No. 24A

In the Supreme Court of the United States

UNITED STATES OF AMERICA, ET AL., APPLICANTS

v.

EMILY SHILLING, ET AL.

APPLICATION FOR A STAY OF THE INJUNCTION ISSUED BY THE UNITED STATES DISTRICT COURT FOR THE WESTERN DISTRICT OF WASHINGTON

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PARTIES TO THE PROCEEDING

Applicants (defendants-appellants below) are the United States of America; Donald J. Trump, President of the United States, in his official capacity; Peter Hegseth, Secretary of Defense, in his official capacity; the United States Department of Defense; Daniel P. Driscoll, Secretary of the Army, in his official capacity; the United States Department of the Army; John C. Phelan, Secretary of the Navy, in his official capacity; the United States Department of the Navy; Gary Ashworth, Acting Secretary of the Air Force, in his official capacity; and the United States Department of the Air Force.*

Respondents (plaintiffs-appellees below) are Commander Emily Shilling; Commander Blake Dremann; Lieutenant Commander Geirid Morgan; Sergeant First Class Cathrine Schmid; Sergeant First Class Jane Doe; Staff Sergeant Videl Leins; Sergeant First Class Sierra Moran; Matthew Medina; and Gender Justice League.

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* After applicants filed their notice of appeal to the Ninth Circuit, the district court dismissed Donald J. Trump, in his official capacity as President of the United States, as a defendant in this case. See D. Ct. Docket Entry No. 106 (Mar. 28, 2025).

RELATED PROCEEDINGS

United States District Court (W.D. Wash.):

Shilling v. *United States*, No. 25-cv-241 (Mar. 27, 2025)

United States Court of Appeals (9th Cir.):

Shilling v. *Trump*, No. 25-2039 (Apr. 18, 2025)

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Pursuant to Rule 23 of the Rules of this Court and the All Writs Act, 28 U.S.C. 1651, the Solicitor General—on behalf of applicants the United States, et al.—respectfully files this application for a stay of the injunction issued by the U.S. District Court for the Western District of Washington (App., *infra*, 190a-256a) pending the consideration and disposition of the government's appeal to the United States Court of Appeals for the Ninth Circuit and pending any further review in this Court.

In this case, the district court issued a universal injunction usurping the Executive Branch's authority to determine who may serve in the Nation's armed forces—despite this Court previously staying injunctions against a materially indistinguishable policy. In February 2025, the Department of Defense adopted its current policy, which generally disqualifies from military service individuals who have gender dysphoria or have undergone medical interventions for gender dysphoria. The policy was based in part on the findings of a panel of experts convened during the first Trump Administration, which found that service by individuals with gender dys-

phoria was contrary to "military effectiveness and lethality." App., *infra*, 8a. Respondents challenged the Department's 2025 policy on equal protection and other grounds. Despite this Court's admonition that professional military judgments about the composition of the armed forces should be given "great deference," *Winter* v. *Natural Res. Def. Council, Inc.*, 555 U.S. 7, 24 (2008) (citation omitted), the district court issued a universal injunction against the 2025 policy. In so doing, the court ordered the government to maintain a different policy that the Department has deemed "incompatible with the high mental and physical standards necessary for military service." App., *infra*, 124a.

As noted, this case does not plow new ground. In 2018, then-Secretary of Defense James Mattis adopted a policy, materially indistinguishable from the one at issue here, that generally disqualified individuals with gender dysphoria from military service. Certain plaintiffs challenged the Mattis policy on equal protection and other grounds, and district courts enjoined the policy on a universal basis.

This Court stayed those injunctions, see *Trump* v. *Karnoski*, 586 U.S. 1124 (2019); *Trump* v. *Stockman*, 586 U.S. 1124 (2019), and it should do the same here. Because the 2025 policy, like the Mattis policy, turns on a medical condition (gender dysphoria) and related medical interventions, the Constitution demands only rational-basis review, especially in the military context. The 2025 policy, like the Mattis policy, readily satisfies that review. It is *undisputed* that gender dysphoria is a medical condition associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning. App., *infra*, 185a. And in the 2025 policy, as in the Mattis policy before it, the Department rationally determined that service by individuals with gender dysphoria would undermine military effectiveness and lethality—consistent with similar, longstanding determinations for

a wide range of other medical conditions (such as asthma and hypertension). *Id.* at 74a, 93a; D. Ct. Doc. 73-5, at 15 (Mar. 13, 2025).

The district court's injunction cannot be squared with the substantial deference that the Department's professional military judgments are owed. Nor can the court's injunction be squared with this Court's decisions to stay the injunctions against the Mattis policy. In staying those injunctions, this Court necessarily determined that the government was likely to succeed in defending the Mattis policy on the merits. Yet the district court failed to identify any relevant difference in the 2025 policy that would justify a different conclusion here. Although the court noted that the 2025 policy narrows the circumstances in which an otherwise disqualified person may nonetheless serve, App., *infra*, 193a, the 2025 policy merely reflects a more cautious approach to the risks associated with gender dysphoria and related medical interventions, *id.* at 122a. Nothing in the Constitution prohibits the Department from making that modest change, which does not alter the conclusion that rational-basis review applies and is satisfied. And in suggesting that experience under the policies of the last Administration shows that service by individuals with gender dysphoria does not present meaningful risks, *id.* at 235a-236a, the court improperly second-guessed the military's own assessment of those risks, *id.* at 122a.

The Ninth Circuit's denial of a stay likewise cannot be reconciled with this Court's decisions to stay the injunctions against the Mattis policy. In a one-page order, the Ninth Circuit asserted that the government had not shown that it would suffer irreparable harm absent a stay. But in staying the injunctions against the Mattis policy, this Court necessarily determined that those injunctions would otherwise cause the government irreparable harm. The same is true here: Like the injunctions against the Mattis policy, the injunction against the 2025 policy irreparably

harms the government by forcing it to maintain a policy that the Department has found to be inconsistent with "the best interests of the Military Services" and with "the interests of national security." App., *infra*, 126a.

Absent a stay, the district court's universal injunction will remain in place for the duration of further review in the Ninth Circuit and in this Court—a period far too long for the military to be forced to maintain a policy that it has determined, in its professional judgment, to be contrary to military readiness and the Nation's interests. The government therefore respectfully requests a stay of the injunction in its entirety pending further review. At minimum, this Court should stay the injunction's universal scope, so that the injunction blocks the implementation of the 2025 policy only as to the eight individual respondents in this case.

STATEMENT

A. The Military's Policies

1. To assemble a military of "qualified, effective, and able-bodied persons," 10 U.S.C. 505(a), the Department of Defense (Department or DoD) has traditionally set demanding standards for military service, App., *infra*, 12a. The Department's accession standards—the standards that govern entry into the military—list hundreds of medical conditions that are disqualifying absent a waiver. *Id.* at 67a-108a. The list includes cataracts, asthma, high blood pressure (hypertension), diabetes, severe headaches, and other common medical conditions. *Id.* at 69a, 74a, 93a, 98a, 102a. The list also contains various mental, behavioral, and learning disorders, including autism spectrum disorders, bipolar and related disorders, eating disorders, suicidality, obsessive-compulsive disorders, anxiety and depressive disorders in specified circumstances, and substance-related and addictive disorders (except using caffeine or tobacco). *Id.* at 104a-106a. Because of the Department's rigorous accession

standards, "[t]he vast majority of Americans from ages 17 to 24—that is, 71%—are ineligible to join the military without a waiver for mental, medical, or behavioral reasons." *Id.* at 16a.

In general, the Department has aligned the mental disorders it has deemed presumptively disqualifying with those listed in the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*), published by the American Psychiatric Association (APA). App., *infra*, 20a. The 1980 edition of the *DSM* recognized "[t]ranssexualism" as a disorder whose "essential features" were "a persistent sense of discomfort and inappropriateness about one's anatomic sex and a persistent wish to be rid of one's genitals and to live as a member of the other sex." APA, *Diagnostic and Statistical Manual of Mental Disorders* 261-262 (3d ed. 1980) (*DSM-III*). When the *DSM* was updated in 1994, "[t]ranssexualism" was subsumed within the term "[g]ender [i]dentity [d]isorder." APA, *Diagnostic and Statistical Manual of Mental Disorders* 785 (4th ed. 1994) (*DSM-IV*). Consistent with the *DSM*, the military's accession standards had for decades treated a "history of * * * transsexualism" as disqualifying. App., *infra*, 20a (brackets and citation omitted). Likewise, the military's retention standards—the standards that govern the retention and separation of persons already serving in the military—had historically treated transsexualism as a "permissible basis" for discharging a servicemember. *Id.* at 17a. Again, that was consistent with the Department's demanding standards for military service, which identify mental disorders recognized by the *DSM* as permissible grounds for discharging servicemembers. See, *e.g.*, D. Ct. Doc. 73-5, at 36-37.

2. In 2013, when the APA published the fifth edition of the *DSM* (known as the *DSM-5*), it replaced the term "gender identity disorder" with "gender dysphoria." App., *infra*, 22a. The *DSM-5* defines gender dysphoria as a "marked incongru-

ence between one's experienced/expressed gender and assigned gender, of at least 6 months' duration," that is "manifested" in various specified ways and is "associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning." APA, *Diagnostic and Statistical Manual of Mental Disorders* 452-453 (5th ed. 2013) (*DSM-5*); see App., *infra*, 185a. According to the *DSM-5*, some adults with gender dysphoria may desire cross-sex hormone interventions or sex-reassignment surgery. *DSM-5*, at 454; see App., *infra*, 32a. The *DSM-5* further observes that adults with gender dysphoria are at "increased risk for suicidal ideation, suicide attempts, and suicides," *DSM-5*, at 454, and "may have coexisting mental health problems, most commonly anxiety and depressive disorders," *id.* at 459.

Under the *DSM-5*, "[*g*]*ender dysphoria*" and "[*t*]*ransgender*" are distinct terms: Whereas "[*t*]*ransgender* refers to the broad spectrum of individuals who transiently or persistently identify with a gender different from their natal [*i.e.*, birth] gender," "[*g*]*ender dysphoria* refers to the distress that may accompany the incongruence between one's experienced or expressed gender and one's assigned gender." *DSM-5*, at 451. The *DSM-5* emphasizes that "not all individuals will experience distress as a result of such incongruence" and that the term "[*g*]*ender dysphoria*," unlike the previous term "*gender identity disorder*," "focuses on dysphoria as the clinical problem, not identity per se." *Ibid.*; see App., *infra*, 30a ("'[N]ot all transgender people suffer from gender dysphoria and that distinction,' according to the APA, 'is important to keep in mind.'") (quoting APA, *Expert Q & A: Gender Dysphoria*).

3. In 2016, then-Secretary of Defense Ashton Carter ordered the military to adopt new accession standards by July 2017. App., *infra*, 24a. Under the new accession standards, a history of transsexualism would no longer be disqualifying.

But Secretary Carter recognized the need for "[m]edical standards" that "ensure that those entering service are free of medical conditions or physical defects that may require excessive time lost from duty." *Id.* at 4a. Secretary Carter therefore ordered that the new accession standards treat a "history of gender dysphoria," a "history of medical treatment associated with gender transition," and a "history of sex reassignment or genital reconstruction surgery" as "disqualifying," with certain exceptions. *Id.* at 25a-26a. For example, Secretary Carter ordered that the new accession standards treat a "history of gender dysphoria" as "disqualifying, unless, as certified by a licensed medical provider, the applicant has been stable without clinically significant distress or impairment in social, occupational, or other important areas of functioning for 18 months." *Id.* at 25a.

Secretary Carter also ordered the military to adopt new retention standards, effective immediately. App., *infra*, 24a. Under the new retention standards, servicemembers who were diagnosed with gender dysphoria were permitted to undergo "gender transition" and serve in their "transitioned gender." *Id.* at 24a-25a. But servicemembers who did "not meet the clinical criteria for gender dysphoria" "remain[ed] subject to the standards and requirements applicable to their biological sex." *Id.* at 25a. Thus, absent a diagnosis of the clinically significant distress or impairment that constitutes gender dysphoria, servicemembers had to use the berthing, bathroom, and shower facilities corresponding to their sex even if they personally identified with the opposite sex. See *id.* at 39a. They likewise had to meet the physical-fitness, body-fat, uniform, and grooming standards applicable to their sex. See *id.* at 39a-40a.

4. In June 2017—before the Carter accession standards were set to take effect—then-Secretary of Defense James Mattis determined, "after consultation with the Secretaries and Chiefs of Staff of each Service," that it was necessary to defer

those standards until the military could "'evaluate more carefully'" their potential effect "'on readiness and lethality.'" App., *infra*, 27a (citation omitted). Secretary Mattis established a panel of experts to "conduct an independent multi-disciplinary review and study of relevant data and information pertaining to transgender Service members." *Ibid.* (citation omitted). The panel consisted of "senior uniformed and civilian Defense Department and U.S. Coast Guard leaders." *Id.* at 7a. After "extensive review and deliberation" over several months, the panel "exercised its professional military judgment" and presented its independent recommendations to the Secretary. *Id.* at 28a.

In February 2018, Secretary Mattis sent President Trump a memorandum proposing a new policy consistent with the panel's conclusions, along with a lengthy report explaining the policy. App., *infra*, 7a-54a. Recognizing that the new policy reflected "the exercise of [Secretary Mattis's] independent judgment," the President issued a memorandum permitting the Secretaries of Defense and Homeland Security "to implement" it. *Military Service by Transgender Individuals*, 83 Fed. Reg. 13,367, 13,367 (Mar. 23, 2018).

Under the Mattis policy, individuals "who [we]re diagnosed with, or ha[d] a history of, gender dysphoria [we]re generally disqualified from accession or retention in the Armed Forces," except under "limited circumstances." App., *infra*, 52a. The Mattis accession standards thus treated a "history of gender dysphoria" as disqualifying, unless applicants could "demonstrate 36 consecutive months of stability—i.e., absence of gender dysphoria—immediately preceding their application; they ha[d] not transitioned to the opposite gender; and they [we]re willing and able to adhere to all standards associated with their biological sex." *Ibid.* Similarly, the Mattis retention standards generally treated a diagnosis of gender dysphoria as cause for discharge,

unless a servicemember was "willing and able to adhere to all standards associated with [the servicemember's] biological sex, the Service member d[id] not require gender transition, and the Service member [wa]s not otherwise non-deployable for more than 12 months or for a period of time in excess of that established by Service policy (which may be less than 12 months)." *Ibid.* In addition, the Mattis policy, like the Carter policy before it, required servicemembers without a history or diagnosis of gender dysphoria to serve in their "biological sex." *Id.* at 9a.

Several district courts entered universal preliminary injunctions against the Mattis policy on the view that the policy was a "ban on military service by openly transgender people." *Karnoski* v. *Trump*, No. 17-cv-1297, 2018 WL 1784464, at *1 (W.D. Wash. Apr. 13, 2018), vacated, 926 F.3d 1180 (9th Cir. 2019); see *Doe* v. *Trump*, 315 F. Supp. 3d 474, 492 (D.D.C. 2018), rev'd, 755 Fed. Appx. 19 (D.C. Cir. 2019); *Stockman* v. *Trump*, 331 F. Supp. 3d 990, 1001 (C.D. Cal. 2018), vacated, No. 18-56539, 2019 WL 6125075 (9th Cir. Aug. 26, 2019). In each case, the government sought from this Court a grant of certiorari before judgment or, in the alternative, a stay of the injunction pending appeal. See *Trump* v. *Karnoski*, Nos. 18-676, 18A625; *Trump* v. *Doe*, Nos. 18-677, 18A626; *Trump* v. *Stockman*, Nos. 18-678, 18A627. The government emphasized that "the Mattis policy turn[ed] on a medical condition (gender dysphoria) and related treatment (gender transition)"—rather than transgender status—and was consistent with equal protection, due process, and the First Amendment. Pet. at 19, *Trump* v. *Karnoski*, No. 18-676 (Nov. 23, 2018); see *id.* at 19-25. While the government's requests were pending in this Court, the D.C. Circuit vacated the injunction in one of the cases. See *Doe* v. *Shanahan*, 917 F.3d 694 (2019) (separate opinions); *Doe* v. *Shanahan*, 755 Fed. Appx. 19 (2019) (per curiam). Soon after,

this Court granted stays of the injunctions in the other two cases. See *Trump* v. *Karnoski*, 586 U.S. 1124 (2019); *Trump* v. *Stockman*, 586 U.S. 1124 (2019).

5. In 2021, President Biden revoked President Trump's memorandum permitting implementation of the Mattis policy. Exec. Order No. 14,004, § 2 (Jan. 25, 2021), 86 Fed. Reg. 7471, 7472 (Jan. 28, 2021). Thereafter, then-Secretary of Defense Lloyd Austin issued new accession standards, but those standards still treated a "[h]istory of gender dysphoria," a history of "gender affirming surgery," and a "[h]istory of gender-affirming hormone therapy" as disqualifying under specified circumstances. App., *infra*, 82a, 84a, 100a, 106a. For example, the Austin accession standards treated a "[h]istory of gender dysphoria" as disqualifying if the condition was "[s]ymptomatic within the previous 18 months" or was "[a]ssociated with comorbid mental health disorders." *Id.* at 106a. Secretary Austin also issued new retention standards that permitted servicemembers diagnosed with gender dysphoria to undergo "gender transition" and serve in their asserted gender identity, but that required servicemembers without such a diagnosis to serve in their sex. DoD Instruction 1300.28, *In-Service Transition for Transgender Service Members* 7-8 (Apr. 30, 2021).

6. Soon after taking office in January 2025, President Trump issued Executive Order No. 14,183, declaring it to be "the policy of the United States Government to establish high standards for troop readiness, lethality, cohesion, honesty, humility, uniformity, and integrity." App., *infra*, 114a. Finding that policy to be "inconsistent with the medical, surgical, and mental health constraints on individuals with gender dysphoria," *ibid.*, the President ordered the Department to update the military's accession and retention standards, *id.* at 114a-115a.

On February 26, 2025, the Department issued a new policy with updated accession and retention standards. App., *infra*, 124a-136a. The 2025 policy was based on "consideration of, among other things, the President and Secretary's written direction, existing and prior DoD policy, and prior DoD studies and reviews of service by individuals with gender dysphoria." *Id.* at 121a. That consideration included Secretary Mattis's 2018 memorandum, which determined, based on the work of a panel of experts, that "there are substantial risks associated with allowing accession and retention of individuals with a history or diagnosis of gender dysphoria"; a 2021 review conducted by the Department's Psychological Health Center of Excellence and the Accession Medical Standards Analysis and Research Activity, which "found that nearly 40% of Service members with gender dysphoria in an observed cohort were non-deployable over a 24 month period"; a 2025 medical-literature review conducted by the Office of the Assistant Secretary of Defense for Health Affairs, which reported that "the suicide attempt rate is estimated to be 13 times higher among transgender individuals compared to their cisgender counterparts," and that "the strength of evidence on transgender mental health and gender-affirming care is low to moderate"; and a review of cost data by the Office of the Assistant Secretary of Defense for Health Affairs, which found that, "between 2015 and 2024, DoD spent $52,084,407 providing care to active duty Service members to treat gender dysphoria." *Id.* at 121a-122a. Based on its review, the Department determined that, "[w]hile Service members with gender dysphoria volunteered to serve their country, the costs associated with their health care, coupled with the medical and readiness risks associated with their diagnosis and associated treatment that can limit their deployability, make continued service by such individuals incompatible with the Department's rigorous standards and national security imperative to deliver a ready, deployable force." *Id.* at 122a.

Under the 2025 policy, as under the Mattis policy, individuals "who have a current diagnosis or history of, or exhibit symptoms consistent with, gender dysphoria" are presumptively disqualified from accession and retention. App., *infra*, 129a, 131a. "'[E]xhibit[ing] symptoms consistent with gender dysphoria'" means "exhibit[ing] such symptoms as would be sufficient to constitute a diagnosis" under the criteria set forth in the *DSM-5*. *Id.* at 181a n.2. The 2025 policy likewise treats a "history of cross-sex hormone therapy or sex reassignment or genital reconstruction surgery as treatment for gender dysphoria or in pursuit of a sex transition" as disqualifying for accession and retention. *Id.* at 129a, 131a. Under the 2025 policy, however, an individual with a disqualifying history or condition "may be considered for a retention or accession waiver on a case-by-case basis where there is a compelling Government interest * * * that directly supports the Department's warfighting capabilities," such as "special experience, special training, and advanced education in a highly technical career field designated as mission critical and hard to fill." *Id.* at 179a. To be eligible for such a waiver, an individual must meet criteria similar to the criteria set forth in the Mattis policy: The individual must "demonstrate[] 36 consecutive months of stability in the individual's sex"; the individual must "demonstrate[] that he or she has never attempted to transition to any sex other than his or her sex"; and the individual must be "willing and able to adhere to all applicable standards, including the standards associated with his or her sex." *Id.* at 179a-180a. Finally, the 2025 policy, like the Carter, Mattis, and Austin policies before it, requires servicemembers without gender dysphoria to serve "in accordance with their sex." *Id.* at 126a-127a.

B. Procedural History

Respondents are seven trans-identifying individuals who are currently serving in the military, one trans-identifying individual who wishes to join the military, and

an advocacy organization whose members include three of the individual respondents. See App., *infra*, 118a, 140a-141a. Characterizing Executive Order No. 14,183 and the 2025 policy as a "ban" on military service by "transgender people," *id.* at 138a, respondents sued in the Western District of Washington, challenging the "[b]an" as a violation of equal protection, the First Amendment, procedural due process, and the doctrine of equitable estoppel, *id.* at 168a-175a. Respondents moved for a universal preliminary injunction. D. Ct. Doc. 23 (Feb. 19, 2025).

On March 27, 2025, the district court granted respondents' motion and entered a universal preliminary injunction prohibiting the government from implementing Executive Order No. 14,183 and the 2025 policy and requiring the government to maintain the Austin policy. App., *infra*, 190a-191a. Agreeing with respondents' characterization of the 2025 policy as "a *de facto* blanket prohibition on transgender service," *id.* at 193a, the court held that respondents were likely to succeed on their equal protection claim, *id.* at 217a-237a. The court concluded that the 2025 policy was subject to intermediate scrutiny because the policy discriminated based on transgender status and sex. *Id.* at 220a-226a. The court further concluded that the 2025 policy failed intermediate scrutiny because "banning transgender persons from serving" was not "substantially related to achieving military readiness," *id.* at 231a; to "achieving unit cohesion, good order, or discipline," *id.* at 234a; or to "cost effectiveness," *id.* at 235a. The court also held that the 2025 policy would not survive even rational-basis review because the 2025 policy "reli[ed] on seven-year-old predictions from the Mattis Policy" without citing "updated data." *Id.* at 235a-236a. The court likewise held that respondents were likely to succeed on their First Amendment, procedural due process, and equitable estoppel claims. *Id.* at 237a-249a. And it concluded that

respondents had satisfied the remaining preliminary injunction factors. *Id.* at 249a-253a. The court denied the government's request for a stay. *Id.* at 188a-189a.

The government appealed and asked the Ninth Circuit for an administrative stay and a stay pending appeal. On March 31, the Ninth Circuit denied the government's request for an administrative stay. App., *infra*, 257a. Nearly three weeks later, on April 18, the Ninth Circuit issued a one-page order denying the government's request for a stay pending appeal. *Id.* at 258a. The court stated that the government had not shown that it "will suffer irreparable harm absent a stay." *Ibid.**

ARGUMENT

Under Rule 23 of the Rules of this Court and the All Writs Act, 28 U.S.C. 1651, the Court may stay a district order's interlocutory order granting emergency relief. See, *e.g.*, *Trump* v. *International Refugee Assistance Project*, 582 U.S. 571 (2017) (per curiam); *Brewer* v. *Landrigan*, 562 U.S. 996 (2010); *Brunner* v. *Ohio Republican Party*, 555 U.S. 5, 6 (2008). An applicant must show (1) a likelihood of success on the merits, (2) a reasonable probability of obtaining certiorari, and (3) a likelihood of irreparable harm. See *Hollingsworth* v. *Perry*, 558 U.S. 183, 190 (2010) (per curiam). In "close cases," "the Court will balance the equities and weigh the relative harms." *Ibid.*

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* Two other challenges to the 2025 policy are pending in other courts. In *Talbott* v. *Trump*, No. 25-cv-240 (D.D.C.), the district court issued a universal preliminary injunction barring the government from implementing Executive Order No. 14,183 and the 2025 policy, 2025 WL 842332, at *3 (Mar. 18, 2025), and denied the government's motion to dissolve the injunction, 2025 WL 914716, at *2 (Mar. 26, 2025). The government appealed and sought an administrative stay and a stay pending appeal. The D.C. Circuit granted an administrative stay and heard oral argument on the government's motion for a stay pending appeal on April 22. See *Talbott* v. *United States*, No. 25-5087 (2025). In *Ireland* v. *Hegseth*, No. 25-cv-1918 (D.N.J.), the district court issued a 14-day temporary restraining order (TRO) barring the government from implementing Executive Order No. 14,183 and the 2025 policy as to the two named plaintiffs in that case. See D. Ct. Doc. 28, at 8 (Mar. 24, 2025), *Ireland*, *supra* (No. 25-cv-1918). That TRO has expired, and the court has not renewed it.

All of those factors strongly support a stay of the district court's universal injunction against the 2025 policy in this case. Indeed, this Court has previously stayed universal injunctions blocking the Mattis policy—a DoD policy that likewise presumptively disqualified individuals with gender dysphoria from military service. See *Trump* v. *Karnoski*, 586 U.S. 1124 (2019); *Trump* v. *Stockman*, 586 U.S. 1124 (2019). There is no basis for a different outcome here.

I. THE GOVERNMENT IS LIKELY TO SUCCEED ON THE MERITS

In granting stays of the injunctions against the Mattis policy, this Court necessarily determined that the government was likely to succeed on the merits of the plaintiffs' challenges to that policy. See *Hollingsworth*, 558 U.S. at 190 ("To obtain a stay * * * , an applicant must show * * * a fair prospect that a majority of the Court will vote to reverse the judgment below."). Respondents raise similar challenges to the 2025 policy, and neither court below identified any relevant difference between that policy and the Mattis policy. Accordingly, this Court should reach the same conclusion as it did before: The government is likely to succeed on the merits.

A. The 2025 Policy Is Consistent With Equal Protection

The 2025 policy does not discriminate against any suspect or quasi-suspect class. Instead, like the Carter, Mattis, and Austin policies before it, the 2025 policy draws classifications based on a medical condition (gender dysphoria) and related medical interventions. Thus, especially given the military context, the 2025 policy warrants only rational-basis review, which it easily satisfies.

1. The 2025 policy warrants only rational-basis review

a. Gender dysphoria is a medical condition "associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning." *DSM-5*, at 453. The 2025 policy presumptively disqualifies from mili-

tary service individuals with gender dysphoria. App., *infra*, 129a, 131a. It also disqualifies from military service individuals who have received interventions related to gender dysphoria—*i.e.*, "cross-sex hormone therapy or sex reassignment or genital reconstruction surgery." *Id.* at 129a; see *id.* at 131a.

The 2025 policy thus turns on a medical condition (gender dysphoria) and related medical interventions. There is nothing suspect about those classifications. The same classifications appear in the *DSM-5*, which identifies "gender dysphoria" as a medical condition that may lead some to seek "hormone treatment" or "gender reassignment surgery." *DSM-5*, at 454. The same classifications also appear in the Department's prior Carter, Mattis, and Austin policies. See pp. 6-10, *supra*. For example, the Carter accession standards treated a history of "gender dysphoria," "medical treatment associated with gender transition," or "sex reassignment or genital reconstruction surgery" as "disqualifying," with certain exceptions. App., *infra*, 25a-26a. Likewise, the Austin accession standards—which the district court's injunction requires the military to keep in place—treats a history of "gender dysphoria," "gender affirming surgery," or "gender-affirming hormone therapy" as disqualifying under specified circumstances. *Id.* at 82a, 84a, 100a, 106a.

Because the 2025 policy, like the Carter, Mattis, and Austin policies before it, draws classifications based on a medical condition and related medical interventions, the 2025 policy warrants only rational-basis review. See, *e.g.*, *Board of Trs. of the Univ. of Ala.* v. *Garrett*, 531 U.S. 356, 365-368 (2001). Because that would be true even in the civilian context, it follows *a fortiori* in the military context. Any greater level of scrutiny would conflict with the "healthy deference" that the political branches are owed "in the area of military affairs." *Rostker* v. *Goldberg*, 453 U.S. 57, 66 (1981) (upholding Congress's decision to exclude women from Selective Service

registration). That deference reflects the recognition "[n]ot only" that "courts [are] 'ill-equipped to determine the impact upon discipline that any particular intrusion upon military authority might have,'" but also that "military authorities have been charged by the Executive and Legislative Branches with carrying out our Nation's military policy." *Goldman* v. *Weinberger*, 475 U.S. 503, 507-508 (1986) (upholding Air Force's decision to prohibit clinical psychologist from wearing a yarmulke while in uniform) (citation omitted); see *Winter* v. *Natural Res. Def. Council, Inc.*, 555 U.S. 7, 24 (2008) (explaining that "complex, subtle, and professional decisions as to the composition * * * of a military force" are "essentially professional military judgments") (citation omitted). Thus, even if an analogous policy in the civilian context would somehow call for closer scrutiny despite being based on a medical condition rather than transgender status, the military's 2025 policy would still warrant the most deferential standard of review. See *Rostker*, 453 U.S. at 67 ("[T]he tests and limitations to be applied may differ because of the military context."); cf. *Goldman*, 475 U.S. at 507 (explaining that judicial "review of military regulations challenged on First Amendment grounds is far more deferential than constitutional review of similar laws or regulations designed for civilian society").

b. The district court nevertheless concluded that the 2025 policy triggers intermediate scrutiny. App., *infra*, 220a-226a. But none of its rationales is tenable, especially since all of them would equally condemn the Austin policy that the court ordered the Department to maintain.

The district court primarily sought to justify intermediate scrutiny on the ground that the 2025 policy discriminates based on transgender status. App., *infra*, 220a-223a. But the 2025 policy "focuses on dysphoria as the clinical problem, not identity per se." *DSM-5*, at 451. Like the *DSM-5* and the Carter, Mattis, and Austin

policies, the 2025 policy uses the term gender dysphoria to "refer[] to the *distress* that may accompany the incongruence between one's experienced or expressed gender and one's assigned gender." *Ibid.* (emphasis added); see App., *infra*, 181a n.2 (adopting the *DSM-5*'s "diagnostic criteria" for gender dysphoria). As the APA has emphasized, "not all individuals will experience distress as a result of such incongruence," *DSM-5*, at 451, so "[n]ot all transgender people suffer from gender dysphoria," App., *infra*, 30a (brackets in original) (quoting APA, *Expert Q & A: Gender Dysphoria*). "Conversely, not all persons with gender dysphoria are transgender." *Id.* at 30a n.57; see *ibid.* (giving, as an example, men who suffer genital wounds in combat and who "feel that they are no longer men because their bodies do not conform to their concept of manliness") (citation omitted).

The district court stated that gender dysphoria is "closely correlated" with being transgender. App., *infra*, 221a. But such correlation does not justify equating one with the other. See *Geduldig* v. *Aiello*, 417 U.S. 484, 496 n.20 (1974) ("While it is true that only women can become pregnant it does not follow that every legislative classification concerning pregnancy is a sex-based classification."); see also *Dobbs* v. *Jackson Women's Health Org.*, 597 U.S. 215, 236 (2022) (reaffirming the same). In any event, even if the 2025 policy discriminated based on transgender status, heightened scrutiny would still be inappropriate because trans-identifying people are not a suspect or quasi-suspect class. See *City of Cleburne* v. *Cleburne Living Ctr., Inc.*, 473 U.S. 432, 441-447 (1985) (declining to recognize a new quasi-suspect class).

The district court also sought to justify intermediate scrutiny on the ground that the 2025 policy discriminates based on sex. App., *infra*, 223a-226a. But the 2025 policy references "sex" in only two contexts, neither of which constitutes sex discrimination. First, certain provisions of the 2025 policy, like provisions of previous DoD

policies, reference "sex" in the context of describing certain medical interventions. See, *e.g.*, *id.* at 129a. Those provisions, however, turn on the nature of the medical intervention (*e.g.*, "sex reassignment" surgery "in pursuit of a sex transition"), not on the individual's sex. *Ibid.* They thus do not warrant intermediate scrutiny. Second, the 2025 policy requires servicemembers who have never been diagnosed with gender dysphoria—and who have never received related interventions—to serve in their sex and to meet the standards and requirements applicable to their sex. *Id.* at 126a. But the Carter, Mattis, and Austin policies required the same thing. See pp. 7, 9, 10, *supra*. What respondents challenge is not the sex-based standards themselves—which the court's injunction leaves in place—but the Department's 2025 decision not to provide a *special exemption* from those sex-based standards for servicemembers who have gender dysphoria and seek to undergo gender transition and serve in their asserted gender identity. App., *infra*, 126a-127a. Failing to provide a preferential exemption from valid sex-based standards for individuals who have a particular medical condition (gender dysphoria) and who seek related interventions (gender transition) is not even arguably sex discrimination warranting intermediate scrutiny. In any event, even if the 2025 policy discriminated based on sex, intermediate scrutiny would still be inappropriate because of the deference owed to the military in this context. See *Trump* v. *Hawaii*, 585 U.S. 667, 703-704 (2018); *Rostker*, 453 U.S. at 66; pp. 16-17, *supra*.

2. The 2025 policy satisfies rational-basis review

The 2025 policy satisfies the deferential standard that applies here. The government has undisputedly important interests in maintaining military readiness, cohesion, good order, and discipline, as well as in managing the military's costs. App.,

infra, 228a. And like the Mattis policy before it, the 2025 policy is rationally related to achieving those ends.

a. The Department's accession standards have historically treated a long list of medical conditions, including mental disorders in the *DSM*, as presumptively disqualifying. App., *infra*, 67a-108a. After the APA revised the *DSM* in 2013 to identify gender dysphoria as a disorder "associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning," *DSM-5*, at 453, Secretary Carter added "gender dysphoria" to the list, along with "medical treatment associated with gender transition," including "sex reassignment or genital reconstruction surgery," App., *infra*, 25a-26a. Secretary Carter did so to "ensure that those entering service are free of medical conditions or physical defects that may require excessive time lost from duty." *Id.* at 4a.

The 2025 accession standards, which likewise treat gender dysphoria and related medical interventions as presumptively disqualifying, rationally serve the same purpose. App., *infra*, 129a, 131a. To be sure, the 2025 accession standards narrow the circumstances in which an applicant may overcome the presumptive disqualification. Under the Carter accession standards, for example, a "history of gender dysphoria" is "disqualifying, unless, as certified by a licensed medical provider, the applicant has been stable without clinically significant distress or impairment in social, occupational, or other important areas of functioning for 18 months." *Id.* at 25a. Under the 2025 accession standards, in contrast, a history of gender dysphoria is disqualifying unless an applicant obtains a waiver, which may be granted only if "there is a compelling Government interest" in allowing the applicant to join the military, the applicant "demonstrates 36 consecutive months of stability in [his or her] sex," the applicant "demonstrates that he or she has never attempted to transition to any

sex other than his or her sex," and the applicant "is willing and able to adhere to all applicable standards, including the standards associated with his or her sex." *Id.* at 179a-180a.

Those differences, however, are of no constitutional significance. The Department's prior Carter, Mattis, and Austin policies all recognized that gender dysphoria is a medical condition that poses *some* risk to military readiness. See, *e.g.*, App., *infra*, 4a. That is why all of those policies included gender dysphoria on the military's list of presumptively disqualifying conditions. See pp. 6-10, *supra*. In narrowing the circumstances in which that presumption of disqualification may be overcome, the 2025 policy simply reflects a more cautious approach to those risks—which is precisely the kind of exercise of professional military judgment that the Constitution does not authorize courts to second-guess. See *Winter*, 555 U.S. at 24 ("[This Court] 'give[s] great deference to the professional judgment of military authorities concerning the relative importance of a particular military interest.'") (quoting *Goldman*, 475 U.S. at 507).

b. The 2025 retention standards also satisfy rational-basis review. The 2025 policy requires current servicemembers who have never been diagnosed with gender dysphoria—and who have never received related medical interventions—to serve in their sex and to meet the standards and requirements applicable to their sex. App., *infra*, 126a. As noted, the Carter, Mattis, and Austin policies required the same thing. See pp. 7, 9, 10, *supra*. That requirement of the 2025 policy—and of the Carter, Mattis, and Austin policies before it—rests on the Department's rational determination that a servicemember who is not experiencing "clinically significant distress or impairment" has no grounds to be excused from serving in the member's sex or from meeting the standards and requirements applicable to that sex. *DSM-5*, at 453.

Where the 2025 retention standards differ from the Carter and Austin retention standards is in their approach to "gender transition" as a treatment for gender dysphoria. The Carter and Austin retention standards permitted servicemembers who were diagnosed with gender dysphoria to undergo "gender transition" and serve in their asserted gender identity. See pp. 7, 10, *supra*. In contrast, the 2025 retention standards, like the Mattis retention standards, generally disqualify servicemembers who are diagnosed with gender dysphoria instead of allowing them to undergo "gender transition." See pp. 8-9, 12, *supra*. As above, however, the differences between the policies are constitutionally immaterial. The 2025 policy, like the Mattis policy before it, rests on the Department's considered military judgment that "making accommodations for gender transition" would "likely undermine" "military effectiveness and lethality." App., *infra*, 51a; see *id.* at 122a.

First, accommodating gender transition as a treatment for gender dysphoria would "present a significant challenge for unit readiness." App., *infra*, 45a. The report accompanying the Mattis policy, which the Department considered in formulating the 2025 policy, noted the existence of "considerable scientific uncertainty" concerning whether "transition-related" interventions, such as "cross-sex hormone therapy" and "sex reassignment surgery," "fully remedy * * * the mental health problems associated with gender dysphoria." *Id.* at 42a; see *id.* at 121a. The Mattis report reasoned, moreover, that even if such interventions could fully remedy the "serious problems associated with gender dysphoria," most servicemembers undergoing such interventions could be rendered "non-deployable for a potentially significant amount of time." *Id.* at 45a. The report noted, for example, that some servicemembers would have to leave their "theater of operations" to be able to undergo "cross-sex hormone therapy or sex reassignment surgery." *Id.* at 43a. In formulating the 2025 policy, the

Department also considered more recent reviews that reinforced the same points, including a 2025 medical-literature review that reported that "the strength of evidence on transgender mental health and gender-affirming care is low to moderate," and a 2021 review that "found that nearly 40% of Service members with gender dysphoria in an observed cohort were non-deployable over a 24 month period." *Id.* at 121a-122a.

Second, accommodating gender transition as a treatment for gender dysphoria would undermine "unit cohesion and good order and discipline." App., *infra*, 46a; see *id.* at 45a-51a. The military maintains separate berthing, bathroom, and shower facilities for each sex. *Id.* at 45a. The Mattis report expressed concern that allowing individuals who retained the anatomy of their sex to use the facilities of their preferred gender "would invade the expectations of privacy" of the other servicemembers sharing those facilities. *Id.* at 47a; see *United States* v. *Virginia*, 518 U.S. 515, 550 n.19 (1996) (recognizing that it is "necessary to afford members of each sex privacy from the other sex in living arrangements"). The military also maintains different sets of physical-fitness, body-fat, uniform, and grooming standards for males and females. App., *infra*, 45a. The Mattis report expressed concern, for instance, that allowing a "biological male" to "compete against females in gender-specific physical training" would pose a serious safety risk and generate perceptions of unfairness. *Id.* at 41a; see *id.* at 39a; *Virginia*, 518 U.S. at 550 n.19 (acknowledging that it is "necessary" to "adjust aspects of the physical training programs" for servicemembers to address biological differences between the sexes).

Third, accommodating gender transition as a treatment for gender dysphoria would be "disproportionately costly on a per capita basis." App., *infra*, 51a. The Mattis report cited the Department's own experience under the Carter policy. *Ibid.* The report explained that, since implementation of the Carter policy, medical costs

for servicemembers with gender dysphoria had increased nearly 300% compared to servicemembers without gender dysphoria. *Ibid.* Several commanders had also reported that providing servicemembers in their units with transition-related interventions required the use of "operations and maintenance funds to pay for * * * extensive travel throughout the United States to obtain specialized medical care." *Ibid.* Particularly "in light of the absence of solid scientific support for the efficacy of [transition-related] treatment," the Mattis report found the costs of accommodating "gender transition" disproportionate. *Ibid.* And in formulating the 2025 policy, the Department also considered a more recent review that found that, "between 2015 and 2024, DoD spent $52,084,407 providing care to active duty Service members to treat gender dysphoria." *Id.* at 122a.

In deciding not to accommodate gender transition as a treatment for gender dysphoria, the Department specifically considered—and rejected—the "prior DoD policy" of the past few years that took a contrary approach to gender transition. App., *infra*, 121a. That "studied choice of one alternative in preference to another," *Rostker*, 453 U.S. at 72, in light of "military operations and needs," *id.* at 68, is precisely the type of judgment deserving of deference, *ibid.* The Constitution does not authorize courts to second-guess the approach to gender transition adopted by the 2025 policy (and by the Mattis policy before it).

3. Neither court below identified any relevant difference between the 2025 policy and the Mattis policy

In staying the injunctions against the Mattis policy, this Court necessarily determined that the Mattis policy was likely consistent with equal protection. See *Karnoski*, 586 U.S. at 1124; *Stockman*, 586 U.S. at 1124. Neither court below identified

anything about the 2025 policy that would justify a different conclusion as to its constitutionality.

The Ninth Circuit did not even attempt to identify any difference between the two policies, denying a stay solely based on the government's purported lack of irreparable harm. App., *infra*, 258a. And while the district court stated that the 2025 policy "goes further than" the Mattis policy, it failed to identify any constitutionally relevant difference. *Id.* at 193a. Under the 2025 policy, as under the Mattis policy, "persons who are diagnosed with, or have a history of, gender dysphoria are generally disqualified from accession or retention in the Armed Forces." *Id.* at 52a; see *id.* at 129a, 131a. The 2025 policy merely narrows the circumstances in which such a person may nevertheless serve. For example, the 2025 policy, unlike the Mattis policy, requires a showing of "a compelling Government interest" for an otherwise disqualified person to obtain a waiver. *Id.* at 179a. And the 2025 policy, unlike the Mattis policy, provides no exemption for current servicemembers who have already received a diagnosis of gender dysphoria. See *id.* at 15a-16a. But those differences between the 2025 policy and the Mattis policy—like any differences between the 2025 policy and the Carter and Austin policies—simply reflect a more cautious approach to the "risks associated with allowing the accession and retention of individuals with a history or diagnosis of gender dysphoria." *Id.* at 8a; see pp. 21, 24, *supra*. Nothing in the Constitution forbids such an approach.

The district court also suggested that the 2025 policy could not withstand rational-basis review without "updated data"—*i.e.*, data showing that the judgments underlying the Mattis policy are still valid. App., *infra*, 236a. That suggestion is mistaken for several reasons. First, under rational-basis review, the government has no burden to "produce evidence" in support of a policy *at all*; instead, the plaintiff

bears the burden "'to negative every conceivable basis which might support'" the policy, "whether or not the basis has a foundation in the record." *Heller* v. *Doe*, 509 U.S. 312, 320-321 (1993) (citation omitted). Second, the fact that, during the last Administration, the Austin policy took a different approach to the risks associated with allowing the accession and retention of individuals with a history or diagnosis of gender dysphoria does not mean that those risks do not exist—let alone foreclose the 2025 policy from taking a more cautious approach to those risks. In relying on experience under the Austin policy to suggest that those risks are not meaningful, the court improperly second-guessed the military's own assessment of those risks. And third, in formulating the 2025 policy, the Department *did* consider more recent studies, which reinforced the risks that the Mattis report had identified. App., *infra*, 121a-122a; see D. Ct. Doc. 71-3 (Mar. 12, 2025); D. Ct. Doc. 71-4 (Mar. 12, 2025). The 2025 policy thus readily satisfies rational-basis review.

B. Respondents' Other Challenges To The 2025 Policy Lack Merit

Respondents also raise First Amendment, due process, and equitable estoppel challenges to the 2025 policy. Those challenges are similar to the First Amendment and due process challenges that this Court considered—and found unlikely to succeed—in granting stays of the injunctions against the Mattis policy. See, *e.g.*, Pet. at 25, *Karnoski*, *supra* (No. 18-676); Gov't Stay Appl. at 28, *Karnoski*, *supra* (No. 18A625). The government is similarly likely to succeed on respondents' remaining challenges in this case.

1. Respondents contend that the 2025 policy violates the First Amendment because it "prohibits transgender people from disclosing that they are transgender or expressing a gender identity that is different from their sex assigned at birth." D. Ct. Doc. 23, at 28 (Feb. 19, 2025). But the 2025 policy does not "prohibit[] transgender

people from disclosing that they are transgender." *Ibid.* Like the *DSM-5* on which it is based, the 2025 policy "focuses on dysphoria as the clinical problem, not identity per se." *DSM-5*, at 451. Nothing under the 2025 policy turns on a person's identity—let alone whether a person "disclos[es]" a particular identity. D. Ct. Doc. 23, at 28.

The 2025 policy, like the Carter, Mattis, and Austin policies that preceded it, requires servicemembers who have never been diagnosed with gender dysphoria—and who have never received related interventions—to serve in their sex and to meet the standards and requirements applicable to their sex. App., *infra*, 126a; see pp. 7, 9, 10, *supra*. But that does not violate the First Amendment, any more than it did under the Carter, Mattis, and Austin policies. Requiring servicemembers to use certain berthing, bathroom, and shower facilities is a regulation of conduct, not speech. See, *e.g.*, *Sorrell* v. *IMS Health Inc.*, 564 U.S. 552, 567 (2011) (distinguishing "restrictions on protected expression" from "restrictions on * * * nonexpressive conduct," and reaffirming that "the First Amendment does not prevent restrictions directed at * * * conduct from imposing incidental burdens on speech"). And requiring servicemembers to meet certain uniform and grooming standards "foster[s] instinctive obedience, unity, commitment, and esprit de corps" while burdening expression only incidentally, if at all. *Goldman*, 475 U.S. at 507. "The essence of military service 'is the subordination of the desires and interests of the individual to the needs of the service.'" *Ibid.* (citation omitted). The First Amendment does not require the military to make exception to its uniform and grooming standards to accommodate the personal preferences of particular servicemembers. See *id.* at 508-510.

Respondents also contend that the 2025 policy violates the First Amendment by requiring the use of pronouns that "reflect a Service member's sex." App., *infra*, 126a; see D. Ct. Doc. 23, at 28. "But 'within the military community there is simply

not the same individual autonomy as there is in the larger civilian community.'" *Goldman*, 475 U.S. at 507 (brackets and citation omitted). The policy on pronoun use is merely one of many protocols governing how servicemembers should be addressed within the military community. The First Amendment does not stand in the way of such efforts to maintain "good order and discipline" within military ranks. App., *infra*, 126a; see *Goldman*, 475 U.S. at 507 ("'The military must insist upon * * * a discipline without counterpart in civilian life' in order to prepare for and perform its vital role.") (brackets and citation omitted).

2. Respondents' contention that the 2025 policy violates procedural due process also fails. Respondents have no constitutionally protected liberty or property interest in continued military service or the employment benefits that come with military service. See *Board of Regents* v. *Roth*, 408 U.S. 564, 569-579 (1972) (holding that a non-tenured professor at a state university had no constitutionally protected liberty or property interest in continued employment). And to the extent respondents assert that current servicemembers have a constitutionally protected liberty interest in avoiding the "reputational harm" from being discharged under the 2025 policy, respondents are mistaken. D. Ct. Doc. 23, at 31. The 2025 policy provides that the Department will characterize the service of anyone who is discharged as "honorable except where the Service member's record otherwise warrants a lower characterization." App., *infra*, 126a. The 2025 policy therefore does not threaten the reputational harm that respondents allege.

In any event, respondents' claim is not that the Department must follow additional *procedures* before discharging servicemembers under the 2025 policy; it is that servicemembers should not be discharged under the 2025 policy *at all*. See D. Ct. Doc. 23, at 32-33. Indeed, respondents acknowledge that they "do not challenge the

procedures that will be used to determine whether, for example, a particular individual has a history of gender dysphoria." D. Ct. Doc. 82, at 22 (Mar. 19, 2025). Instead, respondents "challenge the *basis*" for their "disqualification as unconstitutional." *Ibid.* (emphasis added). That is a *substantive* due process challenge, not a *procedural* one. See *Connecticut Dep't of Pub. Safety* v. *Doe*, 538 U.S. 1, 8 (2003) (finding a similar claim to be "actually a substantive challenge * * * 'recast in "procedural due process" terms'") (quoting *Reno* v. *Flores*, 507 U.S. 292, 308 (1993)). And because the 2025 policy is rationally related to legitimate government interests, respondents' due process challenge fails. See pp. 19-26, *supra*.

3. Finally, respondents assert that the Department is equitably estopped from implementing the 2025 policy against current servicemembers who have undergone gender transition while serving in the military. D. Ct. Doc. 23, at 33-35. But this Court has "reversed every finding of estoppel" against the government that it has reviewed, and there is no basis for estoppel here. *OPM* v. *Richmond*, 496 U.S. 414, 422 (1990). To begin, estoppel may never run against the government. See *id.* at 423 (reserving the question "whether an estoppel claim could ever succeed against the Government"). But even if it could, it would require a showing of "some type of 'affirmative misconduct.'" *Id.* at 421 (citation omitted). Respondents make no such showing here. They allege that the Department adopted the 2025 policy after permitting current servicemembers to undergo gender transition under previous policies. D. Ct. Doc. 23, at 34. But a mere policy change—here, one based on a reevaluation of the risks associated with accommodating gender transition, see App., *infra*, 122a—cannot be described as misconduct, let alone affirmative misconduct.

C. At Minimum, The District Court Erred In Granting A Universal Injunction

Even setting aside the district court's errors on the merits, the court improperly enjoined the 2025 policy on a universal basis. The court should have limited any injunction to the eight individual respondents in this case. App., *infra*, 140a-141a.

1. Nationwide or universal remedies exceed "the power of Article III courts," conflict with "longstanding limits on equitable relief," and impose a severe "toll on the federal court system." *Hawaii*, 585 U.S. at 713 (Thomas, J., concurring); see *Department of State* v. *AIDS Vaccine Advocacy Coal.*, 145 S. Ct. 753, 756 (2025) (Alito, J., dissenting); *Labrador* v. *Poe*, 144 S. Ct. 921, 923-924 (2024) (Gorsuch, J. concurring); *DHS* v. *New York*, 140 S. Ct. 599, 599-601 (2020) (Gorsuch, J., concurring).

Start with the constitutional problem: Article III authorizes federal courts to exercise only "judicial Power," which extends only to "Cases" and "Controversies." U.S. Const. Art. III, § 2, Cl. 1. Under that power, courts can adjudicate "claims of infringement of individual rights," "whether by [the] unlawful action of private persons or by the exertion of unauthorized administrative power." *Lujan* v. *Defenders of Wildlife*, 504 U.S. 555, 577 (1992) (citation omitted). Courts that sustain such claims may grant the challenger appropriate relief—for instance, an injunction preventing the enforcement of a challenged law or policy against that individual—but cannot grant relief to strangers to the litigation. Article III does not empower federal courts to "exercise general legal oversight of the Legislative and Executive Branches." *TransUnion LLC* v. *Ramirez*, 594 U.S. 413, 423-424 (2021). To reach beyond the litigants and to enjoin the Executive Branch's actions toward third parties "would be not to decide a judicial controversy, but to assume a position of authority over the

governmental acts of another and co-equal department, an authority which plainly [courts] do not possess." *Massachusetts* v. *Mellon*, 262 U.S. 447, 489 (1923).

Universal injunctions also contravene this Court's precedents on Article III standing. "[S]tanding is not dispensed in gross," so plaintiffs must establish standing "for each form of relief that they seek." *Murthy* v. *Missouri*, 603 U.S. 43, 61 (2024) (citations omitted). And a plaintiff's remedy must be "limited to the inadequacy that produced his injury in fact." *Gill* v. *Whitford*, 585 U.S. 48, 66 (2018) (brackets and citation omitted). Even if respondents have standing to seek relief for themselves, they lack standing to seek relief for third parties, as to whom plaintiffs cannot "sufficiently answer the question: 'What's it to you?'" *TransUnion*, 594 U.S. at 423 (citation and internal quotation marks omitted).

Universal injunctions also transgress restrictions on courts' equitable powers. Federal courts sitting in equity must apply "'traditional principles of equity jurisdiction'" and may award only those remedies that were "traditionally accorded by courts of equity." *Grupo Mexicano de Desarrollo S.A.* v. *Alliance Bond Fund, Inc.*, 527 U.S. 308, 319 (1999) (citation omitted). Congress may by statute authorize new remedies, but courts may not on their own authority "create remedies previously unknown to equity jurisprudence." *Id.* at 332; see *Alexander* v. *Sandoval*, 532 U.S. 275, 286 (2001) (new remedies "must be created by Congress").

American courts of equity traditionally "did not provide relief beyond the parties to the case." *Hawaii*, 585 U.S. at 717 (Thomas, J., concurring). They have instead long followed the "rule that injunctive relief should be no more burdensome to the defendant than necessary to provide complete relief to the plaintiffs." *Califano* v. *Yamasaki*, 442 U.S. 682, 702 (1979). Unsurprisingly, then, there appear to have been "no national injunctions against federal defendants for the first century and a half of

the United States." Samuel L. Bray, *Multiple Chancellors: Reforming the National Injunction*, 131 Harv. L. Rev. 417, 428 (2017).

Instead, in a 19th-century case where a lower court issued a universal injunction against the enforcement of a *state* statute, this Court agreed that the challenged statute violated the Constitution, see *Scott* v. *Donald*, 165 U.S. 58, 99-101 (1897), but nonetheless held in a separate opinion that the universal injunction was unlawful and that relief should have been "restricted to the part[y] named as plaintiff," *Scott* v. *Donald*, 165 U.S. 107, 117 (1897). And in a similar modern-day precedent, this Court agreed that a statute prohibiting federal employees from accepting honoraria violated the First Amendment, but held that the injunction protecting "any Executive Branch employee" was overbroad and had to be "limited to the parties before the Court." *United States* v. *National Treasury Employees Union*, 513 U.S. 454, 462, 477 (1995). The Court considered it inappropriate "to provide relief to nonparties when a narrower remedy will fully protect the litigants." *Id.* at 478.

Universal injunctions also subvert the Article III hierarchy of judicial review. Ordinarily, the coercive effect of a court's judgment extends only to the case at hand, but the *stare decisis* effect of the court's opinion may extend to other cases, depending on the court's position in the Article III hierarchy. A district court's opinion has no binding precedential effect at all, even in the same district or on the same judge in a different case. See *Camreta* v. *Greene*, 563 U.S. 692, 709 n.7 (2011). A court of appeals' published opinion, in turn, constitutes controlling precedent throughout the relevant circuit, though not in other circuits. See *Poe*, 144 S. Ct. at 932 (Kavanaugh, J., concurring). And, of course, this Court's decisions constitute controlling precedent throughout the Nation. If this Court were to hold a challenged statute or policy unconstitutional, the government could not "successfully enforce [it] against anyone,

party or not, in light of *stare decisis*." *Griffin* v. *HM Florida-ORL, LLC*, 144 S. Ct. 1, 1 (2023) (statement of Kavanaugh, J.). When district courts grant universal injunctions, they upend that system, imbuing the orders of courts of first instance with the type of nationwide effect usually reserved for the precedents of the court of last resort.

Further, universal injunctions "render meaningless rules about joinder and class actions." *United States* v. *Texas*, 599 U.S. 670, 703 (2023) (Gorsuch, J., concurring in the judgment). They can "sweep up nonparties who may not wish to receive the benefit of the court's decision." *Ibid.*; see *Arizona* v. *Biden*, 40 F.4th 375, 396 (6th Cir. 2022) (Sutton, C.J., concurring) ("Nationwide injunctions * * * sometimes give States victories they do not want.").

Universal injunctions cause significant harm to the government. They invite forum shopping because different challengers need not file different challenges in different courts if one challenger who files one suit in one court can secure victory nationwide. See *Poe*, 144 S. Ct. at 927 (Gorsuch, J., concurring). They force the government "to seek immediate relief from one court and then the next, with the finish line in this Court." *Ibid.* They countermand the principle that the government is not subject to non-mutual issue preclusion—*i.e.*, that the government may relitigate an issue against one party even if it has lost that issue against another party in another case. See *United States* v. *Mendoza*, 464 U.S. 154, 162-163 (1984). And they operate asymmetrically, granting relief to strangers everywhere whenever a single plaintiff prevails, but not precluding continued litigation by others if some plaintiffs lose. See *DHS*, 140 S. Ct. at 601 (Gorsuch, J., concurring).

Finally, universal injunctions harm the courts. "By their nature, universal injunctions tend to force judges into making rushed, high-stakes, low-information decisions." *DHS*, 140 S. Ct. at 600 (Gorsuch, J., concurring). They exert substantial

pressure on this Court's emergency docket, forcing the Court to confront difficult issues without "the airing of competing views" among "multiple judges and multiple circuits." *Ibid.* And they needlessly encourage "[r]epeated and essentially head-on confrontations between the life-tenured branch and the representative branches." *Valley Forge Christian Coll.* v. *Americans United for Separation of Church & State, Inc.*, 454 U.S. 464, 474 (1982) (citation omitted).

2. In entering a universal injunction in this case, the district court did not grapple with those principles. Instead, the court issued a "nationwide" injunction merely because of the "nationwide" scope of the 2025 policy. App., *infra*, 255a. But Article III and principles of equity require courts to tailor injunctions to the scope of the plaintiff's injury, not to the scope of the defendant's policy. The court's contrary view "lacks a limiting principle and would make nationwide injunctions the rule rather than the exception with respect to all actions of federal agencies." *Arizona*, 40 F.4th at 397 (Sutton, C.J., concurring).

Indeed, this Court has previously stayed a nationwide injunction against a military policy to the extent it swept beyond the parties to the case. *United States Dep't of Def.* v. *Meinhold*, 510 U.S. 939 (1993). *Meinhold* involved a facial constitutional challenge by a discharged member of the Navy to the Department's then-existing policy disqualifying servicemembers based on sexual orientation. *Meinhold* v. *United States Dep't of Def.*, 34 F.3d 1469, 1472-1473 (9th Cir. 1994). After the district court enjoined the Department from "taking any actions against gay or lesbian servicemembers based on their sexual orientation" nationwide, *ibid.*, this Court stayed that order to the extent it "grant[ed] relief to persons other than [the plaintiff]," *Meinhold*, 510 U.S. at 939.

Any injunctive relief in this case likewise should not extend beyond the eight individual respondents in this case. App., *infra*, 140a-141a. An injunction so limited would fully redress any purported injuries not only to the individual respondents themselves, but also to Gender Justice League (GJL), the organizational respondent in this case. *Id.* at 141a. The only GJL members whom GJL has identified as potentially harmed by the 2025 policy are three of the individual respondents. *Id.* at 118a.

II. THE OTHER FACTORS SUPPORT STAYING THE DISTRICT COURT'S INJUNCTION

In staying the injunctions against the Mattis policy, this Court necessarily determined that the other stay factors—*i.e.*, whether the underlying issues warrant review, whether the government likely faces irreparable harm, and the balance of equities—supported relief. Those factors likewise support relief here.

A. The Questions Presented By The District Court's Injunction Plainly Warrant This Court's Review

If the Ninth Circuit were to uphold the district court's injunction, certiorari would clearly be warranted. Respondents challenge the 2025 policy on equal protection, First Amendment, due process, and equitable estoppel grounds. Those challenges concern a matter of imperative public importance: the authority of the U.S. military to determine who may serve in the Nation's armed forces. Relying on the conclusions of a panel of experts and other studies and reviews of service by individuals with gender dysphoria, the Department determined that "the medical, surgical, and mental health constraints" on individuals with gender dysphoria "are incompatible with the high mental and physical standards necessary for military service." App., *infra*, 124a; see *id.* at 121a-122a.

The district court's injunction nullifies that exercise of professional military judgment and blocks the implementation of a policy that the Department has deemed

necessary to maintain its "rigorous standards" and "deliver a ready, deployable force." App., *infra*, 122a. If the Ninth Circuit were to affirm the injunction, a judicial intrusion of that significance into the operation of our Nation's armed forces would unquestionably warrant this Court's review. See *Department of the Navy* v. *Egan*, 484 U.S. 518, 520 (1988) (granting certiorari to address interference with Executive Branch determinations that were of "importance * * * to national security concerns"); see also *Winter*, 555 U.S. at 12. Indeed, this Court frequently grants plenary review in response to lower-court decisions blocking significant federal policies or programs, even outside the military context. See, *e.g.*, *Becerra* v. *Braidwood Mgmt., Inc.*, No. 24-316, 2025 WL 65913 (U.S. Jan. 10, 2025); *Garland* v. *VanDerStok*, 144 S. Ct. 1390 (2023).

B. The District Court's Injunction Causes Irreparable Harm To The Government And To The Public

The district court's injunction irreparably harms the Executive Branch by preventing a branch of government from carrying out its work—here, the Department of Defense's responsibility for military readiness. The President holds "the mandate of the people to exercise his executive power." *Myers* v. *United States*, 272 U.S. 52, 123 (1926). The Executive Branch exists to carry out his policies. While courts may adjudicate the lawfulness of those policies in justiciable cases, they irreparably injure our democratic system when they forbid the government to effectuate those policies against anyone anywhere in the Nation, and all the more so when the policy is lawful. See *Doe #1* v. *Trump*, 957 F.3d 1050, 1084 (9th Cir. 2020) (Bress, J., dissenting); cf. *Maryland* v. *King*, 567 U.S. 1301, 1303 (2012) (Roberts, C.J., in chambers) ("Any time a State is enjoined by a court from effectuating statutes enacted by representatives of its people, it suffers a form of irreparable injury.") (brackets and citation omitted).

That injury to our democratic system is particularly pronounced in the area of military affairs. The Constitution entrusts to the political branches the authority to determine the composition of the armed forces. See *Winter*, 555 U.S. at 24; *Rostker*, 453 U.S. at 66. The Department exercised that authority in adopting the 2025 policy to exclude "individuals who have a current diagnosis or history of, or exhibit symptoms consistent with, gender dysphoria." App., *infra*, 124a. The district court's injunction nevertheless forces the military to maintain a different policy—one that the Department has concluded is inconsistent with "the best interests of the Military Services" and with "the interests of national security." *Id.* at 126a. The court's injunction thus irreparably interferes with "the professional judgment of military authorities" in "carrying out our Nation's military policy." *Goldman*, 475 U.S. at 507-508.

In denying the government's motion for a stay, the Ninth Circuit merely asserted, without further analysis, that the government had not demonstrated that it "will suffer irreparable harm absent a stay." App., *infra*, 258a. But that conclusion cannot be squared with this Court's decisions to stay the injunctions against the Mattis policy. See *Karnoski*, 586 U.S. at 1124; *Stockman*, 586 U.S. at 1124. In granting those stays, this Court necessarily determined that the government was likely to suffer irreparable harm absent a stay. See *Hollingsworth*, 558 U.S. at 190 ("To obtain a stay * * * , an applicant must show * * * a likelihood that irreparable harm will result from the denial of a stay."). Just as the injunctions against the Mattis policy irreparably harmed the government by requiring the military to maintain a prior policy that was "not conducive to military effectiveness and lethality," App., *infra*, 8a, the injunction here irreparably harms the government by requiring the military to do the same. Indeed, if the separation of powers means anything, the government obvi-

ously suffers irreparable harm when an unelected judge usurps the role of the political branches in operating the Nation's armed forces.

C. The Balance Of Equities Favors Staying The District Court's Injunction

On the other side of the balance, vacating the district court's injunction would not cause respondents irreparable harm. Alleging the same types of harms raised by the plaintiffs who unsuccessfully challenged the Mattis policy, the individual respondents assert that the 2025 policy will either lead to their discharge or stand in the way of joining the military in the first place. D. Ct. Doc. 23, at 35-36; see, *e.g.*, Joint Opp. at 30-31, *Karnoski*, *supra* (No. 18A625). But the loss of employment and associated benefits are not *irreparable* harms. See *Sampson* v. *Murray*, 415 U.S. 61, 92 n.68 (1974) (holding that "an employee's discharge, together with the resultant effect on the employee," ordinarily does not amount to irreparable injury). And any assertion that the 2025 policy will cause respondents reputational harm is unfounded, given that any discharge under the policy will be "honorable except where the Service member's record otherwise warrants a lower characterization." App., *infra*, 126a. In any event, any harm to respondents is substantially outweighed by the harm to the government and to the public from forcing the military to maintain a policy that the Department has deemed inconsistent with "the best interests of the Military Services" and with "the interests of national security." *Ibid.*; see *Winter*, 555 U.S. at 23 (holding that "[e]ven if plaintiffs ha[d] shown irreparable injury from the Navy's training exercises, any such injury [wa]s outweighed by the public interest and the Navy's interest in effective, realistic training of its sailors"). The balance of equities therefore tips decisively in favor of staying the injunction—just as it did when this Court stayed the injunctions against the Mattis policy.

CONCLUSION

This Court should stay the district court's injunction in its entirety. At minimum, this Court should stay the injunction except as to the eight individual respondents in this case.

Respectfully submitted.

D. JOHN SAUER
Solicitor General

APRIL 2025

APPENDIX

SECRETARY OF DEFENSE
1000 DEFENSE PENTAGON
WASHINGTON, DC 20301-1000

JUN 30 2016

MEMORANDUM FOR SECRETARIES OF THE MILITARY DEPARTMENTS
CHAIRMAN OF THE JOINT CHIEFS OF STAFF
UNDER SECRETARIES OF DEFENSE
DEPUTY CHIEF MANAGEMENT OFFICER
CHIEF OF THE NATIONAL GUARD BUREAU
GENERAL COUNSEL OF THE DEPARTMENT OF DEFENSE
DIRECTOR, COST ASSESSMENT AND PROGRAM EVALUATION
INSPECTOR GENERAL OF THE DEPARTMENT OF DEFENSE
DIRECTOR, OPERATIONAL TEST AND EVALUATION
DEPARTMENT OF DEFENSE CHIEF INFORMATION OFFICER
ASSISTANT SECRETARY OF DEFENSE FOR LEGISLATIVE AFFAIRS
ASSISTANT TO THE SECRETARY OF DEFENSE FOR PUBLIC AFFAIRS
DIRECTOR, NET ASSESSMENT
DIRECTORS OF THE DEFENSE AGENCIES
DIRECTORS OF THE DOD FIELD ACTIVITIES

SUBJECT: Directive-type Memorandum (DTM) 16-005, "Military Service of Transgender Service Members"

References: DoD Directive 1020.02E, "Diversity Management and Equal Opportunity in the DoD," June 8, 2015
DoD Directive 1350.2, "Department of Defense Military Equal Opportunity (MEO) Program," August 18, 1995
DoD Instruction 6130.03, "Medical Standards for Appointment, Enlistment, or Induction in the Military Services," April 28, 2010, as amended

Purpose. This DTM:

- Establishes policy, assigns responsibilities, and prescribes procedures for the standards for retention, accession, separation, in-service transition, and medical coverage for transgender personnel serving in the Military Services.

- Except as otherwise noted, this DTM will take effect immediately. It will be converted to a new DoDI. This DTM will expire effective June 30, 2017.

Applicability. This DTM applies to OSD, the Military Departments (including the Coast Guard at all times, including when it is a Service in the Department of Homeland Security by agreement with that Department), the Office of the Chairman of the Joint Chiefs of Staff and the

Joint Staff, the Combatant Commands, the Office of the Inspector General of the Department of Defense, the Defense Agencies, the DoD Field Activities, and all other organizational entities within the DoD.

Policy.

- The defense of the Nation requires a well-trained, all-volunteer force comprised of Active and Reserve Component Service members ready to deploy worldwide on combat and operational missions.

- The policy of the Department of Defense is that service in the United States military should be open to all who can meet the rigorous standards for military service and readiness. Consistent with the policies and procedures set forth in this memorandum, transgender individuals shall be allowed to serve in the military.

- These policies and procedures are premised on my conclusion that open service by transgender Service members while being subject to the same standards and procedures as other members with regard to their medical fitness for duty, physical fitness, uniform and grooming, deployability, and retention, is consistent with military readiness and with strength through diversity.

Responsibilities

- The Secretaries of the Military Departments will:

  - Take immediate action to identify all DoD, Military Department, and Service issuances, the content of which relate to, or may be affected by, the open service of transgender Service members.

  - Draft revisions to the issuances identified, and, as necessary and appropriate, draft new issuances, consistent with the policies and procedures in this memorandum.

  - Submit to the Under Secretary of Defense for Personnel and Readiness (USD(P&R)) the text of any proposed revisions to existing Military Department and Service regulations, policies, and guidance, and of any proposed new issuance, no later than 30 days in advance of the proposed publication date of each.

- The USD(P&R) will:

  - Take immediate action to identify all DoD, Military Department, and Service issuances, the content of which relate to, or may be affected by, the open service of transgender Service members.

- Draft revisions to the issuances identified in this memorandum and, as necessary and appropriate, draft new issuances consistent with the policies and procedures in this memorandum.

Procedures. See Attachment.

Releasability. **Cleared for public release**. This DTM is available on the DoD Issuances Website at http://www.dtic.mil/whs/directives.

Ash Carter

Attachment:
As stated

cc:
Secretary of Homeland Security
Commandant, United States Coast Guard

ATTACHMENT

PROCEDURES

1. SEPARATION AND RETENTION

a. Effective immediately, no otherwise qualified Service member may be involuntarily separated, discharged or denied reenlistment or continuation of service, solely on the basis of their gender identity.

b. Transgender Service members will be subject to the same standards as any other Service member of the same gender; they may be separated, discharged, or denied reenlistment or continuation of service under existing processes and basis, but not due solely to their gender identity or an expressed intent to transition genders.

c. A Service member whose ability to serve is adversely affected by a medical condition or medical treatment related to their gender identity should be treated, for purposes of separation and retention, in a manner consistent with a Service member whose ability to serve is similarly affected for reasons unrelated to gender identity or gender transition.

2. ACCESSIONS

a. Medical standards for accession into the Military Services help to ensure that those entering service are free of medical conditions or physical defects that may require excessive time lost from duty. Not later than July 1, 2017, the USD(P&R) will update DoD Instruction 6130.03 to reflect the following policies and procedures:

(1) A history of gender dysphoria is disqualifying, **unless**, as certified by a licensed medical provider, the applicant has been stable without clinically significant distress or impairment in social, occupational, or other important areas of functioning for 18 months.

(2) A history of medical treatment associated with gender transition is disqualifying, **unless**, as certified by a licensed medical provider:

(a) the applicant has completed all medical treatment associated with the applicant's gender transition; and

(b) the applicant has been stable in the preferred gender for 18 months; and

(c) If the applicant is presently receiving cross-sex hormone therapy post-gender transition, the individual has been stable on such hormones for 18 months.

(3) A history of sex reassignment or genital reconstruction surgery is disqualifying, **unless**, 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; and

(b) no functional limitations or complications persist, nor is any additional surgery required.

b. The Secretaries of the Military Departments and the Commandant, United States Coast Guard, may waive or reduce the 18-month periods, in whole or in part, in individual cases for applicable reasons.

c. The standards for accession described in this memorandum will be reviewed no later than 24 months from the effective date of this memorandum and may be maintained or changed, as appropriate, to reflect applicable medical standards and clinical practice guidelines, ensure consistency with military readiness, and promote effectiveness in the recruiting and retention policies and procedures of the Armed Forces.

3. IN-SERVICE TRANSITION

a. Effective October 1, 2016, DoD will implement a construct by which transgender Service members may transition gender while serving, in accordance with DoDI 1300.28, which I signed today.

b. Gender transition while serving in the military presents unique challenges associated with addressing the needs of the Service member in a manner consistent with military mission and readiness needs.

4. MEDICAL POLICY. Not later than October 1, 2016, the USD(P&R) will issue further guidance on the provision of necessary medical care and treatment to transgender Service members. Until the issuance of such guidance, the Military Departments and Services will handle requests from transgender Service members for particular medical care or to transition on a case-by-case basis, following the spirit and intent of this memorandum and DoDI 1300.28.

5. EQUAL OPPORTUNITY

a. All Service members are entitled to equal opportunity in an environment free from sexual harassment and unlawful discrimination on the basis of race, color, national origin, religion, sex, or sexual orientation. It is the Department's position, consistent with the U.S. Attorney General's opinion, that discrimination based on gender identity is a form of sex discrimination.

b. The USD(P&R) will revise DoD Directives (DoDDs) 1020.02E," Diversity Management and Equal Opportunity in the DoD," and 1350.2,"Department of Defense Military Equal Opportunity (MEO) Program," to prohibit discrimination on the basis of gender identity and to incorporate such prohibitions in all aspects of the DoD MEO program. The USD(P&R) will prescribe the period of time within which Military Department and Service issuances implementing the MEO program must be conformed accordingly.

6. EDUCATION AND TRAINING

a. The USD(P&R) will expeditiously develop and promulgate education and training materials to provide relevant, useful information for transgender Service members, commanders, the force, and medical professionals regarding DoD policies and procedures on transgender service. The USD(P&R) will disseminate these training materials to all Military Departments and the Coast Guard not later than October 1, 2016.

b. Not later than November 1, 2016, each Military Department will issue implementing guidance and a written force training and education plan. Such plan will detail the Military Department's plan and program for training and educating its assigned force (to include medical professionals), including the standards to which such education and training will be conducted, and the period of time within which it will be completed.

7. IMPLEMENTATION AND TIMELINE

a. Not later than October 1, 2016, the USD(P&R) will issue a Commander's Training Handbook, medical guidance, and guidance establishing procedures for changing a Service member's gender marker in DEERS.

b. In the period between the date of this memorandum and October 1, 2016, the Military Departments and Services will address requests for gender transition from serving transgender Service members on a case-by-case basis, following the spirit and intent of this memorandum and DoDI 1300.28.

SECRETARY OF DEFENSE
1000 DEFENSE PENTAGON
WASHINGTON, DC 20301-1000

FEB 22 2018

MEMORANDUM FOR THE PRESIDENT

SUBJECT: Military Service by Transgender Individuals

"Transgender" is a term describing those persons whose gender identity differs from their biological sex. A subset of transgender persons diagnosed with gender dysphoria experience discomfort with their biological sex, resulting in significant distress or difficulty functioning. Persons diagnosed with gender dysphoria often seek to transition their gender through prescribed medical treatments intended to relieve the distress and impaired functioning associated with their diagnosis.

Prior to your election, the previous administration adopted a policy that allowed for the accession and retention in the Armed Forces of transgender persons who had a history or diagnosis of gender dysphoria. The policy also created a procedure by which such Service members could change their gender. This policy was a departure from decades-long military personnel policy. On June 30, 2017, before the new accession standards were set to take effect, I approved the recommendation of the Services to delay for an additional six months the implementation of these standards to evaluate more carefully their impact on readiness and lethality. To that end, I established a study group that included the representatives of the Service Secretaries and senior military officers, many with combat experience, to conduct the review.

While this review was ongoing, on August 25, 2017, you sent me and the Secretary of Homeland Security a memorandum expressing your concern that the previous administration's new policy "failed to identify a sufficient basis" for changing longstanding policy and that "further study is needed to ensure that continued implementation of last year's policy change would not have ... negative effects." You then directed the Department of Defense and the Department of Homeland Security to reinstate the preexisting policy concerning accession of transgender individuals "until such time as a sufficient basis exists upon which to conclude that terminating that policy" would not "hinder military effectiveness and lethality, disrupt unit cohesion, or tax military resources." You made clear that we could advise you "at any time, in writing, that a change to this policy is warranted."

I created a Panel of Experts comprised of senior uniformed and civilian Defense Department and U.S. Coast Guard leaders and directed them to consider this issue and develop policy proposals based on data, as well as their professional military judgment, that would enhance the readiness, lethality, and effectiveness of our military. This Panel included combat veterans to ensure that our military purpose remained the foremost consideration. I charged the Panel to provide its best military advice, based on increasing the lethality and readiness of America's armed forces, without regard to any external factors.

The Panel met with and received input from transgender Service members, commanders of transgender Service members, military medical professionals, and civilian medical

professionals with experience in the care and treatment of individuals with gender dysphoria. The Panel also reviewed available information on gender dysphoria, the treatment of gender dysphoria, and the effects of currently serving individuals with gender dysphoria on military effectiveness, unit cohesion, and resources. Unlike previous reviews on military service by transgender individuals, the Panel's analysis was informed by the Department's own data obtained since the new policy began to take effect last year.

Based on the work of the Panel and the Department's best military judgment, the Department of Defense concludes that there are substantial risks associated with allowing the accession and retention of individuals with a history or diagnosis of gender dysphoria and require, or have already undertaken, a course of treatment to change their gender. Furthermore, the Department also finds that exempting such persons from well-established mental health, physical health, and sex-based standards, which apply to all Service members, including transgender Service members without gender dysphoria, could undermine readiness, disrupt unit cohesion, and impose an unreasonable burden on the military that is not conducive to military effectiveness and lethality.

The prior administration largely based its policy on a study prepared by the RAND National Defense Research Institute; however, that study contained significant shortcomings. It referred to limited and heavily caveated data to support its conclusions, glossed over the impacts of healthcare costs, readiness, and unit cohesion, and erroneously relied on the selective experiences of foreign militaries with different operational requirements than our own. In short, this policy issue has proven more complex than the prior administration or RAND assumed.

I firmly believe that compelling behavioral health reasons require the Department to proceed with caution before compounding the significant challenges inherent in treating gender dysphoria with the unique, highly stressful circumstances of military training and combat operations. Preservation of unit cohesion, absolutely essential to military effectiveness and lethality, also reaffirms this conclusion.

Therefore, in light of the Panel's professional military judgment and my own professional judgment, the Department should adopt the following policies:

- Transgender persons with a history or diagnosis of gender dysphoria are disqualified from military service, except under the following limited circumstances: (1) if they have been stable for 36 consecutive months in their biological sex prior to accession; (2) Service members diagnosed with gender dysphoria after entering into service may be retained if they do not require a change of gender and remain deployable within applicable retention standards; and (3) currently serving Service members who have been diagnosed with gender dysphoria since the previous administration's policy took effect and prior to the effective date of this new policy, may continue to serve in their preferred gender and receive medically necessary treatment for gender dysphoria.

- Transgender persons who require or have undergone gender transition are disqualified from military service.

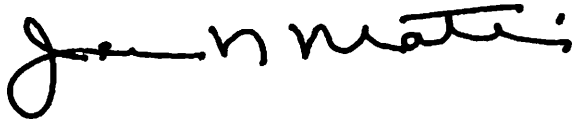
- Transgender persons without a history or diagnosis of gender dysphoria, who are otherwise qualified for service, may serve, like all other Service members, in their biological sex.

I have consulted with the Secretary of Homeland Security, and she agrees with these proposed policies.

By its very nature, military service requires sacrifice. The men and women who serve voluntarily accept limitations on their personal liberties – freedom of speech, political activity, freedom of movement - in order to provide the military lethality and readiness necessary to ensure American citizens enjoy their personal freedoms to the fullest extent. Further, personal characteristics, including age, mental acuity, and physical fitness – among others – matter to field a lethal and ready force.

In my professional judgment, these policies will place the Department of Defense in the strongest position to protect the American people, to fight and win America's wars, and to ensure the survival and success of our Service members around the world. The attached report provided by the Under Secretary of Defense for Personnel and Readiness includes a detailed analysis of the factors and considerations forming the basis of the Department's policy proposals.

I therefore respectfully recommend you revoke your memorandum of August 25, 2017, regarding Military Service by Transgender Individuals, thus allowing me and the Secretary of Homeland Security with respect to the U.S. Coast Guard, to implement appropriate policies concerning military service by transgender persons.



Attachment:
As stated

cc:
Secretary of Homeland Security

DEPARTMENT OF DEFENSE REPORT AND RECOMMENDATIONS ON MILITARY SERVICE BY TRANSGENDER PERSONS

FEBRUARY 2018

Table of Contents

Executive Summary

It is a bedrock principle of the Department of Defense that any eligible individual[1] who can meet the high standards for military service without special accommodations should be permitted to serve. This is no less true for transgender persons than for any other eligible individual. This report, and the recommendations contained herein, proceed from this fundamental premise.

The starting point for determining a person's qualifications for military duty is whether the person can meet the standards that govern the Armed Forces. Federal law requires that anyone entering into military service be "qualified, effective, and able-bodied."[2] Military standards are designed not only to ensure that this statutory requirement is satisfied but to ensure the overall military effectiveness and lethality of the Armed Forces.

The purpose of the Armed Forces is to fight and win the Nation's wars. No human endeavor is more physically, mentally, and emotionally demanding than the life and death struggle of battle. Because the stakes in war can be so high—both for the success and survival of individual units in the field and for the success and survival of the Nation—it is imperative that all Service members are physically and mentally able to execute their duties and responsibilities without fail, even while exposed to extreme danger, emotional stress, and harsh environments.

Although not all Service members will experience direct combat, standards that are applied universally across the Armed Forces must nevertheless account for the possibility that any Service member could be thrust into the crucible of battle at any time. As the Department has made clear to Congress, "[c]ore to maintaining a ready and capable military force is the understanding that each Service member is required to be available and qualified to perform assigned missions, including roles and functions outside of their occupation, in any setting."[3] Indeed, there are no occupations in the military that are exempt from deployment.[4] Moreover, while non-combat positions are vital to success in war, the physical and mental requirements for those positions should not be the barometer by which the physical and mental requirements for all positions, especially combat positions, are defined. Fitness for combat must be the metric against which all standards and requirements are judged. To give all Service members the best chance of success and survival in war, the Department must maintain the highest possible standards of physical and mental health and readiness across the force.

While individual health and readiness are critical to success in war, they are not the only measures of military effectiveness and lethality. A fighting unit is not a mere collection of individuals; it is a unique social organism that, when forged properly, can be far more powerful than the sum of its parts. Human experience over millennia—from the Spartans at Thermopylae to the band of brothers of the 101st Airborne Division in World War II, to Marine squads fighting building-to-building in Fallujah—teaches us this. Military effectiveness requires

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[1] 10 U.S.C. §§ 504, 505(a), 12102(b).
[2] 10 U.S.C. § 505(a).
[3] Under Secretary of Defense for Personnel and Readiness, "Fiscal Year 2016 Report to Congress on the Review of Enlistment of Individuals with Disabilities in the Armed Forces," pp. 8-9 (Apr. 2016).
[4] Id.

transforming a collection of individuals into a single fighting organism—merging multiple individual identities into one. This transformation requires many ingredients, including strong leadership, training, good order and discipline, and that most intangible, but vital, of ingredients—unit cohesion or, put another way, human bonding.

Because unit cohesion cannot be easily quantified, it is too often dismissed, especially by those who do not know what Justice Oliver Wendell Holmes called the "incommunicable experience of war."[5] But the experience of those who, as Holmes described, have been "touched with fire" in battle and the experience of those who have spent their lives studying it attest to the enduring, if indescribable, importance of this intangible ingredient. As Dr. Jonathan Shay articulated it in his study of combat trauma in Vietnam, "[s]urvival and success in combat often require soldiers to virtually read one another's minds, reflexively covering each other with as much care as they cover themselves, and going to one another's aid with little thought for safety."[6] Not only is unit cohesion essential to the health of the unit, Dr. Shay found that it was essential to the health of the individual soldier as well. "Destruction of unit cohesion," Dr. Shay concluded, "cannot be overemphasized as a reason why so many psychological injuries that might have healed spontaneously instead became chronic."[7]

Properly understood, therefore, military effectiveness and lethality are achieved through a combination of inputs that include individual health and readiness, strong leadership, effective training, good order and discipline, and unit cohesion. To achieve military effectiveness and lethality, properly designed military standards must foster these inputs. And, for the sake of efficiency, they should do so at the least possible cost to the taxpayer.

To the greatest extent possible, military standards—especially those relating to mental and physical health—should be based on scientifically valid and reliable evidence. Given the life-and-death consequences of warfare, the Department has historically taken a conservative and cautious approach in setting the mental and physical standards for the accession and retention of Service members.

Not all standards, however, are capable of scientific validation or quantification. Instead, they are the product of professional military judgment acquired from hard-earned experience leading Service members in peace and war or otherwise arising from expertise in military affairs. Although necessarily subjective, this judgment is the best, if not only, way to assess the impact of any given military standard on the intangible ingredients of military effectiveness mentioned above—leadership, training, good order and discipline, and unit cohesion.

For decades, military standards relating to mental health, physical health, and the physiological differences between men and women operated to preclude from military service transgender persons who desired to live and work as the opposite gender.

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[5] *The Essential Holmes: Selections from the Letters, Speeches, Judicial Opinions, and Other Writings of Oliver Wendell Holmes, Jr.*, p. 93 (Richard Posner, ed., University of Chicago Press 1992).
[6] Jonathan Shay, *Achilles in Vietnam*, p. 61 (Atheneum 1994).
[7] Id. at 198.

Relying on a report by an outside consultant, the RAND National Defense Research Institute, the Department, at the direction of Secretary Ashton Carter, reversed that longstanding policy in 2016. Although the new policy—the "Carter policy"—did not permit all transgender Service members to change their gender to align with their preferred gender identity, it did establish a process to do so for transgender Service members who were diagnosed with gender dysphoria—that is, the distress or impairment of functioning that is associated with incongruity between one's biological sex and gender identity. It also set in motion a new accession policy that would allow applicants who had a history of gender dysphoria, including those who had already transitioned genders, to enter into military service, provided that certain conditions were met. Once a change of gender is authorized, the person must be treated in all respects in accordance with the person's preferred gender, whether or not the person undergoes any hormone therapy or surgery, so long as a treatment plan has been approved by a military physician.

The new accession policy had not taken effect when the current administration came into office. Secretary James Mattis exercised his discretion and approved the recommendation of the Services to delay the Carter accession policy for an additional six months so that the Department could assess its impact on military effectiveness and lethality. While that review was ongoing, President Trump issued a memorandum to the Secretary of Defense and the Secretary of Homeland Security with respect to the U.S. Coast Guard expressing that further study was needed to examine the effects of the prior administration's policy change. The memorandum directed the Secretaries to reinstate the longstanding preexisting accession policy until such time that enough evidence existed to conclude that the Carter policy would not have negative effects on military effectiveness, lethality, unit cohesion, and military resources. The President also authorized the Secretary of Defense, in consultation with the Secretary of Homeland Security, to address the disposition of transgender individuals who were already serving in the military.

Secretary Mattis established a Panel of Experts that included senior uniformed and civilian leaders of the Department and U.S. Coast Guard, many with experience leading Service members in peace and war. The Panel made recommendations based on each Panel member's independent military judgment. Consistent with those recommendations, the Department, in consultation with the Department of Homeland Security, recommends the following policy to the President:

A. Transgender Persons Without a History or Diagnosis of Gender Dysphoria, Who Are Otherwise Qualified for Service, May Serve, Like All Other Service Members, in Their Biological Sex. Transgender persons who have not transitioned to another gender and do not have a history or current diagnosis of gender dysphoria—i.e., they identify as a gender other than their biological sex but do not currently experience distress or impairment of functioning in meeting the standards associated with their biological sex—are qualified for service, provided that they, like all other persons, satisfy all standards and are capable of adhering to the standards associated with their biological sex. This is consistent with the Carter policy, under which transgender persons without a history or diagnosis of gender dysphoria must serve, like everyone else, in their biological sex.

B. Transgender Persons Who Require or Have Undergone Gender Transition Are Disqualified. Except for those who are exempt under this policy, as described below, and except where waivers or exceptions to policy are otherwise authorized, transgender persons who are diagnosed with gender dysphoria, either before or after entry into service, and require transition-related treatment, or have already transitioned to their preferred gender, should be ineligible for service. For reasons discussed at length in this report, the Department concludes that accommodating gender transition could impair unit readiness; undermine unit cohesion, as well as good order and discipline, by blurring the clear lines that demarcate male and female standards and policies where they exist; and lead to disproportionate costs. Underlying these conclusions is the considerable scientific uncertainty and overall lack of high quality scientific evidence demonstrating the extent to which transition-related treatments, such as cross-sex hormone therapy and sex reassignment surgery—interventions which are unique in psychiatry and medicine—remedy the multifaceted mental health problems associated with gender dysphoria.

C. Transgender Persons With a History or Diagnosis of Gender Dysphoria Are Disqualified, Except Under Certain Limited Circumstances. Transgender persons who are diagnosed with, or have a history of, gender dysphoria are generally disqualified from accession or retention in the Armed Forces. The standards recommended here are subject to the same procedures for waiver or exception to policy as any other standards. This is consistent with the Department's handling of other mental conditions that require treatment. As a general matter, only in the limited circumstances described below should persons with a history or diagnosis of gender dysphoria be accessed or retained.

1. *Accession of Individuals Diagnosed with Gender Dysphoria.* Persons with a history of gender dysphoria may access into the Armed Forces, provided that they can demonstrate 36 consecutive months of stability (i.e., absence of gender dysphoria) immediately preceding their application; they have not transitioned to the opposite gender; and they are willing and able to adhere to all standards associated with their biological sex.

2. *Retention of Service Members Diagnosed with Gender Dysphoria.* Consistent with the Department's general approach of applying less stringent standards to retention than to accession in order to preserve the Department's substantial investment in trained personnel, Service members who are diagnosed with gender dysphoria after entering military service may be retained without waiver, provided that they are willing and able to adhere to all standards associated with their biological sex, the Service member does not require gender transition, and the Service member is not otherwise non-deployable for more than 12 months or for a period of time in excess of that established by Service policy (which may be less than 12 months).[8]

3. *Exempting Current Service Members Who Have Already Received a Diagnosis of Gender Dysphoria.* Transgender Service members who were diagnosed with gender dysphoria by a military medical provider after the effective date of the Carter policy, but before the effective date of any new policy, may continue to receive all medically necessary care,

[8] Under Secretary of Defense for Personnel and Readiness, "DoD Retention Policy for Non-Deployable Service Members" (Feb. 14, 2018).

to change their gender marker in the Defense Enrollment Eligibility Reporting System (DEERS), and to serve in their preferred gender, even after the new policy commences. This includes transgender Service members who entered into military service after January 1, 2018, when the Carter accession policy took effect by court order. The Service member must, however, adhere to the Carter policy procedures and may not be deemed to be non-deployable for more than 12 months or for a period of time in excess of that established by Service policy (which may be less than 12 months). While the Department believes that its solemn promise to these Service members, and the investment it has made in them, outweigh the risks identified in this report, should its decision to exempt these Service members be used by a court as a basis for invalidating the entire policy, this exemption is and should be deemed severable from the rest of the policy.

Although the precise number is unknown, the Department recognizes that many transgender persons who desire to serve in the military experience gender dysphoria and, as a result, could be disqualified under the recommended policy set forth in this report. Many transgender persons may also be unwilling to adhere to the standards associated with their biological sex as required by longstanding military policy. But others have served, and are serving, with distinction under the standards for their biological sex, like all other Service members. Nothing in this policy precludes service by transgender persons who do not have a history or diagnosis of gender dysphoria and are willing and able to meet all standards that apply to their biological sex.

Moreover, nothing in this policy should be viewed as reflecting poorly on transgender persons who suffer from gender dysphoria, or have had a history of gender dysphoria, and are accordingly disqualified from service. The vast majority of Americans from ages 17 to 24—that is, 71%—are ineligible to join the military without a waiver for mental, medical, or behavioral reasons.[9] Transgender persons with gender dysphoria are no less valued members of our Nation than all other categories of persons who are disqualified from military service. The Department honors all citizens who wish to dedicate, and perhaps even lay down, their lives in defense of the Nation, even when the Department, in the best interests of the military, must decline to grant their wish.

Military standards are high for a reason—the trauma of war, which all Service members must be prepared to face, demands physical, mental, and moral standards that will give all Service members the greatest chance to survive the ordeal with their bodies, minds, and moral character intact. The Department would be negligent to sacrifice those standards for any cause. There are serious differences of opinion on this issue, even among military professionals, but in the final analysis, given the uncertainty associated with the study and treatment of gender dysphoria, the competing interests involved, and the vital interests at stake—our Nation's defense and the success and survival of our Service members in war—the Department must proceed with caution.

[9] The Lewin Group, Inc., "Qualified Military Available (QMA) and Interested Youth: Final Technical Report," p. 26 (Sept. 2016).

History of Policies Concerning Transgender Persons

For decades, military standards have precluded the accession and retention of certain transgender persons.[10] Accession standards—i.e., standards that govern induction into the Armed Forces—have historically disqualified persons with a history of "transsexualism." Also disqualified were persons who had undergone genital surgery or who had a history of major abnormalities or defects of the genitalia. These standards prevented transgender persons, especially those who had undergone a medical or surgical gender transition, from accessing into the military, unless a waiver was granted.

Although retention standards—i.e., standards that govern the retention and separation of persons already serving in the Armed Forces—did not require the mandatory processing for separation of transgender persons, it was a permissible basis for separation processing as a physical or mental condition not amounting to a disability. More typically, however, such Service members were processed for separation because they suffered from other associated medical conditions or comorbidities, such as depression, which were also a basis for separation processing.

At the direction of Secretary Carter, the Department made significant changes to these standards. These changes—i.e., the "Carter policy"—prohibit the separation of Service members on the basis of their gender identity and allow Service members who are diagnosed with gender dysphoria to transition to their preferred gender.

Transition-related treatment is highly individualized and could involve what is known as a "medical transition," which includes cross-sex hormone therapy, or a "surgical transition,"

[10] For purposes of this report, the Department uses the broad definition of "transgender" adopted by the RAND National Defense Institute in its study of transgender service: "an umbrella term used for individuals who have sexual identity or gender expression that differs from their assigned sex at birth." RAND National Defense Research Institute, *Assessing the Implications of Allowing Transgender Personnel to Serve Openly,* p.75 (RAND Corporation 2016), available at https://www.rand.org/content/dam/rand/pubs/research_reports/RR1500/RR1530/RAND_RR1530.pdf ("RAND Study"). According to the Human Rights Campaign, "[t]he transgender community is incredibly diverse. Some transgender people identify as male or female, and some identify as genderqueer, nonbinary, agender, or somewhere else on or outside of the spectrum of what we understand gender to be." Human Rights Campaign, "Understanding the Transgender Community," https://www.hrc.org/resources/understanding-the-transgender-community (last visited Feb. 14, 2018). A subset of transgender persons are those who have been diagnosed with gender dysphoria. According to the *Diagnostic and Statistical Manual of Mental Disorders* published by the American Psychiatric Association, "gender dysphoria" is a "marked incongruence between one's experienced/expressed gender and assigned gender" that "is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning." American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)*, pp. 452-53 (5th ed. 2013). Based on these definitions, a person can be transgender without necessarily having gender dysphoria (i.e., the transgender person does not suffer "clinically significant distress or impairment" on account of gender incongruity). A 2016 survey of active duty Service members estimated that approximately 1% of the force—8,980 Service members—identify as transgender. Office of People Analytics, Department of Defense, "2016 Workplace and Gender Relations Survey of Active Duty Members, Transgender Service Members," pp. 1-2. Currently, there are 937 active duty Service members who have been diagnosed with gender dysphoria since June 30, 2016. In addition, when using the term "biological sex" or "sex," this report is referring to the definition of "sex" in the RAND study: "a person's biological status as male or female based on chromosomes, gonads, hormones, and genitals (intersex is a rare exception)." RAND Study at 75.

which includes sex reassignment surgery. Service members could also forego medical transition treatment altogether, retain all of their biological anatomy, and live as the opposite gender—this is called a "social transition."

Once the Service member's transition is complete, as determined by the member's military physician and commander in accordance with his or her individualized treatment plan, and the Service member provides legal documentation of gender change, the Carter policy allows for the Service member's gender marker to be changed in the DEERS. Thereafter, the Service member must be treated in every respect—including with respect to physical fitness standards; berthing, bathroom, and shower facilities; and uniform and grooming standards—in accordance with the Service member's preferred gender. The Carter policy, however, still requires transgender Service members who have not changed their gender marker in DEERS, including persons who identify as other than male or female, to meet the standards associated with their biological sex.

The Carter policy also allows accession of persons with gender dysphoria who can demonstrate stability in their preferred gender for at least 18 months. The accession policy did not take effect until required by court order, effective January 1, 2018.

The following discussion describes in greater detail the evolution of accession and retention standards pertaining to transgender persons.

Transgender Policy Prior to the Carter Policy

A. Accession Medical Standards

DoD Instruction (DoDI) 6130.03, *Medical Standards for Appointment, Enlistment, or Induction in the Military Services*, establishes baseline accession medical standards used to determine an applicant's medical qualifications to enter military service. This instruction is reviewed every three to four years by the Accession Medical Standards Working Group (AMSWG), which includes medical and personnel subject matter experts from across the Department, its Military Services, and the U.S. Coast Guard. The AMSWG thoroughly reviews over 30 bodily systems and medical focus areas while carefully considering evidence-based clinical information, peer-reviewed scientific studies, scientific expert consensus, and the performance of existing standards in light of empirical data on attrition, deployment readiness, waivers, and disability rates. The AMSWG also considers inputs from non-government sources and evaluates the applicability of those inputs against the military's mission and operational environment, so that the Department and the Military Services can formally coordinate updates to these standards.

Accession medical standards are based on the operational needs of the Department and are designed to ensure that individuals are physically and psychologically "qualified, effective, and able-bodied persons"[11] capable of performing military duties. Military effectiveness requires that the Armed Forces manage an integrated set of unique medical standards and qualifications because all military personnel must be available for worldwide duty 24 hours a day without

[11] 10 U.S.C. § 505(a).

restriction or delay. Such duty may involve a wide range of demands, including exposure to danger or harsh environments, emotional stress, and the operation of dangerous, sensitive, or classified equipment. These duties are often in remote areas lacking immediate and comprehensive medical support. Such demands are not normally found in civilian occupations, and the military would be negligent in its responsibility if its military standards permitted admission of applicants with physical or emotional impairments that could cause harm to themselves or others, compromise the military mission, or aggravate any current physical or mental health conditions that they may have.

In sum, these standards exist to ensure that persons who are under consideration for induction into military service are:

- free of contagious diseases that probably will endanger the health of other personnel;
- free of medical conditions or physical defects that may require excessive time lost from duty for necessary treatment or hospitalization, or probably will result in separation from service for medical unfitness;
- medically capable of satisfactorily completing required training;
- medically adaptable to the military environment without the necessity of geographical area limitations; and
- medically capable of performing duties without aggravation of existing physical defects or medical conditions.[12]

Establishing or modifying an accession standard is a risk management process by which a health condition is evaluated in terms of the probability and effect on the five listed outcomes above. These standards protect the applicant from harm that could result from the rigors of military duty and help ensure unit readiness by minimizing the risk that an applicant, once inducted into military service, will be unavailable for duty because of illness, injury, disease, or bad health.

Unless otherwise expressly provided, a current diagnosis or verified past medical history of a condition listed in DoDI 6130.03 is presumptively disqualifying.[13] Accession standards reflect the considered opinion of the Department's medical and personnel experts that an applicant with an identified condition should only be able to serve if they can qualify for a waiver. Waivers are generally only granted when the condition will not impact the individual's assigned specialty or when the skills of the individual are unique enough to warrant the additional risk. Waivers are not generally granted when the conditions of military service may aggravate the existing condition. For some conditions, applicants with a past medical history may nevertheless be eligible for accession if they meet the requirements for a certain period of "stability"—that is, they can demonstrate that the condition has been absent for a defined period

[12] Department of Defense Instruction 6130.03, *Medical Standards for Appointment, Enlistment, or Induction in the Military Services* (Apr. 28, 2010), incorporating Change 1, p. 2 (Sept. 13, 2011) ("DoDI 6130.03").
[13] Id. at 10.

of time prior to accession.[14] With one exception,[15] each accession standard may be waived in the discretion of the accessing Service based on that Service's policies and practices, which are driven by the unique requirements of different Service missions, different Service occupations, different Service cultures, and at times, different Service recruiting missions.

Historically, mental health conditions have been a great concern because of the unique mental and emotional stresses of military service. Mental health conditions frequently result in attrition during initial entry training and the first term of service and are routinely considered by in-service medical boards as a basis for separation. Department mental health accession standards have typically aligned with the conditions identified in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM), which is published by the American Psychiatric Association (APA). The DSM sets forth the descriptions, symptoms, and other criteria for diagnosing mental disorders. Health care professionals in the United States and much of the world use the DSM as the authoritative guide to the diagnosis of mental disorders.

Prior to implementation of the Carter policy, the Department's accession standards barred persons with a "[h]istory of psychosexual conditions, including but not limited to transsexualism, exhibitionism, transvestism, voyeurism, and other paraphilias."[16] These standards were consistent with DSM-III, which in 1980, introduced the diagnosis of transsexualism.[17] In 1987, DSM-III-R added gender identity disorder, non-transsexual type.[18] DSM-IV, which was published in 1994, combined these two diagnoses and called the resulting condition "gender identity disorder."[19] Due to challenges associated with updating and publishing a new iteration of DoDI 6130.03, the DoDI's terminology has not changed to reflect the changes in the DSM, including further changes that will be discussed later.

DoDI 6130.03 also contains other disqualifying conditions that are associated with, but not unique to, transgender persons, especially those who have undertaken a medical or surgical transition to the opposite gender. These include:

- a history of chest surgery, including but not limited to the surgical removal of the breasts,[20] and genital surgery, including but not limited to the surgical removal of the testicles;[21]

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[14] See, e.g., id. at 47.
[15] The accession standards for applicants with HIV are not waivable absent a waiver from both the accessing Service and the Under Secretary of Defense for Personnel and Readiness. See Department of Defense Instruction 6485.01, *Human Immunodeficiency Virus (HIV) in Military Service Members* (Jun. 7, 2013).
[16] DoDI 6130.03 at 48.
[17] American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders (DSM-III)*, pp. 261-264 (3rd ed. 1980).
[18] American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders (DSM-III-R)*, pp. 76-77 (3rd ed. revised 1987).
[19] American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)*, pp. 532-538 (4th ed. 1994).
[20] DoDI 6130.03 at 18.
[21] Id. at 25-27.

- a history of major abnormalities or defects of the genitalia, including but not limited to change of sex, hermaphroditism, penis amputation, and pseudohermaphroditism;[22]
- mental health conditions such as suicidal ideation, depression, and anxiety disorder;[23] and
- the use of certain medications, or conditions requiring the use of medications, such as hormone therapies and anti-depressants.[24]

Together with a diagnosis of transsexualism, these conditions, which were repeatedly validated by the AMSWG, provided multiple grounds for the disqualification of transgender persons.

B. Retention Standards

The standards that govern the retention of Service members who are already serving in the military are generally less restrictive than the corresponding accession standards due to the investment the Department has made in the individual and their increased capability to contribute to mission accomplishment.

Also unlike the Department's accession standards, each Service develops and applies its own retention standards. With respect to the retention of transgender Service members, these Service-specific standards may have led to inconsistent outcomes across the Services, but as a practical matter, before the Carter policy, the Services generally separated Service members who desired to transition to another gender. During that time, there were no express policies allowing individuals to serve in their preferred gender rather than their biological sex.

Previous Department policy concerning the retention (administrative separation) of transgender persons was not clear or rigidly enforced. DoDI 1332.38, *Physical Disability Evaluation*, now cancelled, characterized "sexual gender and identity disorders" as a basis for allowing administrative separation for a condition not constituting a disability; it did not require mandatory processing for separation. A newer issuance, DoDI 1332.18, *Disability Evaluation System (DES)*, August 5, 2014, does not reference these disorders but instead reflects changes in how such medical conditions are characterized in contemporary medical practice.

Earlier versions of DoDI 1332.14, *Enlisted Administrative Separations*, contained a cross reference to the list of conditions not constituting a disability in former DoDI 1332.38. This was how "transsexualism," the older terminology, was used as a basis for administrative separation. Separation on this basis required formal counseling and an opportunity to address the issue, as well as a finding that the condition was interfering with the performance of duty. In practice, transgender persons were not usually processed for administrative separation on account of gender dysphoria or gender identity itself, but rather on account of medical comorbidities (e.g., depression or suicidal ideation) or misconduct due to cross dressing and related behavior.

[22] Id.
[23] Id. at 47-48.
[24] Id. at 48.

The Carter Policy

At the direction of Secretary Carter, the Department began formally reconsidering its accession and retention standards as they applied to transgender persons with gender dysphoria in 2015. This reevaluation, which culminated with the release of the Carter policy in 2016, was prompted in part by amendments to the DSM that appeared to change the diagnosis for gender identity disorder from a disorder to a treatable condition called gender dysphoria. Starting from the assumption that transgender persons are qualified for military service, the Department sought to identify and remove the obstacles to such service. This effort resulted in substantial changes to the Department's accession and retention standards to accommodate transgender persons with gender dysphoria who require treatment for transitioning to their preferred gender.

A. Changes to the DSM

When the APA published the fifth edition of the DSM in May 2013, it changed "gender identity disorder" to "gender dysphoria" and designated it as a "condition"—a new diagnostic class applicable only to gender dysphoria—rather than a "disorder."[25] This change was intended to reflect the APA's conclusion that gender nonconformity alone—without accompanying distress or impairment of functioning—was not a mental disorder.[26] DSM-5 also decoupled the diagnosis for gender dysphoria from diagnoses for "sexual dysfunction and parphilic disorders, recognizing fundamental differences between these diagnoses."[27]

According to DSM-5, gender dysphoria in adolescents and adults is "[a] marked incongruence between one's experience/expressed gender and assigned gender, of at least 6 months' duration, as manifested by at least two of the following":

- A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics).
- A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender (or in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics).

[25] See American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)*, pp. 451-459 (5th ed. 2013) ("DSM-5").
[26] RAND Study at 77; see also Hayes Directory, "Sex Reassignment Surgery for the Treatment of Gender Dysphoria" (May 15, 2014), p. 1 ("This change was intended to reflect a consensus that gender nonconformity is not a psychiatric disorder, as it was previously categorized. However, since the condition may cause clinically significant distress and since a diagnosis is necessary for access to medical treatment, the new term was proposed."); Irene Folaron & Monica Lovasz, "Military Considerations in Transsexual Care of the Active Duty Member," *Military Medicine*, Vol. 181, pp. 1182-83 (2016) ("In the DSM-5, [gender dysphoria] has replaced the diagnosis of 'gender identity disorder' in order to place the focus on the dysphoria and to diminish the pathology associated with identity incongruence.").
[27] Irene Folaron & Monica Lovasz, "Military Considerations in Transsexual Care of the Active Duty Member," *Military Medicine*, Vol. 181, p. 1183 (2016).

- A strong desire for the primary and/or secondary sex characteristics of the other gender.
- A strong desire to be of the other gender (or some alternative gender different from one's assigned gender).
- A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender).
- A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender).

Importantly, DSM-5 observed that gender dysphoria "is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning."[28]

B. The Department Begins Review of Transgender Policy

On July 28, 2015, then Secretary Carter issued a memorandum announcing that no Service members would be involuntarily separated or denied reenlistment or continuation of service based on gender identity or a diagnosis of gender dysphoria without the personal approval of the Under Secretary of Defense for Personnel and Readiness.[29] The memorandum also created the Transgender Service Review Working Group (TSRWG) "to study the policy and readiness implications of welcoming transgender persons to serve openly."[30] The memorandum specifically directed the working group to "start with the presumption that transgender persons can serve openly without adverse impact on military effectiveness and readiness, unless and except where objective practical impediments are identified."[31]

As part of this review, the Department commissioned the RAND National Defense Research Institute to conduct a study to "(1) identify the health care needs of the transgender population, transgender Service members' potential health care utilization rates, and the costs associated with extending health care coverage for transition-related treatments; (2) assess the potential readiness impacts of allowing transgender Service members to serve openly; and (3) review the experiences of foreign militaries that permit transgender Service members to serve openly."[32] The resulting report, entitled *Assessing the Implications of Allowing Transgender Personnel to Serve Openly*, reached several conclusions. First, the report estimated that there are between 1,320 and 6,630 transgender Service members already serving in the active component of the Armed Forces and 830 to 4,160 in the Selected Reserve.[33] Second, the report predicted "annual gender transition-related health care to be an extremely small part of the overall health care provided to the [active component] population."[34] Third, the report estimated that active component "health care costs will increase by between $2.4 million and $8.4 million annually—an amount that will have little impact on and represents an exceedingly small proportion of

[28] American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)*, p. 453 (5th ed. 2013).
[29] Memorandum from Ashton Carter, Secretary of Defense, "Transgender Service Members" (July 28, 2015).
[30] Id.
[31] Id.
[32] RAND Study at 1.
[33] Id. at x-xi.
[34] Id. at xi.

[active component] health care expenditures (approximately $6 billion in FY 2014)."[35] Fourth, the report "found that less than 0.0015 percent of the total available labor-years would be affected, based on estimated gender transition-related health care utilization rates."[36] Finally, the report concluded that "[e]xisting data suggest a minimal impact on unit cohesion as a result of allowing transgender personnel to serve openly."[37] "Overall," according to RAND, "our study found that the number of U.S. transgender Service members who are likely to seek transition-related care is so small that a change in policy will likely have a marginal impact on health care costs and the readiness of the force."[38]

The RAND report thus acknowledged that there will be an adverse impact on health care utilization and costs, readiness, and unit cohesion, but concluded nonetheless that the impact will be "negligible" and "marginal" because of the small estimated number of transgender Service members relative to the size of the active component of the Armed Forces. Because of the RAND report's macro focus, however, it failed to analyze the impact at the micro level of allowing gender transition by individuals with gender dysphoria. For example, as discussed in more detail later, the report did not examine the potential impact on unit readiness, perceptions of fairness and equity, personnel safety, and reasonable expectations of privacy at the unit and sub-unit levels, all of which are critical to unit cohesion. Nor did the report meaningfully address the significant mental health problems that accompany gender dysphoria—from high rates of comorbidities and psychiatric hospitalizations to high rates of suicide ideation and suicidality—and the scope of the scientific uncertainty regarding whether gender transition treatment fully remedies those problems.

C. New Standards for Transgender Persons

Based on the RAND report, the work of the TSRWG, and the advice of the Service Secretaries, Secretary Carter approved the publication of DoDI 1300.28, *In-service Transition for Service Members Identifying as Transgender*, and Directive-type Memorandum (DTM) 16-005, "Military Service of Transgender Service Members," on June 30, 2016. Although the new retention standards were effective immediately upon publication of the above memoranda, the accession standards were delayed until July 1, 2017, to allow time for training all Service members across the Armed Forces, including recruiters, Military Entrance Processing Station (MEPS) personnel, and basic training cadre, and to allow time for modifying facilities as necessary.

1. *Retention Standards*. DoDI 1300.28 establishes the procedures by which Service members who are diagnosed with gender dysphoria may administratively change their gender. Once a Service member receives a gender dysphoria diagnosis from a military physician, the physician, in consultation with the Service member, must establish a treatment plan. The treatment plan is highly individualized and may include cross-sex hormone therapy (i.e., medical transition), sex reassignment surgery (i.e., surgical transition), or simply living as the opposite gender but without any cross-sex hormone or surgical treatment (i.e., social

[35] Id. at xi-xii.
[36] Id. at xii.
[37] Id.
[38] Id. at 69.

transition). The nature of the treatment is left to the professional medical judgment of the treating physician and the individual situation of the transgender Service member. The Department does not require a Service member with gender dysphoria to undergo cross-sex hormone therapy, sex reassignment surgery, or any other physical changes to effectuate an administrative change of gender. During the course of treatment, commanders are authorized to grant exceptions from physical fitness, uniform and grooming, and other standards, as necessary and appropriate, to transitioning Service members. Once the treating physician determines that the treatment plan is complete, the Service member's commander approves, and the Service member produces legal documentation indicating change of gender (e.g., certified birth certificate, court order, or U.S. passport), the Service member may request a change of gender marker in DEERS. Once the DEERS gender marker is changed, the Service member is held to all standards associated with the member's transitioned gender, including uniform and grooming standards, body composition assessment, physical readiness testing, Military Personnel Drug Abuse Testing Program participation, and other military standards congruent to the member's gender. Indeed, the Service member must be treated in all respects in accordance with the member's transitioned gender, including with respect to berthing, bathroom, and shower facilities. Transgender Service members who do not meet the clinical criteria for gender dysphoria, by contrast, remain subject to the standards and requirements applicable to their biological sex.

2. *Accession Standards*. DTM 16-005 directed that the following medical standards for accession into the Military Services take effect on July 1, 2017:

(1) A history of gender dysphoria is disqualifying, unless, as certified by a licensed medical provider, the applicant has been stable without clinically significant distress or impairment in social, occupational, or other important areas of functioning for 18 months.

(2) A history of medical treatment associated with gender transition is disqualifying, unless, as certified by a licensed medical provider:

(a) the applicant has completed all medical treatment associated with the applicant's gender transition; and
(b) the applicant has been stable in the preferred gender for 18 months; and
(c) if the applicant is presently receiving cross-sex hormone therapy post-gender transition, the individual has been stable on such hormones for 18 months.

(3) A history of sex reassignment or genital reconstruction surgery is disqualifying, unless, 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; and

(b) no functional limitations or complications persist, nor is any additional surgery required.[39]

[39] Memorandum from Ashton Carter, Secretary of Defense, "Directive-type Memorandum (DTM) 16-005, 'Military Service of Transgender Service Members,'" Attachment, pp. 1-2 (June 30, 2016).

Panel of Experts Recommendation

The Carter policy's accession standards for persons with a history of gender dysphoria were set to take effect on July 1, 2017, but on June 30, after consultation with the Secretaries and Chiefs of Staff of each Service, Secretary Mattis postponed the new standards for an additional six months "to evaluate more carefully the impact of such accessions on readiness and lethality."[40] Secretary Mattis specifically directed that the review would "include all relevant considerations" and would last for five months, with a due date of December 1, 2017.[41] The Secretary also expressed his desire to have "the benefit of the views of the military leadership and of the senior civilian officials who are now arriving in the Department."[42]

While Secretary Mattis's review was ongoing, President Trump issued a memorandum, on August 25, 2017, directing the Secretary of Defense, and the Secretary of Homeland Security with respect to the U.S. Coast Guard, to reinstate longstanding policy generally barring the accession of transgender individuals "until such time as a sufficient basis exists upon which to conclude that terminating that policy and practice" would not "hinder military effectiveness and lethality, disrupt unit cohesion, or tax military resources."[43] The President found that "further study is needed to ensure that continued implementation of last year's policy change would not have those negative effects."[44] Accordingly, the President directed both Secretaries to maintain the prohibition on accession of transgender individuals "until such time as the Secretary of Defense, after consulting with the Secretary of Homeland Security, provides a recommendation to the contrary" that is convincing.[45] The President made clear that the Secretaries may advise him "at any time, in writing, that a change to this policy is warranted."[46] In addition, the President gave both Secretaries discretion to "determine how to address transgender individuals currently serving" in the military and made clear that no action be taken against them until a determination was made.[47]

On September 14, 2017, Secretary Mattis established a Panel of Experts to study, in a "comprehensive, holistic, and objective" manner, "military service by transgender individuals, focusing on military readiness, lethality, and unit cohesion, with due regard for budgetary constraints and consistent with applicable law."[48] He directed the Panel to "conduct an independent multi-disciplinary review and study of relevant data and information pertaining to transgender Service members."[49]

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[40] Memorandum from James N. Mattis, Secretary of Defense, "Accession of Transgender Individuals into the Military Services" (June 30, 2017).
[41] Id.
[42] Id.
[43] Memorandum from Donald J. Trump, President of the United States, "Military Service by Transgender Individuals" (Aug. 25, 2017).
[44] Id. at 1.
[45] Id. at 2.
[46] Id.
[47] Id.
[48] Memorandum from James N. Mattis, Secretary of Defense, "Terms of Reference—Implementation of Presidential Memorandum on Military Service by Transgender Individuals," pp. 1-2 (Sept. 14, 2017).
[49] Id. at 2.

The Panel consisted of the Under Secretaries of the Military Departments (or officials performing their duties), the Armed Services' Vice Chiefs (including the Vice Commandant of the U.S. Coast Guard), and the Senior Enlisted Advisors, and was chaired by the Under Secretary of Defense for Personnel and Readiness or an official performing those duties. The Secretary of Defense selected these senior leaders because of their experience leading warfighters in war and peace or their expertise in military operational effectiveness. These senior leaders also have the statutory responsibility to organize, train, and equip military forces and are uniquely qualified to evaluate the impact of policy changes on the combat effectiveness and lethality of the force. The Panel met 13 times over a span of 90 days.

The Panel received support from medical and personnel experts from across the Departments of Defense and Homeland Security. The Transgender Service Policy Working Group, comprised of medical and personnel experts from across the Department, developed policy recommendations and a proposed implementation plan for the Panel's consideration. The Medical and Personnel Executive Steering Committee, a standing group of the Surgeons General and Service Personnel Chiefs, led by Personnel and Readiness, provided the Panel with an analysis of accession standards, a multi-disciplinary review of relevant data, and information about medical treatment for gender dysphoria and gender transition-related medical care. These groups reported regularly to the Panel and responded to numerous queries for additional information and analysis to support the Panel's review and deliberations. A separate working group tasked with enhancing the lethality of our Armed Forces also provided a briefing to the Panel on their work relating to retention standards.

The Panel met with and received input from transgender Service members, commanders of transgender Service members, military medical professionals, and civilian medical professionals with experience in the care and treatment of individuals with gender dysphoria. The Panel also reviewed information and analyses about gender dysphoria, the treatment of gender dysphoria, and the effects of currently serving individuals with gender dysphoria on military effectiveness, unit cohesion, and resources. Unlike past reviews, the Panel's analysis was informed by the Department's own data and experience obtained since the Carter policy took effect.

To fulfill its mandate, the Panel addressed three questions:

- Should the Department of Defense access transgender individuals?
- Should the Department allow transgender individuals to transition gender while serving, and if so, what treatment should be authorized?
- How should the Department address transgender individuals who are currently serving?

After extensive review and deliberation, which included evidence in support of and against the Panel's recommendations, the Panel exercised its professional military judgment and made recommendations. The Department considered those recommendations and the information underlying them, as well as additional information within the Department, and now proposes the following policy consistent with those recommendations.

Recommended Policy

To maximize military effectiveness and lethality, the Department, after consultation with and the concurrence of the Department of Homeland Security, recommends cancelling the Carter policy and, as explained below, adopting a new policy with respect to the accession and retention of transgender persons.

The Carter policy assumed that transgender persons were generally qualified for service and that their accession and retention would not negatively impact military effectiveness. As noted earlier, Secretary Carter directed the TSRWG, the group charged with evaluating, and making recommendations on, transgender service, to "start with the presumption that transgender persons can serve openly without adverse impact on military effectiveness and readiness, unless and except where objective practical impediments are identified."[50] Where necessary, standards were adjusted or relaxed to accommodate service by transgender persons. The following analysis makes no assumptions but instead applies the relevant standards applicable to everyone to determine the extent to which transgender persons are qualified for military duty.

For the following reasons, the Department concludes that transgender persons should not be disqualified from service solely on account of their transgender status, provided that they, like all other Service members, are willing and able to adhere to all standards, including the standards associated with their biological sex. With respect to the subset of transgender persons who have been diagnosed with gender dysphoria, however, those persons are generally disqualified unless, depending on whether they are accessing or seeking retention, they can demonstrate stability for the prescribed period of time; they do not require, and have not undergone, a change of gender; and they are otherwise willing and able to meet all military standards, including those associated with their biological sex. In order to honor its commitment to current Service members diagnosed with gender dysphoria, those Service members who were diagnosed after the effective date of the Carter policy and before any new policy takes effect will not be subject to the policy recommended here.

Discussion of Standards

The standards most relevant to the issue of service by transgender persons fall into three categories: mental health standards, physical health standards, and sex-based standards. Based on these standards, the Department can assess the extent to which transgender persons are qualified for military service and, in light of that assessment, recommend appropriate policies.

A. Mental Health Standards

Given the extreme rigors of military service and combat, maintaining high standards of mental health is essential to military effectiveness and lethality. The immense toll that the burden and experience of combat can have on the human psyche cannot be overstated. Therefore, putting individuals into battle, who might be at increased risk of psychological injury, would be reckless, not only for those individuals, but for the Service members who serve beside them as well.

[50] Memorandum from Ashton Carter, Secretary of Defense, "Transgender Service Members" (July 28, 2015).

The Department's experience with the mental health issues arising from our wars in Afghanistan and Iraq, including post-traumatic stress disorder (PTSD), only underscores the importance of maintaining high levels of mental health across the force. PTSD has reached as high as 2.8% of all active duty Service members, and in 2016, the number of active duty Service members with PTSD stood at 1.5%.[51] Of all Service members in the active component, 7.5% have been diagnosed with a mental health condition of some type.[52] The Department is mindful of these existing challenges and must exercise caution when considering changes to its mental health standards.

Most mental health conditions and disorders are automatically disqualifying for accession absent a waiver. For example, persons with a history of bipolar disorder, personality disorder, obsessive-compulsive disorder, suicidal behavior, and even body dysmorphic disorder (to name a few) are barred from entering into military service, unless a waiver is granted.[53] For a few conditions, however, persons may enter into service without a waiver if they can demonstrate stability for 24 to 36 continuous months preceding accession. Historically, a person is deemed stable if they are without treatment, symptoms, or behavior of a repeated nature that impaired social, school, or work efficiency for an extended period of several months. Such conditions include depressive disorder (stable for 36 continuous months) and anxiety disorder (stable for 24 continuous months).[54] Requiring a period of stability reduces, but does not eliminate, the likelihood that the individual's depression or anxiety will return.

Historically, conditions associated with transgender individuals have been automatically disqualifying absent a waiver. Before the changes directed by Secretary Carter, military mental health standards barred persons with a "[h]istory of psychosexual conditions, including but not limited to transsexualism, exhibitionism, transvestism, voyeurism, and other paraphilias."[55] These standards, however, did not evolve with changing understanding of transgender mental health. Today, transsexualism is no longer considered by most mental health practitioners as a mental health condition. According to the APA, it is not a medical condition for persons to identify with a gender that is different from their biological sex.[56] Put simply, transgender status alone is not a condition.

Gender dysphoria, by contrast, is a mental health condition that can require substantial medical treatment. Many individuals who identify as transgender are diagnosed with gender dysphoria, but "[n]ot all transgender people suffer from gender dysphoria and that distinction," according to the APA, "is important to keep in mind."[57] The DSM-5 defines gender dysphoria as

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[51] Deployment Health Clinical Center, "Mental Health Disorder Prevalence among Active Duty Service Members in the Military Health System, Fiscal Years 2005-2016" (Jan. 2017).
[52] Id.
[53] DoDI 6130.03 at 47-48.
[54] Id.
[55] Id. at 48.
[56] DSM-5 at 452-53.
[57] American Psychiatric Association, "Expert Q & A: Gender Dysphoria," available at https://www.psychiatry.org/patients-families/gender-dysphoria/expert-qa (last visited Feb. 14, 2018). Conversely, not all persons with gender dysphoria are transgender. "For example, some men who are disabled in combat, especially if their injury includes genital wounds, may feel that they are no longer men because their bodies do not conform to their concept of manliness. Similarly, a woman who opposes plastic surgery, but who must undergo mastectomy because of breast

a "marked incongruence between one's experience/expressed gender and assigned gender, of at least 6 months duration," that is manifested in various specified ways.[58] According to the APA, the "condition is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning."[59]

Transgender persons with gender dysphoria suffer from high rates of mental health conditions such as anxiety, depression, and substance use disorders.[60] High rates of suicide ideation, attempts, and completion among people who are transgender are also well documented in the medical literature, with lifetime rates of suicide attempts reported to be as high as 41% (compared to 4.6% for the general population).[61] According to a 2015 survey, the rate skyrockets to 57% for transgender individuals without a supportive family.[62] The Department is concerned that the stresses of military life, including basic training, frequent moves, deployment to war zones and austere environments, and the relentless physical demands, will be additional contributors to suicide behavior in people with gender dysphoria. In fact, there is recent evidence that military service can be a contributor to suicidal thoughts.[63]

Preliminary data of Service members with gender dysphoria reflect similar trends. A review of the administrative data indicates that Service members with gender dysphoria are eight times more likely to attempt suicide than Service members as a whole (12% versus 1.5%).[64]

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cancer, may find that she requires reconstructive breast surgery in order to resolve gender dysphoria arising from the incongruence between her body without breasts and her sense of herself as a woman." M. Jocelyn Elders, George R. Brown, Eli Coleman, Thomas Kolditz & Alan Steinman, "Medical Aspects of Transgender Military Service," *Armed Forces & Society*, p. 5 n.22 (Mar. 2014).

[58] DSM-5 at 452.

[59] DSM-5 at 453.

[60] Cecilia Dhejne, Roy Van Vlerken, Gunter Heylens & Jon Arcelus, "Mental health and gender dysphoria: A review of the literature," *International Review of Psychiatry*, Vol. 28, pp. 44-57 (2016); George R. Brown & Kenneth T. Jones, "Mental Health and Medical Health Disparities in 5135 Transgender Veterans Receiving Healthcare in the Veterans Health Administration: A Case-Control Study," *LGBT Health*, Vol. 3, p. 128 (Apr. 2016).

[61] Ann P. Haas, Philip L. Rodgers & Jody L. Herman, *Suicide Attempts among Transgender and Gender Non-Conforming Adults: Findings of the National Transgender Discrimination Survey*, p. 2 (American Foundation for Suicide Prevention and The Williams Institute, University of California, Los Angeles, School of Law 2014), available at https://williamsinstitute.law.ucla.edu/wp-content/uploads/AFSP-Williams-Suicide-Report-Final.pdf; H.G. Virupaksha, Daliboyina Muralidhar & Jayashree Ramakrishna, "Suicide and Suicide Behavior among Transgender Persons," *Indian Journal of Psychological Medicine*, Vol.38, pp. 505-09 (2016); Claire M. Peterson, Abigail Matthews, Emily Copps-Smith & Lee Ann Conard, "Suicidality, Self-Harm, and Body Dissatisfaction in Transgender Adolescents and Emerging Adults with Gender Dysphoria," *Suicide and Life Threatening Behavior*, Vol. 47, pp. 475-482 (Aug. 2017).

[62] Ann P. Haas, Philip L. Rodgers & Jody L. Herman, *Suicide Attempts among Transgender and Gender Non-Conforming Adults: Findings of the National Transgender Discrimination Survey*, pp. 2, 12 (American Foundation for Suicide Prevention and The Williams Institute, University of California, Los Angeles, School of Law 2014), available at https://williamsinstitute.law.ucla.edu/wp-content/uploads/AFSP-Williams-Suicide-Report-Final.pdf.

[63] Raymond P. Tucker, Rylan J. Testa, Mark A.Reger, Tracy L. Simpson, Jillian C. Shipherd, & Keren Lehavot, "Current and Military-Specific Gender Minority Stress Factors and Their Relationship with Suicide Ideation in Transgender Veterans," *Suicide and Life Threatening Behavior* DOI: 10.1111/sltb.12432 (epub ahead of print), pp. 1-10 (2018); Craig J. Bryan, AnnaBelle O. Bryan, Bobbie N. Ray-Sannerud, Neysa Etienne & Chad E. Morrow, "Suicide attempts before joining the military increase risk for suicide attempts and severity of suicidal ideation among military personnel and veterans," *Comprehensive Psychiatry*, Vol. 55, pp. 534-541 (2014).

[64] Data retrieved from Military Health System data repository (Oct. 2017).

Service members with gender dysphoria are also nine times more likely to have mental health encounters than the Service member population as a whole (28.1 average encounters per Service member versus 2.7 average encounters per Service member).[65] From October 1, 2015 to October 3, 2017, the 994 active duty Service members diagnosed with gender dysphoria accounted for 30,000 mental health visits.[66]

It is widely believed by mental health practitioners that gender dysphoria can be treated. Under commonly accepted standards of care, treatment for gender dysphoria can include: psychotherapy; social transition—also known as "real life experience"—to allow patients to live and work in their preferred gender without any hormone treatment or surgery; medical transition to align secondary sex characteristics with patients' preferred gender using cross-sex hormone therapy and hair removal; and surgical transition—also known as sex reassignment surgery—to make the physical body—both primary and secondary sex characteristics—resemble as closely as possible patients' preferred gender.[67] The purpose of these treatment options is to alleviate the distress and impairment of gender dysphoria by seeking to bring patients' physical characteristics into alignment with their gender identity—that is, one's inner sense of one's own gender.[68]

Cross-sex hormone therapy is a common medical treatment associated with gender transition that may be commenced following a diagnosis of gender dysphoria.[69] Treatment for women transitioning to men involves the administration of testosterone, whereas treatment for men transitioning to women requires the blocking of testosterone and the administration of estrogens.[70] The Endocrine Society's clinical guidelines recommend laboratory bloodwork every 90 days for the first year of treatment to monitor hormone levels.[71]

As a treatment for gender dysphoria, sex reassignment surgery is "a unique intervention not only in psychiatry but in all of medicine."[72] Under existing Department guidelines

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[65] Data retrieved from Military Health System data repository (Oct. 2017). Study period was Oct. 1, 2015 to July 26, 2017.
[66] Data retrieved from Military Health System data repository (Oct. 2017).
[67] RAND Study at 5-7, Appendices A & C; see also Hayes Directory, "Sex Reassignment Surgery for the Treatment of Gender Dysphoria," p. 1 (May 15, 2014) ("The full therapeutic approach to [gender dysphoria] consists of 3 elements or phases, typically in the following order: (1) hormones of the desired gender; (2) real-life experience for 12 months in the desired role; and (3) surgery to change the genitalia and other sex characteristics (e.g., breast reconstruction or mastectomy). However, not everyone with [gender dysphoria] needs or wants all elements of this triadic approach."); Irene Folaron & Monica Lovasz, "Military Considerations in Transsexual Care of the Active Duty Member," *Military Medicine*, Vol. 181, p. 1183 (Oct. 2016) ("The Endocrine Society proposes a sequential approach in transsexual care to optimize mental health and physical outcomes. Generally, they recommend initiation of psychotherapy, followed by cross-sex hormone treatments, then [sex reassignment surgery].").
[68] RAND Study at 73.
[69] Wylie C. Hembree, Peggy Cohen-Kettenis, Lous Gooren, Sabine Hannema, Walter Meyer, M. Hassan Murad, Stephen Rosenthal, Joshua Safer, Vin Tangpricha, & Guy T'Sjoen, "Endocrine Treatment of Gender-Dysphoric/Gender Incongruent Persons: An Endocrine Society Clinical Practice Guideline," *The Journal of Clinical Endocrinology & Metabolism*, Vol. 102, pp. 3869-3903 (Nov. 2017).
[70] Id. at 3885-3888.
[71] Id.
[72] Ceclilia Dhejne, Paul Lichtenstein, Marcus Boman, Anna L. Johansson, Niklas Långström & Mikael Landén, "Long-Term Follow-Up of Transsexual Persons Undergoing Sex Reassignment Surgery: Cohort Study in Sweden," *PLoS One*, Vol. 6, pp. 1-8 (Feb. 2011); see also Hayes Directory, "Sex Reassignment Surgery for the Treatment of

implementing the Carter policy, men transitioning to women may obtain an orchiectomy (surgical removal of the testicles), a penectomy (surgical removal of the penis), a vaginoplasty (surgical creation of a vagina), a clitoroplasty (surgical creation of a clitoris), and a labiaplasty (surgical creation of the labia). Women transitioning to men may obtain a hysterectomy (surgical removal of the uterus), a mastectomy (surgical removal of the breasts), a metoidioplasty (surgical enlargement of the clitoris), a phalloplasty (surgical creation of a penis), a scrotoplasty (surgical creation of a scrotum) and placement of testicular prostheses, a urethroplasty (surgical enlargement of the urethra), and a vaginectomy (surgical removal of the vagina). In addition, the following cosmetic procedures may be provided at military treatment facilities as well: abdominoplasty, breast augmentation, blepharoplasty (eyelid lift), hair removal, face lift, facial bone reduction, hair transplantation, liposuction, reduction thyroid chondroplasty, rhinoplasty, and voice modification surgery.[73]

The estimated recovery time for each of the surgical procedures, even assuming no complications, can be substantial. For example, assuming no complications, the recovery time for a hysterectomy is up to eight weeks; a mastectomy is up to six weeks; a phalloplasty is up to three months; a metoidioplasty is up to eight weeks; an orchiectomy is up to six weeks; and a vaginoplasty is up to three months.[74] When combined with 12 continuous months of hormone therapy, which is required prior to genital surgery,[75] the total time necessary for surgical transition can exceed a year.

Although relatively few people who are transgender undergo genital reassignment surgeries (2% of transgender men and 10% of transgender women), we have to consider that the rate of complications for these surgeries is significant, which could increase a transitioning Service member's unavailability.[76] Even according to the RAND study, 6% to 20% of those receiving vaginoplasty surgery experience complications, meaning that "between three and 11 Service members per year would experience a long-term disability from gender reassignment

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Gender Dysphoria," p. 2 (May 15, 2014) (noting that gender dysphoria "does not readily fit traditional concepts of medical necessity since research to date has not established anatomical or physiological anomalies associated with [gender dysphoria]"); Hayes Annual Review, "Sex Reassignment Surgery for the Treatment of Gender Dysphoria" (Apr. 18, 2017).

[73] Memorandum from Defense Health Agency, "Information Memorandum: Interim Defense Health Agency Procedures for Reviewing Requests for Waivers to Allow Supplemental Health Care Program Coverage of Sex Reassignment Surgical Procedures" (Nov. 13, 2017); see also RAND Study at Appendix C.

[74] University of California, San Francisco, Center of Excellence for Transgender Health, "Guidelines for the Primary and Gender-Affirming Care of Transgender and Gender Nonbinary People," available at http://transhealth.ucsf.edu/trans?page=guidelines-home (last visited Feb. 16, 2018); Discussion with Dr. Loren Schechter, Visiting Clinical Professor of Surgery, University of Illinois at Chicago (Nov. 9, 2017).

[75] RAND Study at 80; see also Irene Folaron & Monica Lovasz, "Military Considerations in Transsexual Care of the Active Duty Member," *Military Medicine*, Vol. 181, p. 1184 (Oct. 2016) (noting that Endocrine Society criteria "require that the patient has been on continuous cross-sex hormones and has had continuous [real life experience] or psychotherapy for the past 12 months").

[76] Sandy E. James, Jody L. Herman, Susan Rankin, Mara Keisling, Lisa Mottet & Ma'ayan Anafi, *The Report of the 2015 U.S. Transgender Survey*, pp. 100-103 (National Center for Transgender Equality 2016) available at https://www.transequality.org/sites/default/files/docs/USTS-Full-Report-FINAL.PDF.

surgery."[77] The RAND study further notes that of those receiving phalloplasty surgery, as many as 25%—one in four—will have complications.[78]

The prevailing judgment of mental health practitioners is that gender dysphoria can be treated with the transition-related care described above. While there are numerous studies of varying quality showing that this treatment can improve health outcomes for individuals with gender dysphoria, the available scientific evidence on the extent to which such treatments fully remedy all of the issues associated with gender dysphoria is unclear. Nor do any of these studies account for the added stress of military life, deployments, and combat.

As recently as August 2016, the Centers for Medicare and Medicaid Services (CMS) conducted a comprehensive review of the relevant literature, over 500 articles, studies, and reports, to determine if there was "sufficient evidence to conclude that gender reassignment surgery improves health outcomes for Medicare beneficiaries with gender dysphoria."[79] After reviewing the universe of literature regarding sex reassignment surgery, CMS identified 33 studies sufficiently rigorous to merit further review, and of those, "some were positive; others were negative."[80] "Overall," according to CMS, "the quality and strength of evidence were low due to mostly observational study designs with no comparison groups, subjective endpoints, potential confounding . . . , small sample sizes, lack of validated assessment tools, and considerable [number of study subjects] lost to follow-up."[81] With respect to whether sex reassignment surgery was "reasonable and necessary" for the treatment of gender dysphoria, CMS concluded that there was "not enough high quality evidence to determine whether gender reassignment surgery improves health outcomes for Medicare beneficiaries with gender dysphoria and whether patients most likely to benefit from these types of surgical intervention can be identified prospectively."[82]

Importantly, CMS identified only six studies as potentially providing "useful information" on the effectiveness of sex reassignment surgery. According to CRS, "the four best designed and conducted studies that assessed the quality of life before and after surgery using validated (albeit, non-specific) psychometric studies did not demonstrate clinically significant changes or differences in psychometric test results after [sex reassignment surgery]."[83]

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[77] RAND Study at 40-41.
[78] Id. at 41.
[79] Tamara Jensen, Joseph Chin, James Rollins, Elizabeth Koller, Linda Gousis & Katherine Szarama, "Final Decision Memorandum on Gender Reassignment Surgery for Medicare Beneficiaries with Gender Dysphoria," Centers for Medicare & Medicaid Services, p. 9 (Aug. 30, 2016) ("CMS Report").
[80] Id. at 62.
[81] Id.
[82] Id. at 65. CMS did not conclude that gender reassignment surgery can never be necessary and reasonable to treat gender dysphoria. To the contrary, it made clear that Medicare insurers could make their own "determination of whether or not to cover gender reassignment surgery based on whether gender reassignment surgery is reasonable and necessary for the individual beneficiary after considering the individual's specific circumstances." Id. at 66. Nevertheless, CMS did decline to require all Medicare insurers to cover sex reassignment surgeries because it found insufficient scientific evidence to conclude that such surgeries improve health outcomes for persons with gender dysphoria.
[83] Id. at 62.

Additional studies found that the "cumulative rates of requests for surgical reassignment reversal or change in legal status" were between 2.2% and 3.3%.[84]

A sixth study, which came out of Sweden, is one of the most robust because it is a "nationwide population-based, long-term follow-up of sex-reassigned transsexual persons."[85] The study found increased mortality and psychiatric hospitalization for patients who had undergone sex reassignment surgery as compared to a healthy control group.[86] As described by CMS: "The mortality was primarily due to completed suicides (19.1-fold greater than in [the control group]), but death due to neoplasm and cardiovascular disease was increased 2 to 2.5 times as well. We note, mortality from this patient population did not become apparent until after 10 years. The risk for psychiatric hospitalization was 2.8 times greater than in controls even after adjustment for prior psychiatric disease (18%). The risk for attempted suicide was greater in male-to-female patients regardless of the gender of the control."[87]

According to the Hayes Directory, which conducted a review of 19 peer-reviewed studies on sex reassignment surgery, the "evidence suggests positive benefits," including "decreased [gender dysphoria], depression and anxiety, and increased [quality of life]," but "because of serious limitations," these findings "permit only weak conclusions."[88] It rated the quality of evidence as "very low" due to the numerous limitations in the studies and concluded that there is

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[84] Id.

[85] Cecilia Dhejne, Paul Lichtenstein, Marcus Boman, Anna L. Johansson, Niklas Långström & Mikael Landén, "Long-Term Follow-Up of Transsexual Persons Undergoing Sex Reassignment Surgery: Cohort Study in Sweden," *PLoS One*, Vol. 6, p. 6 (Feb. 2011); see also id. ("Strengths of this study include nationwide representativity over more than 30 years, extensive follow-up time, and minimal loss to follow-up. . . . Finally, whereas previous studies either lack a control group or use standardised mortality rates or standarised incidence rates as comparisons, we selected random population controls matched by birth year, and either birth or final sex.").

[86] Id. at 7; see also at 6 ("Mortality from suicide was strikingly high among sex-reassigned persons, also after adjustment for prior psychiatric morbidity. In line with this, sex-reassigned persons were at increased risk for suicide attempts. Previous reports suggest that transsexualism is a strong risk factor for suicide, also after sex reassignment, and our long-term findings support the need for continued psychiatric follow-up for persons at risk to prevent this. Inpatient care for psychiatric disorders was significantly more common among sex-reassigned persons than among matched controls, both before and after sex reassignment. It is generally accepted that transsexuals have more psychiatric ill-health than the general population prior to the sex reassignment. It should therefore come as no surprise that studies have found high rates of depression, and low quality of life, also after sex reassignment. Notably, however, in this study the increased risk for psychiatric hospitalization persisted even after adjusting for psychiatric hospitalization prior to sex reassignment. This suggests that even though sex reassignment alleviates gender dysphoria, there is a need to identify and treat co-occurring psychiatric morbidity in transsexual persons not only before but also after sex reassignment.").

[87] CMS Report at 62. It bears noting that the outcomes for mortality and suicide attempts differed "depending on when sex reassignment was performed: during the period 1973-1988 or 1989-2003." Cecilia Dhejne, Paul Lichtenstein, Marcus Boman, Anna L. Johansson, Niklas Långström & Mikael Landén, "Long-Term Follow-Up of Transsexual Persons Undergoing Sex Reassignment Surgery: Cohort Study in Sweden," *PLoS One*, Vol. 6, p. 5 (Feb. 2011). Even though both mortality and suicide attempts were greater for transsexual persons than the healthy control group across both time periods, this did not reach statistical significance during the 1989-2003 period. One possible explanation is that mortality rates for transsexual persons did not begin to diverge from the healthy control group until after 10 years of follow-up, in which case the expected increase in mortality would not have been observed for most of the persons receiving sex reassignment surgeries from 1989-2003. Another possible explanation is that treatment was of a higher quality from 1989-2003 than from 1973-1988.

[88] Hayes Directory, "Sex Reassignment Surgery for the Treatment of Gender Dysphoria," p. 4 (May 15, 2014).

not sufficient "evidence to establish patient selection criteria for [sex reassignment surgery] to treat [gender dysphoria]."[89]

With respect to hormone therapy, the Hayes Directory examined 10 peer-reviewed studies and concluded that a "substantial number of studies of cross-sex hormone therapy each show some positive findings suggesting improvement in well-being after cross-sex hormone therapy."[90] Yet again, it rated the quality of evidence as "very low" and found that the "evidence is insufficient to support patient selection criteria for hormone therapy to treat [gender dysphoria]."[91] Importantly, the Hayes Directory also found: "Hormone therapy and subsequent [sex reassignment surgery] failed to bring overall mortality, suicide rates, or death from illicit drug use in [male-to-female] patients close to rates observed in the general male population. It is possible that mortality is nevertheless reduced by these treatments, but that cannot be determined from the available evidence."[92]

In 2010, Mayo Clinic researchers conducted a comprehensive review of 28 studies on the use of cross-sex hormone therapy in sex reassignment and concluded that there was "very low quality evidence" showing that such therapy "likely improves gender dysphoria, psychological functioning and comorbidities, sexual function and overall quality of life."[93] Not all of the studies showed positive results, but overall, after pooling the data from all of the studies, the researchers showed that 80% of patients reported improvement in gender dysphoria, 78% reported improvement in psychological symptoms, and 80% reported improvement in quality of life, after receiving hormone therapy.[94] Importantly, however, "[s]uicide attempt rates decreased after sex reassignment but stayed higher than the normal population rate."[95]

The authors of the Swedish study discussed above reached similar conclusions: "This study found substantially higher rates of overall mortality, death from cardiovascular disease and suicide, suicide attempts, and psychiatric hospitali[z]ations in sex-reassigned transsexual individuals compared to a healthy control population. This highlights that post[-]surgical transsexuals are a risk group that need long-term psychiatric and somatic follow-up. Even though surgery and hormonal therapy alleviates gender dysphoria, it is apparently not sufficient to remedy the high rates of morbidity and mortality found among transsexual persons."[96]

Even the RAND study, which the Carter policy is based upon, confirmed that "[t]here have been no randomized controlled trials of the effectiveness of various forms of treatment, and

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[89] Id. at 3.
[90] Hayes Directory, "Hormone Therapy for the Treatment of Gender Dysphoria," pp. 2, 4 (May 19, 2014).
[91] Id. at 4.
[92] Id. at 3.
[93] Mohammad Hassan Murad, Mohamed B. Elamin, Magaly Zumaeta Garcia, Rebecca J. Mullan, Ayman Murad, Patricia J. Erwin & Victor M. Montori, "Hormonal therapy and sex reassignment: a systematic review and meta-analysis of qualify of life and psychosocial outcomes," *Clinical Endocrinology*, Vol. 72, p. 214 (2010).
[94] Id. at 216.
[95] Id.
[96] Ceclilia Dhejne, Paul Lichtenstein, Marcus Boman, Anna L. Johansson, Niklas Långström & Mikael Landén, "Long-Term Follow-Up of Transsexual Persons Undergoing Sex Reassignment Surgery: Cohort Study in Sweden," *PLoS One*, Vol. 6, pp. 1-8 (Feb. 2011).

most evidence comes from retrospective studies."[97] Although noting that "[m]ultiple observational studies have suggested significant and sometimes dramatic reductions in suicidality, suicide attempts, and suicides among transgender patients after receiving transition-related treatment," RAND made clear that "none of these studies were randomized controlled trials (the gold standard for determining treatment efficacy)."[98] "In the absence of quality randomized trial evidence," RAND concluded, "it is difficult to fully assess the outcomes of treatment for [gender dysphoria]."[99]

Given the scientific uncertainty surrounding the efficacy of transition-related treatments for gender dysphoria, it is imperative that the Department proceed cautiously in setting accession and retention standards for persons with a diagnosis or history of gender dysphoria.

B. Physical Health Standards

Not only is maintaining high standards of mental health critical to military effectiveness and lethality, maintaining high standards of physical health is as well. Although technology has done much to ease the physical demands of combat in some military specialties, war very much remains a physically demanding endeavor. Service members must therefore be physically prepared to endure the rigors and hardships of military service, including potentially combat. They must be able to carry heavy equipment sometimes over long distances; they must be able to handle heavy machinery; they must be able to traverse harsh terrain or survive in ocean waters; they must be able to withstand oppressive heat, bitter cold, rain, sleet, and snow; they must be able to endure in unsanitary conditions, coupled with lack of privacy for basic bodily functions, sometimes with little sleep and sustenance; they must be able to carry their wounded comrades to safety; and they must be able to defend themselves against those who wish to kill them.

Above all, whether they serve on the frontlines or in relative safety in non-combat positions, every Service member is important to mission accomplishment and must be available to perform their duties globally whenever called upon. The loss of personnel due to illness, disease, injury, or bad health diminishes military effectiveness and lethality. The Department's physical health standards are therefore designed to minimize the odds that any given Service member will be unable to perform his or her duties in the future because of illness, disease, or injury. As noted earlier, those who seek to enter military service must be free of contagious diseases; free of medical conditions or physical defects that could require treatment, hospitalization, or eventual separation from service for medical unfitness; medically capable of satisfactorily completing required training; medically adaptable to the military environment; and medically capable of performing duties without aggravation of existing physical defects or medical conditions.[100] To access recruits with higher rates of anticipated unavailability for deployment thrusts a heavier burden on those who would deploy more often.

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[97] RAND Study at 7.
[98] Id. at 10 (citing only to a California Department of Insurance report).
[99] Id.
[100] DoDI 6130.03 at 2.

Historically, absent a waiver, the Department has barred from accessing into the military anyone who had undergone chest or genital surgery (e.g., removal of the testicles or uterus) and anyone with a history of major abnormalities or defects of the chest or genitalia, including hermaphroditism and pseudohermaphroditism.[101] Persons with conditions requiring medications, such as anti-depressants and hormone treatment, were also disqualified from service, unless a waiver was granted.[102]

These standards have long applied uniformly to all persons, regardless of transgender status. The Carter policy, however, deviates from these uniform standards by exempting, under certain conditions, treatments associated with gender transition, such as sex reassignment surgery and cross-sex hormone therapy. For example, under the Carter policy, an applicant who has received genital reconstruction surgery may access without a waiver if a period of 18 months has elapsed since the date of the most recent surgery, no functional limitations or complications persist, and no additional surgery is required. In contrast, an applicant who received similar surgery following a traumatic injury is disqualified from military service without a waiver.[103] Similarly, under the Carter policy, an applicant who is presently receiving cross-sex hormone therapy post-gender transition may access without a waiver if the applicant has been stable on such hormones for 18 months. In contrast, an applicant taking synthetic hormones for the treatment of hypothyroidism is disqualified from military service without a waiver.[104]

C. Sex-Based Standards

Women have made invaluable contributions to the defense of the Nation throughout our history. These contributions have only grown more significant as the number of women in the Armed Forces has increased and as their roles have expanded. Today, women account for 17.6% of the force,[105] and now every position, including combat arms positions, is open to them.

The vast majority of military standards make no distinctions between men and women. Where biological differences between males and females are relevant, however, military standards do differentiate between them. The Supreme Court has acknowledged the lawfulness of sex-based standards that flow from legitimate biological differences between the sexes.[106] These sex-based standards ensure fairness, equity, and safety; satisfy reasonable expectations of privacy; reflect common practice in society; and promote core military values of dignity and respect between men and women—all of which promote good order, discipline, steady leadership, unit cohesion, and ultimately military effectiveness and lethality.

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[101] Id. at 25-27.
[102] Id. at 46-48.
[103] Id. at 26-27.
[104] Id. at 41.
[105] Defense Manpower Data Center, Active and Reserve Master Files (Dec. 2017).
[106] For example, in *United States v. Virginia*, the Court noted approvingly that "[a]dmitting women to [the Virginia Military Institute] would undoubtedly require alterations necessary to afford members of each sex privacy from the other sex in living arrangements, and to adjust aspects of the physical training programs." 518 U.S. 515, 550-51 n.19 (1996) (citing the statute that requires the same standards for women admitted to the service academies as for the men, "except for those minimum essential adjustments in such standards required because of physiological differences between male and female individuals").

For example, anatomical differences between males and females, and the reasonable expectations of privacy that flow from those differences, at least partly account for the laws and regulations that require separate berthing, bathroom, and shower facilities and different drug testing procedures for males and females.[107] To maintain good order and discipline, Congress has even required by statute that the sleeping and latrine areas provided for "male" recruits be physically separated from the sleeping and latrine areas provided for "female" recruits during basic training and that access by drill sergeants and training personnel "after the end of the training day" be limited to persons of the "same sex as the recruits" to ensure "after-hours privacy for recruits during basic training."[108]

In addition, physiological differences between males and females account for the different physical fitness and body fat standards that apply to men and women.[109] This ensures equity and fairness. Likewise, those same physiological differences also account for the policies that regulate competition between men and women in military training and sports, such as boxing and combatives.[110] This ensures protection from injury.

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[107] See, e.g., Department of the Army, Training and Doctrine Command, TRADOC Regulation 350-6, "Enlisted Initial Entry Training Policies and Administration," p. 56 (Mar. 20, 2017); Department of the Air Force, Air Force Instruction 32-6005, "Unaccompanied Housing Management," p. 35 (Jan 29., 2016); Department of the Army, Human Resources Command, AR 600-85, "Substance Abuse Program" (Dec. 28, 2012) ("Observers must . . . [b]e the same gender as the Soldier being observed.").

[108] See 10 U.S.C. § 4319 (Army), 10 U.S.C. § 6931 (Navy), and 10 U.S.C. § 9319 (Air Force) (requiring the sleeping and latrine areas provided for "male" recruits to be physically separated from the sleeping and latrine areas provided for "female" recruits during basic training); 10 U.S.C. § 4320 (Army), 10 U.S.C. § 6932 (Navy), and 10 U.S.C. § 9320 (Air Force) (requiring that access by drill sergeants and training personnel "after the end of the training day" be limited to persons of the "same sex as the recruits").

[109] See, e.g., Department of the Army, Army Regulation 600-9, "The Army Body Composition Program," pp. 21-31 (June 28, 2013); Department of the Navy, Office of the Chief of Naval Operations Instruction 6110.1J, "Physical Readiness Program," p. 7 (July 11, 2011); Department of the Air Force, Air Force Instruction 36-2905, "Fitness Program," pp. 86-95, 106-146 (Aug. 27, 2015); Department of the Navy, Marine Corps Order 6100.13, "Marine Corps Physical Fitness Program," (Aug. 1, 2008); Department of the Navy, Marine Corps Order 6110.3A, "Marine Corps Body Composition and Military Appearance Program," (Dec. 15, 2016); see also United States Military Academy, Office of the Commandant of Cadets, "Physical Program Whitebook AY 16-17," p. 13 (specifying that, to graduate, cadets must meet the minimum performance standard of 3:30 for men and 5:29 for women on the Indoor Obstacle Course Test); Department of the Army, Training and Doctrine Command, TRADOC Regulation 350-6, "Enlisted Initial Entry Training Policies and Administration," p. 56 (Mar. 20, 2017) ("Performance requirement differences, such as [Army Physical Fitness Test] scoring are based on physiological differences, and apply to the entire Army.").

[110] See, e.g., Headquarters, Department of the Army, TC 3-25.150, "Combatives," p. A-15 (Feb. 2017) ("Due to the physiological difference between the sexes and in order to treat all Soldiers fairly and conduct gender-neutral competitions, female competitors will be given a 15 percent overage at weigh-in."); id. ("In championships at battalion-level and above, competitors are divided into eight weight class brackets. . . . These classes take into account weight and gender."); Major Alex Bedard, Major Robert Peterson & Ray Barone, "Punching Through Barriers: Female Cadets Integrated into Mandatory Boxing at West Point," *Association of the United States Army* (Nov. 16, 2017), https://www.ausa.org/articles/punching-through-barriers-female-cadets-boxing-west-point (noting that "[m]atching men and women according to weight may not adequately account for gender differences regarding striking force" and that "[w]hile conducting free sparring, cadets must box someone of the same gender"); RAND Study at 57 (noting that, under British military policy, transgender persons "can be excluded from sports that organize around gender to ensure the safety of the individual or other participants"); see also International Olympic Committee Consensus Meeting on Sex Reassignment and Hyperandrogensim (Nov. 2015), https://stillmed.olympic.org/Documents/Commissions_PDFfiles/Medical_commission/2015-11_ioc_

Uniform and grooming standards, to a certain extent, are also based on anatomical differences between males and females. Even those uniform and grooming standards that are not, strictly speaking, based on physical biology nevertheless flow from longstanding societal expectations regarding differences in attire and grooming for men and women.[111]

Because these sex-based standards are based on legitimate biological differences between males and females, it follows that a person's physical biology should dictate which standards apply. Standards designed for biological males logically apply to biological males, not biological females, and vice versa. When relevant, military practice has long adhered to this straightforward and logical demarcation.

By contrast, the Carter policy deviates from this longstanding practice by making military sex-based standards contingent, not necessarily on the person's biological sex, but on the person's gender marker in DEERS, which can be changed to reflect the person's gender identity.[112] Thus, under the Carter policy, a biological male who identifies as a female (and changes his gender marker to reflect that gender) must be held to the standards and regulations for females, even though those standards and regulations are based on female physical biology, not female gender identity. The same goes for females who identify as males. Gender identity alone, however, is irrelevant to standards that are designed on the basis of biological differences.

Rather than apply only to those transgender individuals who have altered their external biological characteristics to fully match that of their preferred gender, under the Carter policy, persons need not undergo sex reassignment surgery, or even cross-sex hormone therapy, in order to be recognized as, and thus subject to the standards associated with, their preferred gender. A male who identifies as female could remain a biological male in every respect and still must be treated in all respects as a female, including with respect to physical fitness, facilities, and uniform and grooming. This scenario is not farfetched. According to the APA, not "all individuals with gender dysphoria desire a complete gender reassignment. . . . Some are satisfied with no medical or surgical treatment but prefer to dress as the felt gender in public."[113] Currently, of the 424 approved Service member treatment plans, at least 36 do not include cross-

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consensus_meeting_on_sex_reassignment_and_hyperandrogenism-en.pdf; NCAA Office of Inclusion; NCAA Inclusion of Transgender Student-Athletes (Aug. 2011), https://www.ncaa.org/sites/default/files/Transgender_Handbook_2011_Final.pdf.

[111] "The difference between men's and women's grooming policies recognizes the difference between the sexes; sideburns for men, different hairstyles and cosmetics for women. Establishing identical grooming and personal appearance standards for men and women would not be in the Navy's best interest and is not a factor in the assurance of equal opportunity." Department of the Navy, Navy Personnel Command, Navy Personnel Instruction 156651, "Uniform Regulations," Art. 2101.1 (July 7, 2017); see also Department of the Army, Army Regulation 670-1, "Wear and Appearance of Army Uniforms and Insignia," pp. 4-16 (Mar. 31, 2014); Department of the Air Force, Air Force Instruction 26-2903, "Dress and Personal Appearance of Air Force Personnel," pp. 17-27 (Feb. 9, 2017); Department of the Navy, Marine Corps Order P1020.34G, "Marine Corps Uniform Regulations," pp. 1-9 (Mar. 31, 2003).

[112] Department of Defense Instruction 1300.28, *In-service Transition for Service Members Identifying as Transgender*, pp. 3-4 (June 30, 2016).

[113] American Psychiatric Association, "Expert Q & A: Gender Dysphoria," available at https://www.psychiatry.org/patients-families/gender-dysphoria/expert-qa (last visited Feb. 14, 2018).

sex hormone therapy or sex reassignment surgery.[114] And it is questionable how many Service members will obtain any type of sex reassignment surgery. According to a survey of transgender persons, only 25% reported having had some form of transition-related surgery.[115]

The variability and fluidity of gender transition undermine the legitimate purposes that justify different biologically-based, male-female standards. For example, by allowing a biological male who retains male anatomy to use female berthing, bathroom, and shower facilities, it undermines the reasonable expectations of privacy and dignity of female Service members. By allowing a biological male to meet the female physical fitness and body fat standards and to compete against females in gender-specific physical training and athletic competition, it undermines fairness (or perceptions of fairness) because males competing as females will likely score higher on the female test than on the male test and possibly compromise safety. By allowing a biological male to adhere to female uniform and grooming standards, it creates unfairness for other males who would also like to be exempted from male uniform and grooming standards as a means of expressing their own sense of identity.

These problems could perhaps be alleviated if a person's preferred gender were recognized only after the person underwent a biological transition. The concept of gender transition is so nebulous, however, that drawing any line—except perhaps at a full sex reassignment surgery—would be arbitrary, not to mention at odds with current medical practice, which allows for a wide range of individualized treatment. In any event, rates for genital surgery are exceedingly low—2% of transgender men and 10% of transgender women.[116] Only up to 25% of surveyed transgender persons report having had some form of transition-related surgery.[117] The RAND study estimated that such rates "are typically only around 20 percent, with the exception of chest surgery among female-to-male transgender individuals."[118] Moreover, of the 424 approved Service member treatment plans available for study, 388 included cross-sex hormone treatment, but only 34 non-genital sex reassignment surgeries and one genital surgery have been completed thus far. Only 22 Service members have requested a waiver for a genital sex reassignment surgery.[119]

Low rates of full sex reassignment surgery and the otherwise wide variation of transition-related treatment, with all the challenges that entails for privacy, fairness, and safety, weigh in favor of maintaining a bright line based on biological sex—not gender identity or some variation thereof—in determining which sex-based standards apply to a given Service member. After all, a person's biological sex is generally ascertainable through objective means. Moreover, this approach will ensure that biologically-based standards will be applied uniformly to all Service members of the same biological sex. Standards that are clear, coherent, objective, consistent, predictable, and uniformly applied enhance good order, discipline, steady leadership, and unit cohesion, which in turn, ensure military effectiveness and lethality.

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[114] Data reported by the Departments of the Army, Navy, and Air Force (Oct. 2017).
[115] Id.
[116] Sandy E. James, Jody L. Herman, Susan Rankin, Mara Keisling, Lisa Mottet & Ma'ayan Anafi, *The Report of the 2015 U.S. Transgender Survey*, pp. 100-103 (National Center for Transgender Equality 2016) available at https://www.transequality.org/sites/default/files/docs/USTS-Full-Report-FINAL.PDF.
[117] Id. at 100.
[118] RAND Study at 21.
[119] Defense Health Agency, Supplemental Health Care Program Data (Feb. 2018).

New Transgender Policy

In light of the forgoing standards, all of which are necessary for military effectiveness and lethality, as well as the recommendations of the Panel of Experts, the Department, in consultation with the Department of Homeland Security, recommends the following policy:

A. Transgender Persons Without a History or Diagnosis of Gender Dysphoria, Who Are Otherwise Qualified for Service, May Serve, Like All Other Service Members, in Their Biological Sex.

Transgender persons who have not transitioned to another gender and do not have a history or current diagnosis of gender dysphoria—i.e., they identify as a gender other than their biological sex but do not currently experience distress or impairment of functioning in meeting the standards associated with their biological sex—are eligible for service, provided that they, like all other persons, satisfy all mental and physical health standards and are capable of adhering to the standards associated with their biological sex. This is consistent with the Carter policy, under which a transgender person's gender identity is recognized only if the person has a diagnosis or history of gender dysphoria.

Although the precise number is unknown, the Department recognizes that many transgender persons could be disqualified under this policy. And many transgender persons who would not be disqualified may nevertheless be unwilling to adhere to the standards associated with their biological sex. But many have served, and are serving, with great dedication under the standards for their biological sex. As noted earlier, 8,980 Service members reportedly identify as transgender, and yet there are currently only 937 active duty Service members who have been diagnosed with gender dysphoria since June 30, 2016.

B. Transgender Persons Who Require or Have Undergone Gender Transition Are Disqualified.

Except for those who are exempt under this policy, as described below in C.3, and except where waivers or exceptions to policy are otherwise authorized, persons who are diagnosed with gender dysphoria, either before or after entry into service, and require transition-related treatment, or have already transitioned to their preferred gender, should be disqualified from service. In the Department's military judgment, this is a necessary departure from the Carter policy for the following reasons:

1. *Undermines Readiness.* While transition-related treatments, including real life experience, cross-sex hormone therapy, and sex reassignment surgery, are widely accepted forms of treatment, there is considerable scientific uncertainty concerning whether these treatments fully remedy, even if they may reduce, the mental health problems associated with gender dysphoria. Despite whatever improvements in condition may result from these treatments, there is evidence that rates of psychiatric hospitalization and suicide behavior remain higher for persons with gender dysphoria, even after treatment, as compared to persons without gender dysphoria.[120] The persistence of these problems is a risk for readiness.

[120] See *supra* at pp. 24-26.

Another readiness risk is the time required for transition-related treatment and the impact on deployability. Although limited and incomplete because many transitioning Service members either began treatment before the Carter policy took effect or did not require sex reassignment surgery, currently available in-service data already show that, cumulatively, transitioning Service members in the Army and Air Force have averaged 167 and 159 days of limited duty, respectively, over a one-year period.[121]

Transition-related treatment that involves cross-sex hormone therapy or sex reassignment surgery could render Service members with gender dysphoria non-deployable for a significant period of time—perhaps even a year—if the theater of operations cannot support the treatment. For example, Endocrine Society guidelines for cross-sex hormone therapy recommend quarterly bloodwork and laboratory monitoring of hormone levels during the first year of treatment.[122] Of the 424 approved Service member treatment plans available for study, almost all of them—91.5%—include the prescription of cross-sex hormones.[123] The period of potential non-deployability increases for those who undergo sex reassignment surgery. As described earlier, the recovery time for the various sex reassignment procedures is substantial. For non-genital surgeries (assuming no complications), the range of recovery is between two and eight weeks depending on the type of surgery, and for genital surgeries (again assuming no complications), the range is between three and six months before the individual is able to return to full duty.[124] When combined with 12 continuous months of hormone therapy, which is recommended prior to genital surgery,[125] the total time necessary for sex reassignment surgery could exceed a year. If the operational environment does not permit access to a lab for monitoring hormones (and there is certainly debate over how common this would be), then the Service member must be prepared to forego treatment, monitoring, or the deployment. Either outcome carries risks for readiness.

Given the limited data, however, it is difficult to predict with any precision the impact on readiness of allowing gender transition. Moreover, the input received by the Panel of Experts varied considerably. On one hand, some commanders with transgender Service members

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[121] Data reported by the Departments of the Army and Air Force (Oct. 2017).

[122] Wylie C. Hembree, Peggy Cohen-Kettenis, Lous Gooren, Sabine Hannema, Walter Meyer, M. Hassan Murad, Stephen Rosenthal, Joshua Safer, Vin Tangpricha, & Guy T'Sjoen, "Endocrine Treatment of Gender-Dysphoric/Gender Incongruent Persons: An Endocrine Society Clinical Practice Guideline," *The Journal of Clinical Endocrinology & Metabolism*, Vol. 102, pp. 3869-3903 (Nov. 2017).

[123] Data reported by the Departments of the Army, Navy, and Air Force (Oct. 2017). Although the RAND study observed that British troops who are undergoing hormone therapy are generally able to deploy if the "hormone dose is steady and there are no major side effects," it nevertheless acknowledged that "deployment to all areas may not be possible, depending on the needs associated with any medication (e.g., refrigeration)." RAND Study at 59.

[124] For example, assuming no complications, the recovery time for a hysterectomy is up to eight weeks; a mastectomy is up to six weeks; a phalloplasty is up to three months; a metoidioplasty is up to 8 weeks; an orchiectomy is up to 6 weeks; and a vaginoplasty is up to three months. See University of California, San Francisco, Center of Excellence for Transgender Health, "Guidelines for the Primary and Gender-Affirming Care of Transgender and Gender Nonbinary People," available at http://transhealth.ucsf.edu/trans?page=guidelines-home (last visited Feb. 16, 2018); see also Discussion with Dr. Loren Schechter, Visiting Clinical Professor of Surgery, University of Illinois at Chicago (Nov. 9, 2017).

[125] RAND Study at 80; see also id. at 7; Irene Folaron & Monica Lovasz, "Military Considerations in Transsexual Care of the Active Duty Member," *Military Medicine*, Vol. 181, p. 1184 (Oct. 2016) (noting that Endocrine Society criteria "require that the patient has been on continuous cross-sex hormones and has had continuous [real life experience] or psychotherapy for the past 12 months").

reported that, from the time of diagnosis to the completion of a transition plan, the transitioning Service members would be non-deployable for two to two-and-a-half years.[126] On the other hand, some commanders, as well as transgender Service members themselves, reported that transition-related treatment is not a burden on unit readiness and could be managed to avoid interfering with deployments, with one commander even reporting that a transgender Service member with gender dysphoria under his command elected to postpone surgery in order to deploy.[127] This conclusion was echoed by some experts in endocrinology who found no harm in stopping or adjusting hormone therapy treatment to accommodate deployment during the first year of hormone use.[128] Of course, postponing treatment, especially during a combat deployment, has risks of its own insofar as the treatment is necessary to mitigate the clinically significant distress and impairment of functioning caused by gender dysphoria. After all, "when Service members deploy and then do not meet medical deployment fitness standards, there is risk for inadequate treatment within the operational theater, personal risk due to potential inability to perform combat required skills, and the potential to be sent home from the deployment and render the deployed unit with less manpower."[129] In short, the periods of transition-related non-availability and the risks of deploying untreated Service members with gender dysphoria are uncertain, and that alone merits caution.

Moreover, most mental health conditions, as well as the medication used to treat them, limit Service members' ability to deploy. Any DSM-5 psychiatric disorder with residual symptoms, or medication side effects, which impair social or occupational performance, require a waiver for the Service member to deploy.[130] The same is true for mental health conditions that pose a substantial risk for deterioration or recurrence in the deployed environment.[131] In managing mental health conditions while deployed, providers must consider the risk of exacerbation if the individual were exposed to trauma or severe operational stress. These determinations are difficult to make in the absence of evidence on the impact of deployment on individuals with gender dysphoria.[132]

The RAND study acknowledges that the inclusion of individuals with gender dysphoria in the force will have a negative impact on readiness. According to RAND, foreign militaries that allow service by personnel with gender dysphoria have found that it is sometimes necessary to restrict the deployment of transitioning individuals, including those receiving hormone therapy and surgery, to austere environments where their healthcare needs cannot be met.[133] Nevertheless, RAND concluded that the impact on readiness would be minimal—e.g., 0.0015% of available deployable labor-years across the active and reserve components—because of the

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[126] Minutes, Transgender Review Panel (Oct. 13, 2017).
[127] Id.
[128] Minutes, Transgender Review Panel (Nov. 9, 2017).
[129] Institute for Defense Analyses, "Force Impact of Expanding the Recruitment of Individuals with Auditory Impairment," pp. 60-61 (Apr. 2016).
[130] Modification Thirteen to U.S. Central Command Individual Protection and Individual, Unit Deployment Policy, Tab A, p. 8 (Mar. 2017).
[131] Id.
[132] See generally Memorandum from the Assistant Secretary of Defense for Health Affairs, "Clinical Practice Guidance for Deployment-Limiting Mental Disorders and Psychotropic Medications," pp. 2-4 (Oct. 7, 2013).
[133] RAND Study at 40.

exceedingly small number of transgender Service members who would seek transition-related treatment.[134] Even then, RAND admitted that the information it cited "must be interpreted with caution" because "much of the current research on transgender prevalence and medical treatment rates relies on self-reported, nonrepresentative samples."[135] Nevertheless, by RAND's standard, the readiness impact of many medical conditions that the Department has determined to be disqualifying—from bipolar disorder to schizophrenia—would be minimal because they, too, exist only in relatively small numbers.[136] And yet that is no reason to allow persons with those conditions to serve.

The issue is not whether the military can absorb periods of non-deployability in a small population; rather, it is whether an individual with a particular condition can meet the standards for military duty and, if not, whether the condition can be remedied through treatment that renders the person non-deployable for as little time as possible. As the Department has noted before: "[W]here the operational requirements are growing faster than available resources," it is imperative that the force "be manned with Service members capable of meeting all mission demands. The Services require that every Service member contribute to full mission readiness, regardless of occupation. In other words, the Services require all Service members to be able to engage in core military tasks, including the ability to deploy rapidly, without impediment or encumbrance."[137] Moreover, the Department must be mindful that "an increase in the number of non-deployable military personnel places undue risk and personal burden on Service members qualified and eligible to deploy, and negatively impacts mission readiness."[138] Further, the Department must be attuned to the impact that high numbers of non-deployable military personnel places on families whose Service members deploy more often to backfill or compensate for non-deployable persons.

In sum, the available information indicates that there is inconclusive scientific evidence that the serious problems associated with gender dysphoria can be fully remedied through transition-related treatment and that, even if it could, most persons requiring transition-related treatment could be non-deployable for a potentially significant amount of time. By this metric, Service members with gender dysphoria who need transition-related care present a significant challenge for unit readiness.

2. *Incompatible with Sex-Based Standards.* As discussed in detail earlier, military personnel policy and practice has long maintained a clear line between men and women where their biological differences are relevant with respect to physical fitness and body fat standards; berthing, bathroom, and shower facilities; and uniform and grooming standards. This line promotes good order and discipline, steady leadership, unit cohesion, and ultimately military

[134] Id. at 42.
[135] Id. at 39.
[136] According to the National Institute of Mental Health, 2.8% of U.S. adults experienced bipolar disorder in the past year, and 4.4% have experienced the condition at some time in their lives. National Institute of Mental Health, "Bipolar Disorder" (Nov. 2017) https://www.nimh.nih.gov/health/statistics/bipolar-disorder.shtml. The prevalence of schizophrenia is less than 1%. National Institute of Mental Health, "Schizophrenia" (Nov. 2017) https://www.nimh.nih.gov/health/statistics/schizophrenia.shtml.
[137] Under Secretary of Defense for Personnel and Readiness, "Fiscal Year 2016 Report to Congress on the Review of Enlistment of Individuals with Disabilities in the Armed Forces," p. 9 (Apr. 2016).
[138] Id. at 10.

effectiveness and lethality because it ensures fairness, equity, and safety; satisfies reasonable expectations of privacy; reflects common practice in the society from which we recruit; and promotes core military values of dignity and respect between men and women. To exempt Service members from the uniform, biologically-based standards applicable to their biological sex on account of their gender identity would be incompatible with this line and undermine the objectives such standards are designed to serve.

First, a policy that permits a change of gender without requiring any biological changes risks creating unfairness, or perceptions thereof, that could adversely affect unit cohesion and good order and discipline. It could be perceived as discriminatory to apply different biologically-based standards to persons of the same biological sex based on gender identity, which is irrelevant to standards grounded in physical biology. For example, it unfairly discriminates against biological males who identify as male and are held to male standards to allow biological males who identify as female to be held to female standards, especially where the transgender female retains many of the biological characteristics and capabilities of a male. It is important to note here that the Carter policy does not require a transgender person to undergo any biological transition in order to be treated in all respects in accordance with the person's preferred gender. Therefore, a biological male who identifies as female could remain a biological male in every respect and still be governed by female standards. Not only would this result in perceived unfairness by biological males who identify as male, it would also result in perceived unfairness by biological females who identify as female. Biological females who may be required to compete against such transgender females in training and athletic competition would potentially be disadvantaged.[139] Even more importantly, in physically violent training and competition, such as boxing and combatives, pitting biological females against biological males who identify as female, and vice versa, could present a serious safety risk as well.[140]

This concern may seem trivial to those unfamiliar with military culture. But vigorous competition, especially physical competition, is central to the military life and is indispensable to the training and preparation of warriors. Nothing encapsulates this more poignantly than the words of General Douglas MacArthur when he was superintendent of the U.S. Military Academy and which are now engraved above the gymnasium at West Point: "Upon the fields of friendly

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[139] See *supra* note 109. Both the International Olympic Committee (IOC) and the National Collegiate Athletic Association (NCAA) have attempted to mitigate this problem in their policies regarding transgender athletes. For example, the IOC requires athletes who transition from male to female to demonstrate certain suppressed levels of testosterone to minimize any advantage in women's competition. Similarly, the NCAA prohibits an athlete who has transitioned from male to female from competing on a women's team without changing the team status to a mixed gender team. While similar policies could be employed by the Department, it is unrealistic to expect the Department to subject transgender Service members to routine hormone testing prior to biannual fitness testing, athletic competition, or training simply to mitigate real and perceived unfairness or potential safety concerns. See, e.g., International Olympic Committee Consensus Meeting on Sex Reassignment and Hyperandrogensim (Nov. 2015), https://stillmed.olympic.org/Documents/Commissions_PDFfiles/Medical_commission/2015-11_ioc_consensus_meeting_on_sex_reassignment_and_hyperandrogenism-en.pdf; NCAA Office of Inclusion, NCAA Inclusion of Transgender Student-Athletes (Aug. 2011), https://www.ncaa.org/sites/default/files/Transgender_Handbook_2011_Final.pdf.

[140] See *supra* note 109.

strife are sown the seeds that, upon other fields, on other days will bear the fruits of victory."[141] Especially in combat units and in training, including the Service academies, ROTC, and other commissioning sources, Service members are graded and judged in significant measure based upon their physical aptitude, which is only fitting given that combat remains a physical endeavor.

Second, a policy that accommodates gender transition without requiring full sex reassignment surgery could also erode reasonable expectations of privacy that are important in maintaining unit cohesion, as well as good order and discipline. Given the unique nature of military service, Service members of the same biological sex are often required to live in extremely close proximity to one another when sleeping, undressing, showering, and using the bathroom. Because of reasonable expectations of privacy, the military has long maintained separate berthing, bathroom, and shower facilities for men and women while in garrison. In the context of recruit training, this separation is even mandated by Congress.[142]

Allowing transgender persons who have not undergone a full sex reassignment, and thus retain at least some of the anatomy of their biological sex, to use the facilities of their identified gender would invade the expectations of privacy that the strict male-female demarcation in berthing, bathroom, and shower facilities is meant to serve. At the same time, requiring transgender persons who have developed, even if only partially, the anatomy of their identified gender to use the facilities of their biological sex could invade the privacy of the transgender person. Without separate facilities for transgender persons or other mitigating accommodations, which may be unpalatable to transgender individuals and logistically impracticable for the Department, the privacy interests of biological males and females and transgender persons could be anticipated to result in irreconcilable situations. Lieutenants, Sergeants, and Petty Officers charged with carrying out their units' assigned combat missions should not be burdened by a change in eligibility requirements disconnected from military life under austere conditions.

The best illustration of this irreconcilability is the report of one commander who was confronted with dueling equal opportunity complaints—one from a transgender female (i.e., a biological male with male genitalia who identified as female) and the other from biological females. The transgender female Service member was granted an exception to policy that allowed the Service member to live as a female, which included giving the Service member access to female shower facilities. This led to an equal opportunity complaint from biological females in the unit who believed that granting a biological male, even one who identified as a female, access to their showers violated their privacy. The transgender Service member responded with an equal opportunity complaint claiming that the command was not sufficiently supportive of the rights of transgender persons.[143]

The collision of interests discussed above are a direct threat to unit cohesion and will inevitably result in greater leadership challenges without clear solutions. Leaders at all levels

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[141] Douglas MacAruthur, *Respectfully Quoted: A Dictionary of Quotations* (1989), available at http://www.bartleby.com/73/1874.html.
[142] See *supra* note 108.
[143] Minutes, Transgender Review Panel (Oct. 13, 2017). Limited data exists regarding the performance of transgender Service members due to policy restrictions in Department of Defense 1300.28, *In-Service Transition for Transgender Service Members* (Oct. 1, 2016), that prevent the Department from tracking individuals who may identify as transgender as a potentially unwarranted invasion of personal privacy.

already face immense challenges in building cohesive military units. Blurring the line that differentiates the standards and policies applicable to men and women will only exacerbate those challenges and divert valuable time and energy from military tasks.

The unique leadership challenges arising from gender transition are evident in the Department's handbook implementing the Carter policy. The handbook provides guidance on various scenarios that commanders may face. One such scenario concerns the use of shower facilities: "A transgender Service member has expressed privacy concerns regarding the open bay shower configuration. Similarly, several other non-transgender Service members have expressed discomfort when showering in these facilities with individuals who have different genitalia." As possible solutions, the handbook offers that the commander could modify the shower facility to provide privacy or, if that is not feasible, adjust the timing of showers. Another scenario involves proper attire during a swim test: "It is the semi-annual swim test and a female to male transgender Service member who has fully transitioned, but did not undergo surgical change, would like to wear a male swimsuit for the test with no shirt or other top coverage." The extent of the handbook's guidance is to advise commanders that "[i]t is within [their] discretion to take measures ensuring good order and discipline," that they should "counsel the individual and address the unit, if additional options (e.g., requiring all personnel to wear shirts) are being considered," and that they should consult the Service Central Coordination Cell, a help line for commanders in need of advice.

These vignettes illustrate the significant effort required of commanders to solve challenging problems posed by the implementation of the current transgender service policies. The potential for discord in the unit during the routine execution of daily activities is substantial and highlights the fundamental incompatibility of the Department's legitimate military interest in uniformity, the privacy interests of all Service members, and the interest of transgender individuals in an appropriate accommodation. Faced with these conflicting interests, commanders are often forced to devote time and resources to resolve issues not present outside of military service. A failure to act quickly can degrade an otherwise highly functioning team, as will failing to seek appropriate counsel and implementing a faulty solution. The appearance of unsteady or seemingly unresponsive leadership to Service member concerns erodes the trust that is essential to unit cohesion and good order and discipline.

The RAND study does not meaningfully address how accommodations for gender transition would impact perceptions of fairness and equity, expectations of privacy, and safety during training and athletic competition and how these factors in turn affect unit cohesion. Instead, the RAND study largely dismisses concerns about the impact on unit cohesion by pointing to the experience of four countries that allow transgender service—Australia, Canada, Israel, and the United Kingdom.[144] Although the vast majority of armed forces around the world do not permit or have policies on transgender service, RAND noted that 18 militaries do, but only four have well-developed and publicly available policies.[145] RAND concluded that "the available research revealed no significant effect on cohesion, operational effectiveness, or

[144] RAND Study at 45.
[145] Id. at 50.

readiness."[146] It reached this conclusion, however, despite noting reports of resistance in the ranks, which is a strong indication of an adverse effect on unit cohesion.[147] Nevertheless, RAND acknowledged that the available data was "limited" and that the small number of transgender personnel may account for "the limited effect on operational readiness and cohesion."[148]

Perhaps more importantly, however, the RAND study mischaracterizes or overstates the reports upon which it rests its conclusions. For example, the RAND study cites *Gays in Foreign Militaries 2010: A Global Primer* by Nathaniel Frank as support for the conclusions that there is no evidence that transgender service has had an adverse effect on cohesion, operational effectiveness, or readiness in the militaries of Australia and the United Kingdom and that diversity has actually led to increases in readiness and performance.[149] But that particular study has nothing to do with examining the service of transgender persons; rather, it is about the integration of homosexual persons into the military.[150]

With respect to transgender service in the Israeli military, the RAND study points to an unpublished paper by Anne Speckhard and Reuven Paz entitled *Transgender Service in the Israeli Defense Forces: A Polar Opposite Stance to the U.S. Military Policy of Barring Transgender Soldiers from Service*. The RAND study cites this paper for the proposition that "there has been no reported effect on cohesion or readiness" in the Israeli military and "there is no evidence of any impact on operational effectiveness."[151] These sweeping and categorical claims, however, are based only on "six in-depth interviews of experts on the subject both inside and outside the [Israeli Defense Forces (IDF)]: two in the IDF leadership—including the spokesman's office; two transgender individuals who served in the IDF, and two professionals who serve transgender clientele—before, during and after their IDF service."[152] As the RAND report observed, however: "There do appear to be some limitations on the assignment of transgender personnel, particularly in combat units. Because of the austere living conditions in these types of units, necessary accommodations may not be available for Service members in the midst of a gender transition. As a result, transitioning individuals are typically not assigned to combat units."[153] In addition, as the RAND study notes, under the Israeli policy at the time, "assignment of housing, restrooms, and showers is typically linked to the birth gender, which does not change in the military system until after gender reassignment surgery."[154] Therefore, insofar as a Service member's change of gender is not recognized until after sex reassignment

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[146] Id. at 45.
[147] Id.
[148] Id.
[149] Id.
[150] Nathaniel Frank, "Gays in Foreign Militaries 2010: A Global Primer," p. 6 *The Palm Center* (Feb. 2010), https://www.palmcenter.org/wpcontent/uploads/2017/12/FOREIGNMILITARIESPRIMER2010FINAL.pdf ("This study seeks to answer some of the questions that have been, and will continue to be, raised surrounding the instructive lessons from other nations that have lifted their bans on openly gay service.").
[151] Rand Study at 45.
[152] Anne Speckhard & Reuven Paz, "Transgender Service in the Israeli Defense Forces: A Polar Opposite Stance to the U.S. Military Policy of Barring Transgender Soldiers from Service," p. 3 (2014), http://www.researchgate.net/publication/280093066.
[153] RAND Study at 56.
[154] Id. at 55.

surgery, the Israeli policy—and whatever claims about its impact on cohesion, readiness, and operational effectiveness—are distinguishable from the Carter policy.

Finally, the RAND study cites to a journal article on the Canadian military experience entitled *Gender Identity in the Canadian Forces: A Review of Possible Impacts on Operational Effectiveness* by Alan Okros and Denise Scott. According to RAND, the authors of this article "found no evidence of any effect on unit or overall cohesion."[155] But the article not only fails to support the RAND study's conclusions (not to mention the article's own conclusions), but it confirms the concerns that animate the Department's recommendations. The article acknowledges, for example, the difficulty commanders face in managing the competing interests at play:

> Commanders told us that the new policy fails to provide sufficient guidance as to how to weigh priorities among competing objectives during their subordinates' transition processes. Although they endorsed the need to consult transitioning Service members, they recognized that as commanding officers, they would be called on to balance competing requirements. They saw the primary challenge to involve meeting trans individual's expectations for reasonable accommodation and individual privacy while avoiding creating conditions that place extra burdens on others or undermined the overall team effectiveness. To do so, they said that they require additional guidance on a range of issues including clothing, communal showers, and shipboard bunking and messing arrangements.[156]

Notwithstanding its optimistic conclusions, the article also documents serious problems with unit cohesion. The authors observe, for instance, that the chain of command "has not fully earned the trust of the transgender personnel," and that even though some transgender Service members do trust the chain of command, others "expressed little confidence in the system," including one who said, "I just don't think it works that well."[157]

In sum, although the foregoing considerations are not susceptible to quantification, undermining the clear sex-differentiated lines with respect to physical fitness; berthing, bathroom, and shower facilities; and uniform and grooming standards, which have served all branches of Service well to date, risks unnecessarily adding to the challenges faced by leaders at all levels, potentially fraying unit cohesion, and threatening good order and discipline. The Department acknowledges that there are serious differences of opinion on this subject, even among military professionals, including among some who provided input to the Panel of Experts,[158] but given the vital interests at stake—the survivability of Service members, including

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[155] Id. at 45.
[156] Alan Okros & Denise Scott, "Gender Identity in the Canadian Forces," *Armed Forces and Society* Vol. 41, p. 8 (2014).
[157] Id. at 9.
[158] While differences of opinion do exist, it bears noting that, according to a Military Times/Syracuse University's Institute for Veterans and Military Families poll, 41% of active duty Service members polled thought that allowing gender transition would hurt their unit's readiness, and only 12% thought it would be beneficial. Overall, 57% had a negative opinion of the Carter policy. Leo Shane III, "Poll: Active-duty troops worry about military's transgender

transgender persons, in combat and the military effectiveness and lethality of our forces—it is prudent to proceed with caution, especially in light of the inconclusive scientific evidence that transition-related treatment restores persons with gender dysphoria to full mental health.

3. *Imposes Disproportionate Costs.* Transition-related treatment is also proving to be disproportionately costly on a per capita basis, especially in light of the absence of solid scientific support for the efficacy of such treatment. Since implementation of the Carter policy, the medical costs for Service members with gender dysphoria have increased nearly three times—or 300%—compared to Service members without gender dysphoria.[159] And this increase is despite the low number of costly sex reassignment surgeries that have been performed so far.[160] As noted earlier, only 34 non-genital sex reassignment surgeries and one genital surgery have been completed,[161] with an additional 22 Service members requesting a waiver for genital surgery.[162] We can expect the cost disparity to grow as more Service members diagnosed with gender dysphoria avail themselves of surgical treatment. As many as 77% of the 424 Service member treatment plans available for review include requests for transition-related surgery, although it remains to be seen how many will ultimately obtain surgeries.[163] In addition, several commanders reported to the Panel of Experts that transition-related treatment for Service members with gender dysphoria in their units had a negative budgetary impact because they had to use operations and maintenance funds to pay for the Service members' extensive travel throughout the United States to obtain specialized medical care.[164]

Taken together, the foregoing concerns demonstrate why recognizing and making accommodations for gender transition are not conducive to, and would likely undermine, the inputs—readiness, good order and discipline, sound leadership, and unit cohesion—that are essential to military effectiveness and lethality. Therefore, it is the Department's professional military judgment that persons who have been diagnosed with, or have a history of, gender dysphoria and require, or have already undergone, a gender transition generally should not be eligible for accession or retention in the Armed Forces absent a waiver.

C. Transgender Persons With a History or Diagnosis of Gender Dysphoria Are Disqualified, Except Under Certain Limited Circumstances.

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policies," *Military Times* (July 27, 2017) available at https://www.militarytimes.com/news/pentagon-congress/2017/07/27/poll-active-duty-troops-worry-about-militarys-transgender-policies/.

[159] Minutes, Transgender Review Panel (Nov. 2, 2017).

[160] Minutes, Transgender Review Panel (Nov. 2, 2017).

[161] Data retrieved from Military Health System Data Repository (Nov. 2017).

[162] Defense Health Agency Data (as of Feb. 2018).

[163] Data reported by the Departments of the Army, Navy, and Air Force (Oct. 2017).

[164] Minutes, Transgender Review Panel (Oct. 13, 2017); see also Irene Folaron & Monica Lovasz, "Military Considerations in Transsexual Care of the Active Duty Member," *Military Medicine*, Vol. 181, p. 1185 (Oct. 2016) ("As previously discussed, a new diagnosis of gender dysphoria and the decision to proceed with gender transition requires frequent evaluations by the [mental health professional] and endocrinologist. However, most [military treatment facilities] lack one or both of these specialty services. Members who are not in proximity to [military treatment facilities] may have significant commutes to reach their required specialty care. Members stationed in more remote locations face even greater challenges of gaining access to military or civilian specialists within a reasonable distance from their duty stations.").

As explained earlier in greater detail, persons with gender dysphoria experience significant distress and impairment in social, occupational, or other important areas of functioning. Gender dysphoria is also accompanied by extremely high rates of suicidal ideation and other comorbidities. Therefore, to ensure unit safety and mission readiness, which is essential to military effectiveness and lethality, persons who are diagnosed with, or have a history of, gender dysphoria are generally disqualified from accession or retention in the Armed Forces. The standards recommended here are subject to the same procedures for waiver as any other standards. This is consistent with the Department's handling of other mental conditions that require treatment. As a general matter, only in the limited circumstances described below should persons with a history or diagnosis of gender dysphoria be accessed or retained.

1. *Accession of Individuals Diagnosed with Gender Dysphoria*. Given the documented fluctuations in gender identity among children, a history of gender dysphoria should not alone disqualify an applicant seeking to access into the Armed Forces. According to the DSM-5, the persistence of gender dysphoria in biological male children "has ranged from 2.2% to 30%," and the persistence of gender dysphoria in biological female children "has ranged from 12% to 50%."[165] Accordingly, persons with a history of gender dysphoria may access into the Armed Forces, provided that they can demonstrate 36 consecutive months of stability—i.e., absence of gender dysphoria—immediately preceding their application; they have not transitioned to the opposite gender; and they are willing and able to adhere to all standards associated with their biological sex. The 36-month stability period is the same standard the Department currently applies to persons with a history of depressive disorder. The Carter policy's 18-month stability period for gender dysphoria, by contrast, has no analog with respect to any other mental condition listed in DoDI 6130.03.

2. *Retention of Service Members Diagnosed with Gender Dysphoria*. Retention standards are typically less stringent than accession standards due to training provided and on-the-job performance data. While accession standards endeavor to predict whether a given applicant will require treatment, hospitalization, or eventual separation from service for medical unfitness, and thus tend to be more cautious, retention standards focus squarely on whether the Service member, despite his or her condition, can continue to do the job. This reflects the Department's desire to retain, as far as possible, the Service members in which it has made substantial investments and to avoid the cost of finding and training a replacement. To use an example outside of the mental health context, high blood pressure does not meet accession standards, even if it can be managed with medication, but it can meet retention standards so long as it can be managed with medication. Regardless, however, once they have completed treatment, Service members must continue to meet the standards that apply to them in order to be retained. Therefore, Service members who are diagnosed with gender dysphoria after entering military service may be retained without waiver, provided that they are willing and able to adhere to all standards associated with their biological sex, the Service member does not require gender transition, and the Service member is not otherwise non-deployable for more than 12 months or for a period of time in excess of that established by Service policy (which may be less than 12 months).[166]

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[165] DSM-5 at 455.

[166] Under Secretary of Defense for Personnel and Readiness, "DoD Retention Policy for Non-Deployable Service Members" (Feb. 14, 2018).

3. *Exempting Current Service Members Who Have Already Received a Diagnosis of Gender Dysphoria*. The Department is mindful of the transgender Service members who were diagnosed with gender dysphoria and either entered or remained in service following the announcement of the Carter policy and the court orders requiring transgender accession and retention. The reasonable expectation of these Service members that the Department would honor their service on the terms that then existed cannot be dismissed. Therefore, transgender Service members who were diagnosed with gender dysphoria by a military medical provider after the effective date of the Carter policy, but before the effective date of any new policy, may continue to receive all medically necessary treatment, to change their gender marker in DEERS, and to serve in their preferred gender, even after the new policy commences. This includes transgender Service members who entered into military service after January 1, 2018, when the Carter accession policy took effect by court order. The Service member must, however, adhere to the procedures set forth in DoDI 1300.28, and may not be deemed to be non-deployable for more than 12 months or for a period of time in excess of that established by Service policy (which may be less than 12 months). While the Department believes that its commitment to these Service members, including the substantial investment it has made in them, outweigh the risks identified in this report, should its decision to exempt these Service members be used by a court as a basis for invalidating the entire policy, this exemption instead is and should be deemed severable from the rest of the policy.

Conclusion

In making these recommendations, the Department is well aware that military leadership from the prior administration, along with RAND, reached a different judgment on these issues. But as the forgoing analysis demonstrates, the realities associated with service by transgender individuals are more complicated than the prior administration or RAND had assumed. In fact, the RAND study itself repeatedly emphasized the lack of quality data on these issues and qualified its conclusions accordingly. In addition, that study concluded that allowing gender transition would impede readiness, limit deployability, and burden the military with additional costs. In its view, however, such harms were negligible in light of the small size of the transgender population. But especially in light of the various sources of uncertainty in this area, and informed by the data collected since the Carter policy took effect, the Department is not convinced that these risks could be responsibly dismissed or that even negligible harms should be incurred given the Department's grave responsibility to fight and win the Nation's wars in a manner that maximizes the effectiveness, lethality, and survivability of our most precious assets—our Soldiers, Sailors, Airmen, Marines, and Coast Guardsmen.

Accordingly, the Department weighed the risks associated with maintaining the Carter policy against the costs of adopting a new policy that was less risk-favoring in developing these recommendations. It is the Department's view that the various balances struck by the recommendations above provide the best solution currently available, especially in light of the significant uncertainty in this area. Although military leadership from the prior administration reached a different conclusion, the Department's professional military judgment is that the risks associated with maintaining the Carter policy—risks that are continuing to be better understood as new data become available—counsel in favor of the recommended approach.

DoD INSTRUCTION 6130.03, VOLUME 1

MEDICAL STANDARDS FOR MILITARY SERVICE: APPOINTMENT, ENLISTMENT, OR INDUCTION

Originating Component:	Office of the Under Secretary of Defense for Personnel and Readiness
Effective: **Change 5 Effective:**	May 6, 2018 May 28, 2024
Releasability:	Cleared for public release. Available on the Directives Division Website at https://www.esd.whs.mil/DD/.
Reissues and Cancels:	DoD Instruction 6130.03, "Medical Standards for Appointment, Enlistment, or Induction in the Military Services," April 28, 2010, as amended
Approved by:	Robert L. Wilkie, Under Secretary of Defense for Personnel and Readiness
Change 5 Approved by:	Ashish S. Vazirani, Performing the Duties of the Under Secretary of Defense for Personnel and Readiness

Purpose: This instruction is composed of two volumes, each containing its own purpose. In accordance with the authority in DoD Directive 5124.02:

- This instruction establishes policy, assigns responsibilities, and prescribes procedures for medical standards for the Military Services.
- This volume establishes physical and medical standards for appointment, enlistment, or induction into the Military Services.

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SECTION 1: GENERAL ISSUANCE INFORMATION

1.1. APPLICABILITY.

a. This volume applies to:

(1) OSD, the Military Departments (including the Coast Guard at all times, including when it is a Service in the Department of Homeland Security by agreement with that Department), the Office of the Chairman of the Joint Chiefs of Staff and the Joint Staff, the Combatant Commands, the Office of Inspector General of the Department of Defense, the Defense Agencies, the DoD Field Activities, and all other organizational entities within the DoD.

(2) The Reserve Components, which include the Army and the Air National Guards of the United States, in accordance with Title 10, United States Code (U.S.C.).

(3) The United States Merchant Marine Academy in accordance with Section 310.56 of Title 46, Code of Federal Regulations requiring the candidate to meet the physical requirements prescribed by the Department of the Navy for appointment as a midshipman in the United States Navy Reserve.

b. The entities in Paragraphs 1.1.a.(1) through 1.1.a.(3) are referred to collectively in this volume as the "DoD Components."

1.2. POLICY.

It is DoD policy to:

a. Use the guidance in this volume for appointment, enlistment, or induction of personnel into the Military Services.

b. Use common medical standards for appointment, enlistment, or induction of personnel into the Military Services.

c. Eliminate inconsistencies and inequities in the DoD Components, in accordance with DoD Instruction (DoDI) 1350.02, based on race, sex, gender identity, sexual orientation, or location of examination when applying these standards. The DoD Components will consider disqualification for pregnancy as temporary.

d. 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.

(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.

e. Allow applicants who do not meet the physical and medical standards in this volume to be considered for a medical waiver.

1.3. INFORMATION COLLECTIONS.

DD Form 2807-2, "Accessions Medical History Report"; DD Form 2808, "Report of Medical Examination"; or equivalent electronic templates and the supplemental health documents referred to in Paragraph 2.4.d.(2) of this volume have been assigned Office of Management and Budget control number 0704-0413 in accordance with the procedures in Volume 2 of DoD Manual 8910.01. The expiration date of this information collection is listed on the DoD Information Collections System at https://reginfo.gov/public.

1.4. SUMMARY OF CHANGE 5.

The changes to this volume standardize the purpose statement, update references, correct spelling errors, and delete a duplicative sentence.

SECTION 2: RESPONSIBILITIES

2.1. UNDER SECRETARY OF DEFENSE FOR PERSONNEL AND READINESS (USD(P&R)).

The USD(P&R):

a. Ensures that the standards in Sections 5 and 6 are implemented throughout the DoD Components.

b. Eliminates inconsistencies and inequities, in accordance with DoDI 1350.02, based on race, sex, gender identity, sexual orientation, or location of examination in DoD Component application of these standards.

c. Maintains and convenes the chartered Medical and Personnel Executive Steering Committee (MEDPERS).

d. Through the Assistant Secretary of Defense for Manpower and Reserve Affairs, the Deputy Assistant Secretary of Defense for Military Personnel Policy (DASD(MPP)) provides guidance to the United States Military Entrance Processing Command (USMEPCOM) to implement the standards in Sections 5 and 6 for all Services.

2.2. ASSISTANT SECRETARY OF DEFENSE FOR HEALTH AFFAIRS.

Under the authority, direction, and control of the USD(P&R), the Assistant Secretary of Defense for Health Affairs reviews, approves, and issues clarifying guidance regarding the standards in Sections 5 and 6.

2.3. DIRECTOR, DEFENSE HEALTH AGENCY.

Under the authority, direction, and control of the USD(P&R), through the Assistant Secretary of Defense for Health Affairs, the Director, Defense Health Agency:

a. In accordance with DoD Directive 5124.02, provides guidance to the DoD Medical Examination Review Board (DoDMERB) to implement the standards in Sections 5 and 6.

b. Coordinates with, and supports, the Secretary of the Navy with processing applicants seeking entry into the Military Services from Guam and the surrounding area.

2.4. SECRETARIES OF THE MILITARY DEPARTMENTS AND COMMANDANT, UNITED STATES COAST GUARD.

The Secretaries of the Military Departments and the Commandant, United States Coast Guard:

a. Direct their respective Military Services to apply and uniformly implement the standards contained in this volume.

b. Authorize the medical waiver of the standards in individual cases for applicable reasons and ensure uniform waiver determinations.

c. Ensure that accurate International Classification of Diseases codes are assigned to all medical conditions resulting in a personnel action, such as separation, waiver, or assignment limitation, and that such codes are included in all records of such actions.

d. Ensure that medical information for "Existed Prior to Service" discharges is provided to the USMEPCOM by Service training centers conducting basic military training. Medical information includes:

(1) A copy of the trainee's medical discharge summary and related medical documents.

(2) Copies of DD Forms 2807-2; 2807-1, "Report of Medical History"; and 2808 or equivalent electronic templates, including supplemental behavioral health screening documents.

(3) Consultation reports or other medical documentation used in the enlistment process and qualification decision.

e. Eliminate inconsistencies and inequities, in accordance with DoDI 1350.02, based on race, sex, gender identity, sexual orientation, or examination location in the application of these standards by the DoD Components and ensure all personally identifiable information is handled in accordance with DoDI 5400.11 and DoD 5400.11-R.

2.5. SECRETARY OF THE NAVY.

In addition to the responsibilities in Paragraph 2.4., the Secretary of the Navy directs the medical processing for applicants seeking entry into the Military Services from Guam and the surrounding area while applying and uniformly implementing the standards contained within this volume.

SECTION 3: MEDPERS

3.1. ORGANIZATION.

The MEDPERS convenes at least twice a year under the joint guidance of the DASD(MPP) and the Deputy Assistant Secretary of Defense for Health Services Policy and Oversight (DASD(HSP&O)) and in accordance with the MEDPERS charter.

3.2. AGENDA.

The MEDPERS:

a. Provides the Accession and Retention Medical Standards Working Group (ARMSWG) with guidance and oversight on setting standards for accession medical and physical processes.

b. Directs research and studies as necessary to produce evidence-based accession standards using the Medical Standards Analysis and Research.

c. Ensures medical and personnel community coordination when changing policies that affect each community and other relevant DoD Components.

SECTION 4: ARMSWG

4.1. PURPOSE.

The ARMSWG—a chartered working group under the MEDPERS—convenes at least quarterly, under the joint guidance of the DASD(HSP&O) and the DASD(MPP), to bring together representatives from the DoD medical and personnel community for the development, discussion, and recommendation of issues pertaining to military medical standards for accession, enlistment, and induction of personnel into military service, and retention in military service.

4.2. OVERALL GOALS.

The ARMSWG:

a. Provides guidance to Medical Standards Analytics and Research on accession- and retention-related operational analysis and research performed to support life-cycle medical standards.

b. Provides a forum for discussing interrelated personnel and medical issues related to accession and retention, such as:

(1) The operational capability of personnel to ensure the best physical and medical outcomes of the military force.

(2) Cost considerations to maintain a force of healthy Service members.

(3) Medical conditions that may interfere with the capability of personnel completing training and maintaining worldwide deployability.

c. Reviews, develops, and submits proposed updates to this volume and Volume 2 of this issuance to the USD(P&R).

d. Receives and responds to taskings from MEDPERS and makes recommendations to MEDPERS regarding accession and retention medical issues as appropriate.

e. Maintains records and minutes of ARMSWG meetings.

4.3. CO-CHAIRS.

The DASD(HSP&O) and the DASD(MPP) will each select one representative to co-chair the ARMSWG. The ARMSWG co-chairs will:

a. Draft the ARMSWG charter for MEDPERS approval.

b. Record and retain meeting minutes and other committee records.

c. Schedule meetings as required.

4.4. MEMBERSHIP.

The ARMSWG membership will include medical and personnel representatives from:

a. Each Military Service.

b. The Joint Staff.

c. Other organizations as required in accordance with the ARMSWG charter.

SECTION 5: MEDICAL STANDARDS FOR APPOINTMENT, ENLISTMENT, OR INDUCTION

5.1. APPLICABILITY.

a. The medical standards in this volume apply to applicants for appointment as commissioned or warrant officers or enlistment in any Military Service and Component, to include federally recognized units or organizations of the National Guard.

(1) For medical conditions or defects that predate the current enlistment or appointment and were not aggravated in the line of duty, these standards apply to enlistees during the first 6 months of the current period of active duty or during the applicant's initial period of active duty for training until their return to the Reserve Components.

(2) For medical conditions or defects that did not predate the current enlistment or appointment but occurred prior to the applicant shipping for the initial period of active duty for training.

(3) Applicants for re-accession in any Military Service and Component, including federally recognized units or organizations of the National Guard after a period of more than 12 months have elapsed since the date on their DD Form 214, "Certificate of Uniformed Service," or separation orders, as applicable. These applicants no longer have a status in any component of the military.

b. The medical standards in this volume do not apply to the following:

(1) For medical conditions or defects that predate the current enlistment and were aggravated in the line of duty refer to Volume 2.

(2) For medical conditions or defects that did not predate the current enlistment or appointment, but that occurred during the initial period of active duty refer to Volume 2.

(3) For Service members currently serving in the Individual Ready Reserves refer to Volume 2.

5.2. PROCEDURES.

a. Applicants for appointment, enlistment, or induction into the Military Services will:

(1) Fully disclose all medical history.

(2) Submit all medical documentation related to medical history as requested to the USMEPCOM and DoDMERB, including the names of their medical insurer and past medical providers.

(3) Provide authorization for the DoD Components to request and obtain their medical records.

(a) Authorize the DoD to request medical or behavioral health data from data holders (e.g. healthcare providers, clinics, hospitals, insurance companies, pharmacy benefit managers, pharmacies, health information exchanges, and Federal and State agencies) including the release of complete transcripts of health data to the DoD medical authority for the processing of their application for military service.

(b) Authorize holders of their health data to report to the DoD whether any data they hold or have held about them has been amended or restricted.

(4) Acknowledge that information provided constitutes an official statement, and that any persons making false statements could face fines, penalties, and imprisonments pursuant to Section 1001 of Title 18, U.S.C. If the applicant is selected for enlistment, appointment, or entrance into a formal military instruction program leading to an appointment commissioning program based on a false statement, the applicant can be tried by court-martial or meet an administrative board for discharge and could receive a less than honorable discharge.

(5) Acknowledge that any cadet or midshipman, whether contracted or noncontracted, who has a change in medical status that is related to a standard in this regulation, understands that the change may disqualify them and that they will require an evaluation or physical before determining accession qualifications.

b. The USMEPCOM and DoDMERB will:

(1) Render medical qualification decisions by using standard medical terminology to describe a medical condition, rather than International Classification of Disease codes.

(2) Use coding to document personnel actions in order to collect information to enable research, analyses, and support for evidence-based medical standards. Medical disqualifications will be coded in a manner that indicates which medical standard described in Section 6 is disqualifying.

c. The DoD Components:

(1) May initiate and request a medical waiver. Each DoD Component's waiver authority for medical conditions will make a determination based on all available information regarding the issue or condition, as well as the specific needs of the Military Service.

(2) Will specify any medical condition which causes a personnel action, such as separation, medical waiver, or assignment limitation, by utilizing standard medical terminology, the International Classification of Diseases, Current Procedural Terminology, or the Healthcare Common Procedure Coding System for data collection and analysis in support of evidence-based standards.

SECTION 6: DISQUALIFYING CONDITIONS

6.1. MEDICAL STANDARDS.

a. Unless otherwise stipulated, the conditions listed in this section are those that do not meet the standard by virtue of current diagnosis, or for which the candidate has a verified past medical history. The medical standards for appointment, enlistment, or induction into the Military Services are classified into general systems in Paragraphs 6.2. through 6.30.

b. Unless otherwise stipulated, the standards in this section apply to an applicant's biological sex or the presence of male or female sex organs or tissue.

6.2. HEAD.

a. Deformities of the skull, face, or mandible of a degree that may reasonably be expected to prevent the individual from properly wearing a protective mask or military headgear.

b. Loss, or absence of the bony substance of the skull not successfully corrected by reconstructive materials, or leaving any residual defect in excess of 1 square inch (6.45 square centimeters (cm)), or the size of a U.S. quarter coin.

6.3. EYES.

a. Lids.

(1) Current symptomatic blepharitis.

(2) Current blepharospasm.

(3) Current dacryocystitis, acute or chronic.

(4) Defect or deformity of the lids or other disorders affecting eyelid function, including ptosis, sufficient to interfere with vision, require head posturing, or impair protection of the eye from exposure.

(5) Current growths or tumors of the eyelid, other than small, non-progressive, asymptomatic, benign lesions.

b. Conjunctiva.

(1) Current acute or chronic conjunctivitis excluding seasonal allergic conjunctivitis.

(2) Current pterygium if condition encroaches on the cornea in excess of 3 millimeters (mm), is symptomatic, interferes with vision, or is progressive.

(3) History of pterygium recurrence after any prior surgical removal.

c. Cornea.

(1) Corneal dystrophy or degeneration of any type, including, but not limited to, keratoconus of any degree.

(2) History of any incisional corneal surgery including, but not limited to, partial or full thickness corneal transplant, radial keratotomy, astigmatic keratotomy, or corneal implants (e.g., Intacs®).

(3) Corneal refractive surgery performed with an excimer or femtosecond laser, including, but not limited to, photorefractive keratectomy, laser epithelial keratomileusis, laser-assisted *in situ* keratomileusis, and small incision lenticule extraction, if any of the following conditions are met:

(a) Pre-surgical refractive error in either eye exceeded a spherical equivalent of +8.00 or -8.00 diopters.

(b) Pre-surgical astigmatism exceeded 3.00 diopters.

(c) Within 180 days of accession medical examination.

(d) Complications, ongoing medications, ophthalmic solutions, or any other therapeutic interventions required beyond 180 days of procedure.

(e) Post-surgical refraction in each eye is not stable.

1. For refractive surgery procedures within the previous 36 months, stability is demonstrated by at least two separate post-operative refractions performed at least 1 month apart that demonstrate no more than +/- 0.50 diopters difference in sphere or no more than +/- 0.50 diopters in cylinder.

2. For refractive surgery procedures more than 36 months ago, stability is demonstrated by at least two separate post-operative refractions that demonstrate no more than +/- 1.00 diopters difference in sphere or no more than +/- 1.00 diopters in cylinder.

(4) Current or recurrent keratitis.

(5) History of herpes simplex virus keratitis.

(6) Current corneal neovascularization, unspecified, or corneal opacification from any cause that is progressive or reduces vision.

(7) Any history of uveitis or iridocyclitis.

d. Retina.

Any history of any abnormality of the retina, choroid, or vitreous.

e. Optic Nerve.

(1) Any history of optic nerve disease, including but not limited to optic nerve inflammation, optic nerve swelling, or optic nerve atrophy.

(2) Any optic nerve anomaly.

f. Lens.

(1) Current aphakia, history of lens implant to include implantable collamer lens, or any history of dislocation of a lens.

(2) Any history of opacities of the lens, including cataract.

g. Ocular Mobility and Motility.

(1) Current or recurrent diplopia.

(2) Current nystagmus other than physiologic "end-point nystagmus."

(3) Strabismus, if any of the conditions in Paragraphs 6.3.g.(a)-(d) apply:

(a) Esotropia more than 15 prism diopters;

(b) Exotropia more than 10 prism diopters;

(c) Hypertropia more than 5 prism diopters; or

(d) Strabismus resulting in posturing (head tilt or turn), diplopia, or correctable vision that does not meet the applicable standards for enlistment or commission.

(4) History of restrictive ophthalmopathies.

h. Miscellaneous Defects and Diseases.

(1) History of abnormal visual fields.

(2) Absence of an eye.

(3) History of disorders of globe.

(4) Current unilateral or bilateral exophthalmoses.

(5) History of glaucoma, ocular hypertension, pre-glaucoma, or glaucoma suspect.

(6) Any abnormal pupillary reaction to light or accommodation.

(7) Asymmetry of pupil size greater than 2 mm.

(8) Current night blindness.

(9) History of intraocular foreign body, or current corneal foreign body.

(10) History of ocular tumors.

(11) History of any abnormality of the eye or adnexa, not specified in Paragraphs 6.3.h.(1)-(10), which threatens vision or visual function.

6.4. VISION.

a. Current distant visual acuity of any degree that does not correct with spectacle lenses to at least 20/40 in each eye.

b. For entrance into Service academies and officer programs, the individual DoD Components may set additional requirements. The DoD Components will determine special administrative criteria for assignment to certain specialties.

c. Current near visual acuity of any degree that does not correct with spectacle lenses to at least 20/40 in the better eye.

d. Current refractive error (hyperopia, myopia, astigmatism) in excess of -8.00 or +8.00 diopters spherical equivalent or astigmatism in excess of 3.00 diopters.

e. Any condition that specifically requires contact lenses for adequate correction of vision, such as corneal scars and opacities and irregular astigmatism.

f. Color vision requirements will be set by the individual DoD Components.

6.5. EARS.

a. Current defect that would require either recurrent evaluation or treatment or that may reasonably be expected to prevent or interfere with the proper wearing or use of military equipment (including hearing protection) including atresia of the external ear or severe microtia, congenital or acquired stenosis, chronic otitis externa, or severe external ear deformity.

b. Any history of Ménière's Syndrome, recurrent labyrinthitis, or other chronic diseases of the vestibular system.

c. Recurrent or persistent vertigo in the previous 12 months.

d. History of any surgically implanted hearing device.

e. History of cholesteatoma.

f. History of any inner or middle ear surgery.

g. Current perforation of the tympanic membrane or history of surgery to correct perforation during the preceding 6 months.

h. Chronic Eustachian tube dysfunction as evidenced by any of these conditions in the previous 24 months:

(1) More than one episode of acute otitis media, serous otitis media, or persistent middle ear effusion;

(2) Pressure equalization tubes; or

(3) Any atraumatic tympanic membrane rupture.

6.6. HEARING.

a. Audiometric hearing levels are measured by audiometers calibrated to the standards in American National Standards Institute S3.6-2010 and will be used to test the hearing of all applicants.

b. Current hearing threshold level in either ear that exceeds:

(1) Twenty-five decibels (dB) averaged at 500, 1000, and 2000 cycles per second;

(2) Thirty dB at 500, 1000, or 2000 cycles per second;

(3) Thirty-five dB at 3000 cycles per second;

(4) Forty-five dB at 4000 cycles per second; or

(5) No standard for 6000 cycles per second.

c. Unexplained asymmetric hearing loss as defined by a difference of 30 or more dB between the left and right ears at any one or more frequencies between 500 hertz, 1000 hertz, or 2000 hertz.

d. History of using hearing aids.

6.7. NOSE, SINUSES, MOUTH, AND LARYNX.

a. Current cleft lip or palate defects not satisfactorily repaired by surgery or that prevent drinking from a straw or that may reasonably be expected to interfere with using or wearing military equipment.

b. Current ulceration of oral mucosa or tongue, excluding aphthous ulcers.

c. Symptomatic vocal cord dysfunction, including, but not limited to:

(1) Vocal cord paralysis.

(2) Paradoxical vocal cord movement.

(3) Spasmodic dysphonia.

(4) Non-benign polyps.

(5) Chronic hoarseness.

(6) Chronic laryngitis (lasting longer than 21 days).

(7) History of vocal cord dysfunction with respiratory symptoms or exercise intolerance.

d. Current olfactory deficit.

e. Greater than one episode of epistaxis requiring medical intervention (urgent care or emergency department treatment or procedure) in the past 24 months.

f. Current chronic sinusitis, current nasal polyp or polypoid mass(es) or history of sinus surgery within the last 24 months, excluding antrochoanal polyp or sinus mucosal retention cyst.

g. Current symptomatic perforation of nasal septum.

h. History of deformities or conditions or anomalies of the upper alimentary tract, mouth, tongue, palate, throat, pharynx, larynx, and nose, that interfered with chewing, swallowing, speech, or breathing.

6.8. DENTAL.

a. Current diseases or pathology of the jaws or associated tissues that prevent the jaws' normal functioning. A minimum of 6 months healing time must elapse for any individual who completes surgical treatment of any maxillofacial pathology lesions.

b. Temporomandibular disorders or myofascial pain that have been symptomatic or required treatment within the last 12 months.

c. Current severe malocclusion, which interferes with normal chewing or requires immediate and protracted treatment, or a relationship between the mandible and maxilla that prevents satisfactory future prosthodontic replacement.

d. Eight or more teeth with visually apparent decay, cavities, or caries.

e. Large edentulous areas of greater than four contiguous missing teeth, unless restored by a well-fitting prosthesis (e.g., fixed bridge, implants, or removable dentures) that allows for adequate chewing and processing of a normal diet.

f. Ongoing endodontic (root canal) treatment, unless the applicant is entering the Delayed Entry Program and a civilian or military dentist or endodontist provides documentation that active endodontic treatment will be completed before the anticipated date of being sworn to active duty.

g. Current orthodontic appliances (mounted or removable, e.g., Invisalign®) for continued active treatment unless:

(1) The appliance is permanent or removable retainer(s); or

(2) An orthodontist (civilian or military) provides documentation that:

(a) Active orthodontic treatment will be completed before being sworn in to active duty; or

(b) All orthodontic treatment will be completed before beginning active duty.

h. The presence of wisdom teeth (third molars), if currently symptomatic.

6.9. NECK.

a. Current presence of a cervical rib, if it has caused symptoms, including, but not limited to, thoracic outlet syndrome, subclavian vein thrombosis, or other symptoms of nerve or vascular compression.

b. Current congenital mass, including cyst(s) of branchial cleft origin or those developing from the remnants of the thyroglossal duct or history of surgical correction, within 12 months.

c. Current contraction of the muscles of the neck, spastic or non-spastic, or cicatricial contracture of the neck to the extent that it may reasonably be expected to interfere with properly wearing a uniform or military equipment, or is so disfiguring as to reasonably be expected to interfere with or prevent satisfactorily performing military duty.

6.10. LUNGS, CHEST WALL, PLEURA, AND MEDIASTINUM.

a. Any abnormal findings on imaging or other examination of body structure, such as the lungs, diaphragm, or other thoracic or abdominal organs, unless the findings have been evaluated and further surveillance or treatment is not required.

b. Current abscess of the lung or mediastinum.

c. Infectious pneumonia within the previous 3 months.

d. History of recurrent (2 or more episodes within an 18-month period) infectious pneumonia after the 13th birthday.

e. History of airway hyper responsiveness including asthma, reactive airway disease, exercise-induced bronchospasm or asthmatic bronchitis, after the 13th birthday.

(1) Symptoms suggestive of airway hyper responsiveness include, but are not limited to, cough, wheeze, chest tightness, dyspnea, or functional exercise limitations after the 13th birthday.

(2) History of prescription or use of medication (including, but not limited to, inhaled or oral corticosteroids, leukotriene receptor antagonists, or any beta agonists) for airway hyper responsiveness after the 13th birthday.

f. Chronic obstructive pulmonary disease including, but not limited to, bullous or generalized pulmonary emphysema or chronic bronchitis.

g. Bronchiectasis (after the 1st birthday).

h. Bronchopleural fistula, unless resolved with no sequelae.

i. Current chest wall malformation, including but not limited to pectus excavatum or pectus carinatum which has been symptomatic, interfered with vigorous physical exertion, has been recommended for surgery, or may interfere with wearing military equipment.

j. History of empyema unless resolved with no sequelae.

k. Interstitial lung disease including pulmonary fibrosis.

l. Current foreign body in lung, trachea, or bronchus.

m. History of thoracic surgery including open and endoscopic procedures.

n. Pleurisy or pleural effusion within the previous 3 months.

o. History of spontaneous pneumothorax.

p. Pneumothorax due to trauma or surgery occurring within the previous 12 months.

q. History of chest wall surgery, including breast, during the previous 6 months, or with persistent functional limitations.

r. Tuberculosis:

(1) History of active pulmonary or extra-pulmonary tuberculosis in the previous 24 months or history of active pulmonary or extra-pulmonary tuberculosis without reliable documentation of adequate treatment, or

(2) History of latent tuberculosis infection~~,~~; as defined by current Centers for Disease Control and Prevention guidelines, unless documentation of completion of appropriate treatment.

s. History of pulmonary or systemic embolus.

t. History of other disorders, including but not limited to cystic fibrosis or porphyria, that prevent satisfactorily performing duty, or require frequent or prolonged treatment.

u. History of nocturnal ventilation support, respiratory failure, or any requirement for chronic supplemental oxygen use.

v. History of pulmonary hypertension or right ventricular systolic pressure greater than 30 mm of mercury (mmHg) or pulmonary artery systolic pressure greater than or equal to 36 mmHg on the most recent echocardiogram.

6.11. HEART.

a. History of valvular repair or replacement.

b. History of the following valvular conditions as listed in the current American College of Cardiology and American Heart Association guidelines and evidenced by echocardiogram within the previous 12 months:

(1) Moderate or severe pulmonic regurgitation.

(2) Moderate or severe tricuspid regurgitation.

(3) Moderate or severe mitral regurgitation.

(4) Mild, moderate, or severe aortic regurgitation.

(5) Mitral valve prolapse associated with:

(a) Mild or greater mitral regurgitation.

(b) Cardiopulmonary symptoms.

(c) Medical therapy specifically for this condition.

c. Bicuspid aortic valve with any degree of stenosis or regurgitation or aortic dilatation.

d. All valvular stenosis.

e. History of atherosclerotic coronary artery disease.

f. The presence of an implantable pacemaker or defibrillator.

g. History of supraventricular tachycardia if:

(1) History of atrial fibrillation or flutter.

(2) Any atrioventricular (AV) nodal reentrant tachycardia or AV reentrant tachycardia (e.g., Wolff-Parkinson-White syndrome) unless successfully treated with catheter ablation, no recurrence of symptoms after 3 months, and documentation of normal electrocardiograph.

h. Premature atrial or ventricular contractions sufficiently symptomatic to require treatment, or result in physical or psychological impairment.

i. Abnormal findings on the most recent electrocardiogram (ECG), with the exception of the findings in Paragraphs 6.11.i.(1)-(10) in an asymptomatic applicant with a normal clinical examination:

(1) Incomplete right bundle branch block.

(2) Early repolarization.

(3) Sinus bradycardia with a rate between 40 and 59 beats per minute.

(4) Ectopic atrial or junctional rhythm.

(5) Sinus arrhythmia (heart rate variation with respiration).

(6) First-degree AV block.

(7) Mobitz Type I (Wenckebach) second-degree AV block.

(8) Left axis deviation defined as QRS axis -30 degrees to -90 degrees.

(9) Right axis deviation defined as QRS axis more than 120 degrees.

(10) Single premature ventricular contraction (PVC) on a 10-second tracing.

j. The following abnormal electrocardiograph patterns:

(1) Long QT (QTc of more than 470 milliseconds in males or more than 480 milliseconds in females);

(2) Brugada Type I pattern; or

(3) Ventricular pre-excitation pattern that does not meet the qualification criteria in Paragraph 6.11.g.

k. History of ventricular arrhythmias including ventricular fibrillation, tachycardia, or multifocal premature ventricular contractions other than occasional asymptomatic unifocal premature ventricular contractions.

l. History of conduction disorders, including, but not limited to, disorders of sinus arrest, asystole, Mobitz type II second-degree AV block, and third-degree AV block.

m. History of myocardial infarction or congestive heart failure.

n. History of cardiomyopathy or hypertrophy.

o. Any personal history of hypertrophic cardiomyopathy or a family history of hypertrophic cardiomyopathy, unless the applicant is asymptomatic with a normal echocardiogram performed within the previous 12 months.

p. History of myocarditis or pericarditis unless the individual is free of all cardiac symptoms, does not require medical therapy, and has a normal electrocardiogram and a normal echocardiogram for at least 12 months after the event.

q. History of recurrent myocarditis or pericarditis.

r. Tachycardia as indicated by a resting heart rate of more than 100 beats per minute present on three or more separate measurements.

s. History of congenital anomalies of the heart and great vessels other than the following conditions. Excepted conditions require the applicant to be asymptomatic with an otherwise normal current echocardiogram within the previous 12 months and no residual symptoms (e.g., pulmonary hypertension, myocardial dysfunction, or arrythmia).

(1) Dextrocardia with situs inversus without any other anomalies.

(2) Ligated or occluded patent ductus arteriosus.

(3) Corrected atrial septal defect without residua.

(4) Patent foramen ovale.

(5) Corrected ventricular septal defect without residua.

t. History of recurrent syncope or presyncope, including black out, fainting, loss or alteration of level of consciousness (excludes single episode of vasovagal reaction with identified trigger such as venipuncture) unless it has not recurred during the previous 24 months while off all medication for treatment of this condition.

u. Unexplained cardiopulmonary symptoms (including, but not limited to, syncope, presyncope, chest pain, palpitations, and dyspnea on exertion) in the previous 12 months.

v. History of Postural Orthostatic Tachycardia Syndrome (POTS) or syndrome of inappropriate sinus tachycardia (IST).

w. History of rheumatic fever if associated with rheumatic heart disease or indication for ongoing prophylactic medication.

6.12. ABDOMINAL ORGANS AND GASTROINTESTINAL SYSTEM.

a. Esophageal Disease.

(1) History of Gastro-Esophageal Reflux Disease, with complications, including, but not limited to:

(a) Stricture.

(b) Dysphagia.

(c) Recurrent symptoms or esophagitis despite maintenance medication.

(d) Barrett's esophagus.

(e) Extraesophageal complications such as: reactive airway disease; recurrent sinusitis or dental complications; unresponsive to acid suppression.

(2) History of surgical correction (e.g., fundoplication) for Gastro-Esophageal Reflux Disease within 6 months or with complications.

(3) History of dysmotility disorders including, but not limited to, diffuse esophageal spasm, nutcracker esophagus, and achalasia.

(4) History of eosinophilic esophagitis.

(5) History of other esophageal strictures (e.g., from ingesting lye).

(6) History of esophageal disease not specified above; including, but not limited to, neoplasia, ulceration, varices, or fistula.

b. Stomach and Duodenum.

(1) Current dyspepsia, gastritis, or duodenitis despite medication (over the counter or prescription).

(2) Current gastric or duodenal ulcers, including, but not limited to, peptic ulcers and gastrojejunal ulcers:

(a) History of a treated ulcer within the previous 3 months.

(b) Recurrent or complicated by bleeding, obstruction, or perforation within the previous 5 years.

(3) History of surgery for peptic ulceration or perforated ulcer.

(4) History of gastroparesis of greater than 6 week~~'~~s ' duration, confirmed by scintigraphy or equivalent test.

(5) History of bariatric surgery of any type (e.g., lap-band or gastric bypass surgery for weight loss).

(6) History of gastric varices.

c. Small and Large Intestine.

(1) History of inflammatory bowel disease, including, but not limited to, Crohn's disease, ulcerative colitis, ulcerative proctitis, or indeterminate colitis.

(2) Current infectious colitis.

(3) History of intestinal malabsorption syndromes, including, but not limited to, celiac sprue, pancreatic insufficiency, post-surgical, and idiopathic.

(4) Dietary intolerances that may interfere with military duty or consuming military rations. Lactase deficiency does not meet the standard when it is of sufficient severity to require frequent intervention, or will interfere with military duties.

(5) History of gastrointestinal functional or motility disorders including but not limited to volvulus within the previous 24 months, or any history of pseudo-obstruction or megacolon.

(6) Current chronic constipation, requiring prescription medication or medical interventions (e.g., pelvic floor physical therapy, biofeedback therapy).

(7) History of diarrhea of greater than 6 weeks' duration, regardless of cause, persisting or symptomatic in the previous 24 months.

(8) History of gastrointestinal bleeding, including positive occult blood, if:

(a) The cause is known but has not been corrected; or

(b) The cause is unknown and bleeding has occurred within the previous 12 months.

(9) History of irritable bowel syndrome that has been symptomatic or medically managed within the previous 24 months.

(10) History of symptomatic diverticular disease of the intestine.

(11) Personal or family history of familial adenomatous polyposis syndrome or hereditary non-polyposis colon cancer (Lynch syndrome).

d. Hepatic-Biliary Tract.

(1) History of chronic Hepatitis B unless successfully treated and the cure is documented. A documented cure for Hepatitis B is viral clearance as evidenced by Hepatitis B serology:

(a) Surface antigen negative.

(b) Surface antibody positive.

(c) Core antibody positive.

(2) History of chronic Hepatitis C, unless successfully treated and with documentation of a cure as evidenced by a viral load of "0" or "undetectable" measured at least 12 weeks after completion of a full course of therapy.

(3) Other acute hepatitis in the previous 6 months, or persistence of symptoms or abnormal serum aminotransferases after 6 months, or objective evidence of impairment of liver function.

(4) History of cirrhosis, hepatic abscess, or complications of chronic liver disease.

(5) History of symptomatic gallstones or gallbladder disease unless successfully treated.

(6) History of sphincter of Oddi dysfunction.

(7) History of choledochal cyst.

(8) History of primary biliary cirrhosis or primary sclerosing cholangitis.

(9) History of metabolic liver disease, excluding Gilbert's syndrome. This includes, but is not limited to, hemochromatosis, Wilson's disease, or alpha-1 anti-trypsin deficiency.

(10) History of alcoholic or non-alcoholic fatty liver disease if there is evidence of chronic liver disease, manifested as impairment of liver function or hepatic fibrosis.

(11) History of traumatic injury to the liver within the previous 6 months.

e. Pancreas.

History of:

(1) Pancreatic insufficiency.

(2) Acute pancreatitis, unless due to cholelithiasis successfully treated by cholecystectomy.

(3) Chronic pancreatitis.

(4) Pancreatic cyst or pseudocyst.

(5) Pancreatic surgery.

f. Anorectal.

(1) Current anal fissure or anal fistula.

(2) History of rectal prolapse or stricture within the previous 24 months.

(3) History of fecal incontinence after the 13th birthday.

(4) Current hemorrhoid (internal or external), if symptomatic or requiring medical intervention within the previous 60 days.

g. Abdominal Wall.

(1) Current abdominal wall hernia other than small (less than 2 cm in size), asymptomatic inguinal or umbilical hernias.

(2) History of open or laparoscopic abdominal surgery during the previous 3 months.

(3) The presence of any ostomy (gastrointestinal or urinary).

6.13. FEMALE GENITAL SYSTEM.

a. Abnormal uterine bleeding associated with any of the conditions in Paragraph 6.13.a.(1)-(4):

(1) Heavy menstrual bleeding within the previous 6 months defined as periods:

(a) Heavy enough to soak more than one pad per hour on more than two cycles within the previous 6 months;

(b) Lasting longer than 8 days on more than one cycle within the preceding 6 months; or

(c) Associated with anemia.

(2) Irregular menses more than twice within the previous 6 months defined as periods that were fewer than 21 days apart or associated with anemia.

(3) Oligomenorrhea of fewer than four menstrual cycles within the previous 6 months, unless a result of intentional menstrual suppression via external hormone regulation, an implant, or an intrauterine device.

(4) More than 1 day of school or work missed in the previous 6 months due to symptoms associated with menstrual cycles.

b. Primary amenorrhea.

c. Current unexplained secondary amenorrhea.

d. Dysmenorrhea resulting in missing more than 1 day of work or school within the previous 6 months.

e. History of symptomatic endometriosis.

f. Any undiagnosed or untreated disorder of sex development.

g. History of urogenital reconstruction or surgery (including, but not limited to, gender affirming surgery), if:

(1) A period of 18 months has not elapsed since the date of the most recent surgery;

(2) Associated with genitourinary dysfunction or recurrent urinary tract infection;

(3) Associated with functional limitations of activities of daily living or a physically active lifestyle; or

(4) Additional surgery is anticipated.

h. Current ovarian cyst(s) greater than 5 cm.

i. Polycystic ovarian syndrome unless no evidence of metabolic complications as specified by National Heart, Lung, and Blood Institute and American Heart Association Guidelines.

j. Current pelvic inflammatory disease.

k. History of chronic pelvic pain (6 months or longer) within the previous 24 months.

l. Pregnancy through 6 months postpartum.

m. Current uterine enlargement.

n. History of genital infection or ulceration, including, but not limited to, herpes genitalis or condyloma acuminatum, if any of the following apply:

(1) Current lesions are present.

(2) Use of chronic suppressive therapy is needed.

(3) There have been three or more outbreaks per year.

(4) Any outbreak in the previous 12 months that interfered with normal life activities.

(5) After the initial outbreak, treatment that included hospitalization or intravenous therapy.

o. Abnormal cervical, vaginal, or vulvar cytology if:

(1) The most recent exams shows cervical intraepithelial neoplasia II or higher grade cytology, independent of human papillomavirus status;

(2) The applicant's treating healthcare provider recommends an ongoing surveillance or treatment schedule more frequent than every 6 months; or

(3) There has been a finding of ASCUS-H, atypical squamous cells of undetermined significance, human papillomavirus positive, or low-grade squamous intraepithelial lesion that has not received follow-up testing with a repeat pap smear, colposcopy, or co-testing to confirm cervical intraepithelial neoplasia grade I or lower grade.

p. Any history of vaginal, vulvar, or cervical intraepithelial neoplasia grade 3 or higher within the previous 36 months.

q. History of abnormal endometrial pathology excluding benign endometrial polyp.

6.14. MALE GENITAL SYSTEM.

a. Current undescended testicle, congenital absence of one or both testicles that has not been verified by surgical exploration, or unexplained absence of both testicles.

b. History of epispadias or hypospadias when accompanied by history of urinary tract infection, urethral stricture, urinary incontinence, symptomatic chordee, or genitourinary dysfunction unless currently asymptomatic and more than 18 months.

c. Current enlargement or mass of testicle, epididymis, or spermatic cord, in addition to those described elsewhere in Paragraph 6.14.

d. Current hydrocele or spermatocele associated with pain or which precludes a complete exam of the scrotal contents.

e. Current varicocele, unless it is:

(1) On the left side only.

(2) Asymptomatic and smaller than the testes.

(3) Reducible.

(4) Without associated testicular atrophy.

f. Current or history of recurrent orchitis or epididymitis.

g. History of penis amputation that has not been definitively surgically treated to establish a functional urinary tract.

h. History of Peyronie's disease.

i. History of genital infection or ulceration, including, but not limited to, herpes genitalis or condyloma acuminatum, if:

(1) Current lesions are present;

(2) Use of chronic suppressive therapy is needed;

(3) There are three or more outbreaks per year;

(4) Any outbreak in the previous 12 months interfered with normal activities; or

(5) After the initial outbreak, treatment included hospitalization or intravenous therapy.

j. History of urethral condyloma acuminatum.

k. History of acute prostatitis within the previous 24 months, history of chronic prostatitis, or history of chronic pelvic pain syndrome.

l. History of chronic or recurrent scrotal pain or unspecified symptoms associated with male genital organs.

m. Any undiagnosed or untreated disorder of sex development.

n. History of urogenital reconstruction or surgery (including, but not limited to, gender affirming surgery), if:

(1) A period of 18 months has not elapsed since the date of the most recent surgery;

(2) Associated with genitourinary dysfunction or recurrent urinary tract infection;

(3) Associated with functional limitations of activities of daily living or a physically active lifestyle; or

(4) Additional surgery is anticipated.

6.15. URINARY SYSTEM.

a. History of interstitial cystitis or painful bladder syndrome.

b. Lower urinary tract infection (cystitis):

(1) For males, any cystitis not related to an indwelling catheter or genitourinary surgery.

(2) For females:

(a) Current cystitis; or

(b) Recurrent cystitis, not related to an indwelling catheter or genitourinary surgery, defined as:

1. Two episodes of acute bacterial cystitis and associated symptoms within the previous 6 months;

2. Three episodes within the previous 12 months;

3. Requiring daily suppressive antibiotics; or

4. Non-responsive to antibiotics for 10 days.

c. Current urethritis.

d. History or treatment of the following voiding symptoms within the previous 12 months in the absence of a urinary tract infection:

(1) Urinary frequency or urgency more than every 2 hours on a daily basis.

(2) Nocturia more than two episodes during sleep period.

(3) Enuresis.

(4) Incontinence of urine, such as urge or stress.

(5) Urinary retention.

(6) Dysuria.

e. History of neurogenic bladder or other functional disorder of the bladder that requires urinary catheterization with intermittent or indwelling catheter for any period greater than 2 weeks.

f. History of bladder augmentation, urinary diversion, or urinary tract reconstruction.

g. History of abnormal urinary findings in the absence of urinary tract infection:

(1) Gross hematuria.

(2) Persistent microscopic hematuria (3 or more red blood cells per high-powered field urinalyses).

(3) Pyuria (6 or more white blood cells per high-powered field in 2 of 3 properly collected urinalyses).

h. Current or recurrent urethral or ureteral stricture or fistula involving the urinary tract.

i. Absence of one kidney, congenital or acquired.

j. Asymmetry in size or function of kidneys, including, but not limited to, duplex kidney.

k. History of renal transplant.

l. Chronic or recurrent pyelonephritis or any other unspecified infections of the kidney.

m. History of polycystic kidney.

n. History of horseshoe kidney.

o. Hydronephrosis on most recent imaging not related to pregnancy.

p. History of acute nephritis.

q. History of chronic kidney disease of any type as evidenced by:

(1) Estimated glomerular filtration rate of less than 60 milliliters per minute per 1.73 square meter of body surface area for a period of 3 months or longer;

(2) Abnormal renal imaging;

(3) Cellular casts or active urine sediment; or

(4) Abnormal renal biopsy.

r. History of acute kidney injury requiring dialysis.

s. History of proteinuria with a protein-to-creatinine ratio greater than 0.2 in a random urine sample, more than 48 hours after strenuous activity.

t. Urolithiasis if any of the following apply:

(1) Current stone of 3 mm or greater.

(2) Current multiple stones of any size.

(3) History of symptomatic urolithiasis within the previous 12 months.

(4) History of nephrocalcinosis, bilateral renal calculi, or recurrent urolithiasis at any time.

(5) History of urolithiasis requiring a procedure.

6.16. SPINE AND SACROILIAC JOINT CONDITIONS.

a. Ankylosing spondylitis or other inflammatory spondylopathies.

b. History of any condition, in the previous 24 months, or any recurrence, including but not limited to the spine or sacroiliac joints, with or without objective signs, if:

(1) It prevented the individual from successfully following a physically active avocation in civilian life, or was associated with local or radicular pain, muscular spasms, postural deformities, or limitation in motion;

(2) It required external support;

(3) It required frequent treatment or limitation of activities of daily living or a physically active lifestyle; or

(4) It required the applicant to use medication for more than 6 weeks.

(5) It caused one or more episodes of back pain lasting greater than 6 weeks requiring treatment other than self-care.

(6) It involved surgery to the spine or spinal cord, other than a single-level lumbar or thoracic diskectomy, meeting the criteria in Paragraph 6.16.i.

(7) It required interventional procedures, including, but not limited to, spinal injections, nerve blocks, or radio ablation procedures.

c. Current deviation or curvature of the spine from normal alignment, structure, or function if:

(1) It prevents the individual from following a physically active avocation in civilian life;

(2) It can reasonably be expected to interfere with the proper wearing of military uniform or equipment;

(3) It is symptomatic within the previous 24 months; or

(4) There is lumbar or thoracic scoliosis greater than 30 degrees, or thoracic kyphosis greater than 50 degrees when measured by the Cobb Method.

d. History of congenital fusion involving more than 2 vertebral bodies or any surgical fusion of spinal vertebrae.

e. Current dislocation of the vertebra.

f. History of vertebral fractures including:

(1) Cervical spine fracture.

(2) Fracture(s) of elements of the posterior arch (i.e., pedicle, lamina, pars interarticularis).

(3) Fracture of lumbar or thoracic vertebral body that exceeds 25 percent of the height of a single vertebra or that has occurred within the previous 12 months or is symptomatic.

(4) Fractures of the transverse or spinous process if currently symptomatic.

g. History of juvenile epiphysitis with any degree of residual change indicated by X-ray or Scheuermann's kyphosis.

h. History of lumbar disc pathology, including, but not limited to, bulges, herniations, protrusions, and extrusions associated with symptoms, treatment, or limitations of activities of daily living or a physically active lifestyle, in the previous 24 months or any history of recurrent symptoms.

i. History of surgery to correct herniated nucleus pulposus other than a single-level lumbar or thoracic diskectomy that is currently asymptomatic with full resumption of unrestricted activity for at least 12 months.

j. Spinal dysraphisms other than spina bifida occulta.

k. History of spondylolysis or spondylolisthesis, congenital or acquired.

6.17. UPPER EXTREMITY CONDITIONS.

a. Limitation of Motion.

Current active joint ranges of motion less than:

(1) Shoulder.

(a) Forward elevation to 130 degrees.

(b) One hundred and thirty degrees abduction.

(c) Sixty degrees external and internal rotation at 90 degrees abduction.

(d) Cross body reaching 115 degrees adduction.

(2) Elbow.

(a) Flexion to 130 degrees.

(b) Extension to 30 degrees.

(3) Forearm.

(a) Pronation to 60 degrees.

(b) Supination to 60 degrees.

(4) Wrist.

(a) Forty degrees of flexion;

(b) Forty degrees of extension; or

(c) Forty degrees of combined radial-ulnar deviation.

(5) Hand, Fingers, and Thumb.

Inability to clench fist, pick up a pin, grasp an object, or touch tips of at least three fingers with thumb.

b. Hand and Fingers.

(1) Absence of any bony portion of the fingers or thumb.

(2) Absence of hand or any portion thereof.

(3) Current polydactyly or syndactyly.

(4) Current intrinsic hand muscle paralysis, weakness (4 or less on a scale of 5 using a manual muscle test), or atrophy of the hand or thenar, including, but not limited to, those caused by nerve paralysis, nerve injury, or nerve entrapment (carpal, radial and cubital tunnel syndromes, and brachial plexus).

c. Residual Weakness and Pain.

Current disease, injury, or congenital condition with residual weakness, pain, sensory disturbance, or other symptoms that may reasonably be expected to prevent satisfactory performance of duty, including, but not limited to, chronic joint pain associated with the shoulder, the upper arm, the elbow, the forearm, the wrist and the hand; or chronic joint pain as a late effect of fracture of the upper extremities, as a late effect of sprains without mention of injury, and as late effects of tendon injury.

6.18. LOWER EXTREMITY CONDITIONS.

a. General.

(1) Current deformities, disease, or chronic joint pain of pelvic region, thigh, lower leg, knee, ankle, or foot that prevent the individual from following a physically active avocation in civilian life, or that may reasonably be expected to interfere with walking, running, weight bearing, or satisfactorily completing training or military duty.

(2) Current discrepancy in leg-length that causes a limp.

b. Limitation of Motion.

Current active joint ranges of motion less than:

(1) Hip.

(a) Flexion to 90 degrees.

(b) No demonstrable flexion contracture.

(c) Extension to 10 degrees (beyond 0 degrees).

(d) Abduction to 45 degrees.

(e) Rotation of 60 degrees (internal and external combined).

(2) Knee.

(a) Full extension to 0 degrees.

(b) Flexion to 110 degrees.

(3) Ankle.

(a) Dorsiflexion to 10 degrees.

(b) Planter flexion to 30 degrees.

(c) Subtalar eversion and inversion totaling 5 degrees.

c. Foot and Ankle.

(1) Current absence of a foot or any portion thereof, other than absence of a single lesser toe that is asymptomatic and does not impair function of the foot.

(2) Deformity of the toes that may reasonably be expected to prevent properly wearing military footwear or impair walking, marching, running, maintaining balance, or jumping.

(3) Symptomatic deformity of the toes (acquired or congenital), including, but not limited to, conditions such as hallux valgus, hallux varus, hallux rigidus, hammer toe(s), claw toe(s), or overriding toe(s).

(4) Clubfoot or pes cavus that may reasonably be expected to interfere with properly wearing military footwear or causes symptoms when walking, marching, running, or jumping.

(5) Rigid or symptomatic pes planus (acquired or congenital).

(6) Current ingrown toenails, if infected or symptomatic.

(7) Current or recurrent plantar fasciitis.

(8) Symptomatic neuroma.

d. Leg, Knee, Thigh, and Hip.

(1) Current loose or foreign body in the knee joint.

(2) Instability of the knee, as evidenced by:

(a) Three or more surgeries in the same knee joint.

(b) History of posterior cruciate ligament tear or partial anterior cruciate ligament tear within the previous 12 months or that is not fully rehabilitated.

(3) Complete anterior cruciate ligament tear that has not been surgically corrected.

(4) History of surgical reconstruction of knee ligaments within the previous 12 months, or which is symptomatic or unstable or shows signs of thigh or calf atrophy.

(5) Recurrent anterior cruciate ligament reconstruction.

(6) Current medial or lateral meniscal injury with symptoms or limitation of activities of daily living or a physically active lifestyle.

(7) Surgical meniscal repair, within the previous 6 months or with residual symptoms or limitation of activities of daily living or a physically active lifestyle.

(8) Surgical partial meniscectomy within the previous 3 months or with residual symptoms or limitation of activities of daily living or a physically active lifestyle.

(9) Meniscal transplant.

(10) Symptomatic medial and lateral collateral ligament instability or injury.

(11) History of developmental dysplasia (congenital dislocation) of the hip, osteochondritis of the hip (Legg-Calve-Perthes Disease), or slipped capital femoral epiphysis of the hip.

(12) History of hip dislocation.

(13) Symptomatic osteochondritis of the tibial tuberosity (Osgood-Schlatter Disease) within the previous 12 months.

(14) Stress fractures, either recurrent or a single episode occurring during the previous 12 months.

(15) Recurrent periostitis, shin splints, or tibial stress syndrome within the previous 12 months.

6.19. MISCELLANEOUS CONDITIONS OF THE EXTREMITIES.

a. History of clinically diagnosed anterior knee pain including, but not limited to:

(1) Patellofemoral syndrome.

(2) Patellofemoral pain syndrome.

(3) Chondromalacia patella that was symptomatic or required treatment or limitations of activities of daily living or a physically active lifestyle in the previous 12 months.

(4) Any history of recurrent anterior knee pain syndrome.

b. History of any dislocation, subluxation, or instability of the hip, knee, ankle, subtalar joint, foot, shoulder, wrist, elbow except for "nursemaid's elbow," or dislocated finger.

c. Acromioclavicular separation within the previous 12 months or if symptomatic.

d. History of osteoarthritis or traumatic arthritis of isolated joints that has interfered with a physically active lifestyle, or that may reasonably be expected to prevent satisfactorily performing military duty.

e. Fractures, if:

(1) Current malunion or non-union of any fracture (except asymptomatic ulnar styloid process fracture).

(2) Current retained hardware (including plates, pins, rods, wires, or screws) used for fixation that is symptomatic or may reasonably be expected to interfere with properly wearing military equipment or uniforms. Retained hardware is not disqualifying if fractures are healed, ligaments are stable, and there is no pain.

f. Current orthopedic implants or devices to correct congenital or post-traumatic orthopedic abnormalities except for bone anchor and hardware as allowed in accordance with Paragraph 6.19.e.(2).

g. History of contusion of bone or joint if:

(1) The injury is of more than a minor nature with or without fracture, nerve injury, open wound, crush, or dislocation which occurred within the previous 6 months;

(2) Recovery has not been sufficiently completed or rehabilitation has not been sufficiently resolved;

(3) The injury may reasonably be expected to interfere with or prevent performance of military duty; or

(4) The contusion requires frequent or prolonged treatment.

h. History of joint replacement or resurfacing of any site.

i. History of hip arthroscopy or femoral acetabular impingement.

j. History of neuromuscular paralysis, weakness, contracture, or atrophy not completely resolved and of sufficient degree to reasonably be expected to interfere with or prevent satisfactorily performing military duty.

k. Current symptomatic osteochondroma or history of two or more osteocartilaginous exostoses.

l. History of atraumatic fractures or bone mineral density below the expected range for age with risk factors for low bone density.

m. Osteopenia, osteoporosis, or history of fragility fracture.

n. History of osteomyelitis within the previous 12 months, or history of recurrent osteomyelitis.

o. History of osteochondral defect, formerly known as osteochondritis dissecans.

p. Surgically or radiographically demonstrated chondromalacia of Grade II or higher.

q. History of cartilage surgery, including, but not limited to, cartilage debridement or chondroplasty for Grade II or greater chondromalacia, microfracture, or cartilage transplant procedure.

r. History of any post-traumatic or exercise-induced compartment syndrome.

s. History of osteonecrosis of any bone.

t. History of recurrent tendon disorder, including, but not limited to, tendonitis, tendinopathy, or tenosynovitis.

u. Stress reaction in a weight bearing bone within the previous 6 months.

6.20. VASCULAR SYSTEM.

a. History of abnormalities of the arteries, including, but not limited to, aneurysms, arteriovenous malformations, atherosclerosis, or arteritis (e.g., Kawasaki's disease).

b. Current or medically managed hypertension.

c. Elevated systolic blood pressure of greater than 140 mmHg or diastolic pressure greater than 90 mmHg confirmed by a manual blood pressure cuff averaged over two or more properly measured, seated blood pressure readings on separate days within a 5-day period (an isolated,

single-day blood pressure elevation is not disqualifying unless confirmed on 2 separate days within a 5-day period).

d. History of peripheral vascular disease, including, but not limited to, diseases such as Raynaud's Disease and vasculitides.

e. History of venous diseases, including, but not limited to, recurrent thrombophlebitis, thrombophlebitis during the preceding year, or evidence of venous incompetence, such as edema, skin ulceration, or symptomatic varicose veins that would reasonably be expected to limit duty or properly wearing military uniform or equipment.

f. History of deep venous thrombosis or pulmonary embolism.

g. History of operation or endovascular procedure on the arterial or venous systems, including, but not limited to, vena cava filter, angioplasty, venoplasty, thrombolysis, or stent placement.

h. History of Marfan's Syndrome, Loeys-Dietz, or Ehlers Danlos IV.

i. Dilatation of the aorta on the most recent echocardiogram, CT, or MRI, including aortic root and ascending thoracic aorta.

j. Coarctation of the aorta regardless of treatment by surgery, balloon, or stent.

6.21. SKIN AND SOFT TISSUE CONDITIONS.

a. Applicants under treatment with systemic retinoids, including, but not limited to, isotretinoin (e.g., Accutane®), do not meet the standard until 4 weeks after completing therapy.

b. Severe nodulocystic acne, on or off antibiotics.

c. History of dissecting scalp cellulitis, acne inversa, or hidradenitis suppurativa.

d. History of atopic dermatitis or eczema requiring treatment other than over-the-counter hydrocortisone or moisturizer therapy in the previous 36 months or with active lesions or residual hyperpigmented or hypopigmented areas at the time of the entrance examination.

e. History of recurrent or chronic non-specific dermatitis within the previous 24 months, including contact (irritant or allergic) or dyshidrotic dermatitis requiring treatment other than over-the-counter medication.

f. Cysts, if:

(1) The current cyst (other than pilonidal cyst) is of such a size or location as to reasonably be expected to interfere with properly wearing military equipment.

(2) The current pilonidal cyst is associated with a tumor mass or discharging sinus, or is a surgically resected pilonidal cyst that is symptomatic, unhealed, or less than 6 months post operative. A pilonidal cyst that has been simply incised and drained does not meet the military accession medical entrance standard.

g. History of bullous dermatoses, including, but not limited to, dermatitis herpetiformis, pemphigus, and epidermolysis bullosa.

h. Current or chronic lymphedema.

i. History of furunculosis or carbuncle if extensive, recurrent, or chronic.

j. History of severe hyperhidrosis of hands or feet unless controlled by topical medications.

k. History of congenital or acquired anomalies of the skin, such as nevi or vascular tumors that may interfere with military duties or cause constant irritation.

l. Current lichen planus (either cutaneous or oral).

m. History of oculocutaneous albinism, Neurofibromatosis I (Von Recklinghausen's Disease), Neurofibromatosis II, and tuberous sclerosis.

n. History of photosensitivity, including, but not limited to, any primary sun-sensitive condition, such as polymorphous light eruption or solar urticaria, or any dermatosis aggravated by sunlight, such as lupus erythematosus, porphyria, and xeroderma pigmentosa.

o. History of psoriasis excluding non-recurrent childhood guttate psoriasis.

p. History of chronic radiation dermatitis (radiodermatitis).

q. History of scleroderma.

r. History of chronic urticaria lasting longer than 6 weeks even if it is asymptomatic when controlled by daily maintenance therapy.

s. Current symptomatic plantar wart(s).

t. Current scars or keloids that can reasonably be expected to interfere with properly wearing military clothing or equipment, or to interfere with satisfactorily performing military duty due to pain or decreased range of motion, strength, or agility.

u. Prior burn injury involving 18 percent or more body surface area (including graft sites), or resulting in functional impairment to such a degree, due to scarring, as to interfere with satisfactorily performing military duty due to pain or decreased range of motion, strength, temperature regulation, or agility.

v. Current localized fungal infections, if they can be reasonably expected to interfere with properly wearing military equipment or performing military duties. For systemic fungal infections, refer to Paragraph 6.23.s.

w. History of any dermatologic condition severe enough to warrant use of systemic steroids for greater than 2 months, or any use of other systemic immunosuppressant medications.

x. Conditions with malignant potential in the skin including, but not limited to, high-grade atypia, basal cell nevus syndrome, oculocutaneous albinism, xeroderma pigmentosum, Muir Torre Syndrome, Dyskeratosis Congenita, Gardner Syndrome, Peutz-Jeghers Syndrome, Cowden Syndrome, Multiple Endocrine Neoplasia, Familial Atypical Multiple Mole Melanoma Syndrome, and Birt-Hogg-Dube Syndrome.

y. History of cutaneous malignancy before the 25th birthday including, but not limited to, basal cell carcinoma and squamous cell carcinoma. History of the following skin cancers at any age: malignant melanoma, Merkel cell carcinoma, sebaceous carcinoma, Paget's disease, extramammary Paget's disease, microcystic adnexal carcinoma, other adnexal neoplasms, and cutaneous lymphoma including mycosis fungoides.

z. History of lupus erythematosus.

aa. History of congenital disorders of cornification including, but not limited to, ichthyosis vulgaris, x-linked ichthyosis, lamellar ichthyosis, Darier's Disease, Epidermal Nevus Syndrome, and any palmo-plantar keratoderma.

ab. History of congenital disorder of the hair and nails including, but not limited to, pachyonychia congenita or ectodermal dysplasia.

ac. History of dermatomyositis.

6.22. BLOOD AND BLOOD FORMING SYSTEM.

a. Acquired anemia (hemoglobin less than 13.5 grams per deciliter (g/dl) for males or less than 12 g/dl for females) that has not been corrected to normal values as evidenced by a normal hemoglobin within 6 months or that requires ongoing maintenance with agents other than oral supplementation, diet, or menstruation control.

b. Hereditary hemoglobin disorders, if any of the following apply (Sickle cell trait with hemoglobin S fraction of less than 45 percent; alpha thalassemia trait and beta thalassemia trait in the absence of anemia are normal variants and are not considered hemoglobin disorders):

(1) Sickle cell disease (e.g., hemoglobin SS, hemoglobin SC, and hemoglobin S/beta thal);

(2) Associated with anemia (hemoglobin less than 13.5 g/dl for males or less than 12 g/dl for females);

(3) Sickle cell trait with a hemoglobin S fraction of 45 percent or higher; or

(4) History of exercise collapse in an individual with sickle cell trait.

c. History of coagulation defects.

d. Any history of chronic, or recurrent thrombocytopenia.

e. History of deep venous thrombosis or pulmonary embolism.

f. History of chronic or recurrent agranulocytosis or leukopenia.

g. History of chronic polycythemia, chronic leukocytosis, or chronic thrombocytosis.

h. Disorders of the spleen including:

(1) Current splenomegaly.

(2) History of splenectomy.

6.23. SYSTEMIC CONDITIONS.

a. History of disorders involving the immune mechanism, including immunodeficiencies.

b. Presence of human immunodeficiency virus (HIV) or laboratory evidence of infection or false-positive screening test(s) with ambiguous results by supplemental confirmation test(s) is not, in itself, disqualifying with respect to covered personnel (including Military Service Academy cadets and midshipmen, contracted SROTC cadets and midshipmen, and other participants in in-service commissioning programs seeking to commission while a Service member). Such covered personnel will be evaluated on a case-by-case basis.

c. Tuberculosis.

(1) History of active pulmonary or extra pulmonary tuberculosis in the previous 24 months or history of active pulmonary or extra-pulmonary tuberculosis without reliable documentation of adequate treatment.

(2) History of latent tuberculosis infection, as defined by current Centers for Disease Control guidelines, unless there is documentation of completion of appropriate treatment.

d. History of syphilis without appropriate documentation of treatment and cure.

e. History of anaphylaxis other than anaphylaxis to a single medication or medication class.

f. History of systemic allergic reaction to biting or stinging insects, unless it was limited to a large local reaction or unless there is documentation of 3 years of maintenance venom immunotherapy.

g. History of acute allergic reaction to fish, crustaceans, shellfish, peanuts, or tree nuts including the presence of a food-specific immunoglobulin E antibody if accompanied by a correlating clinical history.

h. History of cold- or exercise-induced urticaria.

i. History of malignant hyperthermia.

j. History of industrial solvent or other chemical intoxication with sequelae.

k. History of motion sickness resulting in recurrent incapacitating symptoms.

l. History of muscular dystrophies or myopathies.

m. History of amyloidosis.

n. History of eosinophilic granuloma and all other forms of histiocytosis except for healed eosinophilic granuloma, when occurring as a single localized bony lesion and not associated with soft tissue or other involvement.

o. History of polymyositis or dermatomyositis complex with or without skin involvement.

p. History of rhabdomyolysis.

q. History of sarcoidosis.

r. Current active systemic fungus infections or ongoing treatment for systemic fungal infection. History of systemic fungal infection unless resolved or treated without sequelae.

s. History of angioedema, other than angioedema in response to a single medication or medication class.

6.24. ENDOCRINE AND METABOLIC CONDITIONS.

a. Current adrenal dysfunction or any history of adrenal dysfunction requiring treatment or hormone replacement or the presence of adrenal adenoma.

b. Diabetic disorders, including:

(1) History of diabetes mellitus.

(2) History of unresolved pre-diabetes mellitus (as defined by the American Diabetes Association) within the previous 24 months.

(3) History of gestational diabetes mellitus.

(4) Current persistent glycosuria, when associated with impaired glucose metabolism or renal tubular defects.

c. History of pituitary dysfunction except for resolved growth hormone deficiency.

d. History of pituitary tumor unless proven non-functional, less than 1 cm and stable in size for the previous 12 months.

e. History of diabetes insipidus.

f. History of primary hyperparathyroidism unless surgically corrected.

g. History of hypoparathyroidism or history of hypocalcemia that requires calcitriol.

h. Current goiter.

i. Thyroid nodule unless a solitary thyroid nodule less than 10 mm or less than 3 cm with benign histology or cytology, and that does not require ongoing surveillance.

j. History of complex thyroid cyst or simple thyroid cyst greater than 2 cm or symptomatic simple thyroid cyst regardless of size.

k. Current hypothyroidism unless asymptomatic and demonstrated euthyroid by normal thyroid stimulating hormone testing within the previous 12 months.

l. History of hyperthyroidism unless treated successfully with surgery or radioactive iodine.

m. Current nutritional deficiency diseases, including, but not limited to, beriberi, pellagra, and scurvy.

n. Dyslipidemia with low-density lipoprotein greater than 200 milligrams per deciliter (mg/dL) or triglycerides greater than 400 mg/dL. Dyslipidemia requiring more than one medication or low-density lipoprotein greater than 190 mg/dL on therapy. All those on medical management must have demonstrated no medication side effects (e.g., myositis, myalgias, or transaminitis) for a period of 6 months.

o. Metabolic syndrome, as defined in accordance with the 2005 National Heart, Lung, and Blood Institute and American Heart Association Scientific Statement as any three of the following:

(1) Medically controlled hypertension or elevated blood pressure of greater than 130 mmHg systolic or greater than 85 mmHg diastolic.

(2) Waist circumference greater than 35 inches for women and greater than 40 inches for men.

(3) Medically controlled dyslipidemia or triglycerides greater than 150 mg/dL.

(4) Medically controlled dyslipidemia or high-density lipoprotein less than 40 mg/dL in men or less than 50 mg/dL in women.

(5) Fasting glucose greater than 100 mg/dL.

p. Metabolic bone disease including but not limited to:

(1) Osteopenia, osteoporosis, or low bone mass with history of fragility fracture.

(2) Paget's disease.

(3) Osteomalacia.

(4) Osteogenesis imperfecta.

q. History of hypogonadism that is congenital, treated with hormonal supplementation, or of unexplained etiology.

r. History of islet-cell tumors, nesidioblastosis, or hypoglycemia.

s. History of gout.

t. History of gender-affirming hormone therapy that fails to meet the stability criteria in Paragraphs 6.24.t.(1)-(4):

(1) Use of current medication for at least 12 months or no longer requiring such hormones as certified by a treating healthcare provider.

(2) Documentation from a treating healthcare provider that the individual is free of adverse symptoms or medication side effects while meeting the adequacy of dosing targets (laboratory and other clinical targets established by the treating provider).

(3) At least one properly timed hormone laboratory test current within 12 months that shows that the serum hormone level (total and/or free testosterone for masculinizing hormone therapy and serum estradiol for feminizing hormone therapy) is within the physiologic target range, collected after the individual has been on the current medication dose and route for at least 90 days.

(4) Affirmation from the treating provider that no additional gender-affirming treatment is anticipated, other than hormone maintenance.

6.25. RHEUMATOLOGIC CONDITIONS.

a. History of systemic lupus erythematosus.

b. History of progressive systemic sclerosis, including calcinosis, Raynaud's phenomenon, esophageal dysmotility, scleroderma, or telangiectasia syndrome.

c. History of rheumatoid arthritis.

d. History of Sjögren's syndrome.

e. History of vasculitis, including, but not limited to, polyarteritis nodosa, arteritis, Behçet's, Takayasu's arteritis, and Anti Neutrophil Cytoplasmic Antibody associated vasculitis.

f. History of Henoch-Schonlein Purpura occurring after the 19th birthday or within the previous 24 months.

g. History of non-inflammatory myopathy including, but not limited to, muscular dystrophies and metabolic myopathy such as glycogen storage disease, lipid storage disease, and mitochondrial myopathy.

h. History of fibromyalgia or myofascial pain syndrome.

i. History of chronic wide-spread pain or complex regional pain syndrome.

j. History of chronic fatigue syndrome, systemic exertion intolerance disease, or chronic multisystem illness.

k. History of spondyloarthritis, including, but not limited to, ankylosing spondyloarthritis, psoriatic arthritis, reactive arthritis (formerly known as Reiter's disease), or spondyloarthritis associated with inflammatory bowel disease.

l. History of joint hypermobility syndrome (formerly Ehler's Danlos syndrome, Type III).

m. History of any structural connective tissue disease including, but not limited to, Ehlers Danlos syndrome, Marfan syndrome, Pseudoxanthoma Elasticum, relapsing polychondritis, and osteogenesis imperfecta.

n. History of immunoglobulin G (IgG)-4 related disease.

o. History of idiopathic inflammatory myositis, including, but not limited to, polymyositis or dermatomyositis, anti-synthetase syndrome, and necrotizing myopathy.

p. History of any rheumatologic or autoimmune condition severe enough to warrant using systemic steroids for more than 2 months or any use of other systemic immunosuppressant medications.

q. History of antiphospholipid antibody syndrome.

r. History of juvenile idiopathic arthritis or adult Still's disease.

s. History of auto-inflammatory disease or periodic fever syndromes, including, but not limited to, familial Mediterranean fever and tumor necrosis factor receptor-associated periodic syndrome (TRAPS).

6.26. NEUROLOGIC CONDITIONS.

a. History of cerebrovascular conditions, including, but not limited to, subarachnoid or intracerebral hemorrhage, vascular stenosis, aneurysm, stroke, transient ischemic attack, or arteriovenous malformation.

b. History of congenital or acquired anomalies of the central nervous system or meningocele.

c. History of disorders of meninges, including, but not limited to, cysts except for asymptomatic incidental arachnoid cysts demonstrated to be stable by neurological imaging over a 6-month or longer time period.

d. History of neurodegenerative disorders, including, but not limited to, those disorders affecting the cerebrum, basal ganglia, cerebellum, spinal cord, peripheral nerves, or muscles.

e. History of headaches within the previous 24 months that:

(1) Were severe enough to cause the individual to miss work, school, sports, or other activities more than twice within 12 months;

(2) Required prescription medications more than twice within 12 months; or

(3) Involved the use of prophylactic medication or therapy.

f. History of complex migraines associated with neurological deficit other than scotoma.

g. History of cluster headaches.

h. History of moderate or severe brain injury.

i. History of head trauma if associated with:

(1) Post-traumatic seizure(s) occurring more than 30 minutes after injury;

(2) Persistent motor, sensory, vestibular, visual, or any other focal neurological deficit;

(3) Persistent impairment of cognitive function;

(4) Persistent alteration of personality or behavior;

(5) Cerebral traumatic findings, including, but not limited to, epidural, subdural, subarachnoid, or intracerebral hematoma on neurological imaging;

(6) Associated abscess or meningitis;

(7) Cerebrospinal fluid rhinorrhea or otorrhea persisting more than 7 days;

(8) Penetrating head trauma, including radiographic evidence of retained foreign body or bony fragments secondary to the trauma, or operative procedure in the brain; or

(9) Any basilar or depressed skull fracture.

j. History of mild brain injury if:

(1) The injury occurred within the previous month;

(2) Neurological evaluation shows residual symptoms, dysfunction or activity limitations, or complications;

(3) Two episodes of mild brain injury occurred with or without loss of consciousness within the previous 12 months; or

(4) Three or more episodes of mild brain injury.

k. History of persistent post-concussive symptoms that interfere with normal activities or have duration of more than 1 month. Symptoms include, but are not limited to, headache, vomiting, disorientation, spatial disequilibrium, impaired memory, poor mental concentration, shortened attention span, dizziness, or altered sleep patterns.

l. History of infectious processes of the central nervous system, including, but not limited to, encephalitis, neurosyphilis, or brain abscess.

m. History of meningitis within the previous 12 months or with persistent neurologic defects.

n. History of paralysis, weakness, lack of coordination, or sensory disturbance or other specified paralytic syndromes, including, but not limited to, Guillain-Barre Syndrome.

o. History of chronic pain or pain syndrome (including, but not limited to, complex regional pain syndrome, amplified musculoskeletal pain syndrome (AMPS) or neuralgias).

p. Any atraumatic seizure occurring after the 6th birthday, unless the applicant has been free of seizures and has not taken medication for seizures for a period of 60 months and has a normal sleep-deprived electroencephalogram and normal neurology evaluation after discontinuing seizure medications.

q. History of chronic nervous system disorders, including, but not limited to, myasthenia gravis, multiple sclerosis, tremor, and tic disorders (e.g., Tourette's Syndrome).

r. History of central nervous system shunts of all kinds including endoscopic third ventriculocisternostomy.

s. History of recurrent syncope, presyncope, or atraumatic loss of consciousness, including altered level of consciousness, unless the applicant has been off all relevant medication and experienced no recurrence during the previous 24 months, excluding a single episode of vasovagal reaction with identified trigger such as venipuncture.

t. History of muscular dystrophies or myopathies.

6.27. SLEEP DISORDERS.

a. Chronic insomnia as defined by the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, or the use of medications or other substances to promote sleep 15 or more times over the past 12 months.

b. History of sleep-related breathing disorders, including, but not limited to, sleep apnea unless definitively treated by surgical intervention with resolution of symptoms.

c. History of narcolepsy, cataplexy, or other hypersomnia disorders.

d. Circadian rhythm disorders requiring treatment or special accommodation.

e. History of parasomnia, including, but not limited to, sleepwalking, or night terrors, after the 13th birthday.

f. Current diagnosis or treatment of sleep-related movement disorders, including, but not limited to, restless leg syndrome (i.e., Willis-Ekbom Disease) for which prescription medication is recommended.

6.28. LEARNING, PSYCHIATRIC, AND BEHAVIORAL DISORDERS.

a. Attention Deficit Hyperactivity Disorder, if with:

(1) A recommended or prescribed Individualized Education Program, 504 Plan, or work accommodations after the 14th birthday;

(2) A history of comorbid mental disorders;

(3) Prescribed medication in the previous 24 months; or

(4) Documentation of adverse academic, occupational, or work performance.

b. History of learning disorders after the 14th birthday, including, but not limited to, dyslexia, if any of the following apply:

(1) With a recommended or prescribed Individualized Education Program, 504 Plan, or work accommodations after the 14th birthday;

(2) With a history of comorbid mental disorders; or

(3) With documentation of adverse academic, occupational, or work performance.

c. Autism spectrum disorders.

d. History of disorders with psychotic features such as schizophrenic disorders, delusional disorders, or other unspecified psychoses or mood disorders with psychotic features.

e. History of bipolar and related disorders (formerly identified as mood disorders not otherwise specified) including, but not limited to, cyclothymic disorders and affective psychoses.

f. Depressive disorder if:

(1) Outpatient care including counseling required for longer than 12 cumulative months;

(2) Symptoms or treatment within the previous 36 months;

(3) The applicant required any inpatient treatment in a hospital or residential facility;

(4) Any recurrence; or

(5) Any suicidality (in accordance with Paragraph 6.28.m.).

g. History of a single adjustment disorder if treated or symptomatic within the previous 6 months, or any history of chronic (lasting longer than 6 months) or recurrent episodes of adjustment disorders.

h. History of conduct disorders, oppositional defiance disorders, and other behavior disorders.

i. History of personality disorder or maladaptive personality traits including reasonable suspicion for the presence of an undiagnosed personality disorder, based on:

(1) Documentation of the recurrent inability to adapt in a school, employment, or training setting that resulted in significant distress or functional impairment within the previous 24 months and that is not better accounted for by another condition; or

(2) Psychological testing revealing that the degree of immaturity, instability, personality inadequacy, impulsiveness, or dependency may reasonably be expected to interfere with their adjustment to the Military Services.

j. Encopresis after 13th birthday.

k. History of any eating disorder.

l. Any current communication disorder that significantly interferes with producing speech or repeating commands.

m. History of suicidality, including:

(1) Suicide attempt(s);

(2) Suicidal gesture(s);

(3) Suicidal ideation with a plan; or

(4) Any suicidal ideation within the previous 12 months.

n. History of self-harm that is endorsed, documented, or otherwise clinically suspected based on scarring.

o. History of obsessive-compulsive or related disorder(s).

p. History of trauma or stressor related disorders, including, but not limited to, post traumatic stress disorder.

q. History of anxiety disorders if:

(1) Outpatient care including counseling was required for longer than 12 cumulative months.

(2) Symptomatic or treatment within the previous 36 months.

(3) The applicant required any inpatient treatment in a hospital or residential facility.

(4) Any recurrence.

(5) Any suicidality (in accordance with Paragraph 6.28.m.).

r. History of dissociative disorders.

s. History of somatic symptoms and related disorders.

t. History of gender dysphoria if:

(1) Symptomatic within the previous 18 months; or

(2) Associated with comorbid mental health disorders.

u. History of paraphilic disorders.

v. Any history of substance-related and addictive disorders (except using caffeine or tobacco).

w. History of prescription with psychotropic medication within the previous 36 months, unless a shorter period is authorized in another standard.

x. History of other mental disorders that may reasonably be expected to interfere with or prevent satisfactory performance of military duty.

y. Prior psychiatric hospitalization for any cause.

6.29. TUMORS AND MALIGNANCIES.

a. Current benign tumors or conditions that would reasonably be expected to interfere with function, to prevent properly wearing the uniform or protective equipment, or would require frequent specialized attention.

b. History of malignancy.

c. History of cutaneous malignancy, meeting criteria in Paragraph 6.21.y.

6.30. MISCELLANEOUS CONDITIONS.

a. Any current acute pathological condition, including, but not limited to, communicable, infectious, parasitic, or tropical diseases, until recovery has occurred without relapse or sequelae.

b. History of porphyria.

c. History of cold-related disorders, including, but not limited to, frostbite, chilblain, and immersion foot.

d. History of angioedema, including hereditary angioedema.

e. History of receiving organ or tissue transplantation other than dental allograft organ or tissue transplantation other than dental or orthopedic ligament graft.

f. History of pulmonary or systemic embolism.

g. History of untreated acute or chronic metallic poisoning (including, but not limited to, lead, arsenic, silver, beryllium, or manganese), or current complications or residual symptoms of such poisoning.

h. History of heatstroke, or recurrent heat injury or exhaustion.

i. History of any condition that may reasonably be expected to interfere with the successful performance of military duty or training or limit geographical assignment.

j. History of any medical condition severe enough to warrant use of systemic steroids for greater than 2 months, or any use of other systemic immunosuppressant medications.

k. Current use of medication for HIV pre-exposure prophylaxis (PrEP), unless the applicant provides documentation of compliance with Centers for Disease Control and Prevention HIV guidelines to include:

(1) Normal results from laboratory surveillance (at a minimum, serum creatinine, glomerular filtration rate, and 4th generation HIV test) within the previous 90 days.

(2) Confirmation by the treating healthcare provider of medication compliance, absence of side effects, and receipt of instruction on proper use of PrEP.

l. Current use of medication(s) delivered via an injectable or transdermal mechanism (e.g., allergy immunotherapy, transdermal or injectable hormones or contraceptives) or which otherwise require(s) refrigeration, unless there is written confirmation by the individual's treating provider that the medication or therapy can be safely postponed, discontinued, or switched to an alternative delivery system without adverse risk to the individual, if the current delivery method (or refrigeration, if applicable) is not available or not authorized during periods of training or deployment.

GLOSSARY

G.1. ACRONYMS.

ACRONYM	MEANING
AMPS	amplified musculoskeletal pain syndrome
ARMSWG	Accession and Retention Medical Standards Working Group
AV	atrioventricular
cm	centimeter
CT	computerized tomography
DASD(HSP&O)	Deputy Assistant Secretary of Defense for Health Services Policy and Oversight
DASD(MPP)	Deputy Assistant Secretary of Defense for Military Personnel Policy
dB	Decibels
DD	Department of Defense (forms)
DoDI	DoD instruction
DoDMERB	DoD Medical Examination Review Board
ECG	electrocardiogram
g/dl	grams per deciliter
HIV	human immunodeficiency virus
immunoglobulin G	IgG
IST	inappropriate sinus tachycardia
MEDPERS	Medical and Personnel Executive Steering Committee
mg/dL	milligrams per deciliter
mm	Millimeters
mmHg	millimeters of mercury
MRI	magnetic resonance imaging
POTS	postural orthostatic tachycardia syndrome
PrEP	pre-exposure prophylaxis
PVC	premature ventricular contraction
TRAPS	tumor necrosis factor receptor-associated periodic syndrome
U.S.C.	United States Code
USD(P&R)	Under Secretary of Defense for Personnel and Readiness

ACRONYM	MEANING
USMEPCOM	United States Military Entrance Processing Command

G.2. DEFINITIONS.

Unless otherwise noted, these terms and their definitions are for the purpose of this volume.

TERM	DEFINITION
504 Plan	The 504 Plan is a plan developed to ensure that a child who has a disability identified in accordance with Section 504 of the Rehabilitation Act of 1973, as amended and codified at Section 701 of Title 29, U.S.C. and is attending an elementary or secondary educational institution receives accommodations that will ensure their academic success and access to the learning environment.
accession	An enlistment, appointment, or induction that increases the incremental strength of the Regular or Reserve Components of the Military Services. Personnel enlisted under the Delayed Entry Program are not involved in this category.
covered personnel	Individuals who have been identified as HIV positive, are asymptomatic, and who have a clinically confirmed undetectable viral load.
existed prior to service	A term used to signify there is clear and unmistakable evidence that the disease or injury, or the underlying condition producing the disease or injury, existed prior to the individual's entry into military service.
gender identity	An individual's internal or personal sense of gender, which may or may not match the individual's biological sex.
induction	Transition from civilian to military status for a period of definite military obligation in accordance with Chapter 49 of Title 50, U.S.C., also known as the "Military Selective Service Act."
medical waiver	A formal request to consider the suitability for service of an applicant who, because of current or past medical conditions, does not meet medical standards. Upon the completion of a thorough review, the applicant may be considered for a waiver. The applicant must have displayed sufficient mitigating circumstances/provided medical documentation that clearly justify waiver consideration. The Secretaries of the Military Departments may delegate the final approval authority for all waivers.

TERM	DEFINITION
MEDPERS	Includes leaders from the DoD medical and personnel communities to develop, discuss, and make decisions about common medical issues that require resolution. The primary focus is the nexus of medical and personnel systems that impact the total force, including those seeking entry into the armed forces and those who must depart prior to completion of an enlistment or career.
Military Department	Defined in the DoD Dictionary of Military and Associated Terms.
National Heart, Lung, and Blood Institute	An agency within the National Institutes of Health that provides global leadership for a research, training, and education program to promote the prevention and treatment of heart, lung, and blood diseases and enhance the health of all individuals so that they can live longer and more fulfilling lives.
stress reaction	Defined in UpToDate Overview of Stress Fractures.
treating healthcare provider	A licensed provider working within their scope of practice who assumes responsibility for management, treatment, or ongoing care of a patient.

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Centers for Disease Control and Prevention, "HIV Guidelines," current edition[2]

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deWeber, K. (2020, December 10). Overview of Stress Fractures. UpToDate.[5]

Diagnostic and Statistical Manual of Mental Disorders, current edition

DoD 5400.11-R, "Department of Defense Privacy Program," May 14, 2007

DoD Directive 5124.02, "Under Secretary of Defense for Personnel and Readiness (USD(P&R))," June 23, 2008

DoD Instruction 1350.02, "DoD Military Equal Opportunity Program," September 4, 2020, as amended

DoD Instruction 5400.11, "DoD Privacy and Civil Liberties Programs," January 29, 2019, as amended

DoD Instruction 6130.03, Volume 2, "Medical Standards for Military Service: Retention," September 4, 2020, as amended

DoD Manual 8910.01, Volume 2, "DoD Information Collections Manual: Procedures for DoD Public Information Collections," June 30, 2014, as amended

International Classification of Diseases, Tenth Revision, Clinical Modification[6]

National Heart, Lung, and Blood Institute and American Heart Association Scientific Statement, "Diagnosis and management of the metabolic syndrome," October 25, 2005

Office of the Chairman of the Joint Chiefs of Staff, "DoD Dictionary of Military and Associated Terms," current edition

Under Secretary of Defense for Personnel and Readiness, Medical and Personnel Executive Steering Committee Charter, September 2012[7]

[1] Available for purchase at http://www.ansi.org/.
[2] Available at https://www.cdc.gov/hiv/guidelines/index.html.
[3] Available at https://www.cdc.gov/tb/publications/guidelines/default.htm.
[4] Available at https://www.cms.gov/Medicare/Coding/MedHCPCSGenInfo.
[5] Available at https://www.uptodate.com/contents/overview-of-stress-fractures.
[6] Available at https://icd10cmtool.cdc.gov/?fy=FY2023.
[7] This reference can be acquired by contacting the Office of the Deputy Assisant Secretary of Defense for Military Personnel Policy at (703) 697-9273.

United States Code, Title 10

United States Code, Title 18, Section 1001

United States Code, Title 29, Section 701 (also known as the "Rehabilitation Act of 1973," as amended)

United States Code, Title 50, Chapter 49 (also known as the "Military Selective Service Act")

Federal Register / Vol. 90, No. 21 / Monday, February 3, 2025 / Presidential Documents 8757

Presidential Documents

Executive Order 14183 of January 27, 2025

Prioritizing Military Excellence and Readiness

By the authority vested in me as President by the Constitution and the laws of the United States of America, and as Commander in Chief of the Armed Forces of the United States, and to ensure the readiness and effectiveness of our Armed Forces, it is hereby ordered:

Section 1. *Purpose.* The United States military has a clear mission: to protect the American people and our homeland as the world's most lethal and effective fighting force. Success in this existential mission requires a singular focus on developing the requisite warrior ethos, and the pursuit of military excellence cannot be diluted to accommodate political agendas or other ideologies harmful to unit cohesion.

Recently, however, the Armed Forces have been afflicted with radical gender ideology to appease activists unconcerned with the requirements of military service like physical and mental health, selflessness, and unit cohesion. Longstanding Department of Defense (DoD) policy (DoD Instruction (DoDI) 6130.03) provides that it is the policy of the DoD to ensure that service members are ''[f]ree of medical conditions or physical defects that may reasonably be expected to require excessive time lost from duty for necessary treatment or hospitalization.'' As a result, many mental and physical health conditions are incompatible with active duty, from conditions that require substantial medication or medical treatment to bipolar and related disorders, eating disorders, suicidality, and prior psychiatric hospitalization.

Consistent with the military mission and longstanding DoD policy, expressing a false ''gender identity'' divergent from an individual's sex cannot satisfy the rigorous standards necessary for military service. Beyond the hormonal and surgical medical interventions involved, adoption of a gender identity inconsistent with an individual's sex conflicts with a soldier's commitment to an honorable, truthful, and disciplined lifestyle, even in one's personal life. A man's assertion that he is a woman, and his requirement that others honor this falsehood, is not consistent with the humility and selflessness required of a service member.

For the sake of our Nation and the patriotic Americans who volunteer to serve it, military service must be reserved for those mentally and physically fit for duty. The Armed Forces must adhere to high mental and physical health standards to ensure our military can deploy, fight, and win, including in austere conditions and without the benefit of routine medical treatment or special provisions.

Sec. 2. *Policy.* It is the policy of the United States Government to establish high standards for troop readiness, lethality, cohesion, honesty, humility, uniformity, and integrity. This policy is inconsistent with the medical, surgical, and mental health constraints on individuals with gender dysphoria. This policy is also inconsistent with shifting pronoun usage or use of pronouns that inaccurately reflect an individual's sex.

Sec. 3. *Definitions.* The definitions in the Executive Order of January 20, 2025 (Defending Women from Gender Ideology Extremism and Restoring Biological Truth to the Federal Government) shall apply to this order.

Sec. 4. *Implementation.* (a) Within 60 days of the date of this order, the Secretary of Defense (Secretary) shall update DoDI 6130.03 Volume 1 (Medical Standards for Military Service: Appointment, Enlistment, or Induction

(May 6, 2018), Incorporating Change 5 of May 28, 2024) and DoDI 6130.03 Volume 2 (Medical Standards for Military Service: Retention (September 4, 2020), Incorporating Change 1 of June 6, 2022) to reflect the purpose and policy of this Order.

(b) The Secretary shall promptly issue directives for DoD to end invented and identification-based pronoun usage to best achieve the policy outlined in section 2 of this order.

(c) Within 30 days of the date of this order, the Secretary shall:

(i) identify all additional steps and issue guidance necessary to fully implement this order; and

(ii) submit to the President through the Assistant to the President for National Security Affairs a report that summarizes these steps.

(d) Absent extraordinary operational necessity, the Armed Forces shall neither allow males to use or share sleeping, changing, or bathing facilities designated for females, nor allow females to use or share sleeping, changing, or bathing facilities designated for males.

(e) Within 30 days of the issuance of the respective updates, directives, and guidance under subsections (a), (b), and (c) of this section, the Secretary of Homeland Security shall, with respect to the Coast Guard, issue updates, directives, and guidance consistent with the updates, directives, and guidance issued under subsections (a), (b), and (c) of this section.

Sec. 5. *Implementing the Revocation of Executive Order 14004.* (a) Pursuant to the Executive Order of January 20, 2025 (Initial Rescissions of Harmful Executive Orders and Actions), Executive Order 14004 of January 25, 2021 (Enabling All Qualified Americans To Serve Their Country in Uniform), has been revoked. Accordingly, all policies, directives, and guidance issued pursuant to Executive Order 14004 shall be rescinded to the extent inconsistent with the provisions of this order.

(b) The Secretary and, with respect to the Coast Guard, the Secretary of Homeland Security, shall take all necessary steps to implement the revocations described in subsection (a) of this section and ensure that all military departments and services fully comply with the provisions of this order.

Sec. 6. *Severability.* If any provision of this order, or the application of any provision to any person or circumstance, is held to be invalid, the remainder of this order and the application of its provisions to any other persons or circumstances shall not be affected thereby.

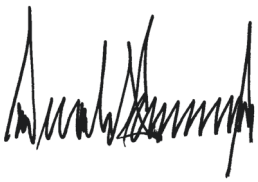
Sec. 7. *General Provisions.* (a) Nothing in this order shall be construed to impair or otherwise affect:

(i) the authority granted by law to an executive department or agency, or the head thereof; or

(ii) the functions of the Director of the Office of Management and Budget relating to budgetary, administrative, or legislative proposals.

(b) This order shall be implemented consistent with applicable law and subject to the availability of appropriations.

(c) This order is not intended to, and does not, create any right or benefit, substantive or procedural, enforceable at law or in equity by any party against the United States, its departments, agencies, or entities, its officers, employees, or agents, or any other person.



THE WHITE HOUSE,
January 27, 2025.

[FR Doc. 2025–02178
Filed 1–31–25; 8:45 am]
Billing code 3395–F4–P

The Honorable Benjamin H. Settle

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON AT SEATTLE

SHILLING, et al.,

Plaintiffs,

v.

DONALD J. TRUMP, in his official capacity as President of the United States, et al.,

Defendants.

Case No. 2:25-cv-241

DECLARATION OF DANIELLE ASKINI AUBAIN AS EXECUTIVE DIRECTOR OF GENDER JUSTICE LEAGUE IN SUPPORT OF PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION

I, Danielle Askini Aubain, declare as follows:

1. Gender Justice League ("GJL") is a non-profit organization with its principal place of business in Seattle, Washington. GJL is a civil and human rights organization that advocates on behalf of transgender individuals in Washington State. GJL's mission is to create a community for transgender people to live their lives safely and true to themselves, and free from discrimination. GJL works to empower transgender people to combat discrimination, prejudice, and violence they face in their daily lives by providing education on the civil and human rights afforded all people on the basis of sexual orientation and gender identity.

2. GJL is a membership based organization whose members include transgender

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individuals who wish to serve in the United States military, such as Matthew Medina, who is also a plaintiff in the present case, and those who currently serve in the military, such as Cathrine Schmid and Videl Leins, who likewise are plaintiffs in the present case. GJL sues on behalf of its members who are currently negatively affected by the ban on open service by transgender individuals in the military.

3. GJL has members who are actively serving in the military who have relied upon the approval of their transition plans in deciding if and when to come out and to take medical steps to transition.

4. GJL has members who are seeking to enlist in the military but who are afraid to be open about their transgender status.

5. GJL has strong interests in opposing structural and unlawful discrimination targeted at transgender individuals and in protecting the right of all people, including transgender individuals, to serve openly in the military and pursue that career free from discrimination and other violations of their constitutional rights. These interests are inherent to GJL's mission and vision expressed above.

6. I, Danielle Askini Aubain, serve as the Executive Director for GJL.

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

DATED: February 12, 2025

Danielle Askini Aubain
Danielle Askini Aubain (Feb 14, 2025 15:03 PST)

Danielle Askini Aubain

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2/26/2025 8:09 PM

ACTION MEMO

FOR: DARIN S. SELNICK, PERFORMING THE DUTIES OF THE UNDER SECRETARY OF DEFENSE FOR PERSONNEL AND READINESS

FROM: Tim Dill, Performing the Duties of the Assistant Secretary of Defense for Manpower and Reserve Affairs

SUBJECT: Implementing Guidance for Prioritizing Military Excellence and Readiness Executive Order (EO)

- **Purpose.** Recommend you sign the memorandum at TAB A to implement EO 14183, "Prioritizing Military Excellence and Readiness," January 27, 2025, consistent with SecDef guidance provided on February 7, 2025 (TAB B).

– **Discussion**

  – On January 27, 2025, President Trump issued Executive Order 14183 (TAB C), stating that "military service must be reserved for those mentally and physically fit for duty," and that "[t]he Armed Forces must adhere to high mental and physical health standards to ensure our military can deploy, fight, and win, including in austere conditions and without the benefit of routine medical treatment or special provisions.

  – The EO states that "[i]t is the policy of the United States Government to establish high standards for troop readiness, lethality, cohesion, honesty, humility, uniformity, and integrity. This policy is inconsistent with the medical, surgical, and mental health constraints on individuals with gender dysphoria." The EO then instructs SecDef to issue guidance and actions in light of the EO within 30-60 days.

  – The EO further adopts the definitions in EO 14168, "Defending Women from Gender Ideology Extremism and Resorting Biological Truth to the Federal Government," January 20, 2025 (TAB D), including that "'sex' shall refer to an individual's immutable biological classification as either male or female." As directed by EO 14168, the Department of Health and Human Services has issued further guidance on the definitions of "male" and "female."

  – SecDef issued guidance to the Department on February 7, 2025, directing a pause for "all new accessions for individuals with a history of gender dysphoria" and a pause for "all unscheduled, scheduled, or planned medical procedures associated with affirming or facilitating a gender transition for Service members… ."

  – SecDef further authorized and directed you "to provide additional policy and implementation guidance… including guidance regarding service by Service members with a current diagnosis or history of gender dysphoria… ."

  – The memorandum at TAB A, among other actions:

- Cancels the following DoD issuances, policies, and memoranda:
  - DoD Instruction (DoDI) 1300.28, "In-Service Transition for Transgender Service Members," April 30, 2021, as amended (TAB 1)
  - Defense Health Agency Procedural Instruction 6025.21, "Guidance for Gender-Affirming Health Care of Transgender and Gender-Diverse Active and Reserve Component Service Members," May 12, 2023 (TAB 2)
  - Acting Assistant Secretary of Defense for Health Affairs Memorandum, "Guidance for Treatment of Gender Dysphoria for Active and Reserve Component Service Member," July 29, 2016 (TAB 3)
  - Principal Deputy Assistant Secretary of Defense for Health Affairs Memorandum, "Guidance for Medical Care in Military Treatment Facilities for Service Members Diagnosed with Gender Dysphoria," March 18, 2019 (TAB 4)
- Directs updates to the following DoD issuances, consistent with the memorandum:
  - DoDI 6130.03, Volume 1, "Medical Standards for Military Service: Appointment, Enlistment, or Induction," May 6, 2018, as amended (TAB 5)
  - DoDI 6130.03, Volume 2, "Medical Standards for Military Service: Retention," September 4, 2020, as amended (TAB 6)
  - DoDI 1327.06, "Leave and Liberty Policy and Procedures," June 16, 2009, as amended (TAB 7)
  - DoDI 1322.22, "Military Service Academies," September 24, 2015, as amended (TAB 8)
  - DoDI 1215.08, "Senior Reserve Officers' Training Corps (ROTC) Programs," January 19, 2017, as amended (TAB 9)
  - DoDI 6025.19, "Individual Medical Readiness Program," July 13, 2022 (TAB 10)
- Establishes as DoD policy that "the medical, surgical, and mental health constraints on individuals with gender dysphoria or who have a current diagnosis or history of, or exhibit symptoms consistent with, gender dysphoria" are inconsistent with the "high standards for Service member readiness, lethality, cohesion, honesty, humility, uniformity, and integrity."
- Determines that "[i]ndividuals who have a current diagnosis or history of, or exhibit symptoms consistent with, gender dysphoria are no longer eligible for

military service," directs that "Service members who have a current diagnosis or history of, or exhibit symptoms consistent with, gender dysphoria will be processed for separation from military service…," and prohibits their accession, all subject to certain exceptions.

- Establishes that DoD only recognizes two sexes: male and female, and that these sexes are not changeable. It further requires all Service members to serve in accordance with their sex as defined in EO 14168, "Defending Women from Gender Ideology Extremism and Resorting Biological Truth to the Federal Government."

- Establishes clear requirements on pronoun usage when referring to Service members.

- Prohibits the use of DoD funds to pay for Service members' unscheduled, scheduled, or planned medical procedures associated with facilitating sex reassignment surgery, genital reconstruction surgery as treatment for gender dysphoria, or newly initiated cross-sex hormone therapy, subject to certain exceptions.

– This policy was informed through consideration of, among other things, the President and Secretary's written direction, existing and prior DoD policy, and prior DoD studies and reviews of service by individuals with gender dysphoria, including a review of medical literature regarding the medical risks associated with presence and treatment of gender dysphoria. This consideration included:

  - SecDef Memorandum, "Military Service by Transgender Individuals," February 22, 2018, which "conclude[d] that there are substantial risks associated with allowing accession and retention of individuals with a history or diagnosis of gender dysphoria… ." This conclusion was informed by an extensive inquiry conducted by a panel of experts (TAB 11).

  - A 2021 review conducted by DoD's Psychological Health Center of Excellence and the Accession Medical Standards Analysis and Research Activity which found that "rates of disability evaluation were estimated to be higher among [transgender] service members… ." (TAB 12) Additionally, this review found that nearly 40% of Service members with gender dysphoria in an observed cohort were non-deployable over a 24 month period. This level of non-deployability creates significant readiness risk and places additional burdens on Service members without gender dysphoria to meet requirements.

  - A 2025 medical literature review conducted by the Office of the Assistant Secretary of Defense for Health Affairs that included findings that "55% of transgender individuals experienced suicidal ideation and 29% attempted suicide in their lifetime,…[and] the suicide attempt rate is estimated to be 13 times higher among transgender individuals compared to their cisgender counterparts,"

"transgender individuals are approximately twice as likely to receive a psychiatric diagnosis compared to cisgender individuals," and that the strength of evidence on transgender mental health and gender-affirming care is low to moderate (TAB 13).

- A review of cost data by the Office of the Assistant Secretary of Defense for Health Affairs indicated that, between 2015 and 2024, DoD spent $52,084,407 providing care to active duty Service members to treat gender dysphoria, including $15,233,158 for psychotherapy; $3,135,593 for hormone therapy, and $14,324,739 for surgical care.

– While Service members with gender dysphoria volunteered to serve their country, the costs associated with their health care, coupled with the medical and readiness risks associated with their diagnosis and associated treatment that can limit their deployability, make continued service by such individuals incompatible with the Department's rigorous standards and national security imperative to deliver a ready, deployable force.

RECOMMENDATION: Sign the memorandum at TAB A.

Attachments:

File Folder:

TAB A	Performing the Duties of the Under Secretary of Defense for Personnel and Readiness, "Additional Guidance on Prioritizing Military Excellence and Readiness," Memorandum for Signature
TAB B	Secretary of Defense Memorandum, "Prioritizing Military Excellence and Readiness," February 7, 2025
TAB C	Executive Order 14183, "Prioritizing Military Excellence and Readiness," January 27, 2025
TAB D	Executive Order 14168, "Defending Women from Gender Ideology Extremism and Restoring Biological Truth to the Federal Government," January 20, 2025
TAB E	Coord

Binder:

TAB 1	DoDI 1300.28, "In-Service Transition for Transgender Service Members," April 30, 2021, as amended
TAB 2	Defense Health Agency Procedural Instruction 6025.21, "Guidance for Gender-Affirming Health Care of Transgender and Gender-Diverse Active and Reserve Component Service Members," May 12, 2023
TAB 3	Acting Assistant Secretary of Defense for Health Affairs Memorandum, "Guidance for Treatment of Gender Dysphoria for Active and Reserve Component Service Member," July 29, 2016
TAB 4	Principal Deputy Assistant Secretary of Defense for Health Affairs Memorandum, "Guidance for Medical Care in Military Treatment Facilities for Service Members Diagnosed with Gender Dysphoria," March 18, 2019
TAB 5	DoD Instruction (DoDI) 6130.03, Volume 1, "Medical Standards for Military Service: Appointment, Enlistment, or Induction," May 6, 2018, as amended

TAB 6	DoDI 6130.03, Volume 2, "Medical Standards for Military Service: Retention," September 4, 2020, as amended
TAB 7	DoDI 1327.06, "Leave and Liberty Policy and Procedures," June 16, 2009, as amended
TAB 8	DoDI 1322.22, "Military Service Academies," September 24, 2015, as amended
TAB 9	DoDI 1215.08, "Senior Reserve Officers' Training Corps (ROTC) Programs," January 19, 2017, as amended
TAB 10	DoDI 6025.19, "Individual Medical Readiness Program," July 13, 2022
TAB 11	Secretary of Defense Memorandum, "Military Service by Transgender Individuals," February 22, 2018
TAB 12	Accession Medical Standards Analysis and Research Activity (AMSARA) Report, "Analysis of Medical Administrative Data on Transgender Service Members," July 14, 2021
TAB 13	Office of the Assistant Secretary of Defense for Health Affairs Literature Review: Level of Evidence for Gender-Affirming Treatments

OFFICE OF THE UNDER SECRETARY OF DEFENSE
4000 DEFENSE PENTAGON
WASHINGTON, D.C. 20301-4000

PERSONNEL AND READINESS

FEB 2 6 2025

MEMORANDUM FOR SENIOR PENTAGON LEADERSHIP
COMMANDERS OF THE COMBATANT COMMANDS
DEFENSE AGENCY AND DOD FIELD ACTIVITY DIRECTORS

SUBJECT: Additional Guidance on Prioritizing Military Excellence and Readiness

As directed by the Secretary of Defense in his February 7, 2025, memorandum, "Prioritizing Military Excellence and Readiness," it is Department policy that, pursuant to Executive Order 14183, "Prioritizing Military Excellence and Readiness," the medical, surgical, and mental health constraints on individuals who have a current diagnosis or history of, or exhibit symptoms consistent with, gender dysphoria are incompatible with the high mental and physical standards necessary for military service.

The attachment to this memorandum provides supplemental policy guidance and establishes a reporting mechanism to ensure Department compliance. The policy guidance in the attachment: (1) supersedes any conflicting policy guidance in Department of Defense issuances and other policy guidance and memoranda; and (2) is effective immediately and will be incorporated into respective Department issuances, as appropriate.

The following DoD issuances will be updated to reflect guidance in this attachment, as appropriate:

- Department of Defense Instruction (DoDI) 6130.03, Volume 1, "Medical Standards for Military Service: Appointment, Enlistment, or Induction," May 6, 2018, as amended
- DoDI 6130.03, Volume 2, "Medical Standards for Military Service: Retention," September 4, 2020, as amended
- DoDI 1327.06, "Leave and Liberty Policy and Procedures," June 16, 2009, as amended
- DoDI 1322.22, "Military Service Academies," September 24, 2015, as amended
- DoDI 1215.08, "Senior Reserve Officers' Training Corps (ROTC) Programs," January 19, 2017, as amended
- DoDI 6025.19, "Individual Medical Readiness Program," July 13, 2022

Effective immediately, the following issuances, policies, and memoranda are cancelled:

- DoDI 1300.28, "In-Service Transition for Transgender Service Members," April 30, 2021, as amended
- Defense Health Agency Procedural Instruction 6025.21, "Guidance for Gender-Affirming Health Care of Transgender and Gender-Diverse Active and Reserve Component Service Members," May 12, 2023
- Acting Assistant Secretary of Defense for Health Affairs Memorandum, "Guidance for Treatment of Gender Dysphoria for Active and Reserve Component Service Member," July 29, 2016
- Principal Deputy Assistant Secretary of Defense for Health Affairs Memorandum, "Guidance for Medical Care in Military Treatment Facilities for Service Members Diagnosed with Gender Dysphoria," March 18, 2019

The Assistant Secretary of Defense for Manpower and Reserve Affairs will be responsible for all data collection and reporting. The first report is due March 26, 2025. All Department of Defense and Military Service policy recissions and updates must be completed no later than June 25, 2025.

Service members being processed for separation in accordance with this policy will be afforded all statutorily required rights and benefits.

Darin S. Selnick
Performing the Duties of the Under Secretary of Defense for Personnel and Readiness

Attachments:
As stated

cc:
Commandant of the Coast Guard
Assistant Secretary of Defense for Health Affairs
Assistant Secretary of Defense for Manpower and Reserve Affairs
Director, Defense Health Agency
Deputy Chief of Staff, G-1, U.S. Army
Deputy Commandant for Manpower and Reserve Affairs, U.S. Marine Corps
Chief of Naval Personnel, U.S. Navy
Deputy Chief of Staff for Personnel, U.S. Air Force
Deputy Chief of Space Operations, Personnel
Director for Manpower and Personnel, J1
Surgeon General, Public Health Service
Administrator, National Oceanic and Atmospheric Administration

ATTACHMENT
Service Members and Applicants for Military Service who Have a Current Diagnosis or History of, or Exhibit Symptoms Consistent with, Gender Dysphoria

1. **Policy.** It is DoD policy that:

a. Service in the Military Services is open to all persons who can meet the high standards for military service and readiness without special accommodations.

b. It is the policy of the United States Government to establish high standards for Service member readiness, lethality, cohesion, honesty, humility, uniformity, and integrity. This policy is inconsistent with the medical, surgical, and mental health constraints on individuals with gender dysphoria or who have a current diagnosis or history of, or exhibit symptoms consistent with, gender dysphoria.

c. Military service by Service members and applicants for military service who have a current diagnosis or history of, or exhibit symptoms consistent with, gender dysphoria is incompatible with military service. Service by these individuals is not in the best interests of the Military Services and is not clearly consistent with the interests of national security.

d. Individuals who have a current diagnosis or history of, or exhibit symptoms consistent with, gender dysphoria are no longer eligible for military service, except as set forth in sections 4.1.c. and 4.3.c. of this attachment.

e. Service members who have a current diagnosis or history of, or exhibit symptoms consistent with, gender dysphoria will be processed for separation from military service in accordance with section 4.4. of this attachment. Characterization of service under these procedures will be honorable except where the Service member's record otherwise warrants a lower characterization.

f. The Department only recognizes two sexes: male and female. An individual's sex is immutable, unchanging during a person's life. All Service members will only serve in accordance with their sex, defined in Executive Order 14168, "Defending Women from Gender Ideology Extremism and Restoring Biological Truth to the Federal Government," as "an individual's immutable biological classification as either male or female."

g. Where a standard, requirement, or policy depends on whether the individual is a male or female (e.g., medical fitness for duty, physical fitness and body fat standards; berthing, bathroom, and shower facilities; and uniform and grooming standards), all persons will be subject to the standard, requirement, or policy associated with their sex.

h. Pronoun usage when referring to Service members must reflect a Service member's sex. In keeping with good order and discipline, salutations (e.g., addressing a senior officer as "Sir" or "Ma'am") must also reflect an individual's sex.

i. Absent extraordinary operational necessity, the Military Services will not allow male Service members to use or share sleeping, changing, or bathing facilities designated for females, nor allow female Service members to use or share sleeping, changing, or bathing facilities designated for males.

j. No funds from the Department of Defense will be used to pay for Service members' unscheduled, scheduled, or planned medical procedures associated with facilitating sex reassignment surgery, genital reconstruction surgery as treatment for gender dysphoria, or newly initiated cross-sex hormone therapy.

k. Consistent with existing law and Department policy, commanders shall protect the privacy of protected health information they receive under this policy in the same manner as they would with any other protected health information. Such health information shall be restricted to personnel with a specific need to know; that is, access to information must be necessary for the conduct of official duties. Personnel shall also be accountable for safeguarding this health information consistent with existing law and Departmental policy.

2. Applicability. This policy guidance applies to the Office of the Secretary of Defense, the Military Departments, the Office of the Chairman of the Joint Chiefs of Staff, the Joint Staff, the Combatant Commands, the Office of Inspector General of the Department of Defense, the Defense Agencies, the DoD Field Activities, and all other organizational entities within the DoD.

3. Responsibilities.

3.1. Under Secretary of Defense for Personnel and Readiness (USD(P&R)).

The USD(P&R) will:

a. Update or rescind existing DoD issuances, or publish new issuances, as necessary pursuant to this guidance.

b. Ensure all Military Department and Military Service regulations, policies, and guidance are consistent with this attachment.

3.2. Assistant Secretary of Defense for Manpower and Reserve Affairs (ASD(M&RA)).

Under the authority, direction, and control of the USD(P&R), the ASD(M&RA) will:

a. Coordinate with the Assistant Secretary of Defense for Health Affairs (ASD(HA)) in the management and implementation of this guidance, and issue clarifying guidance, as appropriate.

b. Serve as the primary point of contact, through the Deputy Assistant Secretary of Defense for Military Personnel Policy (DASD(MPP)), for those responsibilities assigned in sections 3.3. through 3.6. of this attachment and provide reports in accordance with section 7 of this attachment, until a determination is made and notification provided to the Secretaries of the Military Departments that the reports may be cancelled.

c. Oversee the recission and updates to applicable DoD issuances, policy memoranda, and other guidance documents in accordance with this guidance.

3.3. ASD(HA).

Under the authority, direction, and control of the USD(P&R), the ASD(HA) will:

a. Coordinate with the ASD(M&RA) in the management and implementation of health care matters associated with this guidance, and issue clarifying guidance, as appropriate.

b. Oversee the recission of, and updates to, applicable DoD issuances, Defense Health Agency issuances, and other policy memoranda or guidance documents in accordance with this guidance.

c. Consider requests submitted by the Secretaries of the Military Departments, on a case-by-case basis, for an exception to section 1.j.. The ASD(HA) may authorize an exception to section 1.j. of this attachment for non-surgical care if required to protect the health of Service members. This authority may not be further delegated.

d. Submit to the DASD(MPP) a report in accordance with section 7 of this attachment.

3.4. Secretaries of the Military Departments.

The Secretaries of the Military Departments will:

a. Adhere to all provisions of this guidance.

b. Update or publish new regulations, policies, and guidance to implement the provisions of this attachment.

c. Ensure the protection of personally identifiable information, protected health information, and personal privacy considerations, consistent with existing law and DoD policy.

d. Implement processes for the assessment and oversight of compliance with DoD, Military Department, and Military Service regulations, policies, and guidance applicable to Service members and applicants for military service who have a current diagnosis or history of, or exhibit symptoms consistent with, gender dysphoria.

e. Establish procedures and implement steps to identify Service members who have a current diagnosis or history of, or exhibit symptoms consistent with, gender dysphoria within 30 days of this memorandum.

f. Within 30 days of identification pursuant to section 3.4.e. of this attachment, begin separation actions, in accordance with section 4.4. of this attachment, for Service members who have a current diagnosis or history of, or exhibit symptoms consistent with, gender dysphoria and are not granted a waiver pursuant to section 4.3.c. of this attachment.

g. Ensure all Service members who have a current diagnosis or history of, or exhibit symptoms consistent with, gender dysphoria and are assigned to the Office of the Secretary of Defense, Defense Agencies, DoD Field Activities, Combatant Commands, and other Joint assignments are reassigned to their respective Military Services for the purpose of initiating administrative separation processes.

h. Ensure all personnel systems accurately reflect each Service member's sex.

i. Submit to the DASD(MPP) a report in accordance with section 7 of this attachment.

3.5. Chairman of the Joint Chiefs of Staff.

The Chairman of the Joint Chiefs of Staff will:

a. Adhere to all provisions of this guidance.

b. Ensure the Commanders of the Combatant Commands adhere to all provisions of this guidance.

c. Consolidate and submit to the DASD(MPP) a report on Combatant Command compliance with section 5 of this attachment, in accordance with section 7 of this attachment.

d. Submit to the DASD(MPP) a report in accordance with section 7 of this attachment.

3.6. Defense Agency and DoD Field Activity Directors.

The Defense Agency and DoD Field Activity Directors will:

a. Ensure compliance with section 5 of this attachment.

b. Submit to the DASD(MPP) a report in accordance with section 7 of this attachment.

4. Procedures.

4.1. Appointment, Enlistment, or Induction into the Military Services.

a. Applicants for military service and individuals in the Delayed Training/Entry Program who have a current diagnosis or history of, or exhibit symptoms consistent with, gender dysphoria are disqualified for military service.

b. A history of cross-sex hormone therapy or sex reassignment or genital reconstruction surgery as treatment for gender dysphoria or in pursuit of a sex transition, is disqualifying.

c. Applicants disqualified pursuant to sections 4.1.a. and 4.1.b. of this attachment may be considered for a waiver on a case-by-case basis, provided there is a compelling Government interest in accessing the applicant that directly supports warfighting capabilities. The applicant

must be willing and able to adhere to all applicable standards, including the standards associated with the applicant's sex.

d. Applicants disqualified pursuant to sections 4.1.a. and 4.1.b. of this attachment and not granted a waiver pursuant to section 4.1.c. of this attachment shall not ship to Initial Entry Training.

e. Offers of admission to a Military Service Academy or the Senior Reserve Officers' Training Corps to individuals disqualified pursuant to sections 4.1.a. and 4.1.b. of this attachment shall be rescinded except where the individual is granted a waiver pursuant to section 4.1.c. of this attachment. Senior Reserve Officers' Training Corps students otherwise disqualified pursuant to sections 4.1.a. and 4.1.b. of this attachment may still participate in classes taught or coordinated by the Senior Reserve Officer's Training Corps that are open to all students at the college or university concerned. All individuals enrolled or participating in the Senior Reserve Officers' Training Corps, whether under contract or not contracted, will follow standards for uniform wear consistent with the individual's sex in accordance with section 5 of this attachment.

f. Individuals disqualified pursuant to sections 4.1.a. and 4.1.b. of this attachment are subject to separation from a Military Service Academy in accordance with DoDI 1322.22, or from the Senior Reserve Officers' Training Corps in accordance with DoDI 1215.08, unless the individual is granted a waiver consistent with section 4.1.c. of this attachment. Absent any other basis for separation or disenrollment, such individuals will not be subject to monetary repayment of educational benefits (i.e., recoupment) nor subject to completion of a military service obligation.

4.2. Medical Care.

a. In accordance with DoDI 6025.19 and DoDI 1215.13, Service members have a responsibility to maintain their health and fitness, meet individual medical readiness requirements, and report any medical and health (including mental health) issues that may affect their readiness to deploy or fitness to continue serving in an active status.

b. All unscheduled, scheduled, or planned surgical procedures associated with facilitating sex reassignment for Service members diagnosed with gender dysphoria are cancelled.

c. Cross-sex hormone therapy for Service members who have a current diagnosis or history of, or exhibit symptoms consistent with, gender dysphoria that began prior to the date of this memorandum may, if recommended by a DoD health care provider (HCP) in order to prevent further complications, be continued until separation is complete.

d. Service members may consult with a DoD HCP concerning a diagnosis of gender dysphoria and receive mental health counseling for a diagnosis of gender dysphoria. The retention or processing for separation of such Service members will follow procedures in section 4.3. or section 4.4. of this attachment, as appropriate.

4.3. Retention.

a. Service members who have a current diagnosis or history of, or exhibit symptoms consistent with, gender dysphoria are disqualified from military service.

b. Service members who have a history of cross-sex hormone therapy or a history of sex reassignment or genital reconstruction surgery as treatment for gender dysphoria or in pursuit of a sex transition, are disqualified from military service.

c. Service members disqualified pursuant to sections 4.3.a. and 4.3.b. of this attachment may be considered for a waiver on a case-by-case basis, provided there is a compelling Government interest in retaining the Service member that directly supports warfighting capabilities and the Service member concerned meets the following criteria:

1. The Service member demonstrates 36 consecutive months of stability in the Service member's sex without clinically significant distress or impairment in social, occupational, or other important areas of functioning; and

2. The Service member demonstrates that he or she has never attempted to transition to any sex other than their sex; and

3. The Service member is willing and able to adhere to all applicable standards, including the standards associated with the Service member's sex.

4.4. Separation.

a. Service members who have a current diagnosis or history of, or exhibit symptoms consistent with, gender dysphoria and are not granted a waiver pursuant to section 4.3. of this attachment will be processed for administrative separation in accordance with, and afforded all applicable administrative processing protections in, DoDI 1332.14 and DoDI 1332.30. The Secretaries of the Military Departments will direct the administrative separation of (1) any enlisted Service member prior to the expiration of the member's term of service following a determination that doing so is in the best interest of the relevant Military Service; or (2) any officer whose retention is not clearly consistent with the interests of national security.

1. Service members are ineligible for referral to the Disability Evaluation System (DES) when they have a current diagnosis or history of, or exhibit symptoms consistent with, gender dysphoria, not constituting a physical disability pursuant to DoDI 1332.18.

2. Service members may be referred to the DES if they have a co-morbidity, or other qualifying condition, that is appropriate for disability evaluation processing in accordance with DoDI 1332.18, prior to processing for administrative separation.

3. Service members who are processed for separation pursuant to this policy will be designated as non-deployable until their separation is complete.

4. Service members who have a current diagnosis or history of, or exhibit symptoms consistent with, gender dysphoria may elect to separate voluntarily in the 30 days following signature of this guidance. Such Service members may be eligible for voluntary separation pay in accordance with 10 U.S.C. § 1175a and DoDI 1332.43. Service members eligible for voluntary separation pay will be paid at a rate that is twice the amount the Service member would have been eligible for involuntary separation pay, in accordance with DoDI 1332.29.

5. Service members separated involuntarily pursuant to this policy may be provided full involuntary separation pay in accordance with 10 U.S.C. § 1174 and DoDI 1332.29.

6. All enlisted Service members who are involuntarily separated pursuant to this policy will, if desired by the Service member, be afforded an administrative separation board.

7. All officers who are involuntarily separated pursuant to this policy will be afforded a Board of Inquiry, if desired by the officer, in accordance with 10 U.S.C. § 1182.

8. Service members identified pursuant to section 3.4.e. of this attachment with over 18 but less than 20 years of total active duty service are eligible for early retirement under the Temporary Early Retirement Authority in accordance with DoDI 1332.46.

9. Eligible Service members (including active duty Service members and Reserve or National Guard members when on active duty orders for 30 or more consecutive days) who are processed for separation pursuant to this policy, and their covered dependents, remain eligible for TRICARE for 180 days in accordance with 10 U.S.C. § 1145.

10. Service members choosing voluntary separation will not have to repay any bonuses received prior to the date of this memorandum, even if they have a remaining service obligation, pursuant to 37 U.S.C. § 373(b)(1). The Military Departments may recoup any bonuses received prior to the date of this memorandum for Service members choosing to be involuntarily separated.

11. The Secretaries of the Military Departments shall waive any remaining military service obligation for Service members who are separated pursuant to this policy.

b. Separation proceedings for individuals identified pursuant to section 3.4.e. of this attachment will be initiated after the Secretaries of Military Departments complete the requirements in section 3.4.e. of this attachment.

c. Nothing in this attachment precludes appropriate administrative or disciplinary action for Service members who refuse orders from lawful authority to comply with applicable standards or otherwise do not meet standards for performance and conduct.

5. Sex.

5.1. Military Records. All military records will reflect the Service member's sex.

5.2. Military Standards.

a. Access to intimate spaces will be determined by Service members' or applicants for military service's sex. The Military Services will apply all standards that involve consideration of the Service members' sex, to include, but not limited to:

1. Uniforms and grooming.

2. Body composition assessment.

3. Medical fitness for duty.

4. Physical fitness and body fat standards.

5. Berthing, bathroom, and shower facilities.

6. Military personnel drug abuse testing program participation.

b. All such shared intimate spaces will be clearly designated for either male, female, or family use.

c. Exceptions to this requirement may be made only in cases of extraordinary operational necessity. During deployments, or in austere environments where space is limited, commanders will prioritize unit cohesion and readiness while adhering to this policy.

6. Administrative Absence for Service Members with a Current History or Diagnosis of, or Symptoms Consistent with, Gender Dysphoria.

6.1. Administrative Absence.

a. In order to maintain good order and discipline in accordance with section 5 of this attachment, the Secretary of the Military Department concerned may place Service members being processed for separation under the criteria in section 4.4.a. of this attachment in an administrative absence status, with full pay and benefits, until their separation is complete.

b. Service members in an administrative absence status in accordance with this section will be designated as non-deployable until their separation is complete.

c. Service members in an administrative absence status in accordance with this section will complete the Transition Assistance Program in accordance with DoDI 1332.35.

7. Reporting.

7.1. Report Requirements.

a. No later than March 26, 2025, and every 30 days thereafter, submit via a Correspondence and Task Management System (CATMS) tasker a memorandum to the DASD(MPP) providing the following:

1. Identification of all DoD, Military Department, and Military Service issuances, regulations, policy memoranda, and other guidance where the content of which relate to, or may be affected by, guidance provided in this attachment.

2. Status of updates to the aforementioned DoD, Military Department, and Military Service issuances, regulations, policy memoranda, and other guidance.

3. Draft revisions to the aforementioned DoD, Military Department, and Military Service issuances, regulations, policy memoranda, and other guidance.

4. Status of system of records updates.

5. Status of, and progress on, separations of Service members who have a current diagnosis or history of, or exhibit symptoms consistent with, gender dysphoria in accordance with section 4.4. of this attachment.

6. Status of, and progress on, compliance with section 5 of this attachment.

GLOSSARY

G.1. Acronyms

Acronym	Meaning
ASD(HA)	Assistant Secretary of Defense for Health Affairs
ASD(M&RA)	Assistant Secretary of Defense for Manpower and Reserve Affairs
CATMS	Correspondence and Task Management System
DASD(MPP)	Deputy Assistant Secretary of Defense for Military Personnel Policy
DES	Disability Evaluation System
DoDI	DoD Instruction
U.S.C.	United States Code
USD(P&R)	Under Secretary of Defense for Personnel and Readiness

G.2. Definitions

Unless otherwise noted, these terms and their definitions are for the purposes of this attachment.

Term	Definition
cross-sex hormone therapy	The use of feminizing hormones by a male or the use of masculinizing hormones by a female.
gender dysphoria	A marked incongruence between one's experienced or expressed gender and assigned gender of at least 6 months' duration, as manifested by conditions specified in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders: Fifth Edition, page 452, which is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning.
gender identity	Defined in Executive Order 14168 as a fully internal and subjective sense of self, disconnected from biological reality and sex and existing on an infinite continuum, that does not provide a meaningful basis for identification and cannot be recognized as a replacement for sex.
sex	Defined in Executive Order 14168 as an individual's immutable biological classification as either male or female.

REFERENCES

Executive Order 14168, "Defending Women from Gender Ideology Extremism and Restoring Biological Truth to the Federal Government," January 20, 2025
Executive Order 14183, "Prioritizing Military Excellence and Readiness," January 27, 2025
DoDI 1215.08, "Senior Reserve Officers' Training Corps (ROTC) Programs," January 19, 2017, as amended
DoDI 1215.13, "Ready Reserve Member Participation Policy," May 5, 2015
DoDI 1322.22, "Military Service Academies," September 24, 2015, as amended
DoDI 1327.06, "Leave and Liberty Policy and Procedures," June 16, 2009, as amended
DoDI 1332.14, "Enlisted Administrative Separations," August 1, 2024
DoDI 1332.18, "Disability Evaluation System," November 10, 2022
DoDI 1332.29, "Involuntary Separation Pay (Non-Disability)," March 3, 2017
DoDI 1332.30, "Commissioned Officer Administrative Separations," May 11, 2018, as amended
DoDI 1332.35, "Transition Assistance Program (TAP) for Military Personnel," September 26, 2019
DoDI 1332.43, "Voluntary Separation Pay (VSP) Program for Service Members," November 28, 2017
DoDI 1332.46, "Temporary Early Retirement Authority (TERA) for Service Members," December 21, 2018
DoDI 6025.19, "Individual Medical Readiness Program," July 13, 2022
DoDI 6130.03, Volume 1, "Medical Standards for Military Service: Appointment, Enlistment, or Induction," May 6, 2018, as amended
DoDI 6130.03, Volume 2, "Medical Standards for Military Service: Retention," September 4, 2020, as amended
American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders: Fifth Edition, May 18, 2013
Title 10, United States Code
Title 37, United States Code

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON
AT SEATTLE

COMMANDER EMILY SHILLING; COMMANDER BLAKE DREMANN; LIEUTENANT COMMANDER GEIRID MORGAN; SERGEANT FIRST CLASS CATHRINE SCHMID; SERGEANT FIRST CLASS JANE DOE; SERGEANT FIRST CLASS SIERRA MORAN; STAFF SERGEANT VIDEL LEINS; MATTHEW MEDINA; and GENDER JUSTICE LEAGUE,

Plaintiffs,

v.

DONALD J. TRUMP, in his official capacity as President of the United States; UNITED STATES OF AMERICA; PETER HEGSETH, in his official capacity as Secretary of Defense; UNITED STATES DEPARTMENT OF DEFENSE; DANIEL P. DRISCOLL, in his official capacity as Secretary of the Army; UNITED STATES DEPARTMENT OF THE ARMY; TERENCE EMMERT, in his official capacity as Acting Secretary of the Navy; UNITED STATES DEPARTMENT OF THE NAVY; GARY ASHWORTH, in his official capacity as Acting

Case No. 2:25-cv-241-BHS

FIRST AMENDED COMPLAINT FOR DECLARATORY AND INJUNCTIVE RELIEF

CAPTION CONTINUED ON NEXT PAGE

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Lambda Legal Defense and Education Fund, Inc.
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Human Rights Campaign Foundation
1640 Rhode Island Ave NW
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Phone: 202.527.3669

Secretary of the Air Force; UNITED STATES DEPARTMENT OF THE AIR FORCE,

Defendants.

NATURE OF ACTION

1. This action challenges the constitutionality of Executive Order No. 14183, *Prioritizing Military Excellence and Readiness* (the "2025 Military Ban"), which President Donald J. Trump issued on January 27, 2025,[1] and related official federal policy and directives, which together ban a group of Americans—transgender people—from serving their Country in the military simply because of who they are.

2. There are currently thousands of transgender people selflessly and patriotically serving in our Nation's armed services across myriad roles, and many others seek to follow the same noble path. Transgender service members take the same oath as every other service member to serve our Nation and place themselves in harm's way—potentially paying the ultimate price—in service of our Country. And to be clear, our country *needs* ready, able, and willing service members to stand up and protect our freedoms. But the 2025 Military Ban turns them away and kicks them out—for no legitimate reason. Rather, it baselessly declares ***all*** transgender people unfit to serve, insults and demeans them, and cruelly describes every one of them as incapable of "an honorable, truthful, and disciplined lifestyle, even in one's personal life," based solely because they are transgender. These assertions are, of course, false.

3. Nevertheless, the 2025 Military Ban denies the existence of transgender people altogether, branding all people whose gender identities differ from the sex assigned to them at birth as a "falsehood" and lacking the "humility and selflessness required of a service member." 2025 Military Ban § 1. It incorporates the definitions of another executive order (the "Gender Identity

[1] Exec. Order No. 14183, *Prioritizing Military Excellence and Readiness*, 90 Fed. Reg. 8,757 (Feb. 3, 2025), https://www.govinfo.gov/content/pkg/FR-2025-02-03/pdf/2025-02178.pdf.

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Executive Order")[2] which proclaims that having a gender identity incongruent with one's sex designated at birth is a "false belief." 2025 Military Ban § 3; Gender Identity Executive Order § 2(f).

4. The 2025 Military Ban directs the Secretary of Defense to adopt and execute a policy establishing that a person being transgender is incompatible with military service, thereby preventing existing service members who are transgender from continuing to serve and preventing transgender people from enlisting in, or acceding to, the armed forces in the future. 2025 Military Ban § 4(a)–(c). It further directs the Secretary of Homeland Security to adopt and execute the same with respect to the Coast Guard. 2025 Military Ban § 4(e).

5. The 2025 Military Ban and related federal policy and directives undermine military readiness, endanger our safety, and violate the United States Constitution. IT also represents an abrupt and misguided change from current military policy.

6. Plaintiffs are seven existing service members who have served honorably and openly as transgender in the military for years; one transgender person who, were it not for 2025 Military Ban and related policy and directives, meets the requirements to serve and who wishes to enlist; and an organizational Plaintiff with transgender military members.

7. Three Plaintiffs are senior officers. Commander Shilling, Commander Dremann, and Lieutenant Commander Morgan are senior Naval officers. Each has an impressive military record. Commander Shilling has flown 60 combat missions. Commander Dremann has supervised hundreds of personnel maintaining United States Marine Corps aircraft and repairing submarines for deployment. And Lieutenant Commander Morgan manages a substantial science and technology funding portfolio.

8. Four Plaintiffs are senior enlisted service members in the Army and the Air Force with equally admirable service records. Sergeant First Class Doe works as a satellite

[2] Exec. Order No. 14168, *Defending Women from Gender Ideology Extremism and Restoring Biological Truth to the Federal Government*, 90 Fed. Reg. 8,615 (Jan. 30, 2025), https://www.govinfo.gov/content/pkg/FR-2025-01-30/pdf/2025-02090.pdf.

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communications operator, Sergeant First Class Schmid holds the military occupational specialty of Signals Intelligence Analyst, Sergeant First Class Moran coordinates planning and operations for her battalion, and Staff Sergeant Videl Leins works on high voltage power plants.

9. One Plaintiff, Matthew Medina, seeks to enlist in the United States Marine Corps in order to serve his country and simultaneously escape generational poverty. And the organization, Gender Justice League, seeks to protect its members who are or aspire to be service members from discrimination.

10. By categorically excluding transgender people, the 2025 Military Ban and related federal policy and directives violate the equal protection and due process guarantees of the Fifth Amendment and the free speech guarantee of the First Amendment. They lack any legitimate or rational justification, let alone the compelling and exceedingly persuasive ones required. Accordingly, Plaintiffs seek declaratory, and preliminary and permanent injunctive, relief.

PARTIES

Plaintiffs

11. Plaintiff **Commander Emily "Hawking" Shilling** is a 42-year-old woman who resides in Maryland. She has served for more than 19 years in the United States Navy and is currently stationed in Maryland. Commander Shilling is transgender.

12. Plaintiff **Commander Blake Dremann** is a 43-year-old man who is stationed in Guam. He has served for more than 19 years in the United States Navy. Commander Dremann is transgender.

13. Plaintiff **Lieutenant Commander Geirid Morgan** is a 45-year-old woman who resides in Maryland. She has served for more than 14 years in the United States Navy and is currently stationed in Maryland. Lieutenant Commander Morgan is transgender.

14. Plaintiff **Sergeant First Class Cathrine Schmid** is a 40-year-old woman who resides in Baltimore, Maryland. She has served in the United States Army for more than 20 years

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and is currently stationed at Fort George G. Meade in Maryland. Sergeant First Class Schmid is transgender.

15. Plaintiff **Sergeant First Class Jane Doe** is a 37-year-old woman who resides in Olympia, Washington. She has served in the United States Army for over 17 years and is currently stationed at Joint Base Lewis-McChord (JBLM) in the State of Washington. Sergeant First Class Doe is transgender.

16. Plaintiff **Sergeant First Class Sierra Moran** is a 31-year-old woman who resides in Tacoma, Washington. She has served in the U.S. Army for almost 10 years and is currently stationed at Joint Base Lewis-McChord in the State of Washington. Sergeant First Class Moran is transgender.

17. Plaintiff **Staff Sergeant Videl Leins** is a 34-year-old woman who resides in Las Vegas, Nevada. She has served in the United States Air Force for 16 years. Staff Sergeant Leins is transgender.

18. Plaintiff **Mr. Matthew Medina** is a 23-year-old man who resides in New Jersey. He wishes to serve in the military. Mr. Medina is transgender.

19. Commander Shilling, Commander Dremann, Lieutenant Commander Morgan, Sergeant First Class Schmid, Sergeant First Class Doe, Staff Sergeant Leins, and Mr. Medina are referred to collectively as the "Individual Plaintiffs."

20. Plaintiff **Gender Justice League** is a Washington State-based gender and sexuality civil and human rights organization. Gender Justice League's principal place of business is in Seattle, Washington. Gender Justice League brings its claims on behalf of its members. Gender Justice League is referred to as the "Organizational Plaintiff." Multiple Individual Plaintiffs are members of Gender Justice League.

Defendants

21. Defendant **Donald J. Trump** is the President of the United States of America and Commander in Chief of the U.S. military. On January 27, 2025, President Trump signed and issued

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the 2025 Military Ban. He is responsible for the actions and decisions that Plaintiffs challenge in this action. He is sued in his official capacity.

22. Defendant **United States of America** encompasses all federal agencies and departments, including the United States Department of Defense and United States Department of Homeland Security, that are responsible for implementing the 2025 Military Ban.

23. Defendant **Peter Hegseth** is the Secretary of the United States Department of Defense. Secretary Hegseth is responsible for all aspects of the operation and management of the Department of Defense, including the implementation of the 2025 Military Ban. He is sued in his official capacity.

24. Defendant **United States Department of Defense** is a cabinet-level department of the United States federal government. The Department of Defense is composed of the office of the Secretary of Defense; the Joint Chiefs of Staff; the Joint Staff; America's Defense Agencies; the Department of Defense Field Activities; the Departments of the Army, Navy, and Air Force; the unified and specified combatant commands, such other offices, agencies, activities, and commands as may be established or designated by law or by the President; and all offices, agencies, activities, and commands under any of their control or supervision. Under the direction of Secretary Hegseth, the Department of Defense is responsible for administration and enforcement of the 2025 Military Ban.

25. Defendant **Daniel P. Driscoll** is the Secretary of the United States Department of the Army. He is the leader of Department of the Army and is responsible for its administration and operation. He is sued in his official capacity.

26. Defendant **Department of the Army** is one of three military departments of the Department of Defense and is responsible for the administration and operation of the United States Army.

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27. Defendant **Terence Emmert** is the Acting Secretary of the United States Department of the Navy. He is the leader of Department of the Navy and is responsible for its administration and operation. He is sued in his official capacity.

28. Defendant **Department of the Navy** is one of three military departments of the Department of Defense and is responsible for the administration and operation of the United States Navy and the United States Marine Corps.

29. Defendant **Gary Ashworth** is the Acting Secretary of the Air Force. He is the leader of Department of the Air Force and is responsible for its administration and operation. He is sued in his official capacity.

30. Defendant **Department of the Air Force** is one of three military departments of the Department of Defense and is responsible for the administration and operation of the United States Air Force and the United States Space Force.

31. Defendants Defense Secretary Hegseth, Department of Defense, Secretary of the Army Driscoll, Department of the Army, Acting Secretary of the Navy Emmert, Department of the Navy, Acting Secretary of the Air Force Ashworth, and Department of the Air Force are referred to collectively as the "Agency Defendants."

JURISDICTION AND VENUE

32. This Court has jurisdiction pursuant to 28 U.S.C. § 1331 as this action arises under the laws of the United States and the United States Constitution; 28 U.S.C. § 1346, as a civil action against the United States founded upon the Constitution, an Act of Congress, or an executive regulation; and 28 U.S.C. § 1361, as an action to compel an officer or employee of the United States or an agency to perform a duty owed to a plaintiff..

33. Venue is proper in the Western District of Washington under 28 U.S.C. §§ 1391(b)(2) and 1391(e) because each defendant is an agency of the United States or an officer of the United States sued in their official capacity, Defendants Department of the Army and Department of the Air Force and Plaintiff Jane Doe reside at Joint Base Lewis–McChord in Pierce

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County within this District, Plaintiff Gender Justice League resides in King County within this District, and a substantial part of the events or omissions giving rise to this action occurred and continue to occur in this District because Defendants Department of the Army and Department of the Air Force and Plaintiff Jane Doe reside in this District and Defendants Department of the Army and Department of the Air Force are among the federal agencies that have been instructed to implement, administer, and enforce the 2025 Military Ban.

34. An actual controversy exists between the parties within the meaning of 28 U.S.C. § 2201(a), and this Court may grant declaratory, injunctive, and other relief pursuant to 28 U.S.C. §§ 2201–2202 and Rules 57 and 65 of the Federal Rules of Civil Procedure.

35. This Court has personal jurisdiction over each of the Defendants because their enforcement of the 2025 Military Ban occurs within Washington.

FACTUAL ALLEGATIONS

Background Information Regarding Transgender People

36. Gender identity is a person's fundamental, internal sense of belonging to a particular gender. It is a core characteristic of human identity that everyone possesses. Gender identity is innate and has a biological basis.

37. Although most people have a gender identity that matches their sex assigned at birth, this is not the case for transgender people, who are defined as transgender because their gender identity is incongruent with the sex they were assigned at birth. Transgender people have existed throughout human history, although understanding of transgender people has grown in modern times.

38. A person's sex is generally designated at birth based on external genitalia. But other sex-related characteristics can include chromosomes, hormone levels, internal reproductive organs, and also gender identity.

39. When someone's sex-related characteristics are not in typical alignment with each other, gender identity is the critical determinant of sex.

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40. Attempts to change an individual's gender identity to bring it into alignment with the sex that the individual was assigned at birth are ineffective and potentially harmful.

41. For transgender people, the incongruence between their gender identity and sex assigned at birth can cause clinically significant distress, which is known as gender dysphoria.

42. According to the American Psychiatric Association's *Diagnostic & Statistical Manual of Mental Disorders, Fifth Edition, Text Revision*, "gender dysphoria" is the diagnostic term for the condition experienced by some transgender people of clinically significant distress resulting from the lack of congruence between their gender identity and the sex assigned to them at birth.

43. Gender dysphoria can be treated in accordance with widely recognized, well-established, and evidence-based clinical practice guidelines. Treatment for gender dysphoria aims to resolve the distress associated with the incongruence between a transgender person's assigned sex at birth and their gender identity.

44. The health and wellbeing of all people, including those who are transgender, depends on their ability to live in a manner consistent with their gender identity. As such, living in a manner consistent with one's gender identity is a key aspect of treatment for gender dysphoria.

45. The process by which transgender people come to live in a manner consistent with their gender identity, rather than the sex they were assigned at birth, is known as transition.

46. The steps that transgender people take to transition are not identical for every individual, but they generally include social, legal, and medical transition.

47. Social transition entails the adoption of a gender role matching one's gender identity. This can include using a new name, pronouns that correspond to a person's gender identity, and adopting dress or grooming styles that more authentically reflect a person's gender.

48. Legal transition involves steps to conform one's legal identity to one's gender identity, such as legally changing one's name and updating the name and gender marker on one's driver's license and birth certificate.

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49. Medical transition includes treatment that brings one's body into alignment with one's gender identity, such as hormone therapy. Whether any particular treatment is medically necessary or even appropriate, however, depends on the needs of the individual.

50. These various components associated with transition—social, legal, and medical transition—do not change an individual's gender but instead bring the individual's social presentation, legal identity, and physical appearance into greater typical alignment with their gender.

The Individual Plaintiffs' Military Service

Commander Emily "Hawking" Shilling

51. Commander Shilling has served in the Navy for over 19 years. She commissioned as an officer in November 2005.

52. Commander Shilling has served as a combat aviator. She was deployed to Afghanistan and Iraq on board an aircraft carrier, from which she conducted 60 combat missions, leading to the award of three Air Medals for her meritorious service. During this time, she was also awarded the Daedalian Award for Superior Airmanship During an Emergency in which, through her calm execution and superior flying skills, she saved both her aircraft and its four crew members from imminent ejection and destruction over the Pacific Ocean. Commander Shilling has earned one meritorious Service Medal, two Navy Commendations and three United States Navy and United States Marine Corps Achievement Medals.

53. Commander Shilling then served as a United States Navy Test Pilot, where she conducted high-risk flight tests to advance aviation technology and improve aircraft capabilities.

54. Commander Shilling currently serves as an Aerospace Engineering Duty Officer, charged with leading large Naval acquisition programs. Her work directly impacts the future of naval aviation, ensuring that the fleet remains operationally effective, technologically advanced, and mission-ready,

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55. The Navy has invested over 20 million dollars in Commander Shilling's training and flight experience.

56. Commander Shilling is transgender. She was assigned the sex of male at birth, but her gender identity is female.

57. Commander Shilling began to come to terms with her gender approximately six years ago in 2019 and began living openly as female outside of work at that time.

58. In 2021, once military policy allowed, Commander Shilling transitioned socially and medically within the military.

59. Commander Shilling has taken legal steps to transition. She legally changed her first name to Emily. She also changed her name and gender marker to female on her driver's license, birth certificate, social security card and records, and passport.

60. The military updated Commander Shilling's gender marker in the Defense Enrollment Eligibility Reporting System ("DEERS") in Fall 2021.

61. In consultation with healthcare professionals, Commander Shilling has taken clinically appropriate steps to transition.

62. In Spring 2023, Commander Shilling regained her flight clearance post-transition to fly high-performance jets. The Naval Aerospace Medical Institute, after extensive evaluations, determined there was no medical reason to deny her flight clearance.

63. Commander Shilling has engaged in speech and conduct disclosing her transgender status and expressing her gender identity, including within the Navy, and wants to continue to be able to do so without fear of retaliation or discharge.

64. Being able to serve openly as a transgender person has made Commander Shilling an even more productive, healthy member of her command. Being able to lead with authenticity and integrity has only strengthened her relationships with fellow service members.

65. Since the 2025 Military Ban was issued, Commander Shilling has felt deeply unsettled, betrayed, and fearful for her future in the military and her bodily autonomy. After

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dedicating her entire adult life to the Navy, her ability to continue serving is now in jeopardy solely because of her identity as a transgender woman.

Commander Shilling and her partner have built their lives around military service, and they have three children who depend on her continued employment. If she is forcibly discharged, her family will face immediate financial and personal instability, as well as the loss of essential benefits like health care, housing allowances, and retirement security.

Commander Blake Dremann

66. Commander Blake Dremann has served in the Navy for over 19 years. Commander Dremann currently serves on the USS Frank Cable in Guam as a supply officer. As part of his duties, he supervises 40 sailors and five junior officers working to repair submarines for forward deployment. Prior to his current assignment, he served as a supply officer at the aviation maintenance depot in North Carolina, and numerous other assignments, including service on a submarine from 2011 to 2015.

67. Commander Dremann has received two Defense Meritorious Service Medals, two Meritorious Service Medals, a Joint Service Commendation Medal, a Navy and Marine Corps Commendation Medal, a Joint Service Achievement Medal and four Navy and Marine Corps Achievement Medals.

68. In 2015, Commander Dremann was awarded the Vice Admiral Robert F. Batchelder Award, the Navy League's award to junior officers who gave significant contributions to the operational readiness of the fleet.

69. Commander Dremann is preparing for his 12th career deployment.

70. Commander Dremann is transgender. He was assigned the sex of female at birth, but his gender identity is male.

71. Commander Dremann has changed his legal name and other identity documents and gender marker in DEERS. Mr. Dremann was the first person in the Navy to amend their gender in DEERS.

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72. Commander Dremann has engaged in speech and conduct disclosing his transgender status and his gender identity, including by coming out to his chain of command and fellow service members, taking steps to transition, and living openly as male, and wants to continue to be able to do so without fear of retaliation or discharge.

73. While being able to live openly has made him a better person, sustained and superior performance and merit is why he continues to serve in the United States Navy.

74. Since the 2025 Military Ban was issued, Commander Dremann has been deeply concerned about his future in the U.S. Navy and he is worried about his retirement eligibility, being pulled from going on deployment, and leaving his department with a hole in it.

Lieutenant Commander Geirid Morgan

75. Lieutenant Commander Morgan has served in the U.S. Navy for 14 years. She initially served as an enlisted service member from 1998 to 2002, and after earning her Ph.D. from the University of Utah, she commissioned as an Officer and reentered active service in 2015.

76. Lieutenant Commander Morgan's initial occupational specialty was as an enlisted Navy diver where she supported mission critical security operations following the September 11, 2001 attacks.

77. Lieutenant Commander Morgan currently works as a Program Officer with the Office of Naval Research where she manages a science and technology funding portfolio that invests in fundamental and applied human physiology research efforts to fill current and projected operational capability gaps in the U.S. Navy and the United States Marine Corps.

78. Lieutenant Commander Morgan is transgender. She was assigned the sex of male at birth, but her gender identity is female.

79. Lieutenant Commander Morgan has changed her legal name and gender and other identity documents and has changed her name and gender marker in DEERS.

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80. Being able to serve openly as who she is has made Lieutenant Commander Morgan a stronger asset to the military. She is able to forge stronger relationships through increased trust, which has led to two of her most productive years as a working professional in the military.

81. Since the 2025 Military Ban was issued, Lieutenant Commander Morgan has felt deeply devalued and attacked by the 2025 Military Ban. The language in the 2025 Military Ban Executive Order is particularly difficult for Lieutenant Commander Morgan to absorb given its dehumanizing and genuine antipathy towards who she is, and its contempt for her military service and complete disregard for her family's well-being as military dependents.

82. Involuntary separation from the Navy would cause Lieutenant Commander Morgan measurable and immediate harm by upending her retirement and long-term economic prospects and eliminating the substantial personal investment she has made in her military-specific professional development, one that does not translate into civilian life. It would also cause great harm to her family, who relies on her health care coverage to provide care for Lieutenant Commander Morgan's son, who suffers from a complex metabolic disease that requires treatment.

Plaintiff Sergeant First Class Cathrine "Katie" Schmid

83. Plaintiff Sergeant First Class Cathrine "Katie" Schmid is a 40-year-old woman who resides in Baltimore, Maryland. She has served in the United States Army for more than 20 years and is currently stationed at Fort George G. Meade in Maryland.

84. Sergeant First Class Schmid was born at K.I. Sawyer Air Force Base in Michigan, and was raised in Portland, Oregon. She has always been a patriotic American with a desire to serve others and was drawn to opportunities presented by serving in the Army. She is proud to put on her uniform each day and serve her country.

85. Sergeant First Class Schmid holds the military occupational specialty of Signals Intelligence Analyst within the Army and currently performs duties as a Brigade Equal Opportunity Advisor. She has previously performed duties as a Multi-Domain Intelligence Non-Commissioned Officer in Charge, Senior Technical Intelligence Sergeant, Platoon Sergeant,

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Signals Intelligence Sergeant, Squad Leader, Multifunction Team Leader, Brigade Land and Ammunition NCO, Brigade Current Operations NCO, Signals Intelligence Analyst, All-Source Analysis System Master Analyst, Human Intelligence Collector, and Counterintelligence Agent. She joined the Army in 2005.

86. Sergeant First Class Schmid is transgender. She was assigned the sex of male at birth but has a female gender identity. She knew from a young age in life that she was female.

87. Sergeant First Class Schmid began to come to terms with her gender identity approximately eleven years ago. At that time, she started to see a mental health professional who diagnosed her with gender dysphoria.

88. Sergeant First Class Schmid began living openly as a woman in 2014.

89. In consultation with health care professionals, Sergeant First Class Schmid has taken clinically appropriate steps to transition.

90. Sergeant First Class Schmid has taken legal steps to transition. She legally changed her first name to Cathrine. She also changed her name and changed her gender marker to female on her driver's license, passport, and social security records.

91. Sergeant First Class Schmid has worked with her chain of command throughout her transition, and both they and other enlisted personnel have been supportive of her throughout that process. Her gender marker in DEERS reflects that she is female.

92. Sergeant First Class Schmid is recognized and treated as female in all aspects of military life, including in social interactions and in her compliance with women's grooming, facilities use, and physical training requirements.

93. The fact that Sergeant First Class Schmid is transgender has not prevented her from doing her job in the military, nor has it prevented others from doing their jobs in the military. Sergeant First Class Schmid performs valuable services for the Army, and her performance of those duties strengthen our nation's military readiness.

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94. Sergeant First Class Schmid has received numerous awards and decorations for her service and has been promoted since coming out as transgender to her chain of command.

95. Being able to serve openly as a transgender woman has made Sergeant First Class Schmid a stronger asset for the military. She is able to function as a productive, healthy member of the military, and she is able to forge stronger relationships with others in her unit.

96. Sergeant First Class Schmid has engaged in speech and conduct disclosing her transgender status and expressing her gender identity, including within the Army, by coming out to her chain of command and her fellow service members, taking steps to transition, and living openly as a woman in military life. She wants to continue to be able to engage in speech and conduct disclosing her transgender status and expressing her gender identity.

97. The 2025 Military Ban has caused Sergeant First Class Schmid great fear and anxiety, as it risks her ability to fulfill her remaining service requirements, her continued employment in the Army, and her retirement benefits. Her intent and desire are to finish her current term of service in 2026 and then to apply for another position in her unit before retiring.

98. Sergeant First Class Schmid also relies on her employment with the military to provide continuity of critical health care to her disabled wife.

99. In addition to her concerns about loss of employment and benefits, the 2025 Military Ban also causes Sergeant First Class Schmid distress because it tells her fellow soldiers—for whom she would lay down her life—that her very existence is a threat to them.

Plaintiff Sergeant First Class Jane Doe

100. Plaintiff Sergeant First Class Jane Doe is 37 years old. She is actively serving in the United States Army and has served for over 17 years.

101. Sergeant First Class Doe has worked as a satellite communications operator and maintainer for more than ten years. She was deployed to Iraq for most of 2009 and then again to Iraq in 2011, and she also served nine months in Kuwait.

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102. Sergeant First Class Doe has received numerous awards and decorations for her service in the Army.

103. Sergeant First Class Doe is transgender. She was assigned male at birth, but her gender identity is female.

104. Since coming out as transgender, Sergeant First Class Doe has been selected for positions of increased responsibility and trust, completed a nine-month assignment to Kuwait, and was promoted into senior leadership. She is currently preparing for two international missions this year in key leadership positions.

105. Sergeant First Class Doe came out about her gender identity in 2021 and has lived as female since then. She has updated her gender marker in DEERS, on her passport, and on her state identification.

106. In consultation with health care professionals, Sergeant First Class Doe has taken clinically appropriate steps to transition.

107. Sergeant First Class Doe and her family recently relocated to a location with a higher cost of living for her military job. Her military job provides the majority of the income and health benefits for her family, which includes her wife and child. She plans to pass her GI Bill education benefits to her child and has planned on receiving retirement benefits from the military. The 2025 Military Ban has caused Sergeant First Class Doe to fear for her and her family's future and safety.

108. Sergeant First Class Doe wishes to continue her service. If she is forced to leave military service before reaching 20 years of service, she risks losing the retirement benefits and GI bill benefits that she has worked to establish over the past 17 years.

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Plaintiff Sergeant First Class Sierra Moran

109. Sergeant First Class Sierra Moran is 31 years old. She is actively serving in the United States Army and has served almost 10 years.

110. Sergeant First Class Moran helps lead the planning and operations for her battalion. She organizes training and helps plan overseas deployments.

111. Sergeant Moran holds a top-secret clearance.

112. Prior to her current role, Sergeant First Class Moran was deployed to Korea where she monitored networks for the Korean peninsula for all military operations. Sergeant First Class Moran has received three U.S. Army commendations medals, and two U.S. Army achievement medals, one earned while on an air defense artillery mission in Korea in 2017.

113. Sergeant First Class Moran is transgender. She was assigned the sex of male at birth but has a female gender identity.

114. Sergeant First Class Moran began coming to terms with her gender identity in 2019.

115. Sergeant First Class Moran obtained a legal name change and began medical care in 2021.

116. Sergeant First Class Moran wishes to continue her service. If she is forced to leave the military due to the Ban, she would be deprived of being able to serve her country openly and honestly, and it difficult to provide for her family. She would lose a sense of purpose.

Plaintiff Staff Sergeant Videl Leins

117. Plaintiff Staff Sergeant Leins is 34-years-old. She is actively serving in the United States Air Force and has served for 16 years.

118. Staff Sergeant Leins works on various electrical systems including high voltage power plants, interior wiring, fire alarms, and airfield lighting.

119. Staff Sergeant Leins joined the military to develop her career and gravitated towards the Air Force to follow in her grandfather's footsteps.

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120. Staff Sergeant Leins has been deployed overseas five times—she volunteered for her first deployment to Iraq, served back-to-back deployments in Kuwait, and was deployed to Korea twice. She is currently stationed at Nellis Air Force Base in Las Vegas, Nevada.

121. Staff Sergeant Leins is transgender. She was assigned the sex of male at birth but has a female gender identity.

122. Staff Sergeant Leins began coming to terms with her gender identity in 2016. She began living openly as a woman in 2022.

123. In consultation with healthcare professionals, Staff Sergeant Leins has taken clinically appropriate steps to transition.

124. Staff Sergeant Leins has taken legal steps to transition. She has changed her name and gender marker on her driver's license. She has amended her birth certificate.

125. The 2025 Military Ban has left Staff Sergeant Leins uncertain about her future, which has taken a toll on her mental and emotional wellbeing. It has created a sense of distance and unease.

126. Staff Sergeant Leins relies on her military-provided healthcare to provide services to her child. The 2025 Military Ban not only threatens her military career but also her family's well-being.

Plaintiff Matthew Medina

127. Plaintiff Mr. Matthew Medina is a 23-year-old man who was born in California and currently resides in New Jersey.

128. Mr. Medina was raised under difficult circumstances, and he hopes to rise above the adverse circumstances he experienced as a youth to deliver his family from generational poverty and to find role models and support in the brotherhood of the Marines. He has been preparing to join the military for the past year, including by consulting with a recruiter, completing his application documents, and working to meet tattoo removal and physical fitness requirements.

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Mr. Medina chose the Marines because the Marines consider themselves the best and brightest, and he wants to be counted among their ranks.

129. Mr. Medina was raised in a single parent household and had hoped to enlist in order to help support his mother and his 12-year-old sister, and invest in his future family. Without the military's assistance, Mr. Medina will be unable to afford the higher education he was planning to pursue, which upends his career goals and his future earning potential. Mr. Medina feels that transgender people should be able to serve their country and avail themselves of the opportunities provided by the military to create a foundation for themselves and their families.

130. Mr. Medina is transgender. He was assigned the sex of female at birth, but his gender identity is male.

131. Mr. Medina has known since he was young that he is a male.

132. Mr. Medina has taken clinically appropriate steps as part of his medical transition, has changed the gender marker on his identity documents, and lives in all ways as a man.

133. Mr. Medina believes that the 2025 Military Ban seeks to erase his identity and declare his identity as something dishonorable. This has caused him to feel discomfort and pain, akin to being bullied, as the 2025 Military Ban denies him the right to be treated with dignity and respect as he serves his country.

The Organizational Plaintiff: Gender Justice League

134. Founded in 2012, Gender Justice League is a civil and human rights membership organization that, as relevant here, advocates on behalf of transgender individuals in the State of Washington and across the country. It has offices in Seattle, Washington and Alexandria, Virginia. It seeks to create a community for transgender people and to empower them to combat the structural oppression, discrimination, and violence they face in their daily lives.

135. Gender Justice League sues on behalf of its members, including multiple Individual Plaintiffs, and other prospective and current transgender service members who are currently adversely affected by the 2025 Military Ban.

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Prior Military Service by Transgender Individuals

136. There are thousands of transgender service members in the United States Armed Forces.

137. Though there has never been a federal statute excluding transgender people from military service, prior to 2016, the military appears to have had a practice of excluding transgender people from service based on Department of Defense and service-specific rules and regulations.

138. This earlier military exclusionary policy was based on an inaccurate, historical, pathological view that regarded transgender people as deviants. This view was discredited long ago following psychological and medical advances in the understanding of gender identity and of transgender people.

139. Despite this earlier practice of exclusion, transgender people have always served in the military.

140. As noted by former Secretary of Defense Ash Carter ("Secretary Carter"), transgender people "often had to serve in silence alongside their fellow comrades in arms."

141. Transgender people have played essential, mission-critical roles in the military, even when they have not had the ability to serve openly.

142. According to a study conducted by the Williams Institute at the University of California, Los Angeles, an estimated 134,300 transgender people are veterans or are retired from guard or reserve service.

143. It is a statistical certainty that transgender people have sacrificed their lives during military service to the United States.

After Study and Deliberation, the Military Explicitly Permits Transgender People to Serve

144. The military's prior exclusionary policy barring transgender people from serving was the subject of extensive research and study, which concluded that it lacked any valid justification.

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145. For example, in March 2014, the Transgender Military Service Commission (the "Commission") issued a report analyzing the military's prior exclusionary policy. The Commission, which was co-chaired by a former U.S. Surgeon General, was convened to determine whether the ban was based on medically sound reasons. The Commission found that there was "no compelling medical rationale" for banning military service by transgender people.

146. In May 2014, then-Secretary of Defense Chuck Hagel publicly stated that he was receptive to reviewing and reassessing the rules that govern service by transgender people. He explained that "[e]very qualified American who wants to serve our country should have an opportunity if they fit the qualifications and can do it."

147. In July 2015, then-Secretary Carter admitted that Department of Defense regulations regarding transgender service members "[were] outdated and [were] causing uncertainty that distracted commanders from our core missions." He also recognized the many transgender people who were already serving in the military: "We have transgender soldiers, sailors, airmen and Marine—real, patriotic Americans—who I know are being hurt by an outdated, confusing, inconsistent approach that's contrary to our value of service and individual merit."

148. Accordingly, Secretary Carter announced the creation of a working group to study for six months the policy and readiness implications of permitting transgender individuals to serve openly. This working group was chaired by the Under Secretary of Defense for Personnel and Readiness and comprised senior representatives from each of the military services, the Joint Staff, and relevant components from the Office of the Secretary of Defense.

149. In addition to creating a working group, Secretary Carter also directed that, effective July 13, 2015, no service member could be involuntarily separated or denied reenlistment or continuation of active or reserve service based on their gender identity without the approval of the Under Secretary of Defense for Personnel and Readiness.

150. On information and belief, separations of service members on the basis of their gender identity fell sharply after July 2015, and there were very few, if any, service members who

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were separated on that basis from July 2015 to June 2016. In effect, transgender people served without issue in the military from July 2015 to June 2016, as well as likely before that period, albeit under the threat of separation.

151. In or around July 2015, Secretary Carter also directed the commencement of a study to evaluate the implications of allowing transgender people to serve openly in the military. The Department of Defense commissioned the RAND Corporation, a non-profit, non-partisan research organization, to conduct the study. The Department asked RAND to (1) identify the health care needs of the transgender population and the costs associated with providing transition-related care to transgender service members, (2) assess the readiness implications of allowing transgender service members to serve openly, and (3) review the experiences of foreign militaries that permit transgender individuals to serve openly. The findings from the study, which reflected the culmination of months of research and spanned 91 pages, were publicly released in May 2016.

152. As detailed further below, the RAND study demonstrated that the cost of providing transition-related care is exceedingly small relative to the Department of Defense's overall health care expenditures, that there are no readiness implications that prevent transgender members from serving openly, and that foreign militaries have successfully permitted open service without a negative effect on effectiveness, readiness, or unit cohesion.

153. The leadership of the Armed Services—including the Joint Chiefs of Staff, the Service Secretaries, and Secretary Carter—together with personnel, training, readiness, and medical specialists from across the Department of Defense, studied the available data, including the findings and analysis from RAND. They also received input from transgender service members, from outside expert groups, and from medical professionals outside the Department of Defense. They looked carefully at what lessons could be learned from outside the U.S. military, including from allied militaries that permit transgender people to serve openly, as well as from the private sector.

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154. As a result of this deliberative process and year-long study, on June 30, 2016, Secretary Carter announced that the military was ending the ban on open service by transgender people. The conclusion was supported by, among other things, the need to recruit and retain the individuals most highly qualified to serve. Effective immediately, transgender service members were permitted to serve openly and could no longer be discharged or otherwise separated from the military solely for being transgender. Department of Defense materials explained that "[t]his policy change was crafted through a comprehensive and inclusive process that included the leadership of the Armed Services, medical and personnel experts across the Department, transgender Service members, outside medical experts, advocacy groups, and the RAND Corporation."

155. In the accompanying directive-type memorandum regarding the policy change, Secretary Carter explained that the policies and procedures permitting open service were premised on the conclusion that "open service by transgender Service members . . . is consistent with military readiness and with strength through diversity."

156. The policy change was announced through a press conference held by Secretary Carter as well as through a section of the Department of Defense website titled "Department of Defense Transgender Policy." That website lists the highlights of the policy change, links to various Department of Defense resources related to the policy change, and includes a video that assures transgender individuals: "Transgender Members Can Now Serve Openly."

157. The Department of Defense planned a 12-month implementation process that would proceed in stages, beginning with the needs of current service members and their commanders, followed by training for the entire force, and concluding with the accession of transgender recruits.

158. On September 30, 2016, within 90 days after the lifting of the ban, the Department of Defense issued a training handbook for commanders, transgender service members, and the force, titled "Transgender Service in the U.S. Military: An Implementation Handbook." The 71-

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page handbook was designed to help transgender service members in their transition, help commanders with their duties and responsibilities, and help all service members understand the new policies allowing open service by transgender service members. The handbook illustrates that open service has been workable and practicable.

159. Also, within 90 days of the lifting of the prior ban, the Department of Defense issued medical guidance for providing transition-related care to transgender service members, who were also able to begin the process to officially change their gender marker in the military's personnel management systems.

160. Over the next nine months following the lifting of the ban (i.e., from October 2016 to June 2017), the services conducted training of the force based on detailed guidance and training materials regarding the policy change.

The 2017 Ban on Transgender Military Service Members

161. Through a series of three tweets on July 26, 2017, President Trump unilaterally reversed the U.S. military's policy of permitting open service by transgender individuals and dismantled the years of work that led to the development and implementation of that policy.

162. The "process" that led to the "2017 Ban"—to the extent there was any meaningful process at all—was the antithesis of the deliberative, comprehensive, and inclusive process that led to the rescission of the prior ban.

163. President Trump's unilateral decision to bar transgender individuals from the military was met with widespread opposition and condemnation. Attorneys general from 17 states and the District of Columbia joined a letter denouncing the President's exclusion of transgender individuals from the military as "blatant discrimination" that violates "fundamental constitutional and American values." The states included California, Connecticut, Delaware, Illinois, Iowa, Maine, Maryland, Massachusetts, Minnesota, New Mexico, New York, Oregon, Pennsylvania, Rhode Island, Vermont, Virginia and Washington.

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164. Fifty-six retired generals and admirals issued a public statement on August 1, 2017, warning that the proposed ban on transgender service members would downgrade military readiness. The statement noted that two four-star generals and former chairmen of the Joint Chiefs of Staff—Army General Martin Dempsey and Navy Admiral Mike Mullen—have publicly supported open service by transgender individuals.

165. In response to the 2017 Ban, a lawsuit, *Karnoski v. Trump*, was filed in the Western District of Washington alleging that the 2017 Ban was unconstitutional, which led to a nationwide preliminary injunction in 2017. After entry of the preliminary injunction, the military altered its policy in significant respects. The injunction was subsequently stayed by the U.S. Supreme Court while the government appealed the decision to the United States Court of Appeals for the Ninth Circuit. The appeals court issued a ruling holding that heightened scrutiny must apply to classifications singling out transgender people for discrimination, including within the military context. The appeals court sent the case back to the district court to apply heightened scrutiny and consider whether the court's preliminary injunction should continue in light of the military's changes to its policies relating to the 2017 Ban. The appeals court emphasized that although the military is entitled to deference, such deference "does not mean abdication," and defendants bear the burden of establishing that they reasonably determined the policy significantly furthers the government's important interests, which "is not a trivial burden."

166. Similar challenges were filed in *Doe v. Trump*, a lawsuit filed in the District of Columbia, *Stockman v. Trump*, filed in the Central District of California, and *Stone v. Trump*, filed in the District of Maryland. Each of these challenges also led to preliminary injunctive relief against the 2017 Ban.

President Biden Enables All Qualified Americans to Serve Their Country in Uniform, Rescinds the 2017 Ban, and Opens Up the Armed Forces to More Soldiers

167. On January 25, 2021, after carefully considering the conclusions made by the Secretary of Defense in 2016 as well as the public testimony of then-serving Chiefs of Staff of the

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Army, Naval Operations, Commandant of the United States Marine Corps, and Chief of Staff of the Air Force in 2018 that transgender service did not create any issues with regard to unit cohesion or morale, President Joseph R. Biden issued Executive Order No. 14004, *Enabling All Qualified Americans to Serve Their Country in Uniform*, directing the Secretary of Defense and Secretary of Homeland Security to ensure that transgender service members could serve free from discrimination.[3]

168. Under Executive Order 14004, transgender service members were held to the exact same rigorous standards as every other service member. They were no longer arbitrarily barred from service because they are transgender.

169. The Chiefs of Staff to each military branch have testified that there have been no negative effects on readiness due to transgender individuals serving in the U.S. military. Additionally, data obtained by the Pentagon has shown that the cost of providing medical care to transgender troops has been miniscule.

170. The American Medical Association, American Psychological Association, and American Psychiatric Association all oppose the banning of transgender people from the military, agreeing that there is no medical reason transgender troops should be barred from serving.

171. Executive Order No. 14004 thus furthered the goals of the U.S. military. It opened up the military ranks to additional individuals who met the readiness qualifications to serve in the armed forces.

The 2025 Ban on Transgender Military Service Members

172. On August 8, 2023, President Trump announced that he would "restore the Trump ban on transgender [sic] in the military," adding, "we had it banned, we had it banned." He then impersonated a General asking, "what do you think of transgender?" and responding "Uh, I don't like it, sir."

[3] Exec. Order No. 14004, *Enabling All Qualified Americans to Serve Their Country in Uniform*, 86 Fed. Reg. 7,471 (Jan. 28, 2021), https://www.govinfo.gov/content/pkg/FR-2021-01-28/pdf/2021-02034.pdf.

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173. On December 22, 2024, then-President-Elect Trump declared that "I will sign Executive Orders to . . . get transgender [sic] out of the military and out of our elementary schools and middle schools and high schools."

174. On January 27, 2025, barely one week into office, President Trump upended the lives of thousands of transgender service members by issuing the 2025 Military Ban. The executive order rescinds President Biden's Executive Order No. 14004 and bans transgender people from military service, stating that transgender status is incompatible with military service and directing the Secretary of Defense to update the standards for retention and accession to reflect this policy.

175. The 2025 Military Ban expresses a demeaning and disparaging viewpoint about transgender people throughout. The Executive Order asserts that having a gender identity that is inconsistent with one's sex assigned at birth "conflicts with a soldier's commitment to an honorable, truthful, and disciplined lifestyle, even in one's personal life. A man's assertion that he is a woman, and his requirement that others honor this falsehood is not consistent with the humility and selflessness required of a service member." 2025 Military Ban § 1.

176. The 2025 Military Ban directs the Secretary of Defense to "update DoDI 6130.03 Volume 1 (Medical Standards for Military Service: Appointment, Enlistment, or Induction (May 6, 2018) Incorporating Change 5 of May 28, 2024) and DoDI 6130.03 Volume 2 (Medical Standards for Military Service: Retention (September 4, 2020), Incorporating Change 1 of June 6, 2022) to reflect the purpose and policy of this Order" within 60 days. 2025 Military Ban § 4(a).

177. The 2025 Military Ban has immediate effect, ordering that "the Armed Forces shall neither allow males to use or share sleeping, changing, or bathing facilities designated for females, nor allow females to use or share sleeping, changing, or bathing facilities designated for males." 2025 Military Ban § 4(d).

178. The 2025 Military Ban incorporates the definitions from the Gender Identity Executive Order, stating that they "shall apply" to the 2025 Military Ban. 2025 Military Ban § 3.

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179. These definitions express a disparaging, demeaning, idiosyncratic, and unscientific viewpoint about transgender people and gender identity. Together, the definitions deny the existence of gender identities that differ from a person's sex assigned at birth and deny the existence of people who are transgender.

180. Specifically, the Gender Identity Executive Order says that it is the "policy of the United States to recognize two sexes, male and female," which "are not changeable and are grounded in fundamental and incontrovertible reality." Gender Identity Executive Order § 2 ("Policy and Definitions").

181. The Gender Identity Executive Order further defines "Female" to mean "a person belonging, at conception, to the sex that produces the large reproductive cell," Gender Identity Executive Order § (d); and "Male" to mean "a person belonging, at conception, to the sex that produces the small reproductive cell," *id.* § 2(e).

182. The Gender Identity Executive Order also adopts the following definition of what it terms "Gender ideology" and "Gender identity":

> (f) "Gender ideology" replaces the biological category of sex with an ever-shifting concept of self-assessed gender identity, permitting the false claim that males can identify as and thus become women and vice versa, and requiring all institutions of society to regard this false claim as true. Gender ideology includes the idea that there is a vast spectrum of genders that are disconnected from one's sex. Gender ideology is internally inconsistent, in that it diminishes sex as an identifiable or useful category but nevertheless maintains that it is possible for a person to be born in the wrong sexed body.
>
> (g) "Gender identity" reflects a fully internal and subjective sense of self, disconnected from biological reality and sex and existing on an infinite continuum, that does not provide a meaningful basis for identification and cannot be recognized as a replacement for sex.

Gender Identity Executive Order § 2(f), (g).

183. The 2025 Military Ban further requires the Secretary of Defense promptly to issue directives preventing the use of pronouns that accord with the gender identities of transgender service members. 2025 Military Ban § 4(b).

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184. On February 26, 2025, DoD released further guidance implementing the 2025 Military Ban ("February 26 Guidance"), which restates a complete ban of transgender individuals from military service. February 26 Guidance § 1.

185. Service members and applicants for military service, including those with admission offers to a military service academy, who have a gender dysphoria diagnosis, a history of having gender dysphoria, a history of attempting to transition, or exhibit symptoms of having gender dysphoria are disqualified for military service. February 26 Guidance §§ 4.1, 4.3.

186. To make its policy abundantly clear, DoD declared on its X account (@DODResponse) the next day that, "Transgender troops are disqualified from service without an exemption."

187. The establishment of procedures for identifying servicemembers who are transgender for purposes of separation begins immediately. February 26 Guidance §§ 1(e), 3.4(e), 4.4. Separations commence by March 28, 2025, 30 days from issuance of the February 26 Guidance. *Id.* §§ 1(e) 3.4(f), 4.4(b).

188. Until the separations are completed, transgender service members must serve in their sex assigned at birth for purposes of use of honorifics and self-identification, military records, uniform and grooming, medical and physical fitness standards, restrooms, and housing. February 26 Guidance §§ 1(h)–(i), 5.

189. Service members being processed for separation are deemed non-deployable and may be placed on administrative absence status. February 26 Guidance §§ 4.4(a)(3), 6.1.

190. All surgical procedures for treating gender dysphoria are immediately cancelled and servicemembers who require hormone therapy but have not yet initiated treatment will no longer be provided with such care. February 26 Guidance §§ 1(j), 4.2.

191. To expedite the purge of transgender service members from the military, DoD seeks to pressure transgender servicemembers into voluntary separation by March 26, 2025 with financial inducements and penalties. February 26 Guidance §§ 4.4(a)(4), (10).

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192. There is no exception for a transgender individual to serve under the 2025 Military Ban as they can only do so by proving that they are not transgender. February 26 Guidance §§ 4.1(c), 4.3(c). Both active-duty service members and accession candidates are required to serve under the "standards associated with the[ir] … [birth] sex." *Id.* §§ 4.1(c), 4.3(c)(3). No service member can serve in the military if they have ever "attempted to transition to any sex other than their sex," *i.e.*, identified with any gender other than their sex assigned at birth. *Id.* § 4.3(c)(2).

193. DoD has acknowledged as much, stating that retention of transgender service members is "unlikely." *Talbott v. Trump*, 25-cv-00240-ACR (Dkt. No. 66) at 5. And under clarifying guidance issued on February 28, 2025, DoD again encourages transgender service members to voluntarily separate from the military by March 26, 2025. February 28 Clarifying Guidance at 1.

194. In light of the 2025 Military Ban and related federal policy and directives, transgender service members are now no longer able to serve openly on the same terms as before the order. Any present-day speech or conduct that "openly" discloses a transgender individual's gender identity or transgender status while serving in the military or even in their private lives places them in violation of the 2025 Military Ban, subjecting them to discharge and other "action . . . against [them]."

195. Defendants are responsible for implementing and enforcing the 2025 Military Ban and related policy and directives.

196. Banning ready, willing, and able service members does not further the objectives of the United States Armed Forces. The military needs more recruits to maintain readiness and fill its ranks. But the 2025 Military Ban turns them away and forces current decorated service members to hide their identity, quit, or be separated from the military.

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CAUSES OF ACTION

FIRST CAUSE OF ACTION
EQUAL PROTECTION VIOLATION

197. Plaintiffs incorporate paragraphs 1 through 196 as though fully set forth herein.

198. Plaintiffs Shilling, Dremann, Morgan, and Medina state this claim against Defendants Trump, United States, Hegseth, Department of Defense, Emmert, and United States Department of the Navy.

199. Plaintiffs Schmid, Moran, and Doe state this claim against Defendants Trump, United States, Hegseth, Department of Defense, Driscoll, and United States Department of the Army.

200. Plaintiff Leins states this claim against Defendants Trump, United States, Hegseth, Department of Defense, Ashworth, and United States Department of the Air Force.

201. Plaintiff Gender Justice League states this claim against all Defendants.

202. Plaintiffs state this cause of action against individual Defendants in exclusively their official capacities for purposes of seeking declaratory and injunctive relief and challenge the 2025 Military Ban and related federal policy and directives both facially and as applied to them or, as to the Gender Justice League, as applied to its members.

203. The Fifth Amendment to the United States Constitution provides that no person shall be deprived of life, liberty, or property without due process of law. The Due Process Clause of the Fifth Amendment includes within it a prohibition against the denial of equal protection by the federal government, its agencies, or its officials or employees that is commensurate with the Equal Protection Clause of the Fourteenth Amendment.

204. The Equal Protection Clause of the Fourteenth Amendment, which is incorporated into the Fifth Amendment, protects individuals from discrimination based on sex and transgender status.

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205. The 2025 Military Ban and Defendants' conduct in implementing, administering, and enforcing the 2025 Military Ban and related official federal policy and directives has resulted in a ban on transgender people serving in the military that discriminates against Individual Plaintiffs and the transgender members of Gender Justice League based on sex and transgender status.

206. Defendants' disparate treatment of transgender people facially and intentionally discriminates against transgender people based on sex and transgender status in violation of the equal protection guarantee, without even a legitimate justification, let alone the important, exceedingly persuasive, or compelling one required.

207. The 2025 Military Ban and related federal policy and directives reflect and are based on impermissible animus towards transgender people, which renders them invalid as a whole.

208. Defendants have violated the equal protection rights of transgender people, including Individual Plaintiffs and members of Gender Justice League, under the Fifth Amendment.

SECOND CAUSE OF ACTION
FREE SPEECH VIOLATION

209. Plaintiffs incorporate paragraphs 1 through 196 as though fully set forth herein.

210. Plaintiffs Shilling, Dremann, Morgan, and Medina state this claim against Defendants Trump, United States, Hegseth, Department of Defense, Emmert, and United States Department of the Navy.

211. Plaintiffs Schmid, Moran, and Doe state this claim against Defendants Trump, United States, Hegseth, Department of Defense, Driscoll, and United States Department of the Army.

212. Plaintiff Leins states this claim against Defendants Trump, United States, Hegseth, Department of Defense, Ashworth, and United States Department of the Air Force.

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213. Plaintiff Gender Justice League states this claim against all Defendants.

214. Plaintiffs state this cause of action against Defendants in exclusively their official capacities for purposes of seeking declaratory and injunctive relief and challenge the 2025 Military Ban and related federal policy and directives both facially and as applied to them or, as to the organizational plaintiffs, as applied to their members.

215. The 2025 Military Ban and related federal policy and directives violate the Free Speech Clause of the First Amendment because they impermissibly burden and chill the exercise of the Individual Plaintiffs' and of Gender Justice League's transgender members' constitutionally protected speech, expression, and expressive conduct based on the content and viewpoint of their speech, even in their private lives.

216. All Individual Plaintiffs and many transgender members of Gender Justice League have been open about their status as transgender either in the context of seeking to join the military or in the course of their military service.

217. All Individual Plaintiffs and transgender members of Gender Justice League want to continue being open about their status as transgender and to continue expressing and conducting themselves consistently with their gender.

218. The gender expression of the Individual Plaintiffs and of transgender members of Gender Justice League, the conduct of those individuals that is consistent with their gender, and those individuals' disclosure of their transgender status, all constitute protected First Amendment activity.

219. In issuing the 2025 Military Ban and related federal policy and directives, the government created a bizarre, idiosyncratic, and unscientific definition of so called "gender ideology," and then used it to engage in impermissible viewpoint and content discrimination by penalizing Plaintiffs' speech and expression that conflicts with the government's viewpoint, explicitly restricting such speech and expression even in their private lives.

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220. The viewpoint discrimination memorialized in the 2025 Military Ban relates both to the text of this particular executive order and the way it incorporates by reference the Gender Identity Executive Order.

221. Viewpoint and content discrimination are presumptively unconstitutional.

222. The 2025 Military Ban and related federal policy and directives violate the Free Speech Clause of the First Amendment in many ways, including the following respects:

a. First, the 2025 Military Ban and related federal policy directives impermissibly burden and chill the exercise of constitutionally protected speech, expression, and expressive conduct of the Individual Plaintiffs and of the Gender Justice League's transgender members based on the content and viewpoint of their speech, even in their private lives.

b. Second, Defendants intend the 2025 Military Ban and related federal policy directives to coerce the Individual Plaintiffs and Gender Justice League's transgender members to adopt, endorse, and comply with the government's own idiosyncratic viewpoint as if it were their own, even in their private lives.

c. Third, as to those Individual Plaintiffs and Gender Justice League's transgender members who refuse to be chilled or coerced to adopt the government's preferred message, the 2025 Military Ban and related federal policy and directives discriminate against them for engaging in protected core speech and expressing their own viewpoint.

223. The government lacks even a legitimate justification for its viewpoint and content restrictions, let alone a compelling one.

224. To the contrary, the purpose and effect of the 2025 Military Ban and related federal policy and directives is to chill, coerce, and punish the Individual Plaintiffs, and transgender members of Gender Justice League, for their speech and gender expression—constitutionally protected First Amendment activity—even in their private lives.

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225. Indeed, the 2025 Military Ban on its face labels transgender peoples' expressions of their own identities as inconsistent with "a soldier's commitment to an honorable, truthful, and disciplined lifestyle, even in one's personal life. A man's assertion that he is a woman, and his requirement that others honor this falsehood, is not consistent with the humility and selflessness required of a service member."

226. The reach of the 2025 Military Ban and related federal policy and directives extends to First Amendment activity of a person of ordinary firmness who is transgender by requiring such persons either to attempt to deny who they are and suppress expression of their gender or be denied military service on the same terms as others.

227. The Individual Plaintiffs and Gender Justice League's transgender members are harmed by being denied the opportunity to serve in the military on the same terms as other service members.

228. Thus, the 2025 Military Ban and related federal policy and directives inflict current, direct First Amendment injury on all current and prospective transgender service members, including Individual Plaintiffs and Gender Justice League's transgender members. Further, they face a realistic danger of sustaining ongoing and future injuries.

THIRD CAUSE OF ACTION
PROCEDURAL DUE PROCESS VIOLATION

229. Plaintiffs incorporate paragraphs 1 through 196 as though fully set forth herein.

230. Plaintiffs Shilling, Dremann, and Morgan state this claim against Defendants Trump, United States, Hegseth, Department of Defense, Emmert, and United States Department of the Navy.

231. Plaintiffs Schmid, Moran, and Doe state this claim against Defendants Trump, United States, Hegseth, Department of Defense, Driscoll, and United States Department of the Army.

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232. Plaintiff Leins states this claim against Defendants Trump, United States, Hegseth, Department of Defense, Ashworth, and United States Department of the Air Force.

233. Plaintiff Gender Justice League states this claim against all Defendants.

234. Defendants have violated the procedural due process rights of the Individual Plaintiffs and Gender Justice League's transgender members. Plaintiffs relied detrimentally on the military's policy from 2021 to the present of welcoming open service by transgender people.

235. Plaintiffs who are current service members have a protectible liberty interest in their continued military service. They deserve not to be branded as inferior and unworthy of service based simply on who they are.

236. Plaintiffs who are current service members have a protectible property interest in their continued military service and benefits upon retirement that they have earned. The 2025 Military Ban would deprive them of their careers and the related current and future benefits that they have earned as a result of their military service.

237. Defendants have provided no adequate procedural protections for Plaintiffs or indeed any avenue for redress. The 2025 Military Ban decrees that all transgender people are considered categorically unfit for service, rendering futile any procedures that otherwise might apply to protect service members from arbitrary separation.

238. The 2025 Military Ban directs agencies to pre-judge people categorically as unfit, undermining and rendering futile any procedural protections or process that might otherwise apply. Consequently, the 2025 Military Ban and related federal policy and directives violate the procedural due process rights of Plaintiffs under the Fifth Amendment.

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FOURTH CAUSE OF ACTION
EQUITABLE ESTOPPEL

239. Plaintiffs incorporate paragraphs 1 through 196 as though fully set forth herein.

240. Plaintiffs Shilling, Dremann, and Morgan state this claim against Defendants Trump, United States, Hegseth, Department of Defense, Emmert, and United States Department of the Navy.

241. Plaintiffs Schmid, Moran, and Doe state this claim against Defendants Trump, United States, Hegseth, Department of Defense, Driscoll, and United States Department of the Army.

242. Plaintiff Leins states this claim against Defendants Trump, United States, Hegseth, Department of Defense, Ashworth, and United States Department of the Air Force.

243. Plaintiff Gender Justice League states this claim against all Defendants.

244. The 2025 Military Ban and related federal policy and directives punish Plaintiff current service members for doing precisely what the prior policy invited and induced them to do — disclose their transgender status and take medical and other steps to transition.

245. Plaintiffs Shilling, Dremann, Morgan, Schmid, Doe, Leins, and members of Gender Justice League who are current service members had settled expectations based on the prior policy and reasonably relied on it when they came out as transgender and underwent medical and social transition.

246. Plaintiffs Shilling, Dremann, Morgan, Schmid, Doe, Leins, and members of Gender Justice League who are current service members were induced to disclose their transgender status and would be deprived of both a property and liberty interest due to the effects of the 2025 Military Ban and related federal policy and directives on their continued employment and educational opportunities, and the stigma of having been labeled as presumptively unworthy of continued service.

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247. The 2025 Military Ban and related federal policy and directives works a serious injustice on Plaintiff current service members, including Plaintiffs Shilling, Dremann, Morgan, Doe, Schmid, Leins, and members of Gender Justice League who are currently serving, by punishing them for doing what the government explicitly induced them to do.

248. Defendants therefore should be equitably estopped from implementing the 2025 Military Ban and related federal policies and directives as applied to Plaintiff current service members.

PRAYER FOR RELIEF

WHEREFORE, Plaintiffs respectfully request that this Court:

A. Issue a declaratory judgment, pursuant to 28 U.S.C. §§ 2201–2202, declaring Executive Order No. 14183 (the "2025 Military Ban") and related federal policy and directives unconstitutional on their face and as applied to the Individual Plaintiffs and transgender members of Gender Justice League, for the reasons set forth above;

B. Issue preliminary and permanent injunctive relief enjoining Agency Defendants, their agents, employees, representatives, successors, and any other person or entity subject to their control or acting directly or indirectly in concert with them from implementing, administering, or enforcing Executive Order No. 14183 (the "2025 Military Ban") and related federal policy and directives, including by enjoining any separation, discharge, adverse action, retaliation, or denial of promotion, reenlistment, continuation of service, accession, or appointment because an individual is transgender;

C. Waive the requirement for the posting of a bond of security for the entry of temporary and preliminary relief;

D. Award Plaintiffs their reasonable fees, costs, and expenses, including attorneys' fees, pursuant to 28 U.S.C. § 2412 and any other applicable laws; and

E. Grant any injunctive or other relief that this Court deems just, equitable, and proper.

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March 4, 2025

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MANPOWER AND
RESERVE AFFAIRS

MAR 0 4 2025

MEMORANDUM FOR SENIOR PENTAGON LEADERSHIP
COMMANDERS OF THE COMBATANT COMMANDS
DEFENSE AGENCY AND DOD FIELD ACTIVITY DIRECTORS

SUBJECT: Clarifying Guidance on Prioritizing Military Excellence and Readiness: Retention and Accession Waivers

Pursuant to the attached Performing the Duties of the Under Secretary of Defense for Personnel and Readiness Memorandum, "Additional Guidance on Prioritizing Military Excellence and Readiness," February 26, 2025, it is Department policy that the medical, surgical, and mental health constraints on individuals who meet the following criteria are incompatible with military service:

1. Individuals with a current diagnosis or history of, or exhibit symptoms consistent with, gender dysphoria.

2. Individuals with a history of cross-sex hormone therapy or sex reassignment or genital reconstruction surgery as treatment for gender dysphoria or in pursuit of a sex transition.

Service members and applicants for military service disqualified pursuant to the attached memorandum may be considered for a retention or accession waiver on a case-by-case basis where there is a compelling Government interest in either retaining or accessing such individuals that directly supports the Department's warfighting capabilities.

A compelling Government interest that directly supports warfighting capabilities includes special experience, special training, and advanced education in a highly technical career field designated as mission critical and hard to fill by the Secretary of a Military Department, if such experience, training, and education is directly related to the operational needs of the Military Service concerned. The authority to grant a waiver pursuant to this memorandum shall not be further delegated.

To be eligible for such a waiver, the Service member or applicant for military service must meet the following criteria:

1. The individual demonstrates 36 consecutive months of stability in the individual's sex without clinically significant distress or impairment in social, occupational, or other important areas of functioning; and

2. The individual demonstrates that he or she has never attempted to transition to any sex other than his or her sex; and

3. The individual is willing and able to adhere to all applicable standards, including the standards associated with his or her sex.

In accordance with the reporting requirement in section 7 of the attachment, the Military Services shall track and report on approved retention waivers for Service members retained and approved accession waivers for all applicants who access into a branch or component of the Military Services.

Tim Dill
Performing the Duties of the Assistant Secretary of Defense for Manpower and Reserve Affairs

Attachment:
As stated

cc:
Director, Defense Health Agency
Deputy Assistant Secretary of Defense for Health Services Policy & Oversight (HSP&O)
Deputy Assistant Secretary of Defense for Military Personnel Policy
Deputy Chief of Staff, G-1, U.S. Army
Deputy Commandant for Manpower and Reserve Affairs, U.S. Marine Corps
Chief of Naval Personnel, U.S. Navy
Deputy Chief of Staff for Personnel, U.S. Air Force
Deputy Chief of Space Operations, Personnel
Director for Manpower and Personnel, J1
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Surgeon General of the Navy
Surgeon General of the Air Force

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PERSONNEL AND READINESS

MAR 2 1 2025

MEMORANDUM FOR SENIOR PENTAGON LEADERSHIP
COMMANDERS OF THE COMBATANT COMMANDS
DEFENSE AGENCY AND DOD FIELD ACTIVITY DIRECTORS

SUBJECT: Prioritizing Military Excellence and Readiness: Military Department Identification

This memorandum is not to be implemented at this time due to the preliminary injunction issued in *Talbott v. United States*, No. 1:25-cv-240-ACR (D.D.C. Mar. 18, 2025). When the court order is modified or lifted, this memorandum will be updated accordingly.

As directed in Office of the Under Secretary of Defense for Personnel and Readiness Memorandum, "Additional Guidance on Prioritizing Military Excellence and Readiness," February 26, 2025 (Attachment 1), it is Department policy that Service members[1] who have a current diagnosis or history of, or exhibit symptoms consistent with,[2] gender dysphoria are no longer eligible for military service and will be processed for separation. This memorandum provides guidance to assist the Military Departments in identifying such Service members.

Department policy also requires that Service members abide by the standards of their biological sex. As reiterated in the February 26, 2025 memorandum, "[w]here a standard, requirement, or policy depends on whether the individual is a male or female (e.g., medical fitness for duty, physical fitness and body fat standards; berthing, bathroom, and shower facilities; and uniform and grooming standards), all persons will be subject to the standard, requirement, or policy associated with their sex," and a person's sex refers to their immutable biological classification as either male or female. The Secretaries of the Military Departments are directed to require adherence to these requirements associated with an individual's sex, and address non-compliance with these requirements by Service members appropriately.

Records Review

The primary means of identifying Service members who have a current diagnosis or history of, or exhibit symptoms consistent with, gender dysphoria who are no longer eligible for military service will be through reviewing medical records. All reviews of medical records or other protected health information will be conducted in accordance with DoD Manual 6025.18,

[1] For the purposes of this guidance, the term "Service member" includes cadets and midshipmen admitted to a Military Service Academy and cadets and midshipmen enrolled as members of a Reserve Officers' Training Corps (ROTC) program.

[2] The phrase "exhibit symptoms consistent with gender dysphoria" refers to the diagnostic criteria outlined in the Diagnostic and Statistical Manual of Mental Disorders (Attachment 2). This language applies only to individuals who exhibit such symptoms as would be sufficient to constitute a diagnosis (i.e., a marked incongruence and clinically significant distress or impairment for at least 6 months).

"Implementation of the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule in DoD Health Care Programs," March 13, 2019.

Medical Readiness

The Secretaries of the Military Departments have the authority to direct unit commanders, in coordination with supporting medical assets, to require that all Service members comply with their obligations pursuant to the Individual Medical Readiness (IMR) program and any Military Service-specific IMR guidance. The primary means of assessing medical readiness is the DoD Periodic Health Assessment (PHA), conducted at least annually for all Service members.

Per DoD Instruction 6025.19, "Individual Medical Readiness Program," July 13, 2022, IMR is a Military Service, command, and individual Service member responsibility. As a condition of continued participation in military service, Service members have a responsibility to report medical issues (including physical, dental, and mental/behavioral health) that may affect their readiness to deploy, ability to perform their assigned mission, or fitness for retention in military service to their chain of command.

Within 45 days of this guidance, the PHA self-assessment questionnaire will be modified to require Service members to attest whether they have a current diagnosis or history of, or exhibit symptoms consistent with, gender dysphoria. This attestation will be a standard part of the self-assessment done in conjunction with the annual PHA.

If, during a PHA, a Service Member is identified as having a current diagnosis or history of, or exhibiting symptoms consistent with, gender dysphoria, the facility or location conducting the PHA will be responsible for conducting or coordinating any follow-up medical evaluation, if necessary, and for notifying the Service member's command. Further, such a Service Member must be categorized as "Not Medically Ready" and non-deployable, in accordance with DoD Instruction 6025.19. Service members who do not meet the minimum standards for military service retention, in accordance with Attachment 1, will be recommended for administrative separation or, where appropriate, enrolled in the Disability Evaluation System (e.g., where a co-morbidity or other qualifying condition is present).

Involuntary Separation

Service members identified under the processes detailed in this memorandum and not granted a waiver pursuant to the February 26, 2025 memorandum and the Office of the Assistant Secretary of Defense for Manpower and Reserve Affairs Memorandum, "Clarifying Guidance of Prioritizing Military Excellence and Readiness: Retention and Accession Waivers," March 4, 2025 (Attachment 3), will be processed for involuntary separation. Service members pending involuntary separation may elect to self-identify for separation.

The policy guidance in this memorandum supersedes any conflicting policy guidance in Department of Defense issuances and other policy guidance and memoranda.

Jules W. Hurst III
Performing the Duties of the Under Secretary of Defense for Personnel and Readiness

Attachments:
As stated

cc:
Commandant of the Coast Guard
Assistant Secretary of Defense for Health Affairs
Assistant Secretary of Defense for Manpower and Reserve Affairs
Director, Defense Health Agency
Deputy Assistant Secretary of Defense for Health Services Policy and Oversight
Deputy Assistant Secretary of Defense for Military Personnel Policy
Deputy Chief of Staff, G-1, U.S. Army
Deputy Commandant for Manpower and Reserve Affairs, U.S. Marine Corps
Chief of Naval Personnel, U.S. Navy
Deputy Chief of Staff for Personnel, U.S. Air Force
Deputy Chief of Space Operations, Personnel
Director for Manpower and Personnel, J1
Surgeon General of the Army
Surgeon General of the Navy
Surgeon General of the Air Force

ATTACHMENT 2

DSM-5 Criteria for Gender Dysphoria[1]

A marked incongruence between one's experienced/expressed gender and natal gender of at least 6 months in duration, as manifested by at least two of the following:

A. A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics)

B. A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender (or in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics)

C. A strong desire for the primary and/or secondary sex characteristics of the other gender

D. A strong desire to be of the other gender (or some alternative gender different from one's designated gender)

E. A strong desire to be treated as the other gender (or some alternative gender different from one's designated gender)

F. A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's designated gender)

The condition is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Specify if:

A. The condition exists with a disorder of sex development.

B. The condition is post-transitional, in that the individual has transitioned to full-time living in the desired gender (with or without legalization of gender change) and has undergone (or is preparing to have) at least one sex-related medical procedure or treatment regimen—namely, regular sex hormone treatment or gender reassignment surgery confirming the desired gender (e.g., penectomy, vaginoplasty in natal males; mastectomy or phalloplasty in natal females).

[1] Diagnostic and statistical manual of mental disorders (DSM-5). American Psychiatric Pub.

UNITED STATES DISTRICT COURT

WESTERN DISTRICT OF WASHINGTON AT TACOMA

COMMANDER EMILY SHILLING; et al., Plaintiffs,	2:25-cv-00241-BHS
v.	Tacoma, Washington
DONALD J. TRUMP, in his official capacity as President of the United States; et al., Defendants.	March 25, 2025 10:00 a.m.
	Motion for Preliminary Injunction

VERBATIM REPORT OF PROCEEDINGS
BEFORE THE HONORABLE BENJAMIN H. SETTLE
UNITED STATES DISTRICT JUDGE

Proceedings stenographically reported and transcript produced with computer-aided technology

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Biden appointee" or fill-in-the-blank judge appointee. This only adds to the erosion of confidence in the eyes of many.

The truth is that the district court judges that I know endeavor, as I do, to only serve the Constitution; that is, to protect and defend it and make decisions to the best of our ability based on the Constitution and the laws of the United States that apply to the facts and to the law.

It is part of the genius of our system that there exists, in cases such as this one involving a motion for preliminary injunction, an opportunity for a quick review by the higher courts, in this case, the Ninth Circuit Court of Appeals.

If Judge Reyes denies the motion of the Government to dissolve the injunction, it is expected that that order will be immediately appealed to the D.C. Circuit.

This process, in my view, has served well the United States and her citizens for almost 250 years, and I believe with a citizenry that is well-educated in civics and our constitutional government, it will continue for long, long into the future.

Thank you, again, Counsel, for your work on this matter, and the Court will enter its ruling.

MR. LYNCH: May I offer one thing more? Your Honor, thank you. We asked for this in our PI opposition, but we would request, if the Court does enter a preliminary injunction, that it stay that for 48 hours to give the United

States time to appeal. I just wanted to make sure that request is reiterated on the record. Thank you.

THE COURT: Thank you for reminding me. I'm not going to issue a stay. It will go into effect -- if granted, the motion for a preliminary injunction will go into effect on -- by Thursday at 5:00 p.m.

MR. LYNCH: Okay. Thank you.

THE COURT: I don't see -- the reason for that is I don't see any severe hardship upon the United States Government if it takes a day or two before the circuit gets an appeal.

MR. LYNCH: To be candid, it's mostly because the federal appellate rules require us to request a stay in district court before we can insert an appeal.

THE COURT: I appreciate that.

MR. LYNCH: So we have to do that. Thank you very much, Your Honor.

THE COURT: We'll be in recess.

(Adjourned.)

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON
AT TACOMA

COMMANDER EMILY SHILLING, et al., Plaintiffs, v. UNITED STATES, et al., Defendants.	CASE NO. 25-cv-241-BHS ORDER

ORDER

For the reasons set forth in its Opinion, the Court **GRANTS** plaintiffs' Motion for Preliminary Injunction, Dkt. 23. It further

ORDERS that all defendants **ARE PRELIMINARILY ENJOINED**, pending further order of this Court, from implementing the Military Ban—Executive Order No. 14183. This includes the Hegseth Policy—"Additional Guidance on Prioritizing Military Excellence and Readiness," Dkt. 58-7, and all other memoranda, guidance, policies, or actions issued or forthcoming implementing the Military Ban or the Hegseth Policy.

The effect of the Court's Order is to maintain the status quo of military policy regarding both active-duty and prospective transgender service that existed nationwide

immediately before President Trump issued the Military Ban. For example, the policies described in Department of Defense Instruction (DoDI) 6130.03, Volume 1, "Medical Standards for Military Service: Appointment, Enlistment, or Induction," change 5, May 28, 2024; DoDI 6130.03, Volume 2, "Medical Standards for Military Service: Retention," change 1, June 6, 2022; and DoDI 1300.28, "In-Service Transition for Transgender Service Members," change 1, December 20, 2022. This Order applies to all plaintiffs and any similarly situated individuals nationwide, including those serving out of country.

Dated this 27th day of March, 2025.

BENJAMIN H. SETTLE
United States District Judge

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON
AT TACOMA

COMMANDER EMILY SHILLING, et al.,

Plaintiffs,

v.

UNITED STATES, et al.,

Defendants.

CASE NO. 25-cv-241-BHS

MEMORANDUM OPINION

The day he was inaugurated the second time, President Trump issued Executive Order 14148, revoking President Biden's Executive Order 14004, which permitted transgender individuals to serve openly. A week later, the President issued Executive Order 14183, explaining that the United States Armed Forces had been "recently afflicted with a radical gender ideology to appease activists unconcerned with the requirements of military service[.]" He proclaimed that, "consistent with longstanding Department of Defense policy," expressing a false "gender identity" conflicts with a soldier's commitment to an "honorable, truthful, and disciplined lifestyle, even in one's personal life," and that requiring others to recognize this "falsehood is not consistent with the

humility and selflessness required of a service member." The President's "Military Ban" required Secretary of Defense Hegseth to implement his policy—to root out and separate every transgender service member—within 60 days.

Hegseth issued his Policy on February 26. It requires all military branches to begin the identification and separation process on March 26.[1] Unlike President Trump's first-term 2018 Mattis Policy on transgender service, and unlike President Biden's 2021 Austin Policy, the 2025 Hegseth Policy does not rely on any recent study, evaluation, or evidence. Indeed, consistent with the Military Ban, and unlike the Mattis Policy, the Hegseth Policy imposes a *de facto* blanket prohibition on transgender service. It does so without considering the military's experience under the Austin Policy, whether positive, neutral, or negative.[2] It purports to rely on the outdated Mattis Policy, but goes further than that policy in seeking to eradicate transgender service. An active-duty transgender service member can obtain a waiver and continue to serve if and only if there is "a compelling governmental interest" in their retention *and* they have not had symptoms of gender dysphoria for 36 months, have never attempted to transition, and are willing to serve in their birth sex. The government does not contend that any of the active-duty

[1] There is unrebutted record evidence that this process is already underway.

[2] Plaintiffs submit evidence that their service and that of other transgender service members has not had the damaging effects that purportedly support the Military Ban. The government has in turn provided no evidence supporting the conclusion that military readiness, unit cohesion, lethality, or any of the other touchstone phrases long used to exclude various groups from service have in fact been adversely impacted by open transgender service under the Austin Policy. The Court can only find that there is none.

plaintiffs (or any other transgender service member) could meet this strict standard. Plaintiffs contend that that is the goal: to erase them from the military.

Each of the seven active-duty service member plaintiffs is transgender. Each has been serving openly for almost four years, and some for much longer than that. Commander Emily "Hawking" Shilling, for example, transitioned within the Navy beginning in the fall of 2021 in reliance on the Austin Policy. She has been a Naval Aviator for 19 years. She has flown more than 60 combat missions, including in Iraq and Afghanistan, and was a Navy test pilot. She has 1750 flight hours in high performance Navy jets—including the F/A-18 Super Hornet—and has earned three air medals. She asserts without contradiction that the Navy already spent $20 million training her. There is no claim and no evidence that she is now, or ever was, a detriment to her unit's cohesion, or to the military's lethality or readiness, or that she is mentally or physically unable to continue her service. There is no claim and no evidence that Shilling herself is dishonest or selfish, or that she lacks humility or integrity. Yet absent an injunction, she will be promptly discharged solely because she is transgender.

Plaintiffs ask the Court[3] to preliminarily enjoin implementation of the Military Ban and the ensuing Hegseth Policy as a violation of their constitutional rights, and of

[3] This suit is one of three challenging the Military Ban and the Hegseth Policy. Like the parties, the Court has been following the parallel proceeding in *Talbott v. United States*, No. C25-00240-ACR, 2025 WL 842332 (D.D.C. Mar. 18, 2025). It has read the briefing, the transcripts, and Judge Reyes's thorough memorandum opinion preliminarily enjoining implementation and enforcement of the Military Ban and the Hegseth Policy. The active-duty plaintiffs in each case are separate (though similarly situated) individuals, but other than plaintiffs' declarations, the rest of the evidence appears to be essentially identical. Judge Reyes's factual findings are consistent with that evidence, and the Court similarly finds as facts for

fundamental, established principles of fairness, pending a trial on the merits. They assert Equal Protection, First Amendment, Procedural Due Process, and equitable estoppel claims. They argue that under clear, binding precedent, they are likely to succeed on the merits of each of these claims, and that in the absence of injunctive relief, they face imminent, irreparable harm. They argue there is no creditable claim that the balance of equities or the public interest supports allowing the Military Ban to immediately terminate their honorable service to this country.

The government responds primarily that the Court must defer to the military's (current) judgment; if it says that unit cohesion and readiness, etc., requires the exclusion of—as Judge Reyes aptly phrases it, "fill in the blank"—from military service, then the Court has no authority or ability to question it. Thus, it argues, plaintiffs are unlikely to succeed on the merits of any of their claims. It also argues that plaintiffs face no threat of irreparable injury because, in the military context, a plaintiff must make a much higher showing of such harm than is required in the ordinary case.

It argues that any service member is free to administratively challenge their impending discharge and thus their failure to exhaust such remedies is itself a ripeness bar to their claims. It contends that equity and the public interest are served by exclusion of transgender service members because the Commander in Chief has "determined" that,

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purposes of this motion the unrefuted factual assertions in the record. A similar suit was filed in the District of New Jersey on March 17. *Ireland v. Hegseth et al.*, No. 25-01918-CPO (D.N.J.).

as a class, they lack honesty, humility, and integrity,[4] and there is a strong public interest in deferring to his judgment on which military policies would best protect the nation.

The government's arguments are not persuasive, and it is not an especially close question on this record. The government's unrelenting reliance on deference to military judgment is unjustified in the absence of any evidence supporting "the military's" new judgment reflected in the Military Ban—in its equally considered and unquestionable judgment, that very same military had only the week before permitted active-duty plaintiffs (and some thousands of others) to serve openly. Any evidence that such service over the past four years harmed any of the military's inarguably critical aims would be front and center. But there is none.

Plaintiffs' motion for a preliminary injunction is **GRANTED**. The Court's reasoning is outlined below.[5] To be clear: the government's implementation of the Military Ban and the Hegseth Policy, and any other attempt to identify and separate transgender service members for being transgender is **PRELIMINARILY ENJOINED**, **NATIONALLY**, pending a trial on the merits. A written Order accompanies this Memorandum Opinion.

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[4] This unsupported language originated in the Military Ban. It is repeated in the Hegseth Policy, and again in the government's opposition to plaintiffs' motion. Dkt. 76 at 41–42. At oral argument, the government's attorney confirmed there was "no" support in the record that transgender service members lack honesty, humility, or integrity.

[5] This Court must make findings of fact and conclusions of law when adjudicating an interlocutory injunction. Fed. R. Civ. P. 52(a)(2). The Court makes such preliminary findings and conclusions via this memorandum opinion. *See FTC v. H. N. Singer, Inc.*, 668 F.2d 1107, 1109 (9th Cir. 1982) ("explicit findings of fact were not necessary").

I. BACKGROUND

A. History of Department of Defense Transgender Policy

1. Secretary Carter's Policy: 2015 to 2017

Historically, the Department of Defense did not permit transgender personnel to serve openly in the military. In 2015, then-Secretary of Defense Ashton Carter convened a working group of military and medical experts to review this policy. Bourcicot Decl., Dkt. 32 at 4–5.

The Department of Defense also commissioned the RAND National Defense Research Institute to study the implications of allowing transgender service members to serve openly. RAND Report, Dkt. 32-1 at 4, 10. After extensive research into potential healthcare costs, military readiness, and deployability, RAND found that "a change in policy [would] likely have a marginal impact on healthcare costs and the readiness of the force." *Id.* at 90.

Carter's working group considered the RAND report, as well as expert opinions of senior uniformed and civilian officers and Surgeon Generals from each military department. Dkt. 32 at 5. It concluded that "transgender individuals who meet the standards for military service should be permitted to serve." *Id.*

In 2016, Carter directed the military and all defense organizations to allow transgender service members to serve openly. Carter Policy, Dkt. 33-1 at 2–3. The Policy stated that "open service by transgender Service members while being subject to the same standards and procedures as other members with regard to their medical fitness for duty,

physical fitness, uniform and grooming, deployability, and retention, is consistent with military readiness and strength through diversity." *Id.* at 3.

The Carter Policy modified the military's medical accession and retention standards. *Id.* at 5. Transgender individuals with a history of gender dysphoria and related medical or surgical treatment would not be medically disqualified so long as they had been stable for 18 months. *Id.* at 5–6. Transgender service members could no longer be separated or discharged solely based on their transgender status. *Id.* The Carter Policy also established gender transition processes for service members who sought to transition while serving. *Id.* at 6; 2016 DoD Implementation Handbook, Dkt. 31-5 at 15–16.

2. Secretary Mattis's Policy: 2017 to 2021

In 2017, President Trump "tweeted" that transgender individuals would no longer be allowed to "serve in any capacity in the U.S. Military." Dkt. 31-7. President Trump and then-Secretary of Defense James Mattis issued a memorandum announcing the military's policy would be revised accordingly. Dkt. 31-8.

Several challenges to President Trump's 2017 policy ensued, including, in this District,[6] *Karnoski v. Trump*, No. C17-1297-MJP, 2017 WL 6311305 (W.D. Wash. 2017). Judge Pechman preliminarily enjoined enforcement of the 2017 memorandum, concluding the plaintiffs were likely to succeed on the merits of their Equal Protection, Substantive Due Process, and First Amendment claims. *Id.* at *10.

[6] Three other district courts preliminary enjoined President Trump's 2017 policy: *Doe1 v. Trump*, 275 F.Supp.3d 167 (D.D.C. 2017); *Stockman v. Trump*, 331 F.Supp.3d 990 (C.D. Cal. 2017); *Stone v. Trump*, 280 F.Supp.3d 747 (D. Md. 2017).

Meanwhile, Mattis established an expert panel to review the impact of transgender service members on military readiness and lethality, citing "significant shortcomings" in the RAND report. Mattis Policy, Dkt. 31-10 at 3, 22. The panel met 13 times over 90 days. *Id.* The Department of Defense memorialized the panel's recommendations in a 2018 report that later became the Mattis Policy. *Id.* at 1; Dkt. 76 at 14.

The Mattis Policy promulgated new limitations on transgender service in the military. Transgender individuals with a history of gender dysphoria were disqualified unless they were clinically stable for 36 months, willing to serve in their birth sex, and had not gender transitioned. Mattis Policy, Dkt. 31-10 at 10. Transgender service members diagnosed with gender dysphoria after joining the military were permitted to stay in service if they adhered to their birth sex. *Id.* The Mattis Policy exempted transgender service members diagnosed with gender dysphoria by military medical providers while the Carter Policy was in effect, recognizing their reliance on it: "The reasonable expectation of these Service members that the Department would honor their service on the terms that then existed cannot be dismissed . . . the Department believes that its commitment to these Service members, including the substantial investment it has made in them, outweigh the risks identified in the [Policy]." *Id.* at 48. Existing transgender service members could "continue to receive all medically necessary care, to change their gender marker in the Defense Enrollment Eligibility Reporting System (DEERS), and to serve in their preferred gender, even after the new policy commence[d]." *Id.* at 10–11.

The *Karnoski* defendants moved to dissolve the preliminary injunction based on the Mattis Policy, which the district court denied. *Karnoski v. Trump*, No. C17-1297-MJP, 2018 WL 1784464 (W.D. Wash. 2018). The Ninth Circuit vacated and remanded the decision, concluding that the Mattis Policy constituted a significant change from the 2017 memorandum that could warrant dissolution of the preliminary injunction. 926 F.3d 1180, 1199 (9th Cir. 2019). It directed the district court to give "appropriate military deference" to the Mattis Policy, which "appears to have been the product of independent military judgment." *Id.* at 1202. The parties ultimately stipulated to vacating the preliminary injunction. No. C17-1297-MJP, Dkt. 350.

3. Secretary Austin's Policy: 2021 to 2025

In 2021, President Biden issued an executive order that, once again, instructed the Department of Defense to allow transgender individuals to serve openly in the military. Dkt. 31-11. Under then-Secretary of Defense Lloyd Austin, the Department of Defense reverted to the medical standards for accession and retention of transgender individuals established under the Carter Policy. DoD Instruction 1300.28 on In-Service Transition, Dkt. 33-4; DoD Instruction 6130.03 on Accession and Retention Medical Standards, Dkts. 76-3, 73-5.

Several former military officials under President Biden testify about their positive observations and experiences under the Austin Policy.

Former Navy Secretary, Carlos Del Toro, testifies that in his review of "thousands of disciplinary cases and personnel matters at the highest levels of the Department," he "cannot recollect a single disciplinary case or performance issue related directly to a

service member's transgender status." Del Toro Decl., Dkt. 35 at 3. His experience indicates that "being transgender does not inherently affect a service member's ability to meet [military] standards or to deploy worldwide." *Id.* Rather, he observed "that allowing transgender individuals to serve strengthens unit cohesion by fostering honesty and mutual trust," and helping service members "focus more fully on their duties and build stronger bonds" with their peers. *Id.* at 4.

Former Assistant Air Force Secretary for Manpower and Reserve Affairs, Alex Wagner, testifies he "was not aware of any negative impact that service by transgender Airmen or Guardians had on the Air Force, the Space Force, or our overall military readiness." Wagner Decl., Dkt. 33 at 8. Like Del Toro, Wagner observed that the "Austin policy foster[ed] openness and trust among team members," resulting in "stronger unit cohesion." *Id.* at 8. He did not observe any negative impact on military readiness. *Id.* at 9.

Former Acting Assistant Secretary of the Army for Manpower and Reserve Affairs and Principal Deputy Assistant Secretary of the Army for Manpower and Reserve Affairs, Yvette Bourcicot, was responsible for reviewing gender transition requests from transgender Army personnel. Bourcicot Decl., Dkt. 32 at 7. She testifies she received "only or two such requests per quarter," and "every requesting service member met the necessary standards for serving." *Id.* She also observed "no negative impact from permitting transgender service in the Army or on our military capabilities." *Id.* at 8. In her role, Bourcicot would have been "responsible for resolving" issues relating to the Austin Policy. *Id.* at 9. She did not receive any complaints about transgender service negatively affecting unit readiness and cohesion. *Id.* She notes that while some transgender service

members were temporarily undeployable due to medical procedures, this was "no different than the myriad medical reasons that any service member might become temporarily non-deployable." *Id.*

Former Under Secretaries of Defense for Personnel and Readiness—Gilbert Cisneros, Jr., who served from August 24, 2021 to September 8, 2023, and Ashish Vazirani, who served from September 8, 2023 to January 20, 2025—were tasked with implementing and administering the Austin Policy during virtually all of the Biden Administration. Cisneros Decl., Dkt. 36; Vazirani Decl., Dkt. 34. Cisneros testifies that in his role, he would have been apprised of any "complaints or problems about transgender service members." Cisneros Decl., Dkt. 36 at 6. He "never received or heard a single complaint relating to transgender service members." *Id.* Vazirani observed that the Austin Policy enabled the military to invest in highly trained service members and did not require "any significant changes to the DoD health care system." Vazirani Decl., Dkt. 34 at 3–4. He too did not observe any negative effects on unit readiness and saw improvements in unit cohesion. *Id.* at 5–6.

The government's only rebuttal to the declarations of these senior Department of Defense officials is that of Timothy Dill, the current Assistant Secretary of Defense for Manpower and Reserve Affairs. Dill Decl., Dkt. 76-6. Dill challenges Cisneros and Vazirani's declarations.[7] He asserts the role of Under Secretary of Defense for Personnel and Readiness is "far removed . . . from the individual command level" and that it

[7] Dill does not refute Bourcicot's testimony that she was directly responsible for resolving issues that would have arisen out of the Austin Policy.

involves "large oversight responsibilities" that make it "highly unusual for individualized service member complaints regarding unit cohesion, military readiness, medical readiness, deployability, and lethality to reach" the Under Secretary without "a data call or a study." *Id.* at 3. He testifies that, to his knowledge, "neither Mr. Cisneros nor Mr. Vazirani ever directed a study" on the effects of open transgender service on the military. *Id.*

Cisneros rebuts Dill's assertions. *Talbott*, No. C25-00240-ACR, Cisneros Supp. Decl., Dkt. 53-1.[8] He asserts that it was his "responsibility to be aware of unit cohesion, military readiness, medical readiness, deployability, and lethality. If a unit or service was dealing with readiness issues due to the service by transgender service members, that would have been brought to my attention." *Id.* He testifies he is "aware of no study that has identified a negative impact on unit cohesion, military readiness, medical readiness, deployability, or lethality due to service by transgender individuals or individuals diagnosed with gender dysphoria since transgender persons have been permitted to serve in the last 4 years under the Austin Policy." *Id.*

4. Secretary Hegseth's Policy: 2025

In January 2025, President Trump issued Executive Order No. 14168, "Defending Women from Gender Ideology Extremism and Restoring Biological Truth to the Federal Government," and Executive Order No. 14183, "Prioritizing Military Excellence and Readiness." Dkts. 31-1, 31-13.

[8] Because Cisneros's supplemental declaration has not been filed here, the Court takes judicial notice of the filing in *Talbott*. Fed. R. 201(b)(2).

The President's Military Ban declares:

- "expressing a false 'gender identity' divergent from an individual's sex cannot satisfy the rigorous standards necessary for military service";
- "adoption of a gender identity inconsistent with an individual's sex conflicts with a soldier's commitment to an honorable, truthful, and disciplined lifestyle, even in one's personal life"; and
- the government's policy to "establish high standards for troop readiness, lethality, cohesion, honesty, humility, uniformity, and integrity . . . is inconsistent with the medical, surgical, and mental health constraints on individuals with gender dysphoria" as well as "shifting pronoun usage or use of pronouns that inaccurately reflect an individual's sex."

Dkt. 31-1. It directs the Department of Defense to update its accession and retention policies accordingly. *Id.* The order relies on the Gender Ideology Executive Order to define "sex" as "an individual's immutable biological classification as either male or female," and "gender identity" as "a fully internal and subjective sense of self, disconnected from biological reality and sex and existing on an infinite continuum, that does not provide a meaningful basis for identification and cannot be recognized as a replacement for sex." *Id.*; Gender Ideology Executive Order, Dkt. 31-13.

President Trump also issued a corresponding "Fact Sheet" declaring the Biden Administration "allowed gender insanity to pervade our military organizations," by "not only permitting the military to increase the number of individuals not physically or mentally prepared to serve, but also ordering the Department of Defense to pay for servicemembers' transition surgeries . . . at a cost of millions of dollars to the American

taxpayer." Fact Sheet: President Donald J. Trump Ensures Military Excellence and Readiness, The White House (Jan. 27, 2025).[9]

Promptly resolving to "remove all traces of gender ideology," the Department of Defense paused all new "accessions for individuals with a history of gender dysphoria" and "all . . . medical procedures associated with affirming or facilitating a gender transition for Service members." Jan. 31 DoD Memorandum, Dkt. 58-2; Feb. 7 DoD Memorandum, Dkt. 58-4. The Department of Defense posted on its official Rapid Response X account that "Transgender troops are disqualified from service without an exemption." Amended Complaint, Dkt. 59 at 30. Hegseth reposted the announcement on his official X account.[10]

On February 26, 2025, Dill directed Under Secretary Darin Selnick to implement the Military Ban. 2025 Action Memo, Dkt. 71-1. He explained that the new policy "was informed through consideration of, among other things, the President and Secretary's written direction, existing and prior DoD policy, and prior DoD studies and reviews of service by individuals with gender dysphoria, including a review of medical literature regarding the medical risks associated with presence and treatment of gender dysphoria." *Id.* at 3.

The Department of Defense responded with guidance implementing the Military Ban. The guidance declared that effective March 26, 2025, the policy will be that:

[9] The Court takes judicial notice of the Fact Sheet. Fed. R. Evid. 201(b)(2).

[10] The Court takes judicial notice of these social media posts. *See* @DODResponse, X (Feb. 27, 2025, 12:08 PM); @SecDef, X (Feb. 27, 2025) (repost). Fed. R. Evid. 201(b)(2).

- Individuals who have a history or diagnosis of, or exhibit symptoms consistent with, gender dysphoria are disqualified from military service.
- Individuals with a history of hormone therapy or surgical treatment for gender dysphoria or sex transition are disqualified from military service.
- Current service members who have a history or diagnosis of, or exhibit symptoms consistent with, gender dysphoria will be separated from military service.
- Current service members with a history of hormone therapy or surgical treatment for gender dysphoria or sex transition are disqualified from military service.
- Pronoun usage and salutations must reflect service members' biological sex.
- No funds from the Department of Defense will be used to pay for any medical procedures and treatments associated with gender dysphoria.

Feb. 26 DoD Guidance, Dkt. 58-7.

The Department of Defense may waive these requirements on a "case-by-case basis" if there is a "compelling Government interest . . . that directly supports warfighting capabilities." *Id.* at 6. Current service members disqualified under this policy may only be eligible for a waiver if there is a "compelling Government interest in retaining [them]," they have been clinically stable for 36 months, never attempted to transition to any other sex, and are willing to adhere to their birth sex. *Id.* at 8. Service members ineligible for a waiver could choose to voluntarily separate by March 26. *Id.* at 9. Otherwise, they will be involuntarily separated and "if desired . . . , afforded an administrative separation board." *Id.* The Department of Defense intends to update its medical standards for accession and retention accordingly. *Id.* at 1–2. Service members who involuntarily separate may be

eligible for "involuntary separation pay," though the "Military Departments may recoup any bonuses received" before February 26. *Id.* at 9.

A February 26 "Action Memo" on "Implementing Guidance for Prioritizing Military Excellence and Readiness Executive Order (EO)" accompanied the Hegseth Policy. Dkt. 71-1. It asserts the Hegseth Policy was "informed through consideration of, among other things, the President and Secretary's written direction, existing and prior DoD policy, and prior DoD studies and reviews of service by individuals with gender dysphoria." *Id.* at 3. It cited:

- the Mattis Policy;
- the Department of Defense's 2021 Psychological Health Center of Excellence and the Accession Medical Standards Analysis and Research Activity (AMSARA), which estimated higher rates of disability evaluation among transgender service members and "found that nearly 40% of service members with gender dysphoria in an observed cohort were non-deployable over a 24 month period";
- the Assistant Secretary of Defense for Health Affairs 2025 medical literature review, which found:
  - "55% of transgender individuals experienced suicidal ideation and 29% attempted suicide in their lifetime";
  - "the suicide attempt rate is estimated to be 13 times higher among transgender individuals compared to their cisgender counterparts"; and
  - "transgender individuals are approximately twice as likely to receive a psychiatric diagnosis compared to cisgender individuals," and that the "strength of evidence on transgender mental health and gender-affirming care is low to moderate";
- the Assistant Secretary of Defense for Health Affairs review of 2015 to 2024 cost data related to the healthcare needs of transgender service members, which found "DoD spent $52,084,407 providing care to active duty Service members to treat gender dysphoria, including $15,233,158 for

> psychotherapy; $3,135,593 for hormone therapy, and $14,324,739 for surgical care."

Id. at 3–4 (citing Mattis Policy, Dkt. 71-2; AMSARA Report, Dkt. 71-3; literature review, Dkt. 71-4).

The Action Memo does not accurately summarize the AMSARA report's findings and limitations. *See Talbott*, 2025 WL 842332, at *12–13. AMSARA studied the psychological stability and deployability of individuals with a history or diagnosis of gender dysphoria by comparing available accession records of transgender service members with those of a cohort of other service members with depression. Dkt. 71-3 at 1–2, 8. It confirms that transgender service members were subject to disability *evaluations* far more than all other service members—likely because "members of the transgender community are encouraged (and in many cases required)" to be evaluated more frequently than their cisgender peers. *Id.* at 8, 24 (rate of disability evaluation for transgender service members was 12%, compared to 1–2% among all service members).

One of AMSARA's "key findings" is that rates of transgender service members *experiencing* disability conditions—psychiatric, musculoskeletal, and neurological—were "comparable to those of all service members evaluated for disability." *Id.* at 24. AMSARA acknowledges that the study has several limitations, including that "data w[as] not available from non-transgender service members that could serve as a basis for comparison to indicate if supposed non-deployability rates amongst the transgender cohorts differed from the overall non-deployability rate." *Id.* at 11–12.

The 2025 medical literature review is not specific to military data. Dkt. 71-4. Instead, it compiles 34 prior national and international studies about the "level of evidence for gender-affirming treatments for gender dysphoria." *Id.* at 1. The literature review highlights that "suicide risk among transgender . . . individuals is mitigated by access to gender-affirming care strong social and family support, legal and social recognition, affirming mental health services, community connectedness, and protections against discrimination." *Id.* at 3–4.

Judge Reyes asked the government to submit additional data on the Department's spending and budgets. *Talbott*, No. C25-00240-ACR, Dkts. 66, 66-1.[11] The government responded that in fiscal year 2024, the Department of Defense was appropriated $918.1 billion, stipulating that "the amount cited in the Action Memo"— $52,084,407 spent in treating gender dysphoria—is "but a small fraction of DoD's overall budget." *Id.*, Dkt. 66 at 2. That amounts to approximately $5.2 million per year on average spent on gender dysphoria treatment between 2015 and 2024. If the Department of Defense spent $5.2 million on treating gender dysphoria in 2024, that was about 0.00057% of its 2024 budget. It provided gender-affirming care to 1,892 active-duty service members—less than 0.02% of the 9.5 million beneficiaries covered under the military's TRICARE health

[11] The Court takes judicial notice of the government's filing, Dkt. 66, as to the Department of Defense's budgets and costs in *Talbott*. Fed. R. Evid. 201(b)(2).

system, assuming coverage under TRICARE was similar from 2016 to 2021 to that in 2024. [12] *Id.*, Dkt. 66-1 at 1–2.

Three days after the *Talbott* preliminary injunction and hours before it was to go into effect, the Department of Defense issued new "guidance to assist the Military Departments in identifying" service members who will be affected by the Military Ban. Dkt. 92-1. It clarifies that "[t]he phrase 'exhibit symptoms consistent with gender dysphoria' refers to the diagnostic criteria outlined in the [DSM-5]" and that "[t]his language applies only to individuals who exhibit such symptoms as would be sufficient to constitute a diagnosis." *Id.* at 1 n.2. The military plans to identify such service members "through reviewing medical records," as well as a "Period Health Assessment" in which service members must "attest whether they have a current diagnosis or history of, or exhibit symptoms consistent with, gender dysphoria." *Id.* at 2. Significantly, the March 21 Guidance also reiterates that service members must serve in their birth sex. *Id.* at 1.

Following its March 21 Guidance, the Department of Defense extended its deadline for implementing the Hegseth Policy to March 28, 2025. Dkt. 94-1.

B. The Parties

Plaintiffs include seven transgender service members who have served honorably for years. Plaintiffs Commander Emily Shilling, Commander Blake Dremann, Lieutenant

[12] The Court (gratefully) adopts Judge Reyes's math on this subject: "From January 1, 2016, to May 14, 2021, the military provided gender-affirming care to 1,892 active duty servicemembers. Dkt. 66-1 at 2. That number represents about two hundredths of one percent (0.02%) of the 9.5 million beneficiaries TRICARE covered in 2024. *See id*." 2025 WL 842332, at *14 n.19.

Commander Geirid Morgan, Sergeant First Class Cathrine Schmid, Sergeant First Class Jane Doe, Sergeant First Class Sierra Moran, and Staff Sergeant Videl Leins are openly transgender active-duty service members. Amended Complaint, Dkt. 59. Throughout their 115 years of collective military service, they have been awarded over 70 medals for their honorable service and distinctive performance—in many instances after coming out as transgender. *Id.* at 10, 12, 17, 18; Shilling Decl., Dkt. 24; Dremann Decl., Dkt. 25; Morgan Decl., Dkt. 26; Doe Decl., Dkt. 27; Leins Decl., Dkt. 28; Schmid Decl., Dkt. 39; Moran Decl., Dkt. 87.[13] Many have been deployed on significant domestic and overseas missions after transitioning. *See, e.g.,* Doe Decl., Dkt. 27 at 3.

Each plaintiff testifies that serving openly has improved their focus on their military careers, forged stronger relationships with their peers and commands, and improved trust and transparency among their units, ultimately making each of them a "stronger asset to the military." Dremann Decl., Dkt. 25 at 3; Plaintiffs' Decls., Dkts. 24–28, 39, 87. Plaintiffs assert they would like to continue serving openly in the military in the gender they transitioned to. *Id.* They fear the effect separation would have on their careers, lives, and families. *Id.*

Accession plaintiff Matthew Medina is a 23-year-old transgender man who seeks to join the Marine Corps. Medina Decl., Dkt. 29. Because the Marines "have an age cap

[13] All plaintiffs have submitted declarations, which the government does not contest. The Court provided the parties the opportunity to cross examine any witnesses, Dkt. 65, and the government declined to do so. Dkt. 66. None of the parties requested to present live testimony.

of 28-years-old," Medina fears he will not be eligible to enlist if he waits for the next administration to change its policy on open service by transgender individuals. *Id.* at 3.

Plaintiff Gender Justice League is a human rights organization whose members include openly transgender service members and transgender individuals seeking to join the military. *Id.*

21 States and the Constitutional Accountability Center join as amici. Dkts. 53 and 42.

Defendants include the United States, the Army, the Navy, the Air Force, Secretary of Defense Peter Hegseth, Secretary of the Army Daniel Driscoll, Acting Secretary of the Navy Terence Emmert, and Acting Secretary of the Air Force Gary Ashworth.

C. Challenges to the Military Ban and Hegseth Policy

Plaintiffs assert that the Military Ban violates their constitutional Equal Protection, First Amendment, and Procedural Due Process rights. Active-duty plaintiffs also assert they reasonably and detrimentally relied on the Austin Policy that permitted them to enlist and serve openly, and that equitable estoppel and fundamental fairness preclude the government from this sort of "bait and switch." Dkt. 23 at 32.

They ask the Court to enjoin the military's impending implementation of the Military Ban, arguing that they are likely to succeed on the merits of their claims, that the

balance of hardships weighs in their favor, and that maintaining the status quo pending a trial is equitable and in the public interest. *Id*. at 20.

The government argues that because its military judgment is entitled "unquestionable" deference, plaintiffs are unlikely to succeed on the merits of their claims. Dkt. 76. at 8, 10, 21, 34. It also contends plaintiffs' claims are unripe because they have failed to exhaust the Military Ban's administrative remedies. *Id.* at 19.

Although the Department of Defense's guidance set March 26, 2025, as the effective date of the Military Ban, plaintiffs testify that the Hegseth Policy has already adversely affected them. They have had career opportunities rescinded, had flights booked home from overseas deployment, and been placed on involuntary administrative leave. *See, e.g.,* Moran Decl., Dkt. 87 at 2–3 (Sergeant First Class Moran's application for Officer Candidate School was effectively denied due to the 2025 Military Ban); Morgan Supp. Decl., Dkt. 88 at 1–2 (Lieutenant Commander Morgan's duty assignment to the Armed Forces Radiobiology Research Institute, a significant career milestone that increases chances of promotion to Navy Commander, was rescinded); Leins Supp. Decl., Dkt. 89 at 1–2 (Staff Sergeant Leins was placed on involuntary administrative absence and told she must attend a course to prepare for civilian life); Morgan Supp. Decl., Dkt. 62 at 3–4 (Staff Sergeant Regan Morgan was removed from her forward operating base in a combat zone and was booked on a flight back from overseas deployment).[14]

The government does not challenge this evidence.

[14] Staff Sergeant Morgan is a member of the organizational plaintiff, Gender Justice League. Dkt. 60 at 8.

II. DISCUSSION

A. Plaintiffs' claims are ripe.

The government argues as a threshold matter that active-duty plaintiffs' claims are not ripe because they have failed to exhaust the Hegseth Policy's administrative remedies: "All enlisted Service members who are involuntarily separated . . . will, if desired by the Service member, be afforded an administrative separation board." Dkt. 76 at 19 (citing Feb. 26 DoD Guidance, Dkt. 58-7 at 9).

It asks the Court to accept *Wenger v. Monroe*, 282 F.3d 1068, 1072 (9th Cir. 2002) as authority for the proposition that "an internal military decision is unreviewable unless the plaintiff alleges . . . exhaustion of available intraservice remedies." Dkt. 76 at 19. A closer look, however, reveals that *Wenger* itself expressly obviates the need for exhaustion in this case.

Wenger indeed provides, "'An internal military decision is unreviewable unless the plaintiff alleges (a) a violation of [a recognized constitutional right], a federal statute, or military regulations; and (b) exhaustion of available intraservice remedies.'" 282 F.3d at 1072 (quoting *Khalsa v. Weinberger*, 779 F.2d 1393, 1398 (9th Cir. 1985)). However, it also makes clear that exhaustion is not required if "administrative appeal would be futile; or . . . if substantial constitutional questions are raised." *Id.* (citing *Muhammad v. Sec'y of Army*, 770 F.2d 1494, 1495 (9th Cir. 1985)). Both are true here.

Active-duty plaintiffs' constitutional assertions about the Hegseth Policy are substantial. They also demonstrate that any internal remedies would be futile. Dkt. 23 at 32–33 (citing *Watkins v. United States Army*, 875 F.2d 699, 705 (9th Cir. 1989)); *see also*

Se. Alaska Conservation Council v. Watson, 687 F.2d 1305, 1309 (9th Cir. 1983) (exhaustion not required "where pursuit of administrative remedies would be a futile gesture"). The Hegseth Policy provides that transgender service members will only be exempt from disqualification if, among other requirements, they have "never attempted to transition" *and* are willing to serve in their birth sex. Feb. 26 DoD Guidance, Dkt. 58-7 at 8. All active-duty plaintiffs have taken steps to transition and seek to continue serving openly. As the Policy stands, any attempt to seek internal review necessarily would be fruitless, and thus futile.

The government's opposition falls flat at the outset. Plaintiffs' claims are ripe.

B. Preliminary Injunction Standard.

A party seeking a preliminary injunction "must establish that it is likely to succeed on the merits, that it is likely to suffer irreparable harm in the absence of preliminary relief, that the balance of equities tips in its favor, and that an injunction is in the public interest." *Winter v. Nat. Res. Def. Council, Inc*., 555 U.S. 7, 20 (2008). The last two factors merge when the government is a party. *Drakes Bay Oyster Co. v. Jewell*, 747 F.3d 1073, 1092 (9th Cir. 2014). When considering whether to grant this "extraordinary remedy, . . . courts must balance the competing claims of injury and consider the effect of granting or withholding the requested relief, paying particular regard to the public consequences." *Winter*, 555 U.S. at 24.

The Ninth Circuit recently reiterated that even after *Winter*, its alternate "serious questions" preliminary injunction standard remains viable. *Flathead-Lolo-Bitterroot Citizen Task Force v. Montana*, 98 F.4th 1180, 1190 (9th Cir. 2024) (citing *All. for the*

Wild Rockies v. Cottrell, 632 F.3d 1127, 1132 (9th Cir. 2011) ("[T]he 'serious questions' version of the sliding scale test for preliminary injunctions remains viable after [*Winter*].")).

Under this test, a party is entitled to a preliminary injunction if it demonstrates (1) serious questions going to the merits, (2) a likelihood of irreparable injury, (3) a balance of hardships that tips sharply towards the plaintiff, and (4) the injunction is in the public interest. *Id.* at 1190 (citing *Cottrell*, 632 F.3d at 1135). As to the first factor, the serious questions standard is "a lesser showing than likelihood of success on the merits." *Id*. (citing *All. for the Wild Rockies v. Pena*, 865 F.3d 1211, 1217 (9th Cir. 2017)).

"Serious questions" are ones that "cannot be resolved one way or the other at the hearing on the injunction because they require more deliberative investigation." *Id.* (citation omitted). They "need not promise a certainty of success, nor even present a probability of success, but must involve a fair chance of success on the merits." *Id.* at 1192 (cleaned up).

A preliminary injunction "prohibits a party from taking action" and preserves the *status quo ante litem*, which refers not simply to any situation before the lawsuit was filed, but instead to the "last uncontested status which preceded the pending controversy." *Id*. at 1191.

The parties here seek a preliminary injunction as to all active-duty and accession plaintiffs. Medina and the other accession plaintiffs would still be subject to all other

standards for accession into the Armed Forces.[15] They instead seek to enjoin the Department of Defense from disqualifying them based on their transgender identity—the status quo.

Here, that status quo is before January 20, 2025—before President Trump's first day in office, when he issued Executive Order No. 14148. The last uncontested status preceding this controversy is the Austin Policy, that, for almost four years, had allowed active-duty transgender plaintiffs to serve openly.

C. Likelihood of Success on the Merits.

1. Plaintiffs are Likely to Succeed on the Merits of their Equal Protection Claim.

Plaintiffs' primary claim is that the Military Ban, and the Hegseth Policy and other guidance implementing it, violate their Fifth Amendment constitutional right to Equal Protection under the law. They argue that the government is not free to disregard this protection even when it acts in the area of military affairs; there is no "different equal protection test" for the "military context." Dkt. 23 at 20 (citing *Rostker v. Goldberg*, 453 U.S. 57, 67 (1981)). They argue that the February 26 Guidance does not warrant any deference because it is not the product of a meaningful exercise of independent military judgment. Dkt. 60 at 9.

They argue that the Hegseth Policy is subject to, and cannot survive, heightened scrutiny because it facially classifies and purposefully discriminates based on their transgender status. *Id*. at 20–21 (citing *United States v. Virginia*, 518 U.S. 515, 555

[15] Oral Argument Transcript, Dkt. 102 at 49.

(1996) (heightened scrutiny applied to military college co-education); *Karnoski*, 926 F.3d at 1201 (heightened scrutiny applied to the previous transgender military service ban); and *Witt v. Dep't of Air Force*, 527 F.3d 806, 821 (9th Cir. 2008) (heightened scrutiny applied to military's former "Don't Ask, Don't Tell" policy on an as applied basis)).[16]

They also argue that because the Hegseth Policy classifies based on sex, it is also subject to heightened scrutiny, and that it cannot in any event survive even rational basis review. *Virginia*, 518 U.S. at 555.

Finally, plaintiffs argue that the Military Ban "drips with contempt" and that it, the Hegseth Policy, and related federal policy and directives "reflect and are based on impermissible animus towards transgender people, which renders them invalid as a whole" under any standard of review. Dkt. 59 at 33; Dkt. 23 at 21; Dkt. 82 at 9.

The government denies that the Hegseth Policy discriminates on either transgender or sex status. Dkt. 76 at 15. Instead, it insists it discriminates on gender dysphoria, triggering only rational basis review. But its primary argument, here and elsewhere, is that the Court is ill-equipped to second guess the military's judgment, and if there is a rational basis for its judgment, it is not subject to challenge. *Id*. at 19. It insists that its judgment is entitled to deference. *Id*. at 14. It does not strenuously dispute that the

[16] The Constitutional Accountability Center's amicus brief emphasizes that the military has long relied on concerns about "unit cohesion" and "military effectiveness" to bar racial integration, gay and lesbian service members, and women in combat. Dkt. 42 at 8–9. It asserts "military experts agree that ending those discriminatory policies and ensuring diversity in the military's ranks actually strengthened the military." *Id.* at 9.

Military Ban was motivated by animus towards transgender people, but does contend that even so, there are legitimate reasons for it. *Id.* at 34.

The Fifth Amendment provides that "[n]o person shall . . . be deprived of life, liberty, or property, without due process of law[.]" U.S. Const. amend. V. "The Due Process Clause of the Fifth Amendment contains an equal protection component prohibiting the United States from invidiously discriminating between individuals or groups." *Washington v. Davis*, 426 U.S. 229, 239 (1976). "The Constitution's guarantee of equality 'must at the very least mean that a bare [governmental] desire to harm a politically unpopular group cannot' justify disparate treatment of that group." *United States v. Windsor*, 570 U.S. 744, 770 (2013) (quoting *Dep't of Agric. v. Moreno*, 413 U.S. 528, 534–35 (1973)).

The first step in evaluating an Equal Protection claim is to "determine what level of scrutiny applies to a classification under a law or policy, and to then decide whether the policy at issue survives that level of scrutiny." *Hecox v. Little*, 104 F.4th 1061, 1073 (9th Cir. 2024). The government urges that courts owe deference to its judgment in evaluating Equal Protection claims in the military context. When a policy results from the "professional judgment of military authorities concerning the relative importance of a particular military interest," courts generally defer to the military's determination. *Goldman v. Weinberger*, 475 U.S. 503, 507-08 (1986); *see also Rostker*, 453 U.S. at 67-72 (1981) ("judicial deference ... is at its apogee when legislative action under the congressional authority to raise and support armies and make rules and regulations for their governance is challenged."). But "deference does not mean abdication" and the

court need not defer to unreasonable uses or *omissions in evidence*. *Id.* at 68–70; *see also Witt*, 527 F.3d at 821.

Although they are conceptually distinct, scrutiny and deference are "intertwined" where, as here, the Court considers "the propriety of a military decision concerning transgender persons." *Karnoski*, 926 F.3d at 1199.

a. The Military Ban and Hegseth Policy trigger intermediate scrutiny

(i) The Hegseth Policy discriminates against transgender status

The government argues that the Hegseth Policy does not discriminate against transgender people, but rather only against people who have or have had gender dysphoria. Dkt. 76 at 15. Their efforts are unavailing. Unlike the Mattis Policy, the text of Hegseth Policy scrupulously avoids using the word "transgender"—the word does not appear in the Hegseth Policy. But common sense and binding authority defeat the government's claim that it does not discriminate against transgender people.

The Hegseth Policy uses gender dysphoria as a proxy to ban all transgender service members. Even if transgender service members somehow slip through the current policy, a "law is not immune to an equal protection challenge if it discriminates only against some members of a protected class but not others." *Hecox*, 104 F.4th at 1079. In *Talbott*, the government essentially conceded that "gender dysphoria" and transgender are interchangeable. During oral argument its counsel there asserted that Hegseth likely used "transgender" as "shorthand" for gender dysphoria in his tweet that reads "Transgender troops are disqualified from service without an exemption." *Talbott*, No.

C25-00240-ACR, Dkt. 90, Tr. Mar. 12, 2025, at 19–22. Furthermore, the government here does not dispute that the Hegseth Policy would exclude each plaintiff.

Gender dysphoria is plainly "closely correlated" with being transgender.[17] The Military Ban and Hegseth Policy are certainly not the first attempt to discriminate against disfavored groups by targeting conduct or characteristics "closely correlated" with the group. *See Christian Legal Soc'y Chapter of the Univ. of Cal., Hastings Coll. of the Law v. Martinez*, 561 U.S. 661, 689, (2010) (citing *Lawrence*, 539 U.S. 558, 583 (2003)) (O'Connor, J., concurring) ("While it is true that the law applies only to conduct, the conduct targeted by this law is conduct that is closely correlated with being homosexual. Under such circumstances, [the] law is targeted at more than conduct. It is instead directed toward gay persons as a class.") (alteration in original). Ample other authority has reached the same conclusion. *See C.P. ex rel. Pritchard v. Blue Cross Blue Shield of Ill.*, 2022 WL 17788148, at *6 (W.D. Wash. Dec. 19, 2022) (Bryan, J.) ("A person cannot suffer from gender dysphoria without identifying as transgender.") (cleaned up); *Kadel v. Folwell*, 100 F.4th 122, 146 (4th Cir. 2024) (en banc) ("gender dysphoria is so intimately related to transgender status as to be virtually indistinguishable from it."). In sum, the government's attempt to evade the strictures of intermediate scrutiny by using the term

[17] *Karnoski* did not conduct this analysis because the Mattis Policy used the term transgender. 926 F.3d at 1201 n.18 ("Because the 2018 Policy discriminates on the basis of transgender status on its face, we need not address whether it constitutes discrimination against transgender persons on the alternative ground that gender dysphoria and transition are closely correlated with being transgender").

gender dysphoria fails. The Hegseth Policy plainly discriminates on basis of transgender status.

The Ninth Circuit has repeatedly affirmed that classifications based on transgender status warrant heightened or intermediate scrutiny, and that transgender is at least a quasi-suspect class. [18] *See Karnoski*, 926 F.3d at 1200; *Doe v. Horne*, 115 F.4th 1083, 1102 (9th Cir. 2024); *Hecox*, 104 F.4th at 1079, *as amended* (June 14, 2024); *see also Roe v. Critchfield*, No. 23-2807, -- F.4th--, 2025 WL 865721, at *17 (9th Cir. Mar. 20, 2025) (law regulating transgender bathroom usage discriminates on the basis of transgender status and sex and triggers intermediate scrutiny). The government's primary response to *Karnoski* is that it was wrongly decided. Dkt. 76 at 23. It provides no binding authority or persuasive arguments compelling the Court to break from that precedent. To the contrary, the history the government provides showing how various presidential administrations have given and taken away transgender rights illustrate the "political powerlessness" of the group, one of the factors in determining a quasi-suspect class. Dkt. 76 at 24; *see Lying v. Castillo*, 477 U.S. 635, 638 (1986) (political powerlessness part of quasi suspect class analysis).

Talbott also demonstrates the flaw in the government's argument, repeated here, that the Hegseth Policy does not target transgender service members; it merely addresses a medical condition, gender dysphoria. *Talbott*, 2025 WL 842332, at *10. Judge Reyes's

[18] The government suggests that the Supreme Court is likely to change this determination. Dkt. 76 at 23 (citing *United States v. Skrmetti*, No. 23-477 (*argued* Dec. 4, 2024)). The Court will not decide a case on a party's prediction of what a higher court will decide in the future. *Karnoski* is binding authority.

recent Order denying the government's motion to dissolve the *Talbott* preliminary injunction persuasively explains why the government's March 21 Guidance does not alter the conclusion that, because the Hegseth Policy and subsequent Department of Defense guidance implementing it expressly target transgender service members, intermediate scrutiny applies. It demonstrates that the new guidance instead supports the application of intermediate scrutiny, and why that March 21 Guidance actually *undercuts* each of the government's claimed bases for removing all transgender service members. *Talbott*, 2025 WL 914716, at *3–5.

(ii) The Hegseth Policy discriminates on the basis of sex

The Supreme Court, Ninth Circuit, and many other courts have concluded that discriminating against a person for being transgender inherently discriminates against that individual based on sex. It is "impossible to discriminate against a person for being homosexual or transgender without discriminating against that individual based on sex." *Bostock v. Clayton Cnty*, 590 U.S. 644, 660 (2020). The government argues that *Bostock* is inapplicable in Fifth Amendment Equal Protection analysis because it was a Title VII case. Dkt. 76 at 25. Title VII prohibits discrimination "because of . . . sex." Dkt. 76 at 75 (quoting 42 U.S.C. § 2000e-2(a)(1)). Nothing about differences between Title VII and Fifth Amendment Equal Protection jurisprudence "prevent[s] *Bostock*'s commonsense reasoning—based on the inextricable relationship between transgender status and sex—from [being] appl[ied] to the initial inquiry of whether there has been discrimination on the basis of sex in the equal protection context." *Fowler v. Stitt*, 104 F.4th 770, 790 (10th

Cir. 2024) (citing *Bostock*, 590 U.S. at 660); *see also Talbott*, 2025 WL 842332, at *23–24; *Hecox*, 104 F.4th at 1079 (quoting *Bostock*, 590 U.S. at 660).

Bostock provides a helpful hypothetical involving an employer and two employees that illustrates the "inextricable" relationship between transgender and sex discrimination. 590 U.S. at 660. The two hypothetical employees are identical except that one was a transgender woman and the other a cisgender woman. *Id.* Justice Gorsuch explained that if the employer fires only the transgender woman because she is transgender, it has "intentionally penalize[d]" her "for traits or actions that it tolerates in an employee identified as female at birth." *Id.* He concluded that "if changing the employee's sex would have yielded a different choice by the employer," then the discrimination is based on sex. *Id.* at 659–60.

So too with the Hegseth Policy. The Policy penalizes transgender service members for complying with standard grooming, pronoun usage, and performance metrics that the military requires in cisgender service members. Since it is the birth sex of the service member that triggers the adverse employment action rather than a failure to meet set standards, the discrimination is based on sex.

Bostock aside, the Ninth Circuit has already determined that "discrimination against transgender individuals constitute sex-based discrimination for purposes of the Equal Protection Clause because such policies punish transgender persons for gender non-conformity, thereby relying on sex stereotypes." *Hecox*, 104 F.4th at 1080 (internal quotation marks omitted).

The Military Ban and Hegseth Policy do just that. First, the Military Ban and Hegseth Policy plain text and ensuing guidance classify repeatedly based on sex. *See, e.g.*, Military Ban, Dkt. 31-1 ("adoption of a gender identity *inconsistent with an individual's [birth] sex* conflicts with" military standards) (emphasis added); Hegseth Policy, Dkt. 58-7 at 7 (requires that service members "be willing and able to … [meet] the standards associated with *his or her [birth] sex*" and that they "ha[ve] never attempted to transition to *any sex other than his or her [birth] sex*.") (emphasis added); *id.* at 3 ("All Service members will only serve in accordance with their sex, defined in Executive Order 14168, 'Defending Women from Gender Ideology Extremism and Restoring Biological Truth to the Federal Government'"). "If one must know the sex of a person to know whether or how a provision applies to the person, the provision draws a line based on sex." *Dekker v. Weida*, 679 F.Supp.3d 1271, 1289-90 (N.D. Fla. 2023), *argued*, No. 23-12155 (11th Cir. Nov. 22, 2024). The Hegseth Policy mandates that service members conform with the gender stereotypes of their birth sex by requiring them to dress, meet grooming standards, and use pronouns typically associated with it. Put another way, it relies on overbroad generalizations about sex by assuming that all people born, for example, female must groom and use pronouns typically associated with females and confine themselves to female performance standards[19] in order to have "honesty and integrity." Hegseth Policy, Dkt. 58-7 at 3. If they refuse to conform to these

[19] It is uncontested that some named plaintiffs whose birth sex was female successfully meet male performance standards (and vice versa) in accordance with the Austin Policy.

gender stereotypes associated with their birth sex, the government will separate them, and seek a refund of any retention bonuses earned over their military careers.

In sum, the Military Ban and Hegseth Policy discriminates based on sex, which provides an additional, independent basis for the Court to apply intermediate scrutiny. *Virginia*, 518 U.S. at 555 ("[A]ll gender-based classifications …warrant heightened scrutiny.").

b. Military deference

Under intermediate scrutiny, the government bears the burden to demonstrate that the Military Ban "serves important governmental objectives and that the discriminatory means employed are substantially related to the achievement of those objectives." *Virginia*, 518 U.S. at 524 (internal quotation marks and citations omitted). The government must proffer justifications which are "exceedingly persuasive," "genuine," "not hypothesized," not "invented post hoc in response to litigation," and "must not rely on overbroad generalizations." *Id*. at 531. This "burden of justification" is "demanding"—not "deferential"—and "rests entirely on the [government]." *Id*. at 533.

The government argues that because this case involves judicial review of military decision making, mere rational basis review applies. Dkt. 76 at 14. *Karnoski* rejected this exact argument: "Deference informs the application of intermediate scrutiny, but it does not displace intermediate scrutiny and replace it with rational basis review." 926 F.3d at 1201. The government's suggestion that it is plaintiffs' burden to provide data of the *success* of their service under the Austin Policy (and under the Mattis Policy) is not correct in any event, but it certainly is not true where, as here, the military's judgment is

subject to heightened scrutiny. Intermediate scrutiny places that burden squarely on the government. *Id.* at 1202 (government carries the "not trivial" burden to establish that its policy "significantly furthers" the government's important interests).

Plaintiffs also argue that the Court need not defer to the military's judgment because the Hegseth Policy is not the product of a meaningful exercise of independent military judgment, but rather is a "mere implementation of the Military Ban that itself was issued within a week of President Trump's inauguration." Dkt. 60 at 9. *Karnoski* rejected a similar argument regarding the 2018 Mattis Policy. It determined that "a presumption of deference is owed, because the Mattis Policy appears to have been the product of independent military judgment." 926 F.3d at 1202. Because the Hegseth Policy purports to rely extensively on the Mattis Policy, the Court rejects plaintiffs' argument that it is entitled to no deference at all. Action Memo, Dkt. 71-1 at 4–5.

But the rush to issue the Military Ban and Hegseth Policy with no new military study, evaluation, or evidence does not warrant the same baseline level of deference as the Supreme Court gave in *Rostker* or *Goldman*. In *Rostker*, the gender discrimination in the draft at issue was born from "hearings, floor debate, and in committee" discussions. 453 U.S. at 72. In *Goldman*, the Court noted that the Air Force promulgated a 190-page document (AFR 35–10) detailing the specifics of military uniform, and that this effort evidenced "considered professional judgment" that warranted deference and in part justified the military's refusal to allow the plaintiff to wear a yarmulke. 475 U.S. at 509. The government here has nothing comparable to the military decision making evident in *Rostker* or *Goldman.*

The Department of Defense explains that the Hegseth Policy "was informed through consideration of, among other things," four sources: the Mattis Policy, the AMSARA Report, the 2025 medical literature review, and the cost data review. Action Memo, Dkt. 71-1 at 4–5.

The Court must "apply appropriate military deference" to the Hegseth Policy while applying intermediate scrutiny. It cannot substitute its "own evaluation of evidence for a reasonable evaluation" by the military. *Rostker*, 453 U.S. at 68. But "deference does not mean abdication." *Witt*, 527 F.3d at 821 (quoting *Rostker*, 453 U.S. at 70). If the military's use of the evidence is not reasonable, the Court cannot defer to it. The government bears the burden of establishing that they reasonably determined the Hegseth Policy "significantly furthers" the government's important interests, and that is not a trivial burden.

c. The Military Ban and Hegseth Policy fail intermediate scrutiny

The first step is analyzing whether the government's stated interests are "important." *Virginia*, 518 U.S. at 533. This is self-evident here. It is uncontested that the government has an important interest in maintaining military "readiness, cohesion, good order, discipline" and managing the military's costs.

The next step is determining whether the military ban "significantly furthers" those interests. It does not. The most pointed problem for the government is not just its irrational use of the evidence that it relies on, but the lack of evidence it provides and the ample evidence it simply ignores. The government fails to contend with the reality that transgender service members have served openly for at least four years under the Austin

Policy (some since the Carter Policy in 2016) without any discernable harm to military readiness, cohesion, order, or discipline. It provides no evidence to counter plaintiffs' showing that open transgender service has in fact enhanced each of these interests. Nor does it have any response to plaintiffs' evidence that excluding transgender service would do irreparable harm to those interests. Instead, the government relies on the Mattis Policy's concerns about problems transgender service "could" cause. It uses out of context quotes from medical studies. And it repeatedly asserts that military deference should insulate it from any meaningful review of its rushed decision to revert back to banning transgender service and punishing those who refuse to "voluntarily" separate before it takes away their bonuses and separates them anyway. The Military Ban and the Hegseth Policy do not survive intermediate scrutiny.

(i) Military readiness

The government contends that transgender service members compromise military readiness in at least two ways. First it asserts it is "concerned" about "subjecting those with a history of gender dysphoria to the unique stresses of military life" because it believes they already have high suicidality rates and military life alone can be a contributor to suicidality. Dkt. 76 at 29. Second, it asserts their gender affirming care can make them less deployable. *Id*. at 30.

The government fails to provide rational support for these conclusions and fails to address the evidence to the contrary. Regarding suicide risk, the government relies on the medical literature review. Action Memo, Dkt. 71-1 at 4. But that review does not study the military population. And, unlike the Mattis Policy, because the report is not itself the

product of military decision making, it does not warrant its own military deference. In any event, the review repeatedly emphasized that gender dysphoria is highly treatable and that suicidality reduces with treatment. *Id.* at 2. The government similarly has provided no data supporting the conclusion that transgender service members posed more mental health or suicidality issues than the general military population since the Austin Policy. It similarly fails to acknowledge AMSARA's "key finding" that compared to cisgender service members with depression (from the studied depression cohort), transgender servicemembers "are more likely to remain on active duty longer following cohort eligibility" and "spend less time in a non-deployable status due to mental health reasons." Dkt. 71-3 at 8. The government also fails to acknowledge that military screening for accession already assesses suicide risk, and it offers no explanation for why this is not sufficient to root out suicidality. *See* DoD Instruction 6130.03 on Appointment, Enlistment, or Induction Medical Standards 6.28(m), Dkt. 76-3 at 51. Instead, the government relies only on predictions from the Mattis Policy.

Regarding deployability, the government relies on Mattis Policy data and the AMSARA report, both of which could only make educated predictions about deployability of transgender service members, because they lacked the benefit of four years of transgender service members being deployable. Indeed, the AMSARA report emphasized that more data was needed to determine deployability. Dkt. 71-3 at 11–12.

The government also ignore plaintiffs' persuasive data showing that there have not been deployability concerns. Dkt. 23 at 26 (citing Wagner Decl., Dkt. 33 ¶ 44; Bourcicot Decl., Dkt. 32 ¶ 27). It similarly fails to address plaintiffs' persuasive data that the

military would incur a significant burden to fill vacancies due to the Military Ban and Hegseth Policy, many of whom are deployed oversees. Cisneros Decl., Dkt. 36 ¶¶ 26-27; Skelly Decl., Dkt. 38 ¶ 23. In short, none of the government's data supports its conclusion that banning transgender persons from serving is substantially related to achieving military readiness. And the data the government ignores supports that the Military Ban and Hegseth Policy impedes readiness. It would be an "abdication" of the Court's role to review to defer to the government's out of date and out of context data on this point.

(ii) Unit cohesion, good order, and discipline

The government relies exclusively on the Mattis Policy's predictions to justify concluding that banning transgender service members is substantially related to achieving unit cohesion, good order, and discipline. Dkt. 76 at 32.

First, it raises privacy concerns. It points to the Mattis Policy prediction that allowing transgender service people to use the facilities of their preferred gender "would invade the expectations of privacy" of the other service members sharing living and bathing facilities. Dkt. 76 at 30 (quoting Mattis Policy, Dkt. 31-10 at 42). The government argues that "absent the creation of separate facilities for transitioned or transitioning servicemembers, which could be both 'logistically impracticable for the Department,' as well as unacceptable to those servicemembers, the military would face irreconcilable privacy demands." *Id*. at 30-31 (quoting Mattis Policy, Dkt. 31-10 at 42). It correctly observes that the implementation handbook for the Carter Policy, "repeatedly stressed the need to respect the 'privacy interests' and 'rights of Service members who

are not comfortable sharing berthing, bathroom, and shower facilities with a transitioning Service member[,]' and urged commanders to try to accommodate competing interests to the extent that they could." *Id*. at 31 (quoting 2016 DoD Implementation Handbook, Dkt. 31-5 at 38) (citing *id.* at 22, 29, 33, 60–61, 63–64).

Although respecting the privacy needs of all service members is a worthy objective, the government does not carry its burden to show that reverting to a ban on open transgender service members is a justifiable means of achieving those ends. It relies exclusively on the *predictions* of the Mattis Policy about what issues open transgender service "*could*" pose to privacy concerns. It once again fails to provide any argument or evidence that those predictions came to pass in the years that transgender service members served openly. There is nothing in the record to support that open service required "the creation of separate facilities for transitioned or transitioning servicemembers," Dkt. 76 at 30, and the government does not address the far less drastic suggestions for mitigating privacy concerns outlined in the Carter and Austin Policies. *See, e.g.*, Dkt. 31-5 at 23 (Carter Policy proposes strategies for easing privacy concerns including "adjusting personal hygiene hours"); Dkt. 33-4 at 17 (Austin Policy encourages commanders to consult with "service member and [Service Central Coordination Cell]" for expert advice and assistance with transgender service members' gender transitions when employing privacy measures).

Again relying only on the Mattis Policy predictions, the government argues that "exempting servicemembers from sex-based standards in training and athletic competitions based on gender identity *would* generate perceptions of unfairness in the

ranks" and that allowing a transgender woman to compete with a cisgender woman "could" pose a serious safety risk. Dkt. 76 at 31 (quoting Mattis Policy, Dkt. 31-10 at 35, 41) (emphasis added). The government does not provide any evidence that any of these concerns materialized during the past years of open transgender service. It similarly lacks any evidence to support the assertion that allowing open transgender service would require leadership to "divert" too much time away from military tasks. *Id*.

Plaintiffs provide affirmative evidence from a variety of service member declarants that these past four years of open transgender service helped, rather than hurt, unit cohesion, good order, and discipline. Dkt. 23 at 25–27 (citing Vazirani Decl., Dkt. 34 ¶ 24, Dremann Decl., Dkt. 25 ¶¶ 8, 10-11; Morgan Decl., Dkt. 26 ¶¶ 13, 17-18; Shilling Decl., Dkt. 24 ¶¶ 12-14; Schmid Decl., Dkt. 39 ¶¶ 13-19: Cisneros Decl., Dkt. 36). They also provide evidence from military officials, including former Under Secretary of Defense Cisneros, who testifies that allowing open transgender service "fosters openness and trust among team members, thereby enhancing unit cohesion." Dkt. 36 ¶ 15.

The government does not provide any evidence in support of its claim that open transgender service hurt cohesion. Instead, Assistant Secretary of Defense Timothy Dill testifies merely that "it would be highly unusual for individualized service member complaints regarding unit cohesion, military readiness, medical readiness, deployability, and lethality to reach the level of [Cisneros]." Dkt. 76-6 ¶ 6. But Cisneros clearly explains that "[i]t was [his] responsibility to be aware of unit cohesion military readiness, medical readiness, deployability, and lethality." Dkt. 36 ¶ 3. The Court credits Cisneros's testimony as to his own awareness over Dill's guess as to what he thinks Cisneros's

awareness would have been. The government could have cross examined Cisneros or any of plaintiffs' declarants, but chose not to.

In short, the government falls well short of its burden to show that banning transgender service is substantially related to achieving unit cohesion, good order, or discipline. Although the Court gives deference to military decision making, it would be an abdication to ignore the government's flat failure to address plaintiffs' uncontroverted evidence that years of open transgender service promoted these objectives. It would similarly be an abdication to indulge the government's irrational reliance on predictions from the over 7-year-old Mattis Policy and ignore its failure to provide any updated data.

(iii) Costs

The government asserts that the costs associated with gender-affirming health care make service by transgender members are "disproportionate" and that the money "should be better devoted elsewhere." Dkt. 76 at 33. But its estimate for transgender care costs is a negligible fraction of the military's budget. *Talbott*, No. C25-00240-ACR, Dkt. 66-1. The government provide no updated data comparisons to support its assertion that costs expended on transgender service members are disproportionate. Instead, they rely on the Mattis Policy's assertion that the medical costs for service members with gender dysphoria was "nearly three times" compared to service members without the condition. *Id.* (quoting Mattis Policy, Dkt. 31-10 at 46).

The government does not analyze the costs of discharging and replacing thousands of trained service members, many with decades of experience and specialized skills. Plaintiffs estimate the cost of "separating transgender servicemembers and finding and

training replacements" is "nearly one billion dollars— *more than 100 times greater* than the cost to provide transition-related healthcare.'" Dkt. 23 at 28 (quoting *Karnoski*, 2017 WL 6311305, at *8) (citing Gordon Decl., Dkt. 31-24; Vazirani Decl., Dkt. 34 ¶ 13; Cisneros Decl., Dkt. 36 ¶ 13; Skelly Decl., Dkt. 38 ¶¶ 14, 24).

In any event, the costs associated with providing transition-related care to active-duty service members plainly "are exceedingly minimal." *Karnoski*, 2017 WL 6311305, at *8. Even the government concedes that gender affirming care "is small relative to DoD's total healthcare expenditure." Dkt. 76 at 33. On this record, it cannot show that that banning transgender service is "substantially related" to cost effectiveness.

d. The Government's failure to provide and confront evidence reveal the Military Ban and Hegseth Policy would not survive even rational basis review

Omissions in the Hegseth Policy further undermine the government's argument that the Military Ban forwards its stated interests. The government concedes[20] there is no evidence that being transgender is inconsistent with "honesty," "humility," or "integrity," Military Ban § 2, Dkt. 31-1, and that being transgender "conflicts with a soldier's commitment to an honorable, truthful, and disciplined lifestyle," *id.* § 1.

All of the government's failures illustrate that the Military Ban is not rationally related to the government's stated interest, let alone that it "significantly furthers" important governmental interests. The reliance on seven-year-old predictions from the Mattis Policy while ignoring the reality of years of open service is not reasonable and is not comparable to congressional debates and extensive records supporting the military

[20] *See* Oral Argument Transcript, Dkt. 102 at 31.

decision in *Rostker* and *Goldman*. The near complete absence of updated data here speaks for itself. The government had every opportunity to provide their own declarants to support their points or counter plaintiffs' evidence that open service did not hurt its stated interests. But it did not.

The government's assertion that "trans-identifying persons achieved at least some version of their desired military policy from the last two Democratic Administrations and can *reasonably be expected to do so again* from the next Democratic Administration" is telling. Dkt. 76 at 24 (emphasis added). It very well is reasonable for transgender service members to expect that they be allowed to serve openly when they have done so successfully for years and the government lacks any evidence to justify banning them now. Equal Protection scrutiny does not fluctuate depending on what political party is in administration. The government's "better luck next administration" argument belies its assumption that the Court will defer blindly to the Military Ban without any meaningful review. It cannot and will not. The Military Ban and Hegseth Policy on the present record fails any level of Equal Protection scrutiny.

e. Animus

Plaintiffs contend that the Military Ban and Hegseth Policy are fueled by animus, and consequently fail any level of scrutiny. Dkt. 23at 21–22; Dkt. 82 at 9. The government argues that even if the Court were to find that the Military Ban is motivated by animus, the Court still must uphold it "so long it can be understood to result from a justification independent of unconstitutional grounds." Dkt. 76 at 33–34 (quoting *Trump v. Hawaii*, 585 U.S. 667, 705 (2018)).

Because the Military Ban and Hegseth Policy here cannot survive the intermediate scrutiny that its discrimination triggers nor the rational basis review that the government argues for, the Court need not make an animus determination to grant a preliminary injunction. The Military Ban and Hegseth Policy would fail on this record even if animus was not plain. Although the parties are welcome to raise the implications of animus as litigation continues, this preliminary injunction rests exclusively on the government's failure to meet their burden under any level of review to uphold this ban.

2. Plaintiffs are Likely to Succeed on the Merits of Their First Amendment Claim.

Plaintiffs allege the Hegseth Policy violates the First Amendment's free speech guarantees. Dkt. 23 at 28. They argue the Policy constitutes impermissible content-based and viewpoint-based restrictions on speech by penalizing only transgender service members for expressing a gender identity different from their birth sex, even in their personal lives. *Id.* at 28–29; Dkt. 59 at 34.[21]

The government argues, correctly, that the First Amendment's guarantees in the military context do not reach as far as they do as in civilian society. Dkt. 76 at 34–35 (citing *Goldman v. Weinberger*, 475 U.S. 503 (1986)). It posits the Hegseth Policy's requirement that service members use pronouns consistent with their birth sex reasonably furthers the government's important interest in "uniformity." *Id.* at 35–36. It also asserts

[21] Plaintiffs' reply also alleges the Hegseth Policy is speaker-based discrimination for the sole purpose of exercising a content preference. Dkt. 82 at 20. The Court does not entertain legal arguments raised for the first time in a reply brief. *United States v. Romm*, 455 F.3d 990, 997 (9th Cir. 2006).

the Policy "does not ban anyone based on speech or expressive conduct;" it just "presumptively disqualifies individuals with gender dysphoria." *Id.* at 35.

Under the First Amendment, the government "'has no power to restrict expression because of its message, its ideas, its subject matter, or its content.'" *Reed v. Town of Gilbert*, 576 U.S. 155, 163 (2015) (quoting *Police Dep't of Chicago v. Mosley*, 408 U.S. 92, 95 (1972)). Content-based speech restrictions, comprising discrimination against "particular speech because of the topic discussed or the idea or message expressed," are presumptively unconstitutional and subject to strict scrutiny. *Id.*; *see Karnoski*, 2017 WL 6311305, at *9. Viewpoint-based restrictions, based on the "motivating ideology or the opinion or perspective of the speaker," are a particularly "egregious form of content discrimination." *Rosenberger v. Rector of Univ. of Va.*, 515 U.S. 819, 829 (1995). *See R.A.V. v. City of St. Paul*, 505 U.S. 377 (1992) (First Amendment prevents government from restricting speech "because of disapproval of the ideas expressed."); *Hurley v. Irish-Am. Gay, Lesbian and Bisexual Grp. of Boston*, 515 U.S. 557, 579 (1995) ("While the law is free to promote all sorts of conduct in place of harmful behavior, it is not free to interfere with speech for no better reason than promoting an approved message or discouraging a disfavored one, however enlightened either purpose may strike the government.").

In the military context, judicial review of regulations implicating the First Amendment is more deferential than review of "similar laws or regulations designed for civilian society." *Goldman*, 475 U.S. at 507. *See Parker v. Levy*, 417 U.S. 733, 760 (1974). This is because the "essence of military service 'is the subordination of the

desires and interests of the individual to the needs of the service.'" *Goldman*, 475 U.S. at 507 (quoting *Orloff v. Willoughby*, 345 U.S. 83, 92 (1953)). While military service requires some sacrifices for the sake of "obedience, unity, commitment, and esprit de corps," it does not, "of course, render entirely nugatory the guarantees of the First Amendment." *Id.*

The government cites *Goldman* for the proposition that military deference defeats all of plaintiffs' constitutional claims. Dkt. 76 at 34–36. But *Goldman* concerned Air Force uniform regulations that impinged on religious beliefs, not a free speech restriction. *Goldman*, 475 U.S. at 509–10. More apposite is *Brown v. Giles*, involving an Air Force regulation that required service members to seek permission from their commander before distributing circulating any printed or written material, including petitions for signatures. 444 U.S. 348, 350 (1980).

This case, unlike *Brown*, entails a viewpoint-based restriction on transgender service members' speech and expression. The Hegseth Policy requires that transgender service members "adhere to all . . . standards" associated with their birth sex, including the use of pronouns consistent with their birth sex. Feb. 26 DoD Guidance, Dkt. 58-7 at 3, 7–8. By prohibiting transgender service members from presenting in—effectively, identifying with—a gender different than their birth sex, the Policy imposes a restriction on gender expression that does not conform with their birth sex. *Rosenberger*, 515 U.S. at 829. The Military Ban goes so far as to restrict transgender expression "even in one's personal life." Dkt. 31-1 at 2.

Despite the viewpoint-based restriction at play, the Court applies intermediate scrutiny because of the deference it must give to the military's judgment. But the Hegseth Policy does not survive heightened scrutiny even under such deference. As with plaintiffs' Equal Protection claim, the government has not demonstrated that infringing upon transgender service members' gender expression even in their personal life furthers an important government interest. The military already has separate pronoun, uniform, and grooming standards for men and women. *See Singh v. Berger*, 56 F.4th 88, 101 (D.C. Cir. 2022) (Marine Corps did not have a compelling interest in mandating that male recruits shave their beards and cut their hair in violation of their Sikh faith, partially in view of different shaving and hair styling standards for women). Unlike *Goldman*, where the plaintiff sought to wear a yarmulke that did not conform with military uniform standards, plaintiffs here do not seek to create new pronoun or uniform standards for transgender service members. They instead want the freedom to choose from existing pronoun, uniform, and grooming standards to express their own gender. The government fails to justify denying transgender service members the right to choose between standard military uniforms and pronouns.

3. Plaintiffs are Likely to Succeed on the Merits of Their Procedural Due Process Claim.

Active-duty plaintiffs[22] argue that the Military Ban and the ensuing Hegseth Policy violate their constitutional Procedural Due Process rights because it retroactively

[22] Only active-duty plaintiffs assert Procedural Due Process and equitable estoppel claims. To the extent the Court's preliminary injunction is based on the likelihood of success on the merits of these claims, it applies only to active-duty service members.

punishes them for conduct the government previously approved, offending basic notions of fairness. Dkt. 23 at 31. They accurately assert that the Military Ban and Hegseth Policy retroactively deem them categorically unfit for service based on explicit, stigmatizing, and wholly unsupported labels of dishonesty and dishonor. *Id.*

Plaintiffs implicitly concede, and the government affirmatively asserts, they have no stand-alone constitutionally protected liberty or property interest in continued military service. *See* Dkt. 76 at 36 (citing *Smith v. Harvey*, 541 F.Supp.2d 8, 15–16 (D.D.C. 2008)). But active-duty plaintiffs' Procedural Due Process claim is instead a "stigma plus" claim, based on the insulting language used, and reputational harm and adverse employment status it causes. Dkt. 23 at 31 (citing *Ulrich v. City of San Francisco*, 308 F.3d 968, 981-82 (9th Cir. 2002) ("stigma-plus" test does not require separate protectible interest in employment and stigmatizing statements need only be related to adverse action)).

Plaintiffs also argue, persuasively, that the Military Ban punishes them for "doing precisely what the government invited and induced them to do"—serve openly, provided they met the other requirements for service (which they do). Dkt. 23 at 32. They argue that the government created a reasonable expectation that active-duty plaintiffs would not be punished for disclosing their status and transitioning under the military's approved process for doing so and that due process forbids such a "bait and switch." *Id.* (citing *Baker v. City of SeaTac*, 994 F.Supp.2d 1148, 1154 (W.D. Wash. 2014) (public employees have "property interest in continued employment" when they have "reasonable expectation" based on "existing rules" or mutually explicit

"understandings")). They argue that "elementary considerations of fairness" dictate that individuals should have an opportunity to what the law is and to conform their conduct accordingly; "settled expectations" should not be "lightly disrupted." *Id*. (citing *Landgraf v. USI Film Prods.*, 511 U.S. 244, 265 (1994)). Plaintiffs argue that Procedural Due Process protects against precisely this sort of "retribution" against unpopular groups by restraining arbitrary and potentially vindictive measures. *Id*. (citing *Landgraf*, 511 U.S. at 269).

The government's response ignores this second argument entirely; it does not address *Baker*, *Landgraf*, principles of fairness, settled expectations, or the "bait and switch" nature of the Military Ban. Dkt. 76 at 36–38.

As to plaintiffs' stigma-plus Procedural Due Process claim, the government argues that *Smith*'s holding that there is no constitutionally protected property interest in continued military service is the reason Judge Pechman dismissed the plaintiffs' Procedural Due Process claim in *Karnoski*. Dkt. 76 at 36. But the *Karnoski* plaintiffs did not assert a stigma-plus Procedural Due Process claim and the Court's opinion did not address or dismiss such a claim. Instead, it noted that the plaintiffs' preliminary injunction motion did not "elaborate in detail" on the Procedural Due Process claim they did assert. *Karnoski*, 2017 WL 6311305 at *10 n.5.

The government cites *Christoffersen v. Washington State Air Nat. Guard*, 855 F.2d 1437, 1443 (9th Cir. 1988) for the same proposition: absent a constitutionally protected property interest in continued employment in the Washington Air National Guard, plaintiffs facing separation had no plausible Procedural Due Process claim. Dkt.

76 at 36–37. But the plaintiffs there did not assert a stigma-plus claim, either. *Christoffersen*, 855 F.2d at 1440.

The government correctly cites *Chaudhry v. Aragón*, 68 F.4th 1161, 1170 (9th Cir. 2023) for the proposition that to successfully lodge a stigma-plus Procedural Due Process claim, plaintiffs must show: "(1) the public disclosure of a stigmatizing statement by the government; (2) the accuracy of which is contested; (3) *plus* the denial of some more tangible interest such as employment." Dkt. 76 at 37.

It argues that plaintiffs are not likely to succeed on the merits of their stigma-plus claim because they are "mistaken" that "separation brands them as being dishonest or dishonorable." *Id*. Instead, it asserts, under the Hegseth Policy, the military's characterization of their service on discharge will be "honorable." *Id.* at 41. Because this is not stigmatizing, it argues, such a discharge cannot support a stigma-plus Procedural Due Process claim. *Id*. (citing *Ben-Shalom v. Sec'y of Army*, 489 F. Supp. 964, 972 (E.D. Wis. 1980) (no Procedural Due Process claim where plaintiff's "discharge was honorable, and there was no public disclosure by the Army of the reasons for her discharge.")).

But the government's cite is again incomplete, and the rest of the story supports plaintiffs, not the government. *Ben-Shalom* went on: "To support a 'liberty' interest claim, the petitioner would be required to show that her discharge was based upon 'an unsupported charge which could wrongfully injure (her reputation).'" 489 F.Supp. at 972 (quoting *Arnett v. Kennedy*, 416 U.S. 134, 157 (1974)). Like *Chaudhry* in 2023, *Ben-Shalom* in 1980 recognized that the result is different where "there [is] a public disclosure

of the reasons for discharge by the government which necessarily impose[s] a 'badge of infamy' on the employee." *Id*.

The Court details above the many ways in which the government has already very publicly "branded" transgender service members with demeaning, cruel, and unsupported "badges of infamy." These instances are in the public record. The government cites no authority supporting its claim that the reputational harm is erased for Due Process purposes if the discharge caused by the public stigmatization is nevertheless "honorable."

The Military Ban and Hegseth Policy's demeaning language is repeated even here in the government's response: "The Commander has determined that it is 'the policy of the United States Government to establish high standards for troop . . . honesty, humility, uniformity, and integrity,' and that this policy is 'inconsistent with the . . . constraints on individuals with gender dysphoria.'" Dkt. 76 at 41 (quoting Military Ban). In effect, the government, in line with the Military Ban and Hegseth Policy, posits that, as a class, transgender service members are only in the military as the result of a radical, insane, false gender ideology. *See, e.g.*, Military Excellence and Readiness Fact Sheet ("During the Biden Administration, the Department of Defense allowed gender insanity to pervade our military organizations."). There is no evidence in the record supporting these assertions.

One discharged from service based on these grounds is plainly stigmatized. The accuracy of the government's proclamations is obviously contested, and plaintiffs are about to lose their military careers because of them. An honorable discharge does not

erase or sanitize the language the government uses to describe the character of separated service members under the Military Ban and Hegseth Policy.

Plaintiffs have demonstrated the *Chaudhry* elements of a stigma-plus Procedural Due Process claim. They have also demonstrated that the Military Ban violates "bedrock" Due Process fairness principles precluding arbitrary or vindictive measures that upset settled expectations. On the record before the Court, they are likely to succeed on the merits of their Procedural Due Process claim.

The government's argument that plaintiffs cannot establish the denial of adequate procedural protections because the Hegseth Policy affords them "all statutorily required rights and benefits," Dkt. 76 at 37, is a variation of their ripeness argument, discussed and rejected above.

4. Plaintiffs are Likely to Succeed on the Merits of Their Equitable Estoppel Claim.

Active-duty plaintiffs also assert an equitable estoppel claim, based on similar reasoning: justice and fair play preclude even the military from reneging on its promises and punishing service members for conduct it expressly sanctioned. Dkt. 23 at 33–35. They correctly contend the Hegseth Policy is not only a drastic shift from the recent Austin Policy, it stands in "stark contrast" to even the Mattis Policy upon which it purports to rely. The Mattis Policy incorporated a reliance exception for current service members. Dkt. 31-10 at 3. It did so because the expert report Mattis had commissioned found that such service members' "reasonable expectation" that the military would "honor their service on the terms that then existed cannot be lightly dismissed"—

particularly considering the "substantial investment" the military had made in them. *Id*. at 48.

Plaintiffs rely on *Watkins*, which equitably estopped the Army from refusing in 1982 to again re-enlist Perry Watkins, whom it had drafted in 1967. 875 F.2d at 711. Watkins told the Army in writing he was gay when he was drafted, they accepted him anyway, and he served honorably for more than 14 years despite a regulation clearly prohibiting his service on that basis. *Id.* at 701–03.

Watkins held that equitable estoppel applies to the government if, in addition to the traditional elements, the plaintiff can establish two additional, threshold elements: (1) "affirmative misconduct going beyond mere negligence," and (2) that the government's act will "cause a serious injustice" and the public's interest will not suffer "undue damage" by the imposition of the liability. *Id*. at 707 (citations omitted).

In *Watkins*, the "misconduct" was the Army's affirmative "misrepresentation" that Watkins was qualified when admitting, reclassifying, reenlisting, retaining, and promoting him throughout his exemplary military career, in violation of its own policy. *Id*. The Ninth Circuit had no trouble concluding that Watkins's injury in reliance on the Army's prior approval of his military career—the loss of that career—satisfied "serious injustice" part of the second element, and that any harm to the public interest if he were permitted to re-enlist was "nonexistent." *Id*. at 709.

The Ninth Circuit also easily concluded that Watkins had met the remaining, traditional elements of an equitable estoppel claim:

(1) The party to be estopped must know the facts;

(2) he must intend that his conduct shall be acted on or must so act that the party asserting the estoppel has a right to believe it is so intended;

(3) the latter must be ignorant of the true facts; and

(4) he must rely on the former's conduct to his injury.

Id. (citations omitted). It held that "equity cries out and demands the Army be estopped from refusing to reenlist Watkins." *Id*. at 711.

The government cites *Watkins* for the propositions that equitable estoppel against it requires some "affirmative misrepresentation" on its part, and the threat of "serious injustice" to plaintiffs. Dkt. 76 at 39–40. But it does not attempt to distinguish *Watkins*'s result or otherwise discuss or acknowledge its obvious similarities to the facts and issues here. *Id*.

The government argues that estoppel cannot apply to prevent a federal agency from "changing" its "generally applicable[23] policies." *Id*. at 38. It asserts it made no "definite representations" to induce any specific plaintiff to rely on the Carter or Austin Policy, and that any service member's reliance on the Austin Policy to enlist or transition was not reasonable because governmental policies change all the time, for any number of reasons. *Id*. at 39.

The Court does not agree. The first Trump administration's Mattis Policy recognized that it would be unfair to exclude otherwise qualified service members who had relied on the prior Carter Policy, and that their "reasonable expectations" should not

[23] A policy excluding a quasi-suspect class from service is not remotely "generally applicable."

be "lightly dismissed." Dkt. 31-10 at 48. *Landgraf* used similar language to explain that "elementary considerations of fairness dictate that individuals should have an opportunity to know what the law is and to conform their conduct accordingly; settled expectations should not be lightly disrupted." 511 U.S. at 265. The government's current claim that a service member could not have reasonable relied on its unambiguous rules is unsupportable and unpersuasive.

The government's argument is essentially that no one can rely on any of its rules, because, obviously, things change. There is no cite, no authority, and no logical support for this proposition. There is ample and ancient authority for the opposite conclusion: "the presumption against retroactive legislation is deeply rooted in our jurisprudence, and embodies a legal doctrine centuries older than our Republic." *Landgraf*, 511 U.S. at 265 at n.17 (citing *Kaiser Aluminum & Chemical Corp. v. Bonjorno*, 494 U.S. 827, 842–844, 855–856 (1990) (Scalia, J., concurring); and *Dash v. Van Kleeck*, 7 Johns, *477, *503 (N.Y. 1811) ("It is a principle of the *English* common law, as ancient as the law itself, that a statute, even of its omnipotent parliament, is not to have a retrospective effect")).

If it were true that one could not rely on the government's policies, the Army would not have been estopped from precluding Perry Watkins's re-enlistment. The only difference between *Watkins* and this case is that there, the government's rule was that he could not serve but they let him, for 14 years, before changing its rule and attempting to unfairly enforce its new rule to exclude him. Here, the government's position was that transgender service members were eligible, but the government changed its rule, notwithstanding any justifiable reliance or unjust consequences.

There is "no single test" for "detecting the presence of affirmative misconduct; each case must be decided on its own facts and circumstances." *Watkins*, 875 F.2d at 707. The "misconduct" in *Watkins* was letting him serve when there was a rule saying he could not, and it was estopped from changing its mind. Here, the government allowed transgender service members to serve and transition openly, but the government has now changed its rule and seeks to exclude those service members for the very conduct it previously assured them was not exclusionary. It was misconduct to lull plaintiffs into a false sense of approval and security as to the military's policies on open transgender service. The facts are not exactly the same as in *Watkins*, but the unmistakable and fundamental unfairness is.

Like the Ninth Circuit in *Watkins* this Court has little trouble concluding that all elements of equitable estoppel against the government are present. Active-duty plaintiffs are likely to succeed on the merits of this claim. Equity does not permit this sort of "bait and switch" any more than Due Process does.

D. Plaintiffs Will Suffer Irreparable Harm in the Absence of Injunctive Relief.

Plaintiffs argue, and the Court agrees, that they will suffer irreparable harm absent an injunction. Dkt. 23 at 35. The government responds that plaintiffs' claimed harm "related to loss of employment and . . . reputational damage" in the military context does not amount to irreparable harm. Dkt. 76 at 40 (citing *Hartikka v. United States*, 754 F.2d 1516, 1518 (9th Cir. 1985)). They further contend that because plaintiffs can "contest any separation in the administrative separation board . . . and seek further [internal] review," their asserted harm is remediable, not irreparable. *Id.* at 41.

Irreparable harm is "harm for which there is no adequate legal remedy, such as an award of damages." *Ariz. Dream Act Coal. v. Brewer*, 757 F.3d 1053, 1068 (9th Cir. 2014). When the "internal affairs of the armed forces" are at issue—such as in "cases where military personnel seek preliminary injunctive relief prohibiting a discharge"—plaintiffs must make "stronger showing of irreparable harm than the ordinary standard." *Hartikka*, 754 F.2d at 1518.

For active-duty plaintiffs, loss of employment does not ordinarily constitute irreparable harm if "the temporary loss of income" can ultimately be recovered, and "adequate compensatory or other corrective relief will be available at a later date." *Sampson v. Murray*, 415 U.S. 61, 90 (1974). However, in some "genuinely extraordinary situation[s]," the "circumstances surrounding an employee's discharge, together with the resultant effect of the employee, . . . so far depart from the normal situation that irreparable injury might be found." *Id.* at 92 n.68. For example, the "deprivation of constitutional rights 'unquestionably constitutes irreparable injury.'" *Hernandez v. Sessions*, 872 F.3d 976, 994 (9th Cir. 2017) (quoting *Melendres v. Arpaio*, 695 F.3d 990, 1002 (9th Cir. 2012)). *See Elrod v. Burns*, 427 U.S. 347, 373 (1976) (public employees discharged from employment due to partisan political affiliation incurred the loss of First Amendment freedoms that "unquestionably constitute[d] irreparable injury"). *See also Assoc. Gen. Contractors of Cal., Inc. v. Coal. For Econ. Equity*, 950 F.2d 1401, 1412 (9th Cir. 1991) (alleged constitutional infringement often alone constitutes irreparable harm).

Accession plaintiff Medina alleges he will be unable to realize his long-term military career goals if the Hegseth Policy and Military Ban go into effect. Dkt. 29 at 2–4. He may no longer be eligible to join the Marine Corps even if the Policy is reversed by the next presidential administration. *Id.* at 3. While these harms are specific to Medina, the overarching basis for his irreparable harm is the Policy's violation of his constitutional rights.

Active-duty plaintiffs not only allege constitutional harms, they are disqualified from military service in circumstances far from "common to most discharged employees." *Sampson*, 415 U.S. at 92 n.68. Plaintiffs' disqualification from military service is not simply a "temporary loss of income" for which they will later receive monetary compensation. *Id.* at 90. It is a definitive loss of career in service to their country directly attributable to the likely unconstitutional Hegseth Policy and Military Ban. A service member's choice to pursue a military career and develop unique skills in that career, once wrongfully discharged, cannot find another military employer outside of the United States Armed Forces.

The Court concludes plaintiffs unequivocally meet the heightened standard for irreparable harm.

E. The Balance of Equities and Public Interest Support Injunctive Relief.

The final two elements of *Winter*'s preliminary injunction standard—the balance of equities and the public interest—merge when the government is a party. *Drakes Bay*, 747 F.3d at 1092 (9th Cir. 2014). The Court must balance the competing claims of injury

and must consider the effect on each party of granting or withholding the requested relief. *N. Cheyenne Tribe v. Norton*, 503 F.3d 836, 843–44 (9th Cir. 2007).

Plaintiffs contend that the public's interest is in protecting constitutional rights and that where, as here, they have established a violation of those rights, the balance of equities favor injunctive relief. Dkt. 23 at 37 (citing *Ariz. Dream Act Coal.*, 757 F.3d at 1068). Active-duty plaintiffs argue that without an injunction, the government will cut short their long and honorable military careers, irrevocably damaging their professional and personal lives. *Id.* Similarly, accession plaintiffs face deprivation of constitutional rights and a meaningful opportunity to serve their country.

The government again insists that the Court must defer to its and the Commander and Chief's judgment in military matters. Dkt. 76 at 41. It reiterates that the judgment is "based on" the recommendations of "senior military leaders and experts" who conducted "extensive review and deliberation" and who were "uniquely qualified to evaluate the impacts of policy changes on the combat effectiveness and lethality of the force." *Id.* at 41–42 (citing Mattis Policy, Dkt. 31-10 at 23).

The flaw in this argument is addressed above. The Court (and plaintiffs) cannot and should not dispute the government's assertion that "the Constitution charges the Commander in Chief with ultimate responsibility over the Nation's military policy." *Id.* But the government's exclusive reliance on the Mattis Policy does not support the unquestionable judgment it claims to have reached. First, the military leaders and experts responsible for the Mattis Policy expressly recognized that both settled expectations and the military's investment in transgender service members counseled *against* separating

currently serving transgender service members. Dkt. 31-10 at 48. Mattis—and President Trump—agreed, and the Mattis Policy included a reliance exception. *Id*.

Second, the government's response, like the Hegseth Policy implementing the Military Ban, simply ignores the military's experience under the Mattis Policy *and* the subsequent Austin Policy that permitted open transgender service, together for seven years.

The Court's deference is not absolute. Absent any evidence that such service requires the immediate implementation of the Military Ban and Hegseth Policy, equity and the public interest support enjoining an unsupported, dramatic and facially unfair exclusionary policy.

F. There are Serious Questions Going to the Merits of Each of Plaintiffs' Claims.

The Court concludes plaintiffs are entitled to a preliminary injunction under the alternate *Cottrell* "serious questions" test. Plaintiffs raise serious questions going to their Equal Protection, Due Process, and First Amendment rights. *Flathead-Lolo-Bitterroot Citizen Task Force*, 98 F.4th at 1190. And, the balance of hardships tips sharply towards plaintiffs, who suffer not only loss of employment, income, and reputation, but also a career dedicated to military service. A preliminary injunction is warranted to preserve the status quo.

G. Scope of Injunction.

Plaintiffs ask the Court to enjoin the Military Ban and the Hegseth Policy's enforcement as to themselves and "other current and aspiring transgender

servicemembers" nationwide. Dkt. 23 at 10. The government argues that any injunctive relief should be limited to plaintiffs, and must not "interfere with military assignment, deployment, and operational decisions." Dkt. 76 at 42.

Injunctions are typically "limited . . . only to named plaintiffs where there is no class certification." *Easyriders Freedom F.I.G.H.T. v. Hannigan*, 92 F.3d 1486, 1501 (9th Cir. 1996). However, district courts have "considerable discretion in ordering an appropriate equitable remedy." *City of S.F. v. Trump*, 897 F.3d 1225, 1245 (9th Cir. 2018). "The scope of an injunction is 'dependent as much on the equities of a given case as the substance of the legal issues it presents,' and courts must tailor the scope 'to meet the exigencies of the particular case.'" *Cal. v. Azar*, 911 F.3d 558, 584 (9th Cir. 2018) (quoting *Trump v. Int'l Refugee Assistance Project*, 582 U.S. 571, 580 (2017)) (citations omitted). Where, as here, there is a "sufficiently developed [record] on the nationwide impact" of the challenged actions, courts can craft an injunction to provide nationwide relief. *City of S.F.*, 897 F.3d at 1231, 1244–45.

This is the rare case that warrants a nationwide injunction. The record is clear that the Military Ban would impact all branches of the military nationwide. *See, e.g.*, Dkt. 58-1 (Navy implementation); Dkt. 31-15 (Air Force implementation); Dkt. 58-3 (Army implementation). The Court also notes that 21 States have filed an amicus brief indicating that they and their residents will be harmed by the Military ban if this Court fails to enjoin it. Dkt. 53. While these States are not parties, their participation through an amicus brief demonstrates the ultimate national implications of the Military Ban. If the Court were to limit the injunction to the named plaintiffs, it would surely result in a flood of

virtually identical litigation nationwide. The fact there are two other district courts adjudicating similar cases, one of which has already entered a preliminary injunction,[24] provides an additional basis for issuing a nationwide injunction here. *See California v. United States Dep't of Health & Hum. Servs.*, 941 F.3d 410, 421, 423 (9th Cir. 2019), *judgment vacated on other grounds, Little Sisters of the Poor Saints Peter and Paul Home v. Penn.*, 591 U.S. 657 (2020) (no court has held that "an injunction imposed by one district court against a defendant deprives every other federal court of subject matter jurisdiction over a dispute in which a plaintiff seeks similar equitable relief against the same defendant").

The government does not contest the nationwide impact of the Military Ban or the Hegseth Policy, and they do not explain how a narrower injunction would square with their stated interests in uniformity and unit cohesion. If the Court enjoined the government from implementing the Hegseth Policy and ensuing guidance only as to plaintiffs in this case, the military would presumably begin separating thousands of other transgender service members and refusing to enlist otherwise qualified transgender accession candidates. On the other hand, enjoining such action nationwide pending trial simply continues the status quo. The military has operated under the Austin Policy without any identified complaints about unit cohesion or readiness, for the last four years.

[24] The Talbott preliminary injunction is stayed until 7:00 pm EDT on Friday, March 28. 2025 WL 914716, at *8.

Without nationwide injunctive relief, there will surely be many more lawsuits, leading to the extraordinary and unnecessary expenditure of effort and resources, and the duplication of discovery and motions practice in district courts across the country.

The Court therefore enjoins the Military Ban and Hegseth Policy on a nationwide basis.

III. CONCLUSION

Plaintiffs have established their right to a preliminary injunction. They are likely to succeed on the merits of their claims, and they have raised serious and important questions going to the merits of those claims. Absent an injunction, all transgender service members are likely to suffer the irreparable harm of losing the military service career they have chosen, while otherwise qualified accession plaintiffs will lose the opportunity to serve. Because the military has operated smoothly for four years under the Austin Policy, any claimed hardship it may face in the meantime pales in comparison to the hardships imposed on transgender service members and otherwise qualified transgender accession candidates, tipping the balance of hardships sharply toward plaintiffs. There can be few matters of greater public interest in this country than protecting the constitutional rights of its citizens.

IT IS SO ORDERED.

Dated this 27th day of March, 2025.

BENJAMIN H. SETTLE
United States District Judge

UNITED STATES COURT OF APPEALS

FOR THE NINTH CIRCUIT

FILED

MAR 31 2025

MOLLY C. DWYER, CLERK
U.S. COURT OF APPEALS

EMILY SHILLING; et al.,

Plaintiffs - Appellees,

v.

DONALD J. TRUMP, in his official capacity as President of the United States; et al.,

Defendants - Appellants.

No. 25-2039

D.C. No.
2:25-cv-00241-BHS
Western District of Washington, Seattle

ORDER

Before: TASHIMA, OWENS, and DESAI, Circuit Judges.

The court has received the emergency motion to stay. The request for an administrative stay is denied. *See Doe #1 v. Trump*, 944 F.3d 1222, 1223 (9th Cir. 2019). The existing schedule for the response and the reply remains in effect. *See* Fed. R. App. P. 27(a).

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ORDER

Before: TASHIMA, OWENS, and DESAI, Circuit Judges.

The emergency motion (Docket Entry No. 9) to stay the district court's March 27, 2025 preliminary injunction is denied. *See Nken v. Holder*, 556 U.S. 418, 434 (2009) (defining standard for stay pending appeal). Appellants have not demonstrated that they will suffer irreparable harm absent a stay. *See Washington v. Trump*, 847 F.3d 1151, 1168 (9th Cir. 2017); *see also Doe #1 v. Trump*, 957 F.3d 1050, 1059 (9th Cir. 2020).

The existing briefing schedule remains in effect. The clerk will place this case on the next available calendar after the answering brief is filed. *See* 9th Cir. Gen. Ord. 3.3(f).