

LATHAM & WATKINS LLP  
Marvin S. Putnam (SBN 212839)  
[marvin.putnam@lw.com](mailto:marvin.putnam@lw.com)  
Amy C. Quartarolo (SBN 222144)  
[amy.quartarolo@lw.com](mailto:amy.quartarolo@lw.com)  
Adam S. Sieff (SBN 302030)  
[adam.sieff@lw.com](mailto:adam.sieff@lw.com)  
Harrison J. White (SBN 307790)  
[harrison.white@lw.com](mailto:harrison.white@lw.com)  
355 South Grand Avenue, Suite 100  
Los Angeles, California 90071-1560  
Telephone: +1.213.485.1234  
Facsimile: +1.213.891.8763

National Center for Lesbian Rights  
Shannon P. Minter (SBN 168907)  
[sminter@nclrights.org](mailto:sminter@nclrights.org)  
Amy Whelan (SBN 2155675)  
[awhelan@nclrights.org](mailto:awhelan@nclrights.org)  
870 Market Street, Suite 360  
San Francisco, CA 94102  
Telephone: +1.415.392.6257  
Facsimile: +1.415.392.8442

GLBTQ Legal Advocates & Defenders  
Jennifer Levi (*pro hac vice forthcoming*)  
[jlevi@glad.org](mailto:jlevi@glad.org)  
Mary L. Bonauto (*pro hac vice forthcoming*)  
[mbonauto@glad.org](mailto:mbonauto@glad.org)  
30 Winter Street, Suite 800  
Boston, MA 02108  
Telephone: +1.617.426.1350  
Facsimile: +1.617.426.3594

*Attorneys for Plaintiffs*  
*Aiden Stockman, Nicolas Talbott,*  
*Tamasyn Reeves, Jaquice Tate, John Does 1-2,*  
*Jane Doe, and Equality California*

UNITED STATES DISTRICT COURT  
CENTRAL DISTRICT OF CALIFORNIA

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

Plaintiffs,

v.

DONALD J. TRUMP, et al.

Defendants.

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

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

1 I, Margaret Chamberlain Wilmoth, declare as follows:

2 **Background and Experience**

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

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

11 3. My family's history of military service dates back to the  
12 Revolutionary War. As a small child, I grew up hearing the stories of an aunt who  
13 was a nurse and a neighbor who had served as an Army nurse during World War  
14 II. From the time I was 6 or 7 years old, I knew I wanted to be an Army nurse.  
15 When I graduated with my nursing degrees at the end of the Vietnam War, the  
16 Army was drawing down, so I went into civilian practice. I spent the first seven  
17 years of my nursing career as a teacher and researcher.

18 4. While I was teaching at the University of Delaware, my father, who  
19 had joined the Air Force Reserve after serving as a pilot, encouraged me to pursue  
20 my dream of serving as an Army nurse by joining the United States Army Reserve  
21 (U.S.A.R.). I joined the U.S.A.R. in 1981 and served in various capacities during  
22 over thirty-five years in service, achieving the ranks of Captain, Major, Lieutenant  
23 Colonel, Colonel, Brigadier General, and Major General, before my retirement  
24 from the military on May 1, 2017. When I was promoted to Brigadier General in  
25 2005, I became the first nurse and first woman to command a medical brigade as a  
26 general officer. When I was promoted to Major General, I became only the third  
27 nurse from the Army Reserve ever to achieve that rank.

28 5. From July of 2008 through October 2011, I served as Assistant for

1 Mobilization and Reserve Affairs in the Office of the Secretary of Defense for  
2 Health Affairs. From October 2011 through July of 2014, I served in the Control  
3 Group. In July of 2014, I was appointed Deputy Surgeon General for Mobilization  
4 and Reserve Affairs. When I received this appointment, I became the first nurse in  
5 the more than 106-year history of the Army Reserve and the first woman to serve  
6 in this position. I held this position until my retirement from the military on May  
7 1, 2017.

8 6. In August of 2014, I was also appointed by the Secretary of the Army  
9 to the Army Reserve Forces Policy Committee, where I most recently served as  
10 Deputy Chair. This congressionally-mandated committee's role includes advising  
11 the Secretary of the Army on major policy matters directly affecting the reserve  
12 components and the mobilization preparedness of the Army. I held this position  
13 until my retirement from the military on May 1, 2017.

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

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

1 of Nursing as the Executive Dean and Associate Dean for Academic Affairs.

2 9. Throughout my academic and research careers, my practice and  
3 research focus has been in psychosocial oncology. My research led to the  
4 development of a subspecialty in psychosexual oncology, which focuses on how  
5 surgery, chemotherapy, radiation, and immunotherapy impact body image,  
6 sexuality, and fertility. I have had more than sixty psychosexual oncology  
7 academic papers published on topics such as comparing the effects of lumpectomy  
8 vs. mastectomy on sexual behaviors; and strategies to help nurses become  
9 comfortable with psychosexual assessments of patients.

### 10 **Formation of Working Group**

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

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

28

### Working Group Process

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

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

14. **Step 2: Identifying How Medical Needs Could Be Met Within the Military Health System.** After we understood the universe of potential medical needs of transgender service members, we focused on how the Military Health System (MHS) could meet those needs. For the large majority of medical care needs, we found that MHS was already providing the same or substantially similar

1 services to other service members, and that there would be little, if any, additional  
2 burden on MHS from the provision of the required medical services to transgender  
3 service members.

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

10 16. The Working Group also examined whether there were any  
11 deployment-related obstacles to providing pharmaceutical care that requires  
12 routine doses of medication. We learned that service members with chronic  
13 conditions requiring routine medications regularly take with them enough  
14 medication to last for at least the first ninety (90) days of their deployment.  
15 Examples of such medications would include birth control, hormone replacement  
16 therapy, and medications to address low testosterone, hypertension, and  
17 osteoporosis, among other conditions. Each Combatant Command sets rules in the  
18 form of Personnel Policy Guidance that specifies any special restrictions on  
19 deployability of members to that Command, including medical restrictions. For  
20 example, a theatre that has only intermittent access to a medical supply train might  
21 require service members to bring extra medical supplies or restrict certain service  
22 members from serving in particular locations. Such issues are readily addressed in  
23 the field through the Personnel Policy Guidance, and no unique or different issues  
24 would be raised by the pharmaceutical needs of transgender service members. The  
25 Working Group concluded that no additional burden on deployability would be  
26 created by transgender service members who required routine medication.

27 17. With respect to gynecological care, we learned that MHS already  
28 routinely provides this care to its service members. With transgender service



1 members being permitted to serve openly, the concerns about confidentiality that  
2 might previously have hindered transgender service members from seeking  
3 gynecological care through MHS would no longer be an issue. Transgender  
4 service members would now be able to receive all routine medical care including  
5 gynecological services through MHS, allowing for more complete and coordinated  
6 care for the service members. The Working Group concluded that no additional  
7 burden on MHS would be created by the provision of gynecological care to  
8 transgender service members.

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

19 19. The Working Group also examined whether there were any  
20 deployment or readiness related obstacles associated with addressing the mental  
21 health needs of transgender service members. The Working Group educated itself  
22 in part by consulting with our counterparts in Israel, the United Kingdom, and  
23 Australia, where open service by transgender individuals is permitted. We learned  
24 that those services have seen no reduced ability to serve from transgender service  
25 members due to mental health or other gender identity related issues. The  
26 Working Group also examined our own military's existing policies and learned  
27 that there is a rigorous screening process for all individuals applying to join the  
28 military that includes examination of mental health. The Military Entrance

1 Processing Stations (MEPS) (enlistment processing offices) evaluate psychological  
2 stability as a component of fitness to serve. Additionally, once individuals are in  
3 active or reserve service, mental health is evaluated on an annual basis as part of  
4 the Periodic Health Assessment (PHA). The Working Group found that there was  
5 no reason to think that these pre-existing military policies, when applied to  
6 transgender service members serving openly, would not adequately protect the  
7 services from any mental health issues interfering with deployment.

8       20. With respect to surgical therapy, the Working Group consulted with  
9 surgical experts to determine whether there were any aspects of surgical therapy  
10 for transgender service members in which MHS did not already have the requisite  
11 expertise. We learned that MHS employs general surgeons, urologists who  
12 perform urological surgeries, and obstetrician/gynecologists who perform  
13 gynecological surgeries. Those skill sets are present in a substantial capacity  
14 within MHS, and MHS is able to address most routine surgical needs at or near the  
15 location of its service members. We learned, for instance, that surgeries for  
16 transgender service members would be relatively rare and that many of those  
17 surgeries are already routinely provided to non-transgender service members, such  
18 as hysterectomies or chest surgeries. For surgeries requiring particular expertise,  
19 MHS maintains major medical centers that are equipped to provide a broader array  
20 of services. For surgeries requiring expertise outside of MHS's capacity, service  
21 members are typically referred out to civilian providers. The non-routine surgical  
22 needs of a transgender service member could be addressed either through training  
23 or contracting with surgeons with the appropriate expertise to MHS, or through the  
24 normal process for referring out of MHS to civilian providers. The Working  
25 Group concluded that the surgical needs of transgender service members could be  
26 addressed through either of these methods without creating additional burden on  
27 MHS.

28       21. The Working Group also learned that the development of



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

10       22.   **Step 3: Policy Development.** Throughout this educational process,  
11 the Working Group members developed a deep understanding of the medical needs  
12 of transgender service members. Next, we turned our focus to developing a policy  
13 that would address the psychological and physical needs of transgender individuals  
14 and treat those individuals fairly while keeping readiness and deployability at the  
15 forefront. Developing the protocol was an iterative process involving multiple  
16 rounds of drafting, gathering input from the services, and redrafting.

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

1 medical condition and has been stable in the preferred gender for a sufficient  
2 period of time.

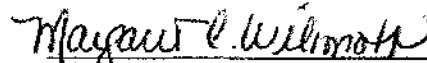
3 24. The Working Group's process for developing the protocol and  
4 recommendations was deliberative and thoughtful, involved significant amounts of  
5 research and education, and in the end resulted in a policy that all services  
6 supported. We were very proud to have developed a policy that treats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

9  
10 [REMAINDER OF PAGE INTENTIONALLY LEFT BLANK]  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25  
26  
27  
28

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25  
26  
27  
28

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

Dated: September 21, 2017



Margaret C. Wilmoth