

OVERCOMING THE PARENTAL VETO:
HOW TRANSGENDER ADOLESCENTS
CAN ACCESS PUBERTY-SUPPRESSING
HORMONE TREATMENT IN THE
ABSENCE OF PARENTAL CONSENT
UNDER THE MATURE MINOR
DOCTRINE

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I. INTRODUCTION

Last year a seventeen-year-old transgender girl killed herself by walking in front of a truck.¹ Prior to her death, the teenager, who was born Joshua Alcorn but identified as female and called herself Leelah, posted a suicide note online describing her family’s negative reaction to her gender identity and her experience with conversion therapy.² In the note (which has been deleted from Alcorn’s Tumblr account at the request of her parents but has been archived by her supporters), Leelah expressed her hopelessness and despair in the face of her Christian parents’ refusal to

¹ Alejandro Alba, *Ohio Transgender Teen Left Online Note Before Suicide: ‘My Death Needs to Mean Something’*, NY DAILY NEWS (Jan. 1, 2015), <http://www.nydailynews.com/news/national/ohio-transgender-teen-leaved-online-note-suicide-article-1.2062844>.

² *Id.*

accept her identity.³ The note described Alcorn's belief that life could not get better if she had to wait to transition any longer:

When I was 16 I realized that my parents would never come around, and that I would have to wait until I was 18 to start any sort of transitioning treatment, which absolutely broke my heart. The longer you wait, the harder it is to transition. I felt hopeless, that I was just going to look like a man in drag for the rest of my life. On my 16th birthday, when I didn't receive consent from my parents to start transitioning, I cried myself to sleep.⁴

Bryan Lower, a writer and editor of *Slate Magazine's* LGBTQ section, wrote an article containing Leelah's last words and emphasized that the teenager's decision to take her own life was influenced not only by her family's lack of support and recognition of her identity, but also her inability to access treatment that would have helped to address her gender dysphoria.⁵ "[S]imply delaying the onset of puberty through the use of hormonal interventions—to minimize dysphoria and allow for a final decision at a later date—is emerging as a best practice; based on her testimony, such a treatment might have saved Alcorn's life had her parents allowed it."⁶ Leelah ended the note pleading, "My death needs to mean something. My death needs to be counted in the number of transgender people who commit suicide this year. I want someone to look at that number and say 'that's fucked up' and fix it. Fix society. Please."⁷ Leelah's suicide note attracted worldwide attention,⁸ sparking an outcry about the treatment of transgender people.⁹ In response to Leelah's highly public suicide, one mother of a transgender teenager, Roz Keith, has rallied other mothers of transgender children seeking to encourage love and support of transgender youth who have not received it at home.¹⁰ Unlike Leelah's parents, Mrs. Keith, the mother of a child born as a girl named Olivia who

³ Ed Pilkington, *Ohio Transgender Teen's Suicide Note: 'Fix Society. Please.'*, THE GUARDIAN (Jan. 5, 2015), <http://www.theguardian.com/world/2015/jan/05/sp-leelah-alcorn-transgender-teen-suicide-conversion-therapy>.

⁴ J. Bryan Lowder, *Listen to Leelah Alcorn's Final Words*, SLATE (Dec. 31, 2014), http://www.slate.com/blogs/outward/2014/12/31/leelah_alcorn_transgender_teen_from_ohio_should_be_honored_in_death.html.

⁵ *Id.*

⁶ *Id.*

⁷ *Id.*

⁸ Sharon Coolidge, *Transgender Teen: "My Death Needs to Mean Something."* CINCINNATI.COM (Dec. 31, 2014), <http://www.cincinnati.com/story/news/2014/12/30/transgender-teen-death-needs-mean-something/21044407/>.

⁹ Pilkington, *supra* note 3; see Andrew Buncombe, *Leelah Alcorn Suicide: Petition Calls for Transgender Teenager's Chosen Name to Be Used on Her Tombstone* (Jan. 1, 2015), <http://www.independent.co.uk/news/world/americas/leelah-alcorn-suicide-petition-calls-for-transgender-teenagers-chosen-name-to-be-used-on-her-tombstone-9953239.html>.

¹⁰ Kristen Jordan Shamus, *Transgender Teen's Acceptance an Act of Love for Family* (Mar. 10, 2015), <http://www.usatoday.com/story/news/nation/2015/03/10/transgender-teens-acceptance-an-act-of-love/24685557/>.

identified as male under the name Hunter, accepted her child's transgenderism and supported his transition.¹¹ Hunter currently takes "puberty blockers" to prevent normal female development from occurring, as well as testosterone hormone therapy.¹² In contrast to Leelah's tragic experience, Hunter gained confidence in expressing himself as his desired gender due to his family's overwhelming support.

Adolescents who suffer from gender dysphoria should have the option of taking hormone blockers that delay puberty (preventing the development of unwanted secondary sex characteristics), even in the absence of parental consent. While courts tend to defer to parental judgment regarding non-emergency treatment for their children, there are exceptions that allow minors to make their own decisions regarding medical treatment. One of these exceptions is the mature minor doctrine. Under this doctrine, "minors who are able to understand the nature and consequences of the medical treatment offered are considered mature enough to consent to or refuse the treatment."¹³ While the mature minor doctrine has not been clearly or consistently applied in the United States, it is the best option by which transgender adolescents can obtain treatment for their gender dysphoria. Courts should apply the mature minor doctrine when determining whether a transgender adolescent should have access to puberty blocking treatment in the absence of parental consent. In applying the mature minor doctrine, courts should take into consideration the minor's individual circumstances, the effectiveness of treatment, and the consequences of denying access to treatment. Finally, courts should determine the minor's maturity and capacity to consent by analyzing the following characteristics that influence adolescent decision making: peer pressure, impulsivity of the minor, and incompleteness of the minor's character. An objective and unbiased application of the mature minor doctrine based on the analysis of these factors should afford minors access to puberty-suppressing treatment and remove barriers to such treatment by eliminating liability for doctors who provide the treatment. As awareness and acceptance of transgender people increase, courts will likely face issues in split-family cases where only one parent supports treatment for the gender non-conforming child. In these cases, it may be in the best interests of the child for courts to apply the mature minor doctrine. Once the maturity of the minor is determined, the urgency and reversibility of the treatment should temper the court's

¹¹ Ronelle Grier, *Call Him Hunter*, DETROIT JEWISH NEWS (July 31, 2014), <https://www.thejewishnews.com/2014/07/31/call-him-hunter/>.

¹² *Id.*

¹³ Garry S. Sigman & Carolyn O'Connor, *Exploration for Physicians of the Mature Minor Doctrine*, 119 J. PEDIATRICS 520, 521 (1991).

concerns in allowing transgender adolescents to make their own transition-related medical care decisions.

Part I provides definitions of relevant terms. Part II introduces the challenges that transgender youth face. These challenges include issues resulting from external pressure from families and communities to conform to traditional gender expectations, obstacles to obtaining “reversible treatment” like hormone blockers, and the requirement of parental consent. Part III describes widely recognized exceptions to the general rule of parental consent. These exceptions are for emancipated minors, minors in need of emergency treatment, and minors seeking certain types of treatment for various conditions. Part IV presents the mature minor doctrine by describing its adoption by courts and state legislators, discussing the doctrine’s strengths as a legal argument for transgender adolescents and factors that courts take into account when assessing minor maturity. Part V discusses factors regarding puberty-suppressing treatment and gender dysphoria that will influence determinations of the maturity of transgender minors to seek such treatment. This part analyzes the age of the adolescent, the nature of gender dysphoria, and the benefits and effectiveness of treatment in combatting gender dysphoria. This part compares the circumstances of transgender adolescents accessing puberty-suppressing treatment to the circumstances of abortion. Part VI focuses on concerns regarding the maturity of adolescents. This part analyzes why mature pregnant minors have the right to obtain abortions without parental consent while criminal juveniles lack the maturity to be fully culpable for their crimes. Both types of circumstance are compared to the situation of adolescents seeking puberty-blocking treatment without parental consent. Part VII describes practical and financial factors that prevent transgender adolescents from obtaining treatment. This part also describes how the issue of accessing treatment without parental consent will arise in split-family cases.

II. DEFINITIONS

Transgender refers to “a diverse group of individuals whose gender does not match their biological sex at birth.”¹⁴ It is an umbrella term for people whose gender identity or expression is not typically associated with their birth sex.¹⁵ The adjective *gender non-conforming* is used to describe people’s behaviors that do not conform to society’s expectations of

¹⁴ Kimberly Tauches, *Transgender*, in *ENCYCLOPEDIA OF GENDER AND SOCIETY* 844, 844 (Jodi O’Brien ed., 2009).

¹⁵ *GLAAD Media Reference Guide – Transgender Issues*, GLAAD, <http://www.glaad.org/reference/transgender> (last visited Oct. 28, 2015).

masculinity and femininity.¹⁶ *Transgender* is distinguished from *gender non-conforming* because not all gender non-conforming people identify as transgender, nor are all transgender people gender non-conforming.¹⁷ These terms are preferable to *transsexual*, which “commonly refers to individuals who seek to live full time in a gender other than that which they were assigned at birth.”¹⁸ *Transsexual* is an older adjective that tends to be associated with those who seek to change their bodies through some surgical or medical intervention (including hormone therapy).¹⁹ Transsexual persons are distinct from *cross-dressers*, who dress in clothes culturally associated with the opposite sex but do not wish to permanently change their sex.²⁰ Since this Note focuses on how puberty suppressants allow adolescents to determine how strongly they desire medical intervention, it is best that these adolescents not be labeled transsexual.

Throughout the Note the terms *adolescent*, *minor*, *juvenile*, and *child* are used, sometimes interchangeably. However, because this Note focuses on the accessibility of treatment used during, or even before, puberty to delay the development of secondary sex characteristics, it is important to distinguish *adolescents* from *minors* and *children*. A *minor* is legally defined as a person below the age of majority (eighteen years of age in most states, although certain acts remain subject to further age related restrictions).²¹ *Child* may also refer to those below the legal age of majority or to anyone below the age of puberty.²² *Adolescent* generally describes an individual between puberty and adulthood (when a human being is fully developed, reaches sexual maturity, or attains the age of majority).²³ Adolescence and puberty are not the same. *Puberty* is “the experience of sexual maturation for girls and boys”²⁴ and encompasses hormonal, physical, and physiological changes in the body during the transition from

¹⁶ *Id.*

¹⁷ *Id.*

¹⁸ Kristen Schilt, *Transsexual*, in *ENCYCLOPEDIA OF GENDER AND SOCIETY* 860, 860 (Jodi O’Brien ed., 2009).

¹⁹ GLAAD, *supra* note 15.

²⁰ *Id.*; see also Schilt, *supra* note 18, at 860.

²¹ *Minor*, *ENCYCLOPEDIA BRITANNICA ONLINE*, <http://www.britannica.com/topic/minor> (last visited Oct. 29, 2015).

²² *Child*, *OXFORDDICTIONARIES.COM*, <http://www.oxforddictionaries.com/definition/english/child> (last visited Oct. 29, 2015).

²³ See *Adult*, *OXFORDDICTIONARIES.COM*, <http://www.oxforddictionaries.com/definition/english/adult> (last visited Oct. 29, 2015) (defining *adult* as “[a] person who is fully grown or developed”); see also *Adult*, *WEST’S ENCYCLOPEDIA OF AMERICAN LAW* (2d ed. 2008), <http://legal-dictionary.thefreedictionary.com/adult> (including the legal definition of the term *adult*).

²⁴ *ENCYCLOPEDIA OF CHILDREN AND CHILDHOOD: IN HISTORY AND SOCIETY* 701–02 (Paula S. Fass ed., 2004).

childhood to adulthood.²⁵ Puberty is characterized by the maturation of sexual organs and the development of secondary sex characteristics.²⁶ Secondary male characteristics include chest and facial hair growth, a deepening voice, and considerable growth in height and mass,²⁷ while secondary female characteristics include the development of breasts and widening of the hips.²⁸ Puberty in girls is also marked by beginning of menstruation cycles.²⁹ *Adolescence*, by contrast, is “the interval of emotional and psychological development between childhood and adulthood.”³⁰ While adolescence largely overlaps with puberty in terms of time, its boundaries are less distinct.³¹ The World Health Organization (WHO) defines an adolescent as any person between ages ten and nineteen.³² However, many American states have statutes that set the age range for adolescence at different years from the WHO.³³

Lastly, this Note will favor the use of the diagnostic term *gender dysphoria* over *gender identity disorder* (GID), in recognition of the changes made in the latest edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-V).³⁴ However, because GID has, until very recently, been used to identify transgender individuals, most studies and scholarship regarding trans-related issues use the term GID or use it interchangeably with gender dysphoria. For this reason, I will use the term GID when discussing research articles and pieces that use the term.

²⁵ THE GALE ENCYCLOPEDIA OF CHILDREN’S HEALTH: INFANCY THROUGH ADOLESCENCE 1830 (Jacqueline L. Longe ed., 2d ed. 2011).

²⁶ THE GALE ENCYCLOPEDIA OF SCIENCE 3580 (K. Lee Lerner & Brenda Wilmoth Lerner eds., 5th ed. 2014).

²⁷ *Id.* at 3582.

²⁸ *Id.*

²⁹ *Id.*

³⁰ THE GALE ENCYCLOPEDIA OF MEDICINE 3635 (Lauri J. Fundukian, ed., 4th ed. 2011).

³¹ *Id.*

³² *Adolescence*, ENCYCLOPEDIA BRITANNICA ONLINE, <http://www.britannica.com/science/adolescence> (last visited Oct. 29, 2015).

³³ For example, in New Mexico, an “*adolescent*” is a person aged thirteen through twenty. N.M. STAT. ANN. § 23-9-2(A) (West 1998). In Florida, an *adolescent* means “a person who is at least 13 years of age but under 18 years of age.” FLA. STAT. ANN. § 394.492(1) (West 2014).

³⁴ In 2012 the American Psychiatric Association’s board of trustees approved changing the latest Diagnostic and Statistical Manual of Mental Disorders (DSM-5) by replacing “Gender Identity Disorder” with “Gender Dysphoria,” which will be used to describe emotional distress over “a marked incongruence between one’s experienced/expressed gender and assigned gender.” Dani Heffernan, *The APA Removes “Gender Identity Disorder” From Updated Mental Health Guide*, GLAAD (Dec. 3, 2012), <http://www.glaad.org/blog/apa-removes-gender-identity-disorder-updated-mental-health-guide>. The change “better characterize[s] the experiences of affected children, adolescents, and adults,” and is aimed at helping transgender individuals “avoid stigma and ensure clinical care for individuals who see themselves to be a different gender than their assigned gender . . . it is important to note that gender nonconformity is not itself a mental disorder.” *Gender Dysphoria*, AM. PSYCHIATRIC PUB., <http://www.dsm5.org/documents/gender%20dysphoria%20fact%20sheet.pdf> (last visited Oct. 29, 2015). This change was lobbied by those who believed that “Gender Identity Disorder” contributed to the stigma against transgender people by characterizing trans-people as mentally ill. Camille Beredjick, *DSM-V to Rename Gender Identity Disorder “Gender Dysphoria,”* ADVOCATE.COM (July 23, 2012), <http://www.advocate.com/politics/transgender/2012/07/23/dsm-replaces-gender-identity-disorder-gender-dysphoria>.

III. CHALLENGES FACING TRANSGENDER ADOLESCENTS

There is no dearth of scholarship documenting the challenges that transgender youth face.³⁵ “In addition to the exogenous factors of rejection, maltreatment, and victimization, youth who self-identity as transgender also experience personal distress and isolation. A primary area of distress is a gender dysphoria . . .”³⁶ Transgender teens and adults face significant health and social risks,³⁷ partly stemming from the hostile social response to gender dysphoria.³⁸ A 2011 study of 201 adolescents admitted to a gender identity clinic in Amsterdam showed that “the majority of gender dysphoric adolescents do not have any comorbid psychiatric disorder, despite their increased suffering from the incongruence between experienced and assigned gender at the start of puberty.”³⁹ This suggests that many difficulties experienced by transgender people result from “conflict with the external environment . . . rather than internal pathology.”⁴⁰ Transgender youth have reported parental rejection to be a particular stressor.⁴¹

A. RESISTANCE TO TREATMENT BY ONE OR BOTH PARENTS

Perhaps the most significant challenge that transgender youth face comes from their families. Transgender youth often endure rejection, neglect, and abuse at home, and sometimes find themselves turned away from their homes entirely.⁴² Transgender youth are at a higher risk of physical and psychological harm than other categories of gender non-conforming youth, and those risks are “especially high when families

35 *Articles on Lesbian, Gay, Bisexual, and Transgender Populations*, STATE U. OF N.Y., U. BUFFALO, SCH. SOCIAL WORK, http://socialwork.buffalo.edu/content/dam/socialwork/home/teaching-resources/Articles_Lesbian_Gay_Bisexual_Transgender%20Population.pdf (last visited Sept. 3, 2015).

36 Arnold H. Grossman & Anthony R. D’Augelli, *Transgender Youth and Life-Threatening Behaviors*, 37 *SUICIDE & LIFE-THREATENING BEHAVIOR* 527, 528 (2007).

37 Joy Jacobson, *Helping Transgender Children and Teens*, 113 *AM. J. NURSING* 18, 18 (Oct. 2013).

38 TransPulse E-Bulletin, *Ontario’s Trans Communities and Suicide: Transphobia is Bad for Our Health*, TRANSPULSE (Nov. 12, 2010), <http://transpulseproject.ca/research/ontarios-trans-communities-and-suicide/>.

39 Annelou L.C. de Vries, Theo A.H. Doreleijers, Thomas D. Steensma & Peggy T. Cohen-Kettenis, *Psychiatric Comorbidity in Gender Dysphoric Adolescents*, 52 *J. CHILD PSYCHOL. & PSYCHIATRY* 1195, 1195 (2011). “Psychiatric comorbidity” is used to refer to gender dysphoric adolescents who had other concurrent psychiatric disorders. According to the authors of the study, while “67.6% of the 105 assessed adolescents had no concurrent psychiatric disorder, 32.4% had at least one and 15.2% had two or more comorbid diagnoses.” *Id.* at 1199.

40 Sonja Shield, *The Doctor Won’t See You Now: Rights of Transgender Adolescents to Sex Reassignment Surgery*, 31 *N.Y.U. REV. L. & SOC. CHANGE* 361, 382 (2007).

41 Ann P. Haas, et. al., *Suicide and Suicide Risk in Lesbian, Gay, Bisexual, and Transgender Populations: Review and Recommendations*, 58 *J. HOMOSEXUALITY* 10, 27 (2011).

42 Julie Anne Howe, *Transgender Youth, the Non-Medicaid Reimbursable Policy, and Why the New York City Foster Care System Needs to Change*, *DUKEMINIER AWARDS* 1, 6 (2012).

exhibit rejecting behaviors toward their transgender children.”⁴³ For instance, according to a 2007 article based on reports from fifty-five transgender youth on their life-threatening behaviors (which included suicide attempts and thoughts of suicide), 73 percent of the youths reported being verbally abused by their parents.⁴⁴ Those who attempted suicide reported more verbal and physical abuse by their parents than those who did not attempt suicide.⁴⁵ Finally, the National Transgender Discrimination Survey from the National Center for Transgender Equality and the National Gay and Lesbian Task Force found that family rejection dramatically increased the likelihood of suicide attempts, with 51 percent of transgender respondents who experienced family rejection reporting having attempted suicide, compared to 32 percent of those whose families did not reject them.⁴⁶ Thus, the increased rate of suicide and depression “is more precisely linked to family rejection of a child’s gender expression or sexual orientation—not to the gender or sexual variance itself, and not to social pressure to conform to gender stereotypes.”⁴⁷

1. *Barriers to Treatment*

Transgender adolescents face significant barriers to transition-related hormonal treatment. All states require parental consent for most medical care provided to minors,⁴⁸ and many courts adopt the view that a minor child cannot consent to medical or surgical treatment.⁴⁹ Certain guidelines regarding the provision of transition-related treatment to transgender people, such as the World Professional Association for Transgender Health (WPATH) Standards of Care (SOC), also impose significant requirements that transgender people must meet to be eligible for treatment. Finally, several court cases exist that address the issue of medical intervention for children who exhibit symptoms of gender dysphoria. These cases involve split-family custody disputes. One custody case in particular demonstrates the challenges that transgender adolescents may face in the form of bias and misunderstanding by judges in regards to gender dysphoria.

43 David Alan Perkiss, *Boy or Girl: Who Gets to Decide? Gender-Nonconforming Children in Child Custody Cases*, 25 HASTINGS WOMEN’S L.J. 57, 61 (2014).

44 Grossman & D’Augelli, *supra* note 36, at 534.

45 *Id.*

46 JAIME M. GRANT ET AL., INJUSTICE AT EVERY TURN: A REPORT OF THE NATIONAL TRANSGENDER DISCRIMINATION SURVEY, NAT’L GAY & LESBIAN TASK FORCE and NAT’L CENTER FOR TRANSGENDER EQUALITY 101 (2011), http://www.thetaskforce.org/static_html/downloads/reports/reports/ntds_full.pdf.

47 Erika Skougard, Note, *The Best Interests of Transgender Children*, UTAH L. REV. 1161, 1175 (2011).

48 *See infra* Part II.B.1.

49 *Id.*

a. *Parental Consent Requirements*

Parental rejection not only influences the psychological distress of transgender adolescents, but also presents a legal barrier to treatment that they need to address their gender dysphoria. For instance, most minors below the age of consent may not authorize their own medical care.⁵⁰ In order to engage in medical decisionmaking, patients have to have the legal capacity to do so. That is, the patient has to be a *competent* adult.⁵¹ An incompetent patient is a patient who “is found by a court to be insane, inadequate, or to *not be an adult*. In such instances, consent [generally] must be obtained from a parent, legal guardian, or the court on behalf of the patient.”⁵² A minor patient is thus deemed by law to be incompetent by virtue of his or her age.⁵³

The Supreme Court has also held that “the Due Process Clause of the Fourteenth Amendment protects the fundamental right of parents to make decisions concerning the care, custody, and control of their children.”⁵⁴ Parents also enjoy a rebuttable presumption that they are acting in the best interests of their children.⁵⁵ The Court justified limiting the scope of minors’ constitutional rights on the assumption that minors do not possess “the capacity to take care of themselves”⁵⁶ and that “during the formative years of childhood and adolescence, minors often lack the experience, perspective, and judgment to recognize and avoid choices that could be detrimental to them.”⁵⁷ Finally, not only are children subject to the control of their parents, but the government “validly may limit the freedom of children to choose for themselves in the making of important, affirmative choices with potentially serious consequences.”⁵⁸ Thus, parental consent is required by most jurisdictions.⁵⁹ The requirement of parental consent is also reflected in medical guidelines on treatment for transgender adolescents, which may impose additional barriers to treatment.

50 Schall v. Martin, 467 U.S. 253, 265 (1984).

51 Dalizza D. Marques-Lopez, Comment, *Not so Gray Anymore: A Mature Minor’s Capacity to Consent to Medical Treatment* (Oct. 2006), <https://www.law.uh.edu/healthlaw/perspectives/2006/%28DM%29MatureMinor.pdf>.

52 WILBURTA Q. LINDH ET AL., DELMAR’S COMPREHENSIVE MEDICAL ASSISTING: ADMINISTRATIVE AND CLINICAL COMPETENCIES 120 (5th ed. 2013) (emphasis added).

53 Marques-Lopez, *supra* note 51.

54 Troxel v. Granville, 530 U.S. 57, 66 (2000).

55 Parham v. J. R., 442 U.S. 584, 624 (1979) (“To be sure, the presumption that a parent is acting in the best interests of his child must be a rebuttable one, since certainly not all parents are actuated by the unselfish motive the law presumes.”).

56 Schall v. Martin, 467 U.S. 253, 265 (1984).

57 Bellotti v. Baird, 443 U.S. 622, 635 (1979); *see infra* Part V.C.

58 *Id.*

59 Doriane Lambelet Coleman & Philip M. Rosoff, *The Legal Authority of Mature Minors to Consent to General Medical Treatment*, 131 PEDIATRICS 786, 792 (2013).

b. *Medical Guidelines*

Medical guidelines and protocols have been developed to guide the treatment of transsexual, transgender, or gender non-conforming people. The most recognized is the WPATH SOC for the Health of Transsexual, Transgender, and Gender-Nonconforming People.⁶⁰ Formerly the Harry Benjamin International Gender Dysphoria Association, WPATH is a professional organization devoted to transgender health, and it promotes extensive psychiatric assessment prior to treatment.⁶¹ For instance, the SOC encourages “extensive exploration of psychological, family, and social issues” before physical interventions are considered for adolescents.⁶² In addition, one of four criteria that it specifies in order for adolescents to receive puberty-suppressing hormones is that the “adolescent has given informed consent and, particularly when the adolescent has not reached the age of medical consent, the parents or other caretakers or guardians have consented to the treatment and are involved in supporting the adolescent throughout the treatment process.”⁶³

While this requirement might seem to undermine the argument that transgender adolescents should access puberty-suppressing hormones in the absence of parental consent, these guidelines were created to help health professionals promote transgender health while respecting the laws of jurisdictions in which the health professionals practice.⁶⁴ In the United States, “the general rule . . . is that minors are legally incompetent to make medical decisions on their own behalf; thus a physician may not treat a minor without the consent of a parent or guardian.”⁶⁵ Without proper consent from parents or guardians, medical professionals can be held liable

60 Lois Jeannine Bookhardt-Murray, *Care of the HIV-Infected Transgender Patient*, MEDSCAPE (Apr. 10, 2012), <http://www.medscape.com/viewarticle/761434> 11. (“The World Professional Association for Transgender Health (WPATH) *Standards of Care*, formerly known as the Harry Benjamin International Gender Dysphoria Association, has recently updated the *WPATH Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People*. Since its first release in 1979, the *WPATH Standards of Care* have been the most recognized standards of care for transgender patients.”) Major corporations like Google have also recognized the WPATH Standards of Care by increasing coverage of transgender healthcare for US employees in accordance with the protocols. A Google spokesman even stated: “As the WPATH Standards of Care are considered the highest standards of care for transgender individuals, we agreed to cover the full range of procedures under WPATH.” See *At Google, a Transgender “Gold Standard”*, ADVOCATE.COM (Nov. 22, 2011), <http://www.advocate.com/business/2011/11/22/google-transgender-gold-standard>.

61 Eli Coleman et al., *The World Prof'l Ass'n For Transgender Health, Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People, Version 7*, 13 INT'L J. TRANSGENDERISM 165, 166 (2007).

62 *Id.*

63 *Id.* at 167.

64 The conflict between what is ethical and what is legal has been raised in various medical and legal articles. *E.g.*, Sigman & O'Connor, *supra* note 13, at 520 (“Ethical decisions regarding consent and confidentiality should be distinguished from legal requirements”); Coleman & Rosoff, *supra* note 59, at 792 (“Ethics is thus continuously operating in the interstices of the law”).

65 Sigman & O'Connor, *supra* note 13, at 521.

for battery if medical treatment is given.⁶⁶ Due to the existence in most states (as well as other countries) of legal rules limiting adolescent decisionmaking in the absence of parental consent, the parental consent requirement was probably included to protect health professionals from liability. This is supported by the existence of risk management guides advising providers to make themselves less vulnerable to litigation by complying with all state and federal regulations and statutes.⁶⁷

Given the serious repercussions of denying treatment to transgender adolescents, discussed later in this Note,⁶⁸ a rigid interpretation of the parental consent criterion in the SOC may represent deference to laws inconsistent with reasonable and proper medical practice.⁶⁹ This conclusion is supported by the fact that the SOC, as well as other guidelines, encourage mental health professionals to encourage families to “have an accepting and nurturing response to the concerns of their gender dysphoric child or adolescent.”⁷⁰

In fact, other sets of standards, protocols, and guidelines exist that place less importance on parental consent, focusing primarily on the needs of the transgender child. For example, the Endocrine Society (a professional international organization devoted to research on hormones and clinical practice of endocrinology) released its own clinical guidelines regarding endocrine treatment of transsexual persons. According to these guidelines, while obtaining consent is preferred (since parental support helps improve the outcome of hormonal treatment), “parental consent may not be required.”⁷¹ By encouraging doctors to help families understand and support their transgender child, guidelines like the SOC or those of the Endocrine Society place great importance on addressing gender dysphoria in children. However, when a transgender adolescent or child is rejected by

66 LINDH ET AL., *supra* note 52, at 120.

67 *Id.*

68 *See infra* part V.B.1.

69 The legal repercussions for doctors and health professionals should a lawsuit occur as a result of not first obtaining parental consent can be serious. *See, e.g.,* Sigman & O'Connor, *supra* note 13, at 522 (“Ethics notwithstanding, any medical treatment of an adolescent resulting in a poor outcome may become the subject of a lawsuit by parents who claim that the physician did not secure their consent”). For example, one court held that “generally speaking, the rule has been considered to be that a surgeon has no legal right to operate upon a child without the consent of his parents or guardian . . .” and that “a surgical operation is a technical battery, regardless of its results, and is excusable only when there is express or implied consent by the patient; or stated somewhat differently, the surgeon is liable in damages if the operation is unauthorized . . .” *Bonner v. Moran*, 126 F.2d 121, 122 (D.C. Cir. 1941). Thus, treatment could amount to assault and battery for which damages are recoverable should it be performed without the parental consent (although liability is probably more likely when the treatment is major and invasive, like surgical operations, and/or of only limited benefit for the minor). *See id.*

70 Coleman et al., *supra* note 61, at 166.

71 Wylie C. Hembree et al., *Endocrine Treatment of Transsexual Persons: An Endocrine Society Clinical Practice Guideline*, 94 J. CLINICAL ENDOCRINOLOGY & METABOLISM 3132, 3142 (2009).

her or his family, not only does the minor suffer from this rejection, but she or he is completely denied the most effective treatment for addressing their gender dysphoria.⁷²

Treatments like psychotherapy (including counseling and supportive therapy) may help reduce distress related to gender dysphoria (although there have been no systematic studies on the effects of this supportive psychotherapy),⁷³ but don't get at the heart of the problem—the development of unwanted permanent secondary sex characteristics. The onset of puberty in transgender youth is often accompanied by increased gender dysphoria, or distress related to the “incongruence between one's affirmed gender and one's assigned (or natal) gender.”⁷⁴ Attempts to “cure” individuals of their gender dysphoria through psychotherapy are “not considered fruitful by the mental health professionals with the most experience working in this area.”⁷⁵ Psychotherapy may be helpful, but only physical interventions like puberty-suppressing hormonal treatment can allow individuals to “buy time” to think about their gender identity.⁷⁶ It makes little sense to encourage parents to maintain a “safe and supportive environment for their transitioning child” aimed at alleviating gender dysphoria,⁷⁷ yet completely deny treatment for the child if those parents reject their child's expressed gender identity and refuse to consent to treatment.

c. Parental Disagreements, the Best Interests of Transgender Children, and Judicial Discretion

In addition to these hurdles to hormonal treatment, transgender minors must also confront misconceptions—if not outright bias—that attorneys and judges may have regarding their gender dysphoria. Advocates and experts maintain that transgender people often face judicial bias and misconceptions about their status in court.⁷⁸ While there have been no

⁷² See *infra* Part V.iii.

⁷³ William Byne et al., *Report of the American Psychiatric Association Task Force on Treatment of Gender Identity Disorder*, 41 ARCHIVES SEXUAL BEHAV. 759, 774 (2012).

⁷⁴ Stephen M. Rosenthal, *Approach to the Patient: Transgender Youth: Endocrine Considerations*, 99 J. CLINICAL ENDOCRINOLOGY & METABOLISM, 4379, 4379 (2014).

⁷⁵ Byne, *supra* note 73, at 744.

⁷⁶ Norman Spack, *Dateline: Hormone Treatment 'Buys Time' for Transgender Kids*, NBCNEWS.COM (July 8, 2012), <http://www.nbcnews.com/video/dateline/48108671#48108671>.

⁷⁷ Coleman et al., *supra* note 61 at 167.

⁷⁸ See *Transgender Clients in Court: Navigating Complex Family Laws and Judicial Bias*, A.B.A. (Aug. 24, 2012), http://americanbar.org/news/abanews/aba-news-archives/2013/08/transgender_clients.html (describing the challenges that transgender people face in family law courts, including navigating confusing marital laws and dealing with a judicial climate that is “hostile” to transgendered parents). A report released by Legal Services for Children, National Juvenile Defender Center, and the National Center for Lesbian Rights also found bias against LGBT youth by the juvenile justice system. KATAYOON MAID, JODY MARKSAMER & CAROLYN REYES, LEGAL SERVICES FOR CHILDREN, NATIONAL JUVENILE DEFENDER CENTER & NATIONAL CENTER FOR LESBIAN

published cases in the United States considering the appropriateness of hormonal interventions,⁷⁹ some judicial decisions considering the treatment of gender dysphoric adolescents reveal that judges may be influenced by misconceptions about gender identity. These decisions involve courts attempting to resolve disputes between parents who are separated or divorced and who do not agree about the best way to handle their child's gender non-conformity.

For instance, in *Smith v. Smith*, an Ohio court decided a custody dispute involving a nine-year-old child assigned as male at birth who expressed a strong desire to live as a girl.⁸⁰ After learning that his ex-wife enrolled the child in a new school as a girl under the name Christine, and that she intended to subject the child to hormonal therapy and surgery to alter the child's gender, the father filed a motion for reallocation of parental rights and requested to be designated the residential parent, which the trial court granted.⁸¹ In an unpublished decision, the Ohio Court of Appeals affirmed that decision and transferred custody to the father. The judge agreed with the father that (despite statements from the child expressing the desire to be a girl and a desire to stay with the mother)⁸² the child did not have GID and agreed with the trial court that the mother rather than GID was the cause of the child's gender-nonconformity.⁸³ While the court recognized the presumption that retaining the original residential parent is in the best interests of the child, it nevertheless transferred custody on the basis that this presumption was rebutted by evidence that the residential parent (the mother) was harming the child by encouraging the child's gender-nonconformity.⁸⁴ The appellate judge's reasoning has been extensively critiqued. For instance, Erika Skougard summarized her issues with the decision:

First, the court failed to recognize serious problems with key expert testimony. Second, in evaluating [the child]'s own testimony, the court discounted strong, direct evidence of [the child]'s preference to live as a girl

RIGHTS, HIDDEN INJUSTICE: LESBIAN, GAY, BISEXUAL, AND TRANSGENDER YOUTH IN JUVENILE COURTS, LEGAL SERVICES FOR CHILDREN 2 (2009), http://www.equityproject.org/wp-content/uploads/2014/08/hidden_injustice.pdf (“The juvenile system is characterized by a profound lack of acceptance of LGBT identity, based in large part on misconceptions about sexual orientation and gender identity”).

⁷⁹ A search, using Westlaw and Lexis Advance, of cases involving issues of parental custody and hormonal treatment of transgender youth yielded no published cases at time of writing.

⁸⁰ See generally, *Smith v. Smith*, 2007-Ohio-1394 (Ohio Ct. App. 2007).

⁸¹ *Id.* at *1–2.

⁸² *Id.* at *2–3.

⁸³ *Id.* at *5, *11 (“The court believed that Appellant had been encouraging her son to be a girl from at least age 4” and that “the child acted like a girl only when he was around his mother, and seemed to have no trouble behaving like a typical boy when he was with his father. The court concluded that Appellant may be forcing her son to become a girl.”).

⁸⁴ *Id.* at *11.

in favor of weaker evidence (or the unsupported presumption) that this preference was either disingenuous or the product of his mother's deliberate manipulation. Third, the record does not support conclusions the court made regarding [the child]'s mother's actions—at most, the court's conclusions represent only the most cynical of all possible interpretations of available facts.⁸⁵

“[S]cholarship about legal issues surrounding gender-nonconforming individuals [shows] that bias and stereotypes play a role in the outcomes of these custody cases[,]”⁸⁶ as this decision suggests.

In custody cases like *Smith*, courts apply a best interests of the child standard, which is generally consistent with § 402 of the Uniform Marriage and Divorce Act (UMDA).⁸⁷ According to the American Law Report *Initial Award or Denial of Child Custody to Homosexual or Lesbian Parent*, courts derive broad discretionary power from the “best-interests-of-the-child” standard embodied in both state statutes and judge-made law. This legal standard gives courts extraordinary latitude in determining what the court believes is in the child’s “best interests” in light of all the factors which could adversely or beneficially affect the child. Any conflict the court perceives as between the child’s best interests and the parents’ rights must be resolved in favor of the child.⁸⁸

Section 402 of the UMDA provides relevant factors that courts should consider in determining custody,⁸⁹ including “the wishes of the child as to his custodian” and “the mental and physical health of all individuals involved.”⁹⁰ However, the judge in *Smith*, completely discounted the evidence of the child’s female gender identity feelings. While the court admitted that “the child’s apparent gender identity problems were having an adverse effect on him, to the point that he discussed suicide,” it argued that this *supported* potentially changing custody of the child to the unsupportive parent.⁹¹ The court believed that the mother, by supporting the child’s gender identity, was the cause of his problems,⁹² despite “the consensus of the psychological profession . . . that gender identity is determined by innate, not external factors.”⁹³

85 Skougard, *supra* note 47, at 1182–83 (2011).

86 Perkiss, *supra* note 43, at 77.

87 See generally UNIF. MARRIAGE & DIVORCE ACT § 402 (1973).

88 Elizabeth Trainor, Annotation, *Initial Award or Denial of Child Custody to Homosexual or Lesbian Parent*, 62 A.L.R.5th 591 (1998).

89 See generally UNIF. MARRIAGE & DIVORCE ACT § 402.

90 *Id.*

91 *Smith v. Smith*, 2007-Ohio-1394, *11 (Ohio Ct. App. 2007).

92 *Id.* (arguing that the trial court properly made a finding that the advantages of changing custody from the supportive mother to the father outweighed the harm. The appellate court agreed with the trial court’s conclusion that “Appellant may be forcing her son to become a girl.”)

93 Perkiss, *supra* note 43, at 73–74.

It is possible that the judge's decision was not improper, as there is evidence that symptoms of gender dysphoria in many children do not persist into adulthood.⁹⁴ Moreover, the main issue discussed by the courts was whether the child had GID, and both parents provided expert witnesses to testify about GID.⁹⁵ The court's own designated psychologist stated that the "[a]ppellant's decision to treat the boy as if he were a girl and as if he had GID was a mistake."⁹⁶ So, it is possible that the trial and appellate court judges were justified in their skepticism of whether the child was really transgender or had been properly diagnosed with GID.⁹⁷ However, Skougard points out serious problems with how the appellate court reached its decision, and criticizes the extreme measures taken to prevent the child from being with the supportive parent.⁹⁸ She argues that the appellate judge conducted his own personal investigation into the GID diagnoses and allowed his personal views regarding Christine's behavior to overshadow the analysis.⁹⁹ In addition, the court-designated psychologist had no experience with childhood gender identity issues, and admitted that "this was the most difficult case he had ever dealt with."¹⁰⁰ David Perkiss, in his criticism of the decision, maintains that the court's decision to make the father the sole residential parent so that the child could find out if he "really was a transgender child" was misguided.¹⁰¹ "The more logical and prudent course of treatment would have been to proceed with hormone treatment because its effects are reversible and have no known negative consequences. Thus, the court's decision actually foreclosed Christine's options, rather than maintain them as it thought it did."¹⁰²

To avoid such a scenario, it is crucial that courts take into account the transgender minor's desires and ability to understand the consequences of

94 Coleman et al., *supra* note 61.

95 *Smith*, 2007-Ohio-1394 at *3.

96 *Id.* at *6.

97 Whether the child had been properly diagnosed with GID was discussed extensively by the appellate and trial courts. The appellate court agreed with the trial court's conclusion that "the child did show interest in girl's clothing, but that he did not have GID, should not be treated for it, and that Appellant could not be trusted to obey any court orders concerning the child's gender confusion." *Id.* at *11.

98 Skougard, *supra* note 47, at 1182–93 (Each parent was initially designated as residential parent during their periods of custody, but the courts found that the "harm" caused by the mother's supportive approach justified designated the father as the sole residential parent and only allowing the mother to file her request for change of custody "should the circumstances change").

99 Skougard, *supra* note 47, at 1183 ("To resolve the experts' disagreement about Ben's diagnosis, the judge personally compared the DSM-IV criteria to his own observations of Ben and concluded that Ben did not have GID. Specifically, the judge explained that during his *in camera* interview with Ben, the child had not been specific enough when describing his preference for 'girl stuff,' and that in the judge's view, Ben's mannerisms were not feminine enough for Ben to have GIDC.").

100 *Smith*, 2007-Ohio-1394 at *6; *see* Perkiss, *supra* note 43, at 73; *see* Skougard, *supra* note 52, at 1185.

101 Perkiss, *supra* note 43, at 74.

102 Skougard, *supra* note 47, at 1182–83.

hormone treatment. By incorporating the mature minor doctrine in custody determinations, courts will be able to make non-biased decisions in the best interests of the minor. Even in non-custody decisions and in the absence of parental support, transgender adolescents should be able to access puberty-suppressing hormonal treatment as long as they are deemed sufficiently mature.

IV. EXCEPTIONS TO THE PARENTAL CONSENT REQUIREMENT

“[E]xceptions to a parent’s right to decide have hemmed in the reach of parental autonomy in a number of important areas.”¹⁰³ There has been a noticeable shift from an absolute parental right to parents being viewed as “fiduciaries entrusted with their children’s welfare.”¹⁰⁴ The Supreme Court has recognized that “[c]onstitutional rights do not mature and come into being magically only when one attains the state-defined age of majority. Minors, as well as adults, are protected by the Constitution and possess constitutional rights.”¹⁰⁵ The Court also “does not question that exceptions from a parental notice requirement are necessary for minors emancipated from the custody or control of their parents . . . and for minors able to demonstrate their maturity for the purpose of choosing to have an abortion.”¹⁰⁶ The Court also “acknowledges the need for an exception where parental notification interferes with emergency medical treatment.”¹⁰⁷ Finally, certain state exceptions to the parental consent rule allow minors to consent to their own health and medical care.¹⁰⁸ While this Note will discuss these exceptions and their usefulness as arguments for obtaining puberty-blocking treatment, its primary focus will be on the mature minor exception.

A. EMANCIPATION AND EMERGENCY EXCEPTIONS

“Under the common law of emancipation, a minor who is ‘not living at home and is self-supporting, is responsible for himself economically and otherwise, and whose parents (voluntarily or involuntarily) have surrendered their parental duties and rights,’ may be adjudicated an

¹⁰³ Cara D. Watts, *Asking Adolescents: Does a Mature Minor Have a Right to Participate in Health Care Decisions?*, 16 HASTINGS WOMEN’S L.J. 221, 228 (2005).

¹⁰⁴ *Id.* at 229.

¹⁰⁵ *Planned Parenthood of Cent. Mo. v. Danforth*, 428 U.S. 52, 74 (1976).

¹⁰⁶ *H. L. v. Matheson*, 450 U.S. 398, 429 (1981).

¹⁰⁷ *Id.*

¹⁰⁸ *See infra* Part IV. III.B.

emancipated minor.”¹⁰⁹ “As a general principal, a teen who is legally emancipated can consent to his or her own medical care.”¹¹⁰ While the minor emancipation laws vary, in many states “the attainment of majority, marriage, and entry into military service have long been recognized as bringing about the emancipation of a minor child.”¹¹¹ This is significant because many transgender youth, due to family rejection, are left to fend for themselves.¹¹² For transgender adolescents who live independently of their parents, emancipation is one solution that would allow them to assume control over their own medical care, and thus obtain treatment for gender dysphoria. However, emancipation is probably not the best option for many transgender adolescents seeking hormonal treatment. “An unfortunate effect of the emancipation doctrine is that it provides adolescents with an incentive to leave their parental home, perhaps prematurely. As a policy matter, we should encourage families to stay together to the extent possible.”¹¹³

The emergency exception is even more limited. Many cases have held that life-threatening circumstances requiring immediate medical attention for minors constitute an emergency that justified treatment without obtaining parental consent.¹¹⁴ While the denial of puberty-suppressing treatment for transgender minors may lead to permanent secondary sex-related physical changes that exacerbate their gender dysphoria-related psychological issues, including increased suicidal tendencies,¹¹⁵ it is unlikely that a court would count this as a life-threatening emergency justifying treatment.¹¹⁶ Thus, because courts have interpreted “emergency”

109 J. Shoshanna Ehrlich, *Grounded in the Reality of Their Lives: Listening to Teens Who Make the Abortion Decision Without Involving Their Parents*, 18 BERKELEY WOMEN'S L.J. 61, 74–75 (2003) (quoting ANGELA RODDEY HOLDER, *LEGAL ISSUES IN PEDIATRICS AND ADOLESCENT MEDICINE* 34 (2d ed. 1985)).

110 *Id.* at 74.

111 Alice M. Wright, Annotation, *What Voluntary Acts of Child, Other than Marriage or Entry into Military Service, Terminate Parent's Obligation to Support*, 55 A.L.R.5th 557 (1998).

112 “[B]ecause youth are coming out as transgender or dressing in clothing thought appropriate only for the other sex at earlier ages, a significant number are being kicked out of family homes.” LISA MÖTTET & JOHN M. OHLE, NAT’L COAL. FOR THE HOMELESS AND THE NAT’L GAY & LESBIAN TASK FORCE POLICY INST., *TRANSITIONING OUR SHELTERS: A GUIDE TO MAKING HOMELESS SHELTERS SAFE FOR TRANSGENDER PEOPLE* 23 (2013).

113 Shield, *supra* note 40, at 422.

114 Danny R. Veilleux, Annotation, *Medical Practitioner's Liability for Treatment Given Child Without Parent's Consent*, 67 A.L.R.4th 511 (1989).

115 Press Release, TransActive Gender Center, *TransActive Secures Coverage for Trans Youth Puberty Suppressing Treatment* (Jan. 11, 2013), <http://www.transactiveonline.org/about/pr/1-11-13.php> (last visited Sept. 3, 2015) (“Pubertal suppression provides transgender adolescents the option of avoiding unwanted, irreversible and deeply distressing changes that come with birth-sex pubertal development Far too often trans adolescents experience increased suicidal ideation as a result of these changes and the indifference of others about the impact these changes have on trans youth.”).

116 The following cases concern the treatment of minors under life-threatening circumstances requiring immediate medical attention. The courts held that the circumstances constituted an emergency with justified treatment without obtaining parental consent. *See e.g.*, *Jackovach v. Yocom*, 237 N.W. 444, 449 (Iowa 1931) (concluding that, in a case involving the amputation of the arm of a seventeen-

narrowly,¹¹⁷ it will be difficult for transgender adolescents to access hormone suppressing treatment under this pathway.¹¹⁸

B. SPECIFIC STATUTORY PARENTAL CONSENT EXCEPTIONS

Another category of exceptions to the parental consent requirement is for specific health problems and services.¹¹⁹ In many states, “minors with certain medical conditions may consent to health care relating to those conditions.”¹²⁰ For example, statutes in some states allow minors to consent to treatment for specific medical problems, including “pregnancy, sexually transmitted diseases, contraception, substance abuse, and mental illness.”¹²¹ In California, for example, a minor who is more than twelve years old may consent to medical care related to the prevention of infections and sexually transmitted diseases, and can “receive an abortion without the consent of a parent or guardian.”¹²² Many states also have statutes that allow minors to obtain outpatient health services, contraceptives, birth control services, or services for the prevention of pregnancy without parental consent.¹²³ These statutes tend to apply “to circumstances under which knowledge of the condition or treatment may subject the minor to social embarrassment or parental punishment and thus deter treatment.”¹²⁴ In fact, a U.S. Congressional assessment stated that “underlying these statutes appears to be a legislative realization that a parental consent requirement might deter some adolescent minors . . . from seeking needed treatment because of a reluctance to reveal such problems to their parents.”¹²⁵

However, a policy or statute that applies to minors seeking access to treatment for gender dysphoria does not seem to exist. While these laws

year-old boy without express consent of the boy or his parents, the surgeon was confronted with an emergency endangering the life of the patient and had a duty to do what the occasion demands without consent of the parents.); *Luka v. Lowrie*, 136 N.W. 1106 (Mich. 1912) (holding that a physician was not liable for operating on a fifteen-year-old boy with a crushed foot without the consent of the boy or his parents after other physicians agreed that amputation was necessary to save the boy’s life); *Plutshack v. Univ. of Minn. Hosp.*, 316 N.W.2d 1, 4 (Minn. 1982) (finding that a doctor was not liable for performing a lumbar puncture on a five-year-old child without parental consent since the procedure was necessary to obtain a spinal-fluid sample needed to diagnose a life-threatening disease.).

¹¹⁷ Shield, *supra* note 40, at 423.

¹¹⁸ *Id.* Shield specifically refers to the difficulty of accessing sex-reassignment treatment under the emergency exception theory. However, it would be difficult to obtain access to puberty-suppressing treatment under the emergency doctrine for exactly the same reasons.

¹¹⁹ U.S. CONGRESS, OFFICE OF TECHNOLOGY ASSESSMENT, *Chapter 17: Consent and Confidentiality in Adolescent Health Care Decisionmaking*, in ADOLESCENT HEALTH VOLUME III: CROSSCUTTING ISSUES IN THE DELIVERY OF HEALTH AND RELATED SERVICES 126 (1991) [hereinafter U.S. Congress Assessment].

¹²⁰ Shield, *supra* note 40, at 399.

¹²¹ Sigman & O’Connor, *supra* note 13, at 521.

¹²² CAL. FAM. CODE § 6925–26 (West 2015).

¹²³ U.S. Congress Assessment, *supra* note 119, at 128–30.

¹²⁴ Sigman & O’Connor, *supra* note 13, at 521.

¹²⁵ U.S. Congress Assessment, *supra* note 119, at 130.

represent a shift away from the entrenched idea that parents are the best and most appropriate decision makers in every aspect of their child's life,¹²⁶ they nevertheless exist for particular policy-based reasons and most likely could not be applied to the medical needs of transgender adolescents who seek treatment without parental consent. "It is also imprudent to assume that a state without a mature minor exception can be convinced to develop one because it already has other condition or status-specific exceptions to the default requirement of parental consent on its books."¹²⁷

The fact that most states have enacted legislation allowing minors of any age to consent to or receive services for a venereal or sexually transmitted disease without parental consent stems from "legislative recognition that society has a critical interest in facilitating and encouraging access to health services to reduce the spread of disease among its citizens."¹²⁸ Regarding the family planning and abortion services exception, restrictions on these services are governed by federal constitutional law, as interpreted by the Supreme Court and lower federal courts.¹²⁹ These exceptions reflect recognition of Supreme Court decisions extending constitutional protections like "right to privacy" to minors with respect to the right to have an abortion and use contraceptives.¹³⁰

V. MATURE MINOR DOCTRINE

Finally, a significant exception related to the status and characteristics of individual minors is the mature minor doctrine.¹³¹ This doctrine "permits minors to make decisions about their health and welfare. It does so by permitting them to consent to their sought-after treatment due to either their age or ability to demonstrate that they are mature enough to make a decision on their own."¹³² A mature minor is commonly defined as "a minor who possesses the cognitive faculties to articulate reasoned decisions regarding his or her health and welfare."¹³³ This doctrine challenges the legal presumption that minors lack the capacity and competence to make their own healthcare decisions on the grounds that "it inequitably denies minors in middle or late *adolescence*—many or most of whom may actually have the requisite decision-making capacity—the power to make

126 Watts, *supra* note 103, at 237.

127 Coleman & Rosoff, *supra* note 59, at 792.

128 U.S. Congress Assessment, *supra* note 119, at 128.

129 *Id.* at 128–29.

130 *Id.*

131 *Id.* at 125.

132 Roger J.R. Levesque, *Mature Minor Doctrine*, in 2 ENCYCLOPEDIA OF ADOLESCENCE 1659, 1659 (Roger J.R. Levesque ed., 2011).

133 Joseph Austin, *Managing Patient Expectations Through Informed Consent*, in PRINCIPLES OF RISK MANAGEMENT AND PATIENT SAFETY 397, 402 (Barbara J. Youngberg ed., 2011).

their own decisions about services.”¹³⁴ The mature minor exception to the parental consent requirement first developed through common law in the 1800s.¹³⁵ It has primarily been recognized by state courts rather than state legislatures,¹³⁶ which have been slower to adopt the doctrine.¹³⁷

The Supreme Court has also made decisions regarding extending minors some constitutional protections, particularly with respect to the right to obtain an abortion.¹³⁸ In *Bellotti v. Baird*, the Court held that if a state requires a pregnant minor to obtain parental consent to an abortion, then the state must also provide “an alternative procedure whereby authorization for the abortion can be obtained,”¹³⁹ or in other words, a “judicial bypass” procedure.¹⁴⁰ The pregnant minor is entitled to seek judicial permission to obtain an abortion and show the judge that “she is mature enough and well enough informed to make her abortion decision, in consultation with her physician, independently of her parent’s wishes.”¹⁴¹ If she satisfies the court that she is mature and well-enough informed to make the abortion decision on her own, then the court must authorize the minor to act.¹⁴² Even if she fails to demonstrate maturity, should the court decide that an abortion would be in her best interest, then she will be able to obtain an abortion sans parental consent. The Supreme Court has also held in *Planned Parenthood of Central Missouri v. Danforth* that “a State could not lawfully authorize an absolute parental veto over the decision of a minor to terminate her pregnancy.”¹⁴³ Although the Court has not articulated such rules for minors outside the reproductive rights context,¹⁴⁴ these decisions demonstrate recognition that minors are capable of making critical decisions in an informed and mature manner.¹⁴⁵

134 U.S. Congress Assessment, *supra* note 119, at 123 (emphasis added).

135 Sigman & O’Connor, *supra* note 13, at 521.

136 *Id.* at 521; *see also* Shield *supra* note 40, at 415.

137 Shield, *supra* note 40, at 415.

138 U.S. Congress Assessment, *supra* note 119, at 129.

139 *Bellotti v. Baird*, 443 U.S. 622, 643 (1979).

140 *See* Jared H. Jones, Annotation, *Women’s Reproductive Rights Concerning Abortion, and Governmental Regulation Thereof—Supreme Court Cases*, 20 A.L.R. Fed. 2d. 1 (2007) (“The U.S. Supreme Court, in the following cases, held or recognized the view that States must provide adequate judicial bypass procedures within parental notification/consent statutes.”).

141 *Bellotti*, 443 U.S. at 643.

142 *Id.* at 647.

143 *Id.* at 639 (citing *Planned Parenthood of Cent. Mo. v. Danforth*, 428 U.S. 52 (1976)).

144 *The Mature Minor Doctrine*, USLEGAL.COM, <http://healthcare.uslegal.com/treatment-of-minors/the-mature-minor-doctrine/> (last visited Sept. 8, 2015) [hereinafter USLEGAL.COM].

145 *See Bellotti* 443 U.S. at 634. The Supreme Court states that the constitutional rights of children cannot be equated with those of adults due to (1) the “peculiar vulnerability of children”; (2) “their inability to make critical decisions in an informed, mature manner”; and (3) the “importance of the parental role in child rearing.” The court’s holding providing adolescents with judicial bypass procedures that permit them to obtain abortions without parental consent if they convince a court that they are mature and informed about their decision indicates that these reasons do not justify an absolute parental veto of a pregnant minor’s decision to obtain an abortion.

A. ADOPTION AND APPLICATION BY STATES

A majority of states have not adopted the mature minor doctrine.¹⁴⁶ In the states that have expressly or impliedly adopted variations of the doctrine through statute or court decisions, how the doctrine is applied and how maturity is determined varies. Some states have adopted a limited mature minor doctrine that allows minors to consent to treatment under certain circumstances. According to Professor Doriane Coleman and Dr. Philip Rosoff in their 2013 analysis of statutory and common law provisions regarding minor consent authority to general medical treatment, “[L]ess than one-fifth of the states (8) have a broad mature minor exception to the standard requirement of parental consent. The remainder have no exception at all (34), have significantly narrower or conditioned versions (6), or permit minors of any age to consent to treatment in all or specific circumstances (3).”¹⁴⁷

1. *Common Law Application of the Mature Minor Doctrine*

The law pertaining to minor consent to treatment involves a combination of common law and statutory law, though many of the states that adopted the doctrine in some form did so through their state high courts.¹⁴⁸ “[L]egislatures around the country have been somewhat reluctant to statutorily authorize mature minors to consent to their own healthcare given what is perceived as a highly subjective analysis of the ‘maturity’ criteria. In contrast . . . courts have continually mulled over these criteria in a host of circumstances . . .”¹⁴⁹

One significant decision is *Cardwell v. Bechtol*, where the Supreme Court of Tennessee held that a mature minor had the capacity to consent to medical procedures based on the common law of the state,¹⁵⁰ but also concluded that application of the mature minor doctrine involves “a question of fact for the jury to determine[:] whether the minor has the capacity to consent and appreciate the nature, the risks, and the consequences of the medical treatment involved.”¹⁵¹

The court also adopted a rule of capacity, characterized as the “Rule of Sevens,” which denies legal capacity to those under the age of seven, rebuttably presumes that those between the ages of seven and fourteen lack such capacity, and rebuttably presumes those between the ages of fourteen

146 Levesque, *supra* note 132, at 1659.

147 Coleman & Rosoff, *supra* note 59, at 787.

148 USLEGAL.COM, *supra* note 144.

149 Nancy Batterman, *Under Age: A Minor's Right to Consent to Health Care*, 10 *TOURO L. REV.* 637, 672 (1994).

150 *Cardwell v. Bechtol*, 724 S.W.2d 739, 744–45 (Tenn. 1987).

151 *Id.* at 749.

and twenty-one have such capacity.¹⁵² Tennessee's decision was cited by the high courts of Illinois,¹⁵³ as well as West Virginia,¹⁵⁴ which have also held that their state's common law recognized the mature minor exception to the parental consent requirement (although neither relied on the Rule of Sevens). Kansas,¹⁵⁵ Maine,¹⁵⁶ and Massachusetts,¹⁵⁷ have also explicitly taken into account a minor's maturity in medical decisionmaking, although the mature minor exception in these cases may have been limited by the facts of the case. For instance, the Massachusetts Supreme Judicial Court concluded that the mature minor rule applies "where the best interests of a minor will be served by not notifying his or her parents of intended medical treatment and where the minor is capable of giving informed consent to that treatment," but did not apply the rule to nonemergency abortions because parental consultation was mandated by statute.¹⁵⁸

2. *Legislative Application of the Mature Minor Doctrine*

Several states have statutes that permit minors to consent to medical treatment based on their maturity and ability to give informed consent; other states have statutes that permit minors to consent to medical treatment based on their age or the availability of their parents to provide consent.¹⁵⁹ For example, some state statutes permit minors of a certain age to consent to medical treatment without regard to the minor's maturity,¹⁶⁰ some permit all minors who are mature and capable of informed consent to consent to medical treatment, but only after their parents are unavailable or unwilling to provide consent,¹⁶¹ or reasonable efforts have been made to obtain

¹⁵² *Id.* at 745.

¹⁵³ *In re E.G.*, 549 N.E.2d 322, 326 (Ill. 1989) ("We see no reason why this right of dominion over one's own person should not extend to mature minors. Furthermore, we find support for this conclusion in a decision of one of our sister States. In *Cardwell v. Bechtol*, 724 S.W.2d 739 (Tenn. 1987), the Tennessee Supreme Court held that a mature minor had the capacity to consent to medical procedures based on the common law of that State.").

¹⁵⁴ *Belcher v. Charleston Area Med. Ctr.*, 422 S.E.2d 827, 837 (W. Va. 1992) ("We agree with the holding of *Cardwell*, and we believe that the mature minor exception is part of the common law rule of parental consent of this state.").

¹⁵⁵ *See generally* *Younts v. St. Francis Hosp. & Sch. of Nursing, Inc.*, 469 P.2d 330 (Kan. 1970).

¹⁵⁶ *See generally In re Swan*, 569 A.2d 1202 (Me. 1990).

¹⁵⁷ *Baird v. Attorney Gen.*, 360 N.E.2d 288, 296 (Mass. 1977).

¹⁵⁸ *Id.* at 754–55.

¹⁵⁹ *Coleman & Rosoff*, *supra* note 59, at 790–91.

¹⁶⁰ For example, Alabama statutorily permits a minor who is either 14 years or older, or who had graduated high school, to consent to medical services without evaluation of the minor's maturity. ALA. CODE § 22-8-4 (2015). *See also* KAN. STAT. ANN. § 38-123b (2014) ("[A]ny minor sixteen (16) years of age or over, where no parent or guardian is immediately available, may give consent to the performance and furnishing of hospital, medical or surgical treatment or procedures and such consent shall not be subject to disaffirmance because of minority.").

¹⁶¹ For example, Alaska provides by statute that minors regardless of age are able to consent to "medical and dental services if their parent or legal guardian" cannot be contacted or is unwilling to consent. ALASKA STAT. § 25.20.025 (2015).

parental consent.¹⁶² Other state statutes provide consent authority to minors under particular circumstances (such as graduating high school),¹⁶³ or authorize minors to consent to medical treatment except for “operations” (in which case parental consent is required).¹⁶⁴

The states that have enacted statutes that explicitly authorize minors who are mature or have provided informed consent to health services are Arkansas, Idaho, and Nevada. In Arkansas, “[a]ny unemancipated minor of sufficient intelligence to understand and appreciate the consequences of the proposed surgical or medical treatment or procedures . . .” may consent to the surgical or medical treatment or procedure.¹⁶⁵ Idaho provides that “[a]ny person who comprehends the need for, the nature of and the significant risks ordinarily inherent in any contemplated hospital, medical, dental, surgical or other health care, treatment or procedure is competent to consent thereto on his or her own behalf.”¹⁶⁶ Nevada provides that parental consent is not necessary for health officers and physicians to “provide treatment for any minor . . . who understands the nature and purpose of the proposed examination or treatment and its probable outcome, and voluntarily requests it.”¹⁶⁷ According to the Office of Technology of the U.S. Congress, the Arkansas statute explicitly authorizes mature minors to consent to health services, while Idaho and Nevada’s statutes “are somewhat ambiguous but could be construed to constitute mature minor consent statutes.”¹⁶⁸

Some states distinguish between evaluations of maturity and evaluations of the capacity to give informed consent.¹⁶⁹ According to Coleman and Rosoff, the concepts are related but distinct.¹⁷⁰ They explain that “a minor may have the cognitive capacity to understand the risks and benefits of particular treatment and the necessary will to decide voluntarily to accept or forego the intervention, but he or she may not otherwise

162 For example, a Delaware statute stipulates that consent to lawful medical treatment may be given by a minor, but only “after reasonable efforts shall have been made to obtain the consent of the parent or guardian of said minor.” DEL. CODE ANN. tit. 13, § 707(b)(5) (2015).

163 See ALASKA STAT. § 25.20.025 (2015); see also MONT. CODE ANN. § 41-1-402(2)(a) (2014) (providing that consent to health services may be given by a minor who “professes . . . to have . . . graduated from high school.”) and 35 PA. CONS. STAT. ANN. § 10101 (West 2015) (“Any minor who is eighteen years of age or older, or has graduated from high school, or has married, or has been pregnant, may give effective consent to medical, dental and health services . . . and the consent of no other person shall be necessary.”).

164 S.C. CODE ANN. § 63-5-340 (2015) (providing that minors aged 16 and over can consent to all medical treatment except operations).

165 ARK. CODE ANN. § 20-9-602 (2015).

166 IDAHO CODE ANN. § 39-4503 (West 2015).

167 NEV. REV. STAT. ANN. § 129.030 (West 2014).

168 U.S. Congress Assessment, *supra* note 119, at 127.

169 Coleman & Rosoff, *supra* note 59, at 789.

170 *Id.*

present as mature based on the indicia of maturity typically expected by the courts.”¹⁷¹

B. USING THE MATURE MINOR DOCTRINE TO PROVE CAPABILITY OF
CONSENTING TO PUBERTY-SUPPRESSING TREATMENT

Transgender adolescents should use the mature minor doctrine to convince courts that they are mature enough to consent to puberty-suppressing treatment without parental consent. Laws regarding the medical decisionmaking capabilities of minors are “evolving and shifting toward allowing mature minors to make informed decisions.”¹⁷² State legislatures and courts increasingly recognize that a bright-line rule regarding who is an adult capable of consent may not be appropriate,¹⁷³ especially in regard to adolescent minors. The mature minor doctrine is a way the legal system can recognize the increasing capacities of minors as they move through adolescence, and transgender rights proponents should invoke it to secure legal autonomy for transgender adolescents seeking treatment despite parental opposition.¹⁷⁴

In addition, a transgender adolescent can point to the laws allowing minors to consent to a variety of medical treatments for specific conditions. These statutes demonstrate state legislatures’ willingness to abrogate parental consent when there is a need for minors to be able to consent to medical treatment.¹⁷⁵ In *In re E.G.*, the Illinois Supreme Court concluded that a seventeen-year-old girl with leukemia was a mature minor who had the right to refuse blood transfusions based on her religious beliefs, mentioning the existence of numerous exceptions within the jurisdiction and others that treat minors as adults under specific circumstances.¹⁷⁶ There is concern that the existence of these specific statutes could be provided as proof that a state intended to require parental consent in all cases outside of these specific statutes. This was the argument raised by the plaintiffs in *Cardwell v. Bechtol*. However, the court in *Cardwell* concluded that the express terms of the statutes are not intended to abrogate judicial adoption of a mature minor exception to the common law rule requiring parental consent.¹⁷⁷ The West Virginia Supreme Court in *Belcher v. Charleston Area*

¹⁷¹ *Id.*

¹⁷² Kathryn Hickey, *Minor’s Rights in Medical Decision Making*, 9 JONA’S HEALTHCARE L., ETHICS, & REG. 104 (2007).

¹⁷³ MARY FRAN HAZINSKI, ET AL., NURSING CARE OF THE CRITICALLY ILL CHILD 1077 (Mary Fran Hazinski ed., 3d ed. 2012).

¹⁷⁴ Levesque, *supra* note 132, at 1660.

¹⁷⁵ Melinda T. Derish & Kathleen Vanden Heuvel, *Mature Minors Should Have the Right to Refuse Life-Sustaining Medical Treatment*, 28 J.L. MED. & ETHICS 109, 114 (2000).

¹⁷⁶ *In re E.G.*, 549 N.E.2d 322, 325 (Ill. 1989).

¹⁷⁷ *Cardwell v. Bechtol*, 724 S.W.2d 739, 744 (Tenn. 1987).

Medical Center also adopted *Cardwell's* answer to the argument that these specific statutory exceptions indicated a legislative intent to reject the mature minor rule.¹⁷⁸

There is also evidence that the medical community supports the mature minor doctrine. For example, the *Model Act Providing for Consent of Minors for Health Services* ("Model Act") released by the American Academy of Pediatrics states that "[a]ny minor who has physical and emotional problems and is capable of making rational decisions, and whose relationship with his parents . . . is in such a state that by informing them the minor will fail to seek initial or future help," may give consent to health care professionals for health services.¹⁷⁹ The policy of the Model Act is echoed by several other pieces that the American Academy of Pediatrics published in its official journal.¹⁸⁰ Two companion pieces published in 1989, the first titled *Children as Decision Makers: Guidelines for Pediatricians*, and the second titled *A Proposal Concerning Decisions to Forego Life-Sustaining Treatment for Young People*, addressed the subject. The first piece insisted that a child's decisionmaking role is a more important issue than the question of legal capacity to consent to healthcare decisions independent of parental wishes. It argued that "when a child whom the physician has deemed mature enough to make the decision in question asks that parents not be notified, there is no legal or moral basis for violating patient confidentiality by informing parents."¹⁸¹ The second piece argued that minors "be allowed to make decisions on their own behalf . . . if they are capable" and that "it is necessary to assess whether or not the minor is mature enough to be the key decision maker."¹⁸²

Courts assessing the maturity of transgender adolescents seeking to consent to puberty suppressants can also look to the treatment of similar issues by courts in other countries. One case that addressed the issue of treatment for transgender adolescents was an Australian family court decision allowing a biologically female foster child named Alex with GID to live as a boy and undergo treatment.¹⁸³ Alex had been placed in foster care due to aggressive and suicidal behavior, and was eventually diagnosed

178 *Belcher v. Charleston Area Med. Ctr.*, 422 S.E.2d 827, 836-37 (W. Va. 1992).

179 Sprague W. Hazard et al., American Academy of Pediatrics, *A Model Act Providing for Consent of Minors for Health Services*, 51 J. AM. ACAD. OF PEDIATRICS 293, 294 (1973).

180 Derish & Heuvel, *supra* note 175, at 113.

181 Nancy M.P. King & Alan W. Cross, *Children as Decision Makers: Guidelines for Pediatricians*, 115 J. PEDIATRICS 10, 15 (1989).

182 Sanford Leikin, *A Proposal Concerning Decisions to Forego Life-Sustaining Treatment for Young People*, 115 J. PEDIATRICS 17, 21 (1989).

183 *Re Alex* [2004] FamCA 297, 242 (Austl.), http://www.austlii.edu.au/au/cases/cth/family_ct/2004/297.html.

with GID at the age of twelve.¹⁸⁴ Alex's legal guardian brought an application to the court to get approval for "reversible hormonal treatment."¹⁸⁵ The court listened to statements by associate professors (one in the Department of Psychiatry and the other in the Department of Pediatrics at the same university) who assessed and treated Alex for issues related to Alex's gender dysphoria and depression. They stressed the urgency of treatment and recommended administering a hypothalamic blocker that would "reduce Alex's oestrogen secretion to prepubertal levels" and thus delay female puberty.¹⁸⁶ Like *Smith v. Smith*, the court used a best interests of the child standard to reach its decision; unlike *Smith*, however, the judge in this case held that reversible puberty-blocking treatment was in the child's best interest.¹⁸⁷ The judge reasoned that:

[i]n light of the adamant nature of Alex's gender identification and the on-going concern as to how traumatised he would be if the proposed treatment were not to otherwise go ahead, I would not delay treatment merely because of the theoretical risk that Alex is constructing his self image as "really" male when in fact he is "really" a female lesbian and will come to see himself that way over time.¹⁸⁸

The court thus concluded that Alex was mature enough to consent to treatment. Scholars have argued that "when and if such a case comes to a United States judge, *Re Alex* offers guidance on how to approach treatment issues and to serve the child's best interests."¹⁸⁹

C. CRITERIA FOR ASSESSING A MINOR'S MATURITY AND CAPACITY TO CONSENT

In applying the mature minor doctrine, courts have and need wide discretion to assess each minor's individual maturity. Every minor's distinctive psyche must be assessed, whether he or she be a child or an adolescent near the age of majority.¹⁹⁰ The determination depends not only

184 *Id.* ¶ 76.

185 *Id.* ¶ 49.

186 *Id.* ¶ 151.

187 *Id.* ¶ 189.

188 *Id.* ¶ 107.

189 Hazel Beh & Milton Diamond, *Ethical Concerns Related to Treating Gender Nonconformity in Childhood and Adolescence: Lessons from the Family Court of Australia*, 15 HEALTH MATRIX 239, 279 (2005); see also Erika Skougard, Note, *The Best Interests of Transgender Children*, UTAH L. REV. 1161, 1175 (2011) (noting that the Australian family court judge in *Re Alex* embraced the reasoning put forth in a study that concluded that a gender-nonconforming child's increased risk of suicide, depression, and anxiety was linked to family rejection of the child's gender expression, finding "a genuine, serious risk Alex would resort to suicide if not permitted to express his internal gender identity").

190 Margot Karen Jackson et al., *Confidentiality and Treatment Decisions of Minor Clients: A Health Professional's Dilemma and Policy Makers Challenge*, 3 SPRINGERPLUS 1, 5 (2014) (recommending that Alberta healthcare providers, when conducting an assessment to determine whether

on the adolescent involved but also on the adolescent's age and condition.¹⁹¹ As Nancy Batterman argued,

[d]espite the benefits that might accrue from statutorily codifying these maturity benchmarks, courts would continue to be drawn into the process of assessing the maturity of individual minors with or without established legislative criteria. Rather than confining the parameters of a court's queries, a better approach is to allow the courts a certain degree of discretion.¹⁹²

There is concern that giving courts the discretion to analyze the maturity of a minor on a case-by-case basis would lead to ad hoc, inconsistent results that would make the application of the mature minor doctrine unpredictable.¹⁹³ This concern is emphasized by cases like *Smith*, where, due to the broad discretion the best-interest-of-the-child standard affords in custody cases, the judge was able to conduct a "personal evaluation" of the minor child's GID that appeared to be influenced by biases and stereotypes regarding traditional gender norms.¹⁹⁴ While there is no fool-proof way of ensuring that bias and ignorance will not influence judge or jury determinations of a minor's maturity, particularly if that minor is a transgender adolescent, these issues may be alleviated if courts adopt a list of criteria to take into account when assessing a minor's capacity to consent. The courts' analyses should involve objective assessment of these criteria. Advocates for transgender adolescents should be prepared to convince the court that the adolescents satisfy this criteria by educating the court about childhood gender issues and common or recommended treatments for gender dysphoria while maintaining credibility with the court.¹⁹⁵

In *Belcher*, the court argued that the capacity to consent depended on the minor's "age, ability, experience, education, training, and degree of maturity or judgment," "the conduct and demeanor of the child at the time of the procedure or treatment," and "whether the minor has the capacity to appreciate the nature, risks, and consequences" of the treatment.¹⁹⁶ In *Cardwell*, the Tennessee Supreme court considered these same factors,¹⁹⁷ as well as the "totality of the circumstances, the nature of the treatment and its

a minor patient has the maturity to provide consent for a treatment or procedure without input of their legal representative, document their assessment to support their decision since "many of the criteria are subjective in nature").

191 Hazinski, *supra* note 173, at 1077.

192 Batterman, *supra* note 149, at 673.

193 Watts, *supra* note 103, at 242.

194 Perkiss, *supra* note 43, at 73, 77–78.

195 Skougard, *supra* note 47, at 1199.

196 *Belcher v. Charleston Area Med. Ctr.*, 422 S.E.2d 827, 838 (W. Va. 1992).

197 *Cardwell v. Bechtol*, 724 S.W.2d 739, 748 (Tenn. 1987).

risks or probable consequences, and the minor's ability to appreciate the risks and consequences” as questions of fact for the jury to decide.¹⁹⁸ The Illinois Supreme Court in *In re E.G.* maintained that the determination of whether a minor was sufficiently mature to make their own healthcare decisions depended on “proof of this maturity by clear and convincing evidence,”¹⁹⁹ but did not specify any factors that would help in making this determination.

Some sources have compiled the factors that courts have used to assess a minor’s capacity to consent. For instance, a Congressional publication on adolescent health found that the following factors supported a determination of a minor’s maturity for purposes of healthcare decisionmaking:

- (1) the treatment is undertaken for the benefit of a minor rather than a third party;
- (2) the particular minor is near the age of majority;
- (3) the minor is considered to have sufficient mental capacity to understand fully the nature and importance of medical steps proposed;
- (4) the procedures are characterized as less than major, ‘not serious’ or not overly ‘complex’.²⁰⁰

The first factor refers to a D.C. Circuit case, *Bonner v. Moran*, which held that a fifteen-year-old boy could not consent to an operation to provide his cousin flesh for a skin graft without the consent of the boy’s parents.²⁰¹ The appellant had been persuaded by his aunt to submit to an operation to provide skin grafts to treat his cousin’s severe burns. The court refused to believe that the appellant was capable of appreciating and did appreciate the nature and consequences of the operation.²⁰² The court concluded that the boy was “immature,” although the court did not explain why. Instead, it argued that “in all such cases, basic consideration is whether the proposed operation is for the benefit of the child,” and found that the operation was not only entirely for the benefit of another, but involved significant “sacrifice” on the part of the child.²⁰³ The holding suggests that if the child was mature and if the operation had not been for the benefit of another person, the court may have held that the surgeon was justified in accepting the minor’s consent.²⁰⁴

198 *Id.* at 749.

199 *In re E.G.*, 549 N.E.2d 322, 327 (Ill. 1989).

200 See U.S. Congress Assessment, *supra* note 119, at 127.

201 See generally *Bonner v. Moran*, 126 F.2d 121 (D.C. Cir. 1941).

202 *Id.* at 122.

203 *Id.* at 121 (describing the “sacrifices” on the part of the boy as “fully two months of schooling, in addition to serious physical pain and possible results affecting his future life. This immature colored boy was subjected several times to treatment involving anesthesia, blood-letting, and the removal of skin from his body, with at least some permanent marks of disfigurement.”).

204 *Id.* at 122–23.

The second factor reflects recognition that an older, adolescent minor is more likely to be independent and capable of understanding the consequences of his or her actions than a younger child. “Adolescents are caught in a limbo-like state between the dependency of childhood and the autonomy of adulthood. Their cognitive ability and capacity to reason are similar to those of an adult.”²⁰⁵ However, courts must also keep in mind one of the main rationales for the parental consent requirement, which “is the need to *protect minors from their own improvident decisionmaking*.”²⁰⁶ Even if an adolescent is capable of rational decisionmaking and understands what treatment entails, he or she may “have more volatile emotions, and may look only at short-term consequences.”²⁰⁷ For these reasons, the age of the minor is a significant factor. While some courts have refused to recognize an exception to parental control even for those minors who are on the cusp of the age of majority,²⁰⁸ courts are likely to find minors who are at least fourteen years of age to be capable of giving informed consent.²⁰⁹

The fourth factor refers to the quality and nature of the medical intervention. “Courts have allowed a minor’s consent to treatment when the procedure or intervention was not ‘major’ or ‘serious’ but not when the treatment was deemed of such risk that the minor needed the protection of an adult’s decision.”²¹⁰ When the treatment will not involve a great deal of risk, judges are less concerned of the consequences of recognizing a minor’s decision to treatment against parental wishes.²¹¹ For example, the Supreme Court of Kansas in *Younts v. St. Francis Hospital and School of Nursing*, held that parental consent was not necessary where the mother of a seventeen-year-old girl was unconscious when her daughter injured the tip of her finger, and the family physician approved surgical procedures that included a skin graft to replace the missing fingertip.²¹² The court reasoned “that under the circumstances the daughter was mature enough to understand the nature and consequences and to knowingly consent to the beneficial surgical procedure made necessary by the accident.”²¹³ This

205 Hickey, *supra* note 172, at 101.

206 See U.S. Congress Assessment, *supra* note 119, at 125.

207 Hickey, *supra* note 172, at 101.

208 *R.J.D. v. Vaughan Clinic, P.C.*, 572 So. 2d 1225, 1227 (Ala. 1990) (holding that a mother had the right to commit her seventeen-year-old unemancipated daughter to a private psychiatric hospital against daughter’s will and without her consent, under the common-law rights and duties of a parent with respect to child).

209 Sigman & O’Connor, *supra* note 13, at 520 (“There is minimal legal risk in allowing adolescents older than 14 years of age to give consent for treatments entailing small degrees of risk, when they can make adult-life decisions and demonstrate signs of maturity.”).

210 *Id.* at 523.

211 Batterman, *supra* note 149, at 672.

212 See generally *Younts v. St. Francis Hosp. & Sch. of Nursing, Inc.*, 469 P.2d 330 (Kan. 1970).

213 *Id.* at 338.

raises the question of whether the factor bears on actual maturity or decisionmaking capacity. The seriousness of the treatment was also a factor in the court's decision in *Bonner v. Moran*, which reasoned that the skin graft operation was "so involved in its technique as to require a mature mind to understand precisely what the donor was offering to give."²¹⁴ These cases suggest that the more serious the proposed treatment, the greater the level of maturity that is required before a child can be considered a mature minor.

Assessment of maturity is also influenced by whether the treatment involves life-sustaining medical care, which is usually serious and major. The Illinois Supreme Court in *In re E.G.* held that the minor was mature enough to refuse life-sustaining medical treatment. The court also argued that a minor's right must be balanced against the state's interest in "(1) the preservation of life; (2) protecting the interests of third parties; (3) prevention of suicide; and (4) maintaining the ethical integrity of the medical profession."²¹⁵ There is some tension between the first factor and the court's decision. The court was probably swayed by the fact that the minor patient was just shy of her eighteenth birthday and had a low chance of survival even if she had received the blood transfusions.²¹⁶ In a similar case, *In re Long Island Jewish Medical Center*, the New York Supreme Court held that a patient with pediatric cancer (who was several weeks from his eighteenth birthday) was not a mature minor and, thus, could not refuse blood transfusions required to provide life-saving treatment for the cancer.²¹⁷ The court refused to adopt or reject the mature minor doctrine, arguing that that was a decision to be made by the state legislature.²¹⁸ These cases indicate that courts take into account the risks and consequences of withholding treatment when assessing the maturity of a minor.

VI. RELEVANT FACTORS THAT INFLUENCE DETERMINATIONS OF MINOR MATURITY

In determining minor maturity, courts will consider the adolescent's age, the nature of puberty-suppressing hormonal treatment, whether the treatment benefits the adolescent, and the risks and consequences of the

214 *Bonner v. Moran*, 126 F.2d 121, 123 (D.C. Cir. 1941).

215 *In re E.G.*, 549 N.E.2d 322, 328 (Ill. 1989).

216 *Id.* at 323 (mentioning that the long-term prognosis for the patient was not optimistic. Even with continued treatment, the patient's survival rate was estimated at 20 to 25 percent).

217 *In re Long Island Jewish Med. Ctr.*, 557 N.Y.S.2d 239, 243 (N.Y. Sup. Ct. 1990) (The court did not reject the mature minor doctrine, but held that the minor did not have a mature understanding of his own religious beliefs or the fatal consequences of rejecting treatment. The court did recommend that "the legislature or the appellate courts take a hard look at the 'mature minor' doctrine and make it either statutory or decisional law in New York State.").

218 *Id.*

treatment. It is important for transgender adolescents that courts understand the effectiveness of puberty-blocking treatment in combatting gender dysphoria, the reversibility of the treatment, and the consequences of denying consent to the treatment. Courts informed on the benefits of reversible puberty-blockers and the issues of gender identity and gender dysphoria will be more inclined to permit mature transgender adolescents to consent to the treatment.

A. AGE

Age is a major factor in the courts' assessments of maturity. In order for puberty-suppressing treatment's effectiveness to be maximized, it would have to be administered right before puberty, or early enough so that the minor's body has not undergone permanent development of secondary sex characteristics of the minor's biological sex. Individuals vary widely in the timing of puberty: "[T]he first signs of puberty may be evident anywhere between 7 to 13 years and 9 to 13 years of age in girls and boys [respectively]."²¹⁹ Since a thirteen-year-old is closer to the age of majority, a court is more likely to assume that the he or she is capable of informed decisionmaking. A relevant issue is the trend in the United States toward earlier emergence of puberty. Studies confirm that more girls are beginning breast development by age seven than in previous decades.²²⁰ Another study found that boys started to sexually develop six months to two years earlier than medical textbooks say is standard.²²¹ This could mean that transgender minors are more likely to undergo sexual development earlier than in the past.

While age is an important factor, "[a]ge alone does not indicate a child's ability to understand. Knowledge, health status, anxiety, experience with decision-making, and each child's unique values and cultural, familial, and religious background all play a role in children's understanding of their situation and affect their ability to make decisions."²²² Age is just one factor and is not dispositive. The following factors would show that a minor

219 Bruce J. Ellix et al., *Quality of Early Family Relationships and the Timing and Tempo of Puberty: Effects Depend on Biological Sensitivity to Context*, 23 DEV. & PSYCHOPATHOLOGY 85, 87 (2011).

220 *Women's Health Watch*, PHARMACY TIMES (Aug. 17, 2010), <http://www.pharmacytimes.com/publications/issue/2010/August2010/WomensHealthWatch-0810>. 90 (2010).

221 Jacque Wilson, *Boys-Like Girls-Hitting Puberty Earlier*, CNN (Oct. 23, 2012, 7:01 AM), <http://www.cnn.com/2012/10/20/health/boys-early-puberty/>.

222 Yoram T. Unguru, *Session 4. Informed Consent and Assent in Pediatrics*, in AMERICAN ACADEMY OF PEDIATRICS (AAP) BIOETHICS RESIDENT CURRICULUM: CASE-BASED TEACHING GUIDES 27 (Mary B. Adam et al. eds., 2011).

seeking hormone therapy has the capacity to consent to the treatment even if she or he is younger than fourteen years old.

B. THE EFFECTIVENESS OF TREATMENT

The nature of puberty-suppressing treatment and the circumstances under which it is administered increase the likelihood that minors seeking it have the capacity to make an informed decision to pursue it. An objective analysis of how the treatment benefits transgender adolescents with very little to no long-term risk to their mental and physical health, and the serious repercussions that may result if treatment is withheld, will persuade courts to permit adolescents to decide on accessing the treatment. Weighing whether adolescents are capable of understanding the consequences of treatment requires knowing what gender dysphoria is, how it affects adolescents diagnosed with the condition, how puberty can exacerbate its symptoms, and how puberty blockers work to combat it.

1. *Gender Dysphoria and its Effects on Transgender Adolescents*

Awareness of gender dysphoria as a mental disorder that can lead to great psychological pain and distress for an adolescent allows courts to properly weigh the benefit of puberty blockers as treatment for this disorder. First, adolescents with gender dysphoria often suffer great distress resulting from the incongruence between their expressed gender and assigned gender. Gender dysphoria is classified as a mental disorder in the DSM-V.²²³ The DSM is the standard classification of mental disorders used by mental health professionals in the United States.²²⁴ The DSM consists of diagnostic classification and criteria sets for each mental disorder, which is relevant to the issue of what transgender adolescents diagnosed with the condition experience. DSM-V separates the diagnosis of gender dysphoria for children from those of adolescents and adults, since the characteristics of gender dysphoria vary with age.²²⁵ For adults and adolescents, the criteria are:

a marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months duration, as manifested by 2 or more of the following indicators:

²²³ Mark Moran, *New Gender Dysphoria Criteria Replace GID*, 48 PSYCHIATRIC NEWS 9, 9 (Apr. 5, 2013).

²²⁴ DSM, AM. PSYCHIATRIC ASS'N, <http://www.psychiatry.org/practice/dsm> (last visited Oct. 30, 2015).

²²⁵ Wynne Parry, *Gender Dysphoria: DSM-5 Reflects Shift in Perspective on Gender Identity*, HUFFINGTON POST HEALTH (Apr. 4, 2013, 2:11 PM), http://www.huffingtonpost.com/2013/06/04/gender-dysphoria-dsm-5_n_3385287.html.

a marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or, in young adolescents, the anticipated secondary sex characteristics)

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

a strong desire for the primary and/or secondary sex characteristics of the other gender

a strong desire to be of the other gender (or some alternative gender different from one's assigned gender)

a strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender)

a strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender).²²⁶

These criteria allow mental health professionals to diagnose gender dysphoria.²²⁷ A diagnosis is more likely when the condition causes clinically significant distress or impairment in important areas of functioning.²²⁸ Courts that understand the seriousness of gender dysphoria and the consequences for the mental health of gender dysphoric adolescents if they are not treated in time will be aware of the necessity of puberty-suppressing treatment for treating the condition.

The Endocrine Society guidelines (which use "GID," as the guidelines were adopted before the changes to the DSM-V) emphasize that "an adolescent with GID often considers the pubertal physical changes to be *unbearable*."²²⁹ The resulting stress puts transgender adolescents at high risk of violence, suicide, and substance abuse.²³⁰ The suicide attempt rate among trans-youth is particularly high.²³¹ In addition, the older an adolescent gets, the more difficult it will be for her or him to live as their desired gender, creating a sense of hopelessness fueling other psychiatric

226 Robert Marvin, *Proposed DSM-5 Revisions to Sexual and Gender Disorder Criteria*, 12 AM. MED. ASS'N. J. ETHICS 673, 673-74 (Aug. 2010).

227 Hembree et al., *supra* note 71, at 4.

228 Arlene Istar Lev, *Gender Dysphoria: Two Steps Forward, One Step Back*, CLINICAL SOC. WORK J. 288, 292 (2013).

229 Hembree et al., *supra* note 71, at 13 (emphasis added).

230 Simona Giordano, *Lives in Chiaroscuro. Should we Suspend the Puberty of Children With Gender Identity Disorder*, 34 J. MED. ETHICS 580, 581 (2008).

231 *Statistics About Youth Suicide*, YOUTH SUICIDE PREVENTION PROGRAM, http://www.yspp.org/about_suicide/statistics.htm (last visited Sept. 3, 2015).

disorders and adversely influencing her or his intellectual development.²³² The development of secondary sex characteristics due to puberty are permanent (without invasive surgical intervention), and transgender youth experiencing the puberty of their assigned gender often experience anxiety, depression, and confusion.²³³ For instance, the Center for Disease Control and Prevention reported that patients trying to live as the sex different from their birth sex find puberty intolerable as they develop secondary sex characteristics.²³⁴ Transgender adolescents are more comfortable expressing their preferred gender identity when they are able to “pass” as the sex that they identify with to others, but pubertal changes make this more difficult.²³⁵

These changes can only be erased with great difficulty by the time the patient has reached the age of majority. “Delaying sex reassignment until adulthood makes transitioning more difficult, less convincing, more expensive, and more invasive.”²³⁶ Even with surgery and cross-hormones, these changes may not be completely rectified. For instance, one report on early hormonal intervention noted that the “[t]he physical treatment outcome following interventions in adulthood is far less satisfactory than when treatment is started at an age at which secondary sex characteristics have not yet been fully developed. This is obviously an enormous and life-long disadvantage.”²³⁷ In fact, the primary cause of health issues for postoperative transsexual people are factors that make it difficult for them to pass as their new gender or remind them of their transsexualism.²³⁸

Finally, withholding treatment can cause adolescents to suffer great anxiety and lead them to take drastic action to alleviate their dysphoria. Transgender adolescents who are refused treatment “might obtain medication [from] the illegal market” and expose themselves to life-threatening conditions through unsupervised use of these drugs.²³⁹ Such illegal use of hormones also increases the risk of getting entangled in the criminal justice system.²⁴⁰ Delayed treatment is associated with poor health

232 Peggy T. Cohen-Kettenis & Stephanie H.M. van Goozen, Pubertal Delay as an Aid in Diagnosis and Treatment of a Transsexual Adolescent, 7 *EUR. CHILD & ADOLESCENT PSYCHIATRY* 246, 246 (1998).

233 *HANDBOOK OF LGBT-AFFIRMATIVE COUPLE AND FAMILY THERAPY* 208 (Jerry J. Bigner & Joseph L. Wetchler eds., 2012).

234 Susan Scutti, *Transgender Youth: Are Puberty-Blocking Drugs an Appropriate Medical Intervention?*, *MED. DAILY* (Jun. 24, 2013, 2:17 PM), <http://www.medicaily.com/transgender-youth-are-puberty-blocking-drugs-appropriate-medical-intervention-247082>.

235 *Id.*

236 Perkiss, *supra* note 43, at 63.

237 Cohen-Kettenis & van Goozen, *supra* note 232, at 246.

238 *Id.*

239 Giordano, *supra* note 230, at 581.

240 *Id.*

for transgender individuals that may persist into adulthood (assuming they make it that far).

2. *How Puberty-Suppressing Treatment Works*

The Endocrine Society clinical practice guidelines—a document for endocrinologists that sets the standards for the care of transsexual and transgender people—provides a good overview of what puberty-blocking treatment entails. Puberty blockers (also called puberty inhibitors, puberty suppressors, hormone suppressors, or GnRH analogues) are a group of medications prescribed by an endocrinologist to suppress or inhibit puberty.²⁴¹ The use of puberty blockers for children diagnosed with gender dysphoria or GID is a relatively new approach to their medical care, but it has shown very promising results.²⁴²

According to the Endocrine Society's guidelines, adolescents may be eligible for puberty-suppressing hormones as soon as pubertal changes have begun.²⁴³ These include the development of secondary sex characteristics.²⁴⁴ In girls the first physical sign of the beginning of puberty is the start of budding of the breasts, followed by an increase in breast and fat tissue.²⁴⁵ Menarche (first occurrence of menstruation) occurs approximately two years later.²⁴⁶ In boys, the first physical change is testicular growth and increase in testosterone levels.²⁴⁷ Puberty blockers, more formally called gonadotropin-releasing hormone (GnRH) analogs, basically “freeze” the child's development before the arrival of these noticeable secondary sex characteristics.²⁴⁸ The Endocrine Society guidelines allow adolescents to start this treatment from Stage Two to Stage Four in the Tanner scale of physical development, although they are most effective if started when a child is entering Stage Two.²⁴⁹ The Tanner Stages (also known as the Tanner Scale) are a method of describing the physical development of human beings from time as children through adolescence and adulthood. An individual's Tanner stage is based on external primary and secondary sex characteristics.²⁵⁰ At the beginning of

241 Norman P. Spack, *Puberty Inhibitors*, TRANSYOUTH FAMILY ALLIES, http://www.imatyfa.org/permanent_files/pubertyblockers101.html (last visited Sept. 3, 2015).

242 *See Infra* part V.A.3.1.

243 Hembree et al., *supra* note 71, at 13.

244 ENCYCLOPEDIA OF HUMAN DEVELOPMENT 1051 (Neil J. Salkind ed., 2008).

245 Hembree et al., *supra* note 71, at 13.

246 *Id.*

247 *Id.*

248 Jesse Green, *S/He: Parents of Transgender Children are Faced with a Difficult Decision, and It's One They Have to Make Sooner Than They Ever Imagined*, NEW YORKER MAG. (May 27, 2012), <http://nymag.com/news/features/transgender-children-2012-6/>.

249 *Id.*; *see also* Coleman et al., *supra* note 61, at 173.

250 JUSTIN CORFIELD, *Tanner Stages*, in ENCYCLOPEDIA OF GLOBAL HEALTH 1644 (Yawei Zhang ed., 2008); *see also* Hembree et al., *supra* note 71, at 13. The Endocrine Society guidelines

Stage Two, there is almost no breast development in girls or genital enlargement in boys.²⁵¹ Girls tend to reach Stage Two at around eleven years old; boys, at about thirteen years old.²⁵² Tanner Stage Two may begin as young as nine years old in both sexes.²⁵³ Studies indicate that most of the children that clinics found eligible for the treatment were at least twelve years old.²⁵⁴

GnRH analogues delay the physical changes of puberty by suppressing estrogen or testosterone production. GnRH analogues block the GnRH receptor in the brain, and this in turn prevents the secretion of endogenous sex hormones (testosterone and estrogen).²⁵⁵ When treated, children receive GnRH analogues until age sixteen, after which cross-hormones may be given.²⁵⁶ At this point, the child will belatedly undergo adolescence—but in the desired gender instead of the dreaded one. [Transgender females] will start to develop round hips and bigger breasts; [transgender males], square shoulders and more prominent Adam’s apples. Later, if surgery ensues, there is much less of the wrong adulthood to undo.²⁵⁷

Alternatives to GnRH analogues are progestins (most commonly medroxyprogesterones),²⁵⁸ which are generally cheaper and less effective.²⁵⁹ They suppress the secretion of gonadotropin (hormones secreted from the pituitary gland that stimulate the growth and activity of the gonads).²⁶⁰ They also “exert a mild peripheral anti-androgen [male sex hormone] effect in boys. Depo-medroxyprogesterone will suppress ovulation and progesterone production for long periods of time, although residual estrogen levels vary.”²⁶¹ Progestins are relatively effective in suppressing menstrual cycles in girls and androgen levels in boys, but are still far less effective than GnRH analogues. Since GnRH is expensive and not always covered by insurance, financial considerations may require treatment with progestins instead.²⁶²

includes tables with descriptions of each stage of the Tanner stages of breast development and male external genitalia.

²⁵¹ Hembree et al., *supra* note 71, at 13.

²⁵² Green, *supra* note 248.

²⁵³ Coleman et al., *supra* note 61, at 177; *see also* Green, *supra* note 248.

²⁵⁴ Coleman et al., *supra* note 61, at 177.

²⁵⁵ Scutti, *supra* note 234.

²⁵⁶ Hembree et al., *supra* note 71, at 3.

²⁵⁷ Green, *supra* note 248.

²⁵⁸ Coleman et al., *supra* note 61, at 177.

²⁵⁹ Hembree et al., *supra* note 71, at 15.

²⁶⁰ *Gonadotropin*, ENCYCLOPEDIA BRITANNICA ONLINE,

<http://www.britannica.com/EBchecked/topic/238273/gonadotropinminor> (last visited Sept. 3, 2015).

²⁶¹ Hembree et al., *supra* note 71, at 15.

²⁶² *Id.* “GnRH analogues are expensive and not always reimbursed by insurance companies. Although there is no clinical experience in this population, financial considerations may require treatment with progestins as a less effective alternative.”

The SOC and Endocrine Society guidelines stipulate that puberty blockers be administered only after the child has been diagnosed with gender dysphoria or GID and after psychiatric or mental health evaluations. “Before any physical interventions are considered for adolescents, extensive exploration of psychological, family, and social issues should be undertaken . . .”²⁶³ The Endocrine Society states that diagnostic procedures for adolescents usually include a “complete psychodiagnostic assessment and, preferably, a child psychiatric evaluation.”²⁶⁴

3. *Benefits of Treatment*

For adolescents diagnosed with gender dysphoria, puberty blockers offer them the best solution to their distress by allowing them to feel comfortable and in control of their identities by the time they reach adulthood and can decide whether to pursue further treatment. The main advantage of puberty suppressing medication is that it gives adolescents time to reflect over their gender identity, without becoming trapped in a body that feels alien and unnatural to them and may well not reflect their ultimate gender identity.²⁶⁵ “As compared with starting sex reassignment long after the first phases of puberty, a benefit of pubertal suppression is relief of gender dysphoria and a better psychological and physical outcome.”²⁶⁶ In addition, a court that is concerned about the possibility of the adolescent changing his or her mind about the treatment would be reassured by the fact that the treatment is reversible.

a. *Reversibility of Treatment*

One of the major rationales behind the parental consent requirement is the fear that adolescents lack the maturity and rationality to comprehend the long-term consequences and risks of certain types of treatment.²⁶⁷ Under the doctrine, minors are considered less likely to have the legal capacity to make decisions for major medical interventions or procedures. A court considering whether an adolescent has the capacity to consent to puberty delaying treatment would need to know the risks that the treatment entailed, and what the consequences would be if it turned out the adolescent did not have gender dysphoria (or if the gender dysphoria did not persist before completion of treatment).

263 Coleman et al., *supra* note 61, at 176.

264 Hembree et al., *supra* note 71, at 8.

265 Giordano, *supra* note 230, at 580.

266 Hembree et al., *supra* note 71, at 13.

267 *See infra* Part V.D.

First, the possibility of the treatment being administered to an adolescent who turns out not to have gender dysphoria is very low. “An important difference between gender dysphoric children and adolescents is in the proportion for whom dysphoria persists into adulthood.”²⁶⁸ While gender dysphoric feelings in most children do not continue into adulthood,²⁶⁹ persistence of gender dysphoria into adulthood is much higher for adolescents.²⁷⁰ In fact, some studies show that many adolescents diagnosed with gender dysphoria or GID who come to clinics for treatment also desire gender reassignment.²⁷¹ Thus, adolescents diagnosed with gender dysphoria are likely to have gender dysphoria when they are adults. However, even if puberty blocking medication were administered to an adolescent who was wrongly diagnosed as gender dysphoric, the treatment is completely reversible and entails little risk. For instance, the WPATH SOC classifies puberty suppressing GnRH analogues as “fully reversible interventions.”²⁷² The Endocrine Society also maintains that “prolonged pubertal suppression using GnRH analogues is reversible and should not prevent resumption of pubertal development upon cessation of treatment.”²⁷³ If an adolescent with gender dysphoria does not become a transgender adult, or if he or she does not wish to transition, then puberty-suppressing drugs need only be withheld for pubertal development to restart as normal (though delayed). If an adolescent does decides to continue with the treatment and eventually transition, then transition will be much smoother with puberty arrested. The adolescent can go from puberty-suppressing hormones to “partially reversible interventions,” including cross-hormones at age sixteen, allowing the adolescent to achieve a much more satisfactory appearance when old enough to pursue sex-reassignment.²⁷⁴ Unlike cross-hormones or surgical intervention, which can permanently modify the body,²⁷⁵ puberty blockers carry much less risk of “post-treatment regret.”²⁷⁶

268 Coleman et al., *supra* note 61, at 172.

269 *Id.* (“Gender dysphoria during childhood does not inevitably continue into adulthood . . . In contrast, the persistence of gender dysphoria into adulthood appears to be much higher for adolescents.”); *see also* Hembree et al., *supra* note 71, at 6.

270 Annelou L.C. de Vries & Peggy T. Cohen-Kettenis, *Clinical Management of Gender Dysphoria in Children and Adolescents: The Dutch Approach*, in *TREATING TRANSGENDER CHILDREN AND ADOLESCENTS: AN INTERDISCIPLINARY DISCUSSION* 7, 16 (Jack Drescher & William Byne eds., 2013) (“While gender dysphoric feelings in younger children will usually remit, in adolescents this is rarely the case”) [hereinafter de Vries, *The Dutch Approach*]; *see also* Coleman et al., *supra* note 61, at 172.

271 de Vries, *The Dutch Approach*, *supra* note 270, at 16.

272 Coleman et al., *supra* note 61, at 176.

273 Hembree et al., *supra* note 71, at 12.

274 Coleman et al., *supra* note 61, at 177.

275 Cross-hormonal treatment is described as partially reversible by the WPATH SOC and the Endocrine Society. According to Simona Giordano, “One final important risk associated with cross sex hormones is that the treatment is only partially reversible. If a patient decides to interrupt treatment,

b. *Empirical Results of Administering Puberty Suppressing Treatment*

Research on the effectiveness of puberty blocking treatment in treating gender dysphoria has shown promising results. Many of these studies are based on a clinic in Amsterdam that treated adolescent patients with puberty blocking medication and carefully tracked their outcomes. This approach to treating gender dysphoria in adolescents is referred to as the “Dutch Protocol” or “Dutch model.” Two studies have shown extremely positive results for those who received the treatment.²⁷⁷ The two studies involved measuring the psychological functioning of the first seventy gender-dysphoric adolescents eligible for puberty suppression at two different times.²⁷⁸ The first measurement occurred during the adolescents’ attendance at the clinic. The second measurement was made shortly before the start of cross-sex hormone treatment.²⁷⁹ According to the studies, the adolescents’ “behavioral and emotional problems and depressive symptoms [had] decreased, while general functioning as measured by the Global Assessment Scale improved significantly during puberty suppression. No adolescent withdrew from puberty suppression and all started cross-sex hormone treatment, the first step of the actual gender reassignment.”²⁸⁰ A second group of those treated with puberty blockers, after being assessed post-operatively, “appeared to be satisfied with their lives and no longer gender dysphoric.”²⁸¹ The studies also stated that there was no confirmation of unfavorable physical effects resulting from early physical intervention.²⁸² Annalou L.C. de Vries and Peggy T. Cohen-Kettenis, in their article describing this Dutch approach, concluded that these initial results demonstrated the effectiveness of GnRH analogues at treating gender dysphoria.²⁸³ These results were supported by another study published in 2014, which was the first “longer-term longitudinal

effects such as voice change and beard growth cannot be changed, although possibly ameliorated, and breast development in males through administration of estrogens and progestin can be only removed with surgery.” SIMONA GIORDANO, CHILDREN WITH GENDER IDENTITY DISORDER: A CLINICAL, ETHICAL, AND LEGAL ANALYSIS 87 (2013).

²⁷⁶ Shield, *supra* note 40, at 388.

²⁷⁷ Shannon Price Minter, *Clinical Management of Gender Dysphoria in Children and Adolescents: The Dutch Approach*, in TREATING TRANSGENDER CHILDREN AND ADOLESCENTS: AN INTERDISCIPLINARY DISCUSSION 7 (Jack Drescher & William Byne eds., 2013).

²⁷⁸ de Vries, *The Dutch Approach*, *supra* note 270, at 20.

²⁷⁹ *Id.*

²⁸⁰ *Id.*

²⁸¹ *Id.* at 20–21.

²⁸² *Id.*

²⁸³ *Id.*

evaluation” of the Dutch approach.²⁸⁴ The study included assessments of fifty-five young adults who were among seventy adolescents prescribed puberty suppression between 2004 and 2011.²⁸⁵ The results of this long-term evaluation of puberty suppression among transgender adolescents indicated that participants no longer suffered from gender dysphoria and were just as happy as their peers.²⁸⁶ “[A]ll young adults in this study were generally satisfied with their physical appearance and none regretted treatment.”²⁸⁷

C. COMPARISON TO ABORTION CONTEXT

The Supreme Court’s rationale behind the parental consent exception for minors’ reproductive and contraceptive decisionmaking applies to transgender adolescents who seek hormonal treatment regardless of their parents’ wishes. In *Bellotti v. Baird*, the Supreme Court presumed that parents act in the best interests of their children,²⁸⁸ yet held that states could not impose an absolute parental veto over a minor’s decision to obtain an abortion.²⁸⁹ The Court distinguished the abortion decision from other decisions made during minority by noting that:

a pregnant adolescent, however, cannot preserve for long the possibility of aborting, which effectively expires in a matter of weeks from the onset of pregnancy. Moreover, the potentially severe detriment facing a pregnant woman . . . is not mitigated by her minority . . . In sum, there are few situations in which denying a minor the right to make an important decision will have consequences so grave and indelible.²⁹⁰

In other words, the urgency of obtaining treatment (an abortion) in that case, and the enduring consequences of withholding that treatment from the minor, convinced the Court that the Constitution did not allow the government to require pregnant adolescents to obtain parental consent to get an abortion.

This reasoning can be applied to transgender adolescents. Like pregnant minors, transgender adolescents have a small window of time during which treatment can be administered. Once a baby is born, it is too

²⁸⁴ Annelou L.C. de Vries et al., *Young Adult Psychological Outcome After Puberty, Suppression and Gender Reassignment*, 134 J. PEDIATRICS 696, 696 (2014) [hereinafter de Vries, *Young Adult Psychological Outcome*].

²⁸⁵ *Id.* at 697.

²⁸⁶ *Id.* at 670; see also Beth Sherouse, *New Study Supports Puberty Blockers for Transgender Youth*, HUMAN RIGHTS CAMPAIGN BLOG (Sept. 11, 2014), <http://www.hrc.org/blog/entry/new-study-supports-puberty-blockers-for-transgender-youth>.

²⁸⁷ de Vries, *Young Adult Psychological Outcome*, *supra* note 284, at 701.

²⁸⁸ *Bellotti v. Baird*, 443 U.S. 622, 638–39 (1979).

²⁸⁹ *Id.* at 653–54.

²⁹⁰ *Id.* at 642.

late to get an abortion; likewise, once pubertal development is complete and secondary sex characteristics have formed, GnRH analogues are not as effective and cannot completely reverse the changes. It is true that while an abortion can no longer be effective once the baby is born,²⁹¹ GnRH analogues can still be useful to those who are further along in their physical and sexual development.²⁹² Nevertheless, “GnRH analogue administration should begin before it is too late to reverse the process.”²⁹³ For instance, once daytime testosterone production commences in boys, virilization (the development of male physical characteristics, including muscle bulk, body hair, and deepening voice) becomes irreversible.²⁹⁴

Without an abortion, a teen will be forced to bear the child, a process that is physically taxing and even dangerous for a young woman.²⁹⁵ The young mother may be burdened by an infant requiring significant care. Even if the mother can put the child up for adoption, there is no foolproof way of ensuring that the child won’t try to contact the mother in the future. There are closed adoptions, in which records of the biological parents are kept sealed, but effects of social media and the internet have made it easier for adoptees to find birth relatives.²⁹⁶ Likewise, without puberty blockers a transgender adolescent will be burdened by physical changes that may not be rectified by cross-hormones or surgery.

Finally, like puberty blockers, there is a reversion element to abortion services. A teen who obtains an abortion is, in effect, preventing further development of the pregnancy and returning her body to the way it was before pregnancy. In fact, many teens desire an abortion for that reason. Thus, for the same reasons why pregnant teens may obtain abortions without parental consent, a transgender teen should access puberty-suppressants without parental consent.

291 Even if the baby is not yet born, a pregnant woman faces time-based restrictions on her ability to obtain an abortion. In many states, abortion is prohibited at twenty-four to twenty-six weeks of pregnancy. See *Abortion Restrictions in States*, N.Y. TIMES (June 17, 2003), http://www.nytimes.com/interactive/2013/06/18/us/politics/abortion-restrictions.html?_r=0.

292 *Youth: Special Considerations*, CTR. EXCELLENCE FOR TRANSGENDER HEALTH, <http://transhealth.ucsf.edu/trans?page=protocol-youth>. (last visited Sept. 3, 2015).

293 Louis J. Gooren, *Care of Transsexual Persons*, 364 NEW ENGLAND J. MED. 1251, 1255 (2011).

294 *Id.*

295 Cristina Herdman, *The Impact of Early Pregnancy and Childbearing on Adolescent Mothers and Their Children*, ADVOC. FOR YOUTH (July 1997), <http://www.advocatesforyouth.org/publications/publications-a-z/432-the-impact-of-early-pregnancy-and-childbearing-on-adolescent-mothers-and-their-children> (“Early childbearing may be life-threatening to both the mother and the child. Mothers younger than 17 face an increased risk of maternal mortality because their bodies are not yet mature enough to bear children.”).

296 Michelle Healy, *Internet is Changing Adoption—For Better and Worse*, USA TODAY (Dec. 13, 2012), <http://www.usatoday.com/story/news/nation/2012/12/12/internet-adoption-changes/1764291/>.

VII. THE MATURITY OF THE MINOR

Transgender adolescents diagnosed with gender dysphoria are not vulnerable to influences that courts believe tend to impair rational decisionmaking in adolescents. These influences were outlined in *Roper v. Simmons*, a Supreme Court case holding that the death penalty for juveniles was an unconstitutional violation of the Eighth Amendment,²⁹⁷ and echoed in other Supreme Court cases.

A. ANALYSIS OF CHARACTERISTICS THAT INFLUENCE ADOLESCENT DECISIONMAKING

The Supreme Court in *Roper v. Simmons*, based its decision on the perception that minors, unlike adults, lack the capability of understanding the consequences of their actions. First, the Court reasoned that minors are more likely to lack maturity or a sense of responsibility than adults, resulting in them making “impetuous and ill-considered actions and decisions.”²⁹⁸ Second, minors “are more vulnerable or susceptible to negative influences and outside pressures, including peer pressure” due to having less control over their own environment.²⁹⁹ Finally, a minor’s character “is not as well formed as that of an adult.”³⁰⁰ The court does not go into much detail about the incomplete character of minors so it will not be discussed much in this Note. This presumption of the immaturity of minors is echoed in other Supreme Court Cases. In *Bellotti v. Baird*, the Court pointed to children’s “peculiar vulnerability” as justification for distinguishing children’s legal status from that of adults,³⁰¹ and in *Eddings v. Oklahoma* the Court argued that youths were “susceptible to influence and to psychological damage.”³⁰² Thus, minors are perceived as inherently immature due to their impulsivity and vulnerability to peer pressure.

This position by the Supreme Court seems to contradict its stance in cases where they held that a sufficiently mature minor possessed the right to obtain an abortion without parental notification.³⁰³ Advocates for juveniles have also adopted “potentially clashing views” of adolescent

297 See generally *Roper v. Simmons*, 543 U.S. 551 (2005).

298 *Id.* at 569.

299 *Id.*

300 *Id.* at 569–70.

301 *Bellotti v. Baird*, 443 U.S. 622, 634 (1979).

302 *Eddings v. Oklahoma*, 455 U.S. 104, 115–16 (1982).

303 See generally *Bellotti*, 443 U.S. at 642; see also *H. L. v. Matheson*, 450 U.S. 398, 409 (1981) (“Although we have held that a state may not constitutionally legislate a blanket, unreviewable power of parents to veto their daughter’s abortion, a statute setting out a ‘mere requirement of parental notice’ does not violate the constitutional rights of an immature, dependent minor”).

decisionmaking capacity.³⁰⁴ The American Psychological Association (APA) has been criticized as having inconsistent stances on the psychological maturity of adolescents. In its Supreme Court amicus brief in *Roper*, the APA described adolescents at ages sixteen and seventeen as “not yet mature in ways that affect their decision-making,” which diminished an adolescent’s blameworthiness.³⁰⁵ However, in its amicus brief in *Hodgson v. Minnesota*, which upheld adolescents’ right to seek an abortion without two-parent notification,³⁰⁶ the APA argued that adolescents were just as able as adults to make competent decisions regarding abortion.³⁰⁷ The apparent contradiction was mentioned by Justice Kennedy, who “explicitly asked at oral argument in *Roper* if the APA had ‘flip-flopped’ between 1989 . . . and 2004.”³⁰⁸

While the views of the APA and the Supreme Court regarding the maturity of pregnant minor and juvenile criminals may appear inconsistent, some scholars argue that the views of the APA and the Supreme Court regarding the maturity of pregnant minors and criminal juveniles are actually compatible. For example, Laurence Steinberg maintains that the views are reconcilable because the “circumstances under which individuals make medical decisions and commit crimes are very different and make different sorts of demands on individuals’ brains and abilities.”³⁰⁹ In other words, an adolescent might be mature enough to understand and make decisions in some situations, but not others. Based on their studies of age differences in cognitive capacity, Steinberg and his colleagues concluded that “[w]hereas adolescents and adults perform comparably on tests measuring the sorts of cognitive abilities that permit logical reasoning about moral, social, and interpersonal matters, adolescents and adults are

304 Kimberly M. Mutcherson, *Minor Discrepancies: Forging a Common Understanding of Adolescent Competence in Healthcare Decision-Making and Criminal Responsibility*, 6 NEV. L.J. 927, 928 (2006).

305 Brief for the American Psychological Association and the Missouri Psychological Association as Amici Curiae Supporting Respondent at 2, *Roper v. Simmons*, 543 U.S. 551 (2005) (No. 03-633), <http://www.apa.org/about/offices/ogc/amicus/roper.pdf>.

306 *Hodgson v. Minnesota*, 497 U.S. 417, 455 (1990) (holding that a provision of a Minnesota abortion statute requiring that both parents be notified of a minor’s intent to obtain an abortion unless the pregnant minor obtains judicial bypass was unconstitutional).

307 Brief for the American Psychological Association as Amicus Curiae Supporting Appellees and Cross-Appellants at 7, *Hodgson v. Minnesota*, 497 U.S. 417 (1990) (No. 86-5423-MN/No. 86-5431-MN), <http://www.apa.org/about/offices/ogc/amicus/hodgson.pdf> (“Based on these established principles of cognitive and moral development, it is now generally accepted that by mid-adolescence (14–15) the great majority of adolescents of average intelligence do not differ from adults in their capacities to understand and reason about medical and psychological treatment alternatives, or in their abilities to comprehend and consider risks and benefits regarding treatment alternatives.”).

308 Laurence Steinberg et al., *Are Adolescents Less Mature Than Adults?: Minor’s Access to Abortion, the Juvenile Death Penalty, and the Alleged APA “Flip-Flop,”* 64 AM. PSYCHOLOGIST 583, 584 (2009) [hereinafter Steinberg, *Are Adolescents Less Mature than Adults*].

309 Laurence Steinberg, *Does Recent Research on Adolescent Brain Development Inform the Mature Minor Doctrine?*, 28 J. MED. & PHIL. 256, 261 (2013) [hereinafter Steinberg, *Recent Research on Adolescent Brain Development*].

not of equal maturity with respect to capacities such as impulse control, sensation seeking, reward sensitivity, and resistance to peer influence.”³¹⁰

Steinberg found that a minor’s ability to make informed and rational decisions was influenced by the surrounding circumstances. When adolescents contemplate medical treatment, they have “time to deliberate before making a final choice, and [have] an opportunity to consult an adult expert.”³¹¹ In the abortion context, Steinberg reported that half of all adolescents consulted nonparental adults and were likely to be informed about the risks and procedures of obtaining an abortion.³¹² “[Thirty-five] states require all women seeking an abortion to receive some type of counseling before the procedure is performed,” and “24 states mandate a waiting period . . . between the counseling and the medical procedure.”³¹³ “These policies discourage impetuous and short-sighted acts and create circumstances under which adolescents’ decision-making has been shown to be just as competent as that demonstrated by adults.”³¹⁴ In contrast, circumstances leading up to a criminal offence are characterized by “heightened emotional arousal, time pressure, and peer influence,”³¹⁵ and “studies indicate that adolescents’ crimes are more often than not impulsive and unplanned.”³¹⁶ In addition, violent crimes are usually committed by adolescents when they are with their friends, which increases the likelihood of impulsivity and sensation-seeking.³¹⁷ This shows that minors are more likely to be capable of mature decisionmaking in contexts that allow for unhurried, logical reflection.³¹⁸ Adolescents are likely to be just as capable of mature decisionmaking as adults “[w]hen it comes to decisions that permit more deliberative, reasoned decision making, where emotional and social influences on judgment are minimized or can be mitigated, and where there are consultants who can provide objective information about the costs and benefits of alternative courses of action . . .”³¹⁹

B. IMPULSIVITY

What does this mean for transgender adolescents who hope to seek hormonal treatment? It means that the adolescent will possess sufficient maturity for sound decisionmaking because the circumstances of obtaining

310 *Id.* at 262.

311 Steinberg, *Are Adolescents Less Mature than Adults*, *supra* note 308, at 586.

312 *Id.*

313 *Id.*

314 Steinberg, *Recent Research on Adolescent Brain Development*, *supra* note 309, at 261.

315 Steinberg, *Are Adolescents Less Mature than Adults*, *supra* note 308, at 586.

316 *Id.*

317 Steinberg, *Recent Research on Adolescent Brain Development*, *supra* note 309, at 261.

318 *Id.* at 264.

319 Steinberg, *Are Adolescents Less Mature than Adults*, *supra* note 308, at 592.

puberty-blocking treatment are clearly more comparable to the circumstances of obtaining an abortion than to circumstances in which minors are involved in criminal conduct. Like abortion, accessing puberty-suppressing treatment involves medical decisionmaking under circumstances that reduce the likelihood of impulsive and ill-considered actions by the adolescent. Transgender adolescents can obtain puberty-suppressing treatment only through consultation with a mental health professional and after undergoing psychological assessment.³²⁰ For example, under the WPATH SOC, adolescents are eligible for treatment only after “demonstrat[ing] a long-lasting and intense pattern of gender nonconformity,” proving that their “[g]ender dysphoria emerged or worsened with the onset of puberty,” and showing that they do not have other coexisting medical and psychological problems that could interfere with treatment.³²¹ Members of the trans-community have criticized protocols like WPATH SOC for being too strict and rigid by not allowing individuals to make informed decisions about their own health without following multiple steps.³²² Transgender people face significant barriers when seeking treatment because doctors, not patients, determine eligibility and readiness for treatment.³²³ Moreover, informed consent must be obtained before hormonal treatment can commence.³²⁴

These barriers show that there is little risk that an adolescent will impulsively take hormones without considering the long-term consequences of treatment. The argument that safeguards deter impulsive medical decisionmaking by minors in the context of abortion applies with even greater force to the context of transgender youth seeking hormone treatment.³²⁵ For instance, while pregnant adolescents have lived with the circumstances of their pregnancy for several months, “[t]ransgender youth have lived with the circumstance of their assigned sex since birth.”³²⁶ In addition, “[t]aking hormones is a process that occurs over time, rather than a single procedure” like abortion.³²⁷ Thus, “[t]he lengthy timeframe creates

320 Maureen Carroll, Commentary, *Transgender Youth, Adolescent Decisionmaking, and Roper v. Simmons*, 56 UCLA L. Rev. 725, 736 (2009).

321 Coleman et al., *supra* note 61, at 177.

322 *Part 2: Medical*, MAINETRANSNET, <http://www.mainetransnet.org/trans/medical.html> (last visited Dec. 13, 2014).

323 Rachel McKinnon, *Trouble Making the Change: My Transgender Experience*, CONVERSATION (Sep. 26, 2013), <http://theconversation.com/trouble-making-the-change-my-transgender-experience-18527>.

324 Coleman et al., *supra* note 61, at 177.

325 Carroll, *supra* note 320, at 743.

326 *Id.*

327 *Id.*

a strong likelihood that a transgender youth seeking hormones has fully considered the consequences of the decision.”³²⁸

C. VULNERABILITY TO PEER PRESSURE

In the criminal justice context, adolescents may be vulnerable to pressure to engage in illegal behavior out of a desire to fit in with peers. This is not a concern in situations where transgender youth seek access to puberty-suppressing treatment because there is no indication that they would face pressure to obtain puberty-suppressing treatment. Transgender adolescents do face significant peer pressure, but not in a way that supports impeding access to hormones. “Transgender youth face sustained and extraordinary pressure, from peers as well as adults and institutions, to conform to the gender traditionally associated with their birth-assigned sex.”³²⁹ Transgender adolescents often deal with prejudice and misconceptions regarding their gender dysphoria, and are more likely to encounter rejection of their gender-nonconforming behavior or expressed gender identity by their peers than support.³³⁰

It could be argued that transgender adolescents seeking puberty-suppressing treatment are influenced by outside pressures because they could more convincingly “pass” as their desired gender by stopping the development of noticeable secondary sex characteristics. A major concern among transgender people who choose to undergo transition are physical factors that make it harder for outsiders to recognize and accept them as their new gender.³³¹ Transgender youth might receive fewer negative responses to their expressions of gender identity if they took hormones that helped them appear as their desired gender. The problem with this reasoning is that “hormones hardly represent the path of least resistance to social acceptance of a gendered self. Moreover, while others’ recognition of an individual’s gender is part of the construction of that gender, seeking recognition is not equivalent to seeking acceptance or approval”³³² For transgender people, having an external appearance that matches their gender identity creates a sense of satisfaction and comfort within themselves.³³³ The desire to avoid being reminded of and associated with

328 *Id.*

329 *Id.* at 745.

330 See Part II.A.; see also HANDBOOK OF GENDER RESEARCH IN PSYCHOLOGY, VOLUME 1 at 24 (Joan C. Chrisler & Donald R. McCreary eds., 2010) (“For adolescents who identify as lesbian, gay, bisexual, or transgender (LGBT), experiences with school and peer group settings can be harsh and unwelcoming. Unfortunately, being labeled as a sexual minority still carries pervasive negative connotations within most adolescent peer groups.”).

331 Cohen-Kettenis & van Goozen, *supra* note 232, at 246.

332 Carroll, *supra* note 320, at 745–46.

333 JANIS GREEN, BECOMING A VISIBLE MAN 90 (June 4, 2004).

their birth sex is not some “weak response to peer pressure.”³³⁴ Thus, a mature transgender adolescent’s right-to-consent to puberty-suppressing hormones is more analogous to a minor’s right to obtain an abortion than a minor’s anti-death penalty rights based on lack of culpability. However, even though transgender adolescents would be found sufficiently mature based on the arguments presented in this Note, they may still be prevented from accessing treatment for practical and financial reasons.

VIII. PRACTICAL CONSIDERATIONS

Puberty blockers can be prohibitively expensive and are only available as injections or implants.³³⁵ The cost of implants varies from \$4500 to \$15,000 and they must be inserted by a surgeon; monthly injections are approximately \$1200 per month.³³⁶ This does not include the cost of other treatment like blood work, x-rays, and office visits.³³⁷ Another major issue for transgender people is that most private and public health insurance plans in the United States “deny coverage for medical procedures and treatments . . . specific to transgender people.”³³⁸ Even if a transgender youth has insurance, many plans do not cover hormone treatment. An adolescent without parental support probably does not have the financial resources to cover the treatment.

One possible source of funds is Medicaid, a social healthcare program for individuals of low income. However, Oregon, the first state to allow low-income teens to use Medicaid coverage for puberty-blocking drugs, did so only recently, in 2014.³³⁹ Other options include organizations created to help fund treatment for transgender people. For example, the Jim Collins Foundation raises money to fund gender-confirming surgeries for transgender people.³⁴⁰ These types of resources are limited, however, leaving many transgender adolescents with no means to pay for treatment even if they could access treatment. In what situation, then, would courts confront the issue of whether a transgender adolescent was sufficiently mature to consent to treatment despite parental rejection? That situation would involve cases similar in facts to *Smith v. Smith*—split-family custody

334 Carroll, *supra* note 320, at 746.

335 Norman P. Spack, *Puberty Inhibitors*, TRANS YOUTH FAMILY ALLIES (last visited Oct. 30, 2015), http://www.imatyfa.org/permanent_files/pubertyblockers101.html

336 *Id.*

337 *Id.*

338 Kellan Baker & Andrew Cray, *Why Gender-Identity Nondiscrimination in Insurance Makes Sense*, CTR. FOR AM. PROGRESS (May 2, 2013), <https://www.americanprogress.org/issues/lgbt/report/2013/05/02/62214/why-gender-identity-nondiscrimination-in-insurance-makes-sense/>.

339 Christina Hoag, *Why Transgender Teens Want Medicaid to Help Pay to Block Puberty*, TAKEPART (Oct. 31, 2014), <http://www.takepart.com/article/2014/10/30/oregon-trans>.

340 THE JIM COLLINS FOUNDATION, <http://jimcollinsfoundation.org/> (last visited Oct. 30, 2015).

dispute cases where a supportive parent is willing to cover hormone treatment and other medical care for his or her transgender child while the other parent opposes the treatment.

A. APPLICATION TO SPLIT FAMILY CASES

In *Smith* the court had to decide whether to change custody from the mother, who believed her child had GID and was willing to pay for puberty-delaying treatment, to the father, who opposed the treatment.³⁴¹ Should a similar case involving a gender dysphoric adolescent come to court, the court must decide in the best interests of the child. This means deciding whether it is in the adolescent's best interest to give custody to the supportive parent willing to cover reversible hormone treatment or to the non-supportive parent. By incorporating the mature minor doctrine in to the best interests of the child doctrine, a court deciding this type of case would consider the wishes of the adolescent and the adolescent's maturity and decisionmaking capabilities. A judge who understands the benefits of puberty blockers, their effectiveness at combatting gender dysphoria, and the reversible nature of the treatment would favor granting custody to the supportive parent if the adolescent can also show that he or she understands the risks and nature of the treatment and makes clear his or her desire to undergo pubertal delay.

IX. CONCLUSION

Transgender adolescents diagnosed with gender dysphoria often suffer serious distress resulting from incongruence between their expressed gender and secondary sex characteristics. This distress is exacerbated by family rejection, leading to increased depression, anxiety, and suicidal tendencies in transgender youth. One treatment shown to be effective in addressing gender dysphoria is the use of puberty-suppressing hormones to delay pubertal development, allowing adolescents to buy time to determine their true gender identity. However, the general rule of parental consent to medical treatment for minors prevents gender dysphoric adolescents from accessing this treatment when their parents are unwilling to agree to the treatment. The issue of whether courts should permit transgender minors to access puberty-delaying treatment emerges in split-family cases where one parent opposes the other parent's support of treatment for their transgender child. In these types of cases, the adoption of the mature minor doctrine can help courts reach a proper decision in the best interests of the child.

341 *Smith v. Smith*, 2007-Ohio-1394, *1, *3 (Ohio Ct. App. 2007).

Evidence showing the effect of gender dysphoria on the minor's mental and emotional state, the effectiveness of puberty blockers at alleviating distress, and the low risk of treatment resulting from its reversibility weigh in favor of granting access to the treatment. A transgender adolescent who understands the risks and procedures of treatment and is capable of rational decisionmaking, is sufficiently mature enough to consent to receiving puberty blockers. Finally, the reasoning behind giving mature minors the right to obtain abortions without parental consent applies to transgender minors who seek treatment for gender dysphoria. Like abortion, access to puberty-suppressing treatment involves unhurried decisionmaking and consultation that deters impulsive decisions by adolescent patients, and decisions by the patients are not improperly influenced by outside pressures. Through the mature minor doctrine, adolescents who prove themselves mature and capable of informed consent should have the right to access puberty-suppressing treatment independent of their parents' wishes.