THE DOCTOR WON'T SEE YOU NOW: RIGHTS OF TRANSGENDER ADOLESCENTS TO SEX REASSIGNMENT TREATMENT

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I.
INTRODUCTION

Transgender adolescents[1] who seek sex reassignment treatment are caught in a dangerous holding pattern. Their gender identity exposes them to significant bias and discrimination at home, at school, and on the street, often to devastating effect.[2] Yet many who are mature, capable of giving informed consent, and have full understanding of their gender identity are prevented from medically transitioning to the gender with which they identify until they reach eighteen, the legal age of consent.

The dangers that transgender youth face during their adolescent years are numerous, scarring, and often have permanent repercussions. Many are kicked out of their homes by their parents and then are placed in foster care or become homeless.[3] Due to discrimination based on their gender nonconformity, many find it difficult to obtain legal employment or housing, and become trapped in a cycle of poverty, homelessness, and criminalization.[4] In addition, the physical changes wrought by puberty are not easily reversed, so an individual barred from sex reassignment procedures until after puberty will forever see the mark of this

1. In this Article I use the term *transgender* to refer to individuals whose gender identity differs from the physical sex they were assigned at birth. *See generally* discussion *infra* Part II.

2. *See* discussion *infra* Part III.A.

3. *See* discussion *infra* Part III.A.2–3.

4. *See id.*

delay on his or her body.[5] Despite these significant harms, and the fact that many adolescents have the maturity to make the decision to seek sex reassignment treatment, most transgender adolescents must bide their time until they turn eighteen and are transformed into legal adults. They are prevented from actualizing their identities and must defer age-appropriate development until later in life, making explorations of intimate relationships and avocation difficult, if not impossible, in the interim.

As a general rule, minors below the age of consent may not authorize their own medical care.[6] The law presumes that parents will act in the best interest of their minor children, so that parents' decisions about whether a transgender adolescent will receive sex reassignment treatment can effectively act as "an absolute, and possibly arbitrary, veto"[7] over the adolescent's identity and physical self-determination until the adolescent turns eighteen. This situation is highly problematic. First, parents may refuse to consent to their child receiving transgender-related treatment, acting out of bias and ignorance rather than their child's genuine need and best interests. Second, there is a high incidence of lesbian, gay, bisexual, and transgender (LGBT)[8] youth in foster care, so transgender youth are highly likely to fall under the guardianship of the State.[9] The State is not always knowledgeable enough or sufficiently free of bias to be able to adequately act in the best interests of transgender youth in its care.

There are, however, several potential remedies. Professional medical treatment protocols already define the circumstances in which adolescents may receive sex reassignment procedures.[10] Medical professionals should provide transgender adolescents with treatment to the fullest extent permissible under these protocols.[11] In addition, where parents or guardians will not consent, competent transgender adolescents should be allowed to consent to their own medical care. The law already provides that adolescents below the age of majority may consent to their own medical care in certain analogous circumstances.[12] Advocates should make use of the legal doctrines underlying this body of law, particularly the mature minor[13] and emancipated minor[14] doctrines, to assist adolescents in gaining access to necessary health treatment. Legislatures should

5. *See* discussion *infra* Part III.B.1.

6. *See* discussion *infra* Part V.A.

7. Bellotti v. Baird (*Bellotti II*), 443 U.S. 622, 643 (1979) (recognizing exception to general requirement of parental consent for minors' medical decisions) (citing Planned Parenthood of Cent. Mo. v. Danforth, 428 U.S. 52, 72 (1976)). The parallels between abortion and access to health care for transgender youth will be discussed further *infra* Parts VI.C.1, VI.D.

8. *See* discussion of terminology *infra* Part II.

9. *See infra* Part III.A.2.

10. *See infra* Part IV.C.

11. *See infra* Part VII.A.

12. *See infra* Part V.B.

13. *See infra* Part VII.B.1.

14. *See infra* Part VII.B.2.

also explicitly codify the right of transgender adolescents to consent to their own medical care.[15]

Medical professionals are understandably concerned that they will face liability if those who obtain sex reassignment treatment later come to regret it. This concern, though important, can be addressed through the framework of existing legal and medical protocols, and thus should not prevent transgender youth from being able to transition. Medical guidelines address concerns that youth might later regret the decision to undergo irreversible procedures.[16] Additionally, adequate standards are built into how the law ascertains the ability of individuals, particularly minors, to give informed consent.[17] Sex reassignment treatment is analogous to other types of medical care to which these legal principles have already been applied which allow minors to safely and legally consent to care. Using these principles and guidelines, those adolescents who might make less-well-considered decisions are screened out, protecting medical professionals from liability should they treat transgender adolescents on the basis of the adolescent's own informed consent.

In this Article, after providing explicit definitions of terms in Part II, I begin in Part III by discussing the harms to the minor who is prevented from accessing necessary treatment, and the physical and mental effects of delaying sex reassignment transition. In Part IV, I discuss the medical and psychiatric establishments' responses to transgender people. In Part V, I outline the informed consent doctrine, which generally bars minors from consenting to their own medical care, and exceptions to this doctrine. In Part VI, I discuss the rationales for granting transgender adolescents the ability to consent to their own sex reassignment treatment, including the harm to the minor who is prevented from accessing necessary treatment, the positive results demonstrated by medical studies of adolescents completing sex reassignment, the fallacy of the judicial presumption that minors do not have the capacity to make adult decisions, and the ways in which case-by-case evaluations of maturity more effectively serve youth and the interests of the State. In Part VII, I suggest several strategies that youth and advocates might use to secure sex reassignment treatment, including education of medical professionals to enforce existing medical protocols, legal advocacy, and legislative solutions.

I will use New York to ground my discussion of consent law. Although the specific formulation for minors' ability to consent to medical care differs from state to state, the general principles remain the same. The paradigm I suggest is therefore applicable nationally. Where New York case law on the exceptions to the informed consent doctrine for minors is lacking, particularly in the health care context, I will draw on persuasive reasoning from other jurisdictions.

15. *See infra* Part VII.D.

16. *See infra* Part IV.C.

17. *See, e.g., infra* Part VII.B.1 (discussing the mature minor exception).

II.
DEFINITIONS

Gender identity is one's "actual or perceived sex, and includes a person's identity, appearance, or behavior, whether or not that identity, appearance, or behavior is different from that traditionally associated with the person's sex at birth."[18] It is important to distinguish gender identity, which is one's internal sense of one's own gender (i.e., male, female), from sexual identity, which describes to whom one is sexually or romantically attracted (i.e., gay, straight, bisexual).

The term *transgender* encompasses people whose gender identity, behavior or presentation varies from or challenges strict gender norms[19] or "whose perceived gender or anatomic sex may be incongruent with their gender expression."[20] Transsexual individuals seek to change the sex category that they were assigned at birth, or seek some other degree of physical alteration to their body to bring their physical self into closer alignment with their internal gender identity.[21] In this Article, I use *transgender* as an umbrella term for gender-nonconforming individuals, and *transsexual* for those who seek to alter their body or their birth-assigned sex category.[22]

In reference specifically to minors, much of the literature uses the term "gender deviant" or "cross gender." Although I will use these terms where necessary to preserve the language of cited texts, in my discussion of minors, I will generally use the terms *gender-variant* or *non-normative* gender identification, expression, or behavior, which I believe are more descriptive and less stigmatizing.

Throughout this Article, I draw on studies of LGBT people generally, in order to assist in drawing conclusions about transgender people specifically. Transgender people are typically folded into a broader "gay, lesbian, bisexual

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18. ALEXANDER JOHN GOODRUM, S. ARIZ. GENDER ALLIANCE, GENDER IDENTITY 101: A TRANSGENDER PRIMER 4 (1998), http://sagatucson.org/saga/index.php (follow "Resources/Links" hyperlink; then follow "Documents" hyperlink; then follow "Gender Identity 101" hyperlink) [hereinafter GENDER IDENTITY 101]. *See also* GAY-STRAIGHT ALLIANCE NETWORK/TIDES CTR., TRANSGENDER LAW CTR. & NAT'L CTR. FOR LESBIAN RIGHTS, BEYOND THE BINARY: A TOOL-KIT FOR GENDER IDENTITY ACTIVISM IN SCHOOLS 5 (2004) ("Gender identity refers to a person's internal, deeply-felt sense of being either male, female, something other, or in between. Everyone has a gender identity.").

19. Kathleen A. Oriel, *Medical Care Of Transsexual Patients*, 4 J. GAY & LESBIAN MED. ASS'N 185, 185 (2000).

20. CITY & COUNTY OF S.F. HUMAN RIGHTS COMM'N, COMPLIANCE GUIDELINES TO PROHIBIT GENDER IDENTITY DISCRIMINATION (Dec. 10, 2003), http://www.sfgov.org/site/sfhumanrights_page.asp?id=6274.

21. Robert J. Stoller, *Male Childhood Transsexualism*, 7 J. AM. ACAD. CHILD PSYCHIATRY 193, 193–95 (1968).

22. For more on gender identity, the difference between sex and gender, and the diversity within the transgender community, see JODY MARKSAMER & DYLAN VADE, TRANSGENDER LAW CTR., TRANSGENDER 101 (2003).

and transgender" category. Within the LGBT population, transgender people are less frequently the specific subject of study, making it necessary to extrapolate from studies based on lesbian, gay, and bisexual (LGB) people. I believe that studies of LGB people may reliably be generalized to apply to transgender people, as many of the issues these populations face are sufficiently alike. For example, the discrimination and harassment faced by gay and lesbian youths has been well documented.[23] Transgender youth are visible to peers as having non-normative gender or sexuality in much the same way that gay and lesbian youth often are. A young effeminate gay man and a teenage male-to-female transgender person will likely face similar slurs from peers. Harassers do not know the gender identity of their targets: both LGB youth and transgender youth are harassed based on their perceived gender, not necessarily their internal gender identity.

Indeed, it is possible that the discrimination suffered by LGB people might be even more pronounced for transgender people. For example, in biannual studies conducted by the Gay Lesbian and Straight Education Network (GLSEN), transgender youth consistently report more incidents of verbal and physical harassment, physical abuse and assault, and feelings of lack of safety at school, compared to gay or lesbian students.[24] The greater visible non-conformity with gender expectations and stereotypes often exposes transgender youth to greater rates of violence and discrimination than their LGB peers. While LGB people violate gender norms by seeking non-heterosexual relationships, challenging the gender stereotype that men date women, transgender people undermine an even more fundamental gender norm: that biology (male or female) determines gender identity (man or woman) and gender

23. *E.g.*, JOSEPH G. KOSCIW & ELIZABETH M. DIAZ, THE GAY, LESBIAN & STRAIGHT EDUC. NETWORK, THE 2005 NATIONAL SCHOOL CLIMATE SURVEY: THE EXPERIENCES OF LESBIAN, GAY, BISEXUAL AND TRANSGENDER YOUTH IN OUR NATION'S SCHOOLS 21–27 (2006), *available at* www.glsen.org/binary-data/GLSEN_ATTACHMENTS/file/585-1.pdf [hereinafter 2005 SCHOOL CLIMATE SURVEY]. This study found that 64% of LGBT youth reported verbal harassment at school related to their sexual orientation, 38% reported being physically harassed because of their sexual orientation, and almost two-thirds felt unsafe at school because of their sexual orientation. This same pool of LGBT students reported that 46% experienced verbal harassment because of how they express their gender, 26% were physically harassed due to their gender expression, and 40% felt unsafe at school because of how they express their gender. *See also* JASON CIANCIOTTO & SEAN CAHILL, THE NAT'L GAY & LESBIAN TASK FORCE POLICY INST., EDUCATION POLICY: ISSUES AFFECTING LESBIAN, GAY, BISEXUAL, AND TRANSGENDER YOUTH 29–40 (2003), *available at* http://www.thetaskforce.org/downloads/EducationPolicy.pdf. *See also* Lambda Legal, Statements on Hate Crime, http://www.lambda.org/1989_statements.htm (last visited Jan. 9, 2007) (collecting statements by public officials on hate crimes against LGB people).

24. *See* 2005 SCHOOL CLIMATE SURVEY, *supra* note 23, at 52–53; JOSEPH G. KOSCIW & ELIZABETH M. DIAZ, THE GAY, LESBIAN & STRAIGHT EDUC. NETWORK, THE 2003 NATIONAL SCHOOL CLIMATE SURVEY: THE EXPERIENCES OF LESBIAN, GAY, BISEXUAL AND TRANSGENDER YOUTH 27 (2004), *available at* http://www.glsen.org/binary-data/GLSEN_ATTACHMENTS/file/300-3.PDF; JOSEPH G. KOSCIW & MK CULLEN, THE GAY, LESBIAN & STRAIGHT EDUC. NETWORK, THE 2001 NATIONAL SCHOOL CLIMATE SURVEY: THE SCHOOL-RELATED EXPERIENCES OF OUR NATION'S LESBIAN, GAY, BISEXUAL AND TRANSGENDER YOUTH 21–22 (2002), *available at* http://www.glsen.org/binary-data/GLSEN_ATTACHMENTS/file/221-1.pdf.

expression (masculine or feminine). Those threatened by challenges to gender stereotypes will likely be made even more uncomfortable by transgender people than by those who are lesbian, gay, or bisexual. Thus, where appropriate in this Article, I will either use the experiences of LGB people as a proxy for those of transgender people, or will extrapolate from reports of LGB people to suggest that the experiences of transgender people might be worse than those reported by their LGB peers.

III.
THE HARMS SUFFERED BY TRANSGENDER ADOLESCENTS CREATE A NEED FOR EARLY TRANSITION

Forcing transgender youth to wait until they are eighteen to begin sex reassignment treatment causes irreparable damage to the minor. During childhood and adolescence they are targets of discrimination and harassment. These experiences cause physical and mental harms, the effects of which cannot be completely erased. The schooling of many transgender students is impaired, interrupted or ended. When children express or disclose a non-normative gender, some parents refuse to let them continue living at home. Transgender youth are at increased risk of violence at school and on the streets, and often face employment and housing discrimination. Because transgender youth frequently avoid initiating platonic or romantic relationships before transitioning, they may developmentally fall behind their peers in these areas. Furthermore, the physical changes of puberty are hard to reverse if sex reassignment treatment is started at a later age. Moreover, many transgender youth could safely initiate sex reassignment treatment at ages younger than eighteen, making these harms a tragic and unnecessary imposition.

A. Discrimination and Harassment Faced by Transgender Youth

Transgender youth face discrimination and violence because they do not conform to what are perceived to be "appropriate" gender behaviors or norms. Some of the problems faced by transgender youth include violence at the hands of their peers and families, housing and employment discrimination, abuse by police, severe mental and physical health issues, and barriers to adequate and sensitive medical care.[25] These harms are exacerbated by a legal system that

25. In 2002, New York City prohibited discrimination on the basis of gender identity. N.Y.C. LOCAL LAW No. 3 § 2 (2002) (codified as amended at N.Y.C. ADMIN. CODE § 8-102(23) (2003)) (defining gender to include "actual or perceived sex and . . . a person's gender identity, self-image, appearance, behavior or expression" regardless of whether it is different from what is "traditionally associated with the legal sex assigned to that person at birth"). The legislative findings are particularly worthy of note:

> [T]he impact of gender-based discrimination is especially debilitating for those whose gender self-image and presentation do not fully accord with the legal sex assigned to them at birth. For those individuals, gender-based discrimination often leads to pariah status including the loss of a job, the loss of an apartment, and the refusal of service in

denies adolescents any power to actualize their identity and instead leaves them to suffer through these challenges until they reach legal adulthood.

No one deserves to be evicted from their home, denied a job, targeted for violence and harassment, or profiled by police, simply for being who they are. We owe it to those who have borne the brunt of these documented harms to do our best to prevent these ills from occurring. Easing access to sex reassignment treatment is only part of the solution, certainly; there are significant changes that also need to happen at many levels of society.[26] However, allowing necessary medical treatment as early as possible when there is a demonstrated need, and minimizing obstacles that force people to wait too long, will help reduce the harms needlessly suffered by transgender people.

1. School-based violence and harassment

Transgender youth face particular harassment in school settings.[27] Due to the social stigma associated with non-normative gender expression, gender-

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public accommodations such as restaurants or stores. The impact of such discrimination can be especially devastating for those who endure other prejudices due to their race, ethnicity, national origin, or citizenship status, in addition to gender-based discrimination.

Id. § 1.

A 2006 decision found that the New York State Human Rights Law, N.Y. EXEC. LAW § 290 (McKinney 2005), protects transgender people. Buffong v. Castle on the Hudson, No. 11634/05, 2005 N.Y. Slip Op. 52314(U), at 2 (Sup. Ct. Aug. 9, 2006), http://www.nycourts.gov/reporter/3dseries/2005/2005_53413.htm ("[T]he word 'sex' in the statute covers transsexuals."). *Buffong* relied on decisions which had interpreted the New York City Human Rights Law to protect transgender people even prior to the 2002 amendment to § 8-102(23) of the N.Y.C. Admin. Code which provided explicit protection to transgender people.

A report published by San Francisco's Human Rights Commission made findings similar to New York's legislative findings above when it investigated discrimination against transgender people in order to provide recommendations to the City. JAMISON GREEN, CITY & COUNTY OF S.F. HUMAN RIGHTS COMM'N, INVESTIGATION INTO DISCRIMINATION AGAINST TRANSGENDERED PEOPLE (Sept. 1994), http://www.sfgov.org/site/uploadedfiles/sfhumanrights/docs/tgreport.pdf. Among other grave findings, this investigative report concluded that "transgendered people are subject to severe discrimination in employment, housing and public accommodations [and]... that trangendered persons have experienced great difficulty in obtaining medical and social services." *Id.* at 7–8. A study by the San Francisco Department of Public Health confirmed that transgender people experienced high rates of abuse and discrimination (verbal abuse: 85%; physical abuse: 30%; employment discrimination: 57%; housing discrimination: 20%). S.F. DEP'T OF PUB. HEALTH, THE TRANSGENDER COMMUNITY HEALTH PROJECT (1999), http://hivinsite.ucsf.edu/InSite.jsp?doc=2098.461e. A study by the Gender Public Advocacy Coalition (GenderPAC) found that 59.5% of transgender people had been victims of violence outside the home. RIKI ANNE WILCHINS, EMILIA LOMBARDI, DANA PRIESING & DIANA MALOUF, GENDERPAC, FIRST NATIONAL SURVEY ON TRANSGENDER VIOLENCE 1 (1997).

26. I do not argue that transitioning in order to assimilate into a traditional gender category and avoid discrimination is an acceptable solution. Rather, I describe the biases faced by transgender youth to demonstrate the real and significant harms suffered.

27. *See, e.g.*, SHANNON MINTER & CHRISTOPHER DALEY, NAT'L CTR. FOR LESBIAN RIGHTS & TRANSGENDER LAW CTR., TRANS REALITIES: A LEGAL NEEDS ASSESSMENT OF SAN FRANCISCO'S TRANSGENDER COMMUNITIES 21 (2003), www.transgenderlawcenter.org/tranny/pdfs/Trans%20Realities%20Final%20Final.pdf [hereinafter TRANS REALITIES].

variant children often experience significant social distress as their peers punish them for behavior that is viewed as gender-inappropriate.[28] This harassment generally begins when children first enter elementary school. In 2004, the Third Circuit heard the case of P.S.,[29] a student who suffered years of harassment by peers:

> . . . In elementary school, P.S. was teased by other children who viewed him as "girlish," but when P.S. began to attend [middle school] in fifth grade, the bullying intensified. . . . P.S was the victim of relentless physical and verbal harassment as well as social isolation by his classmates.
>
> Most of the harassment of P.S. focused on his lack of athleticism, his physique, and his perceived effeminacy. Bullies constantly called P.S. names such as "faggot," "gay," "homo," "transvestite," "transsexual," "slut," "queer," "loser," "big tits," and "fat ass." Bullies told new students not to socialize with P.S. Children threw rocks at P.S., and one student hit him with a padlock in gym class. When P.S. sat down at a cafeteria table, the other students moved. Despite repeated complaints, the school administration failed to remedy the situation.
>
> The constant harassment began to cripple P.S. He became depressed, and his schoolwork suffered. . . .
>
> In eighth grade, the harassment became so intense that P.S. attempted suicide.[30]

P.S.'s school experience is, sadly, not unique. Almost two-thirds of LGBT youth interviewed by GLSEN for its 2005 survey on the incidence of harassment in schools reported being harassed at school in the previous year.[31] When asked how their gender expression had affected their schooling, slightly over 40% reported feeling unsafe at school because of their gender expression,[32] 46% reported being verbally harassed because of their gender expression,[33] 26% reported being physically harassed,[34] and over a quarter had heard teachers or other staff make negative comments about a student's gender expression.[35]

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28. Nancy H. Bartlett, Paul L. Vasey & William M. Bukowski, *Is Gender Identity Disorder in Children a Mental Disorder?*, 43 SEX ROLES: A JOURNAL OF RESEARCH 753, 764–65 (2000) (citing "teasing, rejection, and social ostracism" as examples of punishing behavior by peers).

29. Shore Reg'l High Sch. Bd. of Educ. v. P. S., *ex rel.* P.S., 381 F.3d 194 (3d Cir. 2004).

30. *Id.* at 195–96 (internal quotations omitted).

31. 2005 SCHOOL CLIMATE SURVEY, *supra* note 23, at 26.

32. *Id.* at xiii.

33. *Id.* at 23.

34. *Id.*

35. *Id.* at 16.

Similarly, Domenico Di Ceglie's study of adolescents at his gender identity clinic found that 52% reported relationship difficulties with peers.[36]

As a result of this harassment and violence, many LGBT youth are reluctant to continue attending school. They are five times more likely than their heterosexual peers to miss school due to fear for their personal safety.[37] It has been estimated that 28% of queer students drop out of school—over three times the national average.[38] For those trans-youth who do remain in school, the biased environment frequently causes the quality of their educational experience to suffer. A needs assessment of San Francisco's transgender community found:

> School administrators often fail to acknowledge a student's gender identity by refusing to issue them appropriate identification or allowing them access to appropriate facilities. Teachers regularly refuse to use a student's proper name and rarely prevent other students from committing gender based harassment. In addition to verbal harassment, other students often target transgender and gender non-conforming students for violence and social isolation.[39]

For example, transgender youth are often disciplined for dressing in accordance with their gender identity.[40] Jenny Casciano, site director of a New York

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36. Domenico Di Ceglie, David Freedman, Susan McPherson & Philip Richardson, *Children and Adolescents Referred to a Specialist Gender Identity Development Service: Clinical Features and Demographic Characteristics*, 6 INT'L J. TRANSGENDERISM, Jan.–Mar. 2002, at tbl.8, http://www.symposion.com/ijt/ijtvo06no01_01.htm [hereinafter *Clinical Features and Demographic Characteristics*].

37. Robert Garofalo, R. Cameron Wolf, Shari Kessel, Judith Palfrey & Robert H. DuRant, *The Association between Health Risk Behaviors and Sexual Orientation among a School-based Sample of Adolescents*, 101 PEDIATRICS 895, 900 (1998) [hereinafter *Health Risk Behaviors and Sexual Orientation*], *cited in* Rita Lee, *Health Care Problems of Lesbian, Gay, Bisexual, and Transgender Patients*, 172 W.J. MED. 403, 404 (2000).

38. NAT'L MENTAL HEALTH ASS'N, BULLYING IN SCHOOLS: HARASSMENT PUTS GAY YOUTH AT RISK, http://www1.nmha.org/pbedu/backtoschool/bullyingGayYouth.cfm [hereinafter BULLYING IN SCHOOLS]. *See also* Panel, *Client-Centered Advocacy on Behalf of At-Risk LGBT Youth, in* Symposium, *Queer Law 2000: Current Issues in Lesbian, Gay, Bisexual, and Transgender Law*, 26 N.Y.U. REV. L. & SOC. CHANGE 221, 223 (2000) [hereinafter *Client-Centered Advocacy*] (comments of Jenny Casciano).

> Most of the young people who come to our center are actually not in high school anymore, even if they are between fifteen and eighteen years old and even if they are living at home .... There is often a lengthy time gap between when these youth leave school and when they go back to take their GED exams.

Id.

39. TRANS REALITIES, *supra* note 27, at 21.

40. *See* Doe *ex rel.* Doe v. Yunits, No. 001060A, 2000 WL 33162199 (D. Mass. Oct. 11, 2000), *aff'd*, Doe v. Brockton Sch. Comm., No. 2000-J-638, 2000 WL 33342399 (Mass. App. Ct. Nov. 30, 2000). In *Doe*, a transgender student had to sue the school district to overcome its requirement that she wear boys' clothing. She obtained a preliminary injunction barring the school from abridging her right to wear "any clothing or accessories that any other male or female student could wear without being disciplined." *Id.* at *8. The court held that she was likely to prevail on her sex discrimination claims, *id.* at *6–7, but not on her disability discrimination claim, *id.* at *7.

Similarly, Florida high school senior Nikki Youngblood sued her local school district, alleging that the school's requirement that she wear a "stereotypically feminine" "velvet-like,

City drop-in center for homeless and runaway LGBT youth, has described the harassment and barriers to education that LGBT youth face in the school system, including homophobia from teachers and students alike, and how this treatment negatively affects their schooling.[41] Casciano observes that "[t]hings like Advanced Placement classes very often are not accessed by queer youth because there is a significant and immediate drop in their grades as soon as they come out in school."[42] Her work with young people has led her to conclude that "very little is done for queer youth to address what they face in high schools."[43]

Some students have brought successful lawsuits against schools where they were harassed.[44] Others have worked with advocacy organizations to help make schools safer.[45] Some jurisdictions have responded to this pressure by amending their laws or school policies to provide specific protection on the basis of gender identity,[46] or by establishing specialized schools, such as New York City's Harvey Milk High School,[47] to provide safe learning environments for LGBT students at risk of harm in other schools.

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ruffly, scoop neck drape" for her senior portrait constituted sex discrimination and violation of state and federal constitutional provisions. Complaint at 8, 9, 11, Youngblood *ex rel.* Youngblood v. Sch. Bd. of Hillsborough County, No. 8:02-CV-1089-T-24MAP (M.D. Fla. June 19, 2002). After the district court dismissed the case, the plaintiff appealed to the Eleventh Circuit Court of Appeals. *See* Appeal on Behalf of Appellant/Plaintiff Nicole Youngblood, Sonia Youngblood v. Hillsborough County Sch. Bd., No. 01-15924-CC (11th Cir. May 5, 2003). "While the case was pending . . . the school board agreed to modify its dress code policies to allow for exemptions from any sex-differentiated dress codes." *Youngblood v. School Board of Hillsborough County et al., in On the Docket*, NCLR NEWSLETTER (Nat'l Ctr. for Lesbian Rights, S.F., Cal.) Spring 2005, at 10, *available at* http://www.nclrights.org/newsletter/pdf/spring2005.pdf.

41. *Client-Centered Advocacy*, *supra* note 38, at 222–23.

42. *Id.* at 222.

43. *Id.* at 223.

44. *See, e.g.*, Flores v. Morgan Hill United Sch. Dist., 324 F.3d 1130 (9th Cir. 2003) (alleging school officials violated equal protection rights of students in failing to respond to homophobic harassment of students, and holding students have right to be free from intentional discrimination based on sexual orientation); Shore Reg'l High Sch. Bd. of Educ. v. P.S., *ex rel.* P.S., 381 F.3d 194 (3d Cir. 2004) (upholding ALJ's decision that school district failed to provide "free appropriate public education" for student subjected to severe and prolonged gender- and sexuality-based harassment by other students).

45. GENDER IDENTITY 101, *supra* note 18 (providing ideas and tools for LGBT students and allies).

46. *See, e.g.*, CAL. EDUC. CODE § 220 (West 2000). For a list of statutes and policies, see Transgender Law & Policy Inst., Non-Discrimination Laws and Policies in K–12 Schools, http://www.transgenderlaw.org/college/index.htm#schools (last visited Jan. 9, 2007).

47. The Harvey Milk High School homepage may be found at http://www.hmi.org/ (last visited Jan. 9, 2007), and the New York City Board of Education's description of the school may be found at http://schools.nyc.gov/ourschools/Region9/M586/default.htm?SearchType=school (last visited Jan. 9, 2007). There was an enormous amount of press surrounding the opening of this school. *See, e.g.*, Rose Arce, *Classes Open at Gay High School*, CNN.com, Sept. 8, 2003, http://www.cnn.com/2003/EDUCATION/09/08/gay.school/index.html; Editorial, *The Harvey Milk High School*, N.Y. TIMES, Aug. 3, 2003, at WK10 (opposing plan to establish Harvey Milk High School and urging that schools "dismantle [discrimination] where it occurs" rather than "segregating" students).

Schools bear the responsibility to ensure that their doors are open to all students. There are many ways in which schools can support gender-variant students, whether or not the students are seeking sex reassignment treatment.[48] Schools must be vigilant in guarding the rights of all students, regardless of their gender identity, to receive an education in an environment where their personal safety is not at risk.

In addition, granting transgender youth the ability to begin sex reassignment treatment at whatever age they can demonstrate it is safe and appropriate, even if younger than eighteen, would alleviate many of the internal and external conflicts that trans-youth face. Instead, they must endure discrimination and violence throughout their school years, compromising their education and safety. It is a particular injustice to force transgender students to suffer needlessly through their years as a minor, being subjected to harassment, if they wish to transition and if transitioning would be a safe and appropriate step.

2. Discrimination by parents and the foster care system

Unfortunately, home is often not a safe haven for transgender youth either. One study of clients at a specialized gender identity clinic for adolescents found that over half reported relationship difficulties with their parent or guardian.[49] Learning that a child is gay or transgender often strains the parent-child relationship as the parent struggles to respond. Although many come to accept their child's identity, others do not. Experts have observed that "[s]ome parents subject their children to unethical and often times harmful 'mental health' services. Sometimes other parents bribe, cajole, and beat their children into expressing the gender they were assigned at birth."[50]

When parents guess or youth disclose that they are gay or transgender, it is not uncommon for parents to refuse to allow their child to continue living at home. "[M]ore and more LGBT youths are finding that the price of coming out, or being outed, can lead to being expelled from the only home they have ever known."[51] It has been estimated that approximately one-quarter of LGBT youth are forced by their parents to leave home because of their gender or sexuality.[52]

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48. *See, e.g.*, Patricia Leigh Brown, *Supporting Boys or Girls When the Line Isn't Clear*, N.Y. TIMES, Dec. 2, 2006, at A1 (describing ways that teachers and parents nationally are learning how to support gender-variant children). Florida has been particularly forward-thinking in anticipating how to accommodate these students. *See, e.g.*, Hassan Mirza, *Transgender Child to Enter Florida School*, GAY.COM UK, July 11, 2006, http://www.gay.com/news/article.html?2006/07/11/3 (citing Broward and Miami-Dade school districts as among the most progressive in the country in accommodating transgender students).

49. *Clinical Features and Demographic Characteristics*, *supra* note 36, at tbl.8.

50. TRANS REALITIES, *supra* note 27, at 21–22.

51. Vince Catrone, *The Forgotten Ones, Young, Gay and Homeless*, THE L.A. GAY & LESBIAN CTR. (Nov. 9, 2001) (attributing this trend to "the average age of kids coming out getting lower, and a lack of overall information out there for parents, communities and schools").

52. *See, e.g.*, Sonia Renee Martin, *A Child's Right to Be Gay: Addressing the Emotional Mistreatment of Queer Youth*, 48 HASTINGS L.J. 167, 176 (1996); PAUL GIBSON, U.S. DEP'T OF

Those youth who do not become homeless[53] due to the difficulties their families have in coping with the fact that they have a LGBT child are often placed in foster homes. This has resulted in a disproportionate number of LGBT youth in foster care. James Gilliam, Jr., writing about the problems faced by LGBT youth in foster care, endorses the view that "[t]here is a link, perhaps a very strong one, between a child's sexuality, the ability of families to cope with a gay child, and the likelihood of entry into [the foster care] system."[54] The foster care system has frequently proven equally unable to provide safe and supportive homes for transgender adolescents. Once transgender youth come under the guardianship of the State, they must interact with service providers and official institutions, exposing them to the possibility that biased people will act discriminatorily in their official capacity.

Gilliam notes that "LGBT teens, or those who are perceived as such, often experience more severe problems in the foster care system 'because of prejudice against their sexual orientation or their nonconformity to gender stereotypes.'"[55] Gilliam argues that "[a] variety of factors make LGBT foster youth more vulnerable to mistreatment within the foster care system." First, "because religious organizations operate so many foster homes, religious beliefs about homosexuality" influence how LGBT youth are treated.[56] Second, foster care parents and agencies lack the training that would enable them to respond appropriately to issues relating to gender identity or sexual orientation, and thus they fail to provide necessary services.[57] In addition, "LGBT adolescents are often shifted among different foster homes because they do not fit in where they are initially placed. This creates more problems for these youth as '[t]he constant challenge of adapting to a new environment arouses anxiety and unsettledness.'"[58]

HEALTH & HUMAN SERV., 3 REPORT OF THE SECRETARY'S TASK FORCE ON YOUTH SUICIDE 110, 112 (1989) (reporting that 26% of gay adolescent males were forced to leave home as a result of their sexual identity).

53. *See supra* Part III.A.3.

54. James Gilliam, Jr., *Toward Providing a Welcoming Home for All: Enacting a New Approach to Address the Longstanding Problems Lesbian, Gay, Bisexual, and Transgender Youth Face in the Foster Care System*, 37 LOY. L.A. L. REV. 1037, 1039 (2004) (quoting Colleen A. Sullivan, *Kids, Courts, and Queers: Lesbian and Gay Youth in the Juvenile Justice and Foster Care Systems*, 6 TUL. J.L. & SEXUALITY 31, 35 (1996) (changes in original)).

55. Gilliam, *supra* note 54, at 1038–39 (quoting COLLEEN SULLIVAN, SUSAN SOMMER & JASON MOFF, LAMBDA LEGAL DEF. & EDUC. FUND, YOUTH IN THE MARGINS: A REPORT ON THE UNMET NEEDS OF LESBIAN, GAY, BISEXUAL, AND TRANSGENDER ADOLESCENTS IN FOSTER CARE 7 (2001), http://www.lambdalegal.org/cgi-bin/iowa/news/publications.html?record=899 [hereinafter YOUTH IN THE MARGINS]).

56. Gilliam, *supra* note 54, at 1043. *Cf.* Jarrett Murphy, *Wounded Pride: LGBT Kids Say City-Funded Shelter for the Homeless Breaks Its Covenant*, VILLAGE VOICE, Apr. 26, 2005, at 21 (describing problems at religiously-run youth shelter, and criticizing staff who "bring with them their very strong beliefs on what a young person's conduct should be, and that includes sexual orientation. Those beliefs then play out in delicate issues like where to have transgender people sleep.").

57. *See* Gilliam, *supra* note 54, at 1044.

58. *Id.* at 1045–46 (quoting GERALD P. MALLON, WE DON'T EXACTLY GET THE WELCOME

Lambda Legal Defense and Education Fund studied the experience of LGBT youth in foster care and concluded that the "problems range from a complete lack of recognition of [LGBT youths'] very existence and needs by child welfare systems, to insensitive and discriminatory treatment, to outright harassment and violence at the hands not only of peers or foster parents, but also of the child welfare staff responsible for their protection."[59] Gilliam describes youth who have been "beaten by other residents while staff watched; taunted by foster parents, staff, and other residents because of their homosexuality; sexually assaulted by staff members; and forced to undergo conversion therapy in an attempt to teach them that being gay or lesbian is 'repulsive and deviant.'"[60]

The recent case of *Doe ex rel. Pumo v. Bell*[61] illustrates the discriminatory treatment that transgender youth receive in the foster care system. In *Doe*, a transgender youth who identified as female was placed at a male congregate foster-care facility in New York. The facility staff insisted on referring to her by male pronouns and male name, and quickly implemented a policy to bar her from wearing female clothing. This policy conflicted with Doe's psychiatric treatment plan, under which she was supposed to dress in accordance with her gender identity.[62] The New York State Superior Court held that New York's foster care agency had failed to make reasonable accommodations for her gender identity.[63] In so holding, the court rejected the City's argument that allowing Doe to wear female clothing would pose a safety risk to residents and staff.[64] The court concluded by stating:

> [The foster care agency's] obligation to act in a nondiscriminatory fashion is not satisfied merely by providing a small number of facilities at which children with GID [gender identity disorder] are assured nondiscriminatory treatment. At each and every facility run and operated by the [foster care agency], it must comply with the Human Rights Law's mandate to provide reasonable accommodations to persons with disabilities.[65]

WAGON: THE EXPERIENCES OF GAY AND LESBIAN ADOLESCENTS IN CHILD WELFARE SYSTEMS 54 (1998)).

59. YOUTH IN THE MARGINS, *supra* note 55, at 7.

60. Gilliam, *supra* note 54, at 1039 (citing YOUTH IN THE MARGINS, *supra* note 55, at 9).

61. 754 N.Y.S.2d 846, 854 (Sup. Ct. 2003) (holding that transsexual foster youth are protected by New York state law prohibiting discrimination on the basis of disability in housing).

62. *Id.* at 848.

63. *Id.* at 853. The Court in *Doe* found, *inter alia*, that Doe's gender identity disorder (GID) was a disability within the meaning of New York State's Human Rights Law, N.Y. EXEC. LAW § 292(21). 754 N.Y.S.2d. at 850–51. The use of disability law to enforce rights for transgender people is not without cost: although it provides a strong legal foundation on which to make an argument, it also requires that transgender people be defined as mentally ill, a concept that many understandably resist. For an explanation and discussion of the clinical definition of GID, see *infra* Part IV.A.

64. 754 N.Y.S.2d at 855.

65. *Id.* at 856.

In *Doe*, the court recognized that the foster care agency's refusal to care for Doe in accordance with her gender identity was unlawful discrimination. Experiences such as these underscore how important it is for transgender youth to have an independent means to access trans-specific health care. Because parents and guardians do not always fulfill the ideal parental role anticipated by law and policy, capable adolescents must be empowered to seek and obtain such care themselves.[66] This is particularly true for transgender youth in foster care. Because LGBT youth, and transgender youth in particular, already face such severe discrimination within the foster care system, it is impossible to rely upon that system to act in the best interests of transgender youth under its guardianship.

3. Homelessness, poverty, and criminalization

Transgender youth who are forced out of their homes by their parents may find themselves homeless and without any source of income.[67] There are high numbers of homeless LGBT youth nationally. Studies have found that 25–40% of homeless youth in New York,[68] 25–35% in Los Angeles,[69] and 40% in Seattle[70] are LGBT. Homelessness exposes transgender youth to yet another set of dangers.

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66. *Cf., e.g.*, Nancy Batterman, *Under Age: A Minor's Right to Consent to Health Care*, 10 TOURO L. REV. 637, 669 (1994) (noting that in situations such as incest and child abuse, "the old adage that parents most accurately perceive their child's health care needs falls to pieces and we as a society are forced to consider alternative means to address and treat such children's medical situations").

67. For an excellent depiction of the multiple forces that result in a disproportionate number of transgender people being poor and homeless, see Sylvia Rivera Law Project, Systemic Inequality: Factors Leading to Trans Population Being Disproportionately Poor and Homeless, http://www.srlp.org/documents/disproportionate_poverty.pdf (last visited Jan. 9, 2007).

68. *See* THE N.Y.C. ASS'N OF HOMELESS & STREET-INVOLVED YOUTH ORGS., STATE OF THE CITY'S HOMELESS YOUTH REPORT 2003, GAY, LESBIAN, BISEXUAL, TRANSGENDER (GLBT), HOMELESS YOUTH (2004), http://www.empirestatecoalition.org/rglbt.html (last visited Jan. 9, 2007) [hereinafter HOMELESS YOUTH REPORT 2003]. *See also* Michael C. Clatts, Deborah J. Hillman, Aylin Atillasoy & W. Rees Davis, *Lives in the Balance: A Profile of Homeless Youth in New York City*, *in* THE ADOLESCENT ALONE: DECISION MAKING IN HEALTH CARE IN THE UNITED STATES 139 (Jeffrey Blustein, Carol Levine & Nancy Neveloff Dubler eds., 1999); Tina Rosenberg, *Helping Them Make It through the Night*, N.Y. TIMES, July 12, 1998, at WK16 ("Many [of some 12,000 to 20,000 homeless youth in New York] ran away from foster care. Forty percent are gay, lesbian, bisexual or transgender.... This group is disproportionately homeless because their families sometimes kick them out, and they are often unwelcome and even assaulted in their schools and foster homes."); The Ali Forney Ctr., Housing for Homeless LGBT Youth: Resources for LGBT Youth and Homelessness, http://www.aliforneycenter.org/resources.html (last visited Jan. 9, 2007) ("Thousands of LGBT youth are forced out to the streets every year and they make up approximately 40% of the total homeless youth population. Homeless LGBT youth face homophobia, violence and brutality on the streets and in the youth shelter system, and are at high risk of HIV infection and drug addiction."). In New York, there are only twenty-two GLBT-specific emergency shelter beds available for the estimated 3500 to 7000 homeless GLBT youth in New York City. HOMELESS YOUTH REPORT 2003, *supra*.

69. CAITLIN RYAN & DONNA FUTTERMAN, LESBIAN & GAY YOUTH CARE & COUNSELING 25 (1998).

70. *Id.*

Transgender youth who seek housing in shelters are often barred from gender-segregated shelters, or are placed in gender-specific shelters that do not match their gender identity.[71] Once in the shelters, they face an increased risk of violence and harassment.[72] For example, the only city-funded emergency shelter for youth in New York City is reportedly well-known by LGBT youth as being transphobic and homophobic.[73] One transgender resident reported that when she stayed there, "the staff psychologist refused to call her by her girl name, and the job counselor mocked her feminine appearance. The other residents cornered her, robbed her, and threw things at her while she slept. 'All these acts of violence, the staff really ignored it.'"[74] Such experiences, and other dangers found in shelters, lead many transgender minors to decide to take their chances on the street instead.[75]

Transgender people in general face frequent employment discrimination,[76] which makes finding a job difficult.[77] Homelessness and inexperience in employment contexts compounds this difficulty for transgender youth living on the streets, often forcing them to engage in survival crimes such as theft or sex work.[78] Sex work in particular puts these youth at risk of rape, violence, or

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71. *See, e.g.*, TRANS REALITIES, *supra* note 27, at 8 (stating that sex-segregated residential facilities fail to protect their transgender clients when they "implement insulting grooming policies, require disclosure of private medical information, or fail to protect transgender clients from other residents").

72. *See, e.g.*, Rosenberg, *supra* note 68 ("Although shelter is their most basic need, [youth] do not fit in any city shelter program. They are scared of the giant, dangerous shelters that house adults and need smaller group homes with help for people who may be adults chronologically but not emotionally.").

73. *See* Murphy, *supra* note 56. A staff member of a different shelter stated that there is "a pattern of homophobia . . . . We see staff members behaving in ways that are directly homophobic themselves, and we see staff members failing to intervene to stop homophobia among the other residents." *Id.*

74. *Id.*

75. HOMELESS YOUTH REPORT 2003, *supra* note 68, finding that:

> GLBT youth report being subjected to harassment, threats, and violence in shelters catering to the general homeless youth population. The majority of this harassment comes from other youth but some comes from shelter staff. In recent years there has been an escalation of gang activity at homeless youth service centers . . . . As these gangs are actively homophobic, their prevalence in homeless youth service settings has made it more difficult for GLBT youth to feel safe and stay safe. The majority of homeless GLBT youth choose to survive on the streets, (often through prostitution, thereby placing them at escalated risk for HIV infection), rather than to experience violence and abuse in the shelters.

Id.

76. *See, e.g.*, TRANS REALITIES, *supra* note 27, at 12–13 (finding that almost 50% of transgender survey respondents had experienced employment discrimination).

77. In addition, it is often difficult to work without identity documents that match one's gender presentation. *See, e.g.*, HOMELESS YOUTH REPORT 2003, *supra* note 68 ("In order to obtain a job, however, one needs appropriate identification. Transgender ('trans') youth are easily discriminated against when it comes to producing identification because if they even have it, their identification often contradicts how they appear.").

78. *See, e.g.*, Marya Viorst Gwadz, *Homeless Youth & Work Study Preliminary Findings*,

murder by customers as well as by the police.[79] In addition, their likelihood of ending up in the criminal justice system increases. A 2001 study by the Urban Justice Center found that between four and ten percent of the people in New York's juvenile justice system self-identify as LGBT.[80]

Transgender people are subject to discrimination and violence at the hands of the police.[81] Operating on stereotypes, police often assume that transgender women are sex workers. Such assumptions result in frequent collisions between police and transgender women. A study by the San Francisco Department of Public Health found that 65% of male-to-female (MTF) and 29% of female-to-male (FTM) transgender San Franciscans reported a history of incarceration.[82] Once arrested, whether for actual or assumed sex work—or for other offenses associated with poverty and employment discrimination—transgender people enter a gender-segregated criminal justice system.[83] As with shelters, transgender

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COAL. OF YOUTH & FAMILY SERVS. 2 (Mar. 31, 2005) (on file with *N.Y.U Review of Law & Social Change*).

> They . . . turn to dealing, and car theft, and many become prostitutes to make money and have a place to sleep. They get AIDS—teenagers now acquire H.I.V. at a faster rate than any other group. And few young people who spend nights on the street or in abandoned buildings have the stability to kick drugs or find a job.

Rosenberg, *supra* note 68. *See also* Jordan Smith, *The Lauryn Paige Fuller Story*, AUSTIN CHRONICLE, Feb. 18, 2000, *available at* http://www.austinchronicle.com/gyrobase/Issue/story?oid=oid%3A75904 (describing the life and murder of Lauryn Fuller, *nee* Donald, an 18-year-old Austin, TX resident).

79. *See, e.g.*, Chelsea J. Carter, *Life and Death of a Throwaway Teen*, CHI. TRIB., Sept. 2, 1999, at 8. Carter discusses the life of Ali Forney, a transgender teen who cycled between foster homes, jail, and the street; was forced to rely on petty crimes and sex work to support herself; and who was ultimately shot in the head and killed by a customer at the age of twenty-two. Ali was the third young transgender prostitute murdered in Harlem in fourteen months. The Ali Forney Center, a social services center named after this young person, works to provide homeless LGBT youth with shelter, HIV prevention, and vocational training. Ali Forney Center, htttp://www.aliforneycenter.org. *See also* Atiya Jones, *Hope for Homeless Youth*, N.Y. BLADE, May 14, 2004, *available at* http://nyblade.com/2004/5-14/locallife/main/hope.cfm.

80. RANDI FEINSTEIN, ANDREA GREENBLATT, LAUREN HASS, SALLY KOHN & JULIANNE RANA, LESBIAN & GAY PROJECT OF THE URBAN JUSTICE CTR., JUSTICE FOR ALL? A REPORT ON LESBIAN, GAY, BISEXUAL & TRANSGENDERED YOUTH IN THE NEW YORK JUVENILE JUSTICE SYSTEM 6 (2001), *available at* http://www.urbanjustice.org/pdf/publications/lesbianandgay/justiceforallreport.pdf.

81. *See, e.g.*, TRANS REALITIES, *supra* note 27, at 19 (describing unwarranted stops, searches, pretextual arrests, sexual harassment, and disrespectful behavior by police officers, and citing report documenting that police officers were the perpetrators in nearly 50% of the complaints of hate violence received by advocacy organizations from transgender people). For a graphic depicting the confluence of criminalization of poor and trans people, see Sylvia Rivera Law Project, Low Income Trans People Disproportionately Exposed to Police Violence, Arrest, and Incarceration, Suffer Special Gender-Related Harms in these Processes, http://www.srlp.org/documents/disproproportionate_incarceration.pdf (last visited Jan. 9, 2006).

82. Kristen Clements-Nolle, Rani Marx, Robert Guzman & Mitchell Katz, *HIV Prevalence, Risk Behaviors, Health Care Use, and Mental Health Status of Transgendered Persons: Implications for Public Health Intervention*, 91 AM. J. PUB. HEALTH 915, 917 tbl.1 (2001) [hereinafter *HIV Prevalence*].

83. As noted in *Farmer v. Brennan*, 511 U.S. 825 (1994), transgender prisoners are housed according to their genitals: anyone who has not had genital surgery will be housed as their birth sex, regardless of any other factors. *Id.* at 829. Administrative segregation may be used to protect

people are often housed in the inappropriate gender block area, and face significant risk of harassment and violence from guards and other inmates.[84] While incarcerated, authorities may prevent transsexual inmates from receiving hormones or other medical treatment.[85]

B. Physical and Mental Effects of Delayed Transition

1. Puberty and physical changes

Puberty creates a series of progressive changes in an adolescent's body. These physical changes are not easily erased later, making transitioning at older ages more difficult and less convincing. Thus, early commencement of sex reassignment is preferable, where clinically appropriate.[86] For individuals assigned male at birth, testosterone production beginning in puberty results in the development of secondary sex characteristics such as beard growth and a deepening voice.[87] These effects can be very difficult to reverse or hide once

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a transgender person from violence. It is difficult for transgender prisoners to prove that a prison's failure to protect them from violence was a violation of the Eighth Amendment's cruel and unusual punishment provision, as courts will only so hold if they find that prison officials exhibited "deliberate indifference" to the risk of violence, an exceedingly difficult standard to meet. *Id.* at 834. *See also* Cuoco v. Moritsugo, 222 F.3d 99, 104 (2d Cir. 2000) (describing the deliberate indifference standard). For a general description of transgender people's experiences in prison, see TRANS REALITIES, *supra* note 27, at 23–24, and California Prison Focus, Trans/Gender Variant in Prison Committee, http://www.prisons.org/TIP.htm.

84. *See* Alex Lee, Nowhere to Go But Out: The Collision between Transgender and Gender-Variant Prisoners and the Gender Binary in America's Prisons 27 (Spring 2003) (unpublished comment, on file with Sylvia Rivera Law Project), *available at* http://www.srlp.org/documents/alex_lees_paper2.pdf (describing harassment of transgender prisoners by guards in women's prisons); Christine Peek, *Breaking Out of the Prison Hierarchy: Transgender Prisoners, Rape, and the Eighth Amendment*, 44 SANTA CLARA L. REV. 1211, 1212 (2004).

85. *See, e.g.*, Duncan Osborne, *Trans Inmate Denied Treatment: Dutchess County Juvenile Facility Withholds Hormones From 17-Year-Old*, GAY CITY NEWS, Aug. 1–7, 2003, *available at* http://www.gaycitynews.com/gcn231/transinmate.html.

86. Peggy T. Cohen-Kettenis & Stephanie H.M. van Goozen, *Sex Reassignment of Adolescent Transsexuals: A Follow-Up Study*, 36 J. AM. ACAD. CHILD ADOLESCENT PSYCHIATRY 263, 264 (1997) [hereinafter Cohen-Kettenis & van Goozen, 1997] (finding that physical results of early treatments are more satisfactory than treatments started later, and that unfavorable postoperative outcomes appear to be related to a later rather than earlier start of the procedure). *See also* Michael W. Ross & Jillian A. Need, *Effects on Adequacy of Gender Reassignment Surgery on Psychological Adjustment: A Follow-Up of Fourteen Male-to Female Patients*, 18 ARCHIVE OF SEXUAL BEHAVIOR 145, 152 (1989) (concluding that postoperative psychopathology is generally associated with factors that make the transition unconvincing and remind the patients of their biological sex).

87. *See* Henk Asscherman & Louis J.G. Gooren, *Hormone Treatment in Transsexuals*, 5 J. PSYCHOL. & HUMAN SEXUALITY 39 (1992). "The greater height, the shape of the jaws, the size and shape of the hands and feet, and the narrow width of the pelvis cannot be redressed once they have reached their final size at the end of puberty." *Id.* at 40. "The effects of . . . hormone treatments . . . can be objectively unsatisfactory with regard to reduction of male-type of facial/beard hair and induction of breast development." *Id.* "[E]strogens do not affect the pitch of the voice, and a low voice can be a great handicap. Speech therapy is necessary to achieve a more feminine vocal

transition begins, making it harder to pass as female.[88] Likewise, for individuals assigned female at birth, the development of secondary sex characteristics, such as hips and breasts, can be difficult to minimize later.[89] Imperfect physical outcomes are a primary cause of post-operative mental health issues.[90] Thus, earlier treatment produces a more effective final outcome.[91]

Occasionally a doctor may determine that a gender-variant minor appears to have a stable gender identity with no psychopathology that would contraindicate transition, but the minor has not yet reached an age where transition is appropriate. In such situations, the doctor may prescribe medication that suppresses the production of sex-specific hormones. If prescribed at the start of puberty, puberty will be arrested and the expression of secondary sex characteristics will be delayed.[92] The adolescent and the treating clinician can continue working together to determine that the adolescent's gender identity is genuine without allowing physical changes to occur that could permanently diminish the quality of a later transition.[93] If hormones are stopped, the pubertal process will resume without ill effect.[94] This solution is recommended by some of the lead-

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range." *Id.* at 50. *See also* Cohen-Kettenis & van Goozen, 1997, *supra* note 86, at 264 (reporting physical difficulties of "deep voice and facial scarring due to electrical epilation").

88. Cohen-Kettenis & van Goozen, 1997, *supra* note 86, at 270, comparing patients who transitioned as adults to those who transitioned as adolescents:

> [P]art of the adolescents' better functioning might be due to the fact that they more easily pass in the desired gender role, because of their convincing appearance. With the exception of one M[ale-to-]F[emale], the voices of the M[ale-to-]F[emale]s were not noticeably male-sounding, and all . . . had only sparse beard growth at the time of hormonal treatment. The early antiandrogen treatment apparently had acted in a timely way to block the facial hair growth and the lowering of the voice.

Id., *cited in* Kenneth J. Zucker, *Gender Identity Development and Issues*, 13 CHILD ADOLESCENT PSYCHIATRIC CLINICS N. AM. 551, 565 (2004).

89. *See* Asscherman & Gooren, *supra* note 87, at 40, 51 (noting that lower height and broader hips will not be affected, and that hormone treatment will not reduce breast size).

90. *See* Cohen-Kettenis & van Goozen, 1997, *supra* note 86, at 264 (*citing* Ross & Need, *supra* note 86).

91. *See, e.g.*, Peggy T. Cohen-Kettenis & Stephanie H.M. van Goozen, *Pubertal Delay as an Aid in Diagnosis & Treatment of a Transsexual Adolescent*, 7 EUR. CHILD & ADOLESCENT PSYCHIATRY 246, 246 (1997) [hereinafter *Pubertal Delay*] ("[T]he physical treatment outcome following interventions in childhood is far less satisfactory than when treatment is started at an age at which secondary sex characteristics have not yet been fully developed."); Yolanda L.S. Smith, Stephanie H.M. van Goozen & Peggy T. Cohen-Kettenis, *Adolescents with Gender Identity Disorder Who Were Accepted or Rejected for Sex Reassignment Surgery: A Prospective Follow-Up Study*, 40 J. AM. ACAD. CHILD ADOLESCENT PSYCHIATRY, 472, 472–73 (2001) [hereinafter Smith, van Goozen & Cohen-Kettenis, 2001] (reporting that irreversible physical changes are a major negative consequence of late sex reassignment treatment that may be prevented by beginning treatment early). *See also infra* Part IV.C, describing physical interventions for those under eighteen.

92. Smith, van Goozen & Cohen-Kettenis, 2001, *supra* note 91, at 480; Zucker, *Gender Identity Development and Issues*, *supra* note 88, at 565.

93. Smith, van Goozen & Cohen-Kettenis, 2001, *supra* note 91, at 480.

94. *Id.*

ing clinicians around the world working with transgender youth.[95] Kenneth Zucker of the Child and Adolescent Gender Identity Clinic of Toronto asserts that "although early hormonal treatment is controversial, it may be the treatment of choice after the clinician is confident that other options have been exhausted."[96]

It is important to note that many transgender people, both minors and adults, face unique obstacles when attempting to obtain both basic and trans-specific medical care, the effect of which is to encourage transgender people to seek treatment outside established medical channels.[97] For example, medical providers may be biased or simply unfamiliar with the particular issues and needs of transgender people. Transgender people may be inappropriately denied services altogether, or dehumanized and treated disrespectfully.[98] In addition, accessing sex reassignment treatment requires transgender people to participate in a system that pathologizes them and that frequently insists on labeling their gender in a way that does not match their internal identity.[99] Finally, economic factors severely limit access to medical treatment, as virtually all insurance companies, Medicaid, and Medicare deny reimbursement for hormones or sex reassignment surgery (SRS).[100] These experiences effectively bar many transgender people

95. *Pubertal Delay*, *supra* note 91, at 248 (recommending pubertal delay "[f]or certain selected cases with a life-long consistent and extreme GID"). For a discussion of the ethical responsibility of doctors towards minors who request pubertal-suppression therapy, see Catherine Downs & Stephen Whittle, *Seeking a Gendered Adolescence: Legal and Ethical Problems of Puberty Suppression among Adolescents with Gender Dysphoria*, in OF INNOCENCE & AUTONOMY: CHILDREN, SEX & HUMAN RIGHTS 195 (2000).

96. Zucker, *Gender Identity Development and Issues*, *supra* note 88, at 565. However, Zucker also notes that "[o]ne issue that has not been resolved is the identification of the best candidates for early hormonal treatments." *Id.*

97. *See* TRANS REALITIES, *supra* note 27, at 14–15 (cataloguing discrimination, lack of basic health insurance, insurance that does not cover transitioning procedures, and scarcity of doctors with appropriate expertise, as among the health care difficulties faced by transgender people). *See also* Leslie Feinberg, *Trans Health Crisis: For Us It's Life or Death*, 91 AMER. J. PUB. HEALTH 897 (2001) (relating personal accounts of health care discrimination and making recommendations for health care institutional change); Carrie Davis, Trans-Youth Access to Care: Barriers to Trans-Medical and Mental Health Care, Preliminary Finding (2002) (unpublished manuscript, on file with the *N.Y.U. Review of Law & Social Change*) (reporting the results of a study concerning barriers to health care for transgender youth). *See generally* GLBT HEALTH ACCESS PROJECT, ACCESS TO HEALTH CARE FOR TRANSGENDERED PERSONS IN GREATER BOSTON (2000).

98. There are far too many examples available. Tyra Hunter was injured in an automobile accident in Washington, D.C. When EMS personal discovered that Tyra was transgender, they refused to treat her and she died at the side of the road. Robert Eads, a female to male transperson, died of ovarian cancer after being denied treatment by over twenty doctors. *See* Remembering Our Dead, http://www.rememberingourdead.org/# (last visited Jan. 9, 2007).

99. *See, e.g.*, Dean Spade, *Resisting Medicine, Re/modeling Gender*, 18 BERKELEY WOMEN'S L.J. 15, 18 (2003).

100. Because insurance generally will not cover it, medical treatment—such as hormones and sex reassignment surgery (SRS)—is available only to those who can pay out of pocket. Lack of insurance coverage may discourage transgender people from seeking care, since they know that even if an individual provider is knowledgeable and sensitive, their needs will still not be met. Most private insurance companies deny coverage for SRS procedures, although some carriers have be-

from receiving medical care.

The reality, however, is that many transgender people who are refused treatment or who cannot afford treatment will obtain hormones on the street or through friends.[101] Thus, transgender youth who face barriers to transition may facilitate their own transition without the benefit of medical advice or oversight. A study by the San Francisco Department of Public Health found that 29% of male-to-female (MTF) respondents who had used hormones in the previous six months had obtained them from non-medical sources.[102] Injecting black market hormones carries risks such as contracting HIV from dirty needles or injecting an improper dosage, leading to side effects including death.[103] Thus, it is imperative for doctors to be sensitive to the needs of trans-youth, and to work to reduce the barriers to trans-related health care that cause them to seek unsafe treatment on the black market or to needlessly delay transition.[104]

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gun to provide coverage. *See* Kari E. Hong, *Categorical Exclusions: Exploring Legal Responses to Health Care Discrimination Against Transsexuals*, 11 COLUM. J. GENDER & L. 88, 96–98 (2002); *see also* R. NICK GORTON, JAMIE BUTH & DEAN SPADE, MEDICAL THERAPY AND HEALTH MAINTENANCE FOR TRANSGENDER MEN: A GUIDE FOR HEALTH CARE PROVIDERS 40 (2005), *available at* http://www.ftmi.org/images/0medical.pdf; TRANSGENDER LAW CTR., TRANSGENDER HEALTH AND THE LAW, *available at* http://www.ftmi.org/images/0health_law_fact.pdf (recommending ways to avoid discontinuance of insurance). *See, e.g.*, Aetna Clinical Policy Bulletin 0615: Sex Reassignment Surgery (Oct. 17, 2006) (noting that although most Aetna plans exclude coverage of sex reassignment surgery, some may provide coverage if medically necessary), *available at* http://www.aetna.com/cpb/data/CPBA0615.html. In addition, some private companies and municipalities, such as San Francisco, provide coverage for SRS in their insurance plans. *See* CITY & COUNTY OF S.F. HUMAN RIGHTS COMM'N, S.F. CITY AND COUNTY TRANSGENDER HEALTH BENEFIT (2006), *available at* http://www.tgender.net/taw/SanFranciscoTGBenefitUpdateMar3106.pdf.

Medicare does not pay for sex reassignment surgery or hormone treatment. Medicare Program: National Coverage Decisions, 54 Fed. Reg. 34555, 34572 (Aug. 21, 1989) (citing the controversial status of SRS due to the lack of controlled, long-term studies of its safety and effectiveness and attendant therapies, and the high rate of serious complications associated with the procedure as justification for Medicare not covering "[t]ranssexual surgery"). Shannon Minter has provided a good synopsis of the situation with regard to Medicaid:

> [T]here is no exclusion of sex-reassignment under the federal Medicaid statute. As a result, almost every court that has ever considered the issue has concluded that States cannot categorically exclude sex reassignment surgeries from Medicaid coverage. Despite these holdings, many state Medicaid statutes contain a blanket exclusion for procedures related to sex-reassignment.

SHANNON MINTER, REPRESENTING TRANSSEXUAL CLIENTS: SELECTED LEGAL ISSUES 13–14 (2004) (on file with *N.Y.U. Review of Law & Social Change*) [hereinafter REPRESENTING TRANSSEXUAL CLIENTS].

101. Dan H. Karasic, *Progress In Health Care For Transgendered People*, 6 J. GAY & LESBIAN MED. ASS'N. 157, 157 (2000).

102. *HIV Prevalence*, *supra* note 82, at 919 tbl.4. The statistic was 3% for female-to-males (FTMs). *Id.*

103. *See* T. Nemoto, D. Luke, L. Mamo, A. Ching & J. Patria, *HIV Risk Behaviors Among Male-to-Female Transgenders in Comparison with Homosexual or Bisexual Males and Heterosexual Females*, 11 AIDS CARE 297, 309 (1999).

104. The services provided by San Francisco's Tom Waddell Health Center demonstrate a best-practices model. *See* S.F. DEP'T OF PUB. HEALTH, TRANSGENDER CLINIC, http://www.dph.sf.ca.us/chn/HlthCtrs/transgender.htm; TOM WADDELL HEALTH CTR. TRANSGENDER TEAM,

2. Mental health issues

Numerous misperceptions are associated with the mental health of transgender people, such as the belief that transsexuals have innate mental illnesses,[105] or that they misrepresent their actual experience in order to meet the criteria to obtain sex reassignment treatment. However, researchers have found no correlation between non-normative gender identification and mental illness.[106] While it is true that transgender people do frequently experience difficulties with mental health, these issues typically arise from conflict with the external environment, as detailed in Part III, rather than from internal pathology.[107]

PROTOCOLS FOR HORMONAL REASSIGNMENT OF GENDER 2 (2001), http://www.dph.sf.ca.us/chn/HlthCtrs/HlthCtrDocs/TransGendprotocols.pdf (citing the practice of obtaining hormones or silicone injections on the street as one rationale for establishment of transgender health clinic). *See also* Emilia Lombardi, *Enhancing Transgender Health Care*, 91 AMER. J. PUB. HEALTH 869, 871 (2001) (making recommendations for culturally-sensitive health care); GAY & LESBIAN MED. ASS'N, GUIDELINES FOR CARE OF LESBIAN, GAY, BISEXUAL & TRANSGENDER PATIENTS, *available at* ce54.citysoft.com/_data/n_0001/resources/live/GLMA%20guidelines%202006%20FINAL.pdf; Samuel Lurie, Access to Health Care for Transgender Patients: An Overview, PAETC Training for Trainers, Apr. 14–16, 2003 (on file with *N.Y.U. Review of Law & Social Change*). For more information on Lurie's trainings, and particularly his "Four Steps to Providing Health Care to Transgendered People," go to http://www.tgtrain.org/4steps.html.

105. *See, e.g.*, Leslie M. Lothstein, *Psychological Testing with Transsexuals: A 30-Year Review*, 48 J. PERSONALITY ASSESSMENT 500, 504 (1984) (reviewing psychological literature that suggests "transexualism may be a variant, or subtype, of the spectrum of borderline disturbances"). The American Psychiatric Association's (APA) *Diagnostic and Statistical Manual* (DSM) is the primary text the medical profession uses to diagnose mental illness. The APA no longer sees transsexuality itself as a mental illness: in 1994, it removed the diagnosis of "Transsexual" from the DSM and replaced it with "Gender Identity Disorder" (GID). *See* AM. PSYCHIATRIC ASS'N, DIAGNOSTIC & STATISTICAL MANUAL OF MENTAL DISORDERS 576 (4th ed., text rev., 2000) [hereinafter DSM-IV-TR]. *Compare also* AM. PSYCHIATRIC ASS'N, DIAGNOSTIC & STATISTICAL MANUAL OF MENTAL DISORDERS 74 (3d ed. 1987) [hereinafter DSM-III] (defining transsexualism as "persistent discomfort and sense of inappropriateness about one's assigned sex . . . . [and] persistent preoccupation . . . with getting rid of one's primary and secondary sex characteristics and acquiring [those] of the opposite sex"), *with* AM. PSYCHIATRIC ASS'N, DIAGNOSTIC & STATISTICAL MANUAL OF MENTAL DISORDERS 533 (4th ed. 1994) [hereinafter DSM-IV] (emphasizing "cross-gender identification," including as a necessary criterion to GID diagnosis "personal discomfort about one's assigned sex or a sense of inappropriateness in the gender role of that sex," but not preoccupation with alteration of sex characteristics). This change recognizes that being transgendered is not itself a mental illness, although those who are transgendered may experience significant distress in their daily lives sufficient to rise to the level of a mental disorder. *See* STEPHEN WHITTLE, RESPECT AND EQUALITY: TRANSSEXUAL AND TRANSGENDER RIGHTS 20 (2002). The treatment of transsexuality as a mental illness is remarkably parallel to the treatment of homosexuality as a mental illness in earlier eras. *See infra* note 131 and accompanying text (discussing removal of homosexuality from the DSM in 1973).

106. *See* Smith, van Goozen & Cohen-Kettenis, 2001, *supra* note 91, at 472 (among adolescent patients screened and accepted for hormone treatment at gender clinic, "the often-assumed association between transsexualism and psychopathology has not been found"); Yolanda L.S. Smith, Leo Cohen & Peggy T. Cohen-Kettenis, *Postoperative Psychological Functioning of Adolescent Transsexuals: A Rorschach Study*, 31 ARCHIVES OF SEXUAL BEHAVIOR 255, 256 (2002) [hereinafter Smith, Cohen & Cohen-Kettenis, 2002] (same).

107. The following statement is also applicable to transgender adolescents:

> Unlike many of their heterosexual peers, lesbian and gay adolescents have no built-in support system . . . . Shunned by the social institutions that routinely provide emotional

As gender-variant youth grow up and become increasingly self-aware, they "evaluate themselves on the basis of gender compatibility (especially self-perceived gender typicality) and suffer discomfort, even despair, when they come up wanting."[108] Distress often increases as youth grow older[109] and "[t]hey have to cope with adverse consequences of living with a self-concept that is never socially acknowledged or reinforced."[110] Many gender-variant youth desperately attempt to change their gender expression to fit in, but this does not necessarily reflect their internal gender identity. Indeed, "[a]n adolescent shift toward gender conformity can occur primarily to please the family, and may not persist or reflect a permanent change in gender identity."[111]

In addition to the mental health issues that arise from such conflicts, delaying gender transition until adulthood may also cause collateral mental health and developmental problems.[112] Many transgender people experience depression,[113] which is typically alleviated once sex reassignment treatment commences.[114] Researchers Peggy Cohen-Kettenis and Stephanie van Goozen explain that for trans-youth, "[k]nowing that they will have to await treatment for many years engenders feelings of hopelessness and slows down their social, psy-

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support and positive reinforcement for children and adolescents—families, religious organizations, schools, and peer groups—lesbian and gay adolescents must negotiate many important milestones without feedback or support.

RYAN & FUTTERMAN, *supra* note 69, at 4, *cited in* Gilliam, *supra* note 54, at 1040–41.

108. Susan K. Egan & David G. Perry, *Gender Identity: A Multidimensional Analysis with Implications for Psychosocial Adjustment*, 37 DEV. PSYCHOL. 451, 453 (2001).

109. This increase has been attributed to a "chronicity effect" associated with "the harmful additive influence of being exposed to peer ostracism over time" and "to the children's experience of receiving constant censure for their behaviors." Bartlett, Vasey & Bukowski, *supra* note 28, at 762 (linking distress to "the child's not being permitted to act in the gender-atypical manner he or she desires").

110. Cohen-Kettenis & van Goozen, 1997, *supra* note 86, at 264.

111. THE HARRY BENJAMIN INTERNATIONAL GENDER DYSPHORIA ASSOCIATION'S STANDARDS OF CARE FOR GENDER IDENTITY DISORDERS 9 (6th ed. 2001), http://www.hbigda.org/Documents2/socv6.pdf [hereinafter HBIGDA Standards of Care].

112. *See* Cohen-Kettenis & van Goozen, 1997, *supra* note 86, at 263. Internal records of San Francisco's Tom Waddell Health Center report that 36% of transgender people attending the Center's transgender clinic have a mental health diagnosis. Barry Zevin, *Demographics of the Transgender Clinic at San Francisco's Tom Waddell Health Center*, Transgender Care Conference (2000) (transcript of proceedings), http://hivinsite.ucsf.edu/InSite.jsp?doc=3098.0028. A survey of transgender people by the San Francisco Department of Public Health found that of respondents, 20% of MTFs and 22% of FTMs had been hospitalized for a mental health issue, and 32% of each group had made a suicide attempt. *HIV Prevalence*, *supra* note 82, at 919 tbl.4.

113. *HIV Prevalence*, *supra* note 82, at 919 tbl.4 (finding that 62% of MTFs and 55% of FTMs were depressed). Domenico Di Ceglie's study of adolescents at his gender identity clinic found that 42% suffered from depression. *Clinical Features and Demographic Characteristics*, *supra* note 36, tbl.8.

114. Peggy T. Cohen-Kettenis & Louis J.G. Gooren, *The Influence of Hormone Treatment on Psychological Functioning of Transsexuals*, 5 J. PSYCHOL. & HUMAN SEXUALITY 55, 56 (1992) [hereinafter *Influence of Hormone Treatment*] (describing an initial lifting of depression upon commencing SRS, which may be followed by other emotional difficulties once transition is underway).

chological, and intellectual development."[115] Transgender adolescents often defer or avoid peer or romantic relationships until after sex reassignment, and so are out of sync with their peers, who typically explore such relationships during adolescence.[116] However, these collateral problems may frequently be avoided with earlier commencement of sex reassignment treatment.

The severe stressors that transgender people must contend with result in a higher incidence of depression, suicide, and substance abuse among transgender people than in the general population.[117] The National Mental Health Association has found that LGBT youth have poorer mental health than their peers.[118] Suicide rates, for example, are two to three times higher among LGBT youth.[119] In addition, LGBT adolescents begin using substances at an earlier age than their heterosexual peers, and use substances at greater rates over their lifetimes.[120] Those who become homeless are at particular risk of substance abuse.[121] Because transgender people face increased exposure to violence and discrimination due to their higher visibility, it is possible that the incidence of problems such as depression, suicide, and substance abuse among transgender people may in fact be even greater than that reported for gay and lesbian people. Reduction of social stressors such as discrimination and barriers to treatment could help alleviate the severe cost to the mental health of transgender people.

115. Cohen-Kettenis & van Goozen, 1997, *supra* note 86, at 264.

116. *See Influence of Hormone Treatment*, *supra* note 114, at 57 ("Both female and male transsexuals . . . often have avoided sexual contacts out of reluctance to reveal their transsexuality to others. As a confrontation with their own sexual body parts is very painful, they sometimes have repressed all sexual feelings and have sexually not been very active.").

117. Lee, *supra* note 37, at 403–5.

118. *See* BULLYING IN SCHOOLS, *supra* note 38 (attributing mental health risks to "hatred and prejudice," rather than to "inherent[] . . . identity orientation").

119. *Id.*; *Health Risk Behaviors and Sexual Orientation*, *supra* note 37, at 895. A 2001 study conducted by the Massachusetts Department of Public Health found that 40% of GLB teens had a history of suicide attempts, as compared to 10% of heterosexual teens. Patrick Healy, *Suicides in State Top Homicides*, BOSTON GLOBE, Feb. 28, 2001, at B1.

120. *See Health Risk Behaviors and Sexual Orientation*, *supra* note 37, at 898–99 & tbl.2; Sonia Renee Martin, *A Child's Right to Be Gay: Addressing the Emotional Mistreatment of Queer Youth*, 48 HASTINGS L.J. 167, 178 (1996).

121. *See, e.g.*, Rosenberg, *supra* note 68 ("Most homeless young people use drugs, but researchers warn against concluding that drug abuse leads to homelessness. . . . [A] medical anthropologist commissioned by the Giuliani administration to study New York's homeless teenagers last year, says it is the other way around—most began using drugs only after reaching the street."). *See also* Kristen Clements, Willy Wilkinson, Kerrily Kitano & Rani Marx, *HIV Prevention and Health Service Needs of the Transgender Community in San Francisco*, 3 INT'L J. TRANSGENDERISM (1997), http://www.symposion.com/ijt/hiv_risk/clements.htm (exploring the relationship between housing and employment discrimination, and HIV risk behaviors).

IV.
MEDICAL AND PSYCHIATRIC RESPONSES TO TRANSGENDER PEOPLE

Youth who exhibit non-normative gender identity or behavior[122] quickly come to the attention of parents or teachers. Frequently, they are steered into mental health treatment where they are labeled as suffering from "gender identity disorder" (GID), a diagnostic category used by medical professionals to identify children and adults who exhibit "cross-gender identification" and discomfort with the sex they were assigned at birth.[123]

One of the main goals of GID treatment, preventing the individual from becoming gay,[124] makes such treatment highly problematic. Approximately three-quarters of children diagnosed with GID grow up to identify as gay or lesbian, while many of the rest will identify as transgender.[125] These varied outcomes present a difficult, though resolvable, clinical issue for medical professionals attempting to differentiate those children who will grow up to identity as transgender from those who will grow up to identify as gay or lesbian.[126]

Multiple medical standards of care have been developed to guide treatment of people who seek some degree of medical transition of their sex assignment. The most well-known and commonly followed is the Harry Benjamin International Gender Dysphoria Association's Standards of Care (HBIGDA Standards of Care).[127] Other protocols include the Health Law Standards of Care for Transsexualism (Health Law Standards of Care), which is based on informed consent and relies on the doctor working in partnership with the patient.[128] These standards provide medical professionals with the tools they need to properly identify those adolescents who are appropriate for pubertal-delay medication, hormone treatment, or sex reassignment surgery.

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122. For an analysis of demographic aspects of gender-variance in minors, see Peggy T. Cohen-Kettenis, Allison Owen, Vanessa G. Kaijser, Susan J. Bradley & Kenneth J. Zucker, *Demographic Characteristics, Social Competence, and Behavior Problems in Children with Gender Identity Disorder: A Cross-National, Cross-Clinic Comparative Analysis*, 31 J. ABNORMAL CHILD PSYCHOL. 41 (2003).

123. DSM-IV-TR, *supra* note 105, at 576. The criteria for a diagnosis of Gender Identity Disorder are: A) "There must be evidence of a strong and persistent cross-gender identification"; B) "This cross-gender identification must not merely be a desire for any perceived cultural advantages of being the other sex"; C) "There must also be evidence of persistent discomfort about one's assigned sex or a sense of inappropriateness in the gender role of that sex"; D) The individual must not have a "concurrent physical intersex condition"; and E) "[T]here must be evidence of clinically significant distress or impairment in social, occupational, or other important areas of functioning." *Id.*

124. *See id.*; *infra* text accompanying notes 130–32.

125. *See infra* text accompanying notes 145–47.

126. *See infra* text accompanying notes 152–61.

127. HBIGDA Standards of Care, *supra* note 111.

128. SECOND INT'L CONFERENCE ON TRANSGENDER LAW & EMPLOYMENT POLICY, HEALTH LAW STANDARDS OF CARE FOR TRANSSEXUALISM (1993), *available at* http://www.transgendercare.com/guidance/resources/ictlep_soc.htm#top [hereinafter HEALTH LAW Standards of Care]. *See also* Karasic, *supra* note 101, at 157 (discussing Health Law Standards of Care).

A. Gender Identity Disorder Treatment

Youth diagnosed with GID may be placed into psychiatric treatment by their parents.[129] Medical professionals identify two main goals of such treatment: to prevent children from becoming gay and to reduce social difficulties.[130] Clearly, treatment geared toward the prevention of homosexuality is controversial, as the psychiatric establishment no longer considers homosexuality to be a mental disorder.[131] However, because gender-variant behavior is associated in the popular and clinical imagination with homosexuality, adults often fear that children who do not act the way that boys or girls "should" will grow up to be gay. Treatment of a gender-variant child frequently aims to teach the child to act in "gender-appropriate" ways, a typically unsuccessful effort to ensure that the child will grow up to be heterosexual.[132] For this reason, many have argued that the GID diagnosis is simply the continued pathologization of homosexuality, cloaked in a new veil,[133] and that GID should be removed from the American Psychiatric

129. The mean age of referral in North America is around seven years old. Cohen-Kettenis, Owen, Kaijser, Bradley & Zucker, *supra* note 122, at 42. *See also id.* at 49 (noting main reasons for referral).

130. *See, e.g.*, Kenneth J. Zucker, *Treatment of Gender Identity Disorders in Children*, *in* CLINICAL MANAGEMENT OF GENDER IDENTITY DISORDERS IN CHILDREN & ADULTS 27, 27–30 (Ray Blanchard & Betty W. Steiner eds., 1990). Zucker also identifies goals of treating "underlying psychopathology" and preventing adult transsexualism. *Id.* at 28, 30.

131. The American Psychiatric Association removed homosexuality from the DSM in 1973. Am. Psychiatric Ass'n, Homosexuality and Sexual Orientation Disturbance: Proposed Change in DSM-II: Position Statement (1973), *available at* http://www.psych.org/public_info/libr_publ/position.cfm. This decision occurred against the backdrop of the rise of the gay rights movement, and was based on research showing that most gay, lesbian and bisexual people are no more likely to have mental illnesses than are heterosexual people, and function socially and occupationally at levels equivalent to heterosexuals. Following the removal of homosexuality from the DSM, reparative therapy to "cure" homosexuality was no longer seen as a reputable practice. *See* Am. Psychiatric Ass'n, Psychiatric Treatment and Sexual Orientation Position Statement (1998). Some conservative religious organizations that believe homosexuality is a developmental disorder—for example the National Association for Research and Treatment of Homosexuality—advocate for repathologizing homosexuality. *See, e.g.*, Linda Ames Nicolosi, *Should These Conditions Be Normalized?: American Psychiatric Association Symposium Debates Whether Pedophilia, Gender-Identity Disorder, Sexual Sadism Should Remain Mental Illnesses* (2004), http://www.narth.com/docs/symposium.html. The legacy of homosexuality as mental illness can still be seen today, even in the mainstream, in the approaches taken by clinicians to non-normatively gendered children.

132. *See, e.g.*, KENNETH J. ZUCKER & S.J. BRADLEY, GENDER IDENTITY DISORDER AND PSYCHOSEXUAL PROBLEMS IN CHILDREN AND ADOLESCENTS 265–82 (1995) (explaining treatment rationales). *See also* DAPHNE SCHOLINSKI WITH JANE MEREDITH ADAMS, THE LAST TIME I WORE A DRESS (1997). The author, a masculine child assigned female at birth, was institutionalized from ages fifteen to eighteen, "diagnosed as 'an inappropriate female,' and spent the rest of her high school years undergoing extreme femininity training. At [eighteen], her insurance ran out and she was discharged." Daphne later transitioned and is now Dylan. *See* DYLAN SCHOLINSKI, BIOGRAPHY, http://www.dylanscholinski.com/bio.html (last visited Jan. 9, 2007).

133. *See generally* Susan J. Langer & James I. Martin, *How Dresses Can Make You Mentally Ill: Examining Gender Identity Disorder In Children*, 21 CHILD & ADOLESCENT SOC. WORK J. 5 (2004). *Cf.* Karasic, *supra* note 101, at 157 ("Labeling transgender identity as a mental disorder has many parallels with the inclusion of homosexuality in prior editions of the DSM."). The City

Association's Diagnostic and Statistical Manual of Mental Disorders (DSM), just as homosexuality was a generation ago.[134]

Therapy might indeed be useful for a transgender or gender-variant youth.[135] It could help the youth understand and accept his or her gender identity,[136] manage social difficulties such as conflict with peers and family,[137] and proceed with developmental tasks on a normative schedule.[138] In addition, therapy may assist individuals beginning sex reassignment in coping with the resultant changes and stressors.[139] Many commentators argue that therapeutic goals should also include changing the child's environment by encouraging peers and family to accept the child's gender identity and expression.[140] These

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of San Francisco has called on the American Psychiatric Association to "stop coercive and inappropriate treatment of gender atypical children and youth based on GID . . . and to oppose any treatment designed to manipulate a young person's sexual or gender identity." CITY & COUNTY OF S.F. HUMAN RIGHTS COMM'N, RESOLUTION CONDEMNING USE OF GENDER IDENTITY DISORDER DIAGNOSIS AGAINST CHILDREN & YOUTH 1, 2 (1996). In addition, the fact that 75% of boys with this childhood experience of gender end up identifying as gay when they become adults, *infra* text accompanying note 145, suggests that this is a normal developmental process for gay men, and that it therefore is inappropriate to pathologize it.

134. *See, e.g.*, Richard A. Isay, *Remove Gender Identity Disorder from DSM*, PSYCHIATRIC NEWS, Nov. 21, 1997, at 9.

135. It has been said that "GID is both a necessity and a curse for transgender people, and for LGBT youth in particular" because it allows access to medical treatment but has been used in a discriminatory way. P. LETELLIER & Y.V. LEWIS, CITY & COUNTY OF S.F. HUMAN RIGHTS COMM'N, ECONOMIC EMPOWERMENT FOR THE LESBIAN GAY BISEXUAL TRANSGENDER COMMUNITIES 48 (2000).

136. GID treatment protocols call for clinicians to help children understand and accept their gender identity, whatever that identity might be. *See* discussion *infra* Parts IV.C, VII.A.

137. *See* Kay Bussey & Albert Bandura, *Social Cognitive Theory Of Gender Development And Differentiation*, 106 PSYCHOL. REV. 676 (1999). Bussey and Bandura note that peers regulate each other's gendered conduct though the use of social sanctions. Children as young as age three observed at play were "aware of the social standards associated with gender-linked objects and disapproved of peers' conduct that did not conform to their gender." *Id.* at 698. "In . . . peer interactions, children reward each other for gender-appropriate activities and punish gender conduct considered inappropriate for their gender." *Id.* at 700. *See also supra* text accompanying notes 27–36.

138. Domenico Di Ceglie, *Gender Identity Disorders in Children & Adolescents*, 53 BRIT. J. HOSP. MED. 251 (1995).

139. As Cohen-Kettenis and Gooren explain:

> SRS involves a great deal of loss. There can be a loss of family contacts, friends, employment, housing and social status. Undergoing SRS implicates reorienting to the future in all of the aforementioned areas. During a certain amount of time, the transsexuals' [sic] changes of appearance provide a source of confusion. The ambiguity of the sex characteristics may lead to unpleasant (sometimes even aggressive) confrontations with strangers. . . . Building a new circle of friends . . . is not always easy. . . . The physical changes, though very much desired, can also be psychologically difficult to handle.

Influence of Hormone Treatment, *supra* note 114, at 56–57.

140. *See, e.g.*, Langer & Martin, *supra* note 133, at 19; Susan K. Egan & David G. Perry, *Gender Identity: A Multidimensional Analysis with Implications For Psychosocial Adjustment*, 37 DEV. PSYCHOL. 451, 459 (2001); Nicole Crawford, *Understanding Children's Atypical Gender Behavior*, 34 APA ONLINE 40 (2003) (describing a support group to help parents understand and affirm their gender-variant children); Shannon Minter, Nat'l Ctr. Lesbian Rights, Speech at Hunter

commentators thereby problematize the gender binary system that the DSM implicitly reifies,[141] and resist the conflation of gender *difference* with gender *deviance*.[142]

B. Fears of Post-treatment Regret

Some commentators have identified the possibility that a gender-variant child might grow up to be a gay or lesbian adult, rather than identifying as transgender or transsexual,[143] as one of the most significant reasons to delay the onset of sex reassignment treatment.[144] They understandably fear that the gay or lesbian adult might regret his or her earlier decision to undergo gender transition treatment. The American Psychiatric Association has estimated that approximately 75% of boys in treatment for GID grow up to be gay.[145] Of the remaining 25%, "most" will become heterosexual, while "some" become transgender.[146] The HBIGDA Standards of Care notes that "[t]here is greater fluidity and variability in outcomes, especially in pre-pubertal children. Only a few gender-variant youths become transsexual, although many eventually develop a homosexual orientation. . . . The younger the child the less certain and perhaps more malleable the outcome."[147] A lead researcher summarized the concern:

> Professionals fear that experimenting with certain aspects of gender, such as gender role behaviour, will lead adolescents to conclude that they have a gender identity problem and that they will . . . wrongly seek a medical means of resolving their confusion. The chance of making the wrong diagnosis and the consequent risk of postoperative regret is therefore felt to be higher in adolescents than in adults, as a consequence of the developmental phase itself.[148]

Erik Erikson's work in developmental theory echoes the underlying notion

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College School of Social Work in N.Y., Listening to Gender Variant Children: A Humanistic Strategy for Advocates 3–4 (Mar. 11, 2002), *available at* http://www.nclrights.org/publications/pubs/gvchildren.pdf (describing how parents and teachers supported a child's gender identity exploration); Patricia Leigh Brown, *Supporting Boys or Girls When the Line Isn't Clear*, N.Y. TIMES, Dec. 2, 2006, at A1.

141. *See, e.g.*, Spade, *supra* note 99, at 24–26.

142. *See, e.g.*, Bartlett, Vasey & Bukowski, *supra* note 28, at 772. The authors emphasize that "there exists no agreed-upon definition of 'deviance,'" and offer the definition of the 1985 Penguin Dictionary of Psychology: "Generally, any pattern of behavior that is markedly different from the accepted standards within a society. The connotation is always that moral or ethical issues are involved . . . ." *Id.*

143. For discussion of the distinction between gender identity and sexual identity, see *supra* Part II.

144. *See, e.g.*, Zucker, *Gender Identity Development and Issues*, *supra* note 88, at 562–63 (framing the problem for therapists as an "ethical issue").

145. DSM-IV-TR, *supra* note 105, at 580. "The corresponding percentages for . . . girls are not known." *Id.*

146. *Id.*

147. HBIGDA Standards of Care, *supra* note 111, at 8–9.

148. Cohen-Kettenis & van Goozen, 1997, *supra* note 86, at 263.

that the adolescent's identity is transient. Erikson posited that the key task of adolescence is to successfully navigate the search for self-identity.[149] One risk inherent in adolescent development is that the adolescent will prematurely foreclose this search by committing to an identity without fully considering whether it is truly appropriate for him or her.[150] Erikson believes that by late adolescence, however, many adolescents have explored and resolved key issues of identity and have arrived at a stable sense of self.[151]

The risk of postoperative regret raises a difficult, although resolvable, diagnostic issue for clinicians as they seek to differentiate between those children who will grow up to identify as transgender and those who will grow up to identify as gay or lesbian, in order to determine who might be appropriate for sex reassignment treatment.[152] Recent research suggests that many whose nonnormative gender identification persists into adolescence do continue on to seek sex reassignment treatment or surgery, rather than identifying as gay or lesbian, and that sex reassignment treatment proves beneficial. To assess whether careful screening was able to correctly identify those adolescents who could safely and appropriately undergo sex reassignment surgery (SRS), Peggy Cohen-Kettenis, lead researcher in a Dutch clinic for transgender youth, conducted a study of the first twenty-two consecutive adolescents to have undergone SRS at her clinic.[153] She found that use of the diagnostic criteria endorsed by HBIGDA enabled her to identify those for whom transition was appropriate.[154] To confirm her findings, she then conducted a second study of the next twenty consecutive adolescents who underwent SRS.[155] One to five years after surgery, "none of the subjects expressed feelings of regret about their decision"[156] to transition, and all showed dramatic improvements in their relationships, social life, and psychological functioning.[157] Cohen-Kettenis suggests that those who are able to

149. ERIK H. ERIKSON, IDENTITY, YOUTH, AND CRISIS 91–141 (1968). *See, e.g.*, *id.* at 91 ("We may. . . speak of the identity crisis as the psychosocial aspect of adolsecing.").

150. *See* James Marcia, *Development and Validation of Ego-Identity Status*, 3 J. PERSONALITY & SOC. PSYCHOL. 551, 557–58 (1966) (identifying four modes of resolving identity conflict as identity diffusion, identity moratorium, identity foreclosure, and identity achievement). I suggest, however, that identity foreclosure is more of a risk for heterosexual or non-transgender adolescents, who might adopt beliefs transmitted from family or society without questioning them.

151. ERIKSON, *supra* note 149, at 163–65.

152. *See infra* text accompanying note 163.

153. Cohen-Kettenis & van Goozen, 1997, *supra* note 86. The stated goal of the study was to investigate two clinical decisions: first, "whether it had been a correct decision to allow well-functioning adolescent transsexuals to proceed with the SR procedure after careful screening, given that they were between 16 and 18 years of age." *Id.* at 473. Secondly, the study intended to determine "whether the decision not to allow other adolescent applicants to proceed with the SR procedure before age 18 had been a justified one." *Id.*

154. *Id.* at 264.

155. Smith, van Goozen & Cohen-Kettenis, 2001, *supra* note 91.

156. Cohen-Kettenis & van Goozen, 1997, *supra* note 86, at 267. *See also* Smith, van Goozen & Cohen-Kettenis, 2001, *supra* note 91, at 475, 479 (same).

157. *Id. See generally infra* Part VI.A.

satisfy the stricter criteria for adolescent transition[158] probably had very strong "childhood cross-gender identification;"[159] and the persistence of their gender-variance indicated that it was a resolved part of their identity, which explains their tendency to "show less postoperative regret."[160] She also notes that such children tend to "present earlier for treatment,"[161] so that by later adolescence, they may have already spent years addressing their identity in a therapeutic environment. Cohen-Kettenis' studies indicate that medical professionals are successful in distinguishing between those adolescents who, as adults, will identify as transgender, and those who will identify as gay or lesbian, as follow-up with adolescents in her study confirmed that sex reassignment had been the correct decision.

C. The Harry Benjamin Treatment Protocol

The HBIGDA Standards of Care outlines a protocol, or medical treatment plan, used to guide treatment of individuals experiencing distress caused by their gender identity. The protocol includes guidelines for treatment of transgender adolescents, including tools for assessing readiness for hormone treatment or sex reassignment surgery,[162] as well as a series of physical interventions that may be undertaken sequentially, based on a combination of the individual's need, maturity, and age. HBIGDA recommends that the adolescent proceed slowly through three sequential stages of physical interventions.[163] This permits a balancing of the distress experienced by the adolescent due to the need for physical interventions against the risk that the decision may later be regretted due to changes in the individual's gender identity.

In the first stage, known as "pubertal delay," the interventions are fully reversible. Hormone production (either estrogen or testosterone) is suppressed through the use of puberty-delaying hormones, which arrest the physical changes

158. Cohen-Kettenis & van Goozen, 1997, *supra* note 86, at 264 (describing the "additional criteria . . . used for referral to the second diagnostic phase" in which hormone treatment begins, "because [the clinic was] still in a pioneering phase for adolescents"). In particular, the criteria would tend to select "so-called 'homosexual transsexuals'" who have typically been the more identifiable and successful patients. *Id.* at 270.

159. *Id.* at 270.

160. *Id.*

161. *Id. See also* Peggy T. Cohen-Kettenis, Letter to the Editor, *Gender Identity Disorder in DSM?*, 40 J. AM. ACAD. CHILD & ADOLESCENT PSYCHIATRY 391 (2001). In this letter to the Journal of the American Academy of Child and Adolescent Psychiatry, Cohen-Kettenis wrote that 23% of patients who had been referred to her clinic and diagnosed with GID prior to the age of twelve were later approved for treatment as adolescents, suggesting that a significant percentage of those identified at an early age will later be found appropriate for sex reassignment treatment.

162. The HBIGDA guidelines for adolescent treatment generally track the DSM-IV-TR diagnostic criteria for GID. *See* HBIGDA Standards of Care, *supra* note 111, at 4–6.

163. *Id.* at 10. They suggest that "[m]oving from one state to another should not occur until there has been adequate time for the young person and his/her family to assimilate fully the effects of earlier interventions." *Id.*

of puberty.[164] To be prescribed puberty-delaying hormones, the adolescent must meet the DSM criteria for gender identity disorder of childhood (GIDC), and the family must both consent to the treatment and participate in the therapy.[165] Under the HBIGDA protocol, adolescents "may be eligible for puberty-delaying hormones as soon as pubertal changes have begun," although the protocol anticipates that certain adolescents could begin puberty-delaying hormones prior to the onset of puberty.[166] Delaying puberty allows the individual "to gain time to further explore the gender identity and other developmental issues in psychotherapy [and] to make passing easier if the adolescent continues to pursue sex and gender change."[167]

In the second stage of physical interventions, the results are partially reversible. These interventions include hormone treatment to masculinize or feminize the individual's body.[168] Under the HBIGDA guidelines, adolescents are eligible to begin hormone therapy as early as age sixteen.[169] Parental consent to hormone therapy is recommended but not required.[170] However, "mental health professional involvement" is "an eligibility requirement" for this stage of intervention.[171] Before starting hormone therapy, HBIGDA suggests that the adolescent (and the family, if possible) work with a mental health professional for at least six months.[172] The HBIGDA protocol does not mandate the number of sessions or depth of involvement, instead emphasizing that "the intent is that

164. *Id.* *See also* Smith, van Goozen & Cohen-Kettenis, 2001, *supra* note 91, at 480 ("[W]hen these hormones are administered before puberty, puberty will not occur. Given after the start of puberty, pubertal development will not proceed. An advantage of pubertal delay over cross-sex hormone treatment is that no irreversible steps are taken.").

165. HBIGDA Standards of Care, *supra* note 111, at 10:

> In order to provide puberty delaying hormones to an adolescent, the following criteria must be met: 1. throughout childhood the adolescent has demonstrated an intense pattern of cross-sex and cross-gender identity and aversion to expected gender role behaviors; 2. sex and gender discomfort has significantly increased with the onset of puberty; 3. the family consents and participates in the therapy.

166. *Id.*

167. *Id.*

168. *Id.*

169. *Id.*

170. *Id.*

171. Under the HBIGDA Standards of Care, adolescents who seek to obtain hormone treatment or sex reassignment surgery must be willing to participate in counseling in order to help the adolescent determine the appropriate outcome. HBIGDA recommends that the adolescent be seen by a "child-specialist mental health professional" who can assess and treat the adolescent. The mental health professional should perform a complete psychodiagnostic and psychiatric assessment in order to "explore the nature and characteristics of the child's or adolescent's gender identity." The protocol suggests that this assessment should "include a family evaluation, because other emotional and behavioral problems are very common, and unresolved issues in the child's environment are often present." If additional issues are identified, treatment should also focus on "ameliorating [these] comorbid problems in the child's life." *Id.* at 9.

172. *Id.* at 10.

hormones and the real-life experience be thoughtfully and recurrently considered over time."[173]

The third stage of treatment consists of irreversible interventions. These actions include surgical procedures which give the individual gender-appropriate genitalia, and breasts or chest. The HBIGDA guidelines state:

> Any surgical intervention should not be carried out prior to adulthood, or prior to a real-life experience of at least two years in the gender role of the sex with which the adolescent identifies. The threshold of eighteen should be seen as an eligibility criterion and not an indication in itself for active intervention.[174]

HBIGDA thus sets forth a progressive sequence of physical interventions coupled with therapy, which attempts to strike a balance between reducing the harm suffered by the adolescent and minimizing the risk of subsequent regret.

D. Health Law Standards of Care: An Alternative to HBIGDA

Because it imposes a significant series of requirements the transgender person must meet, and places doctors and social workers in a gatekeeper role between the transgender individual and the treatment sought, the HBIGDA Standards of Care has been criticized as "unnecessarily restrict[ing] access to hormones and surgery."[175] "Not all transgendered people meet the diagnostic criteria for GID. Not every transgendered person intends to complete the 'triadic' sequence of real-life experience, hormones, and surgery. Many lack the considerable financial resources to pay for surgery."[176]

The Health Law Standards of Care was created by the International Conference on Transgender Law and Employment Policy explicitly as an alternative to the HBIGDA Standards of Care.[177] Although the Health Law Standards of Care is available for use, HBIGDA's model is the primary standard of care referenced in the literature. However, the Health Law Standards of Care provides a point of comparison that suggests how doctors might work differently with their transgender patients. Under this standard of care:

> Physicians . . . shall provide hormonal sex reassignment therapy . . . subject only to (1) the physician's reasonable belief that therapy will not aggravate a patient's health conditions, (2) the patient's compliance with periodic blood chemistry checks to ensure a continued healthy condition, and (3) the patient's signature on an informed consent and

173. *Id.* at 10–11.

174. *Id.* at 11.

175. Oriel, *supra* note 19, at 186.

176. Karasic, *supra* note 101, at 157.

177. HEALTH LAW Standards of Care, *supra* note 128 (stating that "[t]he Health Law Standards of Care were developed in the wake of widespread dissatisfaction by many in the transgendered community with the Harry Benjamin Standards of Care.").

waiver of liability form.[178]

> Surgeons . . . shall provide sex reassignment therapy . . . subject only to (1) the surgeon's reasonable belief that the surgery will not aggravate pre-existing health conditions, (2) the surgeon's reasonable determination that the patient has been under hormonal sex reassignment therapy for at least one year, and (3) the patient's signature of an informed consent and waiver of liability form.[179]

This standard of care directs the physician to ensure that treatment will not have a harmful effect on the patient's heath. Patients must give informed consent, but that requirement does not add any additional barriers to the general legal responsibility the physician bears to ensure that her patients are capable of giving informed consent to medical treatment. In particular, therapy is not required, as it is by the HBIGDA protocol.

Although the HBIGDA protocol is the predominant standard of care, advocates should be aware that other protocols exist. The Health Law Standards of Care, along with other standards of care developed by individual clinics,[180] suggests an alternative to the HGIBDA protocol that eliminates the strict prerequisites to treatment and places the focus squarely on the patient's ability to give informed consent.

V.
INFORMED CONSENT LAW

Under the informed consent doctrine, most minors do not have the right to consent to their own medical treatment until they turn eighteen. This doctrine prevents transgender adolescents from accessing trans-related medical care such as hormones and sex reassignment surgery without the consent of their parent or guardian.

A. General Rule

At common law, minors were considered to be legally "incompetent," and therefore lacked capacity to consent to their own health care.[181] As stated by a plurality of the United States Supreme Court in *Carey v. Population Services International*, "the law has generally regarded minors as having a lesser capa-

178. *Id.* Standard 1.

179. *Id.* Standard 3.

180. *See* TOM WADDELL HEALTH CTR. TRANSGENDER TEAM, PROTOCOLS FOR HORMONAL REASSIGNMENT OF GENDER (2001), http://www.dph.sf.ca.us/chn/HlthCtrs/HlthCtrDocs/TransGend protocols.

181. Schall v. Martin, 467 U.S. 253, 265 (1984) ("Children, by definition, are not assumed to have the capacity to take care of themselves. They are assumed to be subject to the control of their parents, and if parental control falters, the State must play its part as *parens patriae*."); *In re* Baby Boy W.A., 773 N.Y.S.2d 255, 257 (N.Y. 2004).

bility for making important decisions."[182] In *Bellotti I*,[183] the Court noted that minors demonstrate "unquestionably greater risks of inability to give an informed consent" than do adults.[184] In *Bellotti II*,[185] the Court justified the diminished scope of minors' constitutional rights on the basis of adolescents' "peculiar vulnerability"[186] and the State's interest in parental involvement in "child rearing."[187] These reasons for denying all minors the authority to consent to their own medical treatment are based on faulty assumptions that will be explored further in Parts VI.A. and VI.B.

In general, individuals gain the right to give informed consent to medical care on their own behalf at age eighteen. "Every person of adult years and sound mind has a right to determine what shall be done with his own body"[188] and to control the course of his medical treatment.[189] This right stems from the individual's liberty interest. The New York Court of Appeals has stated:

> In our system of a free government, where notions of individual autonomy and free choice are cherished, it is the individual who must have the final say in respect to decisions regarding his medical treatment in order to insure that the greatest possible protection is accorded his autonomy and freedom from unwanted interference with the furtherance of his own desires.[190]

All adults are generally presumed to have capacity to give informed consent, unless and until determined by a court to be incompetent.[191] The right to determine what happens to one's body has been upheld for people with mental illness[192] and in cases where individuals sought to reject life-saving treatment.[193]

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182. 431 U.S. 678, 693, n.15 (1977) (Brennan, J., plurality opinion). *See* Thompson v. Oklahoma, 487 U.S. 815, 824 (1988) ("[T]here are differences which must be accommodated in determining the rights and duties of children as compared with those of adults." (quoting Goss v. Lopez, 419 U.S. 565, 590–91 (1975) (Powell, J., dissenting))). *See also* Bonner v. Moran, 126 F.2d 121, 122 (D.C. Cir. 1941).

183. Bellotti v. Baird (*Bellotti I*), 428 U.S. 132 (1976).

184. *Id.* at 147.

185. Bellotti v. Baird (*Bellotti II*), 443 U.S. 622 (1979).

186. *Id.* at 633.

187. *Id.* at 637–39.

188. *In re* Baby Boy W.A., 773 N.Y.S.2d 255, 257 (N.Y. 2004) (quoting the "law of New York" as stated by Judge Cardozo in Schloendorff v. Soc'y of N.Y. Hosp., 105 N.E. 92, 93 (N.Y. 1914)).

189. *In re* Storar, 420 N.E.2d 64, 70 (N.Y. 1981). *See also In re* M.B., 6 N.Y.3d 437, 439 (N.Y. 2006) (holding that Health Care Decisions Act for Mentally Retarded Persons, N.Y. SURR. CT. PROC. ACT § 1750 (McKinney 2003), grants guardians full health care decision-making authority for mentally retarded persons).

190. Rivers v. Katz, 504 N.Y.S.2d 74, 78 (N.Y. 1986).

191. *Id.* at 81 (holding that the burden is on the State to establish incompetence); Kellogg v. Office of Chief Med. Exam'r of City of N.Y., 735 N.Y.S.2d 350, 360 (Sup. Ct. 2001).

192. *See Rivers*, 504 N.Y.S.2d at 79–80.

193. *See Storar*, 420 N.E.2d at 74; Grace Plaza of Great Neck, Inc. v. Elbaum, 623 N.E.2d 513, 514 (N.Y. 1993).

Individuals younger than eighteen may consent to certain types of medical treatment on their own behalf.[194] Outside of those circumscribed areas, however, they must have a surrogate decision-maker.[195] For minors, the primary decision-maker will generally be a parent. "Children, by definition, are not assumed to have the capacity to take care of themselves. They are assumed to be subject to the control of their parents, and if parental control falters, the State must play its part as *parens patriae*."[196] Parents have a liberty interest in being able to raise their children as they see fit.[197] The Supreme Court, in a line of cases evaluating parental rights and minors' autonomy, has established that the Due Process Clause requires deference to parental determinations concerning child-rearing.[198] Parents have a zone of constitutionally protected grounds, such as religion, on which they may base their decisions about how to raise their children.[199] Thus, if parents consent to sex reassignment treatment for a transgender child, there is no legal bar to the child receiving treatment so long as the child's doctor finds it medically appropriate.

Parents enjoy a rebuttable presumption that they are acting in their minor child's best interests.[200] The State will generally defer to parents' decisions un-

194. *See infra* Part V.B.

195. New York provides four options for "persons who are not capable of providing informed consent": a close relative, an appointee of the judge, the court itself upon application, and a "surrogate decision-making committee." N.Y. COMP. CODES R. & REGS. tit. 14, § 710.1(b) (2001).

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

197. U.S. CONST. amend. XIV. *See also* Roe v. Wade, 410 U.S. 113, 153 (1973); Pierce v. Soc'y of Sisters, 268 U.S. 510, 534–35 (1925); Meyer v. Nebraska, 262 U.S. 390, 399 (1923).

198. *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 control of their children"); Santosky v. Kramer, 455 U.S. 745, 753 (1982) (emphasizing the extent of "[t]he 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); Parham 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 upbringing 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. 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").

199. *See, e.g.*, *Pierce*, 268 U.S. at 534–35; *Yoder*, 406 U.S. at 231–32. *But see Prince*, 321 U.S. at 166 ("the family itself is not beyond regulation in the public interest, as against a claim of religious freedom"); *id.* at 167 ("[T]he state has a wide range of power for limiting parental freedom and authority in things affecting the child's welfare, and . . . this includes, to some extent, matters of conscience and religious conviction.").

200. *See, e.g.*, *Parham*, 442 U.S. at 604 ("[T]he traditional presumption that the parents act in the best interests of their child should apply. . . . [H]owever, . . . the child's rights and the nature of the . . . decision are such that parents cannot always have absolute and unreviewable discretion to

less it can demonstrate that it has a compelling interest in intervention. In some circumstances, the State may overrule a parent's decision about what health care their child may receive.[201] In those cases, the parent will be adjudged to have neglected the child's medical care, and the State can then impose its decision about the child's health care.[202]

If, as a general matter, the child is believed to be neglected or abused by the parent, the child may be taken from the parent and placed in state foster care.[203] Under such circumstances, New York statutory law authorizes the local commissioner of social services or health to give effective consent for the medical treatment of abused or neglected children within its care.[204] Thus, any transgender youth living in the foster care system must seek the consent of the local commissioner in order to receive transgender-related medical treatment.

If a parent or foster care guardian will not give consent for a child to access transgender-related health care, the minor may be able to seek permission from the court. One option is for the minor to ask the court to find that the parent has neglected the minor by failing to allow necessary medical treatment.[205] If the court finds the minor to be neglected, the court can then order medical treatment for the minor under New York's Family Court Act section 1012(f).

A second possibility is for the minor to argue that the judicial bypass provision established in the abortion context is applicable to minors seeking other types of health care.[206] Judicial bypass may be a preferable or necessary option

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decide whether to have a child institutionalized.").

201. *See* discussion of court-ordered medical treatment *infra* Part VII.C.

202. The parent, if otherwise fit, will not automatically lose custody due to such a finding of negligence.

203. *See* N.Y. FAM. CT. ACT §§ 1021, 1022, 1024, 1031 (McKinney 1999 & Supp. 2007) (describing procedure for removing child from home and initiating proceedings to determine abuse or neglect); *id.* § 1051 (giving the Family Court power to enter a finding of abuse or neglect).

204. N.Y. SOC. SERV. LAW § 383(b) (McKinney 2003). Under N.Y. Family Court Act section 1027, once a minor has been removed from the custody of his or her parents and placed into state custody, "the court may authorize a physician or hospital to provide medical or surgical procedures if such procedures are necessary to safeguard the child's life or health." N.Y. FAM. CT. ACT § 1027(e) (McKinney 1999 & Supp. 2007).

205. *See infra* Part VII.C (discussing how court-ordered medical treatment might be used to override parental refusal to authorize treatment sought by minor).

206. States which require minors to obtain consent from a parent in order to undergo an abortion must create a judicial bypass procedure. *Bellotti II*, 443 U.S. at 643–44. The line of cases following *Bellotti II* have established general rules about what a state may constitutionally require of a minor who wishes to receive an abortion. States are free to set the age at which a minor may consent to an abortion on her own. *See, e.g.*, Ballard v. Anderson, 484 P.2d 1345 (Cal. 1971) (construing California statute to allow minors to consent to abortion without parental consent). It is constitutional for states to require notification of one or both parents in order for a minor below that age to receive an abortion, as long as the State provides a judicial bypass option. Hodgson v. Minnesota, 497 U.S. 417 (1990). The Supreme Court in *Hodgson* held that a 48-hour waiting period is constitutional and reasonable for "adequate consultation between parent and child." *Id.* at 449.

As New York does not require parental notification or consent in order for a minor to obtain an abortion, New York has not created a statute governing judicial bypass procedures for minors

when parents or the State acting as guardian will not consent to the health care the transgender adolescent seeks. In the abortion context, judicial bypass prevents the unconstitutional outcome of allowing a parent to hold absolute veto power over the minor's decision to terminate her pregnancy,[207] and recognizes that there are circumstances where parental notification is not in the minor's best interests.[208]

The Supreme Court held in *Bellotti II* that a bypass provision must meet four criteria. It must:

> (i) allow the minor to bypass the consent requirement if she establishes that she is mature enough and well enough informed to make the abortion decision independently; (ii) allow the minor to bypass the consent requirement if she establishes that the abortion would be in her best interests; (iii) ensure the minor's anonymity; and (iv) provide for expeditious bypass procedures.[209]

In *Lambert v. Wicklund*,[210] the Court expanded the second *Bellotti* prong, holding that a minor may also use the judicial bypass procedure if she shows that parental notification is not in her best interests.[211]

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seeking abortions or other health care.

In states that have established a judicial bypass procedure, petitions are typically addressed to the family court or district court of the state. *See, e.g.*, DEL. CODE ANN. tit. 24, § 1783(b) (Michie 2005) (stating that a "minor may petition the Family Court . . . of any county of this State for a waiver of the notice requirement [for abortion]"); LA. REV. STAT. ANN. § 40:1299.35.5(B)(1) (West 2001) (stating that "[j]urisdiction to hear applications shall be in the court having juvenile jurisdiction in the parish where the abortion is to be performed or the parish in which the minor is domiciled"); KAN. STAT. ANN. § 65-6705(a) (2002) (stating that "[i]f the minor [objects to parental notification], the minor may petition, on her own behalf or by an adult of her choice, the district court of any county of this State for a waiver of the notice requirement of this subsection"). In New York, the family court retains jurisdiction over any minor placed outside of his or her home. N.Y. FAM. CT. ACT § 1088 (McKinney Supp. 2007).

The court then considers whether to authorize the abortion. *See, e.g.*, DEL. CODE ANN. tit. 24, § 1784(b) (Michie 2002) (stating that "[t]he Court, by a judge, shall grant the written application for a waiver if the facts recited in the application establish that the minor is mature and well-informed enough to make the abortion decision on her own or that it is in the best interest of the minor that notification pursuant to § 1783 of this title be waived"); LA. REV. STAT. ANN. § 40:1299.35.5(B)(1) (West 2001) ("If the court . . . finds, by clear and convincing evidence, that the minor is sufficiently mature and well enough informed to make the decision concerning the abortion on her own, the court shall issue an order authorizing the minor to act on the matter without parental consultation or consent"); KAN. STAT. ANN. §§ 65-6705(e)(1), (e)(2) (2002) (stating that the court shall "grant . . . the minor's application for waiver of notice pursuant to this section, if the court finds that the minor is mature and well-enough informed to make the abortion decision without notice to a person specified in subsection (a)" or "if the court finds that the minor is immature but that notification of a person specified in subsection (a) would not be in the minor's best interest").

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

208. *See Hodgson*, 497 U.S. at 522.

209. *Bellotti II*, 443 U.S. at 643–44.

210. 520 U.S. 292 (1997).

211. *Id.* at 297–98.

Although minors may in some circumstances have no other choice but to petition the court, judicial bypass is not an ideal solution, as it interposes yet another barrier between the minor and her desired health care, and judges are no more likely to be knowledgeable about the needs of transgender adolescents than are parents or the State.[212] A better option is for the minor to be found competent to consent to her own health care through an exception to the informed consent law.

B. Exceptions to Informed Consent Law That Allow Minors to Consent to Their Own Care

Despite the general rule that minors may not consent to their own health care, minors are not entirely without constitutional protection. The Supreme Court, in delineating the boundaries of minors' constitutional rights, has recognized that "[m]inors, as well as adults, are protected by the Constitution and possess constitutional rights,"[213] and that "neither the Fourteenth Amendment nor the Bill of Rights is for adults alone."[214] Although minors do not hold the same array of rights as adults,[215] they do have a "cluster of constitutionally protected choices."[216] The Court has at times used case-by-case determinations to assess a minor's competency to make a decision, rather than relying solely on a bright-line rule tied to chronological age.[217]

Certain state exceptions to the common law informed consent rule allow minors to consent to their own health and medical care.[218] These exceptions are generally divided into two categories. First, minors who bear certain legal sta-

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212. The advantages and disadvantages of judicial bypass will be discussed further in Part VII.D.3, *infra*.

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

214. *In re* Gault, 387 U.S. 1, 13 (1967).

215. Ginsberg v. New York, 390 U.S. 629, 649–50 (1968) (Stewart, J., concurring in judgment) ("[A]t least in some precisely delineated areas, a child . . . is not possessed of that full capacity for individual choice. . . . It is only upon such a premise . . . that a State may deprive children of other rights . . . that would be constitutionally intolerable for adults.").

216. Carey v. Population Serv. Int'l, 431 U.S. 678, 694 (1977) (holding that the State may not impose a blanket prohibition on the right of minors to obtain contraceptives). *E.g.*, McConnell v. Fed. Election Comm'n, 540 U.S. 93, 231 (2003) (monetary contributions to political campaigns); Planned Parenthood v. Danforth, 428 U.S. 52 (1976) (abortion during the first twelve weeks of pregnancy); Tinker v. Des Moines Sch. Dist., 393 U.S. 503 (1969) (political expression at school). *Cf.* Erznoznik v. Jacksonville, 422 U.S. 205, 212–14 (1975) (stating that "[s]peech that is neither obscene as to youths nor subject to some other legitimate proscription cannot be suppressed solely to protect the young from ideas or images that a legislative body thinks unsuitable for them").

217. Brief for Am. Psychological Ass'n, Nat'l Ass'n of Social Workers & Am. Jewish Comm. as Amici Curiae Supporting Petitioners/Cross-Respondents, Hodgson v. Minnesota, 497 U.S. 417 (1990) (No. 88-1125), and Appellees, Ohio v. Akron Ctr. for Reprod. Health, 497 U.S. 502 (No. 88-805) [hereinafter *Amici Curiae Brief*] (citing Fare v. Michael C., 442 U.S. 707, 727 (1979) (waiver of Fifth Amendment rights); Globe Newspaper Co. v. Superior Court, 457 U.S. 596, 608 (1982) (Confrontation Clause)).

218. For more detailed discussion of the contours of these exceptions and how they may be used to empower transgender adolescents to consent to their own health care, see *infra* Part VII.B.

tuses, for example those who are married, parents, or emancipated, may consent to their own health care; second, minors with certain medical conditions may consent to health care relating to those conditions.[219] The New York Legislature has codified some of these common law exceptions allowing minors to give effective consent for medical, dental, health, and hospital services in certain circumstances.[220]

The status exceptions most relevant to the needs of transgender adolescents are the exceptions for emancipated and mature minors. In New York, minors who are married or have given birth are among those who are considered emancipated and who may therefore give effective consent for themselves and their children.[221] The mature minor exception, which allows the court to evaluate the judgment and decision-making capacity of a young person seeking to give legal consent to treatment, is recognized in a number of states, although the extent of its acceptance in New York is unclear.[222]

Minors may also be able to consent to medical care related to specific health conditions. In *Carey v. Population Services International*, the Supreme Court held that under the First and Fourteenth Amendments, states cannot bar minors from buying nonprescription contraceptives.[223] New York and many other state legislatures have expanded the right of minors to access other types of health care because they understand that forcing minors to seek parental consent will result in some number of minors being unable to access necessary treatment.[224] Many states allow minors access to any form of birth control, including prescription birth control and the "morning after pill," even if they have not notified a parent or obtained parental consent.[225] Minors who become pregnant may consent to their own prenatal care in New York.[226] Minors are entitled to confidential family planning services if they are being treated under the auspices of Temporary Aid to Needy Families (TANF), Medicaid, or the Public Health Service Act, and states' efforts to impose parental consent or notification requirements for minors seeking such services have been invalidated.[227] In New York

219. *See generally* Batterman, *supra* note 66.

220. N.Y. PUB. HEALTH LAW § 2504(4) (McKinney 2002 & Supp. 2007). For an excellent summary of the legislative history leading to the enactment of section 2504, see Batterman, *supra* note 66, at 642–46, 653–56.

221. N.Y. PUB. HEALTH LAW §§ 2504(1), (2) (McKinney 2002 & Supp. 2007).

222. *See infra* notes 333–40.

223. 431 U.S. 678, 681–82 (1977).

224. *See* Batterman, *supra* note 66, at 642–46, 653–56.

225. N.Y. Civil Liberties Union, Types of Care Minors Can Receive Without Parental Consent, http://www.nyclu.org/thi/legal_secondary-pages/legal_secondary_parental.html (last visited Jan. 9, 2007). *See also* ALAN GUTTMACHER INST., MINORS' ACCESS TO CONTRACEPTIVE SERVICES (2006), *available at* http://www.guttmacher.org/statecenter/spibs/spib_MACS.pdf.

226. N.Y. PUB. HEALTH LAW § 2504(3) (McKinney 2002 & Supp. 2007).

227. *See* Jones v. T.H., 425 U.S. 986 (1976) (invalidating as inconsistent with the Social Security Act a Utah regulation requiring minors to obtain parental consent before receiving family planning assistance under the Aid to Families with Dependent Children (AFDC) and Medicaid programs); Planned Parenthood Ass'n v. Dandoy, 810 F.2d 984 (10th Cir. 1987); Jane Does 1

all minors may consent to substance abuse treatment[228] and outpatient mental health services,[229] subject to certain conditions, and those over the age of sixteen may consent to inpatient mental health care.[230] Parental consent is not required in order for a minor to be diagnosed or treated for a sexually transmitted disease.[231] Minors may obtain HIV tests without parental consent, though not HIV treatment, as long as they can demonstrate an ability to understand and the capacity to consent.[232]

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through 4 v. State of Utah Dep't of Health, 776 F.2d 253 (10th Cir. 1985); New York v. Heckler, 719 F.2d 1191 (2d Cir. 1983) (invalidating amendment to Public Health Service Act requiring health care providers to notify parents that their minor child is seeking family planning services).

228. N.Y. MENTAL HYG. LAW § 22.11(c) (McKinney 2006):

> If, in the judgment of a physician, parental or guardian involvement and consent would have a detrimental effect on the course of treatment of a minor who is voluntarily seeking treatment for chemical dependence or if a parent or guardian refuses to consent to such treatment and the physician believes that such treatment is necessary for the best interests of the child, such treatment may be provided to the minor . . . without the consent or involvement of the parent or guardian.

229. *Id.* § 33.21(c):

> A mental health practitioner may provide outpatient mental health services . . . to a minor . . . if . . . (1) the minor is knowingly and voluntarily seeking such services; and (2) provision of such services is clinically indicated and necessary to the minor's well-being; and (3)(i) a parent or guardian is not reasonably available; or (ii) requiring parental or guardian consent or involvement would have a detrimental effect on the course of outpatient treatment; or (iii) a parent or guardian has refused to give such consent and a physician determines that treatment is necessary and in the best interests of the minor.

See also id. § 33.21(d) (providing that a minor may consent to an initial interview with a mental health practitioner).

230. N.Y. MENTAL HYG. LAW § 9.13(a) (McKinney 2006) (voluntary admissions for those with mental illnesses):

> If the person is under sixteen years of age, the person may be received as a voluntary patient only on the application of the parent, legal guardian, or next-of-kin of such person, or, subject to the terms of any court order . . . . If the person is over sixteen and under eighteen years of age, the director may, in his discretion, admit such person either as a voluntary patient on his own application or on the application of the person's parent, legal guardian, next-of-kin, or, subject to the terms of any court order.

231. N.Y. PUB. HEALTH LAW § 2305(2) (McKinney 2002 & Supp. 2007):

> A licensed physician, or in a hospital, a staff physician, may diagnose, treat or prescribe for a person under the age of twenty-one years without the consent or knowledge of the parents or guardian of said person, where such person is infected with a sexually transmissible disease, or has been exposed to infection with a sexually transmissible disease.

232. *Id.* § 2781(1); THE ALAN GUTTMACHER INST., MINORS' ACCESS TO STD SERVICES (2004), http://www.guttmacher.org/statecenter/spibs/spib_MASS.pdf. *See also* N.Y. Civil Liberties Union, *supra* note 225.

VI.
TRANSGENDER ADOLESCENTS SHOULD HAVE THE RIGHT TO CONSENT TO THEIR OWN TRANS-RELATED HEALTH CARE

A. Outcome Studies of Sex Reassignment Show Positive Results

There have been several studies that investigated the effectiveness of sex reassignment for adolescents.[233] Peggy Cohen-Kettenis's 1997 study[234] found that transgender adolescents' self-esteem and extroversion increased after sex reassignment treatment, and their feelings of inadequacy decreased.[235] Similarly, Yolanda Smith's 2001 study[236] found that the adolescents' feelings of gender dysphoria greatly diminished after transition.[237] Smith's 2002 study,[238] investigating the level of psychological functioning of transsexual adolescents after sex reassignment, found that symptoms of "distorted and idiosyncratic perception" decreased, and that gender transition did not result in major psychological deterioration.[239] Smith reasoned that the match between physical self and identity that is achieved by means of sex reassignment results in a decrease in psychological conflict and an increase in reality testing.[240] Smith concluded that "the fear that the adolescents' psychological functioning will deteriorate as a consequence of an early start of the sex reassignment procedure is not substantiated. . . . If anything, their functioning changes in a more healthy direction."[241] Taken together, these studies suggest that the mental health of transgender adolescents improves markedly after sex reassignment.

B. Many Adolescents Have the Capacity to Consent

We must take care not to underestimate the decision-making capacity of adolescents. Under New York law, informed consent "means that the patient has

233. *See, e.g.*, Cohen-Kettenis & van Goozen, 1997, *supra* note 86; Smith, van Goozen & Cohen-Kettenis, 2001, supra note 91; Smith, Cohen & Cohen-Kettenis, 2002, *supra* note 106.

234. Cohen-Kettenis & van Goozen, 1997, *supra* note 86, at 266. "The mean age of the group was 17.5 years (range 15 to 20) at the time of the pretest and 22.0 (range 19 to 27) at the follow-up. Nine of the patients had started the 'real-life test' . . . supported by hormone treatment, before the age of 18." *Id.*

235. *Id.* at 268–69.

236. Smith, van Goozen & Cohen-Kettenis, 2001, *supra* note 91, at 475. "The mean age of the [treated] group was 16.6 years (range 15–19) at pretest and 21.0 (range 19–23) at follow-up. Ten . . . had started hormone treatment between 16 and 18 years of age." *Id.*

237. *Id.* at 478–79.

238. Smith, Cohen & Cohen-Kettenis, 2002, *supra* note 106, at 257. This was the same group of twenty-two patients in Cohen-Kettenis and van Goozen's 1997 study. The mean age at follow-up was 22.5 (range 18–27). The mean period between pre-sex reassignment and post-sex reassignment testing was 58.5 months (range 40.5–87.2 months). *Id.*

239. *Id.* at 259.

240. *Id.*

241. *Id.* at 260.

to demonstrate the intellect to understand what is being proposed, to realize and assess the risks and benefits, and to voluntarily consent to or refuse the proposed major medical treatment."[242] Both social science and law have recognized that individuals below the age of eighteen demonstrate the ability to meet this standard.

Empirical studies and developmental theory show that adolescents have the capacity to make health care decisions at a level equal to many adults. In an article calling for the age of consent to be lowered, physician Andrew Newman stated that by the age of fifteen or sixteen, individuals "acquire sufficient decisional capacity to make reasoned decisions."[243] He based his conclusion on a review of the psychology literature finding that minors above the age of fourteen are able to give intelligent consent because they have reached the stage at which individuals can think logically and abstractly and consider the consequences of actions.[244] Adolescents can reason autonomously enough by the age of fourteen or fifteen to be able to give voluntary consent.[245] Lawrence Kohlberg's theories suggest that minors demonstrate moral reasoning comparable to adults by middle adolescence.[246]

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242. N.Y. COMP. CODES R. & REGS. tit. 14, § 710.1(b) (2001). *See also* N.Y. MENTAL HYG. LAW § 80.03(c) (McKinney 2006) ("Lack of ability to consent . . . means the patient cannot adequately understand and appreciate the nature and consequences of a proposed major medical treatment . . . and cannot thereby reach an informed decision to consent to or to refuse such treatment in a knowing and voluntary manner."). *Cf.* N.Y. PUB. HEALTH LAW § 2803-c(3)(a) (McKinney 2002) ("Every patient's . . . right to independent personal decisions and knowledge of available choices [] shall not be infringed"); N.Y. PUB. HEALTH LAW § 2803-c(3)(e) (McKinney 2002) ("Every patient shall have the right . . . to be fully informed . . . and to refuse . . . treatment" upon that information); N.Y. PUB. HEALTH LAW § 2805-d (McKinney 2002) (providing for a cause of action for lack of informed consent defined as nondisclosure of relevant information); N.Y. COMP. CODES R. & REGS. tit. 10, § 751.9(h) (enumerating information doctors must provide to establish informed consent).

243. Andrew Newman, *Adolescent Consent to Routine Medical & Surgical Treatment*, 22 J. LEGAL MED. 501, 528 (2001).

244. *Id.* at 519–20 (discussing Piaget's stage theory). *See also* Elizabeth Cauffman & Laurence Steinberg, *The Cognitive and Affective Influences on Adolescent Decision-Making*, 68 TEMPLE L. REV. 1763, 1768 (1995).

> Developmental theory posits that the cognitive capacity for logical reasoning emerges during early adolescence—the ages of eleven and fourteen. According to Jean Piaget, adolescents who have reached the stage of formal operational thinking are able to reason abstractly and deductively. Once they have reached this stage, adolescents are able to consider the possible in addition to the real, and to think both abstractly and hypothetically. Piaget's theory thus suggests that adolescents who have reached the formal operational stage have cognitive abilities equivalent to those of adults.

Id. (citations omitted).

245. Newman, *supra* note 243, at 520 (citing Thomas Grisso & Linda Vierling, *Minors' Consent to Treatment: A Developmental Perspective*, 9 PROF. PSYCHOL. 412, 416 (1978)). Newman concedes that while the authors concluded that "there is little evidence that minors age 15 and above as a group are any less competent than adults as to ability to consent to medical treatment," they also "cautioned . . . that the entire subject is inadequately researched." Newman, *supra* note 243, at 520.

246. Lawrence Kohlberg, *Moral Stages and Mortalization: The Cognitive-Developmental Approach*, in MORAL DEVELOPMENT AND BEHAVIOR: THEORY, RESEARCH AND SOCIAL ISSUES 31, 33

Empirical studies comparing the health care decision-making of adults and adolescents have substantiated these developmental theories. Two studies examined the real-life decision-making processes of women as they learned that they were pregnant and had to weigh a decision about whether to have an abortion.[247] Both studies found that the adolescents could conceptualize and reason about treatment possibilities as capably as adults.[248] A third study[249] asked a set of nine-year-olds, fourteen-year-olds, eighteen-year-olds, and adults to respond to four hypothetical vignettes and explain what health care decision they would make in each case. The study found no statistically significant difference between the fourteen-year-old minors and the eighteen-year-olds or older adults on any indicia of competency.[250] Rhonda Gay Hartman of the University of Pittsburgh Center for Bioethics and Health Law, who has written extensively on this subject, notes that particularly in the context of important health care decisions, "adolescents are no more susceptible to external influences than are adults in identical situations . . . . Additionally, adolescents have demonstrated remarkable levels of confidence and thoughtfulness in their approach to decision making regarding serious illness, such as leukemia, that sustains a solid basis for making other responsible decisions."[251] The American Academy of Pediatrics recommends that adolescents who are emancipated or have been adjudged ma-

(Thomas Lickona ed., 1976) (asserting that most adolescents over the age of nine and adults operate at the "conventional level," characterized by self-identification or "internaliz[ation of] the rules and expectations of others").

247. Catherine C. Lewis, *A Comparison of Minors' and Adults' Pregnancy Decisions*, 50 AM. J. ORTHOPSYCHIATRY 446 (1980); Bruce Ambuel, *Developmental Trends in Adolescents' Psychological and Legal Competence to Consent to Abortion*, 16 LAW & HUM. BEHAV. 129 (1992).

248. Lewis concluded that "[m]inors were not less *capable* than adults of imagining various effects on their lives," but nonetheless found that "minors were less likely to perceive their own decisions as determined by . . . personal concerns and more likely to cite external determinants of their decision." Lewis, *supra* note 247, at 452. Maintaining that the same moral "competence" as adults was present, *id.* at 449, she suggests that the different focus has to do with greater social pressures and constraints, such as parental consent. *See id.* at 449, 452.

Ambuel studied three groups, aged thirteen to fifteen, sixteen to seventeen, and eighteen to twenty-one. He found no difference in competence between the adolescent groups and the legal adults when considering abortion; when abortion was not under consideration, he found that the fifteen-and-under group was less competent than the others, but that the sixteen- and seventeen-year-olds were as competent as the legal adults. 16 LAW & HUM. BEHAV. at 129–30.

249. Lois A. Weithorn & Susan B. Campbell, *The Competency of Children and Adolescents to Make Informed Treatment Decisions*, 53 CHILD DEV. 1589 (1982).

250. *Id.* at 1595–96.

251. Rhonda Gay Hartman, *AIDS and Adolescents*, 7 J. HEALTH CARE L. & POL'Y 280, 301–2 (2004) (citing Alfio Maggiolini, Riccardo Grassi, Luigia Adamoli, Adele Corbetta, Gustavo Pietropolli Charmet, Katia Provantini, Donatella Fraschini, Momcilo Jankovic, Romana Lia, John Spinetta & Giuseppe Masera, *Self-Image of Adolescent Survivors of Long-term Childhood Leukemia*, 22 J. PEDIATRIC HEMATOLOGY/ONCOLOGY 417, 419–20 (2002); David G. Scherer & N. Dickon Reppucci, *Adolescents' Capacities to Provide Voluntary Informed Consent: The Effects of Parental Influence and Medical Dilemmas*, 12 LAW & HUM. BEHAV. 123, 135 (1988); David G. Scherer, *The Capacities of Minors to Exercise Voluntariness in Medical Treatment Decisions*, 15 LAW & HUM. BEHAV. 431, 444–45 (1991)).

ture minors should be presumed capable of giving effective consent to forego life-sustaining medical treatment.[252]

A common perception of adolescent decision-making is that adolescents are overly influenced by their peers. One might worry, therefore, that a teenager might seek sex reassignment treatment as a means to fit in better with peers. Studies have shown, however, that "susceptibility to peer influence . . . peak[s] sometime around age fourteen, and declin[es] during the early high school years."[253] This, as well as other gains through the teenage years in identity and independent judgment, suggests that older adolescents are likely to have both the cognitive capacity to demonstrate informed consent, and also the psychosocial maturity necessary to make mature decisions.[254]

Statutory and case law in many states recognize that some minors may be mature enough to be found capable of giving effective consent in various contexts. For example, minors are permitted to consent to their own health care under certain conditions,[255] and some states treat minors as adults under the criminal law for certain purposes.[256]

Tort law has developed useful principles for assessing a minor's ability to consent to medical care. The Restatement (Second) of Torts concludes that a minor may give effective consent if she is "capable of appreciating the nature, extent, and probable consequences of the conduct consented to."[257] Tort law also recognizes that the ability of a minor to consent increases during adolescence. Prosser and Keeton state that "[a] minor acquires capacity to consent to different kinds of invasions and conduct at different stages in his development. Capacity exists when the minor has the ability of the average person to understand and weigh the risks and benefits."[258] When making determinations

252. Am. Acad. of Pediatrics, Comm. On Bioethics, *Guidelines on Forgoing Life-Sustaining Medical Treatment*, 93 PEDIATRICS 532, 535 (1994) (stating that "the ethical and legal presumption of [a mature minor's] capacity should govern, unless countervailing evidence arises to call the presumption into question"), *cited in* Rhonda Gay Hartman, *Coming Of Age: Devising Legislation For Adolescent Medical Decision-Making*, 28 AM. J. L. & MED. 409, 430–31 (2002).

253. Cauffman & Steinberg, *supra* note 244, at 1775 (citing B. Bradford Brown, *Peer Groups and Peer Culture*, *in* AT THE THRESHOLD: THE DEVELOPING ADOLESCENT 171, 191 (S. Shirley Feldman & Glen R. Elliot eds., 1990). Cauffman and Steinberg go on to state that "the evidence is that between the ages of ten and eighteen, adolescents grow more able to make decisions on their own, and that sometime between the ages of twelve and sixteen, peer pressure begins to play a smaller role in adolescent decision-making." *Id.* They note that the ability to "demonstrate independent judgment that is based neither on echoing nor defying parental sentiment" also increases significantly from age twelve to sixteen. *Id.* at 1778 (citing studies).

254. *See id.* at 1776–79.

255. These statutes, discussed in greater detail in Part V.B, *supra*, grant the power to give effective consent to minors holding certain statuses such as marriage or parenthood, and minors with certain medical conditions.

256. *See, e.g.*, UTAH R. JUV. P. § 27(A)(2) (2000) (stating that minors age fourteen or older are presumed capable of knowingly and voluntarily waving their rights without the benefit of having a parent, guardian, or legal custodian present during questioning).

257. RESTATEMENT (SECOND) OF TORTS: EFFECT OF CONSENT § 892A cmt. b (1979).

258. W. PAGE KEETON, DAN B. DOBBS, ROBERT E. KEETON & DAVID G. OWEN, PROSSER AND

about a minor's level of maturity, some courts have found the "Rule of Sevens" an "instructive . . . starting point."[259] Under the Rule of Sevens, a minor younger than seven years old is presumed to lack capacity to consent; a minor between the ages of seven and fourteen bears a rebuttable presumption of lack of capacity; and a minor between the ages of fourteen and twenty-one enjoys a rebuttable presumption of capacity.[260] Applying the Rule of Sevens, a minor above the age of fourteen would be presumed capable of giving effective consent to sex reassignment treatment.[261]

The United States Supreme Court addressed the question of the decision-making capacity of minors in its 2005 *Roper v. Simmons* decision.[262] The Court acknowledged that a "lack of maturity and an underdeveloped sense of responsibility are found in youth more often than in adults"[263] and that "juveniles are more vulnerable or susceptible to negative influences and outside pressures, including peer pressure."[264] These generalizations weighed strongly enough for the majority to create a bright-line rule that those under eighteen may not be sentenced to death.[265] However, the majority also recognized that the maturity of minors is not as generalizable, noting that "some under 18 have already attained a level of maturity some adults will never reach."[266] While the Court saw eighteen as an appropriate minimum age for imposition of the death penalty, the Court will continue to make case-by-case evaluations of age in many contexts outside of capital cases.[267] For example, the Court has suggested that ado-

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KEETON ON THE LAW OF TORTS § 18, at 115 (5th ed. 1984).

259. Belcher v. Charleston Area Med. Ctr., 422 S.E.2d 827, 837 n.13 (W. Va. 1992).

260. *See, e.g.*, Cardwell v. Bechtol, 724 S.W.2d 739, 745 (Tenn. 1987). *See also* Pino v. Szuch, 408 S.E.2d 55, 57–58 (W. Va. 1991) (noting that the aforementioned presumptions are standards used to assess a child's capacity to be negligent).

261. When the Tennessee Supreme Court accepted the mature minor doctrine, it explicitly relied on these tort law principles. *Cardwell*, 724 S.W.2d at 755. Following the Rule of Sevens and presuming that those above fourteen are capable of giving informed consent poses a conflict with the HBIGDA Standards of Care, which sets sixteen as the age at which a minor might obtain hormone treatment, and eighteen as the age at which a minor might be eligible for sex reassignment surgery. HBIGDA Standards of Care, *supra* note 111, at 10–11.

262. 543 U.S. 551, 569–70 (2005). Previously, the Court had held that the death penalty was unconstitutional as applied to juveniles under age sixteen. Thompson v. Oklahoma, 487 U.S. 815, 825 (1988). The *Thompson* Court recognized that "every State has adopted 'a rebuttable presumption' that a person under 16 'is not mature and responsible enough to be punished as an adult,' no matter how minor the offense may be." *Id.* at 824–25 n.22.

263. *Roper*, 543 U.S. at 569 (quoting Johnson v. Texas, 509 U.S. 350, 367 (1993)).

264. *Id.* at 569 (citing Eddings v. Oklahoma, 455 U.S. 104, 115 (1982)).

265. *Id.* at 574.

266. *Id. See also id.* at 600 (O'Connor, J., dissenting) (noting that some seventeen-year-old offenders may be just as culpable as adult offenders); *id.* at 620 (Scalia, J., dissenting) ("In other contexts where individualized consideration is provided, we have recognized that at least some minors will be mature enough to make difficult decisions that involve moral considerations.").

267. *Id.* at 572–73 (majority opinion) (justifying the departure from "this Court's own insistence on individualized consideration" by the "marked" differences between juvenile and adult offenders). Even in the capital context, Justices O'Connor and Scalia argued for an individualized assessment of mitigating factors in juvenile cases. *Id.* at 600 (O'Connor, J., dissenting), *id.* at 615–

lescents younger than fifteen may be found mature enough to make their own health care decisions.[268] In addition, recognizing that minors' views should be considered when making decisions about their welfare, Justice Douglas stated in his dissent in *Wisconsin v. Yoder* that fourteen is the age "that the [adolescent's] moral and intellectual maturity . . . approaches that of an adult."[269]

Scientific studies have built a wealth of evidence that adolescents as a group have far greater capacity to make decisions than our legal system's presumptions of incapacity currently recognize. Common law tort principles substantiate this view, as do statutes on the books in many states that allow categories of minors to consent to their own health care. The understanding that an individualized determination of a minor's decision-making capacity must sometimes be allowed has been recognized by the Supreme Court. However, the law still fails to recognize and credit the actual capacity of many minors to make health care decisions.

C. Requiring a Surrogate Decisionmaker Furthers No State Interests

Transgender minors who seek sex reassignment treatment must have their parents or guardians consent on their behalf, or may be able to resort to the courts to overturn a parent or guardian's veto. Barring transgender minors from consenting to their own health care does not further the interests of the State. The State's interests include preserving and supporting a parental role in decision making,[270] ensuring that the minor has the competence to make an informed decision,[271] and supporting the minor in dealing with the psychological and physical effects of the health care decision.[272] These values are adequately addressed through other avenues that do not as substantially burden the minor's interests.

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21 (Scalia, J., dissenting). *See also* Stanford v. Kentucky, 492 U.S. 361, 374 (1989) ("even if the requisite degrees of maturity were comparable, the age statutes in question would still not be relevant. They . . . represent . . . at most a judgment that the vast majority are not [responsible enough to make various decisions]."). Other courts have taken a cue from the Court's decision in *Roper* in considering age in individual cases. *See, e.g.*, Mendez-Alcaraz v. Gonzales, 464 F.3d 842, 850 (9th Cir. 2006) (stating that "focusing on individual life experience rather than simply age is the best way to determine appropriate punishment or treatment"); Henyard v. McDonough, 459 F.3d 1217, 1248 (11th Cir. 2006) (stating that "[a]s with children and the mentally retarded, mental age is not the result of a failure to abide by an expected standard, but an incapacity to evaluate and comprehend it").

268. Akron v. Akron Ctr. for Reprod. Health, 462 U.S. 416, 440 (1983).

269. 406 U.S. 205, 245 n.3 (1972) (Douglas, J., dissenting).

270. *See* Planned Parenthood of Cent. Mo. v. Danforth, 428 U.S. 52, 75 (1976) (discussing the State's alleged interest in the safeguarding of the family unit as a justification for requiring parental consent to abortion, and finding that interest insufficient to overcome the burden on the minor imposed by the requirement).

271. *See* Bellotti v. Baird (*Bellotti II*), 443 U.S. 622, 635 (1979) ("[M]inors often lack the experience, perspective, and judgment to recognize and avoid choices that could be detrimental to them.").

272. *See* H.L. v. Matheson, 450 U.S. 398, 411–13 (1980) (recognizing as "reasonable" the protection of adolescents who are making an abortion decision from "potentially traumatic and permanent consequences").

1. Supporting a parental role

When minors have a trusting relationship with their parents, the law is not necessary to motivate them to talk to their parents about a major health care decision. It has been well established in the abortion context that most minors voluntarily consult an adult before making a life-changing medical decision. For example, one study found that almost 70% of minors whose parents knew about their abortions had informed them voluntarily.[273] A 1992 study by Stanley Henshaw and Kathryn Kost looked at the abortion decision-making process of minors who lived in states that did not require parental notification for abortions. They found that every minor who did not consult a parent did consult another concerned person such as an adult, a boyfriend, or a professional, in addition to clinic staff.[274] A 1999 study of adolescents in Massachusetts by Shoshanna Ehrlich confirmed that almost all minors consult someone else prior to making a decision about whether to have an abortion.[275] Ehrlich found that 97.6% of the minors in the sample she interviewed talked with another person,[276] and 89.2% talked with an adult—generally a doctor, school social worker, clergy person, or adult relative.[277]

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273. Aida Torres, Jacqueline Darroch Forrest & Susan Eisman, *Telling Parents: Clinic Policies and Adolescents' Use of Family Planning and Abortion Services*, 12 FAM. PLAN. PERSP. 284, 288 (1980) (noting that of the 55% of minors who reported that their parents knew about their abortions, 38% said they told them voluntarily).

274. Stanley K. Henshaw & Kathryn Kost, *Parental Involvement in Minors' Abortion Decisions*, 24 FAM. PLAN. PERSP. 196, 196 (1992), *cited in* Planned Parenthood, Teenagers, Abortion, and Government Intrusion Laws, http://www.plannedparenthood.org/news-articles-press/politics-policy-issues/abortion-access/Teenagers-Abortion-and-Government-Intrusion-Laws.htm.

275. 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, 98 (2002).

276. *Id.*:

> Virtually all of the minors in the sample (97.6%) said they talked to someone in the course of making the abortion decision. Of the minors who talked to someone, 82% spoke to two or more people, with a mean of 3.14 consulted. Of those talking to someone, 89.2% talked to an adult . . . , 80.5% talked to a boyfriend, and 40.8% talked to at least one friend.

277. *Id.*:

> Professionals were a very important category of adult contact, with 58% of the total sample, or 65.44% of those involving an adult, speaking with a professional. Of those who involved a professional, 60.83% spoke with a doctor, a nurse, or a health worker in a clinic; 28.3% of the minors talked to a school professional; 52% said a social worker or counselor was helping them; and an additional 25.87% spoke with another type of professional such as a clergy person or community worker. Adult relatives were also an important category of adult contact, with 25% of those involving an adult speaking with an adult relative. Not surprisingly, minors turned to female relatives with far more frequency than male relatives, and of those, sisters were the most important.
>
> A majority of minors (63.4% of those who spoke with an adult) spoke with a boyfriend who was age [eighteen] or over and 16.2% spoke with a friend. An additional 6.9% of the minors spoke with some other type of adult, such as a boss, foster parent, or the parent(s) of her boyfriend. Of these 'other' adults, the parent(s) of

Furthermore, those minors who do not notify their parents prior to seeking an abortion typically have compelling reasons not to.[278] Writing as *amici curiae* in *Ohio v. Akron Center for Reproductive Health* and *Hodgson v. Minnesota*,[279] the American Psychological Association (APA) noted that "in about one-third of cases in which adolescents do not inform their parents about their pregnancy and planned abortion, they are motivated by fear of physical punishment or some other severe reaction."[280] The APA confirms that for most minors, notifying parents "typically . . . triggered a crisis in the family."[281] Henshaw and Kost's study found that of the minors who did not inform their parents of their abortions, "30 percent had histories of violence in their families, feared the occurrence of violence, or were afraid of being forced to leave their homes."[282] In these situations, parental consent laws not only fail to further the State's interest in preserving the family, but may undermine family relationships or even place the minor in danger.

There are clearly some differences between minors seeking abortion and those seeking sex reassignment. In the abortion context, if parents are not informed, they might never discover that their child had an abortion. In contrast, parents will eventually learn of their transgender child's decision to transition, due to physical changes that will become obvious. However, transgender minors who do not wish to obtain consent from their parents to sex reassignment treatment are likely motivated by legitimate reasons, just as are those seeking abortions. If a transgender minor is forced to seek consent from a parent, the parent might take extraordinary measures to prevent the minor from accessing sex reassignment, even when the sex reassignment decision might be in the best interests of the minor. For example, the minor might reasonably fear that their parent might prevent them from transitioning through violence, strict surveillance such

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a boyfriend was by far the most frequent. Lastly, 0.03% of the minors in the sample who spoke with an adult specifically mentioned speaking with a parent.

278. *Id.* at 122–23 ("[T]he most frequently provided reasons included . . . an anticipated severe adverse parental reaction, that parents would be upset/very upset, anticipated harm to the relationship, concern for a parent's well-being, anticipated parental pressure to have the baby, and a problematic family relationship.").

279. *Amici Curiae Brief*, *supra* note 217.

280. *Id.* at 15 ("[E]ven if an adolescent misjudged her parents' response, the perception may be more important than the reality in causing adolescents to delay seeking medical assistance or making a decision whether to abort.") (citing Freddie Clary, *Minor Women Obtaining Abortions: A Study of Parental Notification in a Metropolitan Area*, 72 AM. J. PUB. HEALTH 283, 284 (1982)).

281. *Amici Curiae Brief*, *supra* note 217, at 9.

282. Henshaw & Kost, *supra* note 274, at 196. These findings are confirmed by Ehrlich's study, conducted in Massachusetts during 1998 and 1999. Ehrlich, *supra* note 275. Ehrlich found that the minors who did not inform their parents about their decision to have an abortion:

> had a wide range of reasons explaining why they felt they could not tell a parent about the pregnancy. A significant number (27.4%) stated that their parents would be extremely upset or upset, while a somewhat smaller percentage (22.4%) stated that they feared a severe adverse reaction, such as being kicked out of the house, physical harm, or other kinds of abuse.

Id. at 94.

as preventing the minor from leaving the house, and even forced institutionalization.[283] If minors can consent to their own sex reassignment treatment, when the parent learns about it they will have to address it as something that is in progress, rather than as something that they can prevent. Additionally, as in the abortion context, requiring parental consent forces the minor to disclose at an inflexible time rather than letting disclosure unfold in the particular ways that are appropriate to that family's dynamics.

2. Supporting informed decision making

The State's interest in ensuring that the minor has the competence to make an informed decision is not served by requiring the consent of a surrogate decision-maker. There is no empirical evidence that use of a surrogate decision-maker improves the decision-making process of an otherwise competent minor.[284] As discussed in Part VI.B, many minors demonstrate the ability to consent by middle adolescence. Use of case-by-case determinations of competence will allow identification of those with the ability to consent.

Ideally, the determination of the minor's competence would be performed by the treating doctor, who knows the minor best. Doctors already have existing diagnostic, treatment, and follow-up procedures with which they can effectively identify those transgender youth who can safely transition. An assessment of competence could also be done by courts, who have the expertise to assess a minor's cognitive skills and judgment, and who have developed doctrinal rules to aid them in ascertaining a minor's ability to consent.[285]

Rather than addressing the question of whether the minor should be adjudged a mature or emancipated minor, courts could also be asked to approve the sex reassignment treatment sought by the minor, in a process akin to judicial bypass petitions by minors seeking abortions. However, resorting to the court in this way poses significant drawbacks. Where parents or guardians are unwilling to consent, it has been shown that judicial bypass proceedings fail to add any benefit to the adolescent's decision-making process. In the abortion context, most bypass hearings result in approval of the minor's petition. For example, the

283. *See, e.g.*, SCHOLINSKI & ADAMS, *supra* note 132.

284. The *Amici Curiae* brief in *Ohio v. Akron Center for Reproductive Health* and *Hodgson v. Minnesota*, stated:

> [T]he National Academy of Sciences, in a major review of the research, observed that almost all minors who employ the judicial bypass procedures to avoid parental involvement are held to be mature, and their decisions to have an abortion are held to be in their best interests. This evidence strongly suggests that many adolescents who choose not to consult with their parents are competent to make the abortion decisions.

Amici Curiae Brief, *supra* note 217, at 24. The amici added, "Indeed, it can be seriously questioned whether a notification statute with a bypass procedure in practice does more than expend judicial resources. At worst, it is a source of anxiety, medically harmful delay, and family conflict." *Id.* n.65.

285. *See infra* Parts VII.B.1–3 (discussing rules of decision used to determine the competence of minors in the contexts of mature minors, emancipation, and abortion).

trial court in *Hodgson* found that 3558 of 3573 bypass petitions were granted[286]—an approval rate of 99.6%. One judge who had heard over 1000 bypass petitions "characterize[d] his function as 'a routine clerical function on my part, just like putting my seal and stamp on it.'"[287] Another reflected that "[t]he decision [to have an abortion had] already been made before they have gotten to my chambers. The young women I have seen have been very mature and capable of giving the required consent."[288] Pro forma proceedings such as these do not offer any additional guidance or comfort to the adolescent contemplating a major life change.

Moreover, having to appear before a judge can be a traumatic experience for the minor. The district court in *Hodgson* heard testimony from judges about the fear induced by minors by testifying in court. One judge described the minors' experience as "very nervewracking."[289] Another judge noted, "you see all the typical things that you would see with somebody under incredible amounts of stress, answering monosyllabically, tone of voice, tenor of voice, shaky, wringing of hands."[290] Yet another concluded, "It just gives these kids a rough time. I can't think it accomplishes a darn thing. I think it basically erects another barrier . . . ."[291]

Requiring a judge to act as a surrogate decision-maker not only wastes judicial resources, but may also harmfully delay the minor's access to health care.[292] Both minors and the State would be better served by expanding the opportunities for minors to be found competent to consent to their own health care.

3. Protecting against adverse effects of procedure

The State's interest in supporting the minor in dealing with the psychological effects of the health care decision[293] is met through the medical establishment's use of rigorous diagnostic, treatment, and follow-up procedures with transgender youth—procedures which are already in place and being practiced.[294] In contrast, the use of a surrogate decision-maker does not mitigate any psychological effects, and indeed, could actually exacerbate them, particularly where the parent is not supportive of the transgender adolescent's identity.

286. Hodgson v. State, 648 F. Supp. 756, 765 (D. Minn. 1986).

287. *Id.* at 766.

288. *Id.*

289. *Id.* (quoting testimony of Hon. Gerald Martin).

290. *Id.* (quoting testimony of Hon. William Sweeney).

291. *Id.* (quoting testimony of Paul Garrity, former Massachusetts judge).

292. *See Amici Curiae Brief, supra* note 217, at 24 (citing Gary B. Melton, *Legal Regulation of Adolescent Abortion: Unintended Effects*, 42 AM. PSYCHOLOGIST 79, 82 (1987)).

293. *See* H.L. v. Matheson, 450 U.S. 398, 411–13 (1980).

294. *See supra* Part IV.C (discussing the HBIGDA Standards of Care).

D. The Nature of the Decision Makes Case-by-Case Evaluations of Maturity Necessary

In the abortion context, we recognize that a minor must ultimately be permitted to make a permanent and irrevocable decision about whether to keep her baby.[295] In *Bellotti II*, the Supreme Court explained that the minor must have this right because of "the unique nature and consequences of the abortion decision."[296] More to the point, "denying a minor the right to make [this] important decision will have consequences [that are] grave and indelible.... [T]he abortion decision is one that simply cannot be postponed, or it will be made by default with far-reaching consequences."[297] Because of these grave consequences, the Supreme Court has held that it is necessary to make "case-by-case evaluations of the maturity of pregnant minors."[298]

The Court's rationale applies with equal force to transgender adolescents in need of sex reassignment treatment. For transgender adolescents, the passage of time brings grave and indelible physical changes that are difficult to reverse, and forces them to deal with problems incident to discrimination.[299] Just as with abortion, a transgender youth or her guardian makes a permanent and irrevocable decision with far-reaching consequences, not only when an intentional decision is made, but also "by default" when the decision is postponed for too long.[300] We must recognize the heavy cost to transgender adolescents who are forced to wait to seek sex reassignment treatment until they are transformed at age eighteen into legal adults. Rather than relying on the bright-line rule of age, transgender health care is an area where it is crucial to make case-by-case determinations of the minor's maturity and ability to consent.

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295. Abortion law prioritizes a minor's right to determine what happens to her body over the question of whether it is the "right" decision. A pregnant minor has the right to decide if she wants an abortion. We understand that she may later regret it, but we accord her the right to make this decision. Transgender adolescents should have the same right of self-determination. They should not be held to the impossibly high standard of proving that they will not regret the decision later.

296. Bellotti v. Baird (*Bellotti II*), 443 U.S. 622, 643 (1979). Although the State generally may "resort to objective, though inevitably arbitrary, criteria such as age limits, marital status, or membership in the Armed Forces for lifting some or all of the legal disabilities of minority it may not do so in the context of abortion." *Id.* at 643–44 n.23.

297. *Id.* at 642–43.

298. *Id.*

299. *See supra* Part III.A (describing harassment and violence suffered by transgender adolescents) and Part III.B (describing physical and mental effects of delaying transition).

300. This is not to say that people should transition so as to escape discrimination. Certainly, assimilation and passing are not the solutions of choice for GLBT people or people of color, who also are subject to societal discrimination. However, neither should transgender people be forced to serve as guinea pigs in an effort to teach the world not to discriminate against those who are non-normatively gendered. It is a particular indignity to be both prevented from actualizing one's gender identity and to suffer harm because of this barrier. All people who suffer discrimination based on group membership share an interest in being able to express their identity free from bigotry and discrimination.

VII.
ADVOCACY STRATEGIES FOR EXPANDING MINORS' ACCESS TO TRANSGENDER-RELATED MEDICAL CARE

A. Advocacy with Health Care Professionals

Social workers and doctors serve as gatekeepers to sex reassignment treatment. Too often, they bar the door inappropriately.[301] Treating clinicians could responsibly allow more minors access to sex reassignment treatment without even going beyond current treatment protocols.

The HBIGDA Standards of Care, the leading treatment protocol in the field, relies on therapy as a built-in check.[302] It allows the treating clinician to help the minor ascertain her gender identity while ensuring that she has the capacity to consent to treatment.[303] Although some clinicians view therapy as a way to increase the chance of heterosexuality and gender-normativity,[304] the HBIGDA Standards of Care explains that the treating professional's goal is not to convince the adolescent to accept the gender she was assigned at birth. Rather, HBIGDA recognizes that a non-traditional gender identity or presentation can raise conflict between the individual and her family, peer group, and social environment. The clinician should help the adolescent identify, understand, and accept her gender identity, whatever it might be, and to resolve difficulties associated with her identity.[305] HBIGDA advises that therapy should focus "on reducing distress the child experiences from his or her gender identity problem and other difficulties."[306] At no point does the HBIGDA Standards of Care suggest that the

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301. *See, e.g.*, Karasic, *supra* note 101, at 157 (2000). Doctors and social workers do not always recognize the wide variety of transgender experience:

> [T]here are endless ways to arrive at being transgender and of being transgender. Some transgender people are assigned female at birth, know from day one that they are male, describe their experience as being a man trapped in a woman's body, and live their life as a heterosexual man. This narrative is perpetuated, reinforced, and rewarded by the medical and psychological establishment. Many transgender people share only some part or no part of this narrative. . . . Endless narratives exist.

MARKSAMER & VADE, *supra* note 22. Transgender people must choose between subjecting themselves to this system of power or contesting it, in which case accessing medically supervised treatment becomes nearly impossible.

302. HIBGDA Standards of Care, *supra* note 111. *See generally supra* Part IV.C.

303. For adolescents to begin hormone treatment under the HGIBDA model, therapy "is an eligibility requirement." HBIGDA Standards of Care, *supra* note 111, at 10.

304. *See* discussion *supra* Part IV.A.

305. For example, as part of the recommended psychological intervention, the mental health professional is advised to "recognize and accept the gender identity problem [as] [a]cceptance and removal of secrecy can bring considerable relief." HBIGDA Standards of Care, *supra* note 111, at 9.

306. *Id.* The Standards of Care details some of the ways that such difficulties often arise and suggests ways to work through it:

> The child and family should be supported in making difficult decisions regarding the extent to which to allow the child to assume a gender role consistent with his or her

desired end result should be that the individual accept living in his or her birth gender.

HBIGDA's reliance on therapy reflects the degree to which the medical establishment politicizes and scrutinizes transgender medical treatment. Therapy might often be helpful for transgender adolescents, as it is for many people. But individuals seeking other necessary and non-elective medical treatment are not subjected to the same degree of scrutiny as transgender people. Sex reassignment surgery is often dismissed—incorrectly—as elective and cosmetic. However, even individuals seeking medical treatment which is inarguably elective and cosmetic, such as a nose job or breast augmentation, are not forced to go to therapy and prove that a smaller nose or larger breasts matches their identity to demonstrate their psychological readiness for these procedures.[307]

Further, clinicians should recognize that parental involvement is not always in the minor's best interests. The HBIGDA Standards of Care sees family involvement as important because unresolved issues in the child's environment are often present.[308] The Standards of Care requires parental consent for pubertal-delay treatment, but states only that parental consent is "preferable" for sixteen-year-olds to begin feminizing or masculinizing hormone therapy.[309] The Standards of Care also notes that "[i]n many countries 16-year-olds are legal adults for medical decision-making, and do not require parental consent."[310] In many cases, it is possible and advisable for parents to be brought into the process to learn more about what it means to be transgender and to learn what their child needs, much as PFLAG has acted as a support for parents coming to terms with a child being gay. In some cases, however, parental involvement may be impossible or even harmful for the minor. The United States Supreme Court recognizes that, in some circumstances, the minor's best interests may not be served by parental involvement.[311] By choosing not to make parental consent an absolute requirement for sex reassignment treatment, HBIGDA recognizes this fact as well.

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gender identity. This includes issues of whether to inform others of the child's situation, and how others in the child's life should respond; for example, whether the child should attend school using a name and clothing opposite to his or her sex of assignment. They should also be supported in tolerating uncertainty and anxiety in relation to the child's gender expression and how best to manage it.

Id.

307. My appreciation to Dean Spade, *supra* note 99, for this analogy.

308. *See, e.g.*, HBIGDA Standards of Care, *supra* note 111, at 9–10.

309. *Id.* at 10. Note, however, that while parental consent is not required, the protocol for partially reversible interventions also states that "the mental health professional should be involved with the patient and family for a minimum of six months." *Id.*

310. *Id.* at 10.

311. *See* H.L. v. Matheson, 450 U.S. 398, 414 (1981) (Powell, J., concurring) (clarifying that the holding leaves open the possibility that cases exist in which the best interests of the minor seeking an abortion would not be served by parental notification).

Clinicians could expand their current practice by rigorously following the protocols described above. The HBIGDA protocol makes clear that treatment should help minors identify, understand, and accept their gender identity in order to resolve difficulties associated with their identity. Once the doctor and adolescent decide to consider sex reassignment treatment, they should have the opportunity to evaluate the process "thoughtfully and recurrently . . . over time."[312] The HBIGDA Standards of Care contemplates that minors could begin puberty-delaying hormones prior to the onset of puberty, which would allow adolescents to grapple with their gender identity without the pressures of the ongoing changes of puberty.[313] Adolescents who determine that they are transsexual may then be allowed to proceed with sex reassignment treatment. The HBIGDA protocol contemplates that minors could begin masculinizing or feminizing hormones as early as age sixteen and could receive sex reassignment surgery at age eighteen—i.e. at adulthood or after a "real-life experience of at least two years in the gender role of the sex with which the adolescent identifies."[314] These age guidelines are not hard-and-fast. Indeed, other protocols anticipate that minors could begin hormone treatment and sex reassignment surgery at earlier ages, if the minor can legally give informed consent.[315] In addition, some statutes and legal doctrines allow minors to authorize their own medical treatment. Health care providers can look to these medical protocols for clinical guidance, and to the law for assurance that early sex reassignment treatment is within the types of care to which the law allows minors to consent.[316]

Clinicians have a responsibility to inform themselves about the current state of treatment protocols for youth, to address personal prejudices which impair their ability to treat patients, and to advocate vigorously with relevant administrators, such as clinical directors or risk management advisors, to remove clinically-inappropriate barriers to care. Failure to do so is an abdication of the clinician's professional responsibility.

B. Advocating under the Exceptions to Informed Consent Law

1. The mature minor exception

Under the mature minor doctrine, minors may make decisions on their own, despite not having reached the age of majority, if they are "capable of appreciating [the] nature and consequences"[317] of the decision. The mature minor

312. HBIGDA Standards of Care, *supra* note 111, at 10–11.

313. *See supra* text accompanying notes 166–67.

314. *Id.* at 11.

315. HEALTH LAW Standards of Care, *supra* note 128, Standard 1.

316. Some commentators have even suggested that it may be appropriate to bring negligence actions against those clinicians who refuse to follow current treatment protocols authorizing sex reassignment treatment for some minors. *See, e.g.*, Downs & Whittle, *supra* note 95, at 203–5.

317. H.L. v. Matheson, 450 U.S. 398, 451 n.49 (1981) (Marshall, J., dissenting).

doctrine recognizes that individuals do not suddenly gain the ability to make decisions independently upon reaching the age of eighteen. This doctrine has been followed in common law in a number of states,[318] though legislatures have been slower to adopt it into statute.[319] A national trend has developed toward official recognition that minors can demonstrate the maturity to exercise adult judgment and understand the consequences of their actions.[320] As the Supreme Court of Tennessee has noted, the "[r]ecognition that minors achieve varying degrees of maturity and responsibility (capacity) has been part of the common law for well over a century."[321] Litigation should be undertaken with the goal of expanding courts' acceptance of this doctrine.

In *Bellotti II*, the Supreme Court relied on the mature minor doctrine as one means by which a minor can access an abortion without relying on parental consent.[322] The Court offered a two-prong test to determine if a minor is mature: the minor must show "that she is *mature enough* and *well enough informed* to make her abortion decision, in consultation with her physician, independently of her parents' wishes."[323]

Case law outside of the abortion context suggests two rules that can be used in ascertaining whether a minor is "mature enough" to make a decision concerning her medical treatment. First, she must be aware of the consequences of her actions.[324] Second, she must be able to exercise the judgment of an adult.[325] In

318. These states include: Illinois, *see In re* E.G., 549 N.E.2d 322 (Ill. 1989); Tennessee, *see* Cardwell v. Bechtol, 724 S.W.2d 739 (Tenn. 1987); Maryland, *see* 79 Md. Op. Att'y Gen. 244 (1994); Kansas, *see* Younts v. St. Francis Hosp. & Sch. of Nursing, Inc., 469 P.2d 330, 337 (Kan. 1970); and West Virginia, *see* Belcher v. Charleston Area Med. Ctr., 422 S.E.2d 827 (W.Va. 1992).

319. *See, e.g.*, 750 ILL. COMP. STAT. ANN. 30/3-2 (West 1993) ("'Mature minor' means a person 16 years of age or over and under the age of 18 years who has demonstrated the ability and capacity to manage his own affairs and to live wholly or partially independent of his parents or guardian.").

320. *See, e.g.*, 79 Md. Op. Att'y Gen. 244; *Belcher*, 422 S.E.2d at 829; *In re E.G.*, 549 N.E.2d at 326–27; Newmark v. Williams, 588 A.2d 1108, 1116–17 n.9 (Del. 1991); *Younts*, 469 P.2d at 337; *Cardwell*, 724 S.W.2d 739, *passim*.

321. *Cardwell*, 724 S.W.2d at 744–45. *See also* Del. Op. Att'y Gen. 93-I020, at 2 n.6 (1993) ("[T]here is a definite trend to recognize that mature minors have a constitutional and/or common law right to refuse medical care.").

322. Bellotti v. Baird (*Bellotti II*), 443 U.S. 622, 643 (1979). The other option is for the minor to demonstrate that the abortion is in her best interests. *Id.* at 644. Relying on *Bellotti II*, the Court found a Massachusetts statute unconstitutional "for failure to allow mature minors to decide to undergo abortions without parental consent." H.L. v. Matheson, 450 U.S. 398, 408 (1981). The Court reasoned that although maturity is difficult to define or determine, making arbitrary indicators such as age appealing in their simplicity, "the peculiar nature of the abortion decision" makes case-by-case evaluations of maturity necessary. *Bellotti II*, 443 U.S. at 643 n.23. Two years later in *H.L. v. Matheson*, Chief Justice Burger's opinion and Justice Powell's concurrence both recognized that they did not want to "burden the right of a mature minor or a minor whose best interests would not be served by parental notification." *Matheson*, 450 U.S. at 414 (Powell, J., concurring).

323. *Bellotti II*, 443 U.S. at 643 (emphasis added).

324. *See, e.g., In re E.G.*, 549 N.E.2d at 327–28. *See also Younts*, 469 P.2d at 337 (In context of "a minor surgical procedure," "the sufficiency of a minor's consent depends upon his ability to

Cardwell, the Supreme Court of Tennessee stated that whether or not a minor may be considered mature and capable of giving informed consent "depends upon the age, ability, experience, education, training, and degree of maturity or judgment obtained by the minor, as well as upon the conduct and demeanor of the minor at the time of the incident involved."[326] As for *Bellotti II*'s second requirement that the minor be sufficiently informed of the treatment,[327] Justice Stevens in *Danforth* has stated that the minor must be "capable of understanding the procedure and of appreciating its consequences and those of available alternatives."[328]

Courts applying the mature minor exception have developed several procedural requirements. As seen in *Bellotti II*,[329] consultation with and approval of a physician may be required for a minor to obtain an abortion without parental consent.[330] Once the minor has shown that she is mature and sufficiently in-

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understand and comprehend the nature of the surgical procedure, the risks involved and the probability of attaining the desired results in the light of the circumstances which attend"); *Cardwell*, 724 S.W.2d at 749 (mature minors "appreciate the nature, the risks, and the consequences of the medical treatment involved"); School Officials May Not Perform Emergency Procedures on Terminally Ill Child that are Contrary to Parents' Decision and Physician's Order, 79 Md. Op. Att'y Gen. 244, 246 n.4 (1994).

325. For example, a minor in Maryland is seen as mature and is capable of giving informed consent if he or she can "understand the intricacies of the matter." *In re E.G.*, 549 N.E.2d at 327–28.

326. *Cardwell*, 724 S.W.2d at 748. The minor in *Cardwell* visited an osteopath for treatment of her sore throat. The court held that "Ms. Cardwell had the ability, maturity, experience, education and judgment at her 17 years, 7 months of age to consent knowingly to medical treatment." *Id.* at 749. The discussion of maturity in *Cardwell* relied heavily on the discussion of mature minors in the RESTATEMENT (SECOND) OF TORTS § 892A, cmt. b (1979).

327. The medical malpractice and competency determination contexts provide other illustrations of how courts decide whether a patient was or could be adequately well-informed about a medical decision. Regarding medical malpractice, see N.Y. PUB. HEALTH LAW § 2805-d (McKinney 2004) (defining lack of informed consent for purposes of malpractice action), Messina v. Matarosso, 729 N.Y.S.2d 4 (App. Div. 2001) (citing Cobbs v. Grant, 502 P.2d 1 (Cal. 1972)). Regarding competency determinations, see N.Y. MENTAL HYG. LAW § 80.03(c) (McKinney 2006) (defining lack of informed consent for purposes of surrogate decision-making for medical care and treatment).

328. Planned Parenthood of Cent. Mo. v. Danforth, 428 U.S. 52, 104 (1976). In *Cardwell*, the Supreme Court of Tennessee required that "the totality of the circumstances, the nature of the treatment and its risks or probable consequences, and the minor's ability to appreciate the risks and consequences . . . be considered." *Cardwell*, 724 S.W.2d at 748. Along these same lines of reasoning, a Kansas court held that "the sufficiency of a minor's consent depends upon his ability to understand and comprehend the nature of the surgical procedure, the risks involved and the probability of attaining the desired results in the light of the circumstances which attend." Younts v. St. Francis Hosp. & Sch. of Nursing, Inc., 469 P.2d 330, 337 (Kan. 1970) (holding that consent of parent was not necessary when injured minor was seventeen, was fully informed of the proposed procedure and did not object, operation was minor, mother was unconscious and father lived two hundred miles away).

329. Bellotti v. Baird (*Bellotti II*), 443 U.S. 662, 643 (1979).

330. As discussed in note 301 and accompanying text, *supra*, doctors and social workers play a problematic "gatekeeper" role for transgender people seeking treatment. One of the difficulties posed by the mature minor doctrine is that it puts judges in a gatekeeper role as well. Typically, neither the medical professional nor the judge is transgender or is independently knowledgeable

formed about the treatment sought, the minor's interest should be weighed against the State's interests.[331] When transgender youth are seeking sex reassignment treatment, the state interest is primarily in protecting parental interests and guarding against improper health decisions.[332]

The only New York opinion to consider the mature minor doctrine in the health care context is *In re Long Island Jewish Medical Center*.[333] The question before the court was whether Philip Malcolm, a young man just shy of his eighteenth birthday, could refuse the life-saving medical treatment recommended by the hospital. Philip and his parents were Jehovah's Witnesses, whose faith barred them from receiving blood transfusions. In line with the tenets of his religion, Philip sought to refuse the transfusion that his doctor recommended.[334] Holding that Philip was not a mature minor,[335] the court noted factors including that Philip, a high school senior, had never dated or been away from home, consulted his parents before making decisions, and testified that he considered himself a child.[336] The court concluded that he could not demonstrate "a mature understanding of his own religious beliefs or of the fatal consequences to himself."[337] Because the court found Philip not to be a mature minor on the facts presented, this case leaves unclear whether the mature minor doctrine is precedential law in New York.[338] Rhonda Gay Hartman criticizes this decision as a "departu[re] from the trend toward individualizing the decisional capability of adolescents."[339] She believes the court was motivated by "unease" with allowing the minor to reject a blood transfusion that could save his life.[340]

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about transgender issues. When a non-transgender person is passing judgment on transgender identity and experience, there is a significant risk that the transgender person will be pathologized.

331. *In re* E.G., 549 N.E.2d 322, 328 (Ill. 1989) (balancing a mature minor's interest in consenting to or refusing medical treatment against four state interests: (1) preservation of life; (2) protecting the interests of the parents, guardians, adult siblings, relatives and other third parties; (3) prevention of suicide; and (4) maintaining the integrity of the medical profession); *see also In re* Brown, 689 N.E.2d 397, 402 (Ill. App. Ct. 1997).

332. *See* Planned Parenthood of Cent. Mo. v. Danforth, 428 U.S. 52, 75 (1976); *Bellotti II*, 443 U.S. at 635.

333. 557 N.Y.S.2d 239 (Sup. Ct. 1990).

334. *Id.* at 240, 243.

335. *Id.* at 243.

336. *Id.* at 242.

337. *Id.* at 243.

338. Indeed, the court was explicitly reluctant to apply the doctrine absent statutory or appellate decisional guidance. *Id.*

339. Hartman, *Coming of Age*, *supra* note 252, at 436.

340. *Id.* at 437:

> Using *parens patriae* as a pretext to possibly mask an unease for allowing a young man to refuse treatment that could potentially extend his life, the New York court's narrow view of *parens patriae* thwarted the benevolence underlying it, along with existing state legislative policy—which the court referenced—that increasingly recognizes adolescent legal decision-making for medical treatment.

See also Batterman, *supra* note 66, at 652.

Nonetheless, advocates can use the language of *Long Island Jewish Medical Center* in their efforts to affirmatively establish the mature minor doctrine in New York. Although *Long Island Jewish Medical Center* did not explicitly accept the mature minor doctrine, commentators have argued that this case "implicitly affirmed" the mature minor doctrine.[341] Indeed, the court would not have applied the mature minor test unless it accepted it as a viable legal doctrine in the state. Otherwise, the court would simply have recognized that there was no need to ask whether or not the young man was mature, as his age would have rendered his consent invalid in either case.[342]

In addition, the New York Supreme Court in *Long Island Jewish Medical Center* was overly deferential to higher courts and the legislature. The court recommended "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."[343] Perhaps the court did not think that it had the authority to recognize the mature minor doctrine, or feared being overruled on appeal. Regardless, the court's signal to the legislature and appellate courts lends weight to the theory that the court approved of the mature minor theory, despite not finding for the petitioner in this particular case.

There is ample reason for other New York courts to pick up where *Long Island Jewish Medical Center* left off. Explicitly acknowledging the mature minor doctrine is certainly within the purview of New York courts. With the codification of statutory exceptions to informed consent law,[344] the New York State Legislature has signaled its approval of the growing trend towards adolescent decision-making under the law. New York has demonstrated that it takes seriously minors' privacy and self-determination interests by permitting minors to obtain abortions without parental notification or consent.[345] Additionally, case

341. *See* Batterman, *supra* note 66, at 651–52.

342. Even if *Long Island Jewish* is read as rejecting the mature minor doctrine, the court's reluctance to allow the minor to actualize his health care decision is out of step with the growing trend towards allowing minors to give effective consent for their health care.

343. *In re Long Island Jewish Med. Ctr.*, 557 N.Y.S.2d at 243.

344. *See supra* notes 220–33 and accompanying text.

345. *See* N.Y. PUB. HEALTH LAW § 2504(3) (McKinney 2002 & Supp. 2007). The New York State Legislature had the opportunity in 2001 to add a parental notification requirement to the abortion statute, but declined to do so. *See* S.B. 3277, 2001–2002 Reg. Sess. (N.Y. 2001). This bill was reintroduced in 2005, but died in committee. *See* ASSEMB. B. 6439, 2005–2006 Reg. Sess (N.Y. 2005).

Other jurisdictions that allow minors to have abortions without parental notification or consent are Alaska, California, Connecticut, Florida, Hawaii, Illinois, Montana, Nevada, New Hampshire, New Jersey, New Mexico, Oklahoma, Oregon, Vermont, Washington, and Washington D.C. NARAL Pro-Choice New York, Mandating Parental Notification: Government Restrictions on Adolescent Access to Abortion (Nov. 5, 2004), *available at* http://www.prochoiceny.org/s09issues/200411058.shtml.

In New York, a minor's abortion records may not be released to her parents without her permission. N.Y. Civil Liberties Union, Types of Care Minors Can Receive Without Parental Consent, *available at* http://www.nyclu.org/thi/frames/thi_frameset.html (last visited Jan. 9, 2007).

law in other states adopting the mature minor doctrine provides guidance for New York courts wishing to do the same.[346]

2. The emancipation exception

Justice Marshall, dissenting from the majority opinion in *H.L. v. Matheson*, observed that United States Supreme Court case law "does not question that exceptions from a parental notice requirement are necessary for minors emancipated from the custody or control of their parents."[347] More than thirty states have in some form codified the emancipation exception.[348] Many state statutes specifically allow emancipated minors as well as married minors[349] and those who live independently of their parents[350] to consent to their own medical care.

New York's Public Health Law sections 2504(1) and (2) allows minors who have married or parented children to consent to their own medical care.[351] This statute dovetails with some aspects of what has been termed the "emancipation exception," but does not include every condition that the common law has recognized as conferring legal independence. Under New York case law, minors are also considered emancipated and competent to consent to their medical care if they support themselves,[352] have been inducted into military service,[353] have

346. *See supra* note 318.

347. 450 U.S. 398, 428 n.3 (1981) (Marshall, J., dissenting); *see also id.* at 450 n.48 (summarizing a sample of state emancipation statutes).

348. *See* Lawrence P. Wilkins, *Children's Rights: Removing the Parental Consent Barriers to Medical Treatment of Minors*, 1975 ARIZ. ST. L.J. 31, 59 (1975). At least one court nationally has adopted a more expansive vision of emancipation than that of the majority of courts. In *Smith v. Seibly*, the court stated that "age, intelligence, maturity, training, experience, economic independence or lack thereof, general conduct as an adult and freedom from the control of parents are all factors to be considered" in determining whether a minor should be considered emancipated for purposes of consenting to health care. 431 P.3d 719, 723 (Wash. 1967).

349. The following statutes authorize married minors to consent to their own medical treatment: GA. CODE ANN. § 31-9-2(a)(3) (2006); MD. CODE ANN. HEALTH-GEN. § 20-102(a) (Michie 2005); ALA. CODE ANN. § 22-8-5 (Michie 1997); COLO. REV. STAT. § 13-22-103 (2006); R.I. GEN. LAWS § 23-4.6-1 (2001) (married minor may consent to routine emergency medical or surgical care); S.C. CODE § 20-7-270 (1985), MASS. ANN. LAWS ch. 112, § 12F (West 2003); PA. STAT. ANN. tit. 35, § 10101 (West 2003).

350. ALASKA STAT. §§ 25.20.010, 25.20.020 (2004); COLO. REV. STAT. § 13-22-103 (2006) (applies to a minor fifteen years of age or older); MONT. CODE ANN. § 41-1-402(b) (2005); MASS. ANN. LAWS ch. 112, § 12F (West 2003); NEV. REV. STAT. § 129.030(a) (2005) (minor who has lived separate and apart from his parents for four months may consent to medical treatment); R.I. GEN. LAWS § 23-4.6-1 (2001) (married person may consent to routine emergency medical or surgical care).

351. N.Y. PUB. HEALTH LAW §§ 2504(1), (2) (McKinney 2002 & Supp. 2007). The only case in which New York courts considered the emancipation doctrine in the context of health care was Bach v. Long Island Jewish Hosp., 267 N.Y.S.2d 289 (Sup. Ct. 1966). In this case, a married minor authorized a doctor to perform a biopsy. Upon gaining the age of majority, she sought to disaffirm her consent, arguing that her consent had been invalid as she had been a minor. The court ruled that the minor's consent "was an act of volition, and was a personal right which was validly exercised." *Id.* at 291.

352. *See* Alfonso v. Fernandez, 606 N.Y.S.2d 259, 262 (App. Div. 1993) (citing cases).

353. Fauser v. Fauser, 271 N.Y.S.2d 59, 61 (Fam. Ct. 1966) (noting that the period of eman-

been abandoned by their parents,[354] have constructively abandoned their parents,[355] or have assumed a status "inconsistent with subjection to control by his parent."[356] Thus, whether a minor is emancipated is a factual determination.

A transgender minor who enjoys a positive relationship with her parents, but whose parents will not consent to sex reassignment treatment, might seek emancipation by assuming a status "inconsistent with subjection to control" by her parents. This would allow the minor to be seen as an adult in the eyes of the law despite being under eighteen.[357] In many cases, acts of self-sufficiency, such as establishing one's own apartment and holding a job to support oneself without relying on parents, will be enough to establish emancipation.[358] For example, in *Hotetz v. Hotetz*,[359] a seventeen-year-old who lived separately from his father wrote to his father telling him that he had a job working for an airline and that he intended to go back to school. The minor did not make any mention of his pay or expenses. The court held the seventeen-year-old to be emancipated from his father.[360]

Courts have found children to be emancipated who "without cause, withdr[ew] from parental control and supervision,"[361] particularly if the minor was of employable age.[362] In *Rosemary N.*,[363] the minor was deemed emancipated when she took "calculated and deliberate steps to terminate fully and absolutely the parent-child relationship," including leaving her father's home, taking her stepfather's surname ("the ultimate act of defiance and denial of her relationship with her natural father"), and refusing to visit or communicate with her father.[364]

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cipation ceases when the minor's service ends).

354. *See* Murphy v. Murphy, 133 N.Y.S.2d 796, 797 (Sup. Ct. 1954).

355. *See In re* Roe v. Doe, 272 N.E.2d 567, 569–70 (N.Y. 1971); Alice C. v. Bernard G.C., 602 N.Y.S.2d 623, 625 (App. Div. 1993).

356. *Murphy*, 133 N.Y.S.2d at 797. In that case, the four-year-old plaintiff was injured in a car accident when his father, the driver of the other vehicle, collided with the car in which the child was riding. The court noted a number of factors affecting the determination of whether the child was emancipated by virtue of abandonment by his father, and denied the motion for summary judgment. *Id.* at 799.

357. It should be noted that the status of emancipation is not necessarily permanent. If there is a change in circumstances between a minor and her parents, for example if she reconciles with her parents and is accepted back into their home, the minor may be returned to unemancipated status. *See* Hamdy v. Hamdy, 612 N.Y.S.2d 718 (App. Div. 1994).

358. Parisi v. Parisi, 528 N.Y.S.2d 145, 145 (App. Div. 1988) (holding that minor's move from Suffolk County to Syracuse, where he supported himself and maintained his own apartment, with no intention of returning to maternal home, was sufficient to demonstrate emancipation).

359. 303 N.Y.S.2d 90 (Fam. Ct. 1969).

360. *Id.* at 95. *See also* Bryant v. Bryant, 495 N.Y.S.2d 121, 122 (Sup. Ct. 1985) (holding the minor emancipated on similar facts).

361. *In re* Ontario County Dep't of Soc. Servs. *ex rel.* Christopher L. v. Gail K., 703 N.Y.S.2d 337, 338 (App. Div. 2000). *See also* Comm'r of Soc. Serv. *ex rel.* Jones v. Jones-Gamble, 643 N.Y.S.2d 182 (App. Div. 1996); Alice C. v. Bernard G.C., 602 N.Y.S.2d 623, 630 (App. Div. 1993).

362. *See* Cohen v. Schnepf, 463 N.Y.S.2d 29, 31 (App. Div. 1983).

363. Rosemary N. v. George B., 427 N.Y.S.2d 553 (Fam. Ct. 1980).

364. *Id.* at 554–55 (releasing father from obligation to provide support to eighteen-year-old

A somewhat less extreme example is *Richard O.*,[365] in which a minor was held to be emancipated from his adoptive parents when he left their home to live with his biological mother.[366]

The "withdrawal from parental control" doctrine is typically applied to determine whether a parent is obligated to pay child support.[367] This doctrine has generally been narrowly applied by the courts in order to protect minors against parents who wish to cease child support payments, as it is the policy of New York that parents should support their children.[368] For this reason, when a minor abandons the parental home for good cause, such as when the parents are abusive or negligent,[369] the court is less likely to release the parents from their support requirement by finding the minor emancipated. Because this restrictive interpretation developed in the context of child support payment cases, the situation of a transgender youth seeking emancipation may be distinguishable. Courts are more willing to find a minor emancipated if she instead acts affirmatively to terminate the relationship, simply to be free of parental control, and if she can support herself. Thus, advocates may be more successful in having the minor found to be emancipated where the minor is seeking emancipation under this reasoning, rather than where the parent is seeking to be excused from child support obligations.

Another scenario under which transgender adolescents might seek emancipation is if a child is abandoned by his or her parents. A minor may be deemed emancipated if the parent renounces all legal duties and surrenders all parental rights towards the child,[370] or acts in a way found inconsistent with the performance of parental obligations.[371] Parental behavior on which courts have based findings of emancipation includes "ordering a child to leave his home and get another home."[372] It is rightfully difficult for a parent to legally abandon a child, as policy interests support family unification. However, as it is not uncommon for transgender adolescents to be kicked out by their parents, this prece-

daughter until she reached the age of twenty-one). *See also Jones*, 643 N.Y.S.2d at 184.

365. *In re* Columbia County Dep't Soc. Servs. *ex rel.* William O. v. Richard O., 692 N.Y.S.2d 496 (App. Div. 1999).

366. *Id.* at 499. *See also* Wayne County Dep't of Soc. Servs. v. Hawthorne, 423 N.Y.S.2d 706 (App. Div. 1979) (holding that that a child who voluntarily and without good cause abandons her parents' home thereby forfeits any right to parental support).

367. *See In re* Roe v. Doe, 272 N.E.2d 567 (N.Y. 1971). *See also* Alice C. v. Bernard G.C., 602 N.Y.S.2d 623 (App. Div. 1993).

368. *See, e.g.*, N.Y. FAM. CT. ACT. § 413(1) (McKinney 1999); N.Y. SOC. SERV. LAW § 101(1) (McKinney 2003).

369. *In re* Monroe County Dep't Soc. Servs. v. San Filippo, 578 N.Y.S.2d 766, 767 (App. Div. 1991); *Alice C.*, 602 N.Y.S.2d at 630; *In re* Drago v. Drago, 526 N.Y.S.2d 518, 520 (App. Div. 1988).

370. Bates v. Bates, 310 N.Y.S.2d 26, 30 (Fam. Ct. 1970).

371. *Id.* at 31.

372. Murphy v. Murphy, 133 N.Y.S.2d 796, 797 (Sup. Ct. 1954).

dent of emancipation through parental abandonment would apply to some transgender adolescents.

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. Legislatures should therefore explicitly affirm the mature minor doctrine, so that adolescents who desperately need the autonomy to make their own medical decisions are not forced to resort to emancipation. Doing so would achieve a balance between honoring the autonomy of the minor while preserving the family unit.

3. The emergency exception

Generally, a parent must provide consent for an operation to be performed on a minor child.[373] However, the Supreme Court has recognized that an exception from a parental consent requirement is necessary when securing parental consent would interfere with emergency medical treatment.[374] Under the "emergency" exception to the consent requirement, doctors in New York may treat minor patients without gaining consent from the minor's parents "when, in the physician's judgment an emergency exists and the person is in immediate need of medical attention and an attempt to secure consent would result in delay of treatment which would increase the risk to the person's life or health."[375]

The term "emergency" is not defined by New York statute. However, case law from New York and elsewhere suggests that the emergency standard is a high one.[376] Emergencies have been found in circumstances where a child fractured her arm and needed immediate treatment;[377] and where children or adults were unconscious due to their injuries and treatment could not be delayed.[378] In *McCandless v. State*,[379] the court ruled that an abortion performed on a woman hospitalized for mental health treatment without her or her parents' consent was

373. Anonymous v. State, 236 N.Y.S.2d 88, 90 (App. Div. 1963).

374. H.L. v. Matheson, 450 U.S. 398, 428 n.3 (1981) (Marshall, J., dissenting) (citing majority decision at 407 n.14).

375. N.Y. PUB. HEALTH LAW § 2504(4) (McKinney 2002).

376. Federal statutes also support this conclusion. For example, one federal statute defines the term "emergency medical condition" as:

> a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in—(i) placing the health of the individual [. . .] in serious jeopardy, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part.

42 U.S.C. § 1395dd(e)(1) (2000).

377. Wells v. McGehee, 39 So. 2d 196 (La. Ct. App. 1949).

378. Luka v. Lowrie, 136 N.W. 1106 (Mich. 1912) (addressing situation of boy who was hit by a train, badly injuring his foot and causing him to fall into unconsciousness); Schloendorff v. Soc'y of N.Y. Hosp., 105 N.E. 92, 93 (N.Y. 1914).

379. 162 N.Y.S.2d 570 (App. Div. 1957).

not an emergency, relying in part on the hospital director's testimony that "a week's delay would have made no great difference."[380]

Given how narrowly the term "emergency" has been interpreted by courts, only a small set of urgent medical needs will rise to the level of an "emergency." It will therefore be difficult for transgender adolescents to access sex reassignment treatment under this theory. However, it may be possible to argue that a delay in treatment until the adolescent reaches maturity increases the risk to her life or health. That was, according to Harriet Pilpel's article *Sex-Related Health Care for Minors*, the basis for the New York State Department of Health's decision to allow minors to consent to abortions themselves, "without parental involvement or consent."[381] Analogously, for transgender adolescents, the significant risk of harassment and violence they face at the hands of their peers, families, and strangers might frequently constitute a risk to life and health. In addition, delay of sex reassignment treatment impedes transgender adolescents' ability to complete psychological developmental tasks at age-appropriate times and diminishes the ultimate efficacy of the treatment when it is finally obtained.[382] These negative effects can, and should, be considered risks to an adolescent's health that may rise to the level of an emergency.

4. Exceptions for mental health treatment

New York Mental Hygiene Law section 33.21(c) provides that minors may give valid consent to clinically indicated outpatient mental health services.[383] Since almost all transgender people seeking to obtain sex reassignment treatment have been diagnosed with Gender Identity Disorder (GID),[384] a mental health diagnosis appearing in the Diagnostic and Statistical Manual (DSM),[385] trans-

380. *Id.* at 574 (citing *Schloendorff*). Abortion was a crime at the time in New York. *See id.* at 572–73.

381. Harriet F. Pilpel, Nancy F. Wechsler & Eve W. Paul, *Sex-Related Health Care for Minors*, 173 N.Y.L.J. 39 at 1 (Feb. 27, 1975).

382. *Cf. supra* text accompanying notes 115–16.

383. N.Y. MENTAL HYG. LAW § 33.21(c) (McKinney 2006). The practitioner must determine that:

> (1) the minor is knowingly and voluntarily seeking such services; and (2) provision of such services is clinically indicated and necessary to the minor's well-being; and (3)(i) a parent or guardian is not reasonably available; or (ii) requiring parental or guardian consent or involvement would have a detrimental effect on the course of outpatient treatment; or (iii) a parent or guardian has refused to give such consent and a physician determines that treatment is necessary and in the best interests of the minor.

Id. The practitioner must thoroughly document the reasons for the above determinations and include such documentation in the minor's clinical record; the minor's record must also include a signed statement verifying that she is voluntarily seeking services. *Id.* The consent of a parent or guardian is always required for "surgery, shock treatment, major medical treatment in the nature of surgery, or the use of experimental drugs or procedures." N.Y. MENTAL HYG. LAW § 33.03(b)(4) (McKinney 2006).

384. *See supra* Part IV.A.

385. *See supra* note 123 and accompanying text.

gender youth with GID should be able to obtain treatment for this condition without any requirement that parents consent to or be notified of the treatment. Therefore, if the treating mental health professional believes hormone treatment is a necessary part of the mental health treatment, this statute would authorize the provision of hormone treatment on the minor's consent.[386]

Advocates may find, however, that use of this statute is of only limited benefit to transgender youth, as the consent of a parent or guardian is required for "surgery, shock treatment, major medical treatment in the nature of surgery, or the use of experimental drugs or procedures."[387] Thus, while transgender youth should be able to consent on their own behalf to hormone treatment, youth are not given the ability under this statute to consent to sex reassignment surgery. In addition, any sex reassignment treatment found to be "in the nature of surgery" or "experimental" would require parental consent.[388]

C. Use of Court-Ordered Medical Treatment to Override Parental Veto

Courts have the power to override a parent's medical decision on behalf of her child in order to protect the child. When a child is in need of medical or surgical care, but her parents refuse to consent to medical treatment, a court may intervene using its *parens patriae* power or child neglect statutes to find that the child is neglected by reason of her parents' failure to provide necessary treatment.[389] In such cases of neglect, the court may then order medical treatment for the minor. This option is most commonly exercised in cases where the child's life is at risk, but has also been applied in situations where the medical treatment was in the best interests of the child.[390] Transgender adolescents

386. However, under this statute, the minor must meet additional requirements in order to consent to psychotrophic medication. N.Y. MENTAL HYG. LAW § 33.21(e)(2) (McKinney 2006). Thus, it is possible that access to hormone treatment might be curtailed if opponents argue that provision of hormones should be treated akin to provision of psychotrophic medication, as both are more invasive than talk therapies.

387. *Id.* § 33.03(b)(4).

388. The exclusion for experimental treatment is potentially far-reaching, as sex reassignment treatment has often been categorized as experimental, particularly in the realm of insurance coverage. *See, e.g.*, Hong, *supra* note 100, at 103 n.77.

389. Under New York's Family Court Act, a minor may be found to be neglected if:

> [his or her] physical, mental or emotional condition has been impaired or is in imminent danger of becoming impaired as a result of the failure of his parent or other person legally responsible for his care to exercise a minimum degree of care (A) in supplying the child with adequate . . . medical, dental, optometrical or surgical care, though financially able to do so or offered financial or other reasonable means to do so.

N.Y. FAM. CT. ACT § 1012(f) (McKinney 1999 & Supp. 2007).

390. Best interest is defined in New York as:

> promoting personal well-being by the assessment of the risks, benefits and alternatives to the patient of a proposed major medical treatment, taking into account factors including the relief of suffering, the preservation or restoration of functioning, improvement in the quality of the patient's life with and without the proposed major medical treatment and consistency with the personal beliefs and values known to be held by the patient.

whose parents refuse to consent to sex reassignment treatment may request that the court exercise its power to order treatment, in order to prevent the numerous negative physical and emotional effects of delayed treatment.

The New York Court of Appeals discussed the relationship between the power of the State and the power of parents in the context of minors' medical care in *Matter of Storar*:[391]

> A parent or guardian has a right to consent to medical treatment on behalf of an infant. The parent, however, may not deprive a child of lifesaving treatment, however well intentioned. Even when the parents' decision to decline necessary treatment is based on constitutional grounds, such as religious beliefs, it must yield to the State's interests, as *parens patriae,* in protecting the health and welfare of the child. Of course it is not for the courts to determine the most "effective" treatment when the parents have chosen among reasonable alternatives. But the courts may not permit a parent to deny a child all treatment for a condition which threatens his life.[392]

This principle motivated an earlier court's decision in *In re Vasko*[393] to order, over the parents' objections, an operation to remove a child's eye which had become diseased and was threatening the child's life. The court stated that:

> Medicine and surgery are not exact sciences, and the result of an operation may not be foretold with accuracy. Decision [sic] must be made, and the parents persist in their refusal to consent. Children come into the world helpless, subject to all the ills to which flesh is heir. They are entitled to the benefit of all laws made for their protection—whether affecting their property, their personal rights or their persons—by the Legislature, the sovereign power of the State.[394]

The *Storar* principle is not applied only in cases of life or death. The State also has a "compelling justification" to intrude into the private sphere of the family "where parents have refused to authorize routine medical care that would permit their child to lead a normal and healthy life."[395] In *In re Rotkowitz*,[396]

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14 N.Y. COMP. CODES R. & REGS. tit. 14, § 710.2(a) (2001). However, the courts require a strong showing before they will intercede in a parent's decision about how to rear a child. *See, e.g., In re* Marie B., 465 N.E.2d 807, 809–10 (N.Y. 1984); Wisconsin v. Yoder, 406 U.S. 205, 232–33 (1972).

391. 420 N.E.2d 64 (N.Y. 1981).

392. *Id.* at 73 (citations omitted).

393. 263 N.Y.S. 552 (App. Div. 1933).

394. *Id.* at 555–56.

395. Marzen v. U.S. Dep't of Health & Human Servs., 632 F. Supp. 785, 810 (N.D. Ill. 1986) (citing Prince v. Massachusetts, 321 U.S. 158 (1944)). *See also* Michael Wald, *State Intervention on Behalf of "Neglected" Children: A Search for Realistic Standards*, 27 STAN. L. REV. 985, 1031–33 (1975).

396. 25 N.Y.S.2d 624 (Dom. Rel. Ct. 1941).

the court ordered surgery for a ten-year-old with a foot deformity, over his father's objection. In reaching this decision, the court stated

> When the Legislature clothed this court with the power to make an order for surgical care, it cannot be said that an order is to be made only in case[s] where the parents consented to such order. I must conclude that it was the intention of the Legislature to give power to the justices of this court to order an operation not only in an instance where the life of the child is to be saved but also in instances where the health, the limb, *the person or the future of the child* is at stake.[397]

Courts have also been willing to overrule a parent or guardian's non-consent to a minor's medical treatment where the minor's physical condition places her mental or emotional health at risk. For example, Kevin Sampson, a sixteen-year-old, suffered from Von Recklinghauson's disease, which "manifested itself as a large fold of overgrowth of tissue causing the right eyelid, cheek, corner of the mouth and ear to droop badly."[398] Kevin was illiterate and had not gone to school since he was nine years old, which was attributed in large part to this disfigurement.[399] Despite the fact that the disease did not pose an immediate threat to his life or general health, the treatment was risky, and Kevin's parents opposed the treatment, a New York court held that Kevin should be allowed to have the surgery that his doctors recommended. Explaining that "[a]s things now exist, Kevin can never lead a normal life or be of much benefit to himself or society," the court held that "the operation should be performed if Kevin is to have anything resembling a normal life."[400] The court also found that his mother's failure in her duty to her son constituted neglect within the meaning of the Family Court Act.[401] In reviewing Kevin's case, the New York Court of Appeals noted that the power of the court to order medical treatment is not limited to "drastic or mortal circumstances."[402] Courts may exercise this power "even in the absence of risk to the physical health or life of the subject or to the public."[403]

In *In re Seiferth*,[404] the question before the court was whether to order surgery for a fourteen-year-old minor, Martin, who suffered from a harelip and cleft palate. Martin's father refused to consent to the procedure, so the County Health Department initiated neglect proceedings.[405] The court considered expert testimony that such surgery becomes significantly less successful as the child grows

397. *Id.* at 626–27 (emphasis added).
398. *In re* Sampson, 323 N.Y.S.2d 253, 254 (App. Div. 1971).
399. *Id.* at 255.
400. *Id.*
401. *Id.*
402. *In re* Sampson, 278 N.E.2d 900, 901 (N.Y. 1972) (per curiam).
403. *Id.*
404. 127 N.E.2d 820 (N.Y. 1955).
405. *Id.* at 821.

older.[406] The court also took note of the importance of the period of adolescence, when "social interests" have a great effect.[407] In its discussion, the court quoted Martin's doctor's testimony that "[adolescence] is an extremely important period of time. That child is approaching that age where it is very important [and] significant that correction made at this time could probably put him in a great deal better position to enter that period of life than would otherwise."[408] In this particular case, however, the court declined to order the surgery because both Martin and his father opposed the surgery, so the court was concerned that they would not cooperate with the treatment.[409] However, a different outcome would be likely in a case where an adolescent requested treatment and would fully comply with the doctor's recommendations.

This line of cases establishes that courts have the ability to intercede and order medical treatment for a minor over parental objections not just when there is a risk to the child's life, but also when her physical or emotional health is in jeopardy. For transgender adolescents, the principle articulated in *Sampson* and *Seiferth*—that it may be judged neglect for the parent to bar a minor from accessing health treatment—is particularly important. These cases demonstrate that courts take seriously social harms such as difficulties at school and with peers, and recognize that treatment can arrest these harms, allowing the minor to have "a normal life."

D. Legislative Solutions

Legislation is the optimal solution to transgender adolescents' current difficulties in obtaining sex reassignment treatment. Under existing law, courts are reluctant to extend or increase exceptions to the parental consent requirements in the absence of a clear legislative statement.[410] Although, of course, courts remain free to affirm exceptions to the informed consent law without permission from the legislature,[411] our current piecemeal approach to establishing exceptions to the informed consent law is confusing to doctors, judges, and minors alike.

Such legislation should be passed on the state, rather than federal, level. The requirements of consent are governed by state law, and legislation will have to be tailored for each state in order to fit into its existing legislative framework. In New York, expansion of the informed consent law to include more minors is

406. *Id.*

407. *Id.* at 821–22.

408. *Id.*

409. *Id.* at 823.

410. *See, e.g., In re* Long Island Jewish Med. Ctr., 557 N.Y.S.2d 239, 243 (Sup. Ct. 1990) (applying the mature minor doctrine). For a full discussion of the implications of this case, see *supra* notes 333–43 and accompanying text.

411. "[J]udicial development of the common law is not arrested by piece-meal legislative adoption of specific statutory exceptions to a general common law rule." Cardwell v. Bechtol, 724 S.W.2d 739, 743 (Tenn. 1987).

within the goals of existing New York legislation, as one of the purposes of enacting Public Health Law section 2504 was to "expedite the delivery of health care to those under 21,"[412] which was at that time the age of majority in New York.

Legislation in New York could take several approaches. Legislators might choose to expand the categories which create exceptions to the consent requirement, based on either the minor's status or her medical condition. One way for the Legislature to do this would be to add a "mature minor" provision to Public Health Law section 2504. As part of this amendment, the Legislature could codify the requirements that a minor must meet in order to prove that she has capacity to give informed consent. Alternately, the Legislature could expand the list of medical conditions which allow a minor to consent to her own medical care by carving out a specific exception for minors seeking sex reassignment treatment. Or, if the Legislature wished to safely expand all minors' access to health care by altering the procedural requirements for obtaining consent, they could codify a provision allowing third parties, other than parents or guardians, to give consent on the minor's behalf. Passage of such legislation would also help protect medical professionals from potential liability by clarifying when they may treat transgender adolescents on the basis of the adolescent's own informed consent.

1. Codify the mature minor exception

The mature minor doctrine goes to the heart of the qualities that courts and doctors have found to be integral to sound medical decision-making for adults and minors alike. Codification of the mature minor exception would allow all minors who demonstrate that they understand the risks and consequences of their actions or otherwise demonstrate a capacity for adult judgment to make their own medical decisions.

The mature minor exception is already in effect through common law in other states, and *Long Island Jewish Medical Center* left open the question of whether it is already good law in New York.[413] The New York State Legislature should codify the mature minor exception in order to eliminate this confusion. Such legislation was recommended by the *Long Island Jewish Medical Center* court itself, which suggested "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."[414] Failure to codify additional exceptions to the informed consent law perpetuates a system that has unduly burdened the ability of competent minors to access health care. Scientific studies have disproved the "legal presumption that minors, even in adolescence, are incapable of

412. *See* Alfonso v. Fernandez, 606 N.Y.S.2d 259, 269–70 (1993) (citing Letter of Tarky Lomardi, Jr., Chairman of S. Comm. on Health, May 8, 1972, Bill Jacket, L 1972, ch. 769).

413. *See supra* notes 333–43 and accompanying text.

414. *In re* Long Island Jewish Med. Ctr., 557 N.Y.S.2d 239, 243 (Sup. Ct. 1990).

decision making."[415] This flawed principle "should be reshaped by democratic means. . . . Laws are made by legislatures, and health departments derive authority to promulgate protocol from statutory structure; therefore, the most effective forum for advancing adolescent decisional rights is the legislative process."[416]

Codification of the mature minor exception would most likely track the requirements the United States Supreme Court established in *Bellotti II* for determining whether a minor has the capacity to consent to an abortion, although legislatures are free to be more conciliatory towards adolescents.[417] A model codification of the mature minor doctrine, mirroring the language in *Bellotti II* might state:

> Any person who is mature enough and well informed enough to make his or her health care decision, in consultation with his or her physician, may give effective consent for medical, dental, health, and hospital services for himself or herself, and the consent of no other person shall be necessary.

Such a law would most appropriately modify and be made part of New York Public Health Law section 2504, which codifies the other exceptions under which minors may consent to their own medical care.

The legislation should also direct which court has jurisdiction to adjudicate a minor's maturity, should the issue of maturity be contested. In states that have a judicial bypass procedure, petitions to have a minor adjudged to be a mature minor would most appropriately be directed to that court. In states without a judicial bypass procedure, these petitions should be directed to the court with the most expertise. In New York, that would mostly likely be the Family Court, which already has jurisdiction to evaluate and make health care decisions for minors in other circumstances.[418]

In codifying the mature minor exception, the Legislature might choose to define the key terms "maturity" and "well informed" by incorporating language adopted by states that have considered the issue. In defining maturity, other states have emphasized the minor's ability to appreciate the consequences of his or her actions or to exercise adult judgment.[419] Because assessing a minor's

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415. Hartman, *AIDS and Adolescents*, *supra* note 251, at 281, 295.

416. *Id.* at 295–96.

417. The minor must show "that she is mature enough and well enough informed to make her abortion decision, in consultation with her physician, independently of her parents' wishes." Bellotti v. Baird (*Bellotti II*), 443 U.S. 622, 643 (1979). For the full discussion of *Bellotti II* and the mature minor exception, see *supra* Part VII.B.1.

418. *See supra* notes 204–6 and accompanying text.

419. *See supra* notes 320–21 and accompanying text. New York may also want to consider Tennessee's test of maturity, which evaluates "age, ability, experience, education, training, and degree of maturity or judgment obtained by the minor, as well as . . . the conduct and demeanor of the minor at the time of the incident involved." Cardwell v. Bechtol, 724 S.W.2d 739, 748 (Tenn. 1987). Other guidelines that could assist a legislature in formulating a new standard include Tennessee's requirement that "the totality of the circumstances, the nature of the treatment and its risks or probable consequences, and the minor's ability to appreciate the risks and consequences

awareness of consequences is a more straightforward measure than gauging whether the minor is able to exercise the judgment of an adult, the former is the better test.

Despite the availability of useful language from other jurisdictions, the Legislature is better advised to leave the definition of these terms to the courts. For instance, commentator Nancy Batterman recommends that state legislatures grant "mature minors" the ability to consent to their own health care and leave it to the courts to define that term.[420] Although this will require minors to present their case to courts that may not be familiar with or sympathetic to transgender minors, the legislature is not necessarily a more advantageous forum for transgender minors. In addition, there are several benefits to placing this responsibility in the judiciary. Definition of terms such as these is within the specialized expertise of the courts, which are best equipped to weigh complex factors. Delegating this responsibility to the judiciary will also allow the definition of maturity and what it means for a youth to be "well-informed" to keep pace with developing technology and social standards.[421] Finally, an adverse court decision can be appealed.

Legislatures may feel more comfortable expanding young people's ability to consent to their own health care if there is a concurrent procedural check on this right. Thus, the model statutory formulation above includes a requirement that the minor consult with her physician before giving consent. As the minor will not be able to commence sex reassignment treatment without a physician, this requirement does not add a new and substantial burden for the minor.

2. Create specific exceptions for transgender youth

An alternate approach is to establish a specific exception to the informed consent law for transgender youth. The piecemeal nature and broad range of the present statutory exceptions reflect the fact that adolescents in certain situations both have greater need to make their own decisions and may have greater capacity to make those decisions than other adolescents without similar experience. An exception for transgender youth would fit within the framework of these exceptions.

Transgender youth seeking sex reassignment treatment face many of the same challenges that spurred the legislature to codify the current exceptions to

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are to be considered," *id.*, and Kansas's rule that "the sufficiency of a minor's consent depends upon his ability to understand and comprehend the nature of the surgical procedure, the risks involved and the probability of attaining the desired results in the light of the circumstances which attend." Younts v. St. Francis Hosp. & Sch. of Nursing, Inc., 469 P.2d 330, 337 (Kan. 1970).

420. *See, e.g.*, Batterman, *supra* note 66, at 673.

421. If the legislature uses language that is too specific, it risks creating a statute that is too rigid and unable to adapt to a changing society. The way that society today defines a mature minor may be different than how society in the future defines a mature minor. Thus, leaving it to the common law to develop an body of case law to define that term allows it to keep pace with society's own conception of what a mature minor is.

the informed consent law. The exceptions for prenatal care, substance abuse treatment, diagnosis and treatment of sexually transmitted diseases, and abortion[422] reflect a recognition that, in certain types of health care decisions, a minor's self-determination and wishes for her own body must be the priority. Just as with these other momentous health care decisions, the decision whether an adolescent may receive sex reassignment treatment is time-sensitive, and barring an adolescent from such treatment carries potentially grave consequences.[423]

Some statutes reflect a legislative determination that certain life experiences leave minors without the adult guidance that we would wish for them in a perfect world. These life experiences force minors to make adult decisions at early ages. For example, homeless minors who do not live with their parents may consent to their own medical care in some states.[424] Similarly, the experience of confronting discrimination from family and peers results in many transgender adolescents being able to bring a level of maturity to their decisions that may be less common in other adolescents.

Moreover, in light of such discrimination from family and peers, requiring transgender minors to obtain parental consent may be detrimental or even dangerous to the minors. As the Supreme Court recognized in *H.L. v. Matheson*, an exception to parental consent requirements may be necessary where a "minor makes a claim or showing as to her relations with her parents or demonstrates a hostile home situation."[425] Transgender adolescents often face terrible home situations,[426] and cannot afford to have their health care depend on the approval of a hostile parent or foster care guardian.[427] Thus, adding an exception to the informed consent law for transgender youth would be consistent with the policies that spurred other exceptions to the informed consent law.

3. Expand the role of surrogate decision-makers

A third alternative is for the Legislature to allow a third party to ascertain the minor's ability to consent or to consent on the minor's behalf. This process could take the form of a judicial bypass, as has been implemented in the abortion context, or a surrogate decision-maker.

The United States Supreme Court has held that "the unique nature and consequences of the abortion decision make it inappropriate 'to give a third party an

422. *See supra* Part V.B.

423. *See supra* Part IV.B.

424. *E.g.*, ARIZ. REV. STAT. ANN. § 44-132 (West 2003) (stating "any homeless minor may give consent to the furnishing of hospital, medical and surgical care to such minor, and such consent shall not be subject to disaffirmance because of minority").

425. 450 U.S. 398, 428 n.3 (1981) (Marshall, J., dissenting) (citing majority decision at 407 n.14, internal quotations and changes omitted).

426. *See supra* text accompanying notes 49–52.

427. As the Supreme Court has repeatedly noted in the abortion context, it is inappropriate "to give a third party an absolute, and possibly arbitrary, veto over the decision of the physician and his patient." Planned Parenthood of Cent. Mo. v. Danforth, 428 U.S. 52, 74 (1976).

absolute, and possibly arbitrary, veto over the decision of the physician and his patient to terminate the patient's pregnancy, regardless of the reason for withholding the consent.'"[428] The Court observed that "there are few situations in which denying a minor the right to make an important decision will have consequences so grave and indelible,"[429] as the decision "brings with it adult legal responsibility"[430] and poses "potentially severe detriment."[431] Thus, if the State mandates that a minor obtain parental consent to an abortion, it must also provide a "judicial bypass" procedure, wherein the minor could waive parental notification and instead seek authorization from a court.[432]

Transgender youth advocates might seek to apply these principles and expand the use of bypass procedures for transgender health care decision-making. This would allow minors to seek authorization from the court for the health care they seek if parents refuse to consent.[433] However, although sometimes necessary, forcing transgender youth to appeal to judges is a markedly unsatisfactory solution when the judges may be at best unknowledgeable and at worst hostile to the needs of transgender youth.[434] An adolescent is unlikely to be able to predict prior to making the decision to appeal to a court whether their judge will be sufficiently knowledgeable and free of discrimination to be able to adequately address their request for sex reassignment treatment. Thus, although bringing a court petition may be a minor's only option, the outcome is unpredictable and the process may take a toll on the minor's emotional health.[435]

Bypass procedures are not the only option. Instead, a system of surrogate decision-makers who could consent to treatment on the minor's behalf could be used. The surrogate could be the minor's medical provider, an adult acting *in loco parentis*, such as an adult sibling, or another responsible adult. In the mental health context, New York has established a system of surrogate decision-makers, recognizing that when there are no family members or other such traditional decision-makers, "undue delay" often results when the only remaining option for the person seeking medical treatment is to seek authorization from the

428. Bellotti v. Baird (*Bellotti II*), 443 U.S. 622, 643 (1979) (quoting *Danforth*, 428 U.S at 74).

429. *Bellotti II*, 443 U.S. at 642.

430. *Id.*

431. *Id.*

432. *Id.*

433. Note that this type of court petition asks the court to authorize health care on the minor's behalf, as the minor is legally incapable of consenting herself. By contrast, if the legislature were to codify the mature minor doctrine as discussed in Part VII.D.1, *supra*, the minor would instead petition the court to find that she is a mature minor and therefore capable of consenting on her own behalf to the sought health care.

434. "U.S. Supreme Court Justice Souter has suggested that judges should disqualify themselves where they may not be able to separate their own morals from the choices the teenager must make." Lawrence Schlam & Joseph P. Wood, *Informed Consent to the Medical Treatment of Minors: Law and Practice*, 10 HEALTH MATRIX: J. L.-MED. 141, 162 (2000) (citing a letter written by Justice Souter while serving on the New Hampshire Supreme Court).

435. *See supra* text accompanying notes 289–91.

court.[436] Expanding the statutory authorization for surrogate decision-makers to the transgender minor context could allow minors to avoid the undue delay that might occur if they either had to appeal to a court or wait until they turn eighteen to access the health care they seek.[437]

It would be preferable, however, for such a statute to allow the minor to obtain medical treatment as long as she has consulted with a responsible adult of her own choosing, who could provide consent for the adolescent in the absence of a parent or judicial bypass procedure. As discussed above,[438] most minors consult a trusted adult—generally a medical or social work professional, adult relative, or parental figure—prior to making an important health care decision. Allowing the minor to obtain treatment as long as she has consulted with a responsible adult eliminates state interference with personal health care decisions, while also satisfying the State's interests in ensuring the health and safety of minors.[439]

VIII.
CONCLUSION

Health care for transgender adolescents is an urgent public health crisis. Transgender adolescents should not be forced to leave their families' homes or buy unprescribed hormones on the street in order to access sex reassignment treatment. Nor should they have to endure discrimination and violence until they reach the age of eighteen. Empirical evidence shows that many adolescents demonstrate the ability to make decisions that are just as informed and mature as decisions made by adults, particularly in the health care context. Doctors and advocates should assist transgender adolescents in obtaining necessary medical treatment under the existing legal doctrines detailed above, allowing adolescents to consent to their own health care. Legislatures should also codify additional exceptions to the informed consent law, to eliminate confusion and facilitate access for those in need.

436. *See* N.Y. MENTAL HYG. LAW § 80.0 (McKinney 2006), N.Y. COMP. CODES R. & REGS. tit. 14, § 710.1(b) (2001) (providing that "such decisions could be made by a court of competent jurisdiction upon application").

437. Another useful framework is found in the Model Health-Care Consent Act, which relies on a doctor to assess the minor's maturity and decision-making ability. It allows the health care provider to use their "good faith opinion" to determine whether "an individual otherwise authorized . . . is incapable of making a decision regarding the proposed health care." UNIFORM LAW COMM'RS' MODEL HEALTH-CARE CONSENT ACT § 3 (1982). If an adult acting *in loco parentis* were designated to fill this role, per the Model Act's suggestion that the court might appoint a representative to make health care decisions for an individual, a doctor could apply the incapability determination in situations where the parent or guardian fails to act in the best interests of the minor. *See id.* § 7(a) & cmt.

438. *See supra* text accompanying notes 273–77.

439. *See supra* Part VI.C.