

TRANSGENDER YOUTH, ADOLESCENT DECISIONMAKING, AND *ROPER V. SIMMONS*

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Transgender youth who seek access to hormones encounter a number of barriers that frustrate their ability to express their gender identity and exacerbate the effects of the overwhelming levels of discrimination and harassment they face on a daily basis. Because the parents of transgender youth are often hostile or absent, the parental consent requirement imposed by informed consent laws adds to these barriers. In some states, transgender youth can overcome the obstacles imposed by the parental consent requirement by invoking the mature minor doctrine, which allows physicians to provide medical services without parental consent to adolescents who are sufficiently mature to make the decision. Thus, in this context youth benefit when the law recognizes their decisionmaking capacity.

*In the criminal justice context, in contrast, youth are more likely to benefit when the law recognizes the limits of their decisionmaking capacity. When the U.S. Supreme Court invalidated the juvenile death penalty in *Roper v. Simmons*, for example, it relied in part on a view of adolescents as less mature and therefore less culpable than adults. The *Roper* Court emphasized three areas of difference between adolescents and adults: impulsivity, susceptibility to peer pressure, and incomplete character formation.*

*This Comment evaluates the implications of the *Roper* Court's view of adolescence in the context of transgender youth seeking access to hormones by invoking the mature minor doctrine. A careful, context-specific analysis of the adolescent characteristics identified by the *Roper* Court shows that, rather than posing a conceptual barrier, the decision supports a presumption in favor of allowing transgender youth to obtain hormones without parental consent.*

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INTRODUCTION

In the course of invalidating the juvenile death penalty in *Roper v. Simmons*,¹ the U.S. Supreme Court expressed a negative view of adolescent maturity and decisionmaking ability. The Court’s decision highlighted a paradox faced by youth advocates. Within the criminal justice system, advocating for youth² can require emphasizing the relative immaturity and impulsiveness of adolescents in order to shield them from harsh punishment. In contrast, when youth face issues relating to other areas of law, such as health care, effective advocacy can instead require emphasizing adolescents’ maturity and capacity to make decisions on their own behalf.³ By invalidating the juvenile death penalty, the *Roper* decision protected the Eighth Amendment rights of youth facing the threat of capital punishment. However, by questioning the

1. 543 U.S. 551 (2005).

2. This Comment uses the terms adolescents, minors, juveniles, and youth interchangeably when referring to individuals younger than eighteen years old.

3. See Donald L. Beschle, *Cognitive Dissonance Revisited: Roper v. Simmons and the Issue of Adolescent Decision-Making Competence*, 52 WAYNE L. REV. 1, 32 (2006) (“Many who would applaud the invocation of the *Simmons* rationale to limit the harshness of criminal law as applied to juveniles would object to the use of the same rationale to limit adolescent autonomy in those non-criminal contexts [involving reproductive rights and other types of health care decisions].”); Kimberly M. Mutcherson, *Minor Discrepancies: Forging a Common Understanding of Adolescent Competence in Healthcare Decision-Making and Criminal Responsibility*, 6 NEV. L.J. 927, 928 (2006) (describing the “potentially clashing views of adolescent decision-making capacity” embraced by juvenile justice advocates and adolescent healthcare advocates); see also Larry Cunningham, *A Question of Capacity: Towards a Comprehensive and Consistent Vision of Children and Their Status Under Law*, 10 U.C. DAVIS J. JUV. L. & POL’Y 275, 331 (2006) (noting the inconsistency of “the proposition that a minor is mature enough to make a major decision about whether to carry a baby to term, on the one hand, but developmentally incapable of deciding to avoid committing a capital offense, on the other hand”).

maturity of adolescents as a class, the decision may have exacted a toll for that protection—a toll that might one day be paid by youth facing other legal issues.⁴

The *Roper* Court bolstered its view of adolescence by noting other areas of law in which minors' legal rights are diminished,⁵ giving credence to youth advocates' fears that the impact of the decision could reach beyond the criminal justice system.⁶ However, despite the Court's characterization of its view as consistent with existing legal standards restricting juvenile autonomy, the overall legal regime shows no consistent view of adolescent decisionmaking capability.⁷ The level of deference accorded to adolescent decisions varies considerably across different areas of law.⁸ This variation suggests that any broader legal implications of the *Roper* Court's view of adolescence cannot be reduced to blanket statements. Instead, where an adolescent's legal capacity to make a particular decision is at issue, the implications of the differences between adolescents and adults noted in the *Roper* opinion must be carefully considered as applied to that context.⁹

4. See Beschle, *supra* note 3, at 32–41 (analyzing the potential impact of *Roper* in contexts outside of the criminal law); W. Matt Nakajima, Note, *Life or Death: How Roper v. Simmons Affects Juvenile Abortion Jurisprudence*, 34 N. KY. L. REV. 389 (2007).

5. *Roper*, 543 U.S. at 569 (“In recognition of the comparative immaturity and irresponsibility of juveniles, almost every State prohibits those under 18 years of age from voting, serving on juries, or marrying without parental consent.”).

6. Such concerns are based on the possibility that accepting the *Roper* Court's view of adolescence might “compel the rejection of claims of adolescent autonomy” in other legal contexts. Beschle, *supra* note 3, at 32–33; see also Mutcherson, *supra* note 3, at 928 (“[E]mbracing one view of the developmental capacity of adolescents seems to preclude embracing the other.”). Because autonomy arguments can be central to youth advocacy in multiple areas, including health care, custody, and education, see generally Elisa Poncz, *Rethinking Child Advocacy After Roper v. Simmons: “Kids Are Just Different” and “Kids Are Like Adults” Advocacy Strategies*, 6 CARDOZO PUB. L. POL'Y & ETHICS J. 273 (2008), the rejection of autonomy arguments could have a negative impact on adolescent rights.

7. Cunningham, *supra* note 3, at 277 (“Congress, state legislatures, the Supreme Court, and state courts have created laws and decided cases without a comprehensive vision of what it means to be a child or how children think and behave. Particularly troublesome is the varying manner in which the question of psychological capacity has been addressed by decisionmakers, if at all.”). But see Mutcherson, *supra* note 3, at 954 (noting the consistency among U.S. Supreme Court decisions finding that “young people are consistently flawed and generally immature whether they are committing capital crimes or seeking to terminate an unwanted pregnancy”).

8. Cunningham, *supra* note 3, at 277 (“Some areas of the law view children as ‘infants’ who do not have the capacity to act. . . . Other areas of the law presume capacity in all instances or disregard the question of capacity altogether.”).

9. Cf. Paul Arshagouni, “*But I’m an Adult Now . . . Sort of*”: Adolescent Consent in Health Care Decision-Making and the Adolescent Brain, 9 J. HEALTH CARE L. & POL'Y 315, 363 (2006) (“[T]he same understanding of adolescent development should be applied across the board. But that does not necessarily mean that we will get the same answer in each discipline.”); Mutcherson, *supra* note 3, at 958 (“[D]ecision-making in different contexts is so qualitatively dissimilar that it is not incongruous to find that the same individual's decision-making abilities may be sufficient to support autonomous decision making in one realm but insufficient to support a finding of autonomous decision-making in a distinct set of circumstances.”).

This Comment examines the implications of the adolescent characteristics identified by the *Roper* Court in the context of transgender youth seeking access to hormones without parental consent by invoking the mature minor doctrine. In states that have adopted the mature minor doctrine,¹⁰ a physician may prescribe hormones without parental consent for youth who possess sufficient maturity and knowledge to make the decision on their own behalf.¹¹ However, the mature minor doctrine does not provide a standard for evaluating adolescent maturity,¹² creating a gap that could be filled by the *Roper* Court's discussion of adolescence.¹³ Because the *Roper* Court expressed a generally negative view of adolescent maturity and decisionmaking ability, a superficial reading of *Roper v. Simmons* could pose a conceptual barrier for transgender youth attempting to invoke the mature minor doctrine. Nonetheless, a careful, context-specific application of the Court's reasoning in *Roper* actually supports a presumption in favor of allowing transgender youth to obtain hormones without parental consent.¹⁴

It may seem counterintuitive that a decision critical of adolescent decisionmaking in one context could support a presumption in favor of respecting a particular adolescent decision in another context. However, the divergent outcomes can be reconciled when viewed through the lens of *parens patriae*, the historic responsibility of a sovereign to act as a guardian of those who cannot protect themselves.¹⁵ The government's *parens patriae*

10. Several states, including Arkansas, Idaho, Illinois, Kansas, Mississippi, Nevada, New York, Ohio, Tennessee, and West Virginia, have expressly or impliedly adopted the mature minor doctrine by statute or through case law. See ARK. CODE ANN. § 82-363(g) (1987); IDAHO CODE ANN. § 39-4302 (2002); MISS. CODE ANN. § 41-41-3(3) (2005); NEV. REV. STAT. ANN. § 129.030(2) (LexisNexis 2004); *In re E.G.*, 549 N.E.2d 322 (Ill. 1989); *Younts v. St. Francis Hosp. & Sch. of Nursing, Inc.*, 469 P.2d 330 (Kan. 1970); *Bach v. Long Island Jewish Hosp.*, 267 N.Y.S.2d 289 (1966); *Lacey v. Laird*, 139 N.E.2d 25 (Ohio 1956); *Cardwell v. Bechtol*, 724 S.W.2d 739 (Tenn. 1987); *Belcher v. Charleston Area Med. Ctr.*, 422 S.E.2d 827 (W. Va. 1992). *But see* *Commonwealth v. Nixon*, 761 A.2d 1151 (Pa. 2000) (rejecting the mature minor doctrine in Pennsylvania).

11. See *infra* Part II.B.2. See generally Sonja Shield, *The Doctor Won't See You Now: Rights of Transgender Adolescents to Sex Reassignment Treatment*, 31 N.Y.U. REV. L. & SOC. CHANGE 361 (2007).

12. See *infra* note 99.

13. If a physician provides the youth with the requested medical care, and a subsequent tort action alleges that the youth lacked sufficient maturity to provide informed consent under the mature minor doctrine, the reviewing court would not be required to look to the *Roper* decision as binding precedent. However, the *Roper* Court's discussion of adolescent characteristics would be useful persuasive authority in such a context, as the decision provides guidance about which differences between youth and adults the Court viewed as legally significant when evaluating adolescent maturity and decisionmaking ability.

14. See *infra* Part III.

15. BLACK'S LAW DICTIONARY 1144 (8th ed. 2004); see also *Alfred L. Snapp & Son, Inc., v. Barez*, 458 U.S. 592, 600 & n.8 (1982). The *parens patriae* responsibility has traditionally extended to "persons under legal disability," *Alfred L. Snapp & Son, Inc., v. Barez*, 458 U.S. at 600 n.8 (quoting BLACK'S LAW DICTIONARY 1003 (5th ed. 1979)), a category that includes adolescents. See *Santosky v.*

responsibility to protect youth from harm has different implications in each context.¹⁶ In the criminal justice context, requiring a lesser penalty than death obviously protects juvenile defendants from harm in the form of undeserved capital punishment, while allowing the death penalty does not.¹⁷ In the context of transgender youth seeking access to hormones, in contrast, harm can flow either from denying or from granting access.¹⁸ Limiting decisionmaking autonomy in this context amounts to forcing transgender adolescents down a particular path—one that may involve a great deal of unnecessary suffering.¹⁹

This Comment proceeds as follows. Part I describes the *Roper v. Simmons* decision, focusing on the Court's discussion of adolescent maturity. Part II examines the difficulties facing transgender youth, particularly those seeking access to hormones, and explains the role of decisionmaking autonomy in addressing those difficulties. Part III analyzes the implications of the *Roper* Court's view of adolescence for transgender youth seeking to obtain hormones without parental consent, finding that the opinion supports a presumption in favor of access. The Comment concludes that legal standards requiring differential treatment of youth and adults must develop in a manner consistent with their original protective purpose, or they will do more to harm than to protect those transgender youth who seek access to hormones to facilitate their gender expression.

I. *ROPER V. SIMMONS* AND ADOLESCENT MATURITY

In *Roper v. Simmons*,²⁰ the U.S. Supreme Court held that the juvenile death penalty violated the Eighth Amendment's ban on cruel and unusual

Kramer, 455 U.S. 745, 766 (1982) (noting the state's "*parens patriae* interest in preserving and promoting the welfare of the child"). While the *Roper* decision did not explicitly discuss *parens patriae*, the opinion "utilize[d] key established differences between adults and juveniles that bear a striking resemblance to the foundational basis for operation of the *parens patriae* doctrine in the juvenile court system." Sally T. Green, *Prosecutorial Waiver Into Adult Criminal Court: A Conflict of Interests Violation Amounting to the States' Legislative Abrogation of Juveniles' Due Process Rights*, 110 PENN ST. L. REV. 233, 266 (2005).

16. See generally Rhonda Gay Hartman, *AIDS and Adolescents*, 7 J. HEALTH CARE L. & POL'Y 280, 299–301 (2004) (discussing the development of *parens patriae* authority in the context of adolescent decisionmaking).

17. See Beschle, *supra* note 3, at 40.

18. See *infra* Part III.

19. Cf. Emily A. Bishop, Note, *A Child's Expertise: Establishing Statutory Protection for Intersexed Children Who Reject Their Gender of Assignment*, 82 N.Y.U. L. REV. 531, 566 (2007) (arguing that "each day of forced rearing in an assigned gender role with which one does not identify can inflict severe psychological harm on a child").

20. 543 U.S. 551 (2005).

punishment.²¹ Surveying the laws of the fifty states, the Court found that a national consensus had developed in opposition to imposing the death penalty for crimes committed by offenders younger than eighteen years old.²² The Court reaffirmed its prior holding that “[c]apital punishment must be limited to those offenders . . . whose extreme culpability makes them ‘the most deserving of execution.’”²³ The Court then determined that few if any juveniles could be classified among the most culpable offenders,²⁴ and that nothing short of a categorical rule would protect insufficiently culpable youth against inappropriate imposition of the death penalty.²⁵ The Court found “confirmation” for its decision in international law, noting that the United States was “the only country in the world that continue[d] to give official sanction to the juvenile death penalty.”²⁶

The Court’s assessment of juvenile culpability rested on its view of adolescent maturity. The Court identified three general characteristics of adolescence that weighed against classifying juveniles among the most culpable offenders.²⁷ First, adolescents more often exhibit “a lack of maturity and an underdeveloped sense of responsibility” than adults, which results in “impetuous and ill-considered actions and decisions.”²⁸ Second, youth are “more vulnerable or susceptible to negative influences and outside pressures, including peer pressure,” in part because of their limited “control . . . over their own environment.”²⁹ Third, “the character of a juvenile is not as well formed as that of an adult.”³⁰

The Court rejected the argument that these adolescent characteristics could be evaluated as mitigating factors on a case-by-case basis, determining that nothing short of a categorical rule would adequately protect less-culpable youth from the unjust imposition of capital punishment.³¹ The Court reasoned that “[a]n unacceptable likelihood exists that the brutality or cold-blooded nature of any particular crime would overpower mitigating arguments based on youth as a matter

21. *Id.* at 578.

22. *Id.* at 564–67.

23. *Id.* at 568 (quoting *Atkins v. Virginia*, 536 U.S. 304, 319 (2002)).

24. *Id.* at 569.

25. *Id.* at 572–73.

26. *Id.* at 575. The Court also noted that the United States was one of only two countries worldwide that had not ratified a treaty expressly prohibiting imposition of the death penalty for crimes committed by juvenile offenders. *Id.* at 576.

27. *Id.* at 569–70.

28. *Id.* at 569 (quoting *Johnson v. Texas*, 509 U.S. 350, 367 (1993)).

29. *Id.*

30. *Id.* at 570.

31. *Id.* at 572–73.

of course, even where the juvenile offender's objective immaturity, vulnerability, and lack of true depravity should require a sentence less severe than death."³²

In describing its view of adolescence, the Court cited to four of its own prior cases involving capital punishment and young offenders.³³ The Court also drew support for its view from the fact that "almost every State prohibits those under 18 years of age from voting, serving on juries, or marrying without parental consent."³⁴ In dissent, Justice Scalia argued that the laws cited by the majority were "patently irrelevant" because the question of whether a youth was "mature enough to drive carefully, to drink responsibly, or to vote intelligently" was not equivalent to the question of whether the youth was "mature enough to understand that murdering another human being is profoundly wrong."³⁵

Despite the majority's gestures towards a unified view of adolescence, the American legal system expresses a highly inconsistent view of adolescent maturity and decisionmaking capacity.³⁶ The weight afforded adolescent decisionmaking varies across areas of law, ranging from categorical incapacity,³⁷ to case-by-case analysis with presumptions of capacity or incapacity,³⁸ to categorical capacity.³⁹ Because of this variation, the implications of the *Roper* Court's view of adolescence for other areas of law, if any, cannot be determined in the abstract, but must be considered within the context of a particular adolescent decision being evaluated. One such context involves transgender youth seeking to obtain hormones without parental consent, a situation explored in Part II.

32. *Id.* at 573.

33. *Id.* at 569–75 (citing *Johnson*, 509 U.S. 350 (nineteen-year-old defendant); *Stanford v. Kentucky*, 492 U.S. 361 (1989) (seventeen-year-old defendant); *Thompson v. Oklahoma*, 487 U.S. 815 (1988) (fifteen-year-old defendant); *Eddings v. Oklahoma*, 455 U.S. 104 (1982) (sixteen-year-old defendant)).

34. *Id.* at 569. *But see* *Cunningham*, *supra* note 3, at 310–11 ("[T]hose Justices who supported a categorical determination of incapacity did not give major discussion in their opinions to the common law court decisions in the areas of contract law, property, and torts. . . . To the extent that the Court tried to reconcile the inconsistent view of capacity under law, they were doing so with respect to their own jurisprudence only.").

35. *Roper*, 543 U.S. at 619 (Scalia, J., dissenting) (quoting *Stanford*, 492 U.S. at 374).

36. *See, e.g.*, Donald L. Beschle, *The Juvenile Justice Counterrevolution: Responding to Cognitive Dissonance in the Law's View of the Decision-Making Capacity of Minors*, 48 EMORY L.J. 65 (1999); *Cunningham*, *supra* note 3.

37. *Cunningham*, *supra* note 3, at 287–323 (referring to multiple areas of categorical incapacity, including alcohol, contracts, and voting).

38. *Id.* at 323–53 (describing individual determinations of capacity in a wide range of contexts, including marriage and prosecutorial waiver).

39. *Id.* at 354–64 (noting categorical capacity in situations ranging from mental health treatment to legislative waiver).

II. THE IMPORTANCE OF DECISIONMAKING AUTONOMY FOR TRANSGENDER YOUTH

Transgender youth are those adolescents “whose gender identity or expression does not conform to the social expectations for their assigned sex at birth.”⁴⁰ There is no one way of being transgender, and transgender people make a range of choices regarding their bodies and their gender expression.⁴¹ Some transgender youth seek access to masculinizing or feminizing hormones as a means of facilitating their gender expression.⁴² As this Part describes, for transgender adolescents who do seek to obtain hormones, that access can be tremendously important in helping them to overcome the intense hostility they face on a regular basis. However, barriers imposed by the medical establishment and the legal system make it extremely difficult for transgender youth to obtain hormones.

40. Paisley Currah et al., *Introduction to TRANSGENDER RIGHTS* at xiii, xiv (Paisley Currah et al. eds., 2006). Sex refers to the male or female designation assigned to an individual at birth, usually based on external genitalia. Julie A. Greenberg, *The Roads Less Traveled: The Problem With Binary Sex Categories*, in *TRANSGENDER RIGHTS*, *supra*, at 51, 52. Gender identity, in contrast, refers to an individual’s “internal, deeply felt sense of being either male or female, or something other or in between.” Jamison Green, *Introduction to PAISLEY CURRAH & SHANNON MINTER, TRANSGENDER EQUALITY: A HANDBOOK FOR ACTIVISTS AND POLICYMAKERS* 1, 3 (2000), available at <http://www.thetaskforce.org/downloads/reports/reports/TransgenderEquality.pdf>. This Comment uses transgender as an umbrella term encompassing a wide variety of gender nonconformances, including transsexual and genderqueer identities. See Susan Stryker, *(De)Subjugated Knowledges: An Introduction to Transgender Studies*, in *THE TRANSGENDER STUDIES READER* 1, 4 (Susan Stryker & Stephen Whittle eds., 2006) (discussing the evolution of the word “transgender” and its current usage as “a ‘pangender’ umbrella term”).

41. Dylan Wade, *Expanding Gender and Expanding the Law: Toward a Social and Legal Conceptualization of Gender That Is More Inclusive of Transgender People*, 11 MICH. J. GENDER & L. 253, 268–70 (2005). “Some transgender people undergo no medical care related to their expression of a gender identity that differs from their birth-assigned sex,” while “[o]thers undergo only hormone therapy treatment or any of a number of surgical procedures.” Dean Spade, *Documenting Gender*, 59 HASTINGS L.J. 731, 754 (2008). Among those who do seek medical care to facilitate their gender expression, masculinizing and feminizing hormones are the most common approach. *Id.* at 754–55.

42. Hormones known as blockers suppress the development of secondary sex characteristics that would otherwise result from pubertal changes. Walter Meyer III et al., *The Harry Benjamin International Gender Dysphoria Association’s Standards of Care for Gender Identity Disorders, Sixth Version*, reprinted in 13 J. PSYCHOL. & HUM. SEXUALITY 1, 10 (2001). Masculinizing and feminizing hormones, in contrast, cause transgender youth to develop secondary sex characteristics aligned with their gender identity. *Id.* The effects of blockers are fully reversible, while the effects of masculinizing and feminizing hormones are partially reversible. *Id.* Unless otherwise noted, the discussion in this Comment refers to masculinizing and feminizing hormones rather than blockers.

A. Challenges Facing Transgender Youth

Transgender youth face an overwhelming level of discrimination and violence. A high percentage experience verbal harassment, physical harassment, and assault in the school setting.⁴³ Teachers and administrators frequently fail to protect transgender youth,⁴⁴ and sometimes even participate in or contribute to the harassment.⁴⁵ Rather than providing a refuge from this mistreatment, the home often represents an additional site of harassment and violence: Parental abuse of transgender youth is widespread.⁴⁶ When youth come out as transgender, their parents often kick them out of the house.⁴⁷

As a result of parental abuse and abandonment, transgender youth are overrepresented in the foster care system.⁴⁸ The system consistently fails to meet the emotional and physical needs of transgender youth, whose experiences in foster care continue to be marked by discrimination and violence from other residents and from staff.⁴⁹ Unable to find support from either their families or the foster care system, many transgender youth become homeless.⁵⁰

43. JOSEPH G. KOSCIW & ELIZABETH M. DIAZ, GAY, LESBIAN AND STRAIGHT EDUC. NETWORK, THE 2005 NATIONAL SCHOOL CLIMATE SURVEY: THE EXPERIENCES OF LESBIAN, GAY, BISEXUAL AND TRANSGENDER YOUTH IN OUR NATION'S SCHOOLS 61–62 (2006), available at http://www.glsen.org/binary-data/GLSEN_ATTACHMENTS/file/585-1.pdf (finding that more than half of transgender students surveyed experienced verbal harassment, more than half experienced physical harassment, and a third were assaulted at school); see also Shield, *supra* note 11, at 368–72; Dean Spade, *Compliance Is Gendered: Struggling for Gender Self-Determination in a Hostile Economy*, in TRANSGENDER RIGHTS, *supra* note 40, at 217, 219 (“[H]arassment and violence against trans and gender nonconforming students is rampant in schools, and many drop out before finishing or are kicked out.”).

44. HUMAN RIGHTS WATCH, HATRED IN THE HALLWAYS, ch. 7 (2001), available at <http://www.hrw.org/reports/2001/uslgbt/toc.htm> (“The most common response to harassment [of LGBT students], according to the students we interviewed, is no response. . . . We heard numerous accounts of teachers and administrators who refused to act to protect lesbian, gay, bisexual, and transgender students out of the belief that they get what they deserve.”).

45. *Id.* (describing accounts of “teachers and administrators who actually took part in harassing students because of their actual or perceived sexual orientation or gender identity”); Patience W. Crozier, *Forcing Boys to Be Boys: The Persecution of Gender Non-Conforming Youth*, 21 B.C. THIRD WORLD L.J. 123, 131–32 (2001) (book review) (describing the “abusive and prejudicial treatment” experienced by gender non-conforming youth in schools, and finding that some schools “actively create a hostile environment for these students”); see also Paisley Currah, *Gender Pluralisms Under the Transgender Umbrella*, in TRANSGENDER RIGHTS, *supra* note 40, at 3, 7–8 (describing examples of school officials punishing youth for deviating from traditional gender boundaries).

46. See Christian Burgess, *Internal and External Stress Factors Associated With the Identity Development of Transgendered Youth*, J. GAY & LESBIAN SOC. SERVS., No. 3/4, 1999, at 35, 42; Spade, *supra* note 43, at 219.

47. Shield, *supra* note 11, at 372; Spade, *supra* note 43, at 219.

48. Shield, *supra* note 11, at 373.

49. Shield, *supra* note 11, at 373–75; Spade, *supra* note 43, at 219.

50. Shield, *supra* note 11, at 375; Spade, *supra* note 43, at 219; see also NICHOLAS RAY ET AL., LESBIAN, GAY, BISEXUAL AND TRANSGENDER YOUTH: AN EPIDEMIC OF HOMELESSNESS 58 (2007), available at <http://www.thetaskforce.org/downloads/HomelessYouth.pdf> (“Transgender youth

Transgender adolescents must navigate a hostile world with little familial or institutional support,⁵¹ usually without a network of peers who share their identity.⁵² Experiencing high levels of external conflict without an adequate support structure leads to feelings of isolation, helplessness, and despair.⁵³ Transgender youth suffer from high rates of depression, and commit suicide at alarming rates.⁵⁴ According to some studies, more than half of all transgender youth attempt to kill themselves.⁵⁵

Research has found that “[d]epression, anxiety, and suicidality” among transgender people are “commonly tied to the unmet need for gender-confirming medical care.”⁵⁶ Denying access to hormones “represents a refusal to recognize the humanity of trans people, frustrates their ability to self-determine their gender, infringes on their personal autonomy, and adds to the cumulative effects of the constant discrimination they confront.”⁵⁷ On the other hand, hormone

are disproportionately represented in the homeless population. More generally, some reports indicate that one in five transgender individuals need or are at risk of needing homeless shelter assistance.”).

51. See Crozier, *supra* note 45, at 130 (“Because of the intense homophobia and transphobia present throughout American society, gender non-conforming youth comprise a minority youth population invisible to family, peers, and schools—the main support systems for youth.”).

52. Burgess, *supra* note 46, at 40 (“While many adolescents find solace . . . in peer groups where they can share stories of their physical trials and tribulations, transgender youth seldom have such support systems.”); cf. John Alan Cohan, *Parental Duties and the Right of Homosexual Minors to Refuse “Reparative” Therapy*, 11 BUFF. WOMEN’S L.J. 67, 71 (2002–2003) (“What makes gay and lesbian youth different from other minorities is that they do not, for the most part, grow up with people like themselves.”).

53. Burgess, *supra* note 46, at 35–36 (“In addition to undergoing the regular perils of adolescence, [transgender youth] face an extraordinary amount of additional internal and external pressures associated with their identity development, centered around a society that is overwhelmingly uncomfortable with gender non-conformity. When left unchecked, these pressures amount to extreme isolation and confusion, which can lead to an array of bio-psycho-social problems”); cf. Cohan, *supra* note 52, at 71 (discussing the psychological effects of isolation on gay and lesbian youth, whose “isolation becomes more encompassing if they live in a homophobic social environment”).

54. Shield, *supra* note 11, at 384; *Crossing to Safety: Transgender Health and Homelessness*, HEALING HANDS (Health Care for the Homeless Clinicians’ Network, Nashville, Tenn.), June 2002, at 2 (“High rates of . . . depression, anxiety, and suicide among transgender people attest to the psychological burden of discrimination, isolation, and victimization.”); see also Burgess, *supra* note 46, at 41 (“Because of the internalization of negative attitudes toward gender non-conformity, transgender youth are at an increased risk for low self-esteem, which may manifest itself through depression, substance abuse, self-mutilation and/or suicide.”); Judith Butler, *Undiagnosing Gender*, in TRANSGENDER RIGHTS, *supra* note 40, at 274, 294 (“[T]he cruelty of adolescent peer pressure on transgendered youth can lead to suicide.”).

55. Warren J. Blumenfeld & Laurie Lindop, *Gay, Lesbian, Bisexual, Transgender Youth Suicide*, http://www.outproud.org/article_suicide.html (last visited Sept. 26, 2008) (describing a study finding that “[f]ifty-three percent of transsexuals surveyed had made suicide attempts”); Paul Cody, Counseling Ctr., Univ. of N. H., *Suicide and Gay, Lesbian, Bisexual and Transgender Youth*, <http://www.unhcc.unh.edu/resources/glbtsuicide.html>; see also *Sundstrom v. Frank*, No. 06-C-112, 2007 WL 3046240, at *3 n.2 (E.D. Wis. Oct. 15, 2007).

56. Spade, *supra* note 41, at 755 & n.110.

57. Pooja S. Gehi & Gabriel Arkles, *Unraveling Injustice: Race and Class Impact of Medicaid Exclusions of Transition-Related Health Care for Transgender People*, 4 SEXUALITY RES. & SOC. POL’Y 7, 12 (2007).

treatment has been shown to alleviate depression,⁵⁸ reducing the risk of suicide in transgender youth.⁵⁹ The opportunity to take hormones can facilitate gender self-determination, validating transgender youths' assertion of their gender identities and providing them with a greater degree of control over the gender co-constructed through their daily interactions.⁶⁰ Exerting that control can provide transgender adolescents with a sense of agency, reducing feelings of helplessness and despair.

B. Obstacles to Obtaining Hormones

Despite the benefits of hormones for those who choose to take them, transgender youth seeking access to hormones encounter a number of barriers.⁶¹ Many transgender adolescents cannot overcome these obstacles. As a result, some obtain hormones from sources other than medical professionals.⁶² Those hormones may be of poor quality or inappropriate dosage,⁶³ or they may be taken with reused, infected needles.⁶⁴ Street hormones thus create the potential for serious health problems, and in the case of HIV transmission, may even prove fatal.

58. Meyer et al., *supra* note 42, at 10 (“Hormonal treatment can often alleviate anxiety and depression in people without the use of additional psychotropic medications.”); Shield, *supra* note 11, at 383–84.

59. Cf. Gehi & Arkles, *supra* note 57, at 13 (“Research . . . has shown that transition-related health care is an effective treatment for ameliorating . . . suicidal tendencies.”).

60. Cf. HENRY RUBIN, *SELF-MADE MEN: IDENTITY AND EMBODIMENT AMONG TRANSSEXUAL MEN* 11 (2003) (“[B]odies, especially secondary sex characteristics, facilitate intra-and inter-subjective recognition of a core (gendered) self. Bodies matter for subjects who are routinely misrecognized by others and whose bodies cause them great emotional and physical discomfort.”); Burgess, *supra* note 46, at 45 (“Just a simple validation of who the individual is, including his/her gender identity, can make all the difference in the world for [a transgender] person.”).

61. SYLVIA RIVERA LAW PROJECT, *YOUR HEALTHCARE RIGHTS: TRANS YOUTH IN NEW YORK* 4 (2006), available at http://www.srlp.org/files/HC.youth_.pdf (“Trans youth often have a very hard time getting necessary healthcare. Hormones are especially hard for people under the age of eighteen to get.”).

62. Burgess, *supra* note 46, at 41; *FIERCE! and SRLP Team Up: Safe Hormone Access for Teens!*, SYLVIA RIVERA LAW PROJECT NEWSLETTER (Sylvia Rivera Law Project, New York, N.Y.), Feb. 2004, at 1 [hereinafter “SRLP NEWSLETTER”]; Jessica M. Xavier, Gender Ed. & Advocacy, The Washington Transgender Needs Assessment Survey, <http://www.glaa.org/archive/2000/tgneedsassessment1112.shtml> (last visited Oct. 17, 2008) (reporting the results of a survey in which 58 percent of transgender respondents had “acquired hormones from friends or on the street”).

63. Shield, *supra* note 11, at 381; see also SRLP NEWSLETTER, *supra* note 62 (noting that “improper dosage of hormones can result in stroke and liver damage”).

64. Jordan W. Edwards et al., *Male-to-Female Transgender and Transsexual Clients of HIV Service Programs in Los Angeles County, California*, 97 AM. J. PUB. HEALTH 1030, 1030 (2007) (discussing the high risk of HIV transmission that results from transgender individuals injecting hormones with used needles); see also SRLP NEWSLETTER, *supra* note 62 (noting that “unsanitary [hormone] intake conditions put transgender teens at the risk of contracting HIV and Hepatitis”).

1. Barriers Imposed by the Medical Establishment

Hormones cannot be lawfully obtained without a prescription from a medical professional, posing an obstacle for transgender persons of all ages who experience pervasive discrimination by the medical community.⁶⁵ For example, some health care professionals, acting out of fear or prejudice, refuse to provide transgender persons with any medical services.⁶⁶ Other physicians provide hormones only according to their own narrow conceptions of what constitutes an appropriate expression of transgender identity.⁶⁷ Even trans-friendly practitioners may lack the knowledge and training needed to provide hormones or other services that are specifically related to an individual's gender identity.⁶⁸

For transgender youth, access to hormones is most often denied not through the decision of an individual physician, but through a medical facility's blanket prohibition on providing hormones to anyone under the age of eighteen.⁶⁹ Such policies preclude individualized assessments of whether hormones are appropriate or necessary for a particular transgender youth, and conflict with internationally accepted standards of care providing that "[a]dolescents may be eligible to begin masculinizing or feminizing hormone therapy as early as age 16."⁷⁰

65. SHANNON MINTER & CHRISTOPHER DALEY, *TRANS REALITIES: A LEGAL NEEDS ASSESSMENT OF SAN FRANCISCO'S TRANSGENDER COMMUNITIES*, at I.A (2003) (describing the results of a survey by the National Center for Lesbian Rights and the Transgender Law Center in which "[o]ver 30% of respondents report[ed] that they ha[d] been discriminated against while trying to access health care"); Shield, *supra* note 11, at 380.

66. MINTER & DALEY, *supra* note 65, at II.A.5 (describing the difficulties transgender people face in "finding a doctor who is familiar and comfortable providing primary health care services to a transgender person"); Green, *supra* note 40, at 11–12 ("Many providers treat trans people only with great reluctance, sometimes pointedly harassing them and embarrassing them . . .").

67. See Vade, *supra* note 41, at 271 n.62 ("Transgender women were refused hormones because they did not go to the doctor in a skirt. Transgender men were refused hormones because they disclosed to their doctor that they are gay. Disclosing to one's doctor that one is neither female nor male and obtaining hormones is virtually impossible." (citing interviews, in San Francisco Bay Area, Cal. (2002))).

68. MINTER & DALEY, *supra* note 65, at II.A.5 ("[Transgender] people . . . face a challenge in finding a health care provider who can competently provide services. . . . Even if a particular doctor has the cultural competency to provide good services, no guarantee exists that the doctor's staff and business partners share this competency."); SYLVIA RIVERA LAW PROJECT, *supra* note 61 (noting that some doctors refuse to provide transgender identity-related services because of lack of expertise).

69. Voicemail From Dean Spade, Assistant Professor of Law, Seattle Univ. (Oct. 3, 2008); see, e.g., Fenway Cmty. Health Transgender Health Program, Protocol for Hormone Therapy 2 (Sept. 2007), available at http://www.fenwayhealth.org/site/DocServer/Fenway_Protocols.pdf?docID=2181 ("Candidates [for hormonal treatment] must be at least 18 years of age and able to give informed consent.").

70. Meyer et al., *supra* note 42, at 14.

If a transgender youth does manage to find a nonprejudiced and qualified health care provider working at a facility without a blanket prohibition on prescribing hormones to adolescents, the problem of payment remains.⁷¹ Many transgender people lack health insurance.⁷² Even if a transgender youth has insurance, many plans do not provide coverage for hormone treatment.⁷³ Transgender youth often lack the financial resources to pay out-of-pocket.⁷⁴

Medical treatment protocols create another barrier for transgender youth seeking to obtain hormones. Of the medical professionals willing to prescribe hormones, many follow the Harry Benjamin International Gender Dysphoria Association (HBIIGDA) Standards of Care,⁷⁵ which require a diagnosis of gender identity disorder (GID) prior to treatment.⁷⁶ The HBIIGDA standards set a minimum age of sixteen for the prescription of masculinizing or feminizing hormones.⁷⁷ To obtain a prescription from a physician who follows the HBIIGDA standards, a transgender adolescent must provide a documentation letter written by a mental health professional.⁷⁸ The letter must address at least seven specific points, including the duration and type of

71. See Spade, *supra* note 43, at 228 (“[M]edical care of all kinds, but particularly gender-related medical care, remains extremely inaccessible to most low-income gender-transgressive people.”).

72. Vade, *supra* note 41, at 258 n.14 (citing a number of studies, all of which indicate that only about half of transgender respondents have health insurance).

73. JAMISON GREEN, BECOMING A VISIBLE MAN 91 (2004) (“[H]ormones . . . are some of the most frequently prescribed substances because hormonal imbalances or deficiencies are extremely common. Yet it’s only transsexual people whose hormonal imbalances or deficiencies are restricted from treatment under insurance plans.”); MINTER & DALEY, *supra* note 65, at II.A.5 (“[M]any health insurance plans, HMO plans, and employee benefits plans will deny coverage of hormones, surgery, and other procedures that are a part of a person’s transition.”); Shield, *supra* note 11, at 380.

74. Cf. Abigail English & Madlyn Morreale, *A Legal and Policy Framework for Adolescent Health Care: Past, Present, and Future*, 1 HOUS. J. HEALTH L. & POL’Y 63, 106 (2001) (“[F]ew families and even fewer adolescents can afford to pay out-of-pocket for all the health care they need.”).

75. See Leslie I. Lax, *Is the United States Falling Behind? The Legal Recognition of Post-Operative Transsexuals’ Acquired Sex in the United States and Abroad*, 7 QUINNIPAC HEALTH L.J. 123, 125–26 (2003); see also Meyer et al., *supra* note 42.

76. Meyer et al., *supra* note 42, at 2 (noting that the “clinical threshold” for treatment occurs “[w]hen dissatisfied individuals meet specified criteria in one of two official nomenclatures—the International Classification of Diseases-10 (ICD-10) or the Diagnostic and Statistical Manual of Mental Disorders—Fourth Edition (DSM-IV)—[and therefore] they are formally designated as suffering from a gender identity disorder (GID)”); see also Mark Blankenship, *Affirming Transgender Care*, THE ADVOCATE, Apr. 11, 2006, at 46 (“Transgender people hoping to begin their physical transition are often denied hormone therapy until they endure a lengthy psychological evaluation that proves they suffer from gender identity disorder. The process alienates some trans people, discouraging them from seeking basic medical attention.”).

77. Meyer et al., *supra* note 42, at 14.

78. *Id.* at 10.

therapy that the youth has received.⁷⁹ The physician will not prescribe hormones unless the youth has been in therapy for at least six months.⁸⁰

The GID diagnosis and treatment protocols reflect a medical view of transgender persons that is controversial within transgender communities.⁸¹ Among other problems, this approach treats transgender status as a disorder rather than a variation in human identity.⁸² This Comment does not argue that the medicalized view of transgender persons is appropriate,⁸³ but rather that it creates additional barriers by governing interactions between transgender youth and the medical personnel who control their access to hormones.⁸⁴

Thus, to overcome the obstacles imposed by the medical establishment, a transgender youth must have effective insurance or an independent source of funds, find a qualified and trans-friendly health care provider working at a facility without a blanket prohibition on prescribing hormones to adolescents, be evaluated for and obtain a GID diagnosis, undergo counseling, and satisfy the other restrictions imposed by the medical treatment protocols. If the adolescent manages to clear all of these hurdles, informed consent laws then pose an additional barrier.

2. Restrictions Created by Informed Consent Laws

Physicians cannot provide medical services without a patient's informed consent. Because minors are considered unable to consent on their own behalf, the general rule is that they must obtain parental consent for medical care.⁸⁵

79. *Id.*

80. *Id.* at 14.

81. See, e.g., Butler, *supra* note 54, at 275 (“[O]n the one hand, the [GID] diagnosis continues to be valued because it facilitates an economically feasible way of transitioning. On the other hand, the diagnosis is adamantly opposed because it continues to pathologize as a mental disorder what ought to be understood instead as one among many human possibilities of determining one’s gender for oneself.”).

82. See GID Reform Advocates, <http://www.gidreform.org> (last visited Sept. 26, 2008) (“GID literally implies a ‘disordered’ gender identity.”).

83. See Dean Spade, *Resisting Medicine, Re/modeling Gender*, 18 BERKELEY WOMEN’S L.J. 15, 23 (2003) (criticizing the medicalization of transgender identity and describing “the gulf between trans community understandings of our bodies, our experiences, and our liberation, and the medical interpretations of our lives”).

84. See Vade, *supra* note 41, at 286–87 n.107 (“The [HBIGDA] ‘Standards of Care’ outline who is deemed a real transgender person and who is not, who gets care and who does not. The Standards give doctors the power to make that determination.”).

85. Cunningham, *supra* note 3, at 317 (“Minors are categorically incapable of giving informed consent for most medical procedures. . . . [T]he power to decide when a child will have a medical procedure vests with the child’s lawful guardian, usually a parent.”). A medical professional who provides care to a minor without informed consent from a lawful guardian may face tort liability for battery. See Sarah Katz, *When the Child Is a Parent: Effective Advocacy for Teen Parents in the Child Welfare System*, 79 TEMP. L. REV. 535, 545 (2006).

Parents of transgender youth are often abusive or absent,⁸⁶ so this requirement makes it extremely difficult for adolescents to obtain transition-related medical care.

Transgender youth may be able to overcome the obstacle posed by informed consent laws through the mature minor doctrine, which some states have adopted as an exception to the parental consent requirement.⁸⁷ The mature minor doctrine allows a health care professional to provide treatment without parental consent if the youth is sufficiently mature to make the medical decision on his or her own behalf.⁸⁸ The doctrine varies across states both in its origin⁸⁹ and in its details.⁹⁰ For example, the Illinois common law version of the mature minor doctrine requires that the youth be “mature enough to appreciate the consequences of her actions, and . . . mature enough to exercise the judgment of an adult.”⁹¹ A West Virginia statute defines a mature minor as “a person less than eighteen years of age who has been determined by a qualified physician, a qualified psychologist or an advanced nurse practitioner to have the capacity to make health care decisions.”⁹²

Importantly, all variations of the mature minor doctrine allow a minor to consent to medical treatment without prior permission from a court.⁹³ This means that, unlike judicial bypass procedures under abortion statutes

86. Burgess, *supra* note 46, at 42; Shield, *supra* note 11, at 372; Spade, *supra* note 43, at 219.

87. Cunningham, *supra* note 3, at 324; see Arshagouni, *supra* note 9, at 336–39; Rhonda Gay Hartman, *Adolescent Autonomy: Clarifying an Ageless Conundrum*, 51 HASTINGS L.J. 1265, 1310–17 (2000). The arguments in this Comment supporting a presumption in favor of access in states that have adopted the mature minor doctrine also support the adoption of the doctrine in states that have yet to do so. For further arguments in favor of expanding of the mature minor doctrine, see Shield, *supra* note 11.

Some states have adopted additional exceptions to parental consent that may be applicable to transgender youth. See generally Rhonda Gay Hartman, *Coming of Age: Devising Legislation for Adolescent Medical Decision-Making*, 28 AM. J.L. & MED. 409, 416–22 (2002) (surveying state legislation allowing adolescents to exercise legal autonomy over medical decisionmaking). For example, in some states homeless youth may consent to their own medical care. Shield, *supra* note 11, at 431. Unfortunately, because many transgender adolescents are homeless, this exception is especially relevant to transgender youth seeking hormone treatment. Shield, *supra* note 11, at 375; Spade, *supra* note 43, at 219.

88. See Cunningham, *supra* note 3, at 324 (“The mature minor doctrine essentially carves out a new category of adolescents who, on a case-by-case basis, may have the capacity to give consent for medical treatment.”). In some states, a strand of the emancipated minor doctrine allows medical care without parental consent based on the same general standard. Arshagouni, *supra* note 9, at 335.

89. Some states have adopted the mature minor doctrine by statute, and others through common law. English & Morreale, *supra* note 74, at 71–72.

90. See *id.* at 81–82 (describing variations among minor consent laws in different states).

91. *In re E.G.*, 549 N.E.2d 322, 327–28 (Ill. 1989).

92. W. VA. CODE ANN. § 16-30-3(o) (LexisNexis 2006).

93. See, e.g., *id.* (allowing medical professionals to determine a minor’s capacity to consent to treatment without requiring court involvement); *Belcher v. Charleston Area Med. Ctr.*, 422 S.E.2d 827, 837 (W. Va. 1992) (discussing the common law version of the mature minor doctrine, and noting that it “places the doctor in the difficult position of making the determination of whether the minor at issue is mature”).

requiring parental consent or notification, judicial involvement is not required. Instead, a medical professional's appropriate evaluation of the minor's decisionmaking ability will immunize her from liability even in the absence of a court order allowing treatment.⁹⁴

When a youth seeks medical care without first obtaining a court order, the allocation of burdens under the mature minor doctrine matters. If a state adopts a presumption in favor of allowing medical treatment, a health care professional can provide services with confidence that a good-faith, appropriately documented judgment of a minor's maturity will be respected.⁹⁵ In contrast, if the state adopts a presumption opposing treatment, the resulting uncertainty may lead medical practitioners to deny treatment in order to avoid liability, even if the health care professional deems the minor to be sufficiently mature.⁹⁶ Fear of liability may be one reason that many health care facilities have adopted blanket prohibitions on adolescent access to hormones.⁹⁷ Those policies prevent transgender youth and their physicians from determining an appropriate course of treatment based on the individual adolescent's needs and maturity level. Reducing legal uncertainty could encourage medical clinics to revise their treatment protocols, replacing blanket prohibitions with individualized assessments. Thus, a presumption in favor of allowing transgender youth to obtain hormones under the mature minor doctrine would help to reduce the existing barriers to access, mitigating the well-documented harms experienced by transgender youth.⁹⁸

94. See English & Morreale, *supra* note 74, at 72 ("According to the mature minor doctrine, a physician will not be liable simply on the basis of failing to obtain parental consent when providing non-negligent care that is both low risk and within the mainstream of medical opinion to a minor who is capable of giving informed consent to the care and who does so voluntarily.")

95. *Belcher*, 422 S.E.2d at 837–38 n.14 (noting that in a case of conflict, "the physician's good faith assessment of the minor's maturity level would immunize him or her from liability for the failure to obtain parental consent" and describing the importance of good recordkeeping in such situations).

96. Cf. Note, *Parental Consent Requirements and Privacy Rights of Minors: The Contraceptive Controversy*, 88 HARV. L. REV. 1001, 1005 (1975) ("Apprehension regarding potential liability for providing minors with services absent parental consent persists among physicians and hospitals, for the emancipation and mature minor exceptions call for subtle legal determinations regarding the child's mental capabilities and social milieu that doctors make at their considerable peril. Where uncertainty exists the physician will often refuse to provide nonemergency treatment to minors without obtaining parental consent.")

97. The lack of litigation against physicians and health care facilities that have provided hormones to transgender youth suggests that any such fear is unwarranted. Indeed, "no doctor has been held liable for battery in the past thirty years when treating a patient over age fourteen without parental consent." Lawrence Schlam & Joseph P. Wood, *Informed Consent to the Medical Treatment of Minors: Law and Practice*, 10 HEALTH MATRIX 141, 163 (2000).

98. Such a presumption would not be without precedent. For example, Tennessee adopted a presumption in favor of medical decisionmaking autonomy for youth over the age of fourteen. *Cardwell v. Bechtol*, 724 S.W.2d 739, 749 (Tenn. 1987). The decision was based in part on the Rule of Sevens, which had "been part of the common law for over a century." *Id.* at 744–45 (citing *The Queen v. Smith*, 1 Cox C.C. 260 (1845)). The Rule of Sevens established categorical incapacity for minors under the age

While the mature minor doctrine requires an evaluation of the youth's maturity and decisionmaking ability, it offers little guidance as to how courts should evaluate a medical professional's finding of adolescent maturity.⁹⁹ The lack of such a standard under this doctrine creates a void, leaving courts without a clear means of resolving a claim against a medical provider that an adolescent lacked sufficient maturity to give informed consent to the medical treatment provided. A court deciding a question of mature minor status in such a case might look to the Supreme Court's discussion of adolescent maturity in *Roper v. Simmons*¹⁰⁰ to fill that void. In the context of transgender youth seeking to obtain hormones under the mature minor doctrine, the view of adolescent maturity expressed in *Roper v. Simmons* supports a presumption in favor of access, as Part III explains.

III. APPLYING *ROPER* IN THE CONTEXT OF TRANSGENDER YOUTH SEEKING ACCESS TO HORMONES

As noted, in states adopting the mature minor doctrine, an adolescent can undergo medical treatment without parental consent if a medical professional deems the youth sufficiently mature to make the decision.¹⁰¹ Yet “[c]ourts have spent precious little time trying to define actually what it is to be ‘mature’”¹⁰² under this doctrine, leaving uncertainty as to when courts will respect an adolescent's informed consent to medical treatment. That uncertainty could be resolved by looking to the Supreme Court's analysis in *Roper* of general aspects of adolescent maturity. A reductive, parenthetical view of the *Roper* decision (adolescents are immature) would pose a conceptual obstacle to a finding of sufficient maturity under the mature minor doctrine. A careful, context-specific application of the Court's reasoning indicates that, rather than creating barriers for transgender youth seeking access to hormones, the view of adolescence expressed in *Roper* supports a presumption in favor of respecting a medical provider's decision to provide hormone treatment to a minor without parental consent.

of seven, a rebuttable presumption of no capacity between the ages of seven and fourteen, and a rebuttable presumption of capacity between the ages of fourteen and twenty-one. *Id.* at 745.

99. See *In re E.G.*, 549 N.E.2d 322, 329 (Ill. 1990) (Ward, J., dissenting) (criticizing the Illinois Supreme Court's adoption of the mature minor doctrine because it “does not attempt to state a standard by which ‘mature’ is to be measured by judges in making these important findings”); Arshagouni, *supra* note 9, at 338; Garfield, *supra* note 93, at 93 (noting that scholars have criticized mature minor statutes “because they are ambiguous and do not provide proper guidance to courts for their application”).

100. 543 U.S. 551 (2005).

101. See *supra* Part II.B.2.

102. Arshagouni, *supra* note 9, at 338.

For purposes of argument, this Part adopts the *Roper* Court's view of adolescence in its entirety. It does not attempt either to support or to contest the Court's assertions; other scholars have undertaken those tasks.¹⁰³ Instead, the following discussion assumes that the Court's view will influence legal analysis regardless of its correctness, and seeks to determine the nature of that influence.

A. Characteristics Affecting Adolescent Decisionmaking

The *Roper* Court identified three general characteristics that differentiate youth from adults: impulsivity,¹⁰⁴ susceptibility to peer pressure,¹⁰⁵ and incomplete character formation.¹⁰⁶ Perhaps because the connections are obvious and straightforward, the Court devoted only a few sentences to explaining how those characteristics make adolescents vulnerable to engaging in criminal behavior and limit their culpability for their crimes.¹⁰⁷ In contexts other than illegal activity, each adolescent attribute identified by the *Roper* Court may have less obvious and more complex implications. This Subpart evaluates each identified characteristic of adolescence as it pertains to the legal capacity of transgender youth to consent to hormone treatment. It concludes that impeding access to hormones is more likely to exacerbate than to mitigate the risks flowing from the adolescent characteristics identified by the *Roper* Court.

1. Impulsivity

The *Roper* Court noted that adolescents more often exhibit "a lack of maturity and an underdeveloped sense of responsibility" than adults, which results in "impetuous and ill-considered actions and decisions."¹⁰⁸ In the criminal justice context, adolescent impulsivity suggests that youth may engage in illegal behavior without considering the long-term consequences of their actions. In the context of a transgender youth seeking access to hormones, a court adopting

103. See, e.g., Deborah W. Denno, *The Scientific Shortcomings of Roper v. Simmons*, 3 OHIO ST. J. CRIM. L. 379, 396 (2006) (concluding that "although *Roper* was correct in its result, the Court's use of social science research was, at times, limited and flawed"); Kathryn Lynn Modecki, *Addressing Gaps in the Maturity of Judgment Literature: Age Differences and Delinquency*, 32 LAW & HUM. BEHAV. 78, 78 (2008) (surveying research supporting the proposition that "due to immaturity of judgment, adolescents' antisocial decisions should be viewed through a lens of mitigated criminal culpability").

104. *Roper*, 543 U.S. at 569.

105. *Id.*

106. *Id.* at 570.

107. *Id.* (noting the "susceptibility of juveniles to immature and irresponsible behavior" and explaining why "[t]hese differences [between juveniles and adults] render suspect any conclusion that a juvenile falls among the worst offenders").

108. *Id.* at 569 (quoting *Johnson v. Texas*, 509 U.S. 350, 367 (1993)).

the *Roper* view would evaluate whether adolescent impulsivity leads the youth to take hormones without considering the long-term consequences of the treatment.

Because a transgender youth can lawfully obtain hormones only through consultation with a medical professional,¹⁰⁹ a court could begin this evaluation by considering the process of medical decisionmaking. As a decisionmaking environment, the doctor's office is "more organized, formal, and monitored" than the setting in which a great deal of illegal behavior occurs.¹¹⁰ While the unstructured environment of the street facilitates impulsive behavior, the structured environment of a doctor's office fosters reflection and reasoned analysis.¹¹¹ Moreover, the requirement that physicians obtain informed consent from all patients bolsters patients' decisionmaking processes:

[T]he patient's healthcare provider will inform her of . . . the available treatments and alternatives, and the risks and rewards of her decision to pursue a particular course of treatment or no treatment at all. . . . As she seeks to make a decision, she will have a knowledgeable adult at her disposal from whom she can seek advice and counsel about any given course of action.¹¹²

Thus, multiple aspects of the medical decisionmaking environment ensure consideration of long-term consequences and guard against impulsive decisions.

The argument that existing safeguards deter impulsive medical decisions by adolescent patients has been made persuasively in the context of abortion,¹¹³ and other considerations add to its strength in the context of transgender youth seeking hormone treatment. Transgender youth have lived with the circumstance of their assigned sex since birth, while pregnant adolescents have lived with the circumstance of their pregnancy for a few months at most. Taking hormones is a process that occurs over time, rather than a single procedure.¹¹⁴ Thus, the decision to seek hormones, and the course of treatment itself, occur across an unavoidably longer time frame than the abortion decision and procedure. The lengthy time frame creates a strong likelihood that a transgender youth seeking hormones has fully considered the consequences of the decision.

109. See generally *supra* Part II.B.1.

110. Mutcherson, *supra* note 3, at 959.

111. Cf. *id.* at 929 ("[I]t is logical to conclude that the decision-making process in formal healthcare settings leads to better decisions that the law should support than is the case in the informal settings in which young people decide to participate in criminal activities.").

112. *Id.* at 962.

113. See *id.*

114. See Meyer et al., *supra* note 58, at 20 ("The maximum physical effects of hormones may not be evident until two years of continuous treatment.").

The Gender Identity Disorder (GID) medical treatment protocols impose additional constraints on the physician-patient interaction and create delays between the initial decision to seek hormones and their eventual attainment.¹¹⁵ For example, a physician following the Harry Benjamin International Gender Dysphoria Association (HBIIGDA) Standards of Care will not prescribe hormones for an adolescent until the youth has received at least six months of counseling.¹¹⁶ A court would not have to accept HBIIGDA's problematic and controversial medicalized view of transgender identity as a disorder in order to recognize that the barriers created by GID treatment protocols create additional safeguards against impulsive decisions.

Courts should also recognize that many youth can obtain hormones on the street, through nonmedical sources, without the delays imposed by treatment protocols and informed consent restrictions.¹¹⁷ A youth who instead seeks access through lawful means has shown an ability to consider long-term consequences by choosing the lengthier but medically safer path over the quicker and more dangerous option. On the other hand, denying access through medical channels could cause a youth to seek hormones by other means, putting the youth's health at risk.¹¹⁸

Existing safeguards adequately ensure that adolescent impulsivity will not lead a transgender youth to obtain hormones without considering the long-term consequences, but denying access could trigger a decision to seek hormones through less safe, nonmedical sources. Thus, a court adopting the *Roper* Court's view of adolescence should not consider adolescent impulsivity to weigh against granting transgender youth access to hormones.

2. Susceptibility to Peer Pressure

The *Roper* Court found that youth are "more vulnerable or susceptible to negative influences and outside pressures, including peer pressure," in part because of their limited "control . . . over their own environment."¹¹⁹ In the criminal justice context, adolescent susceptibility to peer pressure suggests that youth will engage in illegal behavior, not because of their culpability, but because of a desire to impress or fit in with peers. In the context of a

115. See generally *supra* notes 75–80 and accompanying text.

116. Meyer et al., *supra* note 42, at 14.

117. See Burgess, *supra* note 46, at 41; SRLP NEWSLETTER, *supra* note 62, at 1; Xavier, *supra* note 62.

118. See *supra* notes 63–64 and accompanying text (discussing the health risks of hormones obtained and injected on the street).

119. *Roper v. Simmons*, 543 U.S. 551, 569 (2005).

transgender youth seeking access to hormones, a court adopting the *Roper* view would evaluate whether adolescent susceptibility to peer pressure creates a danger that the youth will decide to take hormones, not because of the youth's own sense of identity, but because of a desire to reduce peer disapproval of a nonconforming gender expression.¹²⁰

Peer pressure does adversely affect transgender youth, but not in a way that supports impeding access to hormones. Transgender youth face sustained and extraordinary pressure, from peers as well as adults and institutions, to conform to the gender traditionally associated with their birth-assigned sex.¹²¹ Adolescents succumbing to this pressure would adopt a gender presentation associated with their birth-assigned sex. A transgender adolescent requesting access to hormones does the opposite, seeking a gender presentation aligned with the youth's internal sense of identity. By presenting a nonconforming gender in the face of massive pressure not to do so, a transgender youth exhibits the ability to make decisions that do not depend on peer approval. A transgender youth who seeks to obtain hormones has made that decision in spite of massive external pressure, not because of it.

Some might take a different view of the purpose and effect of taking hormones, interpreting hormones as a means of conforming to peer pressure rather than resisting it. Transgender youth taking hormones might indeed receive fewer negative responses to their assertions of gender identity after developing secondary sex characteristics that are socially aligned with that identity. However, hormones hardly represent the path of least resistance to social acceptance of a gendered self. Moreover, while others' recognition of an individual's gender is part of the construction

120. Shield, *supra* note 11, at 404 (evaluating the concern "that a teenager might seek sex reassignment treatment as a means to fit in better with peers").

121. See *supra* Part II.A; see also Burgess, *supra* note 46, at 35–36 ("[Transgender youth] face an extraordinary amount of . . . internal and external pressures associated with their identity development, centered around a society that is overwhelmingly uncomfortable with gender non-conformity."); cf. Holning Lau, *Pluralism: A Principle for Children's Rights*, 42 HARV. C.R.-C.L. L. REV. 317 (2007) (explaining how assimilation demands lead children to suppress minority characteristics). This pressure comes not only from peers and families, but also from the medical establishment. See Butler, *supra* note 54, at 295 (arguing that the GID diagnosis itself may "act precisely as peer pressure, as an elevated form of teasing, as a euphemized form of social violence"). Pressure to express a gender identity conforming to an individual's birth-assigned sex is enforced through legal sanctions and economic consequences. See Nancy J. Knauer, *Gender Matters: Making the Case for Trans Inclusion*, 6 PIERCE L. REV. 1, 2 (2007) (noting that the law "speaks in terms of 'gender fraud' and carefully polices the binary gender system"); Spade, *supra* note 43, at 221 ("Access to participation in the U.S. economy has always been conditioned on the ability of each individual to comply with norms of gendered behavior and expression, and the U.S. economy has always been shaped by explicit incentives that coerce people into normative gender and sexual structures, identities, and behaviors.").

of that gender, seeking recognition is not equivalent to seeking acceptance or approval, as one author explains:

Most of us are not seeking perfection when measured against external stereotypes; rather, most of us are seeking an internal sense of comfort when measured against our own sense of ourselves. When we undertake a sex transition (which in some cases may look or feel like a gender transition) the purpose, usually, is to facilitate our being perceived socially as the men or women we know ourselves to be, even though we may acquire or retain physical differences from other men or women in the process.¹²²

When individuals who are “routinely misrecognized by others” take steps to “facilitate intra-and inter-subjective recognition of a core (gendered) self,”¹²³ their actions reflect a strong sense of that core self, not a weak response to peer pressure.

The *Roper* Court noted that adolescents’ susceptibility to peer pressure results in part from their relative lack of control over their own environment.¹²⁴ Denying transgender adolescents’ requests for hormones diminishes their control over the most personal and fundamental component of their physical environment: their own bodies.¹²⁵ Diminished control would in turn make transgender youth more vulnerable to the psychological harms caused by external pressures including high levels of peer rejection, harassment, and violence.¹²⁶ Thus, if a court adopts a standard that inhibits access to hormones because of concerns about adolescent susceptibility to external pressure, it would thereby increase the harm caused by that pressure. This would be a perverse result. In contrast, if a court adopts a standard that facilitates access to hormones, it would thereby bolster the youth’s sense of control, reducing his or her vulnerability to the psychological harms that physical and emotional abuse can cause. Thus, facilitating access would generally be a more rational response to concerns about adolescent susceptibility to peer pressure.

Transgender youth seeking access to hormones have proven their ability to overcome peer pressure to conform to the gender traditionally associated with their birth-assigned sex, and allowing access can reduce the harms flowing from that pressure. As a result, in the context of transgender youth

122. GREEN, *supra* note 73, at 90.

123. RUBIN, *supra* note 60, at 11.

124. *Roper*, 543 U.S. at 569.

125. See GREEN, *supra* note 73, at 95 (noting that “the body is where we live” while explaining the author’s decision to take hormones and the benefits he subsequently experienced).

126. See *supra* Part II.A.

seeking access to hormones, a court adopting the *Roper* Court's view of adolescence would find that adolescent vulnerability to peer pressure supports a presumption in favor of access.

3. Incomplete Character Formation

The *Roper* Court noted that “the character of a juvenile is not as well formed as that of an adult.”¹²⁷ In the juvenile justice context, adolescents' incomplete character formation suggests that a youth may engage in illegal behavior as a result of transient adolescent characteristics, but will be more responsive than an adult to rehabilitation later in life.¹²⁸ In the context of a transgender youth seeking access to hormones, a court adopting the *Roper* view would evaluate whether adolescents' incomplete character formation creates the risk that a youth may decide to take hormones based on a transient gender identity, but will identify with his or her birth-assigned sex later in life.¹²⁹

The court should begin this evaluation by recognizing the highly parallel risks of facilitating and inhibiting access to hormones. By taking hormones, transgender adolescents will develop secondary sex characteristics¹³⁰ associated with their gender identity.¹³¹ Some of those changes may not be reversible if a youth later identifies with his or her birth-assigned sex.¹³² If access to hormones is denied, on the other hand, transgender youth will develop unwanted secondary sex characteristics through the ongoing process of puberty.¹³³ That

127. *Roper*, 543 U.S. at 570.

128. *Id.* (“The reality that juveniles still struggle to define their identity means it is less supportable to conclude that even a heinous crime committed by a juvenile is evidence of irretrievably depraved character. . . . Indeed, the relevance of youth as a mitigating factor derives from the fact that the signature qualities of youth are transient . . .” (alterations, citation, and internal quotation marks omitted)).

129. Cf. Emily Buss, *Allocating Developmental Control Among Parent, Child and the State*, 2004 U. CHI. LEGAL F. 27, 41 (“In adulthood, our identities become relatively (though certainly not completely) fixed. Until this occurs, however, we should be slow to put decisionmaking control over matters with long-term consequences into the hands of someone with only short-term identity competence.” (footnote omitted)).

130. Secondary sex characteristics include physical features traditionally associated with males (such as facial hair) or females (such as breasts).

131. See Meyer et al., *supra* note 42, at 20 (describing physical changes induced by masculinizing and feminizing hormones).

132. *Id.* (describing reversible and irreversible effects of hormones); Lax, *supra* note 75, at 127 (“While many of the changes induced by hormone therapy are reversible, there are a number of effects that are irreversible, including breast enlargement in natal males and increased facial and body hair, as well as a deepening of the voice in natal females.”).

133. Shield, *supra* note 11, at 378–79; Henk Asscheman & Louis J.G. Gooren, *Hormone Treatment in Transsexuals*, 5 J. PSYCHOL. & HUM. SEXUALITY 39, 39 (1992) (noting that pubertal exposure to testosterone causes “secondary sex characteristics [such] as sexual hair, deepening of the voice, a muscular build, and . . . greater average height” while pubertal exposure to estrogen causes “breast formation and a fat distribution predominantly around the hips”).

process is often traumatic for transgender youth,¹³⁴ and the resulting secondary sex characteristics will become at least somewhat permanent before the youth reaches adulthood and becomes legally capable of consenting to medical treatment on his or her own behalf.¹³⁵ Thus, either improperly granting or improperly denying access to hormones can leave an individual with unwanted sex characteristics as an adult.

The parallel nature of these risks suggests that inhibiting access will result in more future harm than good unless there is a greater than fifty percent chance that the transgender youth's gender identity will significantly change later in life.¹³⁶ The denominator for this comparison does not include all transgender adolescents, because informed consent laws have a practical effect only on those transgender youth who seek to obtain hormones and overcome all other obstacles to access.¹³⁷ Research suggests that very few transgender youth who overcome the obstacles created by the medical establishment will identify with their birth-assigned sex later in life.¹³⁸ Because most of those transgender adolescents are likely to maintain their gender identity as adults,¹³⁹ impeding access out of concerns about incomplete character formation would result in far more harm than good.

Moreover, the unformed nature of adolescent character creates affirmative arguments in favor of access. Character development requires some level of

134. RUBIN, *supra* note 60, at 94–95 (“After puberty, as the process of sexual development took over their bodies, [the subjects of the study] felt simultaneously disembodied and acutely aware of their bodies. . . . They claim that their experiences of puberty were uniquely different, either quantitatively more painful or qualitatively different in kind, than that of most other adolescents.”).

135. Shield, *supra* note 11, at 362–63 (“[T]he 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 delay on his or her body.”); Asscheman & Gooren, *supra* note 133, at 40 (“The greater height, the shape of the jaws, the size and shape of the hands and feet, and the narrow width of the pelvis can not be redressed [through hormones] once they have reached their final size at the end of puberty.”).

136. This refers only to the future balance of subjective harms from granting or denying access. In contrast, the very fact that the transgender youth seeks access to hormones indicates that the current balance of subjective harms favors access.

137. See *supra* Part II.B.1, for a discussion of the barriers that must be overcome before informed consent laws have a practical effect. This Comment does not assume that any of those barriers are appropriate; rather, it simply recognizes that they exist.

138. Darryl B. Hill et al., *Gender Identity Disorders in Childhood and Adolescence: A Critical Inquiry*, in *SEXUAL AND GENDER DIAGNOSES OF THE DIAGNOSTIC AND STATISTICAL MANUAL (DSM): A REEVALUATION* 7, 15 (Dan Karasic & Jack Drescher eds., 2005) (surveying studies addressing “the validity and reliability of the GID diagnosis for children and adolescents”). In one study, researchers found that they were able to diagnose GID in children accurately 69 to 83 percent of the time. *Id.* In another study, twenty-two adolescents diagnosed with GID obtained irreversible sex reassignment surgery, and none expressed regret one to five years later. Shield, *supra* note 11, at 389.

139. Xavier, *supra* note 62 (reporting the results of a survey in which “90% of those [transgender respondents] currently taking hormones state[d] [that] they plan[ne]d to continue taking them for the rest of their lives”).

freedom with regard to the expression of individual identity.¹⁴⁰ The Supreme Court has acknowledged this relationship between character development and expressive freedom in its decisions extending First Amendment protections to public school students.¹⁴¹ Denying access to hormones restricts transgender adolescents' ability to express their identity, which impedes character development.¹⁴² Granting access, in contrast, facilitates that development.

In evaluating how incomplete character formation affects the appropriateness of allowing transgender youth to obtain hormones, a court should also recognize that while gender is constructed through a complex set of interactions between an individual and the outside world, only the individual has complete access to his or her own gender identity.¹⁴³ Medical and legal professionals must rely on inherently imperfect external indicators of that identity. Thus, transgender adolescents necessarily have greater knowledge than medical or legal professionals regarding the status of their gender identity development and its implications for their future selves.

Adolescents' incomplete character formation requires courts to recognize the ongoing changes in the lives of transgender youth seeking access to hormones. Because a court should address those changes in a way that will most likely allow transgender youth to develop into fully autonomous and self-defined adults, this aspect of adolescence also supports a presumption in favor of access.

140. RUBIN, *supra* note 60, at 11 (reporting "that bodies are a crucial element in personal identity formation and perception" as "one of the most significant findings" of the ethnographic study); *cf.* Lau, *supra* note 121, at 320 (arguing that "the state must avoid socialization policies that undermine a child's ability to develop and express her identity" unless "protecting that exercise [of identity interests] would cause cognizable harms to the child or to others").

141. See, e.g., *Tinker v. Des Moines Indep. Cmty. Sch. Dist.*, 393 U.S. 503, 511 (1969) (finding that "students are entitled to freedom of expression" in part because a contrary holding would allow states to run schools in a manner that would "foster a homogenous people" instead of allowing individual development (quoting *Meyer v. Nebraska*, 262 U.S. 390, 402 (1923))). Lower courts have recognized that conduct related to the expression of an individual's gender identity can constitute speech protected by the First Amendment. See *Kastl v. Maricopa County Cmty. Coll.*, No. Civ. 02-1531PHX-SRB, 2004 WL 2008954, at *9 & n.13 (D. Ariz. June 3, 2004); *Zalewska v. County of Sullivan, N.Y.*, 316 F.3d 314, 320 (2d Cir. 2003) (citing with approval *Doe ex rel. Doe v. Yunits*, No. 001060A, 2000 WL 33162199 (Mass. Super. Oct. 11, 2000)).

142. For some transgender youth, restricting access to hormones may impede social development as well. As one scholar has noted, "[b]ecause transgender youth frequently avoid initiating platonic or romantic relationships before transitioning, they may developmentally fall behind their peers in these areas." Shield, *supra* note 11, at 367.

143. *Cf.* Holly Boswell, *The Transgender Paradigm Shift Toward Free Expression*, in GENDER BLENDING 53, 54 (Bonnie Bullough et al. eds., 1997) ("I used to be amazed that, despite my elaborate explanations, no one could ever quite understand my experience of transgender, until I finally realized that neither have I ever understood what it is to be a man or a woman.").

B. Considerations Affecting Case-by-Case Determinations
of Adolescent Decisionmaking

Because the adolescent characteristics identified by the *Roper* Court suggest that denying transgender youth access to hormones is harmful, courts should seek to protect rather than restrict that access when deciding questions of informed consent. Other considerations expressed in *Roper* raise the question of whether that protection can be accomplished through case-by-case evaluations of adolescent maturity.

The *Roper* Court acknowledged that the differences between adolescents and adults might not support a categorical finding of insufficient adolescent culpability for imposition of the death penalty.¹⁴⁴ However, the Court determined that the potential for jury outrage at violent crimes by juvenile defendants created an unacceptable risk that an insufficiently culpable youth would be executed in violation of the Eighth Amendment.¹⁴⁵ The Court noted that “[i]n some cases a defendant’s youth may even be counted against him.”¹⁴⁶ As a result, nothing short of a categorical prohibition of the juvenile death penalty would effectively prevent decisions that were not based on an appropriate evaluation of youthful defendants’ culpability.¹⁴⁷

The *Roper* Court feared that the circumstances of a violent crime committed by a juvenile defendant could overwhelm important mitigating facts, making the jury unable to appropriately evaluate the impact of his age on the proper sentence.¹⁴⁸ Similarly, in the context of transgender youth seeking access to hormones, pervasive societal prejudice against transgender people creates a structural bias that precludes appropriate evaluations of transgender adolescents’ maturity and decisionmaking capacity.

Multiple adults stand between a transgender youth and access to hormones, and all are potentially affected by prejudice against transgender persons. A transgender youth cannot legally obtain hormones without a prescription

144. *Roper v. Simmons*, 543 U.S. 551, 572 (2005) (“Certainly it can be argued, although we by no means concede the point, that a rare case might arise in which a juvenile offender has sufficient psychological maturity, and at the same time demonstrates sufficient depravity, to merit a sentence of death.”).

145. *See id.* at 573 (“An unacceptable likelihood exists that the brutality or cold-blooded nature of any particular crime would overpower mitigating arguments based on youth as a matter of course, even where the juvenile offender’s objective immaturity, vulnerability, and lack of true depravity should require a sentence less severe than death.”).

146. *Id.* In the case before the Court, the prosecutor’s closing argument played on jurors’ fears of youthful offenders. The prosecutor said during closing, “Think about age. Seventeen years old. Isn’t that scary? Doesn’t that scare you? Mitigating? Quite the contrary I submit. Quite the contrary.” *Id.* at 558.

147. *See id.* at 573.

148. *Id.*

from a doctor, and discrimination by the medical community against transgender individuals has been well documented.¹⁴⁹ Unless the mature minor exception applies, a transgender youth's access to hormones depends on parental consent;¹⁵⁰ the prevalence of parental abuse and abandonment of transgender youth¹⁵¹ shows that parenthood does not adequately counteract transphobia.¹⁵² A transgender adolescent's ability to obtain hormones under the mature minor doctrine depends, directly or indirectly,¹⁵³ on a legal system that actively polices and enforces gender norms.¹⁵⁴ There is no reason to believe that a judge or jury evaluating a transgender youth's access to hormones under the mature minor doctrine will be immune from the pervasive transphobia exhibited throughout the court system and the rest of society.

The *Roper* Court also determined that case-by-case evaluations would not provide adequate protection for insufficiently culpable youth.¹⁵⁵ The Court thus adopted a categorical ban on the juvenile death penalty as a procedural safeguard against unjust death sentences.¹⁵⁶ Similarly, because of pervasive transphobia, transgender youth require a procedural safeguard against biased decisions that inappropriately deny their access to hormones.

A presumption in favor of allowing transgender adolescents to obtain hormones without parental consent would act as a procedural safeguard mitigating the role of prejudice against transgender youth.¹⁵⁷ Instead of placing the burden on the medical provider to prove sufficient maturity, this presumption would require the party opposing access to prove the youth's immaturity. A court would not be able to impede a transgender youth's access to hormones in the absence of evidence that the youth lacked adequate maturity and decisionmaking ability, making it less likely that access would be denied based

149. See *supra* notes 65–68 and accompanying text.

150. See *supra* Part II.B.2.

151. See *supra* notes 46–47 and accompanying text.

152. Shield, *supra* note 11, at 363 (“[P]arents 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.”).

153. The legal system may determine access directly, through a specific decision granting or denying a request to obtain hormones without parental consent, or indirectly, through an allocation of burdens that makes court involvement unnecessary. See *supra* notes 93–98 and accompanying text.

154. Knauer, *supra* note 121, at 2; see also Noa Ben-Asher, *Paradoxes of Health and Equality: When a Boy Becomes a Girl*, 16 *YALE J.L. & FEMINISM* 275 (2004) (discussing a case in which a court removed a gender-nonconforming child to foster care because the child’s birth-assigned sex was male but her parents enrolled her in school as a girl).

155. *Roper v. Simmons*, 543 U.S. 551, 573 (2005).

156. *Id.*

157. But see Cunningham, *supra* note 3, at 368 (arguing that “[p]resumptive capacity, as opposed to categorical capacity,” leaves youth “subject to the whims and assumptions of the particular factfinder” assigned to their case).

on animus or prejudice. A presumption in favor of access would also reassure medical professionals that providing appropriate services without affirmative permission from a court would not expose them to legal liability. This presumption would thus limit the need for prior court intervention, resulting in one fewer person whose permission is required and whose potential transphobia could inappropriately deny a transgender youth access to hormones.

Because of the role of bias in case-by-case determinations of whether a health care professional appropriately provided hormones to a transgender youth without parental consent, a presumption in favor of access is necessary to guard against decisions based on prejudice rather than an appropriate evaluation of the youth's decisionmaking ability.

CONCLUSION

Legal concepts, like all abstractions, have the potential to break free of their motivating principles and assume a life of their own. This potential has long been apparent with regard to legally recognized differences between youth and adults. For example, the recognition of youths' greater capacity for rehabilitation and greater need for protection led reformers to separate the juvenile justice system from the adult system and to impose different legal standards for its operation.¹⁵⁸ When the legal rules governing the juvenile justice system became detached from their original purposes, and were used to facilitate punishment rather than rehabilitation, the Supreme Court intervened and held that some aspects of differential treatment could no longer be justified.¹⁵⁹

More recently, the Court affirmed differential treatment of youth and adults with respect to the death penalty. In *Roper v. Simmons*,¹⁶⁰ the Court relied on a view of adolescent maturity that created a need for protection against the unjust imposition of capital punishment for youth who cannot be classified among the most culpable offenders. The implications of the *Roper* Court's view of adolescence for other areas of law must be evaluated in light of the decision's

158. See generally *In re Gault*, 387 U.S. 1, 14–18 (1967) (describing the history and philosophy of the juvenile justice system).

159. See *id.* at 19–20 (requiring due process protections in delinquency proceedings because its absence had “resulted in instances, which might have been avoided, of unfairness to individuals and inadequate or inaccurate findings of fact and unfortunate prescriptions of remedy”); see also *Kent v. United States*, 383 U.S. 541, 555 (1966) (“While there can be no doubt of the original laudable purpose of juvenile courts, studies and critiques in recent years raise serious questions as to whether actual performance measures well enough against theoretical purpose to make tolerable the immunity of the process from the reach of constitutional guaranties applicable to adults.”).

160. 543 U.S. 551.

protective purpose.¹⁶¹ If courts blindly cite *Roper* for the proposition that youth are immature, and fashion legal rules accordingly, the result will be restriction for the sake of restriction. Such rules not only lack justification,¹⁶² they do more harm than good.

Maintaining fidelity of purpose with respect to the *Roper* decision can be accomplished by considering how each of the adolescent characteristics identified in the opinion creates particular risks for youth in other contexts. Imposing restrictions on adolescent autonomy could mitigate those risks in some situations, but may cause additional harm in others. This Comment has argued that the latter situation applies when transgender youth seek to obtain hormones without parental consent. As a result, the *Roper* Court's view of adolescence supports a presumption in favor of allowing transgender youth to obtain hormones without parental consent.

161. Cf. Nakajima, *supra* note 4, at 408 (reconciling juvenile abortion and death penalty cases on the basis that "the Court is oath bound to protect the minor's interest first and foremost").

162. Arshagouni, *supra* note 9, at 343 (arguing that Supreme Court precedent supports the proposition that "in circumstances where adolescents are not immature, or inexperienced, or lacking in judgment, their rights ought not to be infringed").