 and currently in their seventh version, the WPATH SoC set
15 forth the authoritative protocol for the evaluation and treatment of gender
16 dysphoria. This approach is followed by clinicians caring for individuals with
17 gender dysphoria, including veterans in the VHA. As stated above, I was a
18 member of the WPATH committee that authored the SoC (Version 7), published in
19 2011. A true and correct copy of that document is attached hereto as Exhibit D.

20 36. Depending on the needs of the individual, a treatment plan for persons
21 diagnosed with gender dysphoria may involve components that are
22 psychotherapeutic (i.e., counseling as well as social role transition – living in
23 accordance with one’s gender in name, dress, pronoun use); pharmacological (i.e.,
24 hormone therapy); and surgical (i.e., gender confirmation surgeries, like

25 ² Wylie C Hembree, Peggy T Cohen-Kettenis, Louis Gooren, Sabine E
26 Hannema, Walter J Meyer, M Hassan Murad, Stephen M Rosenthal, Joshua D
27 Safer, Vin Tangpricha, Guy G T’Sjoen; Endocrine Treatment of Gender-
28 Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice
Guideline, *The Journal of Clinical Endocrinology & Metabolism*,
<https://doi.org/10.1210/jc.2017-01658>, September, 2017.

1 hysterectomy for those transitioning to the male gender and orchiectomy for those
2 transitioning to the female gender). Under each patient’s treatment plan, the goal
3 is to enable the individual to live all aspects of one’s life consistent with his or her
4 gender identity, thereby eliminating the distress associated with the incongruence.

5 37. There is a wide range in the treatments sought by those suffering from
6 gender dysphoria. For example, some patients need psychotherapy, hormone
7 therapy and surgical intervention, among other gender-affirming treatments, while
8 others need just a subset of the available treatments. Generally, medical and
9 surgical interventions are aimed at bringing a person’s body into a higher degree of
10 conformity with their gender identity. Attempts to do the opposite (i.e., bring the
11 experienced gender identity into alignment with the sex and anatomy of the birth
12 sex are not only ineffective but often considered unethical treatment approaches.

13 38. As outlined further below, treatment protocols for gender dysphoria
14 are comparable to those for other mental health and medical conditions, including
15 those regularly treated within the United States military. *See* RAND Report at 8-9;
16 Elders Commission Report at 13 (“the military consistently retains non-transgender
17 men and women who have conditions that may require hormone replacement”).

18 **PRE-2016 MILITARY POLICY**

19 39. Prior to 2016, military policy treated transgender individuals with
20 gender dysphoria differently than people with other curable conditions.

21 ***Former Enlistment Policy***

22 40. DoDI 6130.03 established the medical standards for accession/entry
23 into military service. Enclosure 4 of the enlistment instruction contains an
24 extensive list of physical and mental conditions that disqualify a person from
25 enlisting in the military. For instance, persons with autism, schizophrenia, or
26 delusional disorders (or a history of treatment for these conditions) are excluded
27 from enlistment. Prior to 2016, that list also contained “change of sex” and
28

1 “transsexualism”, which were outdated references to transgender individuals and
2 individuals with gender dysphoria. *See* Elders Commission Report at 7.

3 41. The enlistment policy allows for the possibility of waivers for a
4 variety of medical conditions. The instruction, however, specifies that entry
5 waivers will not be granted for conditions that would disqualify an individual from
6 the possibility of retention. As discussed further below, because certain conditions
7 related to being transgender (“change of sex”) were formerly grounds for discharge
8 from the military, men and women who are transgender could not obtain medical
9 waivers to enter the military. *Id.* at 7-8.

10 42. Under military instructions, the general purpose of disqualifying
11 applicants based on certain physical and mental conditions is to ensure that service
12 members are: (1) free of contagious diseases that endanger others, (2) free of
13 conditions or defects that would result in excessive duty-time lost and would
14 ultimately be likely to result in separation, (3) able to perform without aggravating
15 existing conditions, and (4) capable of completing training and adapting to military
16 life. *Id.* at 7.

17 43. Because gender dysphoria, as described above, is a treatable and
18 curable condition, unlike other excluded conditions, its inclusion on the list of
19 disqualifying conditions was inappropriate. Individuals with gender dysphoria (or
20 under the language at the time – those who had a “change of sex”) were
21 disqualified from joining the military, despite having a completely treatable, or
22 already treated, condition.

23 44. The enlistment policy treated transgender individuals in an
24 inconsistent manner compared with how the military addressed persons with other
25 curable medical conditions. The result of this inconsistency was that transgender
26 personnel were excluded or singled out for disqualification from enlistment, even
27 when they were mentally and physically healthy.

28

1 45. For example, persons with certain medical conditions, such as
2 Attention Deficit Hyperactivity Disorder (“ADHD”) and simple phobias, could be
3 admitted when their conditions could be managed without imposing undue burdens
4 on others. Individuals with ADHD are prohibited from enlisting unless they meet
5 five criteria, including documenting that they maintained a 2.0 grade point average
6 after the age of 14. Similarly, individuals with simple phobias are banned from
7 enlisting, unless they meet three criteria including documenting that they have not
8 required medication for the past 24 continuous months.

9 46. In short, even though the DoD generally allowed those with
10 manageable conditions to enlist, the former regulation barred transgender service
11 without regard to the condition’s treatability and the person’s ability to serve.

12 ***Former Separation Policy***

13 47. The medical standards for retiring or separating service members who
14 have already enlisted are more accommodating and flexible than the standards for
15 new enlistments.

16 48. Until recently, the medical standards for separation were set forth in
17 DoDI 1332.38. On August 5, 2014, the DoD replaced DoDI 1332.38 with DoDI
18 1332.18, which permits greater flexibility for the service branches to provide
19 detailed medical standards.

20 49. The separation instructions divide potentially disqualifying medical
21 conditions into two different tracks. Service members with “medical conditions”
22 are placed into the medical system for disability evaluation. Under this evaluation
23 system, a MEB conducts an individualized inquiry to determine whether a
24 particular medical condition renders a service member medically unfit for service,
25 on a time-limited or permanent basis. If a service member is determined to be
26 medically unfit, the service member may receive benefits for medical separation or
27 retirement, or may be placed on the Temporary Duty Retirement List with periodic
28

1 reevaluations for fitness to return to duty. While in the U.S. Air Force, I served as
2 an officer on at least 200 such MEBs.

3 50. Under the separation instruction, service members with genitourinary
4 conditions, endocrine system conditions, and many mental health conditions are all
5 evaluated through the medical disability system. *See* DoDI 1332.38 §§ E4.8,
6 E4.11, E4.13; AR 40-501 §§ 2-8, 3-11, 3-17, 3-18, 3-31, 3-32; SECNAVIST
7 180.50_4E §§ 8008, 8011, 8013; U.S. Air Force Medical Standards Directory §§ J,
8 M, Q.

9 51. By contrast, under the separation instructions, a small number of
10 medical and psychiatric conditions are not evaluated through the medical
11 evaluation process. Instead, these conditions are deemed to render service
12 members “administratively unfit.” Service members with “administratively unfit”
13 conditions do not have the opportunity to demonstrate medical fitness for duty or
14 eligibility for disability compensation.

15 52. Under DoDI 1332.38, the “administratively unfit” conditions were
16 listed in Enclosure 5 of the instruction. Since August 5, 2014, when DoDI 1332.18
17 replaced 1332.38, the “administratively unfit” conditions are determined by the
18 service branches, as set forth in AR 40-501 § 3-35; SECNAVIST § 2016; and
19 AFI36-3208 § 5.11.

20 53. Enclosure 5 of DoDI 1332.38 included, among other conditions, bed-
21 wetting, sleepwalking, learning disorders, stuttering, motion sickness, personality
22 disorders, mental retardation, obesity, shaving infections, certain allergies, and
23 repeated infections of venereal disease. It also included “Homosexuality” and
24 “Sexual Gender and Identity Disorders, including Sexual Dysfunctions and
25 Paraphilias.” *See* Elders Commission Report at 8.

26 54. Similarly, the “administratively unfit” conditions in the service
27 branches included “psychosexual conditions, transsexual, gender identity disorder
28 to include major abnormalities or defects of the genitalia such as change of sex or a

1 current attempt to change sex,” AR 40-501 § 3-35(a); “Sexual Gender and Identity
2 Disorders and Paraphilias,” SECNAVIST § 2016(i)(7); and “Transsexualism or
3 Gender Identity Disorder of Adolescence or Adulthood, Nontranssexual Type
4 (GIDAANT),” AFI36-3208 § 5.11.9.5. The service branches retained these bars to
5 service by transgender individuals after DoDI 1332.18 replaced DoDI 1332.38.

6 55. DoDI 1332.14 controlled administrative separations for enlisted
7 persons. Under the instruction, a service member may be separated for the
8 convenience of the government and at the discretion of a commander for “other
9 designated physical or mental conditions.” Before 2016, this particular separation
10 category included “sexual gender and identity disorders.” *Id.*

11 56. Because service members with gender dysphoria were deemed to be
12 “administratively unfit,” they were not evaluated by MEBs and had no opportunity
13 to demonstrate that their condition did not affect their fitness for duty. They were
14 disqualified from remaining in the military despite having a completely treatable
15 condition.

16 57. This was inconsistent with the treatment of persons with other curable
17 medical conditions, who are given the opportunity to demonstrate medical fitness
18 for duty or eligibility for disability compensation. For example, mood and anxiety
19 disorders are not automatically disqualifying for retention in military service.
20 Service members can receive medical treatment and obtain relief in accordance
21 with best medical practices. Mood and anxiety disorders result in separation only
22 if they significantly interfere with duty performance and remain resistant to
23 treatment. In contrast, transgender individuals were categorically disqualified from
24 further service without consideration of their clinical symptoms and any impact on
25 their service.

26 58. The result of this inconsistency was that transgender personnel were
27 singled out for separation, even when they were mentally and physically healthy,
28 solely because they were transgender.

OPEN SERVICE DIRECTIVE

1
2 59. The DoD lifted the ban on open service by transgender military
3 personnel following a June 30, 2016 announcement made by then-Secretary of
4 Defense Ash Carter (“Open Service Directive”).

5 60. Based on my extensive research and clinical experiences treating
6 transgender individuals over decades, the Open Service Directive is consistent with
7 medical science.

8 61. The Open Service Directive also aligns with the conclusions reached
9 by the RAND National Defense Research Institute, the Elders Commission, and
10 the AMA.

11 62. The RAND Report concluded that the military already provides health
12 care comparable to the services needed to treat transgender individuals: “Both
13 psychotherapy and hormone therapies are available and regularly provided through
14 the military’s direct care system, though providers would need some additional
15 continuing education to develop clinical and cultural competence for the proper
16 care of transgender patients. Surgical procedures quite similar to those used for
17 gender transition are already performed within the [Medical Health System] for
18 other clinical indications.” *See* RAND Report at 8.

19 63. The Elders Commission, on which I served, concluded that
20 “[t]ransgender medical care should be managed in terms of the same standards that
21 apply to all medical care, and there is no medical reason to presume transgender
22 individuals are unfit for duty. Their medical care is no more specialized or
23 difficult than other sophisticated medical care the military system routinely
24 provides.” *See* Elders Commission Report at 4.

25 64. Additionally, in a unanimous resolution published on April 29, 2015,
26 the AMA announced its support for lifting the ban on open transgender service in
27
28

1 the military, based on the AMA’s conclusion that there is no grounding in medical
2 science for such a ban.³

3 ***Enlistment Policy for Transgender Individuals***

4 65. The Open Service Directive’s enlistment procedures – which were
5 adopted but never put into effect – are carefully designed to ensure that transgender
6 individuals who enlist in the military do not have any medical needs that would
7 make them medically unfit to serve or interfere with their deployment.

8 66. Under the Open Service Directive, transgender individuals whose
9 condition was stable for 18 months at the time of enlistment would be eligible to
10 enlist, assuming a licensed medical provider certified that the applicant has been
11 stable without clinically significant distress or impairment in social, occupational,
12 or other important areas of functioning for 18 months. *See* DTM-16-005
13 Memorandum and Attachment (June 30, 2016). For example, those seeking to
14 enlist who had been treated with any counseling, cross-sex hormone therapy, or
15 gender confirmation surgeries must have medical confirmation that they have been
16 stable for the last 18 months. Similarly, those applicants taking maintenance cross-
17 sex hormones as follow-up to their transition would also need certification that
18 they had been stable on such hormones for 18 months.

19 67. A history of “sex reassignment or genital reconstruction surgery” is
20 considered disqualifying under the Open Service Directive, unless a licensed
21 medical provider certifies that: (1) a period of 18 months has passed since any
22 surgical intervention; and (2) no functional limitations or complications persist and
23 no additional surgical intervention is needed. In other words, under the Open
24 Service Directive, no transgender individual is permitted to enlist, unless the
25 applicant has been stable in his or her gender for a period of 18 months, has waited
26

27 _____
28 ³ *Available at*
<http://archive.palmcenter.org/files/A-15%20Resoulution%20011.pdf>.

1 18 months since any surgical treatment related to gender transition, and has no
2 medical need for additional surgical care.

3 68. In May 2017, and in anticipation of the implementation of the Open
4 Service Directive’s enlistment procedures, I presented at the national
5 USMEPCOM Leadership Training Seminar on the topic of “Transgender Health
6 Care, Research, and Regulations in the Department of Defense.” My presentation
7 focused on DoDIs related to accessions, and provided extensive training to clinical
8 examiners from all branches of the service, coast-to-coast, and their NCO staff on
9 how to enlist a known transgender person into all branches of the Armed Forces.
10 This training was part of a broader training plan designed to implement all aspects
11 of the Open Service Directive.

12 ***Retention Policy for Transgender Individuals***

13 69. Under the Open Service Directive, gender dysphoria is treated like
14 other curable medical conditions. Individuals with gender dysphoria receive
15 medically necessary care. Service members who are transgender are subject to the
16 same standards of medical and physical fitness as any other service member.⁴

17 70. The Open Service Directive also permits commanders to have
18 substantial say in the timing of any future transition-related treatment for
19 transgender service members. The needs of the military can also take precedence
20 over an individual’s need to transition, if the timing of that request interferes with
21 critical military deployments or trainings.

22 **MEDICAL JUSTIFICATIONS FOR BANNING TRANSGENDER SERVICE**
23 **MEMBERS ARE UNFOUNDED**

24 71. Based upon: (1) my extensive research and experience treating
25 transgender people, most of whom have served this country in uniform, (2) my
26

27 ⁴ *Available at*
28 https://www.defense.gov/Portals/1/features/2016/0616_policy/Guidance_for_Treatment_of_Gender_Dysphoria_Memo_FINAL_SIGNED.pdf.

1 involvement reviewing the medical implications of a ban on transgender service
2 members, and (3) my participation in implementing the Open Service Directive
3 allowing transgender individuals to serve openly, it is my opinion that any medical
4 objections to open service by transgender service members are wholly
5 unsubstantiated and inconsistent with medical science and the ways in which other
6 medical conditions are successfully addressed within the military.

7 ***Mental Health***

8 72. Arguments based on the mental health of transgender persons to
9 justify prohibiting individuals from serving in the military are wholly unfounded
10 and unsupported in medical science. Being transgender is not a mental defect or
11 disorder. Scientists have long abandoned psychopathological understandings of
12 transgender identity, and do not classify the incongruity between a person's gender
13 identity and assigned sex at birth as a mental illness. To the extent the
14 misalignment between gender identity and assigned birth sex creates clinically
15 significant distress (gender dysphoria), that distress is curable through appropriate
16 medical care.

17 73. Sixty years of clinical experience have demonstrated the efficacy of
18 treatment for the distress resulting from gender dysphoria. *See* Elders Commission
19 Report at 10 (“a significant body of evidence shows that treatment can alleviate
20 symptoms among those who do experience distress”). Moreover, “empirical data
21 suggest that many non-transgender service members continue to serve despite
22 psychological conditions that may not be as amenable to treatment as gender
23 dysphoria.” *Id.* at 11.

24 74. The availability of a cure distinguishes gender dysphoria from other
25 mental health conditions, such as autism, bipolar disorder, or schizophrenia, for
26 which there are no cures. There is no reason to single out transgender personnel
27 for separation, limitation of service, or bars to enlistment, based only on the
28 diagnosis or treatment of gender dysphoria. Determinations can and should be

1 made instead on a case-by-case basis depending on the individual's fitness to
2 serve, as is done with other personnel with treatable conditions.

3 75. The military already provides mental health evaluation services and
4 counseling, which is the first component of treatment for gender dysphoria. *See*
5 RAND Report at 8.

6 76. Concerns about suicide and substance abuse rates among transgender
7 individuals are also unfounded when it comes to military policy. At enlistment, all
8 prospective military service members undergo a rigorous examination to identify
9 any pre-existing mental health diagnoses that would preclude enlistment. Once
10 someone is serving in the military, they must undergo an annual mental and
11 physical health screen, which includes a drug screen. If such a screening indicates
12 that a person suffers from a mental illness or substance abuse, then that would be
13 the potential impediment to retention in the military. The mere fact that a person is
14 transgender, however, does not mean that person has a mental health or substance
15 abuse problem or is suicidal.

16 ***Hormone Treatment***

17 77. The argument that cross-sex hormone treatment should be a bar to
18 service for transgender individuals is not supported by medical science or current
19 military medical protocols.

20 78. Hormone therapy is neither too risky nor too complicated for military
21 medical personnel to administer and monitor. The risks associated with use of
22 cross-sex hormone therapy to treat gender dysphoria are low and not any higher
23 than for the hormones that many non-transgender active duty military personnel
24 currently take. There are active duty service members currently deployed in
25 combat theaters who are receiving cross-sex hormonal treatment, following current
26 DoD instructions, without reported negative impact upon readiness or lethality.
27 WPATH has provided a statement on the use of cross-sex hormones in military
28 personnel, including an expected timeline for the most commonly seen effects and

1 side effects (available at:

2 https://s3.amazonaws.com/amo_hub_content/Association140/files/WPATHGuideli
3 [neArmedServices2017_01_19%20\(003\).pdf.](https://s3.amazonaws.com/amo_hub_content/Association140/files/WPATHGuideli))

4 79. The military has vast experience with accessing, retaining, and
5 treating non-transgender individuals who need hormone therapies or replacement,
6 including for gynecological conditions (e.g., dysmenorrhea, endometriosis,
7 menopausal syndrome, chronic pelvic pain, male hypogonadism, hysterectomy, or
8 oophorectomy) and genitourinary conditions (e.g., renal or voiding dysfunctions).
9 Certain of these conditions are referred for a fitness evaluation only when they
10 affect duty performance. *See* Elders Commission at 13.

11 80. In addition, during service when service members develop hormonal
12 conditions whose remedies are biologically similar to cross-sex hormone
13 treatment, those members are not discharged and may not even be referred for a
14 MEB. Examples include male hypogonadism, menstrual disorders, and current, or
15 history of, pituitary dysfunction. *Id.*

16 81. Military policy also allows service members to take a range of
17 medications, including hormones, while deployed in combat settings. *Id.* Under
18 DoD policy only a “few medications are inherently disqualifying for deployment,”
19 and none of those medications are used to treat gender dysphoria. *Id.* (quoting
20 Dept. of Defense, Policy Guidance for Deployment-Limiting Psychiatric
21 Conditions and Medications, 2006 at para. 4.2.3). Similarly, Army regulations
22 provide that “[a] psychiatric condition controlled by medication should not
23 automatically lead to non-deployment.” *See* AR 40-501 § 5-14(8)(a).

24 82. Access to medication is predictable, as “[t]he Medical Health Service
25 maintains a sophisticated and effective system for distributing prescription
26 medications to deployed service members worldwide.” *See* Elders Commission at
27 13. At least as to cross-sex hormones, clinical monitoring for risks and effects is
28 not complicated, and with training and/or access to consultations, can be performed

1 by a variety of medical personnel in the DoD, just as is the case in the VHA. This
2 is the military services' current practice in support of the limited medical needs of
3 their transgender troops in CONUS (Continental United States) and in deployment
4 stations worldwide.

5 83. The RAND Corporation confirms the conclusions I draw from my
6 experience with the military and the Elders Commission. Specifically, the RAND
7 Report notes that the Medical Health System maintains and supports all of the
8 medications used for treatment of gender dysphoria and has done so for treatment
9 of non-transgender service members. In other words, all of the medications
10 utilized by transgender service members for treatment of gender dysphoria are used
11 by other service members for conditions unrelated to gender dysphoria. *See*
12 RAND Report at 8 ("Both psychotherapy and hormone therapies are available and
13 regularly provided through the military's direct care system, though providers
14 would need some additional continuing education to develop clinical and cultural
15 competence for the proper care of transgender patients"). Part of my role with the
16 DoD over the past 18 months has been to provide this continuing education.

17 *Surgery*

18 84. Nor is there any basis in science or medicine to support the argument
19 that a transgender service member's potential need for surgical care to treat gender
20 dysphoria presents risks or burdens to military readiness. The risks associated with
21 gender-confirming surgery are low, and the military already provides similar types
22 of surgeries to non-transgender service members. *See* Elders Commission Report
23 at 14; RAND Report at 8-9.

24 85. For example, the military currently performs reconstructive
25 breast/chest and genital surgeries on service members who have had cancer, been
26 in vehicular and other accidents, or been wounded in combat. *See* RAND Report
27 at 8. The military also permits service members to have elective cosmetic
28 surgeries, like LeFort osteotomy and mandibular osteotomy, at military medical

1 facilities. *See* Elders Commission Report at 14. The RAND Report notes that the
2 “skills and competencies required to perform these procedures on transgender
3 patients are often identical or overlapping. For instance, mastectomies are the
4 same for breast cancer patients and female-to-male transgender patients.” *See*
5 RAND Report at 8.

6 86. There is no reason to provide such surgical care to treat some
7 conditions and withhold identical care and discharge individuals needing such care
8 when it is provided to treat gender dysphoria. Based on risk and deployability
9 alone, there is no basis to exclude transgender individuals from serving just
10 because in some cases they may require surgical treatment that is already provided
11 to other active duty service members.

12 87. The RAND Report also notes the benefit of military medical coverage
13 of transgender-related surgeries because of the contribution it can make to surgical
14 readiness and training. *Id.* (“performing these surgeries on transgender patients
15 may help maintain a vitally important skill required of military surgeons to
16 effectively treat combat injuries during a period in which fewer combat injuries are
17 sustained”).

18 88. The suggestion by some critics that when it comes to enlistment,
19 individuals would join the military just to receive surgical care, is completely
20 unfounded. The level of commitment and dedication in mind, body, and spirit to
21 military service makes it unlikely that someone would enlist and complete a years-
22 long term of initial service simply to access health care services. Moreover,
23 because medically-necessary care for gender dysphoria is now increasingly
24 available in the civilian context, there would be limited need to join the military
25 simply to obtain treatment.

26 ***Deployability***

27 89. Critics have also cited non-deployability, medical readiness, and
28 constraints on fitness for duty as reasons to categorically exclude transgender

1 individuals from military service. Such arguments are unsubstantiated and
2 illogical. As a general matter and based on the experiences of numerous foreign
3 militaries, transgender service members are just as medically fit for service and
4 deployable as non-transgender service members. *Id.* at 60.

5 90. Transgender service members – including service members who
6 receive hormone medication – are just as capable of deploying as service members
7 who are not transgender. DoD rules expressly permit deployment, without need
8 for a waiver, for a number of medical conditions that present a much more
9 significant degree of risk in a harsh environment than being transgender. For
10 example, hypertension is not disqualifying if controlled by medication, despite the
11 inherent risks in becoming dehydrated in desert deployment situations. Heart
12 attacks experienced while on active duty or treatment with coronary artery bypass
13 grafts are also not disqualifying, if they occur more than a year preceding
14 deployment. Service members may deploy with psychiatric disorders, if they
15 demonstrate stability under treatment for at least three months. *See* DoDI 6490.07,
16 Enclosure 3.

17 91. Moreover, although a service member undergoing surgery may be
18 temporarily non-deployable, that is not a situation unique to people who are
19 transgender. Numerous non-transgender service members are temporarily or
20 permanently non-deployable, including pregnant individuals who are not separated
21 as a result. *See* Elders Commission Report at 17.

22 92. Finally, the RAND Report ultimately concluded that the impact of
23 open service of men and women who are transgender on combat readiness would
24 be “negligible.” *See* RAND Report at 70. Based on the available evidence of over
25 18 foreign militaries, RAND found that open service has had “no significant effect
26 on cohesion, operational effectiveness, or readiness.” *Id.* at 60. This includes the
27 experience of Canada, which has permitted open service for over 20 years. *Id.* at
28 52.

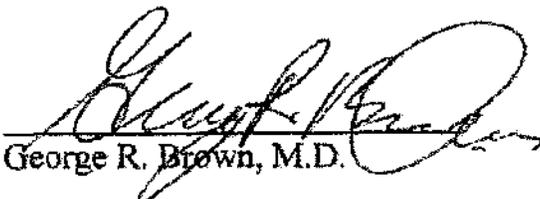
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CONCLUSION

93. There is no evidence that being transgender alone affects military performance or readiness. There is no medical or psychiatric justification for the categorical exclusion of transgender individuals from the Armed Forces, either for new accessions or for retention of transgender active duty service members.

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

Dated: September 24, 2017

By 
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