

September 7, 2018

Director, Office of Regulation Policy and Management  
Department of Veterans Affairs  
810 Vermont Ave NW Room 1063B  
Washington, DC 20420

**Re: Comments in response to “Notice of Petition for Rulemaking and request for comments—Exclusion of Gender Alterations from the Medical Benefits Package.”**

To Whom it May Concern:

Thank you for the opportunity to comment on this request for comments on whether the Department of Veterans Affairs should exclude “gender alterations” (referred to as “surgical treatment for gender dysphoria” or “transition-related treatment” in this comment) from its medical benefits package.

As health care providers with extensive experience treating transgender patients, the undersigned write to provide information on the questions posed by the VA about evidence on the safety and effectiveness of surgical treatment for gender dysphoria, and its impact on mental health and decreasing rates of suicidal ideation and suicidality on the transgender population, including transgender veterans. For the reasons outlined below, the undersigned urge the VA to remove its exclusion of surgical treatment for gender dysphoria from the VA medical benefits package.

**Question 1:**

**What evidence is available about the safety and effectiveness of “gender alterations” for the treatment of Gender Dysphoria and how reliable is that evidence?**

**Uniform professional support for treatment of gender dysphoria with medical and surgical interventions**

International consensus among medical experts, including experienced clinicians and researchers affirms the efficacy of transition-related health care. Major medical professional associations including the American Medical Association, the American Psychiatric Association, the American Psychological Association, the American College of Obstetricians and Gynecologists, the Endocrine Society, and the World Professional Association for Transgender Health have affirmed the appropriateness and medical necessity of medical and surgical therapy and have supported insurance coverage for treatment of appropriate patients diagnosed with Gender Dysphoria.

### The American Psychiatric Association (APA)

The APA's position statement on treatments for patients with Gender Dysphoria states: "Significant and long-standing medical and psychiatric literature exists that demonstrates clear benefits of medical and surgical interventions to assist gender variant individuals seeking transition", therefore the APA "Recognizes that appropriately evaluated transgender and gender variant individuals can benefit greatly from medical and surgical gender transition treatments."<sup>1</sup>

### The American Psychological Association

The American Psychological Association policy statement notes "APA recognizes the efficacy, benefit and medical necessity of gender transition treatments for appropriately evaluated individuals and calls upon public and private insurers to cover these medically necessary treatments."<sup>2</sup>

### The American Medical Association

A decade ago the AMA noted the need for treatment of transgender patients and adopted policy that "Our AMA supports public and private health insurance coverage for treatment of gender dysphoria as recommended by the patient's physician."<sup>3</sup>

### The World Professional Association for Transgender Health

WPATH has stated that "based on clinical and peer reviewed evidence that gender affirming/confirming treatments and surgical procedures, properly indicated and performed as provided by the Standards of Care, have proven to be beneficial and effective in the treatment of individuals with transsexualism or gender dysphoria. Gender affirming/confirming surgery, also known as sex reassignment surgery, plays an undisputed role in contributing toward favorable outcomes." Further, in the same policy statement WPATH "urges health insurance carriers and healthcare providers in the United States to eliminate transgender or transsexual exclusions from their policy documents and medical guidelines, and to provide coverage for transgender patients; also to include in their policy documents and medical guidelines the medically prescribed sex reassignment or gender affirming/confirming services necessary for subscribers' treatment and well-being; and to ensure that ongoing healthcare, both routine and specialized, is readily accessible and affordable to all their subscribers on an equal basis."<sup>4</sup>

### The American College of Obstetricians and Gynecologists

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<sup>1</sup> Drescher, J., Haller, E., & Lesbian, G. (2012). Position statement on access to care for transgender and gender variant individuals. Washington, DC: American Psychiatric Association.

<sup>2</sup> American Psychological Association. (2008). Transgender, gender identity, & gender expression non-discrimination. American Psychological Association.

<sup>3</sup> American Medical Association. (2008). Removing financial barriers to care for transgender patients H-185.950.

<sup>4</sup> Gail, K. (2016). Position Statement on Medical Necessity of Treatment, Sex Reassignment, and Insurance Coverage in the USA. World Professional Association for Transgender Health (WPATH), December, 21.

ACOG Committee Opinion on Health Care for Transgender Individuals notes that “transgender individuals face significant barriers to health care. This includes the failure of most health insurance plans to cover the cost of mental health services, cross-sex hormone therapy, or gender affirmation surgery. This barrier exists despite evidence that such treatments are safe and effective and that cross-gender behavior and gender identity issues are not an issue of choice for the individual and cannot be reversed with psychiatric treatment. With medical and psychiatric care that affirms transgender identity, the transgender individual can lead an enhanced, functional life.”<sup>5</sup>

### The Endocrine Society

The Endocrine Society's Position Statement on Transgender Health affirms that “Medical intervention for transgender individuals (including both hormone therapy and medically indicated surgery) is effective, relatively safe (when appropriately monitored), and has been established as the standard of care.”<sup>6</sup>

### Efficacy of transition related care

In addition to strong support from these major healthcare professional associations recognizing that the peer-reviewed medical literature supports the provision of medical and surgical treatments to transgender patients as medically necessary, the literature itself is pertinent to review in any policy decision such as the Implementation Report undertakes. Unfortunately there are major studies that the Report failed to consider. We have provided a compendium that outlines the evidence in the literature but listed below are some examples of pertinent publications from the peer-reviewed literature not cited in the DoD Report.

A 2007 study reported follow-up data of 807 individuals who underwent surgical gender transition.<sup>7</sup> Summarizing their results, the authors reaffirmed the conclusion of a much-cited 1990 review that gender transition dramatically reduces the symptoms of gender dysphoria, and hence “is the most appropriate treatment to alleviate the suffering of extremely gender dysphoric individuals.”<sup>8</sup> Gijs et al found that, across 18 outcome studies published over two decades 96 percent of subjects were satisfied with transitioning, and “regret was rare.” The authors wrote that, even though there were “methodological shortcomings” to many of the studies they reviewed (lacking controls or randomized samples), “we conclude that SRS [sex reassignment surgery] is an effective treatment for transsexualism and the only treatment that has been

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<sup>5</sup> Health care for transgender individuals. Committee Opinion No. 512. American College of Obstetricians and Gynecologists. *Obstet Gynecol* 2011;118:1454–8.

<sup>6</sup> Position Statement: Transgender Health. The Endocrine Society (2017) [https://www.endocrine.org/-/media/endosociety/files/advocacy-and-outreach/position-statements/2017/position\\_statement\\_transgender\\_health.pdf?la=en](https://www.endocrine.org/-/media/endosociety/files/advocacy-and-outreach/position-statements/2017/position_statement_transgender_health.pdf?la=en)

<sup>7</sup> Gijs, L., & Brewaeys, A. (2007). Surgical treatment of gender dysphoria in adults and adolescents: Recent developments, effectiveness, and challenges. *Annual Review of Sex Research*, 18(1), 178-224.

<sup>8</sup> Green, R., & Fleming, D. T. (1990). Transsexual surgery follow-up: Status in the 1990s. *Annual review of sex research*, 1(1), 163-174.

evaluated empirically with large clinical case series.” Gender transition, they stated, “is not strongly theory driven, but a pragmatic and effective way to strongly diminish the suffering of persons with gender dysphoria.” It must be noted that not all studies of the efficacy of gender transition lack controls. The Dutch authors cite a controlled study from 1990 that compared a waiting-list condition with a treatment condition and found “strong evidence for the effectiveness” of surgical gender transition. Moreover current consensus on the efficacy of surgical treatment for gender dysphoria as well as the serious negative outcomes (including marked suicidality that significantly improves after treatment) ethically precludes modern studies that use untreated transgender patients as controls (other than the patients themselves as pre-treatment controls in cohort studies). No Institutional Review Board would approve a controlled trial of SRS today using anything other than historical or non-transgender controls.

A 2015 Harvard and University of Houston longitudinal study of testosterone treatment also reviewed prior literature and found that numerous recent cross-sectional studies “suggest that testosterone treatment among transgender men is associated with improved mental health and well-being,” including improved quality of life, less anxiety, depression and social distress, and a reduction in overall mental stress.<sup>9</sup>

A 2017 review concluded that “there is an overall Level B evidence for beneficial quality-of-life outcomes for trans female patients after FGCS [Facial Gender Confirmation Surgery]”, and that “the current level of evidence is close to the maximal level of evidence that can be expected for a surgical procedure, as randomized clinical trials will likely never be offered for these procedures. As such, FGCS can no longer be deemed as an aesthetic component of gender-confirming care.”<sup>10</sup>

A 2015 study of the long term outcomes (>10 years) of patients with gender dysphoria treated with hormone therapy and surgery found that on the SCL-90 (Symptom Check List-90) participants had statistically and clinically significant improvements in all 9 measures and the global severity index. They also found statistically and clinically significant improvements in all 8 measures on the IIP (Inventory of Interpersonal Problems). On the Freiburg Personality Inventory of the 12 measures, 3 improved, 1 worsened (openness), and 8 were unchanged.<sup>11</sup>

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<sup>9</sup> Keo-Meier, C. L., Herman, L. I., Reisner, S. L., Pardo, S. T., Sharp, C., & Babcock, J. C. (2015). Testosterone treatment and MMPI-2 improvement in transgender men: A prospective controlled study. *Journal of consulting and clinical psychology*, 83(1), 143.

<sup>10</sup> Berli, J. U., Capitán, L., Simon, D., Bluebond-Langner, R., Plemons, E., & Morrison, S. D. (2017). Facial gender confirmation surgery—review of the literature and recommendations for Version 8 of the WPATH Standards of Care. *International Journal of Transgenderism*, 18(3), 264-270.

<sup>11</sup> Ruppin, U., & Pfäfflin, F. (2015). Long-term follow-up of adults with gender identity disorder. *Archives of sexual behavior*, 44(5), 1321-1329.

A 2016 literature review on suicidal and self injurious behavior in transgender individuals note that while suicidality is higher in transgender populations, it decreased significantly post-operatively.<sup>12</sup>

### **Department of Defense Recommendation and Report**

The request for comment on the petition for rulemaking cites a February 22, 2018 Department of Defense report that “noted considerable scientific uncertainty and overall lack of high quality scientific evidence demonstrating the extent to which transition-related treatments such as sex reassignment surgery remedy the multifaceted mental health problems associated with gender dysphoria.” The VA does not clarify its purpose or meaning for of citing this report, but we will assume they view it as evidence of the safety and effectiveness for the treatment of gender dysphoria, even though it was not conducted by medical professionals or published in a peer-reviewed review. Moreover as the above noted both the peer-reviewed literature and professional consensus demonstrated by policy statements from professional organizations demonstrate that while there may be uncertainty as to certain details about what treatments offer the most benefit for patients with gender dysphoria, there is no scientific uncertainty that medical and surgical treatments offer significant and long term benefits and diminish psychological morbidity and mortality. Thus it is important to address in detail the misleading characterizations, omissions and conclusions within the report.

This comment addresses the arguments raised concerning the evidence cited in the Implementation Report. Before addressing the specific evidence cited in the report, we note that several preeminent health care organizations as well as six former Surgeons General have also responded negatively to the Implementation Report:

#### **The American Medical Association (AMA)**

The AMA responded to the release of the Implementation Report by stating that DoD “mischaracterized and rejected the wide body of peer-reviewed research on the effectiveness of transgender medical care. This research, demonstrating that medical care for gender dysphoria is effective was the rationale for AMA’s adoption of policy by our House of Delegates in 2015, that there is no medically valid reason to exclude transgender individuals from military service.”<sup>13</sup>

#### **The American Psychological Association**

The American Psychological Association’s response to the Implementation Report states: “The American Psychological Association is alarmed by the administration’s misuse of psychological science to stigmatize transgender Americans and justify limiting their ability to serve in uniform and access medically necessary health care. Substantial psychological research shows that gender

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<sup>12</sup> Marshall, E., Claes, L., Bouman, W. P., Witcomb, G. L., & Arcelus, J. (2016). Non-suicidal self-injury and suicidality in trans people: a systematic review of the literature. *International review of psychiatry*, 28(1), 58-69.

<sup>13</sup> <https://www.politico.com/f/?id=00000162-927c-d2e5-ade3-d37e69760000>

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. The science is clear that individuals who are adequately treated for gender dysphoria should not be considered mentally unstable”.<sup>14</sup>

### Former Surgeon Generals

Six former U.S. Surgeons General responded to the report by citing “a global medical consensus” that transgender medical care “is reliable, safe, and effective.”

### Biased and incomplete analysis in the DOD Implementation Report

The Implementation Report relies upon a biased and incomplete set of studies and evidence reviews for its proposition that there is “scientific uncertainty” about the efficacy of transition-related care. Moreover they misinterpret and/or misrepresent the findings of these studies.

Those studies include:

1. Center for Medicaid/Medicare Services Review
2. The Hayes Directory Review
3. Swedish Research
4. The Mayo Clinic Research Study

### *Center for Medicare/Medicaid Services review of literature*

The Implementation Report’s interpretation and application of the CMS findings are highly misleading. The Implementation Report fails to clarify that CMS found that the evidence of clinical effectiveness was inconclusive for the *Medicare* population, not for *all persons* with gender dysphoria. The Medicare program is for people ages 65 and over and people with qualifying disability. CMS was careful to explain that that due to the biology of aging, older adults may respond to health care treatments differently than younger adults and that there is not sufficient medical evidence to support an affirmative National Coverage Determination for this population. The Implementation Report while quoting CMS that there is “not enough high quality evidence to determine whether gender reassignment surgery improves health outcomes for Medicare beneficiaries with gender dysphoria” fails to note that given the Report’s focus on members of the military, CMS’ conclusions would be completely inapplicable to active duty military members who are neither disabled nor over age 65.

The Report also is misleading in that it suggests that CMS’s failure to issue a National Coverage Determination means that they found insufficient evidence for the efficacy of gender reassignment surgery overall (rather than just in elderly or disabled transgender people). The Report is misleading because it again omits a key point regarding National Coverage

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<sup>14</sup> American Psychological Association (2018). APA Statement Regarding Transgender Individuals Serving in Military.

Determinations. Prior to 2014, CMS had in place a negative coverage determination that prohibited Medicare from covering the cost of gender reassignment surgery, but a Department of Health and Human Services Appeals Board overturned the NCD after a comprehensive review of the efficacy literature determined sex reassignment surgery to be safe, effective, and medically necessary. As a result, under Medicare policy, the need for gender reassignment surgery is determined on a case-by-case basis after consultation between a doctor and patient. The CMS review did not contradict the Board's 2014 conclusion that there is a consensus among researchers and mainstream medical organizations that transsexual surgery is an effective, safe and medically necessary treatment for transsexualism." It should also be noted that only a tiny minority of medical and surgical treatments paid under Medicare are covered by an affirmative NCD. By declining to issue an affirmative NCD, CMS placed sex reassignment surgery in the same category as appendectomy, coronary artery bypass grafting, and cataract surgery.

### *Hayes Directory*

The DOD Report also cites the Hayes Directory for its proposition that there is "considerable scientific uncertainty" about whether transition-related treatment remedies symptoms of gender dysphoria.

Hayes is not a scholarly organization and the Hayes Reports have not been published in a peer-reviewed scholarly journal. But Dr. Nick Gorton, a nationally recognized expert on transgender health, conducted a critical analysis of the report cited by DoD as well as a 2004 Hayes Report addressing related research. Dr. Gorton found that "The Hayes Reports evaluating transition related care make repeated substantive errors, evidence poor systematic review technique, are inconsistent in applying their criteria to the evidence, make conclusions not supported by the evidence they present, misrepresent the statements made by professional organizations treating transgender patients, and have a strong systematic negative bias." He concludes that "these problems fatally damage the credibility of their analysis, casting substantial doubt on their conclusions". The reports cannot be relied upon as a valid systematic clinical review of the evidence on transition-related health care.

For example, Hayes claims that its reports are comprehensive, but its 2004 report omitted dozens of relevant studies from its analysis. Dr. Gorton reproduced their literature review and identified 31 applicable scholarly articles that Hayes failed to include in its review. Hayes labels 13 studies it chose for one analysis as consisting only of "chart reviews or case series studies" and concludes that the "studies selected for detailed review were considered to be poor quality studies" when numerous high quality studies were available. Furthermore, the 13 studies Hayes did choose to review were not in fact, only chart reviews and case series studies, but included cohort studies, which are considered higher quality evidence. "By mislabeling all the studies as 'chart reviews or case series,'" Dr. Gorton observed, Hayes is "saying they are lower level evidence than what is actually found in that group of studies." Finally, Hayes erroneously states

that none of the 13 studies “assessed subjective outcome measures before treatment.” Dr. Gorton’s review of the studies, however, shows that three of the studies included such baseline measures. Moreover, while their more recent report includes some though not all relevant studies, they rely on their flawed 2004 report for all research published prior to 2004 thus carrying the mistakes of their initial report into the current version.

In their 2014 update, Hayes asserts that a 2012 Task Force report of the American Psychiatric Association “concluded that the available evidence for treatment of gender dysphoria was low for all populations and treatments and in some cases insufficient for support of evidence-based practice guidelines.” Yet Hayes misrepresents the conclusion of the Task Force by taking quotes out of context and omitting mention of the higher quality evidence the APA also cites--and uses as a basis for recommending consensus-based treatment options that include gender transition. Moreover Hayes misrepresents the APA’s conclusion: the “insufficient” evidence comment by the APA applied only to studies of children and adolescents. What the Task Force concluded about adults with gender dysphoria was that there is sufficient evidence to recommend that treatment including surgical care be offered to appropriate patients..

Quoting the APA fully on this matter illustrates Hayes’s Misrepresentation: “The quality of evidence pertaining to most aspects of treatment in all subgroups was determined to be low; however, areas of broad clinical consensus were identified and were deemed sufficient to support recommendations for treatment in all subgroups. With subjective improvement as the primary outcome measure, current evidence was judged sufficient to support recommendations for adults in the form of an evidence-based APA Practice Guidelines with gaps in the empirical data supplemented by clinical consensus.”

In addition, as mentioned Hayes cannot be considered a part of the peer reviewed medical literature. However comparing Hayes to the peer reviewed literature is instructive. For example, in their 2014 Hayes report on Ancillary Procedures (in which they included FFS), they only analyzed 2 studies for their analysis: Ainsworth (2010) and Becking (1996). This was for literature spanning 2003- April 2014 plus studies identified in Hayes’ 2004 report. Compare this with an article in the peer reviewed literature (Berli 2017)<sup>15</sup>. They include 9 studies from the period 2003-April 2014, three that precede this period (including Becking which Hayes cited as it was used in their 2004 report, but two others as well), and 6 subsequent to April 2014. Berli notes that Ainsworth 2010 was level B evidence, while Hayes erroneously concludes that Ainsworth and Becking are together level D evidence (on their in house levels of evidence matrix, but which generally corresponds to the levels used by the peer reviewed literature). Berli conclude: “Based on the literature review, the level of evidence since the SOC 7 was published

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<sup>15</sup> Berli, J. U., Capitán, L., Simon, D., Bluebond-Langner, R., Plemons, E., & Morrison, S. D. (2017). Facial gender confirmation surgery—review of the literature and recommendations for Version 8 of the WPATH Standards of Care. *International Journal of Transgenderism*, 18(3), 264-270.



has risen from a Level C to a Level B. The current level of evidence is close to the maximal level of evidence that can be expected for a surgical procedure, as randomized clinical trials will likely never be offered for these procedures. As such, FGCS can no longer be deemed as an aesthetic component of gender-confirming care.” It should be noted that SOC7 was published in 2011, so Berli not only assesses that the current level of evidence is B, but that based on papers published through 2011 (all of which were available for Hayes to analyze in 2014), the level of evidence was C. This also points to the negative bias Dr Gorton noted in his reading of the 2004 and 2014 Hayes reports.

Finally, Dr. Gorton observes that, “Hayes writes reports that are aimed to please their customers who are all health care payers interested in being able to refuse to cover expensive or, in the case of transgender patients, politically controversial care. They obscure the nature of their systematically biased analysis by preventing scientists and clinicians from reading the reports and calling attention to their poor quality and systematic bias as would happen to any other evidence based review of healthcare treatments.” Dr Gorton notes that one of the primary means by which this is kept out of the hands of scientists and clinicians is by exorbitant cost. Dr Gorton requested a price for the 2004 Hayes report in 2005 and was quoted a cost of \$6,000. He notes the 2014 Hayes reports’ cost was \$18,000 for the three reports combined. The original 2004 Hayes Report was commissioned by the Washington Department of Social and Health Services. Dr Gorton was an expert witness for Lambda Legal and testified in cases for Medicaid beneficiaries who were denied coverage for sex reassignment therapies by the DSHD. An email from the state of Washington to Hayes was obtained by subpoena from Lambda Legal that indicated DSHS requested Hayes to produce a negative report and paid them \$50,000 for it thus demonstrating the motivation for their strong negative bias. Thus, clients of Hayes who may have paid for the meta-analyses could have a financial interest in declining to reimburse patients for transition-related care and Hayes has a financial interest in keeping their analysis out of the hands of scientists and clinicians so it cannot be refuted as it would be were it published in the peer reviewed literature.

### *Swedish Research*

The Implementation Report cites a 2011 study from Sweden co-authored by Cecilia Dhejne. This was a long term follow up of the suicide rates of treated transgender patients compared to the general Swedish population. The study was careful to indicate that this was not an evaluation of the efficacy of hormonal and surgical therapy for gender dysphoria but simply an analysis of psychiatric morbidity after treatment. After presentation of the data, Dhejne’s paper states: “It is therefore important to note that the current study is only informative with respect to transsexuals persons health after sex reassignment; no inferences can be drawn as to the effectiveness of sex reassignment as a treatment for transsexualism. In other words, the results should not be interpreted such as sex reassignment per se increases morbidity and mortality. Things might have been even worse without sex reassignment. As an analogy, similar studies have found increased

somatic morbidity, suicide rate, and overall mortality for patients treated for bipolar disorder and schizophrenia. This is important information, but it does not follow that mood stabilizing treatment or antipsychotic treatment is the culprit.”

Unfortunately Dhejne’s research is often misinterpreted as it was in the Report to suggest treatment of gender dysphoria is ineffective. In a 2015 interview, Dhejne explained that anti-transgender advocates consistently “misuse the study” she published in 2011 “to support ridiculous claims,” including that transition-related care is not efficacious, which is not what her study found. She said that, “if we look at the literature, we find that several recent studies conclude that WPATH Standards of Care compliant treatment decreases gender dysphoria and improves mental health”.

Dhejne’s 2016 review evaluated more than three dozen cross-sectional and longitudinal studies of prevalence rates of psychiatric conditions among people with gender dysphoria. The authors found, contrary to research cited in the Implementation Report, that in some studies transgender individuals who obtain adequate care can be just as psychologically healthy as their non-transgender peers. Combining the results of these studies, most mental health diagnoses were anxiety and unipolar depression whereas “major psychiatric disorders, such as schizophrenia and bipolar disorder, were rare and were no more prevalent than in the general population.” They concluded that, even when individuals start out with heightened anxiety or depression, they “improve following gender-confirming medical intervention, in many cases reaching normative values.”

### *Mayo Clinic Research*

Similar to the CMS study, the Hayes Directory, and the Swedish research, the Mayo Clinic study concludes that transition-related care mitigates the symptoms of gender dysphoria, with 80 percent of subjects experiencing “significant improvement” in gender dysphoria and quality of life, with 78 percent having “significant improvement” in psychological symptoms. Moreover, data cited in the Mayo Clinic report reach as far back as 1966, covering a period when the social climate for gender transition was far more hostile, and medical and surgical technology was far less advanced than today. It is known that functional surgical outcome and experiences of transphobia both predict negative psychological outcomes.<sup>16,17,18,19</sup> Thus including studies from 5 decades prior likely underestimates the benefits that transgender people gain from more modern treatment technology and in a society that is at least somewhat more accepting.

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<sup>16</sup> Dhejne, C., Van Vlerken, R., Heylens, G., & Arcelus, J. (2016). Mental health and gender dysphoria: A review of the literature. *International review of psychiatry*, 28(1), 44-57.

<sup>17</sup> Bouman, W. P., Davey, A., Meyer, C., Witcomb, G. L., & Arcelus, J. (2016). Predictors of psychological well-being among treatment seeking transgender individuals. *Sexual and Relationship Therapy*, 31(3), 359-375.

<sup>18</sup> Clements-Nolle, K., Marx, R., & Katz, M. (2006). Attempted suicide among transgender persons: The influence of gender-based discrimination and victimization. *Journal of homosexuality*, 51(3), 53-69.

<sup>19</sup> Lombardi, E. (2009). Varieties of transgender/transsexual lives and their relationship with transphobia. *Journal of homosexuality*, 56(8), 977-992.

## Conclusion

- 1) The overwhelming consensus of clinicians and researchers who focus on transgender patients as well as the policy and official positions of multiple major medical professional associations affirms that medical and surgical care for transgender people is not only medically necessary and efficacious but should be covered under public and private insurance.
- 2) Numerous research studies and systematic reviews of the peer reviewed literature demonstrate improvements in quality of life, mental health, and a significantly diminished suicide rate among transgender patients provided medical and surgical treatment for their gender dysphoria. The suicide rates for transgender veterans in the VA is more than twenty times higher than the general VA population.<sup>20</sup> Failure to provide treatments demonstrated to reduce psychiatric morbidity and mortality from suicide to this high risk population of veterans places them at unnecessarily greater risk.
- 3) There are a multitude of issues with problems with use of the DOD Implementation Report to inform the VA's decision on providing medically necessary care to transgender veterans:
  - a) The Report utilizes an inadequate and biased set of data from the medical literature. The report has multiple important omissions, and instead relies on documents such as the Hayes Reports which as detailed above is systematically biased, methodologically flawed, and in no way peer reviewed.
  - b) The Report concludes that there is a significant "scientific uncertainty" as to the efficacy and medical necessity of medical and surgical care for transgender people. This is not only false but negated by the fact that multiple major American and international medical professional associations detailed above have affirmed that this is medically necessary care that should be covered by public and private health insurance.
  - c) The Report inappropriately utilizes CMS' decision to not issue an affirmative National Coverage Determination because of inadequate research into surgical outcomes in the specific populations of elderly and disabled transgender patients. The report makes conclusions as to whether this should be provided to military members who by definition do not fall into the categories on which CMS review of the literature was focused.

Seventeen states and the District of Columbia explicitly cover medical and surgical treatments for patients with gender dysphoria in their state Medicaid programs.<sup>21</sup> Medicare covers surgical

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<sup>20</sup> Blosnich, J. R., Brown, G. R., Shipherd, PhD, J. C., Kauth, M., Piegari, R. I., & Bossarte, R. M. (2013). Prevalence of gender identity disorder and suicide risk among transgender veterans utilizing Veterans Health Administration care. *American Journal of Public Health*, 103(10), e27-e32.

<sup>21</sup> California, Colorado, Hawaii, Illinois, New York, Maryland, Massachusetts, Minnesota, Montana, Nevada, New Hampshire, New Jersey, Oregon, Pennsylvania, Rhode Island, Vermont, Washington, and the District of Columbia

and medical care for transgender patients when it is deemed medically necessary. Nineteen states and the District of Columbia prohibit insurance exclusions for transgender medical and surgical care.<sup>22</sup> Transgender Americans volunteer for military service twice as often as non-transgender Americans.<sup>23</sup> These veterans deserve at a minimum the level of care provided by multiple state Medicaid programs and that is guaranteed by law and policy to people with private insurance in many states.

### **Question 2:**

**Given the challenge of the high rates of Veteran suicide, what does the evidence, including peer-reviewed evidence, suggest about the impact of gender alterations on the rates of suicide and suicide ideation among those suffering from gender dysphoria?**

There is overwhelming consensus among major medical organizations—including the American Medical Association,<sup>24</sup> the American College of Physicians,<sup>25</sup> the American Psychological Association,<sup>26</sup> the American Psychiatric Association,<sup>27</sup> the American Academy of Family Physicians,<sup>28</sup> the Endocrine Society,<sup>29</sup> the American College of Obstetricians and Gynecologists,<sup>30</sup> and the World Professional Association for Transgender Health<sup>31</sup>—that treatments that assist transgender people in living according to their gender identity (transition-related treatment) are effective in treating distress and psychological symptoms associated with gender dysphoria, including by reducing rates of suicidal ideation and behavior. For example, the American Psychiatric Association “[a]dvocates for removal of barriers to care...for gender transition treatment,” emphasizing that “[s]ignificant and long-standing medical and psychiatric literature exists that demonstrates clear benefits of medical and surgical interventions to gender

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<sup>22</sup> [http://www.lgbtmap.org/equality-maps/healthcare\\_laws\\_and\\_policies](http://www.lgbtmap.org/equality-maps/healthcare_laws_and_policies)

<sup>23</sup> Gates, G. J., & Herman, J. (2014). Transgender military service in the United States.

<sup>24</sup> American Medical Association. (2008). *Removing financial barriers to care for transgender patients H-185-950*; (2016). *Clarification of medical necessity for treatment of gender dysphoria H-185.927* (recognizing medical and surgical treatments for gender dysphoria as medically necessary).

<sup>25</sup> Daniel, H. & Butkus, R. (2015). Lesbian, gay, bisexual and transgender health disparities: a policy position paper from the American College of Physicians. *Annals of Internal Medicine*, 163(2), 135-137 (recognizing that transition-related care, in addition to lower levels of stigma and discrimination, have been shown to reduce suicidality and other psychological symptoms among transgender people).

<sup>26</sup> American Psychological Association. (2008) *Policy on transgender, gender identity & gender expression non-discrimination*. Retrieved from <http://www.apa.org/about/policy/transgender.aspx>.

<sup>27</sup> Am. Psychiatric Association. (2012). *Position statement on access to care for transgender and gender variant individuals*. Retrieved from <https://www.psychiatry.org/file%20library/about-apa/organization-documents-policies/policies/position-2012-transgender-gender-variant-access-care.pdf> (recognizing the clear benefits of transition-related surgical interventions for transgender people).

<sup>28</sup> American Academy of Family Physicians. (2012). *Resolution No. 1004: Transgender Care*. Retrieved from [https://www.aafp.org/dam/AAFP/documents/about\\_us/special\\_constituencies/2012RCAR\\_Advocacy.pdf](https://www.aafp.org/dam/AAFP/documents/about_us/special_constituencies/2012RCAR_Advocacy.pdf).

<sup>29</sup> Hembree, W. C. et al.. (2017). Endocrine treatment of gender-dysphoric/gender-incongruent persons: an endocrine society clinical practice guideline. *Journal of Clinical Endocrinology & Metabolism*, 102(11), 3869-3903.

<sup>30</sup> American College of Obstetricians & Gynecologists. (2011). Committee Opinion No. 512: Health care for transgender individuals, *Obstetrics & Gynecology*, 118, 1454-1458.

<sup>31</sup> World Professional Association for Transgender Health. (2011). *Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People*.

variant individuals seeking transition” and “[a]ccess to medical care (both medical and surgical) positively impacts the mental health of transgender and gender variant individuals.”<sup>32</sup>

Numerous peer reviewed studies and meta-analyses, including studies specific to the veteran population, have concluded that access to transition-related surgery has a marked impact in decreasing rates of suicidal ideation and behavior. For example, in a literature review of all peer-reviewed articles published in English between 1991 and 2017 on the effects of transition-related care on the wellbeing of transgender people, a Cornell University research team concluded that surgical and other transition-related treatment substantially lower rates of suicidal ideation and attempts. The team found “broad international consensus in the peer-reviewed literature that gender transition, including medical treatments such as hormone therapy and surgery, improves the overall well-being of transgender individuals,” including with regard to suicidality. Ninety-three percent (93%) of the studies reviewed by the Cornell team found that gender transition improves the wellbeing of transgender people, while the remaining 7% had null or mixed results, and no studies found overall harm.<sup>33</sup>

Specific studies on the veteran transgender population have similarly found that access to transition-related care improves wellbeing. For example, a recent national study of 206 transgender veterans found that comprehensive transition-related surgical care is associated with a substantial reduction in rates of suicidal ideation.<sup>34</sup> The study found that veterans who underwent both chest and genital surgery were less likely to experience suicidal ideation compared to veterans who received hormone therapy alone, as well as compared to veterans who underwent chest surgery or genital surgery but not both. Specifically, while 41.9% of respondents who had received hormone therapy alone experienced suicidal ideation in the past two weeks, only 3.6% of those who had undergone chest and genital surgery reported suicidal ideation during that time period.<sup>35</sup> Similarly, while 64.8% of those who received hormone therapy alone reported suicidal ideation in the past year, the rate dropped to only 21.4% among those who received genital and chest surgery.<sup>36</sup> The study found similar differences in regard to depressive symptoms, with lower PHQ-9 scores for those who had both chest and genital surgery compared to those who had received only hormone therapy.<sup>37</sup>

Numerous other studies from the U.S. and other countries around the world examining the effects of treatment for gender dysphoria have found clear links between access to transition-related care, including surgical care when needed, and reduced rates of suicidal attempts or ideation. Studies generally found that suicide ideation rates dropped substantially for transgender people who had had access to surgical and other transition-related care when compared to those

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<sup>32</sup> American Psychiatric Association(2012) .

<sup>33</sup> The Public Policy Research Portal. (2018). *What does the scholarly research say about the effect of gender transition on transgender well-being?*. Cornell University: Ithaca, NY. Retrieved from <https://whatwewknow.inequality.cornell.edu/topics/lgbt-equality/what-does-the-scholarly-research-say-about-the-well-being-of-transgender-people>

<sup>34</sup> Tucker, R. P., Testa, R. J., Simpson, T. L., Shipherd, J. C., Blosnich, J., & Lehavot, K. (2018). Hormone therapy, gender affirmation surgery, and their association with recent suicidal ideation and depressive symptoms in transgender veterans, *Psychological Medicine*. 1-8. <https://doi.org/10.1017/S0033291717003853>.

<sup>35</sup> Tucker et al. (2018).

<sup>36</sup> Tucker et al. (2018).

<sup>37</sup> Tucker et al. (2018).

who did not or were still in the process of undergoing treatment. For example, one study of suicidality among 433 transgender people in Ontario, Canada found a dramatic drop in past-year suicide attempts among people who had undergone transition-related treatment: while 27% of people who were planning but had not yet begun to undergo treatment and 18% of people who were in the process of undergoing treatment had attempted suicide in the past year, only 1% of those who have medically transitioned attempted suicide in the past year.<sup>38</sup> An analysis of a United Kingdom study of 889 transgender people found that suicide ideation and attempt rates decreased by over twenty times after access to transition-related care, including surgical care, with 63% of respondents thinking about or attempting suicide before they received transition-related care but only 3% thinking about or attempting suicide afterwards.<sup>39</sup> Numerous other studies reported similar decreases in suicidality and other negative health outcomes for transgender patients following access to transition-related care.<sup>40</sup>

Additionally, numerous studies have found that access to transition-related surgery is associated with substantial improvements in other measures of mental health closely tied to suicidality, including anxiety and depression.<sup>41</sup>

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<sup>38</sup> Bauer, G. R., Pyne, J., Francino, M. T., & Hammond, R. (2013). Suicidality among trans people in Ontario: Implications for social work and social justice, *Service social*, 59(1), 35-62.

<sup>39</sup> Bailey, L., Ellis, S. J., & McNeil, J. (2014). Suicide risk in the UK trans population and the role of gender transition in decreasing suicidal ideation and suicide attempt. *The Mental Health Review*, 19(4), 209-220.

<sup>40</sup> E.g., De Cuypere, G., Elaut, E., Heylens, G., Maele, G. V., Selvaggi, G., et al. (2006). Long-term follow-up: Psychosocial outcome of Belgian transsexuals after sex reassignment surgery. *Sexologies*, 15(2), 126-133 (follow-up study on patients who had been treated by the Ghent multidisciplinary team since 1985 found that participants were functioning psychologically, socially, and professionally; found that the suicide attempt rate dropped from 29.3% to 5.1%); Wilson, E. C., Chen, Y., Arayasirikul, S., Wenzel, C., & Raymond, H. F. (2015). Connecting the dots: examining transgender women's utilization of transition-related medical care and associations with mental health, substance use, and HIV. *Journal of Urban Health*, 92(1), 182-192 (study of 314 transgender women finding that access to transition-related surgery and hormone therapy was associated with substantially lower suicidal ideation and other negative health outcomes); Imbimbo, C., Verze, P., Palmieri, A., Longo, N., Fusco, F., Arcaniolo, D., & Mirone, V. (2009). A report from a single institute's 14-year experience in treatment of male-to-female transsexuals. *The Journal of Sexual Medicine*, 6(10), 2736-2745 (finding reduced suicide attempt rate after surgery, as well as high levels of satisfaction); Bauer, G. R., Scheim, A. I., Pyne, J., Travers, R., & Hammond, R. (2015). Intervenable factors associated with suicide risk in transgender persons: a respondent driven sampling study in Ontario, Canada. *BMC Public Health*, 15(1), 1-15 (study of 380 transgender people finding that undergoing transition-related surgery was associated with a 62% reduction in past year suicidal ideation); Boza, C. & Nicholson Perry, K. (2014). Gender-related victimization, perceived social support, and predictors of depression among transgender Australians. *International Journal of Transgenderism*, 15(1), 35-52 (finding that respondents who have had some form of transition-related surgery were substantially less likely to present with symptoms of depression, as were respondents who reported higher levels of social support); Adams, N., Hitomi, M., & Moody, C. (2017). Varied reports of adult transgender suicidality: synthesizing and describing the peer-reviewed and gray literature. *Transgender Health*, 2(1), 60-75 (meta-analysis of research on suicidality noting that growing evidence indicates that "barriers to transition-related healthcare contribute to suicidality among those who desire such measures" and "it typically decreases once desired transitional goals are completed"); Moody, C., Fuks, N., Paláez, S., & Smith, N. (2015). "Without this, I would for sure already be dead": a qualitative inquiry regarding suicide protective factors among trans adults. *Psychology of Sexual Orientation and Gender Diversity*, 2(3), 266-280 (qualitative study of 133 transgender adults finding that transitioning, including accessing medical care, served as protective factor against suicide attempts).

<sup>41</sup> E.g., Public Policy Research Portal of Cornell University (2018); Dhejne, C., Van Vlerken, R., Heylens, G., & Arcelus, J. (2016). Mental health and gender dysphoria: a review of the literature. *International Review of Psychiatric*, 28(1) (review of 38 cross-sectional and longitudinal studies finding that levels of psychopathology and psychiatric disorders among transgender people improve following transition-related medical intervention); ; Schmidt, L. & Levine, R. (2015). Psychological outcomes and reproductive issues among gender dysphoric individuals. *Endocrinology and Metabolism Clinics of North America* 44(4), 773-785 (literature review of

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longitudinal outcome data finding improved psychological symptoms after surgical treatment); van de Grift, T. C., Elaut, E., Cerwenka, S. C., Cohen-Kettenis, P. T., Cuypere G. D., Richter-Appelt, H., & Kreukels, B.P. (2017). Effects of medical interventions on gender dysphoria and body image. *Psychosomatic Medicine*, 79(7), 815-823, <https://www.ncbi.nlm.nih.gov/pubmed/28319558> (longitudinal study finding substantially lower rates of gender dysphoria, psychological symptoms, and body dissatisfaction after surgical or hormone treatment); Heylens, G., Verroken, C., De Cock, S., T'Sjoen, G., & De Cuypere, G. (2014). Effects of different steps in gender reassignment therapy on psychopathology: a prospective study of persons with a gender identity disorder. *The Journal of Sexual Medicine*, 11(1), 119–126. (finding a “marked reduction in psychopathology...during the process of sex reassignment therapy”); Khobzi Rotondi, N., Bauer, G., Scanlon, K., Kaay, M., Travers, R., & Travers, A. (2011). Prevalence of and risk and protective factors for depression in female-to-male transgender Ontarians. *Canadian Journal of Community Mental Health*, 30(2), 135-155 (finding higher rates of depressive symptoms among participants who had never had surgery and participants who were planning but had not begun to receive transition-related care); Kraemer, B., Delsignore, A., Schnyder, U., & Hepp, U. (2008). Body image and transsexualism. *Psychopathology*, 41(2), 96-100 (lower levels of insecurity and anxiety after surgery); Gjis, L. & Brewaeys, A. (2007). Surgical treatment of gender dysphoria in adults and adolescents: recent developments, effectiveness, and challenges. *Annual Review of Sex Research*, 18(1), 178-224 (review of research on surgical care concluding that it is an effective in alleviating psychological symptoms); Owen-Smith, A.A., Gerth, J, Sineath R.C., Brazilay, J., et al. (2018). Association between gender confirmation treatments and perceived gender congruence, body image satisfaction, and mental health in a cohort of transgender individuals. *Journal of Sexual Medicine*, 15(4), 591-600. <https://www.ncbi.nlm.nih.gov/pubmed/29463478> (finding that transition-related care, including surgical care, is associated with substantially higher self-esteem and lower levels of depression and anxiety); Parola, N., Bonierbale, M., Lemaire, A., Aghababian, V., Michel, A., & Lançon, C. (2010). Study of quality of life for transsexuals after hormonal and surgical reassignment. *Sexologies*, 19(1), 24-28 (finding improved quality of life among patients after surgery); Ruppin, U. & Pfäfflin, Friedemann. (2015). Long-Term Follow-Up of Adults with Gender Identity Disorder. *Archives of Sexual Behavior*, 44(5), 1321-1329 (study of 71 transgender people 10 or more years after a legal name change, finding that participants showed significantly fewer psychological and interpersonal problems and a substantially increased life satisfaction at follow-up than at the time of the initial consultation); Papadopoulos, N. A., Zavlin, D., Lellé, J., Henrich, G., et al. (2017). Male-to-female sex reassignment surgery using the combined technique leads to increased quality of life in a prospective study. *Plastic and Reconstructive Surgery*, 140(2), 286-294 (prospective study found improved psychological symptoms and quality of life after surgery, compared to patients’ baseline preoperative responses); de Vries, A. L., McGuire, J. K., Steensma, T. D., Wagenaar, E. C., Doreleijers, T. A., & Cohen-Kettenis, P. T. (2014). Young adult psychological outcome after puberty suppression and gender reassignment. *Pediatrics*, 134(4), 696-704. <http://pediatrics.aappublications.org/content/early/2014/09/02/peds.2013-2958> (longitudinal study finding substantial improvements in psychological and social functioning after transition-related surgeries among young adults). In addition to studies generally examining the impact of surgical and other transition-related care, numerous studies focusing on specific types of surgeries have found improved psychological symptoms. E.g. Ainsworth, T. A. & Spiegel, J. H. (2010). Quality of life of individuals with and without facial feminization surgery or gender reassignment surgery. *Quality of Life Research*, 19(7), 1019-1024, <https://www.ncbi.nlm.nih.gov/pubmed/20461468> (finding that transgender women who had received genital and/or facial surgery had higher mental health-related quality of life than transgender women who had not received either surgery); Davis S. A. & Colton-Meier S. (2014). Effects of testosterone treatment and chest reconstruction surgery on mental health and sexuality in female-to-male transgender people. *International Journal of Sexual Health*, 26(2), 113–128 (finding that transgender men who had received treatment were less likely to report symptoms of depression and anxiety); Weigert, R., Frison, E., Sessiecq, Q., Al Mutairi, K., & Casoli, V. (2013). Patient satisfaction with breasts and psychosocial, sexual, and physical well-being after breast augmentation in male-to-female transsexuals, *Plastic and Reconstructive Surgery*, 132(6), 1421–1429 (finding increased psychological well-being and other health benefits after chest surgery among transgender women); Nelson, L., Whallett, E., & McGregor, J. (2009). Transgender patient satisfaction following reduction mammoplasty. *Journal of Plastic, Reconstructive & Aesthetic Surgery* 62(3), 331-334 (reduction mammoplasty for transgender people associated with high patient satisfaction and improved quality of life).

Significantly, no studies indicate that access to surgery increases suicidality. Previously, the Department of Defense relied upon a 2011 Swedish study<sup>42</sup> to argue that individuals who had received transition-related surgery were at a higher risk for mental health problems such as “increased mortality and psychiatric hospitalization.”<sup>43</sup> Importantly, this study did not, as the Department implies, suggest that transgender individuals who had received transition-related care were more likely to experience psychological symptoms than transgender individuals who did not receive transition-related treatment. Rather, the study compared transgender people with non-transgender people and found that transgender people were more likely to experience psychological symptoms than non-transgender people, although the rates of psychological symptoms and suicidality among transgender people decreased over time and became more similar to those of non-transgender people. The authors of the paper emphasize the following:

It is...important to note that the current study is only informative with respect to transsexuals persons health [sic] after sex reassignment; no inferences can be drawn as to the effectiveness of sex reassignment as a treatment for transsexualism. In other words, the results should not be interpreted such as sex reassignment *per se* increases morbidity and mortality. Things might have been even worse without sex reassignment. As an analogy, similar studies have found increased somatic morbidity, suicide rate, and overall mortality for patients treated for bipolar disorder and schizophrenia. This is important information, but it does not follow that mood stabilizing treatment or antipsychotic treatment is the culprit.<sup>44</sup>

There is no doubt that transgender people experience higher rates of suicidality than the general population and that those disparities are not entirely eliminated by providing access to transition-related care; as discussed below, numerous studies have found that the high levels of stigma, discrimination, and violence that transgender people experience are substantial risk factors for suicidality independently of access to transition-related care. However, what research demonstrates—and what the Dhejne et al. study does not call into question and in fact supports—is that transgender people who are able to access the care they need are far less likely to be at risk for suicidality than transgender people who are not.

Additionally, the study found substantial differences between individuals who underwent transition-related surgery prior to 1989 compared to those who did so after 1989. For example, the study found that while those who transitioned prior to 1989 had higher rates of suicidality than non-transgender people, while those who transitioned after 1989 had rates of suicidality that were not statistically significant compared to non-transgender people.<sup>45</sup> It is known that the functional outcomes of surgeries and patterns of anti-transgender discrimination—both of which

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<sup>42</sup> Dhejne, C., Lichtenstein, P., Boman, M., Johansson, A. V., Långström, N., & Landén, M. (2011). Long-term follow-up of transsexual persons undergoing sex reassignment surgery: cohort study in Sweden. *PLoS One*, 6(2), 1-8. [doi.org/10.1371/journal.pone.0016885](https://doi.org/10.1371/journal.pone.0016885)

<sup>43</sup> Department of Defense (2018). *Department of Defense Report and Recommendations on Military Service by Transgender Persons*. 25.

<sup>44</sup> Dhejne et al. (2011), p. 7.

<sup>45</sup> Dhejne et al. (2011), p. 6. See also Dhejne, C. et al. (2016), p. 52 (literature review by the lead author of the 2011 Swedish study noting that among those who transitioned after 1989, the study found “no difference in the number of suicide attempts compared to [non-transgender control.]”)



have shifted dramatically since 1989—substantially contribute to negative psychological outcomes.<sup>46</sup>

Experts agree that the mental health disparities faced by the transgender community, including rates of suicide ideation, do not reflect inherent pathology, but rather are associated with high levels of discrimination and stigma. As the American Psychiatric Association has stated, “[b]eing transgender or gender variant implies no impairment in judgment, stability, reliability, or general social or vocational capabilities; however, these individuals often experience discrimination due to a lack of civil rights protections for their gender identity or expression.”<sup>47</sup> Instead, studies of transgender veterans, as well as of transgender people overall, demonstrate that suicide ideation and other mental health disparities are associated with denials of care and higher levels of discrimination, including discriminatory policies and rejection in the military contexts. For example, a 2017 analysis of analysis of 6,308 transgender veterans in the Department of Veterans Affairs databases, found that suicide risk was strongly associated with experiences of violence, housing instability, and financial hardship.<sup>48</sup> Other studies reported similar findings among transgender veterans.<sup>49</sup> Studies of transgender people more generally have found that the health disparities they experience are driven by discrimination, rejection, and barriers to care and that those health disparities decrease substantially when transgender people are supported, including by having access to the health care they need without discrimination.<sup>50</sup> These findings were echoed by former military Surgeon Generals in their assessment of the Department of

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<sup>46</sup> See e.g. Dhejne et al. (2016).

<sup>47</sup> American Psychiatric Association (2012).

<sup>48</sup> Blossnich, J. R., Marsiglio, M. C., Dichter, M. E., Gao, S., et al. (2017). Impact of social determinants of health on medical conditions among transgender veterans. *American Journal of Preventive Medicine*, 52(4), 491-498

<sup>49</sup> Lehavot, K., Simpson, T. L., & Shipherd, J. C. (2016). Factors associated with suicidality among a national sample of transgender veterans. *Suicide and Life-Threatening Behavior*, 46(5), 507-524 (finding elevated suicide ideation and attempt rates among transgender veterans and finding that higher suicide attempt and ideation rates were associated with experiences of discrimination within and outside of the military); Tucker, R. P., Testa, R. J., Reger, M. A., Simpson, T. L., Shipherd, J. C., & Lehavot, K. (2018). 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 (finding that suicide ideation among transgender veterans in the past year and past two weeks is associated with higher levels of discrimination and rejection, including in military contexts)

<sup>50</sup> See e.g. Bockting, W. O., Coleman, E., Deutsch, M. B., Guillamon, A., Meyer, W., et al. (2016). Adult development and quality of life of transgender and gender nonconforming people. *Current Opinion in Endocrinology & Diabetes and Obesity*, 23(2), 188-197 (literature review finding that research points to a strong association between stigma and suicidality and depression among transgender people); Bockting, W. O., Miner, M. H., Swinburne Romine, R. E., Hamilton, A., & Coleman, E. (2013). Stigma, mental health, and resilience in an online sample of the US transgender population. *American Journal of Public Health*, 103(5), 943-951; Clements-Nolle, K., Marx, R., & Katz, M. (2006). Attempted suicide among transgender persons: the influence of gender-based discrimination and victimization. *Journal of Homosexuality*, 51(3), 53-69; House, A. A., Van Horn, E., Coppeans, C., & Stepleman, L. M. (2011). Interpersonal trauma and discriminatory events as predictors of suicidal and nonsuicidal self-injury in gay, lesbian, bisexual, and transgender persons. *Traumatology*, 17(2), 75-85; James, S. E., Herman, J. L., Rankin, S., Keisling, M., Mottet, L., & Anafi, M. (2016). *The report of the 2015 U.S. Transgender Survey*. Washington, DC: National Center for Transgender Equality (experiences of violence, discrimination, rejection, and inadequate access to care were associated with higher levels of psychological distress and suicide in a national sample of 27,715 adults); Moody, C. & Smith, N. (2013). Suicide protective factors among trans adults. *Archives of Sexual Behavior*, 42(4), 739-752; Perez-Brumer, A., Hatzenbuehler, M. L., Olbenburg, C. E., & Bockting, W. (2015). Individual- and structural-level risk factors risk factors for suicide attempts among transgender adults, *Behavioral Medicine*, 41(3), 164-171 (study of 1,229 transgender individuals finding an association between social stigma and lifetime suicide attempts).

Defense's Implementation Plan. The report noted that “[e]xtensive research has confirmed that both stigma and the denial of medically necessary care can lead to suicidality” and that military policies such as the ban on transgender service members have in fact “contributed to stigma and deprivation of health care” and exacerbated the problem of suicidality—just as a discriminatory exclusion of health care for transgender veterans would continue to do.<sup>51</sup>

### **Conclusion**

As outlined in this comment, medical experts, associations and numerous studies have overwhelmingly concluded that access to comprehensive transition-related care is effective, and has a marked impact on mental health, including by decreasing rates of suicidal ideation and behavior. The undersigned health care providers urge the VA to remove its exclusion of surgical treatment for gender dysphoria from the VA medical benefits package.

Dr. Nick Gorton

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<sup>51</sup> Arthur, D. C., Pollock, G., Steinman, A. M., Frank, N., Mazur, D. H., & Belkin, A. (2018). *DoD's Rationale for Reinstating Transgender Ban is Contradicted by Evidence*. Palm Center: San Francisco, California.