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# When Parents' Interests and Minors' Best Interests Conflict: The Rights of Transgender Minors to Obtain Puberty Blocking Hormones Absent Parental Consent

Jessica Peslak

**When Parents' Interests and Minors' Best Interests Conflict: The Rights of Transgender Minors to Obtain Puberty Blocking Hormones Absent Parental Consent**

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Parents of transgender minors[1] are increasingly faced with the difficult decision of whether to consent to treatment for a minor with gender dysphoria. Over the last decade, endocrinologists have begun recommending the use of puberty suppressing hormones to temporarily suspend the onset of puberty in gender dysphoric minors and allow additional time for the minor to definitively determine their gender.[2] These puberty suppressing hormones delay the minor's development for several years, potentially as many as seven, and maintain preadolescence both physically and emotionally.[3] Once the minor reaches age sixteen, the minor can then decide whether to proceed with cross-hormone therapy or stop taking puberty-suppressing hormones and begin puberty in accordance with their cisgender; either way use of these hormones grants a minor with gender dysphoria invaluable additional time to decide to either accept or reject their natal gender, and undergo adolescence in the desired gender.[4] The age of sixteen is significant because by age eighteen, most transgender minors are already experiencing adolescent changes, developing all the characteristics of their original gender, and therefore the medical interventions may be unable to stall maturity.[5]

Isaac is a twelve year-old transgender minor who struggled from the onset of puberty in his natal gender and was not able to receive hormonal treatment absent parental consent.[6] His parents faced the difficult decision of whether to consent to puberty suppressing hormones for their

[1] *Minor*, BLACK'S LAW DICTIONARY 126 (5th ed. 2016). A "minor" is legally defined as a someone who has not reached full legal age; a child or juvenile.
[2] Green, *supra* note 2
[3] *Id*.
[4] *Id*.
[5] *Id*.
[6] *Id*.

minor.[7] His parents realized from a young age that Isaac had gender dysphoria: "Who would stick with this transition in the face of such social pain if it weren't true?" his mother said.[8] Once Isaac began experiencing pubescent changes, Isaac asked his parents to consent to puberty suppressing hormones.[9] Like many parents, his mother did not support the treatment, "I instinctually didn't want to start messing with Isaac's endocrine system. I said no."[10] Despite Isaac's pleas and arguments, supported by the advice of "every medical and psychiatric professional", his parents refused to consent to puberty suppressing hormonal treatment .[11] As a result, Isaac experienced pubescent changes, "it didn't make sense to me," he said.[12] When Isaac turned thirteen, and well past Tanner Stage 2,[13] Isaac was terrified of the "super-feminine puberty horrors" that might start at any moment: "the period, of course, and the breasts. I was a ticking clock."[14]

Eventually, Isaac's parents consented to hormonal treatment after he experienced his first menstrual period,[15] which was a extremely upsetting experience.[16] As Isaac's story highlights, immense psychological pain may result when a minor's idea of who they are is betrayed by their body and unsupported by their family and society.[17] Once Isaac's parents realized the effects of gender dysphoria on Isaac, they consented to puberty suppressing hormonal treatments.[18]

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[7] *Id*.
[8] Green, *supra* note 2.
[9] *Id*.
[10] *Id*.
[11] *Id*.
[12] *Id*.
[13] Puberty suppressing hormones are most effective if started when a minor is entering Stage 2 of growth as indicated in the Tanner scale of physical development. At the beginning of Stage 2, there is almost no breast development in females, or genital enlargement in males. Females reach Stage 2 at a mean age of about 11, males at about 13. However, Tanner Stage 2 may begin as young as 9 in both sexes. *Id*.
[14] Green, *supra* note 2.
[15] *Id*.
[16] "A boy bleeding, even if you know the boy is biologically a girl, is a long way from the philosophical conundrums that make it easy for outsiders to mock trans people." *Id*.
[17] *Id*.
[18] *Id*.

Although the puberty suppressing hormonal treatment halted Isaac's menstrual cycle, his parents consented too late, and Isaac had already begun developing breasts before starting treatments.[19] Due to the delay in accessing puberty suppressing hormones, when Isaac reached the age of eighteen and had top sex reassignment surgery, he needed a full mastectomy instead of the simpler "keyhole"[20] surgery that would have sufficed if treatment had begun earlier.[21] As a result, Isaac experienced a longer recuperation period, larger scars, and a chest that may never look quite the same as a cis female.[22] As a result of the surgery and cross-hormone therapy, specifically testosterone, which Isaac started at fifteen, he is happy to see the physical changes of his body.[23] His parents are also relieved they made the correct deicsion for their child.[24] Isaac's father is especially "proud and very quickly got used to the pleasure of having a son".[25] Similar to Isaac, there are numerous stories of transgender minors experiencing the onset of puberty in the opposite sex they identify with because their parents deny and delay access to puberty suppressing hormones.

The use of puberty suppressing hormones for minors with gender dysphoria has gained acceptance since 2009, when this treatment was first endorsed by the Endocrine Society.[26] Puberty suppressing hormones help adolescents decide their true gender by affording minors invaluable time without causing irreversible physical changes.[27] As advocates articulate, "[s]imply delaying

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[19] *Id*.
[20] Small incision made and breast tissue removed with liposuction. This is a much less invasive procedure compared to a full mastectomy. Green, *supra* note 2
[21] *Id*.
[22] *Id*.
[23] *Id*.
[24] *Id*.
[25] *Id*.
[26] Anemona Hartocollis, *The New Girl in School: Transgender Surgery at 18*, N.Y. TIMES. (June 16, 2015), https://www.nytimes.com/2015/06/17/nyregion/transgender-minors-gender-reassignment-surgery.html.
[27] *Id*.

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."[28] This Comment argues that minors should be able to individually consent to puberty suppressing hormones without parental authorization for several reasons. First, puberty suppressing hormones provide adolescents the necessary time to decide their true gender identity. Second, use of puberty suppressing hormones is reversible.[29] This reversibility is significant considering studies suggest most minors with gender dysphoria eventually lose the desire to change their sex, and may grow up to be gay, rather than transgender.[30] Once into adolescence, however, a minor's dysphoria is more likely to remain permanent.[31] Therefore, the use of puberty suppressing hormones will afford minors time to decide their true gender rather than create irreversible change and foreclose the minors' options in the future. Given the benefits of puberty suppressing hormones, Oregon's Medicaid began covering the gamut of treatment, including hormone therapy and puberty suppression, regardless of age, in January 2015 and patients as young as fifteen no longer need parental consent to receive medically necessary treatment.[32] In addition, New York passed a statute in 2016 making Medicaid coverage available for medically necessary hormone therapy and/or gender reassignment surgery to treat gender dysphoria.[33] New York extended coverage to all individuals, not just those over the age of eighteen years old.[34]

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[28] J. Bryan Lowder, *Listen to Leelah Alcorn's Final Words*, SLATE (Dec. 31, 2014), https://slate.com/human-interest/2014/12/leelah-alcorn-transgender-teen-from-ohio-should-be-honored-in-death.html.

[29] This Comment takes no position on whether adolescents should be allowed to consent to cross-sex hormones. The reversibility of puberty blockers, warranting trans minors to consent to their use is not present in the context of cross-sex hormones. In addition, the effects of cross-sex hormones can be permanent and result in infertility.

[30] *Id*.

[31] Green, *supra* note 2.

[32] Anemona Hartocollis, *The New Girl in School: Transgender Surgery at 18*, N.Y. TIMES (June 16, 2015), https://www.nytimes.com/2015/06/17/nyregion/transgender-minors-gender-reassignment-surgery.html.

[33] Matthew Hamilton, *New York Allows Medicaid Coverage For Transgender Minors*, TIMES UNION (December 7, 2016) https://www.timesunion.com/local/article/New-York-allows-Medicaid-coverage-for-transgender-10781863.php.

[34] *Id*.

*Part I* of this Comment explains what gender dysphoria is generally and the treatments available. *Part II* describes the common law presumption and deference to parental authority and the parental role in making medical decisions for their minors. *Part III* explores when and how minors may access puberty suppressing hormones without parental consent or notification. Relying on the U.S. Supreme Court case *Belotti v. Baird*,[35] where the Court held the mature minor doctrine enables a minor to obtain a judicial bypass and circumvent parental consent requirements, this Part proposes a two-fold approach, and considers two narrow exceptions to parental consent requirements in order to allow a minor to access puberty suppressing hormones independently. All minors have the ability to seek a judicial bypass hearing. The first part of this two-fold approach recommends that if, at the judicial bypass hearing, a court determines a minor is not mature or competent enough to make such a medical determination, a medical guardian *ad-litem* should be appointed in order to determine the "best interests" of the minor. The second part of this two-fold approach, will discuss how, if at the judicial bypass hearing the minor proves sufficient competence and maturity, then the minor will be granted a judicial bypass, and gain access to puberty suppressing hormones absent parental consent. Once a medical guardian *ad litem* is appointed or the maturity of the minor is determined, the urgency and reversibility of the treatment should temper the courts and allow these minors to receive puberty suppressing hormones. *Part IV* will argue that the United States should recognize and emulate Australia's approach, which currently allows minors with gender dysphoria to seek puberty suppressing hormones. *Part V* concludes.

[35] Bellotti v. Baird, 443 U.S. 622 (1979).

It is important to define key terms.[36] *Transgender* refers to "a diverse group of individuals whose gender does not match their biological sex at birth."[37] *Gender non-conforming* is used to describe behaviors that do not conform to society's expectations of masculinity and femininity.[38] *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.[39]

Given this Comment's focus on the accessibility of treatment used during, or even before, puberty to delay the development of secondary sex characteristics, it is also important to distinguish adolescents from minors and children. *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). *Adolescence* and *puberty* are not the same. *Puberty* is "the experience of sexual maturation for girls and boys."[40] *Puberty* encompasses hormonal, physical, and physiological changes in the body during the transition from childhood to adulthood.[41] While adolescence largely overlaps with puberty in terms of time, its boundaries are less distinct.[42] The World Health Organization (WHO) defines an adolescent as any person between ages ten and nineteen.[43]

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[36] These terms are preferable to *transsexual.* Kristen Schilt, *Transsexual*, ENCYCLOPEDIA OF GENDER AND SOCIETY, 860, 860 (2009).
[37] Kimberly Tauches, *Transgender*, ENCYCLOPEDIA OF GENDER AND SOCIETY, 844, 844 (2009).
[38] GLAAD Media Reference Guide – *Transgender Issues*, GLAAD, https://www.glaad.org/reference/transgender (last visited Oct. 28, 2015).
[39] *Id*.
[40] ENCYCLOPEDIA OF CHILDREN AND CHILDHOOD: IN HISTORY AND SOCIETY, 701–02 (Paula S. Fass ed., 2004).
[41] THE GALE ENCYCLOPEDIA OF CHILDREN 'S HEALTH: INFANCY THROUGH ADOLESCENCE, 1830 (Jacqueline L. Longe ed., 2d ed. 2011).
[42] THE GALE ENCYCLOPEDIA OF MEDICINE 3635 (Lauri J. Fundukian, ed., 4th ed. 2011).
[43] *Adolescence*, ENCYCLOPEDIA BRITANNICA ONLINE, http://www.britannica.com/science/adolescence (last visited Oct. 29, 2015).

This Comment 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).[44] A minor has gender dysphoria when there is a marked incongruence between one's expressed gender and natal gender for at least six months and is manifested by at least two of the following:

> 1. 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)
> 2. 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)
> 3. A strong desire for the primary and/or secondary sex characteristics of the other gender
> 4. A strong desire to be of the other gender (or some alternative gender different from one's designated gender)
> 5. A strong desire to be treated as the other gender (or some alternative gender different from one's designated gender) 6. A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's designated gender).[45]

## I. Treating Gender-Dysphoric Minors

### A. Gender-Dysphoric Minors and Psychological Well-Being

[44] 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.

[45] Wylie C. Hembree et al., *Endocrine Treatment of Transsexual Persons: An Endocrine Society Clinical Practice Guideline*, 94 J. CLINICAL ENDOCRINOLOGY & METABOLISM 3869–3903 (2017).

While the Supreme Court has recognized the common law presumption that parents act according to their children's best interests,[46] in certain cases (abortion, contraception, sterilization, or organ donation)[47] courts have the discretion to intervene when necessary.[48] Courts may intervene if the best interests of the minor do not properly align with the parents' interests and the parent's decision may place the child at risk of harm or impinge on the child's constitutional right.[49] Specifically, in the context of transgender minors, parents' interests and children's best interests may not always align as parents may reject the idea of medical treatment.[50]

It is important to discuss the large number of transgender adolescents in our society to recognize and appreciate the severity of this issue. The Trans Youth Family Allies (TYFA), a national support organization for parents, found that based on counselor visits to schools, one or two out of 500 students are transgender, which scaled up would suggest 150,000 to 300,000

[46] *See* See Meyer v. Nebraska, 262 U.S. 390, 399–400 (1923) (holding that the rights guaranteed under the Fourteent Amendment include the right to "bring up children"); Pierce v. Soc'y of Sisters, 268 U.S. 510, 534–35 (1925) (stating that "those who nurture [the child] and direct his destiny have the right coupled with the high duty, to recognize and prepare him for additional obligations."); Prince v Massachusetts, 321 U.S. 158, 166 (1944) (stating that "it is cardinal with us that the custody, care and nurture of the child reside first in the parents" but recognizing that the state can limit parental authority when necessary to protect the child's health or protect the public from communicable disease).

[47] *See* Anne Tamar-Mattis, *Exceptions to the Rule: Curing the Law's Failure to Protect Intersex Infants*, 21 BERKELEY J. GENDER L. & JUST. 59 (2006) (discussing these scenarios).

[48] *See* Wisconsin v. Yoder, 406 U.S. 205, 233–34 (1972) ("To be sure, the power of the parent, even when linked to a free exercise claim, may be subject to limitation under *Prince* if it appears that parental decisions will jeopardize the health or safety of the child, or have a potential for significant social burdens."); Parham v. J.R., 442 U.S. 584, 602-603 (1979) (recognizing parents' broad authority over children and "'high duty' to recognize symptoms of illness and to seek and follow medical advice" and noting that the "state is not without constitutional control over parental discretion in dealing with children when their physical or mental health is jeopardized."); Troxel v. Granville, 530 U.S. 57, 65 (2000) ("the interest of parents in the care, custody, and control of their children—is perhaps the oldest of the fundamental liberty interests recognized by [the Supreme] Court.").

[49] *See* Prince v. Massachusetts, 321 U.S. 158, 166 (1944) (stating that "it is cardinal with us that the custody, care and nurture of the child reside first in the parents" but recognizing that the state can limit parental authority when necessary to protect the child's health or protect the public from communicable disease); Wisconsin v. Yoder, 406 U.S. 205, 233–34 (1972) ("To be sure, the power of the parent, even when linked to a free exercise claim, may be subject to limitation under *Prince* if it appears that parental decisions will jeopardize the health or safety of the child, or have a potential for significant social burdens."); Parham v. J.R., 442 U.S. 584, 602–03 (1979) (recognizing parents' broad authority over children and "'high duty' to recognize symptoms of illness and to seek and follow medical advice" and noting that the "state is not without constitutional control over parental discretion in dealing with children when their physical or mental health is jeopardized.")

[50] Green, *supra* note 2

children nationally are transgender.[51] Although no law prohibits minors from receiving puberty blocking hormones, cross-sex hormones, or even sex reassignment surgery, both public and private insurers have generally refused to extend coverage for these procedures to those under the age of eighteen without parental consent.[52]

Transgender youth experiencing puberty often become extremely distressed by the onset of physical characteristics associated with the gender they reject.[53] Gender dysphoric minors may experience family rejection, peer rejection, harassment, trauma, abuse, inadequate housing, legal problems, lack of financial support, and educational problems.[54] Transgender minors also experience alarmingly high rates of verbal harassment, physical violence, and economic discrimination; often at home and at school.[55] 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), seventy-three percent of the youths reported being verbally abused by their parents.[56] In addition, transgender youth often endure rejection, neglect, and abuse from their parents, and sometimes find themselves thrown out of their homes entirely, causing severe psychological and physical harm.[57] 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 fifty-one percent of transgender respondents who experienced family rejection reporting having attempted suicide,

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[51] *Id*.
[52] Anemona Hartocollis, *The New Girl in School: Transgender Surgery at 18*, N.Y. TIMES. (June 16, 2015), https://www.nytimes.com/2015/06/17/nyregion/transgender-minors-gender-reassignment-surgery.html.
[53] *Id*.
[54] AMERICAN PSYCHOLOGICAL ASSOCIATION TASK FORCE ON GENDER IDENTITY AND GENDER VARIANCE (2009), https://www.apa.org/pi/lgbt/resources/policy/gender-identity-report.pdf.
[55] *Id*.
[56] Arnold H. Grossman & Anthony R. D'Augelli, *Transgender Youth and Life-Threatening Behaviors*, 37 SUICIDE & LIFE-THREATENING BEHAVIOR 527, 528 (2007).
[57] 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).

compared to thirty-two percent of those whose families did not reject them.[58] 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."[59] A recent study focusing on transgender youth age fifteen to twenty-one found that forty-five percent had thought of killing themselves, and half of these said their thoughts were related to their transgender status.[60] Given the difficulties transgender minors are faced with, it is not surprising that many transgender minors experience significant mental health issues including depression, suicidality, anxiety, body image issues, substance abuse, and posttraumatic stress disorder.[61] In addition to potentially facing rejection, maltreatment, and victimization, transgender youth also experience personal distress and isolation.[62]

These psychological harms only tend to amplify and worsen with the onset of pubescent changes. The Endocrine Society guidelines emphasize that "an adolescent with gender identity dysphoria (GID) often considers the pubertal physical changes to be unbearable."[63] In addition, as transgender teens mature with age, "[t]hey have to cope with . . . living with a self-concept that is never socially acknowledged or reinforced."[64] The development of secondary sex characteristics due to puberty are permanent (without invasive surgical intervention), and transgender youth

[58] 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).
[59] Erika Skougard, *The Best Interests of Transgender Children*, UTAH L. REV. 1161, 1175 (2011).
[60] SUICIDE PREVENTION RESOURCE CENTER, SUICIDE RISK AND PREVENTION FOR LESBIAN, BISEXUAL, AND TRANSGENDER YOUTH 27 (Effie Malley et al. eds., 2008).
[61] Johanna Olson, *Management of the Transgender Adolescent*, ARCH. PEDIATR. ADOLSEC. MED. 165 (2011).
[62] Arnold H. Grossman & Anthony R. D'Augelli, *Transgender Youth and Life-Threatening Behaviors*, 37 SUICIDE & LIFE-THREATENING BEHAVIOR 527, 528 (2007).
[63] Wylie C. Hembree et al., *Endocrine Treatment of Transsexual Persons: An Endocrine Society Clinical Practice Guideline*, 94 J. CLINICAL ENDOCRINOLOGY & METABOLISM 3132, 3142 (2009).
[64] Sonja Shield, *The Doctor Won't See You Now: Rights of Transgender Adolescents to Sex Reassignment Treatment*, 31 N.Y.U. REV. L. & SOC. CHANGE, 361, 382 (2007).

experiencing the puberty of their natal gender often experience anxiety, depression, and confusion.[65] Moreover, delaying gender transition until adulthood forces transgender minors to wait for treatment, causes feelings of hopelessness, and hinders social, psychological, and intellectual development.[66] This stress also may result in high risk of violence, suicide, and substance abuse.[67] This psychological trauma could be avoided or at least minimized if we afford minors the opportunity to circumvent parental consent requirements and access puberty suppressing hormones.

Allowing minors with gender dysphoria to develop in accordance with their affirmed gender contributes to their self-confidence and ability to "pass" for their affirmed sex.[68] 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 and development of secondary sex characteristics intolerable.[69] Transgender adolescents are more comfortable expressing their preferred gender identity when they are able to "pass" as this gender, but pubertal changes make this appearance more difficult to attain.[70] Pubertal changes can only be reversed or erased with great difficulty by the time the patient has reached the age of majority. Use of puberty-suppressing hormones will allow adolescents to "pass" as their preferred gender by suspending pubescent changes and development of secondary sex characteristics.

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[65] HANDBOOK OF LGBT-AFFIRMATIVE COUPLE AND FAMILY THERAPY 208 (Jerry J. Bigner & Joseph L. Wetchler eds., 2012).
[66] Sonja Shield, *The Doctor Won't See You Now: Rights of Transgender Adolescents to Sex Reassignment Treatment*, 31 N.Y.U. REV. L. & SOC. CHANGE, 361, 382 (2007).
[67] Simona Giordano, *Lives in Chiaroscuro. Should We Suspend the Puberty of Children With Gender Identity Disorder*, 34 J. MED. ETHICS 580, 581 (2008).
[68] JULIA SERANO, WHIPPING GIRL: A TRANSSEXUAL WOMAN ON SEXISM AND THE SCAPEGOATING OF FEMININITY 229, 135 (Seal Press 2007).
[69] Susan Scutti, *Transgender Youth: Are Puberty-Blocking Drugs an Appropriate Medical Intervention?*, MED. DAILY (Jun. 24, 2013, 2:17 PM), http://www.medicaldaily.com/transgender-youth- are-puberty-blocking-drugs-appropriate-medical-intervention-247082.
[70] *Id*.

B. The Gift of Time: Puberty Suppressing Hormones

The use of puberty suppressing hormones has been justified not only to avoid the harms associated with commencing transition as an adult (pubertal changes), but also affording minors sufficient time to explore their gender further and choose their true identity.[71] Importantly, the effects of puberty suppressing hormones, as opposed to cross-sex hormones are their full reversibility.[72] Once treatment is halted, puberty will recommence as usual without adverse consequences.[73] This Comment specifically promotes the use of puberty suppressing hormones given this reversibility as opposed to the use of cross-sex hormones, which may cause permanent infertility.

The current Endocrine Society guidelines allow adolescents to start hormonal treatment from Stage Two to Stage Four in the Tanner scale of physical development, although hormonal treatment is most effective if started during Stage Two, given the potential onset of pubescent changes.[74] The Tanner Stages (also known as the Tanner Scale) are a method of describing the physical development of humans from their time as children through adolescence and adulthood.[75] An individual's Tanner Stage is based on external primary and secondary sex characteristics.[76]

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[71] W. A. Marshall & J. M. Tanner, *Variations in the Pattern of Pubertal Changes in Boys*, 45 ARCH. DIS. CHILD. (1970); W. A. Marshall & J. M. Tanner, *Variations in Pattern of Pubertal Changes in Girls*, 44 ARCH. DIS. CHILD. 291 (1969), *available at* http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2020314/pdf/archdisch01552-0003.pdf. Tanner Staging is a widely accepted model for determining the development of puberty in both boys and girls. Tanner Staging identifies five distinct points of pubertal maturation by measuring the development of genitalia and public hair. This method is reliable because puberty occurs with an identifiable sequence and timing, with minor variation. The HBIGDA Standards of Care recommends initiating the treatment at Tanner Stage Two, for example where for females breast buds and pubic hair begin to appear. However, it maintains the option of initiating the treatment earlier. The five Tanner Stages are reproduced in the Child Growth Foundation report. James M. Tanner, CHILD GROWTH FOUNDATION, PUBERTY AND THE TANNER STAGES(2010), *available at* http://www.childgrowthfoundation.org/psm_tanner_stages.htm (last visited Sept. 4, 2013).
[72] *Id*.
[73] *Id*.
[74] Green, *supra* note 2
[75] *Id*.
[76] JUSTIN CORFIELD, *Tanner Stages*, in ENCYCLOPEDIA OF GLOBAL HEALTH, 1644 (Yawei Zhang ed., 2008).

Females tend to reach Stage Two at approximately eleven years old; boys, at about thirteen years old.[77] However, Tanner Stage Two may begin as young as nine years old in both sexes.[78] The Endocrine Society recommends treating gender-dysphoric adolescents (Tanner Stage 2) by suppressing puberty with GnRH analogues[79] until age sixteen years old, after which cross-sex hormones may be given.[80]

According to the 2009 Endocrine Society guidelines, gender dysphoric youth are considered eligible for puberty suppressing hormonal treatment if they meet DSM-IV criteria for gender dysphoria;[81] are at least Tanner stage two of puberty; demonstrate increased gender dysphoria with pubertal onset; have adequate mental health and social support during treatment; demonstrate no unaddressed medical or psychiatric comorbid conditions that might negatively influence evaluation and treatment of gender dysphoria; and indicate knowledge and understanding of expected outcomes of treatment.[82]

Because of the severe potential consequences of being forced to live as the opposite sex one identifies with, The Endocrine Society advises starting puberty suppressing hormonal treatment during the early stages of puberty to prevent the irreversible development of secondary sex characteristics.[83] Minors with gender dysphoria should experience the first changes of their "endogenous spontaneous puberty," because their emotional reaction to these first physical

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[77] Green, *supra* note 2
[78] 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).
[79] The gonadotropin releasing hormone (GnRH) such as Zoladex or Lupron dramatically reduce, and in some cases stop gonadal homron production, including testosterone, thus preventing the onset of pubescent changes. Wylie C. Hembree et al., *Endocrine Treatment of Transsexual Persons: An Endocrine Society Clinical Practice Guideline*, 94 J. CLINICAL ENDOCRINOLOGY & METABOLISM, 3132–54 (2017).
[80] *Id*.
[81] *Id.*
[82] Stanley Vance, *Psychological and Medical Care of Gender Nonconforming Youth*, 134 PEDIATRICS (2014).
[83] Wylie C. Hembree et al., *Endocrine Treatment of Transsexual Persons: An Endocrine Society Clinical Practice Guideline*, 94 J. CLINICAL ENDOCRINOLOGY & METABOLISM, 3869–3903 (2017); Bouman MB, van Zeijl MCT, Buncamper ME, Meijerink WJHJ, van Bodegraven AA, Mullender MG. Intestinal vaginoplasty revisited: a review of surgical techniques, complications, and sexual function.

changes have diagnostic value in establishing the persistence of their gender dysphoria.[84] But the experience of full endogenous puberty is an undesirable condition for a minor with gender dysphoria[85] and may seriously interfere with the minors' psychological functioning and well-being.[86] Thus, Tanner Stage two is the optimal time to start pubertal suppression.[87] The use of puberty suppressing hormones during this stage of treatment includes gonadotropin-releasing hormone analogues in order to prevent the onset of puberty, and has been administered to children as young as ten years old.[88] Again, administering puberty suppressing hormones at this stage of treatment is reversible, as puberty in the child's biological sex will continue if the treatment is stopped.[89] However, use of cross-sex hormones for the purpose of encouraging the development of physical characteristics in the sex with which the child psychologically identifies may be irreversible.[90] Until very recently, courts considered both stages of treatment (puberty suppressing hormones and cross-sex hormones) together and regarded them as a "special medical procedure", but now courts consider each stage individually[91] and this Comment only promotes access to puberty suppressing hormones.

C. Opposition to Puberty Blockers

[84] *Id*.
[85] Opponents of hormone therapy often fail to distinguish between puberty blocking hormone therapy and hormone therapy that promotes the development of characteristics associated with one gender or the other (cross-sex treatment): It is the latter that may cause sterilization because once puberty-blocking hormone therapy ceases, sexual maturation will restart. David Alan Perkiss, *Boy or Girl: Who Gets to Decide? Gender-Nonconforming Children in Child Custody Cases*, 27 HASTINGS WOMEN'S L.J. 315, 323 (2014).
[86] *Id*. *See supra* Part I.
[87] *Id*.
[88] *Id*.
[89] *Id*.
[90] Wylie C. Hembree et al., *Endocrine Treatment of Transsexual Persons: An Endocrine Society Clinical Practice Guideline*, 94 J. CLINICAL ENDOCRINOLOGY & METABOLISM, 3869–3903 (2017); Bouman MB, van Zeijl MCT, Buncamper ME, Meijerink WJHJ, van Bodegraven AA, Mullender MG. Intestinal vaginoplasty revisited: a review of surgical techniques, complications, and sexual function.
[91] Malcolm K Smith Ben Mathews, *Treatment for Gender Dysphoria in Children: The New Legal, Ethical and Clinical Landscape*, 202 MED. J. AUST. (2015).

Opponents of gender reassignment procedures, such as puberty suppressing hormones, cross-sex hormones, or surgical treatment, suggest instead attempts to "cure" minors of their gender dysphoria through various psychotherapies, known as conversion therapies. These methods are "not considered fruitful by the mental health professionals with the most experience working in this area."[92] In fact, currently California, New Jersey, Oregon, Illinois, Washington, DC, and the Canadian province of Ontario, have banned such therapies undertaken by licensed professionals for minors.[93] In addition, seventeen states have introduced bills in their legislatures seeking to ban these therapies.[94]

First, conversion therapy causes significant physical and psychological harms in otherwise healthy gender nonconforming children, potentially resulting in suicide, self-mutilation, nervous breakdowns, paranoia, feelings of guilt, and post-traumatic stress disorder.[95] In addition, these therapies have a very low "success rate."[96] In fact, use of conversion therapy is not considered a beneficial method by many professionals.[97] Second, the effects of puberty are virtually impossible to erase and by denying puberty blocking hormones, parents deprive their minor child of a critical choice and potentially foreclose the option of a more successful transition as an adult.[98]

Moreover, opponents of puberty suppressing hormones also argue that treatments such as

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[92] Stephen M. Rosenthal, *Approach to the Patient: Transgender Youth: Endocrine Considerations*, 99 J. CLINICAL ENDOCRINOLOGY & METABOLISM, 4379, 4379 (2014); William Byne et al., Report of the American Psychiatric Association Task Force on Treatment of Gender Identity Disorder, 41 ARCHIVES SEXUAL BEHAV. 759, 744 (2012).
[93] Drescher J, Schwartz A, Casoy F, et al. *The Growing Regulation of Conversion Therapy*, 102 J. MED. REGUL. 7–12. (2016).
[94] *Id*.
[95] Karolyn Ann Hicks, *"Reparative" Therapy: Whether Parental Attempts to Change a Child's Sexual Orientation Can Legally Constitute Child Abuse*, 49 AM. U. L. REV. 505, 513–20 (1999).
[96] *Id*.
[97] *Id*.
[98] Chloe Johnson, *Transgender Teens: Doctors Refine Hormone, Other Therapies*, FOSTER'S DAILY JOURNAL (Jan. 27, 2008), http://www.fosters.com/apps/pbcs.dll/article?AID=/20080127/GJNEWS_01/205304745/-1/FOSNEWS (quoting Anne Boedecker, "You don't have to rush to assign kids a gender. It really needs to be driven by the child." Children are more likely to accept a gender-nonconforming peer's gender transition when the transition commences at an earlier age.).

puberty suppressing hormones, are unnecessary and may exacerbate the mental and physical harms suffered by transgender minors.[99] According to these opponents, supporting gender dysphoric minors further subjects these minors to ridicule and rejection by their peers and society.[100] In addition, some opponents find these treatments unnecessary because most minors with gender dysphoria later identify as homosexual, not transgender once they reach adulthood.[101] Opponents fail to recognize the risks of denying puberty blocking hormone treatment to gender dysphoric minors.[102] Denying access to treatment forces minors to develop in the gender they do not conform with and unnecessarily restricts their time to decide their true gender identity.[103] In addition, because the effects of puberty are virtually impossible to erase, the opponents deprive the minor of a critical choice during their development and foreclose the option of a more successful transition as an adult.[104] Use of puberty suppressing hormones is also reversible and even if a minor receives this treatment, these hormones will not foreclose the ability of the minor to later change their mind. Instead, puberty suppressing hormonal treatment merely suspends the pubescent changes and secondary sex characteristics development in order to afford the minor valuable time to explore and determine their sexuality.

## II. Parental Authority

The Supreme Court has recognized that parents have a right to direct their minor child's upbringing, including the authority to make medical decisions on behalf of the child.[105] While the

[99] David Alan Perkiss, *Boy or Girl: Who Gets to Decide? Gender-Nonconforming Children in Child Custody Cases*, 27 HASTINGS WOMEN'S L.J. 315, 323 (2014).
[100] *Id*.
[101] *Id*.
[102] Opponents often misconceive that puberty suppressing hormones cause sterilization and infertility. Infertility and sterilization may potentially result from cross-sex hormones, whereas the effects of puberty suppressing hormones are completely reversible. *Id*.
[103] *Id*.
[104] *Id*.
[105] *See* Wisconsin v. Yoder, 406 U.S. 205, 233-234 (1972) ("To be sure, the power of the parent, even when linked to a free exercise claim, may be subject to limitation under *Prince* if it appears that parental decisions will jeopardize the

Supreme Court has specifically recognized that parents normally enjoy a legal presumption that they are acting in the best interests of their minor children,[106] this right is not absolute. Parental authority has been limited in certain contexts and courts have overridden parental consent requirements when a parents' decision may cause the minor harm or when the decision impinges on the minor's constitutional rights.[107] The Court has intervened and limited parental authority in contexts such as sterilization of incompetent minors, minors seeking an abortion and medical necessity.[108]

### A. Parental Authority to Make Medical Decisions

The Supreme Court has evaluated parental rights as compared with a minor's right to autonomy and recognized that the Due Process Clause requires deference to parental determinations regarding child-rearing.[109] The Court has held that parents enjoy a rebuttable

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health or safety of the child, or have a potential for significant social burdens."); Parham v. J.R., 442 U.S. 584, 602–03 (1979) (recognizing parents' broad authority over children and "'high duty' to recognize symptoms of illness and to seek and follow medical advice" and noting that the "state is not without constitutional control over parental discretion in dealing with children when their physical or mental health is jeopardized."); Troxel v. Granville, 530 U.S. 57, 65 (2000) ("the interest of parents in the care, custody, and control of their children—is perhaps the oldest of the fundamental liberty interests recognized by [the Supreme] Court.").

[106] *Id*.

[107] *See* Prince v. Massachusetts, 321 U.S. 158, 166 (1944) (stating that "it is cardinal with us that the custody, care and nurture of the child reside first in the parents" but recognizing that the state can limit parental authority when necessary to protect the child's health or protect the public from communicable disease); Wisconsin v. Yoder, 406 U.S. 205, 233-234 (1972) ("To be sure, the power of the parent, even when linked to a free exercise claim, may be subject to limitation under *Prince* if it appears that parental decisions will jeopardize the health or safety of the child, or have a potential for significant social burdens."); Parham v. J.R., 442 U.S. 584, 602-603 (1979) (recognizing parents' broad authority over children and "'high duty' to recognize symptoms of illness and to seek and follow medical advice" and noting that the "state is not without constitutional control over parental discretion in dealing with children when their physical or mental health is jeopardized.").

[108] *Id*.

[109] *See* Troxel v. Granville, 530 U.S. 57, 66 (2000) (holding that the Due Process Clause "protects the fundamental right of parents to make decisions concerning the care, custody, and con-trol of their children"); Santosky v. Kramer, 455 U.S. 745, 753 (1982) (emphasizing the extent of "the fundamental liberty interest of natural parents in the care, custody, and management of their child": it survives even a temporary loss of custody to the State due to parental misfeasance); Par-ham v. J.R., 442 U.S. 584, 602 (1979) ("Our jurisprudence historically has reflected Western civilization concepts of the family as a unit with broad parental authority over minor children. Our cases have consistently followed that course."); Quilloin v. Walcott, 434 U.S. 246, 255 (1978) ("We have recognized on numerous occasions that the relationship between parent and child is constitutionally protected."); Wisconsin v. Yoder, 406 U.S. 205, 232 (1972) ("The history and culture of Western civilization reflect a strong tradition of parental concern for the nurture and up-bringing of their children. This primary role of the parents in the upbringing of their children is now established beyond debate as an enduring American tradition."); Prince v. Massachusetts, 321 U.S.

presumption that they are acting in the best interests of their minor children.[110] Also, the Court has justified limiting the scope of minors' constitutional rights on the assumption that minors do not possess "the capacity to take care of themselves."[111] In reaching this conclusion, the Court discussed how "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." Finally, not only are minors subject to the control of their parents, but the government may also "limit the freedom of children to choose for themselves in the making of important, affirmative choices with potentially serious consequences."[112]

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."[113] The requirement of parental consent is also reflected in medical guidelines on treatment for transgender adolescents, which may impose additional barriers to treatment.[114] The Supreme Court has held that the "basis for parental control over the medical decisions for treatment of children is two-fold. It arises from the concept of a constitutional right to family privacy and the legal presumption that parents are best situated to make good decisions because natural bonds of affection lead parents to act in the best interests of their children."[115]

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158, 166 (1944) ("It is cardinal with us that the custody, care and nurture of the child reside first in the parents"); Pierce, 268 U.S. at 534-35 (holding that the Due Process Clause includes the right "to direct the upbringing and education of children under their control"); Meyer, 262 U.S. at 399, 401 (holding that the Due Process clause includes the right of parents to "establish a home and bring up children" and "to control the education of their own").

[110] Parham v. J. R., 442 U.S. 584, 624 (1979).

[111] Schall v. Martin, 467 U.S. 253, 265 (1984).

[112] Bellotti v. Baird, 443 U.S. 622, 635 (1979).

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

[114] Emily Ikuta, *Overcoming the Parental Veto: How Transgender Adolescents can Access Puberty-Suppressing Hormone Treatment in the Absence of Parental Consent Under the Mature Minor Doctrine*, 25 S. CAL. INTERDIS. L.J. 179, 182 (2016).

[115] Parham v. J.R., 442 U.S. 584, 602 (1979).

Although it is well-established that parents normally enjoy a broad latitude in making decisions on behalf of their children, parental rights are not absolute. In general, courts are willing to override parental medical decisions where the life or well-being of a minor is endangered and the court has determined that the parents are failing to provide standard medical care.[116] In addition, certain minors are competent enough to make a determination on their own, as evidence suggests by the age of fifteen years, many adolescents show a reliable level of competence in metacognitive understanding of decision-making, creative problem-solving, correctness of choice, and commitment to a course of action.[117] In fact, "while adolescent decision-making is not adult-like, it is developmentally normative… [and] may be optimized for the fulfillment of the specific goals of this developmental phase."[118] In many countries, individuals are legal adults at the age of sixteen with regard to medical decision making because at this age, most adolescents are deemed capable of making complex cognitive decisions.[119]

### B. Limits on Parental Authority

While the Supreme Court has held that parents enjoy a rebuttable presumption that they act in the best interests of their children, parental authority is not absolute. Specifically, the Supreme Court has limited parental authority over the medical decisions of their minor children in three contexts. First, the Court has limited parental authority to sterilize minors who are mentally ill or developmentally disabled. Second, the Court has limited the scope of parental consent

[116] Anne Tamar-Mattis, *Exceptions to the Rule: Curing the Law's Failure to Protect Intersex Infants*, 21 BERKELEY J. GENDER L. & JUST. 59, 158 (2006).
[117] Mann Leo &, Harmoni Ros, *Power C. Adolescent Decision-Making: The Development of Competence*, 12 J. ADOLESC. 265 (1989).
[118] Hartley, Catherine A and Leah H Somerville. *The Neuroscience of Adolescent Decision-Making Behavioral Sciences*, Curr. Opin. Behav Sci., vol. 5: 108–15 (2015).
[119] Wylie C. Hembree et al., *Endocrine Treatment of Transsexual Persons: An Endocrine Society Clinical Practice Guideline*, 94 J. CLINICAL ENDOCRINOLOGY & METABOLISM 3132, 3142 (2009).

requirements in the abortion context and currently allows minors to seek a judicial bypass. Lastly, the Court has limited parental authority by appointing a medical guardian *ad litem* when a minors' health is at serious risk and the parent's decision further jeopardizes the child's well-being.

1. Sterilization

First, parental authority has been limited in certain circumstances, including the sterilization of minors. In most jurisdictions, either legislatures or courts have decided that parents may no longer authorize the sterilization of children in their care unilaterally without judicial approval.[120] This situation arises most commonly with wards, either adults or minors, who are mentally ill or developmentally disabled.[121]

For example, in *In re Moe*, the parents of a mentally handicapped woman sought a court order permitting sterilization of their child.[122] The parents alleged that their daughter was mentally equivalent to a four year old, had been sexually active, was unable to practice any alternative form of birth control and was unable to care properly for a child.[123] The appellate court ruled this was not enough and provided an extensive procedure for making their determination.[124] The requirements laid out by the court included that: "only the interests of the ward should be considered; the court must assure an adversarial process by appointing an attorney for the ward to vigorously oppose the procedure; and the court must consider the workability of less intrusive measures, the medical necessity, risks and benefits of the procedure, and the possibility of future competence of the ward."[125] As in the case of child sterilizations or organ donations, this

[120] Anne Tamar-Mattis, *Exceptions to the Rule: Curing the Law's Failure to Protect Intersex Infants*, 21 BERKELEY J. GENDER L. & JUST. 59, 96 (2006).
[121] *Id*.
[122] *Id*. at 97.
[123] *Id*.
[124] *Id*.
[125] *Id*. at 97.

representative should be charged with arguing vigorously against the proposed surgery in order to assure a meaningful adversarial process.[126]

The consideration for the Court in the context of sterilization of incompetent minors is the "best interests" of the minor rather than the interests of parents or other parties.[127] In addition, the relevant considerations by the court in determining whether to grant a judicial bypass or appoint a medical guardian *ad litem* should be: short and long term physical risk and benefits, short and long term psychological risks and benefits, maximizing the child's future options, the quality of the evidence offered, and the child's own input.[128]

2. Medical Necessity

In circumstances where a minors' well-being is at risk and the parents refuse medical treatment, the courts will weigh the interests of each party on a case-by-case basis.[129] Factors the courts consider when deciding whether to override parental authority in favor of conventional medical treatment include: the child's specific ailment and prognosis; therapeutic risks and complications; the parents' beliefs and the genuineness of those beliefs; and whether the alternative therapy is under the direction of a licensed physician.[130] In certain circumstances, courts will appoint guardians *ad litem* to advocate for the best interests of the minor in court and to help determine whether the court should override parental authority.

In *In Re Guardianship of L.S. & H.S.*, identical twins were born premature and their circulatory systems were joined at the placenta, causing one twin to receive majority of the blood

[126] *Id*.
[127] *Id*. at 104–05.
[128] *Id*. at 105–07.
[129] Emily Catalano, *Healing or Homicide?: When Parents Refuse Medical Treatment for Their Children on Religious Grounds*, 18 BUFF. J. GENDER L. & SOC. POL'Y 157, 163 (2009-2010).
[130] *Id*. at 169.

circulation.[131] As a result, the other twin's blood platelet count had dropped to such a degree that his life was in danger.[132] The doctor petitioned the court to grant temporary custody guardianship of both children based on "the substantial and immediate risk of physical harm, potential death, and the emergency circumstances surrounding the health and well-being" of both children and requested a "special" guardianship to "provide for the medical care of the twin children."[133] The district court granted the temporary guardianship and later ratified the blood transfusion.[134] The court held that a temporary guardian may be appointed for ten days if the district court, "[f]inds reasonable cause to believe that the proposed ward is unable to respond to a substantial and immediate risk of physical harm or to a need for immediate medical attention."[135] In addition, If the petitioner demonstrated by clear and convincing evidence that the minor was "unable to respond to a substantial and immediate risk of physical harm or to a need for immediate medical attention," the court could extend the temporary guardianship for thirty days.[136]

Importantly, the court noted, "While a parent has a fundamental liberty interest in the 'care, custody, and management' of his child, that interest is not absolute."[137] In addition, the court held, "The state also has an interest in the welfare of children and may limit parental authority," even permanently depriving parents of their children.[138] Therefore, while parents have a parental

[131] Jason S. v. Valley Hosp. Med. Ctr., 120 Nev. 157, 159 (2004)
[132] *Id*.
[133] *Id. at 160.*
[134] *Id*.
[135] *Id*. at 163; NRS 159.052(2)(a).
[136] *Id.* at 163–64.
[137] *Jason*, 120 Nev. at 166.
[138] *Id*.

interest in the care of their child, the State also has an interest in preserving the child's life.[139] If a child is unable to make decisions for themself, the State's interest is heightened.[140]

In *In re McCauley*, an eight year old's life was in serious danger as she needed blood transfusions, however her Jehovah Witness parents objected to treatment.[141] Representatives of the hospital sought an order for the blood transfusion from a Judge, who granted the order.[142] The Judge issued a temporary order authorizing the administration of blood or blood products to the minor.[143] The order authorized the hospital and its medical staff to "provide all reasonable medical care which in their judgment is necessary to preserve the patient's life and health, including but not limited to the administration of blood and/or blood products, throughout the entire course of her treatment for leukemia and related conditions."[144] The court noted that the State, acting as *parens patriae*, may protect the well-being of children in certain situations, and circumvent the parental consent requirement.[145] The court discussed how it utilized the "best interests" test when determining a child's interests if parents refuse to consent to medical treatment.[146]

The court held that although parental rights and religious rights are important, those rights must yield to the state's interest in keeping a child alive when that child is dangerously ill.[147] The court conceded the right of free exercise of religion and the right of a parent to control the

[139] *Id*. at 167.
[140] *Id.* at 166–67.
[141] *In re* McCauley, 409 Mass. 134, (1991).
[142] *Id*. at 135.
[143] *Id*. at 135.
[144] *Id*. at 136.
[145] *Id*. at 136; see also Prince v. Massachusetts, 321 U.S. 158, 166–167, 64 S. Ct. 438, 442–43, 88 L. Ed. 645 (1944). The court also discussed how "[T]he power of the parent, even when linked to a free exercise claim, may be subject to limitation under *Prince* if it appears that parental decisions will jeopardize the health or safety of the child, or have a potential for significant social burdens."; *Id*. at 413. *Wisconsin v. Yoder,* 406 U.S. at 233–234, 92 S.Ct. at 1542–43.
[146] *Id.* at. 136.
[147] *In re McCauley*, 409 Mass. at 139.

upbringing of his or her child are fundamental rights.[148] But although the court conceded this, the court also stated: "[T]hese fundamental principles do not warrant the view that parents have an absolute right to refuse medical treatment for their children on religious grounds. The State's interest in protecting the well-being of children is not nullified merely because the parent grounds his claim to control the child's course of conduct on religion or conscience… the right to practice religion freely does not include liberty to ill health or death."[149]

The use of guardians *ad litem* remain an effective and efficient way to increase the voice of a minor in the court and legal process. The role of guardians *ad litem* includes protecting the child and providing recommendations to the court and assisting counsel.[150] The most significant aspect of the guardian *ad litem's* role is balancing the child's best interest with the state and the parent's interests.[151] The most frequent characterizations of the role of a guardian *ad litem* include: "investigator, champion, and monitor."[152] The guardian *ad litem* should have significant freedom to explore all the options available to the minor, offer the court a wider view of the situation, and provide assistance to the judge in making a more informed decision as they are considered officers of the court.[153]

3. Abortion

Courts have also limited the scope of parental authority when parents interests do not align with a minors best interests in the context of a minor seeking an abortion. In *Belotti v. Baird*,[154] a

[148] *Id*. at 136.
[149] *Id*. at 137.
[150] Tara L. Muhlhauser, *From "Best" to "Better": The Interests Of Children and The Role of A Guardian Ad Litem*, 66 N.D. L. REV. 633 (1990).
[151] *Id*. at 635.
[152] *Id*. at 638.
[153] *Id*. at 639.
[154] Bellotti v. Baird, 443 U.S. 622 (1979).

Massachusetts statute required parental consent before an unmarried woman under the age of eighteen could obtain an abortion.[155] Appellees brought a class action suit challenging the constitutionality of the statute.[156] 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,"[157] or in other words, a "judicial bypass" procedure.[158] The Court held, "a pregnant minor is entitled in such a proceeding to show either: (1) that she is mature enough and well enough informed to make her abortion decision, in consultation with her physician, independently of her parents' wishes; or (2) that even if she is not able to make this decision independently, the desired abortion would be in her best interests."[159] In sum, the procedure must ensure that the provision requiring parental consent does not in fact amount to the "absolute, and possibly arbitrary, veto that was found impermissible in *Danforth*."[160]

The Court therefore held that every minor must have the opportunity to go directly to a court without first consulting or notifying her parents to seek an abortion.[161] If at a judicial bypass hearing, the minor is deemed mature and well informed to make the decision on her own, the court must authorize her to act without parental consultation or consent.[162] However, if she fails to prove to the court that she is competent enough to make a determination independently, she must be permitted to show that an abortion nevertheless would be in her best interests.[163] If the court is persuaded that an abortion is in the minors best interests, the court must authorize the abortion.[164]

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[155] *Id*.
[156] *Id*. at 622.
[157] *Id*. at 643.
[158] *Id*. at 639 (citing Planned Parenthood of Cent. Mo. v. Danforth, 428 U.S. 52 (1976)).
[159] *Id*. at 643–44.
[160] Bellotti v. Baird, 443 U.S. 622 (1979).
[161] *Id*. at 647.
[162] *Id*.
[163] *Id*. at 647–48.
[164] *Id*.

If, however, the court is not persuaded by the minor that she is mature or that the abortion would be in her best interests, it may decline to sanction the operation."[165]

The holding from *Belotti* led to the development of the mature minor doctrine. Mature minors are defined as, "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"[166] or "a minor who possesses the cognitive faculties to articulate reasoned decisions regarding his or her health and welfare."[167] The mature minor 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."[168]

It is well established that an older, adolescent minor is more likely to be independent and capable of understanding the consequences of his or her actions and decisions than a younger child. Courts must consider that one of the main rationales for parental consent requirements, "is the need to protect minors from their own improvident decision making."[169] Even if an adolescent is capable of rational decision making and understands what treatment entails, he or she may "have more volatile emotions, and may look only at short-term consequences."[170] For these reasons, the age of the minor is a significant factor in determining whether the minor is mature and competent

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[165] *Id.* at 647.
[166] Garry S. Sigman & Carolyn O'Connor, *Exploration for Physicians of the Mature Minor Doctrine*, 119 J. PEDIATRICS, 520, 521 (1991).
[167] Joseph Austin, *Managing Patient Expectations Through Informed Consent*, PRINCIPLES OF RISK MANAGEMENT AND PATIENT SAFETY, 397, 402 (Barbara J. Youngberg ed., 2011).
[168] ROGER J.R. LEVESQUE, *Mature Minor Doctrine*, ENCYCLOPEDIA OF ADOLESCENCE, 1659, 1659 (Roger J.R. Levesque ed., 2011).
[169] U.S. CONGRESS, OFFICE OF TECHNOLOGY ASSESSMENT, Chapter 17: Consent and Confidentiality in Adolescent Health Care Decision making, in ADOLESCENT HEALTH VOLUME III: CROSSCUTTING ISSUES IN THE DELIVERY OF HEALTH AND RELATED SERVICES 126 (1991).
[170] Kathryn Hickey, *Minor's Rights in Medical Decision Making*, 9 JONA'S HEALTHCARE L., ETHICS & REG. 104, 101 (2007).

under the mature minor doctrine. While some courts have refused to recognize an exception to parental control even for those minors who are almost the age of majority, courts are generally likely to find minors who are at least fourteen years of age to be capable of giving informed consent.[171]

## III. Two-Fold Proposal

As shown in Part II, courts have limited parental authority in cases where a parents' decision may harm the child or impinge on the child's constitutional rights.[172] The reasons warranting court intervention in those contexts warrant similar intervention when a parent refuses to consent to puberty suppression hormones for their minor child. Parents may not always act in the child's best interests when their child is gender dysphoric. This refusal to consent to treatment may place the child at risk of significant harm and psychological distress.

This Comment proposes that minors have the ability to consent to puberty suppressing hormones over the parents' objection. This two-fold proposal provides two narrow exceptions to parental authority, and allows a minor with gender dysphoria to circumvent parental consent requirements and receive puberty suppressing hormones. All minors have the right to a judicial bypass hearing. This Comment proposes that first, if at the judicial bypass hearing, the court determines the minor is sufficiently mature, then the minor will receive a judicial bypass and be able to independently make the determination whether to receive hormonal treatments absent parental consent. Second, if at the hearing however, the court determines that the minor is not sufficiently mature to make the decision whether to use puberty suppressing hormones, then the

[171] Garry S. Sigman & Carolyn O'Connor, *Exploration for Physicians of the Mature Minor Doctrine*, 119 J. PEDIATRICS 520 (1991) ("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.").
[172] *See Supra* Part II and accompanying text.

court will appoint a medical guardian *ad lidem* to consider the minors' best interests and make recommendations to the court. In addition, this Comment encourages only the use of puberty suppressing hormones, as this treatment is fully reversible and simply affords minors the opportunity to explore their gender more thoroughly and determine their true gender identity while delaying development of secondary sex characteristics.

### A. When Best Interests of Parents and Minors Do Not Align

In certain circumstances, parents' interests and a minor's best interests may not align.[173] As a result, there exists standards, protocols, and guidelines that consider parental consent less important, and instead focus on the needs of the minor with gender dysphoria.[174] 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 gender-dysphoric persons.[175] 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."[176]

By encouraging doctors to help families understand and support their minor with gender dysphoria, guidelines like those created by the Endocrine Society place great importance on addressing gender dysphoria in children.[177] When a transgender adolescent or child is rejected by

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[173] *See Supra* Part I and accompanying text.
[174] Wylie C. Hembree et al., *Endocrine Treatment of Transsexual Persons: An Endocrine Society Clinical Practice Guideline*, 94 J. CLINICAL ENDOCRINOLOGY & METABOLISM 3132 (2009).
[175] Emily Ikuta, *Overcoming the Parental Veto: How Transgender Adolescents can Access Puberty-Suppressing Hormone Treatment in the Absence of Parental Consent Under the Mature Minor Doctrine*, 25 S. CAL. INTERDIS. L.J. 179, 182 (2016).
[176] *Id*.
[177] *Id*.

her parents, not only does the minor suffer psychological harm from rejection, but the minor also suffers harm as a result of being completely denied the most effective treatment for addressing their gender dysphoria.[178] The onset of puberty in minors with gender dysphoria is often accompanied by distress related to the "incongruence between one's affirmed gender and one's assigned (or natal) gender."[179] The psychological distress often increases with age as a result of "the harmful additive influence of being exposed to peer ostracism over time" and "receiving constant censure for their behaviors."[180] Given the various potential psychological effects, it is extremely important to consider the "best interests" of the minor above the requirements for parental consent. It makes little sense to encourage parents to maintain a "safe and supportive environment for their transitioning child" aimed at alleviating gender dysphoria,[181] yet completely deny treatment for the child if those parents reject their child's expressed gender identity and refuse to consent to treatment.

This conflict between a minor's autonomy and parental authority, has led to the establishment of laws regarding the medical decision-making capabilities of minors to be "evolving and shifting toward allowing mature minors to make informed decisions."[182] State legislatures and courts are increasingly recognizing that bright-line rules regarding who is an adult capable of consent may no longer be appropriate,[183] especially considering adolescent minors.

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[178] *Id*.
[179] Stephen M. Rosenthal, *Approach to the Patient: Transgender Youth: Endocrine Considerations*, 99 J. CLINICAL ENDOCRINOLOGY & METABOLISM, 4379, 4379 (2014).
[180] Bartlett, Bukowski & Vasey, *Is Gender Identity Disorder in Children a Mental Disorder?* (2000) SEX ROLES 43 (linking distress to "the child's not being permitted to act in the gender-atypical manner he or she desires").
[181] 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, 167 (2007).
[182] Kathryn Hickey, *Minor's Rights in Medical Decision Making*, 9 JONA'S HEALTHCARE L., ETHICS, & REG. 104 (2007).
[183] MARY HAZINSKI, ET AL., NURSING CARE OF THE CRITICALLY ILL CHILD 1077 (Mary Fran Hazinski ed., 3d ed. 2012).

These bright line rules include age of majority, emancipation conditions, mature minor and age of consent statutes.[184] The mature minor doctrine is a way the legal system recognizes the increasing capacities of minors, and transgender rights proponents should invoke this doctrine to secure legal autonomy for these adolescents seeking treatment despite parental opposition.[185]

The use of a judicial bypass and the alternate appointment of a guardian *ad litem* are both narrow exceptions to the common law rebuttable presumption that parents act in the best interests of their minor children. However, minors suffering from gender dysphoria should be able to circumvent parental consent requirements and limit parental autonomy after either the minor proves mature at the judicial bypass hearing or if not deemed mature at the hearing, when the court appoints a guardian *ad litem* and treatment is in the minors' best interest.

B. Ability to Seek a Judicial Bypass

This two-fold approach first advocates use of the mature minor doctrine to allow minors with gender dysphoria to seek a judicial bypass and circumvent parental consent requirements to access puberty suppressing hormonal treatment. Only after a minor has proven to the court their maturity and competency at a judicial bypass hearing under the mature minor doctrine, may the court grant a bypass and allow the minor to access treatment without parental consent. Use of a judicial bypass may be a preferable or necessary option when parents refuse to consent to puberty suppressing hormonal treatment. In the abortion context, a judicial bypass prevents the unconstitutional outcome of allowing a parent to hold absolute veto power over the minor's decision whether to terminate her pregnancy, and recognizes that there are circumstances where

[184] AMY T. CAMPBELL, ETHICAL CONDUCT OF CLINICAL RESEARCH INVOLVING CHILDREN (Marilyn J. Field et. al. eds., (2004).
[185] ROGER J.R. LEVESQUE, *Mature Minor Doctrine*, ENCYCLOPEDIA OF ADOLESCENCE, 1659, 1660 (Roger J.R. Levesque ed., 2011).

parental notification is not in the minor's best interests.[186] Similarly, a judicial bypass will prevent parents from maintaining absolute veto power over a minor's decision to access hormonal treatment and delay puberty. Again, this treatment is completely reversible, so it affords the minor the necessary time to decide their true gender without any irreversible consequences. Use of a judicial bypass in this context is a narrow exception to parental authority and the rebuttal presumption that parents act in accordance with the best interests of their minor children.

It is also important to compare the urgency of obtaining an abortion with the urgency for a transgender minor receiving puberty suppressing hormones. In *Bellotti v. Baird*, "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."[187] This reasoning of urgency is directly applicable to transgender adolescents facing pubescent changes. Obtaining puberty suppressing hormones is urgent for minors with gender dysphoria as physically, development of secondary sex characteristics may be irreversible or cause more complicated sex reassignment surgeries later in life as well as psychologically lead to increased anxiety and depression as the individual is forced to develop as the gender they do not identify with.[188] Therefore, use of a judicial bypass in the abortion context is significantly similar to the use of a judicial bypass for gender dysphoric minors seeking puberty suppressing treatment given the limited time afforded before pubescent changes begin.

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[186] Sonja Shield, *The Doctor Won't See You Now: Rights of Transgender Adolescents to Sex Reassignment Treatment*, 31 N.Y.U. REV. L. & SOC. CHANGE 361, 396–97 (2005).
[187] Emily Ikuta, *Overcoming the Parental Veto: How Transgender Adolescents can Access Puberty-Suppressing Hormone Treatment in the Absence of Parental Consent Under the Mature Minor Doctrine*, 25 S. CAL. INTERDIS. L.J. 179, 182 (2016).
[188] *See supra* note 44.

C. Appointment of a Guardian *Ad Litem*

The appointment of a guardian *ad litem* by the court in order to consider the minors' best interests and determine if it is necessary to circumvent parental consent to seek treatment directly correlates with use of a guardian *ad litem* in the context of minors with gender dysphoria. In the context of minors with gender dysphoria seeking puberty suppressing hormones, the minors psychological and physical well-being is at severe risk.[189] Transgender minors may face significant mental health risks including depression, suicidality, anxiety, body image issues, substance abuse, and post-traumatic stress disorder as a result.[190] In addition to the exogenous factors of rejection, maltreatment, and victimization, transgender minors may also experience personal distress and isolation.[191] Therefore, the State has an interest in preserving the minors life, and because forcing a minor with gender dysphoria to undergo puberty in the sex they do not identify with may create life-threatening consequences, the State should be able to intervene and appoint a medical guardian *ad litem*.

When the parents' interests conflict with the best interests of the minor in the context of medical necessity, the court should weigh the interests of each party on a case-by-case basis.[192] Courts must recognize that parental consent is already limited in the context of sterilization of incompetent minors, and this limitation should be applied to transgender minors seeking puberty suppressing hormones. As in the case of child sterilizations or organ donations, a guardian *ad lidem* may be appointed and charged with arguing vigorously against the proposed surgery in order

[189] *See supra* Part I and accompanying text.
[190] Johanna Olson, *Management of the Transgender Adolescent*, ARCH. PEDIATR. ADOLSEC. MED. 165 (2011).
[191] Arnold H. Grossman & Anthony R. D'Augelli, *Transgender Youth and Life-Threatening Behaviors*, 37 SUICIDE & LIFE-THREATENING BEHAVIOR 527, 528 (2007).
[192] Emily Catalano, *Healing or Homicide?: When Parents Refuse Medical Treatment for Their Children on Religious Grounds*,18 BUFF. J. GENDER L. & SOC. POL'Y 157, 163 (2009-2010).

to assure a meaningful adversarial process.[193] The consideration for the Court in the context of sterilization of incompetent minors as well as minors seeking puberty suppressing hormones should be "best interests" of the minors, rather than the interests of parents.[194] The court and guardian *ad lidem* should consider the short and long term physical risk and benefits, short and long term psychological risks and benefits, maximizing the child's future options, the quality of the evidence offered, and the child's own input to determine whether to allow the minor to access treatment absent parental consent.

In addition, the court should consider the same factors used in the context of parental refusal to provide medical treatment for religious purposes and appointment of a guardian *ad lidem*: the child's specific ailment and prognosis; therapeutic risks and complications; the parents' beliefs and the genuineness of those beliefs; and whether the alternative therapy is under the direction of a licensed physician.[195] Just as temporary guardianship of a minor may be granted when parents refuse medical treatment for their children on religious grounds, a guardian *ad litem* should be appointed to minors when "the substantial and immediate risk of physical harm, potential death, and the emergency circumstances surrounding the health and well-being"[196] demand it.

## IV. Australia's Approach

The two-fold approach advocated by this Comment is inspired by and adds to the current approach used in Australia, which allows minors to seek access to medical treatment absent parental consent. The United States should recognize Australia's approach, which is similar to

[193] *Id*.
[194] *Id*. at 104–05.
[195] *Id*. at 169.
[196] Jason S. v. Valley Hosp. Med. Ctr., 120 Nev. 157, 160 (2004).

the mature minor doctrine supported in *Bellotti*, and accept a mature minor's right to seek treatment absent parental consent. Australian Courts currently allow minors to consent to their own medical treatment if the child has proven sufficient intelligence and maturity to understand their decision. This approach also recognizes the potentially fatal consequences of denying minors with gender dysphoria timely access to puberty suppressing hormones and therefore considers the best interests of the minor.

A. Gillick Competence

Australia is the leader in the development of the law surrounding medical treatment for minors with gender dysphoria and the United States should acknowledge and expand upon the model employed by their judiciary. The majority of the House of Lords in *Gillick v West Norfolk and Wisbech Health Authority* ('*Gillick*') held that a child is capable of providing their own consent to medical treatment where they are determined to be of sufficient intelligence and maturity to fully understand what is involved; referred to as *Gillick* competency.[197] The House of Lords in *Gillick* was assessing the capacity of a child under sixteen, as children sixteen years and over can give their own consent to medical treatment.[198] The Court determined that a Gillick competent child is one who, "capable of providing his or her own consent to medical treatment where he or she is found to be of sufficient intelligence and maturity to fully understand what is involved."[199]

In 2013, the Full Court of the Family Court of Australia decided *Re: Jamie*, the first ever appellate decision concerning whether court authorization was required to treat children and adolescents with gender dysphoria.[200] In that judgment, the Court considered the application of

[197] The Hon. Justice Strickland, *To Treat or Not to Treat: Legal Responses to Transgender Young People*, Association of Family and Conciliation Courts 51st annual conference, *Building Bridges: A Multidisciplinary Approach to Family Law*, August 14-15 (2016).
[198] *Id*.
[199] *Id.*
[200] *Id*.

principles developed by the High Court of Australia in *Secretary, Department of Health and Community Services; JWB and SMB* (‘*Marion’s Case*’), a case which concerned the proposed sterilization of an intellectually disabled young person, to treatment for gender dysphoria.[201]

In *Re Jamie*, the first stage of treatment for gender dysphoria was considered, involving suppression of puberty through the use of a gonadotrophin releasing hormone.[202] Hormonal treatment was sought on an urgent basis in light of Jamie’s advanced pubertal development.[203] The second stage of the treatment involved administration of cross-sex hormones, and was to commence when Jamie turned sixteen years old, consistent with the guidelines of the United States Endocrine Society.[204] The Court had evidence that suppressing male puberty would prevent emotional and social distress for Jamie because developing a more male appearance could have significantly impacted her mood, self-confidence and social functioning.[205] Stage One treatment using puberty suppressing hormones was said to “minimize the risk” of Jamie developing depression, anxiety and the related risk of self-harm and suicidal behavior.[206] The Court was also informed that an alternative of just a behavioral approach to treatment would be unlikely to be beneficial for Jamie, and that Jamie would find withholding treatment as invasive within itself.[207]

Evidence was presented from Jamie’s Doctor that he was satisfied that Jamie was able to understand the consequences of continued suppression of puberty, but did not possess the level of

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[201] *Id*.
[202] The Hon. Justice Strickland, *To Treat or Not to Treat: Legal Responses to Transgender Young People*, Association of Family and Conciliation Courts 51st annual conference, *Building Bridges: A Multidisciplinary Approach to Family Law*, August 14-15 (2016).
[203] *Id*.
[204] *Id*.
[205] *Id*.
[206] *Id*.
[207] The Hon. Justice Strickland, *To Treat or Not to Treat: Legal Responses to Transgender Young People*, Association of Family and Conciliation Courts 51st annual conference, *Building Bridges: A Multidisciplinary Approach to Family Law*, August 14-15 (2016).

maturity to be responsible of a decision of such gravity.[208] In regards to Jamie's competence to consent to Stage One treatment, the Judge said, "I agree with Dr. C that at Jamie's age, she still needs to be guided by her parents' decision. The finding however is clear, that Jamie herself has a good understanding of and ardently seeks the treatment to start straight away."[209] The Judge also noted, "Jamie's long - standing wishes, the fact of her close family members being able to support her needs, and the real risks to Jamie if this treatment were not commenced, assisted me in reaching the conclusion that the Stage 1 treatment was in Jamie's best interests, and needed to commence as a matter of urgency."[210] Therefore, the court considered a variety of factors including the Jamie's own personal wishes, as well as the health risks involved in preventing treatment, before making its ultimate conclusion that puberty suppressing hormones were the minors' best interest.

The Australian court employed a similar version of the mature minor doctrine emphasized in *Bellotti* and recognized the mature minor's right to consent. This is an important development and promotes the autonomous wishes of a full moral agent. Although the best interests of the child is not always specifically referred to in the judgments arising from applications for a finding of competency, it is clear that judges are deeply concerned with ensuring their orders which are compassionate and empathetic, and accord with expert opinion as well as the child's personal wishes. The Judge in *Re Jamie* also discussed that "treatment for something as personal and essential as the perception of one's gender and sexuality would be the very exemplar of where the rights of a *Gillick* - competent child should be given full effect."

[208] *Id.*
[209] *Id.*
[210] *Id.*

The holding by Australian courts demonstrate an acute awareness of the potentially fatal consequences of denying young people with gender dysphoria timely access to puberty suppressing hormone treatments. It is argued, that in the American context at least, "our current piecemeal approach to establishing exceptions to the informed consent law is confusing to doctors, judges, and minors alike."[211] This new legal landscape in Australia shows there is a growing importance for minors with gender dysphoria to access puberty suppressing hormones absent parental consent and this need is unmet in the United States.

## V. Conclusion

Although parents enjoy a rebuttable presumption that they act in the best interests of their children, in certain situations, a parent may fail to consider the best interest of their minor child with gender dysphoria. The two-fold approach this paper advocates involves two limited exceptions to parental authority. First, for minors deemed mature at a judicial bypass hearing, a bypass should be granted allowing the minor to access puberty suppressing hormones absent parental consent. Second, if a court deems a minor is not mature or competent enough at a judicial bypass hearing, a medical guardian *ad litem* should be appointed to make decisions adjudging the minors' best interests and whether to allow access to puberty suppressing hormones.

[211] Sonja Shield, *The Doctor Won't See You Now: Rights of Transgender Adolescents to Sex Reassignment Treatment*, 31 N.Y.U. REV. L. & SOC. CHANGE 361, 396–97 (2005).