No. 18-35347

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

RYAN KARNOSKI, et al.,
Plaintiffs-Appellees,

STATE OF WASHINGTON, Attorney General's Office Civil Rights Unit,
Intervenor-Plaintiff-Appellee,

v.

DONALD J. TRUMP, in his official capacity as President of the United States, et al.

Defendants-Appellants.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF WASHINGTON

BRIEF OF *AMICI CURIAE* AMERICAN MEDICAL ASSOCIATION, AMERICAN COLLEGE OF PHYSICIANS, AND NINE OTHER HEALTH CARE ORGANIZATIONS IN SUPPORT OF PLAINTIFFS-APPELLEES

Scott B. Wilkens
Counsel of Record
Devi M. Rao
JENNER & BLOCK LLP
1099 New York Ave. NW, Suite 900
Washington, DC 20001
(202) 639-6000
swilkens@jenner.com
drao@jenner.com
Counsel for Amici Curiae (additional counsel on inside cover)

Benjamin J. Brysacz
JENNER & BLOCK LLP
633 West 5th St., Suite 3600
Los Angeles, CA 90071
(213) 239-5100
bbrysacz@jenner.com

CORPORATE DISCLOSURE STATEMENT

Each amicus curiae hereby certifies that it has no parent corporation and that no publicly held corporation owns 10% or more of its stock.

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Page(s)

CASES

OTHER AUTHORITIES

INTEREST OF *AMICI CURIAE*[1]

Amici are eleven leading medical, nursing, mental health, and other health care organizations: American Medical Association, American College of Physicians, Mental Health America, Endocrine Society, Pediatric Endocrine Society, National Association of Social Workers, GLMA: Health Professionals Advancing LGBT Equality, American Medical Women's Association, Association of Medical School Pediatric Department Chairs, American Academy of Nursing, and World Professional Association for Transgender Health.

Collectively, *amici* represent hundreds of thousands of physicians and mental health professionals, including specialists in family medicine, mental health treatment, internal medicine, and endocrinology. *Amici* share a commitment to improving the physical and mental health of all Americans—regardless of gender identity—and to informing and educating lawmakers, the judiciary, and the public regarding the public health impacts of laws and policies.

Amici submit this brief to inform the Court of the consensus among health care professionals regarding what it means to be transgender; the protocols for the

[1] *Amici* hereby certify that no party's counsel authored this brief in whole or in part, no party or party's counsel contributed money intended to fund preparation or submission of this brief, and no person other than *amici* and their counsel contributed money intended to fund preparation or submission of the brief. The parties have consented to the filing of this brief.

treatment of gender dysphoria; and the absence of any legitimate medical reason to exclude transgender individuals from military service or to deny service members access to medically necessary transition-related health care.

SUMMARY OF ARGUMENT

Transgender individuals have a gender identity that is incongruent with the sex they were assigned at birth. The health care community's understanding of what it means to be transgender has advanced greatly over the past century. It is now understood that being transgender implies no impairment in a person's judgment, stability, or general social or vocational capabilities. According to recent estimates, approximately 1.4 million transgender adults live in the United States—0.6 percent of the adult population.

Many transgender individuals experience a condition called gender dysphoria, which is characterized by clinically significant distress or impairment of function resulting from the incongruence between one's gender identity and the sex assigned at birth. The treatment for gender dysphoria is highly effective at reducing or eliminating the incongruence a person experiences between their gender identity and their assigned sex at birth. It is also widely available. The international consensus among health care professionals regarding treatment for gender dysphoria is to assist the patient to live in accordance with his or her gender identity, thus alleviating the

distress or impairment. Treatment for the condition includes physical and mental health care to allow the person to transition from their assigned sex to the sex consistent with their gender identity. Treatment may include any or all of the following: counseling along with social transition (allowing the person to conform to social expectations and norms associated with their identity), and hormone therapy and gender confirming surgeries.

There is no legitimate medical reason why transgender individuals should be excluded from the military or denied transition-related health care. Being transgender does not diminish a person's ability to serve in the military. Like other medical conditions experienced by active duty personnel, gender dysphoria can be resolved with appropriate treatment. Excluding transgender individuals from military service exposes them to stigma and discrimination, and deprives the military of qualified personnel who are willing and able to serve their country.

ARGUMENT

I. What It Means To Be Transgender And To Experience Gender Dysphoria

Transgender individuals have a "gender identity"—a "deeply felt, inherent sense" of their gender—that is not aligned with the sex assigned to them at birth.[2]

[2] Am. Psychol. Ass'n, *Guidelines for Psychological Practice with Transgender and Gender Nonconforming People*, 70 Am. Psychologist 832, 834 (2015) **[hereinafter "Am. Psychol. Ass'n Guidelines"]**; *see also* David A. Levine & Comm. on Adolescence, Am. Acad. of Pediatrics Technical Report, *Office-Based Care for*

Transgender people differ from non-transgender individuals, whose gender identity aligns with the sex assigned at birth.[3] A transgender man is someone who is assigned the sex of female at birth, but transitions later in his life to being male. A transgender woman is an individual who is assigned the sex of male at birth, but transitions later in her life to being female. A transgender man is a man. A transgender woman is a woman.

Recent estimates suggest that approximately 1.4 million transgender adults live in the United States, or 0.6 percent of the adult population.[4] That said, "population estimates likely underreport the true number of [transgender] people."[5]

Lesbian, Gay, Bisexual, Transgender, and Questioning Youth, 132 Pediatrics e297, 298 (2013) **[hereinafter "AAP Technical Report"]**. Although most people have a gender identity that is male or female, some individuals have a gender identity that is "a blend of male or female[,] or an alternative gender." Am. Psychol. Ass'n Guidelines, at 834.

[3] Am. Psychol. Ass'n Guidelines, *supra*, at 861.

[4] Andrew R. Flores, et al., The Williams Inst., *How Many Adults Identify as Transgender in the United States?* 2 (2016), http://williamsinstitute.law.ucla.edu/wp-content/uploads/How-Many-Adults-Identify-as-Transgender-in-the-United-States.pdf.

[5] Am. Psychol. Ass'n Guidelines, *supra*, at 832.

People of all different races and ethnicities identify as transgender.[6] Transgender people live in every state, raise children, and serve in the military.[7]

Our professions recognize that being transgender "implies no impairment in judgment, stability, reliability, or general social or vocational capabilities"—and that stigmatizing transgender people also causes significant harm.[8]

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[6] *See* Halley P. Crissman, et al., *Transgender Demographics: A Household Probability Sample of US Adults*, 2014, 107 Am. J. Pub. Health 213, 214-15 (2017); Andrew R. Flores, et al., The Williams Inst., *Race and Ethnicity of Adults Who Identify as Transgender in the United States* 2 (2016), https://williamsinstitute.law.ucla.edu/wp-content/uploads/Race-and-Ethnicity-of-Transgender-Identified-Adults-in-the-US.pdf.

[7] Gary J. Gates & Jody L. Herman, The Williams Inst., *Transgender Military Service in the United States* (2014), http://williamsinstitute.law.ucla.edu/wp-content/uploads/Transgender-Military-Service-May-2014.pdf; Sandy E. James, et al., Nat'l Center for Transgender Equality, *The Report of the 2015 U.S. Transgender Survey* 2 (2016), http://www.transequality.org/sites/default/files/docs/usts/USTS%20Full%20Report%20-%20FINAL%201.6.17.pdf; Rebecca L. Stotzer, et al., The Williams Inst., *Transgender Parenting: A Review of Existing Research* (2014), http://williamsinstitute.law.ucla.edu/research/parenting/transgender- parenting-oct-2014.

[8] Am. Psychiatric Ass'n, *Position Statement on Discrimination Against Transgender and Gender Variant Individuals* (2012), https://psychiatry.org/File%20Library/About-APA/Organization-Documents-Policies/Policies/Position-2012-Transgender-Gender-Variant-Discrimination.pdf.

A. Gender Identity

"[G]ender identity" refers to a person's internal sense of being male, female, or another gender.[9] Every person has a gender identity,[10] which cannot be altered voluntarily[11] or necessarily ascertained immediately after birth.[12] Many people develop stability in their gender identity between ages three and four.[13]

"[G]ender expression refers to the way a person communicates gender identity to others through behavior, clothing, hairstyles, voice, or body characteristics."[14] There are many individuals who depart from stereotypical male and female

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[9] Am. Psychol. Ass'n, *Answers to Your Questions About Transgender People, Gender Identity, and Gender Expression* 1 (2014), http://www.apa.org/topics/lgbt/transgender.pdf.

[10] *See* Caitlin Ryan, Family Acceptance Project, *Supportive Families, Healthy Children: Helping Families with Lesbian, Gay, Bisexual, & Transgender Children*, 17 (2009), http://familyproject.sfsu.edu/sites/default/files/FAP_English%20Booklet_pst.pdf.

[11] Colt Meier & Julie Harris, Am. Psychol. Ass'n, *Fact Sheet: Gender Diversity and Transgender Identity in Children* 1, http://www.apadivisions.org/division-44/resources/advocacy/transgender-children.pdf; *see also* Am. Acad. of Pediatrics, *Gender Identity Development in Children* (2015), https://healthychildren.org/English/ages-stages/gradeschool/Pages/Gender-Identity-and-Gender-Confusion-In-Children.aspx.

[12] Am. Psychol. Ass'n Guidelines, *supra*, at 862.

[13] *Id*. at 841. "Although gender identity is usually established in childhood, individuals may become aware that their gender identity is not in full alignment with sex assigned at birth in childhood, adolescence, or adulthood." *Id*. at 836.

[14] Am. Psychol. Ass'n, *Answers to Your Questions About Transgender People, supra*, at 1.

appearances and roles, but who are not transgender.[15] Indeed, most people who express their gender in a non-stereotypical or non-conforming manner are or become comfortable with the sex they were assigned at birth.[16]

B. Gender Dysphoria

As noted above, being transgender "implies no impairment in judgment, stability, reliability, or general social or vocational capabilities."[17] However, many transgender individuals are diagnosed with gender dysphoria, a condition that is characterized by clinically-significant distress and anxiety resulting from the incongruence between an individual's gender identity and birth-assigned sex.[18] As discussed in detail below, the recognized treatment for someone with severe gender dysphoria is medical support that allows the individual to transition from their assigned sex to the sex associated with his or her gender identity.[19] These treatments

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[15] Ethan C. Cicero & Linda M. Wesp, *Supporting the Health and Well-Being of Transgender Students*, J. Sch. Nursing 1, 6 (2017).

[16] World Prof'l Ass'n for Transgender Health, *Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People* 5 (7th Version, 2011), http://www.wpath.org/site_page.cfm?pk_association_webpage_menu=1351&pk_association_webpage=4655 **[hereinafter "WPATH Standards of Care"]**.

[17] Am. Psychiatric Ass'n, *Position Statement on Discrimination Against Transgender and Gender Variant Individuals, supra*.

[18] Am. Psychiatric Ass'n, *Diagnostic and Statistical Manual of Mental Disorders* 451-53 (5th ed. 2013) **[hereinafter "DSM-5"]**.

[19] WPATH Standards of Care, *supra*, at 9-10.

are "effective in alleviating gender dysphoria and are medically necessary for many people."[20]

1. The Diagnostic Criteria And Seriousness Of Gender Dysphoria

The Diagnostic and Statistical Manual of Mental Disorders codifies the diagnostic criteria for gender dysphoria in adults as follows: "A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months' duration, as manifested by at least two" out of six criteria, and "clinically significant distress or impairment in social, occupational, or other important areas of functioning."[21] The six criteria include (1) "[a] marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics"; (2) "[a] strong desire to be rid of one's primary and/or secondary sex characteristics"; (3) "[a] strong desire for the primary and/or secondary sex characteristics of the other gender"; (4) "[a] strong desire to be of the other gender (or some alternative gender . . .)"; (5) "[a] strong desire to be treated" as a gender different from one's assigned gender; and (6) "[a] strong conviction that

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[20] *Id*. at 5; *see also* Joycelyn Elders, et al., Palm Center, *Report of the Transgender Military Service Commission* 10 (2014), http://archive.palmcenter.org/files/Transgender%20Military%20Service%20Report_2.pdf **[hereinafter "Elders Commission"]** ("While gender identity disorder was pathologized as an all-encompassing mental illness, gender dysphoria is understood as a condition that is amenable to treatment.").

[21] DSM-5, *supra*, at 451-53.

one has the typical feelings and reactions" of a different gender.[22] Similarly, the World Health Organization's International Classification of Diseases recognizes that gender dysphoria is "characterized by a persistent and intense distress about assigned sex, together with a desire to be (or insistence that one is) of the other sex."[23]

If untreated, gender dysphoria can cause debilitating distress, depression, impairment of function, self-mutilation to alter one's genitals or secondary sex characteristics, other self-injurious behaviors, and suicide.[24] Like other minority groups, transgender individuals also are frequently subjected to prejudice and discrimination in multiple areas of their lives, which intensifies distress. This reality makes access to appropriate medical care all the more important.[25]

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[22] *Id*. at 452.

[23] World Health Organization ("WHO"), *International Classification of Diseases-10* F64.2 (2015 ed.), http://apps.who.int/classifications/icd10/browse/2015/en#/F64.2. For its upcoming International Statistical Classification of Diseases-11, the WHO has proposed using "gender incongruence" as the name for the gender identity–related diagnoses. Wylie C. Hembree, et al., *Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline*, 102 J. Clinical Endocrinology & Metabolism 3869, 3875 (2017).

[24] *See, e.g.*, DSM-5, *supra*, at 455, 458; George R. Brown, *Autocastration and Autopenectomy as Surgical Self-Treatment in Incarcerated Persons with Gender Identity Disorder*, 12 Int'l J. Transgenderism 31, 31-39 (2010).

[25] Michael L. Hendricks & Rylan J. Testa, *A Conceptual Framework for Clinical Work with Transgender and Gender Nonconforming Clients: An Adaptation of the Minority Stress Model*, 43 Prof'l Psychol.: Research & Practice 460 (2012); Jessica Xavier et al, Va. Dep't of Health, *The Health, Health-Related Needs, and Lifecourse Experiences of Transgender Virginians* (2007),

2. The Accepted Treatment Protocols For Gender Dysphoria

Gender dysphoria is completely treatable.[26] Today, transgender people have widespread access to gender-affirming medical and mental health support and treatment.[27] For over 30 years, the accepted treatment protocols for gender dysphoria[28] have sought to alleviate the distress associated with the incongruence between gender identity and birth-assigned sex.[29] These protocols are laid out in the *Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People (Version 7)* developed by *amicus curiae*, the World Professional Association for Transgender Health ("WPATH").[30] Many of the major medical and mental health groups in the United States expressly recognize the WPATH Standards of Care as representing the consensus of the medical and mental health community regarding the appropriate treatment for gender dysphoria.[31]

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http://www.vdh.virginia.gov/content/uploads/sites/10/2016/01/THISFINALREPORTVol1.pdf.

[26] RAND Report, *supra*, at 7; Elders Commission, *supra*, at 10.

[27] Am. Psychol. Ass'n Guidelines, *supra*, at 835; WPATH Standards of Care, *supra*, at 8-9.

[28] Earlier versions of the DSM used different terminology, *e.g.*, gender identity disorder, to refer to this condition. Am. Psychol. Ass'n Guidelines, *supra*, at 861.

[29] Am. Med. Ass'n, Comm. on Human Sexuality, *Human Sexuality* 38 (1972).

[30] WPATH Standards of Care, *supra*.

[31] Am. Med. Ass'n, Policy H-185.950, *Removing Financial Barriers to Care for Transgender Patients* (2008); Am. Psychol. Ass'n, *Report of the APA Task Force on Gender Identity and Gender Variance* 32 (2008), https://www.apa.org/pi/lgbt/resources/policy/gender- identity-report.pdf.

The recommended treatment for gender dysphoria includes assessment, counseling, and, as appropriate, social transition, hormone therapy, and surgical interventions to bring the body into alignment with one's gender identity.[32] However, each patient requires an individualized treatment plan that accounts for the patient's specific needs.[33]

Social transition—*i.e.*, living one's life fully in accordance with one's gender identity—is often a critically important part of treatment. This typically includes publicly identifying oneself as that gender through all of the ways that people signal their gender to others such as through their name, pronoun usage, dress, manner and appearance, and social interactions.[34]

For some people, the course of treatment includes hormone therapy to bring the person's body into alignment with their gender identity.[35] *Amicus curiae* the

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[hereinafter "Am. Psychol. Ass'n Task Force Report"]; AAP Technical Report, *supra*, at 307-08.

[32] Am. Psychol. Ass'n Task Force Report, *supra*, at 32-39; Am. Psychiatric Ass'n Workgroup on Treatment of Gender Dysphoria, *Assessment and Treatment of Gender Dysphoria and Gender Variant Patients: A Primer for Psychiatrists* 16-18 (2016); AAP Technical Report, *supra*, at 307-09.

[33] Am. Psychol. Ass'n Task Force Report, *supra*, at 32.

[34] AAP Technical Report, *supra*, at 308; Am. Psychol. Ass'n Guidelines, *supra*, at 840.

[35] Am. Med. Ass'n, Policy H-185.950, *Removing Financial Barriers to Care for Transgender Patients*, *supra*; Am. Psychol. Ass'n Guidelines, *supra*, at 861, 862; Madeline B. Deutsch, Center of Excellence for Transgender Health, University of California, San Francisco, *Guidelines for the Primary and Gender-Affirming Care*

Endocrine Society, the oldest and largest global professional membership organization representing the field of endocrinology, considers these treatments to be the standard of care for gender dysphoria.[36] A transgender man undergoing hormone therapy, for example, will have hormone levels within the same range as other men; and just as they do in any other man, these hormones will affect most of his major body systems.[37] Hormone therapy physically changes the patient's genitals and secondary sex characteristics such as increased muscle mass, increased body and facial hair, male pattern baldness (for some), and a deepening of the voice in men, and breast growth, female-associated fat distribution, softening of the skin, and decreased muscle mass in women.[38] Hormones have been clinically proven as an effective treatment for gender dysphoria with a low rate of complications.[39]

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of Transgender and Gender Nonbinary People 23 (2d ed. 2016); WPATH Standards of Care, *supra*, at 33, 54.

[36] Hembree, et al., *Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons*, *supra*, at 3869-70; *see also* Alessandra D. Fisher, et al., *Cross-Sex Hormone Treatment and Psychobiological Changes in Transsexual Persons: Two-Year Follow-Up Data*, 101 J. Clinical Endocrinology & Metabolism 4260 (2016).

[37] Hembree, et al., *Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons*, *supra*, at 3885-87.

[38] *Id*. at 3886-89.

[39] Marco Colizzi, Rosalia Costa & Orlando Todarello, *Transsexual Patients' Psychiatric Comorbidity and Positive Effect of Cross-Sex Hormonal Treatment on Mental Health: Results from Longitudinal Study*, 39 Psychoneuroendocrinology 65 (2014); Henk Asscheman, at al., *A Long-Term Follow-Up Study of Mortality in Transsexuals Receiving Treatment with Cross-Sex Hormones*, 164 Eur. J. Endocrinology 635 (2011); Paul J.M. Van Kesteren, et al., *Mortality and Morbidity*

For some patients, relief from gender dysphoria may sometimes require further physical changes to align their bodies with their gender identity.[40] Gender-affirming surgeries may be an appropriate and effective treatment for many patients. These procedures could include chest reconstruction surgery for transgender men, breast augmentation for transgender women, or genital surgeries.[41] Decades of clinical evidence show these surgical procedures are effective in reducing gender dysphoria and improving mental health.[42] Empirical studies reflect the importance of the interplay among treatments, finding hormone therapy in conjunction with psychotherapy and, for some, surgery, to be necessary elements of treating severe levels of gender dysphoria.[43]

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in Transsexual Subjects Treated with Cross-Sex Hormones, 47 Clinical Endocrinology 337 (1997).

[40] WPATH Standards of Care, *supra*, at 54-55.

[41] Hembree, et al., *Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons*, *supra*, at 3893-95; *see also* WPATH Standards of Care, *supra*, at 57-58.

[42] WPATH Standards of Care, *supra; see also* William Byne, et al., *Report of the American Psychiatric Association Task Force on Treatment of Gender Identity Disorder*, 41 Arch. Sexual Behav. 759, 778-79 (2012); Mohammad Hassan Murad, et al., *Hormonal Therapy and Sex Reassignment: A Systematic Review and Meta-Analysis of Quality of Life and Psychosocial Outcomes*, 72 Clinical Endocrinology 214 (2010); Luk Gijs & Anne Brewaeys, *Surgical Treatment of Gender Dysphoria in Adults and Adolescents: Recent Developments, Effectiveness, and Challenges*, 18 Ann. Rev. Sex Res. 178 (2007); Jan Eldh, Agnes Berg & Maria Gustafsson, *Long-Term Follow Up After Sex Reassignment Surgery*, 31 Scand. J. Plastic & Reconstructive Surgery & Hand Surgery 39 (1997).

[43] *See* Gianna E. Israel & Donald E. Tarver II, *Transgender Care: Recommended Guidelines, Practical Information & Personal Accounts* 56-73 (1997).

Ultimately—regardless of the particular treatments required for a specific individual and when such treatment begins—the goal is for individuals with gender dysphoria to experience "identity integration," where "being transgender is no longer the most important signifier of one's identity" and the individual can refocus on their relationships, school, jobs, and other life activities.[44]

II. Excluding Transgender Individuals From Military Service And Denying Medically Appropriate Treatment To Active Duty Transgender Service Members Is Discriminatory And Conflicts With Contemporary Medical Knowledge And Practice.

By requiring all individuals to serve in their birth sex, the Department of Defense (the "Department") bans transgender people from service and denies them medically necessary and effective care.[45]

Major medical organizations such as *amicus curiae* the American Medical Association, the American Psychological Association, and the American Psychiatric Association spoke out against the President's decision to ban transgender individuals from the military, noting the complete lack of any medical justification for enacting a ban.[46] Those groups have renewed their opposition to the modified policy

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[44] Walter Bockting & Eli Coleman, *Developmental Stages of the Transgender Coming-Out Process: Toward an Integrated Identity, in Principles of Transgender Medicine and Surgery* 137, 153 (Randi Ettner, Stan Monstrey & Eli Coleman eds., 2d ed. 2016).

[45] Dep't of Defense, *Report and Recommendations on Military Service by Transgender Persons* (Feb. 2018) **[hereinafter "Implementation Report"]** at 5.

[46] *E.g.*, Am. Med. Ass'n, Policy H-40.966, *Military Medical Policies Affecting*

contained in the Department of Defense Report and Recommendations on Military Service by Transgender Persons ("Implementation Report"). Like the ban before it, the revised policy lacks any valid medical basis. It also poses immediate harms to transgender service members and the public by treating gender dysphoria differently from other medical conditions experienced by service members, by denying the military service of qualified service members and recruits, by perpetuating stigma

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Transgender Individuals ("Our American Medical Association affirms that there is no medically valid reason to exclude transgender individuals from service in the US military and affirms transgender service members be provided care as determined by patient and physician according to the same medical standards that apply to non-transgender personnel."); Am. Psychol. Ass'n, *APA Questions Announcement to Bar Transgender People from US Military* (July 26, 2017), http://www.apa.org/news/press/releases/2017/07/transgender-military.aspx (observing "no scientific evidence that allowing transgender people to serve in the armed forces has had an adverse impact on our military readiness or unit cohesion"); Am. Psychiatric Ass'n, *APA Opposes Banning Transgender Service Members from Serving in Military* (July 27, 2017), https://www.psychiatry.org/newsroom/news-releases/apa-opposes-banning-transgender-service-members-from-serving-in-military ("Banning transgender service members from serving our country harms not just those transgender Americans who have dedicated themselves to service of others, but it unfairly casts a pall over all transgender Americans. Discrimination has a negative impact on the mental health of those targeted."); Letter from American Academy of Nursing President Bobbie Berkowitz to Secretary of Defense Jim Mattis (Aug. 8, 2017), (https://higherlogicdownload.s3.amazonaws.com/AANNET/c8a8da9e-918c-4dae-b0c66d630c46007f/UploadedImages/docs/Policy%20Resources/Cosigned%20Letters/2017_Ltr_DoD_Secy_Trans_8_8_17.pdf) ("The American Academy of Nursing supports existing U.S. Department of Defense (DoD) policy on transgender service members serving in the military developed following extensive study and consultation among military leadership, health experts and others.").

and discrimination, and by delaying or denying medically-necessary transition-related health care. The Department overlooks and mischaracterizes evidence, ignores the high efficacy of gender transition as a treatment for gender dysphoria and thereby reaches a conclusion about the fitness of transgender service members that is at odds with the medical and scientific consensus.

A. The Department's Revised Policy Is At Odds With The Medical And Mental Health Consensus That Transgender Individuals Are Fully Capable Of Military Service.

The medical consensus is clear: transgender individuals are fully capable of serving in the armed forces, and there is no medically valid reason for treating these individuals differently than others with respect to evaluating their individual fitness. For those who require it, gender transition is a highly effective, medically accepted treatment for gender dysphoria.

Medical experts agree that transition-related care is "reliable, safe, and effective."[47] Research and the Department's own data "confirm that transgender personnel, even those with diagnoses of gender dysphoria, are deployable and medically fit."[48] But the Department's conclusion about the efficacy of treatment

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[47] Vice Admiral Donald C. Arthur, et al., *DoD's Rationale for Reinstating the Transgender Ban is Contradicted by Evidenc*e, Palm Center (April 2018) at 4 **[hereinafter, "Palm Center Report"]**, *available at* https://www.palmcenter.org/wp-content/uploads/2018/04/Transgender-troops-are-medically-fit-1.pdf.

[48] *Id.*

"relies on a highly selective review of the relevant scientific evidence" and ignores "a clear scholarly consensus, rooted in decades of robust research, that transgender individuals who have equal access to health care can and do function effectively."[49]

In response to the Implementation Report, *amicus curiae* the American Medical Association wrote to Secretary Mattis to express its professional medical view that "there is no medically valid reason—including a diagnosis of gender dysphoria—to exclude transgender individuals from military service" and that the Pentagon's rationale "mischaracterized and rejected the wide body of peer-reviewed research on the effectiveness of transgender medical care."[50] Also in response to the release of the revised policy, the American Psychological Association explained that "substantial psychological research shows that gender dysphoria is a treatable condition, and does not, by itself, limit the ability of individuals to function well and excel in their work, including in military service."[51] The new policy also attracted criticism from former U.S. Surgeons General, who pointed to "a global medical

[49] *Id.* at 5.
[50] Am. Med. Ass'n, Letter to James N. Mattis from James L. Madara, MD (April 3, 2018).
[51] Am. Psychological Ass'n, *Statement Regarding Transgender Individuals Serving in Military*, (March 26, 2018).

consensus" that transition-related care is "reliable, safe, and effective."[52] The American Psychiatric Association "reiterated its strong opposition" to the policy.[53]

According to a recent report by military experts, "[t]ransgender medical care should be managed in terms of the same standards that apply to all medical care, and there is no medical reason to presume transgender individuals or those who have transitioned genders are unfit for duty. Their medical care is no more specialized or difficult than other sophisticated medical care the military system routinely provides."[54]

The medical consensus is that gender dysphoria is completely treatable with a combination of psychotherapy, hormone therapy, or sex-reassignment surgery. There is no valid medical reason to exclude all transgender individuals from military service when those individuals will be subject to the same medical screening and performance requirements as other service members. [55]

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[52] Palm Center (news release), *Former Surgeons General Debunk Pentagon Assertions about Medical Fitness of Transgender Troops*, (March 28, 2018).
[53] American Psychiatric Association, *APA Reiterates Its Strong Opposition to Ban of Transgender Americans from Serving in the U.S. Military*, (March 24, 2018).
[54] Elders Commission, *supra*, at 4.
[55] Ample research indicates that adults who have received treatment for gender dysphoria experience similar levels of depression and anxiety as the general population. *See, e.g.*, Cecilia Dhejne, et al., *Mental Health and Gender Dysphoria: A Review of the Literature*, 28 Int'l Rev. of Psychiatry 44, 53 (2016) ("findings from most studies showed that the scores of trans people following [gender confirming medical interventions] were similar to those of the general population"); Ester

B. The Department Cherry-Picked Evidence And Mischaracterized Literature In Support Of The Revised Policy.

The evidence that transition-related care is effective is based on "tens of thousands of hours of clinical observations and on decades of peer-reviewed scholarly studies" using multiple methodologies, and in many cases examining an entire country's population of medically transitioning individuals.[56] The global medical consensus is based on extensive, comprehensive literature reviews of relevant scholarship for over the past three decades. A recent global review of peer-reviewed studies of transgender health—which aggregated the results of 56 studies—concluded that 93 percent of study participants undergoing gender transition showed overall improvements, and only 7 percent showed mixed results

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Gomez-Gil, et al., *Hormone-Treated Transsexuals Report Less Social Distress, Anxiety and Depression*, 37 Psychoneuroendocrinology 662 (2012) (noting that "[m]ost transsexual patients attending a gender identity unit reported subclinical levels of social distress, anxiety, and depression," did "not appear to notably differ from the normative sample in terms of mean levels of social distress, anxiety, and depression," and those with treated gender dysphoria "[were] in the normal range"); Steven Weyers, et al., *Long-Term Assessment of the Physical, Mental, and Sexual Health Among Transsexual Women*, 6 The J. of Sexual Medicine 752 (2009) (a study of transgender Belgian women finding "no significant differences" in overall health between subjects and the general population).

[56] Palm Center Report, *supra*, at 5.

or no change.[57] No studies were located that showed gender transition led to harm.[58] Earlier literature reviews reach similar conclusions.[59]

The Implementation Report, however, ignores much of this research and selectively misinterprets the remainder. The Department argues that evidence supporting the efficacy of transition-related care is weak or unreliable because it is not based on randomized controlled trials. However, such trials are not the best evidence in every situation. Indeed, even the studies the Department relies upon explain that "a well-designed and conducted observational study with a large sample size may provide stronger evidence than a poorly designed and conducted randomized controlled trial."[60] The medical community routinely places weight on

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[57] What We Know Project, Center for the Study of Inequality, Cornell University, *What Does the Scholarly Research Say about the Effect of Gender Transition on Transgender Well-being?* (2018).

[58] *Id.*

[59] *See, e.g.*, Freidemann Pfaflin and Astrid Junge, Sex Reassignment—Thirty Years of International Follow-up Studies after Sex Reassignment Surgery: A Comparison Review, 1961-1991 (1998).

[60] Tamara Jensen, et al., *Final Decision Memorandum on Gender Reassignment Surgery for Medicare Beneficiaries with Gender Dysphoria, Centers for Medicare and Medicaid Services (CMS)* at 71 (August 30, 2016). To be sure, not all studies of the efficacy of gender transition lack controls. *E.g.*, Luk Gijs and Anne Brewaeys, *Surgical Treatment of Gender Dysphoria in Adults and Adolescents: Recent Developments, Effectiveness, and Challenges*, 18 Annual Rev. of Sex Research 178 (2007) (describing a 1990 study which involved comparing patients who received treatment to those who remained on the wait list).

other sources of evidence, including "scientific data or research studies published in peer-reviewed medical journals" and the "[c]onsensus of expert medical opinion."[61]

The Department also fails to mention the reason why randomized trials are not used in the study of treatment for gender dysphoria: "the condition is rare, and treatments need to be individually tailored."[62] Indeed, randomly assigning treatments for gender dysphoria would in most cases be unethical.[63]

The Implementation Report also repeatedly asserts that transition-related care does not "fully remedy" symptoms of gender dysphoria.[64] Yet "that is not a standard that the military or other public health entities apply to [treatment] efficacy evaluation."[65] As several former U.S. Surgeons General explain, "[a]n expectation of certainty is an unrealistic and counterproductive standard of evidence for health policy—whether civilian or military—because even the most well-established medical treatments could not satisfy that standard. Indeed, setting certainty as a

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[61] CMS 100-08, Medicare Program Integrity Manual (2000), 13.7.1, *available at* https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS019033.html.

[62] Palm Center Report, *supra*, at 8 (citing Cecilia Dhejne, et al., *Long-Term Follow-up of Transsexual Persons Undergoing Sex Reassignment Surgery: Cohort Study in Sweden*, 6 PLoS One (2011)).

[63] Nathaniel Frank, *The Pentagon Is Wrong. Gender Transition Is Effective*, N.Y. Times, Apr. 9, 2018, https://www.nytimes.com/2018/04/09/opinion/pentagon-transgender.html.

[64] Implementation Report, *supra*, at 24.

[65] Palm Center Report, *supra*, at 8.

standard suggests an inability to refute the research."[66] Requiring such certainty for the treatment of gender dysphoria is a "double standard" for transgender individuals.[67]

Despite decades of scholarship on the topic, the Department was only able to locate four studies supposedly indicating that transition-related care is not effective. *First*, the Implementation Report relies heavily on a 2016 Center for Medicare Services ("CMS") literature review as support for its claim that there is scientific uncertainty about the efficacy of gender transition.[68] This review did not challenge the conclusion that there is "a consensus among researchers and mainstream medical organizations that transsexual surgery is an effective, safe and medically necessary treatment for" gender dysphoria or that robust, peer-reviewed data supported that consensus.[69] All the CMS review concluded was that there was not enough evidence to entitle *every* Medicare beneficiary to receive gender reassignment surgery *as a matter of course*. Moreover, the CMS review limited its conclusions about the efficacy of treatment to the Medicare population, which is different from the general

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[66] Palm Center (news release), *Former Surgeons General Debunk Pentagon Assertions about Medical Fitness of Transgender Troops* (March 28, 2018).
[67] Palm Center Report, *supra*, at 8.
[68] Jensen, et al., *Final Decision Memorandum*, *supra*.
[69] Dep't of Health and Human Servs., Dep't Appeals Board Appellate Division, NCD 140.3, Transsexual Surgery Docket No. A-13-87 Decision No. 2576 at 20 (May 30, 2014).

population "due to the biology of aging, older adults."[70] The case-by-case approach adopted by CMS, and based on the medical consensus, is directly in line with the inclusive policy announced in June 2016 by then Secretary of Defense Ash Carter policy, which authorized treatment for gender dysphoria on a case-by-case basis after consultation.

Second, the Mayo Clinic study relied upon by the Implementation Report likewise undermines the Department's position. That study demonstrates that transition-related care is effective, leading to "significant improvement" of gender dysphoria in 80 percent of subjects.[71]

Third, the Department points to a review produced by the Hayes Directory, supposedly undermining the consensus view that gender transition is safe and effective.[72] However, the Hayes Directory "is not a scholarly organization and the Hayes Reports have not been published in a peer-reviewed journal."[73] Moreover, the Hayes Directory reports mischaracterize the quality of evidence of relevant studies and in some cases omit those studies altogether.[74]

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[70] Jensen, et al., *Final Decision Memorandum*, *supra*, at 54, 57.
[71] Murad, et al., *supra*, at 214.
[72] Implementation Report, *supra*, at 25-26.
[73] Palm Center Report, *supra*, at 10.
[74] *Id.* at 11 (citing R. Nick Gorton, *Research Memo Evaluating the 2014 Hayes Report: "Sex Reassignment Surgery for the Treatment of Gender Dysphoria" and*

Ultimately, only *one* of the studies cited by the Implementation Report for the claim that there is scientific uncertainty about the efficacy of gender transition includes original research. That study included relatively old data regarding transitions that occurred as early as 1973 when the quality of and access to transition-related care were considerably lower.[75] The study noted that those who transitioned more recently experienced fewer problems.[76] And the same co-author has published more recently, concluding that "[r]ates of psychiatric disorders and suicide became more similar to controls over time; for the period 1989-2003, there was no difference in the number of suicide attempts compared to controls."[77]

The Department twists the conclusions of generally accepted treatment guidelines to suggest that individuals receiving hormone treatment are non-deployable for up to a year while their hormone levels are monitored.[78] As explained by Dr. Joshua D. Safer, one of the drafters of the very Endocrine Society practice guidelines relied upon by the Department, "hormone therapy or being on hormone therapy [does] not prevent a servicemember from carrying out their military duties,"

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the 2004 Hayes Report: "Sex Reassignment Surgery and Associated Therapies for Treatment of GID," (April 2018)).

[75] Dhejne, et al., *Long-Term Follow-up, supra*.

[76] *Id.*

[77] Dhejne, et al., *Mental Health and Gender Dysphoria*, *supra*, at 52.

[78] Implementation Report, *supra*, at 33 (citing Hembree, et al., *Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons, supra*).

and the Implementation Report "misrepresent[s]" the Endocrine Society Guidelines.[79] Those guidelines suggested that clinical evaluation and monitoring of hormone levels every 3 months was a *suggestion*, not a requirement and "temporarily (even for up to a 12 month deployment period where laboratory monitoring was not available) freezing the level of hormones a service member receives does not risk any provision of inadequate treatment; nor does it pose any medical or mental health risks *per se*."[80]

Finally, even the Department's own data show that ability to deploy is not a serious concern for gender dysphoric service members. Out of 994 service members diagnosed with gender dysphoria, 40 percent of them deployed in support of operations in the Middle East, and of those deployed personnel only one was unable to complete the deployment due to mental health reasons.[81] Although the Department points to increased health care utilization by transgender service members, many of those visits appear to be the result of bureaucratic requirements

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[79] Declaration of Joshua D. Safer, MD, FACP In Support of Plaintiffs' Opposition to Defendants' Motion to Dissolve the Preliminary Injunction, *Doe v. Donald Trump, et al.*, No. 17-01597, Dkt. No. 133-1 (D.D.C. May 14, 2018) ¶¶ 17-18.
[80] *Id.* ¶ 22.
[81] Palm Center Report, *supra*, at 19 (citing Dep't of Defense, *Health Data on Active Duty Service Members with Gender Dysphoria: Comparison Health Care Data with Statistical Analysis, Deployment, Treatment Plan, Surgical Recovery Times, Separation Data and Cost Data* (Dec. 13, 2017), 10-12).

imposed by the military; not for reasons of medically necessity. In other health care systems, "mental health care utilization among transgender individuals is far lower than the rate reported by the [Department], and also . . . utilization among transgender and non-transgender individuals is roughly equivalent."[82]

The Department also mischaracterizes research regarding suicide and suicidal ideation by transgender individuals, suggesting that transgender service members are "eight times more likely to attempt suicide than Service members as a whole" during a 22 month study.[83] But that misstates the Department's own data, which actually indicated transgender service members were eight times more likely to *contemplate* suicide, not *attempt* it.[84] Moreover, Department data show that the rate of suicidal ideation—i.e., contemplating suicide—is actually much higher in the general service member population than the Implementation Report suggests. According to that data, which tracked service members not being treated for behavioral health problems, "14 percent of service members have had suicidal thoughts at some time in their lives, 11 percent had suicidal thoughts at some point

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[82] Palm Center Report, *supra*, at 27; *see also* Jesse M. Ehrenfeld, et al., *Healthcare Utilization Among Transgender Individuals in California*, 42 J. of Med. Systems 77 (2018) (study of California Health Interview Survey data indicating that transgender individuals "are less likely to utilize healthcare services" than the overall population).

[83] *E.g.*, Implementation Report, *supra*, at 21.

[84] Palm Center Report, *supra*, at 29.

during their military careers, and 6 percent had suicidal thoughts during the past year."[85] Suicide is a problem experienced by the military as a whole—it is not a problem unique to transgender service members.

While there is evidence of a slightly elevated rate of suicidal ideation among transgender service members, the Implementation Report does not take into account the detrimental effects of the transgender ban on transgender service members.[86] The health care community agrees that such discrimination can have negative health effects on the targeted community.[87] Lifting the ban has likely had—and will continue to have—a salutary effect on transgender service member health.

C. The Department Ignored The Benefits Of An Inclusive Policy, And Overestimated Its Negligible Costs.

The Department's claims of "disproportionate costs" are misleading and unfounded.[88] By isolating service members with gender dysphoria and comparing their health care costs to the general population, the Department makes an unsurprising finding—that service members with a diagnosed medical issue consume more health care than the general population—this would be true of any

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[85] Dep't of Defense, Defense Suicide Prevention Office, *Military Suicide Data Surveillance: Baseline Results from Non-Clinical Populations on Proximal Outcomes for Suicide Prevention* at 5 (July 25, 2017).
[86] Palm Center Report, *supra*, at 30.
[87] American Psychological Ass'n, *Statement Regarding Transgender Individuals*, *supra*.
[88] Implementation Report, *supra*, at 41.

population of service members with a diagnosed medical condition. Moreover, the cost of transition related care is not expensive. Across the entire force, transition-related care is estimated to cost 9 cents per service member per month.[89] Even among the transgender service member cohort, costs would average $12.47 per service member per month.[90]

Although the Department now criticizes research and recommendations by the RAND National Defense Research Institute related to the inclusive policy, that research remains valid. The RAND study's predictions about utilization and health care costs proved remarkably accurate, two years into the inclusive policy. For example, RAND estimated that transition-related health care would cost between $2.4 and $8.4 million per year, and in 2017, those costs were $2.2 million.[91]

Further, the Implementation Report mischaracterizes RAND's conclusions. Although RAND did note that there would be "negligible" costs associated with the policy change to a more inclusive policy, it also noted that there would be benefits associated with the policy change.[92]

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[89] Palm Center Report, *supra*, at 42.
[90] *Id.*
[91] *Id.* at 37 (citing Dep't of Defense, *Health Data on Active Duty Service Members with Gender Dysphoria* at 31).
[92] RAND Report, *supra*, at 8 (surgical skills), 45, 60-61 (diversity and readiness).

The Department also ignores the costs inherent in returning to a policy that bans most transgender individuals from serving. Discrimination has real costs, including medical costs. The Implementation Report pretends those costs do not exist. Among other things, banning service by openly transgender, transitioned individuals could deprive 14,700 transgender service members of medically necessary care.[93] Imposing the ban would force transgender service members to hide their identity if they wish to continue serving.

The policy discriminates against transgender people by singling them out as categorically unfit to serve in conformity with their gender identity or if they have received or required transition-related treatment—a conclusion that is flatly contradicted by medical evidence and the consensus of the medical, mental health, and broader health care communities.

[93] RAND Report, *supra*, at 9-10.

CONCLUSION

For the foregoing reasons, *amici* respectfully urge this Court to affirm the judgment below.

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Respectfully submitted,

JENNER & BLOCK LLP

/s/ Scott B. Wilkens
Scott B. Wilkens
Devi M. Rao
1099 New York Avenue, NW Suite 900
Washington, DC 20001-4412
Telephone: 202 639-6000
Facsimile: 202 639-6066

Benjamin J. Brysacz
633 West 5th St.
Suite 3600
Los Angeles, CA 90071
Telephone: 213 239-5100
Facsimile: 213 239-5199

Attorneys for Amici Curiae Medical, Nursing, Mental Health, and Other Health Care Organizations

CERTIFICATE OF COMPLIANCE

This brief complies with the type-volume limitation of Ninth Circuit Rule 32-1(a) because it contains 6,471 words, excluding the parts of the brief exempted by Fed. R. App. P. 32(f) (cover page, disclosure statement, table of contents, table of citations, statement regarding oral argument, signature block, certificates of counsel, addendum, attachments).

This brief also complies with the typeface and type style requirements of Fed. R. App. P. 32(a)(5)-(6) because this brief has been prepared in a proportionally-spaced typeface using Microsoft Office Word in 14-point Times New Roman.

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/s/ Scott B. Wilkens

Scott B. Wilkens
JENNER & BLOCK LLP
1099 New York Ave. NW
Suite 900
Washington, DC 20001
(202) 639-6000
swilkens@jenner.com

Counsel for Amici Curiae

CERTIFICATE OF SERVICE

I hereby certify that on July 3, 2018, I electronically filed the foregoing *amici curiae* brief with the Clerk of the Court for the United States Court of Appeals for the Ninth Circuit by using the CM/ECF system. I certify that all participants in the case are registered CM/ECF users and that service will be accomplished by the CM/ECF system.

Dated: July 3, 2018

/s/ Scott B. Wilkens

Scott B. Wilkens
JENNER & BLOCK LLP
1099 New York Ave. NW
Suite 900
Washington, DC 20001
(202) 639-6000
swilkens@jenner.com
Counsel for Amici Curiae