Establishing an Informed Consent Model for Gender Confirmation Surgery in Minors

Michael Coco*

I. INTRODUCTION

This Article explores the interplay among informed consent, legal incapacity due to age, gender confirmation surgery, and judicial oversight. The goal of this Article is to advocate for an informed consent policy and process that protects minors against their own immaturity

* The author is a registered nurse, attorney, and graduate of Rutgers Law School – Newark. After graduation, he clerked for the New Jersey Supreme Court and went on the practice law at a national law firm. He currently works in the legal and risk management department of a hospital system. The author has published a book on nursing scope of practice and has written blog articles and briefs for law firms and attorneys.

while allowing them autonomy over their bodies and protecting healthcare professionals and institutions from subsequent consent-related lawsuits. Finally, this Article argues that the policymakers should model the aforementioned policy after existing policies that address the needs of similarly situated persons who lack legal capacity. This Article advocates that New Jersey should adopt a standard that requires judicial approval before minors receive certain elective surgeries. Doing so strikes the proper balance between the rights of minors and their protection while preventing overly permissive or restrictive rules based on the political currents of the moment.

II. BACKGROUND

Transgender persons constitute between 0.4% and 1.3% of individuals aged fifteen and older, an estimated twenty-five million people worldwide.[1] The original clinical term used for persons who underwent genital reassignment surgery was transexual.[2] The American Psychiatric Association later described Gender Identity Disorder in 1987 as a condition in which a person's birth sex did not fit his or her gender identity;[3] this term was updated to Gender Dysphoria in 2013.[4] By 2018, the World Health Organization's International Classification of Diseases replaced "transsexualism" with "Gender Incongruence.[5] An understanding of the evolution of terminology is helpful when conducting research on how courts and scholars approached the issue in the past.[6] Today, transgenderism is a political, medical, and legal subject of debate. The impetus for this debate is due, in part, to increased access to gender-affirming care and gender-

1 CECILE A. FERRANDO, ET AL., COMPREHENSIVE CARE OF THE TRANSGENDER PATIENT 3 (Elsevier ed., 1st ed. 2020).

2 Carla Moleiro and Nuno Pinto, *Sexual orientation and gender identity; review of concepts, controversies and their relation to psychopathology classification systems*, 6 FRONT PSYCHOL., 1511 (2015).

3 *See* AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS, 535 (4th ed. 2000).

4 AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS, 451 (5th Ed. 2013).

5 Gail Knudson, Same Winter, Stefan Baral, Sari Reisner and Kevan Wlei, *Evolution of the DSM and Diagnostic Criteria in the DSM 5*, *in* COMPREHENSIVE CARE OF THE TRANSGENDER PATIENT, 8 (Elsevier ed. 2019).

6 *See, e.g.*, David M Neff, *Denial of Title VII Protection of Transsexuals: Ulane v. Eastern Airlines, Inc.*, 34 DEPAUL L. REV. 553, 555 (1985) (explaining: "Simply Stated, '[a] transsexual is an individual anatomically of one sex who firmly believes he [or she] belongs to the other sex.'") (quoting Richards v. U.S. Tennis Ass'n., 400 N.Y.S.2d 267, 270 (N.Y. Sup. Ctr. 1977); *see also*, M.T. v. J.T., 355 A.2d 204, 205 (N.J. Super. Ct. App. Div. 1976).

confirmation surgery ("GCS"), including the availability of certain surgical procedures to minors. These surgeries include restructuring, augmentation, and removal of the breasts and genitals.

Surgical transformation of the genitals is a particularly sensitive area because it often results in sterility of the patient. This risk demonstrates the need for keen scrutiny. In 2020, the World Professional Association for Transgender Health ("WPATH") set forth the following criteria for genital surgery:

> (1) well-documented, persistent gender dysphoria, (2) two letters of referral from mental health professionals well versed in the care of transgender patients, (3) capacity of the patient to engage in informed decision making and consent, (4) well-controlled comorbid medical and mental health conditions, (5) 12 continuous months of hormone therapy, and (6) 12 continuous months of experience living in the gender role consistent with the patient's gender identity. In addition, regular follow-up with a mental health or medical care provider is recommended.[7]

By 2022, the International Journal of Transgender Health, published by WPATH, added a new Standards of Care section for the treatment of adolescents, which included guidelines for gender surgery.[8] WPATH recommends that health care providers assess the emotional and cognitive maturity of the adolescent during the informed consent process and involve the patient's parents or other caregivers.[9] When addressing the youth's ability to provide informed consent, the WPATH recommends the healthcare provider should consider the patient's ability to: "1) comprehend the nature of the treatment; 2) reason about treatment options, including the risks and benefits; 3) appreciate the nature of the decision, including the long-term consequences; and 4) communicate choice."[10] WPATH gives examples of situations where parental or guardian consent is not required. These instances "might include situations in which an adolescent is in foster care, child protective services, or both, and custody and parent involvement would be impossible, inappropriate, or harmful."[11] The

7 FERRANDO, ET AL., *supra* note 1, at 82.

8 E. Coleman, et al., *Standards of Care for the Health of Transgender and Gender Diverse People, Version 8*, 23 INT'L J. TRANSGENDER HEALTH S1, S43 (2022).

9 *Id.* at S61.

10 *Id.*; Petronella Grootens-Wiegers et al., *Medical Decision-Making in Children and Adolescents: Developmental and Neuroscientific Aspects,* 17 BMC PEDIATRICS 1, 2 (2017).

11 Coleman, et al., *supra* note 8, at S58.

WPATH's informed consent recommendations are based on clinical factors, not legal precedent.[12]

A. Political Climate

Issues relating to the LGBTQI+ ("LGBT")[13] community are often marred in political controversy and GCS is no exception. In 2022, the WPATH added special surgical considerations for adolescents, which opened the door for more surgical procedures to be performed on persons under the age of eighteen. On February 22, 2022, Texas Governor Greg Abbott, signed an Executive Order requiring the Texas Department of Family and Protective Services to investigate the parents of children who undergo gender-affirming care and ordered "other state agencies" to investigate licensed health care facilities that perform GCS.[14] In response to Abbott's order, US Secretary of Health and Human Services ("HHS"), Xavier Becerra, issued a statement in support of gender-affirming care for LGBT youth and "reminded" others of the "federal protections that exist to ensure transgender youth receive the care they need."[15] Commensurate with Becerra's statement, the Office for Civil Rights ("OCR") published a document reaffirming HHS's support for gender-affirming care and transgender youth by, in part, asking individuals to file a complaint if they believe their rights are being infringed.[16] The OCR opined that the Texas order potentially infringed on the rights of LGBT persons under Section 1557 of the Affordable Care Act, the privacy rule of the Health Insurance Portability and Accountability Act of 1996, and possibly Section 504 of the Americans with Disabilities Act.[17]

The controversy surrounding GCS goes beyond politics and includes the private medical industry. In October 2022, Vanderbilt

12 Coleman, et al., *supra* note 8, at S58.

13 *Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, Intersex, Plus*, DICTIONARY.COM, https://www.dictionary.com/browse/lgbtqi (last visited Mar. 5, 2023).

14 Letter from Greg Abbot, Governor Tex., to Commissioner Masters (Feb 22, 2022) (available at: https://www.documentcloud.org/documents/21272649-abbott-letter-to-masters); *see also* Op. of KP-0401, Op. Att'ys Gen. 1 (2022).

15 Press Release, HSS, Statement by HHS Sec'y Xavier Becerra Reaffirming HHS Support and Protection for LGBTQI+ Children and Youth (Mar. 2, 2022) available at: https://www.hhs.gov/about/news/2022/03/02/statement-hhs-secretary-xavier-becerra-reaffirming-hhs-support-and-protection-for-lgbtqi-children-and-youth.html.

16 U.S. DEPT. HEALTH AND HUM. SERVS. OFF. FOR C.R., HHS NOTICE AND GUIDANCE ON GENDER AFFIRMING CARE, CIVIL RIGHTS, AND PATIENT PRIVACY (2022), https://www.hhs.gov/sites/default/files/hhs-ocr-notice-and-guidance-gender-affirming-care.pdf (last visited Mar. 5, 2023).

17 *Id.*; *see also* 42 U.S.C. § 18116(a); 42 U.S.C. § 12132; 45 C.F.R. § 164.508.

University Medical Center announced that it would stop performing GCS on minors after receiving pressure from Republican lawmakers and criticism from right-wing media personalities like conservative Matt Walsh.[18] The Vanderbilt University Medical Center GCS program came under fire after a recording surfaced of a speaking assistant professor telling an audience that GCS would bring in "a lot of money."[19] Progressive civil rights groups, like the American Civil Liberties Union, criticized the move.[20]

Political operators on both sides of the aisle are ready to fight over this issue. In 2016, the Department of Health and Human Services ("HHS") interpreted Section 1557 of the Affordable Care Act, 42 U.S.C. § 18116(a), to require physicians to perform gender-transition care and require government health programs to cover such interventions.[21] Conservative and Catholic hospitals challenged the interpretation in the case *Franciscan Alliance Inc. v. Becerra*, eventually winning a permanent injunction victory in 2021.[22] On appeal, the Fifth Circuit affirmed the injunction in a decision that also prevented a newer rule from being imposed on the plaintiffs—one that would have accomplished the same goals and was based on the intervening Supreme Court ruling, *Bostock v. Clayton County*.[23] *Becerra* provides some preliminary guidance on this issue; however, it addresses a different question. The Fifth Circuit's ruling in *Becerra* was grounded in the religious rights of providers and examined whether HHS followed the requisite administrative procedures.[24] The court did not consider the issue of consent.

Understanding the political nature of GCS provides an important foundation for considering issues surrounding informed consent. But what logical bearing does politics have on whether a sixteen-year-old

---

18 Andy Rose, *Vanderbilt Transgender Health Clinic Suspends Gender-Affirming Surgery for Minors*, CNN (Oct. 9, 2022, 2:27 AM), https://www.cnn.com/2022/10/09/us/vanderbilt-suspends-gender-affirming-surgery-minors/index.html; Anders Hagstrom and Danielle Wallce, FOX NEWS, *Vanderbilt University clinic responds to claims of unethical transgender surgery on minors* (April 25, 2023, 1:36 PM), https://www.foxnews.com/us/vanderbilt-university-clinic-responds-claims-unethical-transgender-surgery-minors

19 Timothy H.J. Nerozzi, *Vanderbilt Universtiy Temporarily Pauses Gender Change Operations for Minors*, FOX NEWS (Oct. 8, 2022, 1:54 PM), https://www.foxnews.com/us/vanderbilt-university-temporarily-pauses-gender-change-operation-minors.

20 Rose, *supra* note 18.

21 Franciscan All. Inc., v. Becerra, 553 F.Supp.3d 361, 365 (N.D. Tex. 2021).

22 *Id.* at 378.

23 Franciscan All. Inc., v. Becerra, 47 F.4th 368, 374 (5th Cir. 2022); Bostock v. Clayton Cnty., 140 S.Ct. 1731, 1738–54 (holding that transgender employees are covered under Title VII of the Civil Rights Act of 1964).

24 *Id.*

can consent to GCS? The short answer is nothing. From a democratic point of view, however, political sentiment can impact laws and can lead to expanded or limited access to GCS for minors, depending on the controlling political party and its underlying philosophy. Issues of fundamental bodily autonomy and individual control over one's own medical care should not be left exclusively to the political process, lest the minority risks having their autonomy eroded by the majority. On the other hand, society has a duty to protect minors, and other vulnerable groups, from being unduly influenced by others, or from making poor and irreversible decisions. Courts must consider and balance these concerns, just as courts have in the past.[25]

B. Gender Dysphoria and Gender Confirmation Procedures

The medical community has moved away from the strict classification of "gender identity disorder" and moved toward the newer language that deemphasizes stigma-raising labels and focuses on various types of treatment.[26] Regardless of the current verbiage, the treatment consists of therapy, social adjustment, pharmaceuticals in the form of puberty blockers and steroids, as well as surgery. Understanding the complexities of these surgeries will help legal scholars and practitioners apply the most appropriate legal safeguard to the informed consent process for minors.

There are several different types of GCS, which include "chest reconstruction" and genital reconstruction.[27] Examples of chest or "top" surgery are breast implants in biological males and double mastectomies in biological females. The operative goals of chest surgery are "the aesthetic contouring of the chest by removing breast tissue and excess skin, reducing and repositioning the nipple-areola complex when necessary, releasing the inframammary crease, performing liposuction of the chest, and, when possible, minimizing chest scars and preserving nipple sensitivity."[28] As recent as 2020, medical experts suggested that persons should be the age of majority in a given country for chest surgery eligibility.[29]

25 *Cf. In re* Grady, 85 N.J. 235 (1980) (discussing medical decision-making by third parties).

26 *See* Vin Tangprichia & Joshua D. Safer, *Transgender Men: Evaluation and Management*, UPTODATE (May 2022).

27 *Id.*

28 FERRANDO, ET AL., *supra* note 1, at 76.

29 FERRANDO, ET AL., *supra* note 1, at 73.

Chest procedures carry both intra-operative and post-operative risks. Transwomen may be at higher risk for breast cancer following augmentation mammoplasty, surgical breast enlargement. This risk, however, is likely related to exogenous estrogen therapy than the top surgery itself.[30] Augmentation mammoplasty can make detection of breast cancer more complex, and some believe that the rate of breast cancer will increase as the transgender population increases and ages.[31]

On the other hand, a bilateral mastectomy does not eliminate the possibility of breast cancer in transgender men, but post-surgical malignancies are rare.[32] Complications from augmentation mammoplasty are uncommon, but include hematoma, seroma, and infection that would require revision in the future.[33] As for mastectomy, complications are more common, 11% to 33%, and include hematoma, seroma,[34] infection, delayed healing, and loss of nipple graft.[35] These surgeries may also require revisions, with rates ranging from 9% to over 44%.[36]

Although "bottom" procedures vary, they include, but are not limited to, oophorectomy[37], hysterectomy[38], and vaginectomy.[39] Genital reconstruction is "less popular" due to its cost and high morbidity rates.[40] With respect to genital surgery, male-to-female ("MTF") patients are at risk for "venous thromboembolic events" during the perioperative period.[41] There is no singular surgical technique, and until recently, surgeons rarely shared their techniques.[42] "[V]aginoplasty is irreversible and generally includes orchiectomy [(surgical removal of the testes)]."[43] Complications include bleeding,

30 FERRANDO, ET AL., *supra* note 1, at 79.

31 FERRANDO, ET AL., *supra* note 1, at 79.

32 YUKO KATAYAMA, ET AL., *A Very Rare Case of Breast Cancer in a Female-to-Male Transsexual* 941–43 (2016).

33 FERRANDO, ET AL., *supra* note 1, at 80.

34 A seroma is a buildup of clear fluid in the body, usually after surgery. Dan Brenna, *What is a Seroma?*, WEBMD (Apr. 12, 2021), https://www.webmd.com/skin-problems-and-treatments/what-is-a-seroma.

35 FERRANDO, ET AL., *supra* note 1, at 80.

36 FERRANDO, ET AL., *supra* note 1, at 80.

37 Surgical removal of the ovaries.

38 Surgical removal of the uterus.

39 *See* Tangprichia & Safer, *supra*, note 27 (explaining practices include surgical removal of the ovaries, uterus, and all or part of the vagina).

40 *See* Tangprichia & Safer, *supra*, note 27.

41 FERRANDO, ET AL., *supra* note 1, at 83.

42 FERRANDO, ET AL., *supra* note 1, at 83.

43 FERRANDO, ET AL., *supra* note 1, at 83.

abscess, stricture, infection, wound dehiscence, and flap necrosis.[44] Regret from surgery is rare, ranging from 0% to 3.8% of cases.[45] The "gold standard" for female-to-male ("FTM") genital surgery is the radial forearm free flap phalloplasty.[46] This surgery has a 40% to 41% complication rate, but most patients reported satisfaction with their results.[47] Transgender women may also elect to undergo additional surgeries, like facial feminization.[48]

GCS procedures can affect the body in different ways, and the expected outcomes and potential drawbacks must be considered when determining whether a minor can consent to surgery. Important factors to consider include whether the surgical procedure is reversible and whether it will result in sterility. The courts use these factors when evaluating informed consent decisions made by third parties.[49] Despite the invasiveness of the surgeries, current studies show that transgender people are generally satisfied with their treatments, and surgical regret in adult patients is uncommon.[50]

III. INFORMED CONSENT

Most attorneys are familiar with the doctrine of informed consent as it applies to ethical duties to clients.[51] The concept of informed consent also permeates into other areas of American Jurisprudence. One of the most complicated and litigated areas of informed consent is in healthcare.[52] Questions abound relating to both the application of the doctrine and informed consent as an independent cause of action in a medical malpractice claim.[53] From a practical standpoint, physicians and other healthcare providers look to legal scholars for assistance

44 FERRANDO, ET AL., *supra* note 1, at 90.

45 FERRANDO, ET AL., *supra* note 1, at 91.

46 FERRANDO, ET AL., *supra* note 1, at 94.

47 FERRANDO, ET AL., *supra* note 1, at 96.

48 Tangprichia & Safer, *supra*, note 27.

49 *See, e.g.*, *In re* Grady, 85 N.J. 235 (1980) (evaluating a third-party decisionmaker's ability to consent to sterilization).

50 FERRANDO, ET AL., *supra* note 1, at 91.

51 *E.g.,* N.J. Rules Prof. Conduct 1.4(c) (1984); Delaney v. Dickey, 242 A.3d 257, 269 (N.J. 2020) (explaining an attorney's duty to provide clients with informed consent relating to arbitration provisions in retainer agreements); Sup. Ct. Advisory Comm. on Pro. Ethics Op. No. 697, 911 A.2d 51 (N.J. 2006) (confirming that attorneys must provide clients with informed consent when requesting a conflict waiver).

52 *See, e.g.*, Howard v. Univ. of Med. & Dentistry, 800 A.2d 73 (N.J. 2002).

53 *See, e.g.*, Draper v. Jasionowski, 858 A.2d 1141 (N.J. Super. Ct. App. Div. 2004) (finding a separate cause of action exists based on informed consent for a minor whose mother was not properly informed about a procedure during the minor's birth).

when determining the many aspects of informed consent. For example, a provider might ask what type of consent process is required for chemotherapy treatment. Providers also need to know from whom consent must be obtained and under what conditions. An emergent procedure might necessitate a less robust informed consent process than an elective surgery.[54] This already murky water becomes darker when real-world scenarios add additional obstacles to the equation, such as youth, pregnancy, mental infirmity, physical incapacity, rocky familial relationships, and a myriad of other variables. The important obfuscating factors addressed in this Article are youth, legal incapacity, and bodily autonomy.

A. Evolution

The doctrine of informed consent can be traced back at least two centuries and is "well embedded" in our law.[55] Early in the twentieth century, Justice Benjamin Cardozo announced that patients had the right to be free of "uninvited, unknown surgery, which constitutes a trespass on the patient[.]"[56] Justice Cardozo's opinion was based on the theory that fraud or misrepresentation by a physician could allow for a cause of action based on battery, because the victim did not consent to be touched for the purposes of the unknown surgery.[57] In other words, there is a foundation for the doctrine of informed consent in the intentional torts of assault and battery.[58]

By the mid-twentieth century, as courts began to use a negligence theory to analyze consent causes of action, the case law evolved from consent to informed consent. This allowed for courts to balance the patient's need for sufficient information with the doctor's perception of the appropriate amount of information to impart for decision-making.[59]

54 *See* AMA Code of Medical Ethics, *Informed Consent*, https://code-medical-ethics.ama-assn.org/ethics-opinions/informed-consent (last visited Oct. 9, 2023) (describing informed consent as fundamental to both ethics and law).

55 Largey v. Rothman, 540 A.2d 504, 505 (N.J. 1988) (citing Slater v. Baker Stapleton, 95 Eng. Rep. 860 (K.B. 1767)).

56 *Id.*

57 *Id.* at 505–06 (citing State v. Housekeeper, 16 A. 382, 384 (Md. 1889); W. Page Keeton et al., *Prosser and Keeton on The Law of Torts* §§ 18, 32 (5th ed. 1984)).

58 *See id.* (quoting Justice Cardozo's statement that "[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits and assault").

59 *See id.* (quoting Salgo v. Leland Stanford Jr. Univ. Bd. of Trs., 154 Cal.App.2d 560, 578 (Cal. Ct. App. 1957) ("[A] physician violates his duty to the patient and subjects himself to liability if he withholds any facts which are necessary to form the basis of an intelligent consent by the patient to the proposed treatment.").

Even modern cases, like *Murphy v. Implicito*, remind us of the roots of informed consent: "when a patient gives limited or conditional consent, a health care provider has committed a battery if the evidence shows that the provider acted with willful disregard of the consent given [and thus exceeded its scope]."[60]

1. Modern Theory

One of the earlier statements of the modern informed consent rule is found in *Salgo v. Leland Stanford, Jr. University Board of Trustees*.[61] In *Salgo*, the court declared that "[a] physician violates his duty to his patient and subjects himself to liability if he withholds any facts which are necessary to form the basis of an intelligent consent by the patient to the proposed treatment."[62] Today, under New Jersey law, "[i]nformed consent is a negligence concept predicated on the duty of a physician to disclose to a patient information that will enable him to 'evaluate knowledgeably the options available and the risks attendant upon each' before subjecting that patient to a course of treatment."[63] Adequate consent in modern medicine "presupposes that the patient has the information necessary to evaluate the risks and benefits of all the available options and is competent to do so."[64] In general, it is the doctor's role to provide the necessary medical facts and the patient's role to make the subjective treatment decision based on his or her understanding of those facts.[65]

To sustain a claim based on lack of informed consent, the patient must prove that the doctor withheld pertinent medical information concerning the risks of the procedure or treatment, alternatives, or potential consequences if the procedure or treatment was not

60 Murphy v. Implicito, 920 A.2d 679 (N.J. Super. Ct. App. Div. 2007); *see also* Duncan v. Scottsdale Med. Imaging, Ltd., 70 P.3d 435, 440 (Ariz. 2003).

61 Salgo v. Leland Stanford Jr. Univ. Bd. of Trs., 317 P.2d 170, 181 (Cal. Ct. App. 1957).

62 *Largey*, 540 A.2d at 506 (quoting *Salgo*, 317 P.2d at 181).

63 Perna v. Pirozzi, 457 A.2d 431, 438 (N.J. 1983) (quoting Canterbury v. Spence, 464 F.2d 772, 780 (D.C. Cir.).

64 *In re* Conroy, 486 A.2d 1209, 1222 (N.J. 1985) (citing Sidney H. Wanzer et al., *The Physician's Responsibility Toward Hopelessly Ill Patients*, 310 NEW ENG. J. MED. 955, 957 (1984)) (explaining that "[t]here are three basic prerequisites for informed consent: the patient must have the capacity to reason and make judgments, the decision must be made voluntarily and without coercion, and the patient must have a clear understanding of the risks and benefits of the proposed treatment alternatives or nontreatment, along with a full understanding of the nature of the disease and the prognosis.").

65 David Hilfiker, *Sounding Board. Allowing the debilitated to die. Facing our ethical choices*, 308 NEW ENG. J. MED. 716, 718 (1984) (stating that "our ability [as doctors] to phrase options, stress information, and present our own advice gives us tremendous power.").

undertaken.[66] "The information a doctor must disclose depends on what a reasonably prudent patient would deem significant in determining whether to proceed with the proposed procedure."[67] The standard differs from state to state, with some jurisdictions using the more traditional standard based on what a reasonably prudent physician would deem important for the patient to know about the procedure.[68] About half the states use this traditional standard, and the remaining states use the "reasonable patient" standard.[69] New Jersey moved from the "reasonable physician" to the "reasonable patient" standard in 1988.[70]

2. Specific Legislative, Rule, and Organizational Requirements

The failure to obtain informed consent can result in civil and criminal charges against the provider or healthcare institution.[71] Informed consent standards are outlined in state statutes, court decisions, hospital licensing regulations, professional board regulations, and professional organization positions. For example, the New Jersey Department of Health requires the following:

> (f) Each surgical patient shall have a medical record in accordance with the medical records policies of the hospital. The medical record shall be available to surgical suite personnel prior to surgery and shall include at least:
> 1. A written informed consent form signed by the patient or legal guardian or authorized person according to hospital policy that includes identification of the physician(s)

66 *Pirozzi*, 457 A.2d at 460. *See also* Matthies v. Mastromonaco, 733 A.2d 456, 457 (N.J. 1999) (noting requirement of exploring medically reasonable invasive and noninvasive alternatives, including risks and likely outcomes of both).

67 Howard v. Univ. of Med. & Dentistry of N.J., 800 A.2d 73, 79 (N.J. 2002).

68 Caroline Lowry, *Intersex in 2018: Evaluating the Limitations of Informed Consent in Medical Malpractice Claims as a Vehicle for Gender Justice*, 52 COLUM. J. L. & SOC. PROBS. 321, 337 (2018).

69 *Id.* at 337 (citing Patricia L. Martin, *Moving Toward an International Standard in Informed Consent: The Impact of Intersexuality and the Internet on the Standard of Care*, 9 DUKE J. GENDER L. & POL'Y 135, 146 (2002)).

70 Largey v. Rothman, 540 A.2d 504, 505 (N.J. 1988) (discarding the previous standard and embracing the "reasonable patient" standard).

71 *See* Howard v. Univ. of Med. & Dentistry of N.J., 800 A.2d 73, 77 (N.J. 2002); Perna v. Pirozzi, 457 A.2d 431, 438 (N.J. 1983) ("If the claim is characterized as a failure to obtain informed consent, the operation may constitute an act of medical malpractice; if, however, it is viewed as a failure to obtain any consent, it is better classified as a battery.").

> performing the procedure prior to all procedures requiring informed consent.[72]

Health-related boards and agencies have slightly different definitions of "informed consent" depending on the agency and, in some cases, the medical treatment or procedure.[73] New Jersey's regulations for payment of Medicaid benefits can help form a basis for public policy. New Jersey enumerated certain requirements for informed consent concerning sterilization procedures. Absent emergency, "[a]t least 30 days, but not more than 180 days, shall have passed between the date of informed consent and the date of sterilization[.]"[74] A person must be informed of the following if informed consent is to be considered valid:

> i. Advice that the individual is free to withhold or withdraw consent to the procedure at any time before sterilization without affecting the right to future care or treatment and without loss or withdrawal of any federally funded program benefits to which the individual might be otherwise entitled; and,
> ii. A description of available alternative methods of family planning birth control; and,
> iii. Advice that the sterilization procedure is considered to be irreversible; and,
> iv. A thorough explanation of the specific sterilization procedure to be performed; and,
> v. A full description of the discomfort and risks that may accompany or follow the performing of the procedure, including an explanation of type and possible effects of any anesthetic to be used; and,
> vi. A full description of the benefits or advantages that may be expected as a result of the sterilization; and,
> vii. Advice that the sterilization will not be performed for at least 30 days except for emergency abdominal surgery or premature delivery.[75]

Informed consent for sterilization is not valid if the patient is: "(i) [i]n labor or childbirth; or, (ii) [s]eeking to obtain or obtaining an

---

72 N.J. ADMIN. CODE § 8:43G-34.6(f)(1) (2012).

73 *Compare* N.J. ADMIN. CODE § 13:39-13.2 (2013) (defining "informed consent" for the purpose of collaborative drug therapy by pharmacists) with N.J. ADMIN CODE 13:35-7A(a) (describing "informed consent" to include an agreement by the patient to follow the medical regiment.

74 N.J. ADMIN. CODE § 10:52-2.13(c)(5) (2000).

75 *Id.* § 10:52-2.13(d)(1).

abortion; or, (iii) [u]nder the influence of alcohol or other substances that affect the individual's state of awareness."[76]

Because the principles of bodily autonomy and informed consent are such a ubiquitous and engrained part of the health care profession, health care institutions must create policies and procedures that protect patients, the institution, and providers from complaints and legal claims arising out of informed consent doctrine breaches. Proper informed consent policies protect patients by allowing them to make informed decisions about their health care. In turn, these policies help protect institutions and providers from lawsuits. To be effective at either, however, policies must follow the prevailing legal safeguards that state law establishes. Failure to do so can result in poor patient outcomes, angry families, and pricy litigation.

3. Damages

The basis for damages, like the basis of the informed consent doctrine itself, relies on the premise that: "[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault, for which he is liable in damages."[77] In other words, "[i]n a battery born of the breach of a conditional consent, damages are generally available for the excess harm caused by the specific breach. According to the Restatement [(Second) of Torts], '[i]f the actor exceeds the consent, [the consent] is not effective for the excess.'"[78] For a practical example:

> If an operation is properly performed, albeit by a surgeon operating without the consent of the patient, and the patient suffers no injuries except those which foreseeably follow from the operation, then a jury could find that the substitution of surgeons did not cause any compensable injury. Even there, however, a jury could award damages for mental anguish resulting from the belated knowledge that the operation was performed by a doctor to whom the patient had not given consent. Furthermore, because battery connotes an

76 *Id.* § 10:52-2.13(e)(6).

77 *In re* Conroy, 486 A.2d 1209, 1222 (N.J. 1985) (quoting Schloendorff v. Soc'y of N.Y. Hosp., 105 N.E. 92, 93 (N.Y. 1914)).

78 Murphy v. Implicito, 920 A.2d 678, 687 (N.J. Super. Ct. App. Div. 2007) (quoting RESTATEMENT (SECOND) OF TORTS § 892A (AM. L. INST. 1979)); *see also* Piedra v. Dugan, 21 Cal. Rptr. 3d 36, 49 (Cal. Ct. App. 2004) ("consent does not protect the actor from liability for the excessive act."); Ashcraft v. King, 278 Cal. Rptr. 900, 902 (Cal. Ct. App. 1991).

> intentional invasion of another's rights, punitive damages may be assessed in an appropriate case.[79]

The courts may also award breach of informed consent damages, as well as per quod damages for the patient's spouse, based on a breach of contract theory. The New Jersey Appellate Division recently allowed for recovery on both theories, reasoning, "We add here that even if the breach was not material, that only bears upon the quantum of damages, as even a nonmaterial breach of a contract may be compensable."[80] The New Jersey Appellate Division upheld a per quod claim raised by a plaintiff's wife under contract law, so long as the contractual breach was the proximate cause of the wife's injury.[81] Plaintiffs can also bring battery claims based on a lack of informed consent, but courts reserve these actions for situations where the physician performs a procedure on the wrong body part or without consent entirely.[82]

Finally, if the injury caused by a breach of informed consent cannot be separated from the procedure to which the patient did consent, then damages can be calculated based on the entire surgery.[83] The New Jersey Appellate Division explained, "[s]imply put, if the condition a patient places on his consent to a surgical procedure is material, and that condition is not fulfilled, the surgery is rendered a battery, just as if the doctors had not obtained the patient's consent in the first instance."[84]

B. Analysis

Several factors and interests must be balanced to construct an equitable and practical approach to informed consent for this issue. GCS involves invasive surgical procedures that, in some cases, cause sterility. In all cases, the procedures result in permanent changes in physical appearance. While hesitant to use the term "cosmetic," these procedures could fall under this category, but they are designed to assuage the patient's underlying body dysphoria. Though surgical

79 *Murphy*, 920 A.2d at 687–88 (quoting Perna v. Pirozzi, 457 A.2d 431, 438 (N.J. 1983)).

80 *Id.* at 689–90 (finding breach of contract claim and damages viable where cadaver bone was used against the expressed wishes of the patient).

81 *Id.* at 692.

82 *See* Howard Univ. of Med. & Dentistry of N.J., 800 A.2d 73, 80 (N.J. 2002).

83 *See, e.g.*, Murphy, 920 A.2d at 687 ("[W]here 'it is impossible as a practical matter to sever the harm resulting from the excess from that caused by the permitted act, the actor is subject to liability for the entire harm.") (quoting RESTATEMENT (SECOND) OF TORTS § 892A cmt. h (AM. L. INST. 1979)).

84 *Id.* at 686.

procedures have been used in the past to treat certain non-physical conditions, the dearth of such operations leaves little for comparison when attempting to determine issues of consent and bodily autonomy. Our courts have, however, addressed the consent requirements for sterilization procedures, and these prior cases are helpful in discussing consent and minors who wish to undergo GCS.

No laws exist in New Jersey, nor court opinions as of the date of this Article, that address the question of consent for minors who wish to undergo GCS. Although various state legislatures have proposed new legislation, mainly aimed at limiting or prohibiting these surgeries, it is too early to determine whether such laws will pass or be upheld under judicial scrutiny.[85] Moreover, reliance on the laws of sister states could lead this analysis astray due to the wide differences in state informed consent laws and the political aspects of transgenderism in general. Thus, to provide the best local policy recommendations, this Article confines its analysis to the laws and court decisions of New Jersey, the Third Circuit, decisions, and the United States Supreme Court. Hence, this Article's analysis focuses on determining the rule for informed consent by comparing similar procedures under current New Jersey law.

1. Special Considerations for Minors

The age of majority in New Jersey is eighteen and imparts basic civil and contractual rights and obligations upon all persons when they reach their eighteenth birthday.[86] There are, however, exceptions, discussed *infra*, and several states and countries have set different ages for assigning basic rights and responsibilities to young adults.[87] Though this review focuses on New Jersey, acknowledging the variety of ages of majority underscores the difficulty of determining the age of consent. It is important to explore the rationale and scientific underpinnings for establishing one age or another, as the age of majority. Common knowledge tells us that children lack the cognitive skills, maturity, and life experience to make certain decisions. The difficulty arises in

85 *See, e.g.*, *Governor Stitt Signs Bill to Prevent Gender Transition Services at OU Children's Hospital, Calls for Statewide Ban on Irreversible Transition Surgeries, Hormone Therapies on Minors*, OKLA. GOVERNOR J. KEVIN STITT (Oct. 4, 2022), https://oklahoma.gov/governor/newsroom/newsroom/2022/october2022/governor-stitt-signs-bill-to-prevent-gender-transition-services-.html.

86 *See* N.J. STAT. ANN. 9:17B-1(a); *see also* Standard v. Vas, 652 A.2d 746, 747 (N.J. Super. Ct. App. Div. 1995) (citing Apgar v. Lederle Lab'ys, 588 A.2d 380 (N.J. 1991)).

87 *E.g.*, Nebrask Rev. Stat. 43-2101 (setting the age of majority at 19); Miss. Code Title 1-3-27 (defining a "minor" as a person under the age of 21); Ala. Code § 26-1-1 (setting the age of majority at 19).

determining at what point in young adulthood the ability emerges to make complex and important decisions with sufficient forethought. Even if it were possible to determine a mean or median age when a person is able to make these decisions, manifestation of this ability is predicated on the person's own capacity.[88] In other words, some people are ready to make these decisions earlier than others.

To determine an approximate age for informed consent, the basic biology behind growth and cognitive reasoning must be examined. Humans undergo the greatest period of anatomical growth within the first year of life.[89] 80% of brain growth happens before age two, with most growth occurring by the child's first birthday.[90] Rapid brain growth before the age of two extends the prefrontal cortex of the brain, which is the area that helps us "make sound decisions, . . . [and] maintain emotional stability[.]"[91] The prefrontal cortex "is still maturing in the young adult. . . . It is now apparent that the brain undergoes a remarkable amount of development during the teen years, including a major change of the frontal lobes."[92] The frontal lobe undergoes "extensive . . . growth" during adolescence and is one of "[t]he last areas of the brain to undergo these neurologic changes."[93] The prefrontal cortex and the frontal lobe are "associated with cognitive functioning, such as a person's ability to reason, solve problems, and make decisions. Although controversial, experts report that this process is not complete until people reach their mid-[twentie]s."[94]

Continued body development into the twenties is not limited to neuronal activity. From an anatomical perspective, the skull sutures remain open, and growth is not complete until the closure of the sagittal suture of the skull, which begins around age twenty-two.[95] This mixture of anatomical, physiological, and cognitive differences has, in the past,

88 Daniel W. Belsky, et. Al., Quantification of biological aging in young adults, 112 PNAS 30 (June 1, 2015), (finding difference between chronological and biological age).

89 *See generally* May Thwin et al., *The Effects of Craniectomy Compared to Cranial Vault Remodeling on Morphological, Functional and Neurological Outcomes in Infants with Isolated Non-syndromic Synostosis of the Sagittal Suture: a Systematic Review Protocol* 12 JBI DATABASE SYSTEMATIC REVS. AND IMPLEMENTATION REP. 37, 39 (2014).

90 *Id.*

91 Sandra N. Jones & Vicki D. Lachman, *Continuing the Dialogue: Reducing Minimum Legal Drinking Age Laws from 21 to 18*, 22 J. ADDICTIONS NURSING 138, 140 (2011).

92 *Id.*

93 Heather L. Roebuck et al., *Tanning Beds: Is It Ethical to Ban Minors?*, 11 J. DERMATOLOGY NUR'ES' ASS'N 13, 17 (2019) (citing Mariam Arain et al., *Maturation of the Adolescent Brain*, 9 NEUROPSYCHIATRIC DISEASE TREATMENT 449, 451 (2013)).

94 *Id.* at 17–18.

95 Thwin, *supra* note 9089, at 37.

created similar problems for physicians considering whether to treat an adolescent as an adult for admission and specialty services. For instance, when making decisions on whether trauma patients should be admitted to adult or pediatric units, "the specific age points between [fifteen] and [eighteen] years are most commonly reported as institutional age cutoff[] points" with great variability between facilities."[96] "Admission placement appears to be based primarily on hospital tradition, practitioner preference, or the patient's anatomical or injury requirements."[97] An analysis of the issue of consent for GCS in minors must consider all of these age-related factors.

2. Consent of the Minor Alone

i. Law Review

The first question to explore is whether the minor needs parental consent at all to undergo a sterilizing surgical procedure with irreversible consequences. The New Jersey Legislature recognizes the rights of minors to make their own medical decisions in certain instances and created special consent rules in such situations, including if the minor is: 1) married, 2) emancipated by court order, or 3) consenting on behalf of his or her minor child.[98] A pregnant minor can consent to medical and surgical care related to her pregnancy.[99] Also, a minor who believes that they may be afflicted with a venereal disease or "who is at least 13 years of age and is or believes that he or she may be infected with the human immunodeficiency virus" may also give consent.[100] Consent is also available when a minor "in the judgment of the treating health care professional, appears to have been sexually assaulted, . . . [and such consent is] binding as if the minor had achieved the age of majority[,]" as the case may be.[101] In the foregoing cases involving sexually transmissible infections ("STIs"), consent may not be disclaimed later due to minority status, and the minor's parents must be notified in instances of sexual assault, unless the physician believes that doing so would run contrary to the minor's best interests.[102]

96 Samir Fakhry et. al., *What Makes a Trauma Patient "Pediatric"? Survey of Providers' Admission Decision Making for Pediatric Trauma Patients*, 29 J. TRAUMA NURSING 170, 179 (2022).

97 *Id*.

98 N.J. STAT. ANN. § 9:17A-1.

99 *Id.*

100 N.J. STAT. ANN. § 9:17A-4(a).

101 *Id.*

102 *Id.*

Minors are also able to consent to treatment for drug and alcohol abuse.[103] Such treatment can include hospitalization without the requirement of parental notification.[104] The statute emphasizes:

> The consent of no other person or persons, including but not limited to a spouse, parent, custodian or guardian, shall be necessary in order to authorize a minor to receive such hospital, facility, or clinical care or services, medical or surgical care or services, or counseling services from a physician licensed to practice medicine, an individual licensed or certified to provide treatment for an alcohol use disorder, an advanced practice nurse, or an individual licensed to provide professional counseling under Title 45 of the Revised statutes, as appropriate except that behavioral health care services for the treatment of mental illness or emotional disorders shall be limited to temporary outpatient services only.[105]

The statute does not specify what type of "surgery" would qualify as a treatment for alcoholism. Finally, a minor's parents may still be notified, even over the minor's protestations, if the treating physician believes that such notification is appropriate.[106]

Persons who have reached the age of seventeen may consent to blood donation, and a sixteen-year-old may donate blood with parental consent.[107] In cases where the minor's parents are separated or divorced, "a parent or guardian who has custody (whether sole or joint) will be deemed to be an authorized representative, except where the condition being treated relates to pregnancy, sexually transmitted disease or substance abuse."[108] Aside from the unique issue of pregnancy, the legislature appears to allow minors to consent when: (1) they are seeking psychological treatment for a substance abuse or mental health issue; or (2) they are seeking medical treatment for undesired consequences of intimate relations (STIs). Even though a minor can consent to substance abuse and STI-related treatment, any treatment with the use of medical marijuana still requires parental involvement and consent.[109]

103 N.J. STAT. ANN. § 9:17A-4(b).

104 *Id.*

105 N.J. STAT. ANN. § 9:17A-4.

106 N.J. STAT. ANN. § 9:17A-5 (West 1968).

107 N.J. STAT. ANN. § 9:17A-6(a)-(b) (West 2009).

108 N.J. ADMIN. CODE § 13:35-6.5(a) (2011).

109 *See* N.J. ADMIN. CODE § 13:35-7A.4(c)(2) (2022).

Despite the foregoing carve-outs for consent by minors, the state law for minors to consent to certain activities and enjoy full bodily autonomy is somewhat arbitrary. At twelve, a minor can consent to the treatment of certain STIs, but cannot consent to HIV treatment until thirteen.[110] A seventeen-year-old can consent to a blood donation but cannot consent to accepting Tylenol for a headache from the school nurse.[111] Moreover, minors cannot purchase certain over-the-counter medications or get a tattoo without parental consent.[112] As for care related to psychological conditions, there are varying degrees of exceptions, but no consistent age or rule.[113] Perhaps past legislatures struggled with the same issues addressed herein when trying to create a balanced informed consent process.

To make matters more confusing, young people are not permitted to have full legal authority and autonomy over their bodies, even after reaching the putative age of majority. For example, a person must be twenty-one to purchase tobacco products.[114] Likewise, young people are prohibited from *consuming* alcohol or cannabis until the age of twenty-one, unless medically prescribed.[115] Similarly, the United States Constitution requires that a person be twenty-five years of age to run for federal office,[116] and state laws require that same person reach the age of thirty to be responsible for providing his or her own health insurance.[117] Unfortunately, there is no consistency in New Jersey state law that could be used to extrapolate the age at which a young person can consent to a life-altering surgery, like GCS.[118] When legislation is

110 *See* N.J. STAT. ANN. § 9:17A-4. (allowing consent by a "minor" for treatment of a "venereal disease" without an age qualification, and allowing consent by a minor "who is at least 13 years of age and is or believes that he may be infected with the human immunodeficiency virus or have acquired immune deficiency syndrome").

111 *See, e.g.*, RAMSEY SCH. DIST., https://www.ramsey.k12.nj.us/Page/1561 (last visited Oct. 9, 2023) (stating, "New Jersey State law PROHIBITS administration of ANY medication, including Tylenol, Advil, or any other "over-the-counter" medication without a DOCTOR'S ORDER AND A PARENT'S OR GUARDIAN'S WRITTEN CONSENT) (emphasis on original page).

112 N.J. STAT. ANN. § 2A:170-51.7(1)(a) (restricting the purchase of dextromethorphan); N.J. STAT. ANN. § 2C:40-21.

113 *See, e.g.*, N.J. STAT. ANN. § 9:17A-4 (allowing minors to consent to treatment for alcoholism or drug use; and allowing minors aged 16 and older to consent to outpatient mental health treatment, but not medication)

114 *Id.* § 2A:170-51.4.

115 *Id.* § 2C:33-15; *see* State v. Buglione, 558 A.2d 51, 54 (N.J. Super. Ct. App. Div. 1989) (upholding drinking age law).

116 U.S. CONST. art. I, § 2, cl. 2.

117 *Cf.* N.J.S.A. 17:48-6.19 *et. seq.*

118 *Compare* N.J. STAT. ANN. § 2A:170-51.7(1)(a) (preventing minors from purchasing dextromethorphan with N.J. STAT. ANN. § 9:17A-4 (allowing minors to receive inpatient alcoholism treatment without parental consent).

inconsistent or unclear, judicial precedent and interpretation are informative to help answer open questions. That is not to say legislation is the best way to address this issue. Indeed, as discussed herein, application of judicial oversight is a more equitable solution because it is partially isolated from the political process. Moreover, judicial oversight helps insulate this issue from political headwinds and allows for review of a particular minor's ability to consent on a case-by-case basis.

ii. Anti-Discrimination

When determining specific requirements and privileges for minors and young adults, institutions—including medical providers, courts, and others—must balance the developmental shortcomings among young people with their legal rights. In other words, protecting minors without treating them unfairly based on their age. Age-based discrimination is viewed with rational basis scrutiny under federal law.[119] The New Jersey equal protection test, however, is slightly different. This test is based not on the "Equal Protection Clause" but on an "implicit" concept of equal protection found in Article I, part 1 of the 1947 New Jersey Constitution, which leads to a more expansive protection than its federal counterpart.[120] Thus, equal protection cases in New Jersey weigh the "'nature of the affected right, the extent to which the governmental restriction intrudes upon it, and the public need for the restriction.'"[121] When viewed under the exercise of state police power, "[t]he constitutional principles of due process and equal protection demand that the exercise of the power be devoid of unreason and arbitrariness, and the means selected for the fulfillment of the policy bear a real and substantial relation to that end."[122] Nevertheless, placing limitations based on age requires less justification to pass constitutional muster than other laws that discriminate based on similar immutable traits, allowing for more regulatory flexibility in age-based policies.[123]

119 State v. Chun, 194 N.J. 54, 101 (2008); Kimel v. Fla. Bd. of Regents, 528 U.S. 62, 83 (2000).

120 Chun, 194 N.J. at 101–02; Peper v. Princeton Univ. Bd. of Trs., 77 N.J. 55, 79 (1978).

121 Caviglia v. Royal Tours of Am., 178 N.J. 460, 473 (2004) (quoting Greenberg v. Kimmelman, 99 N.J. 552, 567 (1985)).

122 Katobimar Realty Co. v. Webster, 118 A.2d 824, 828 (N.J. 1955).

123 *Compare* Trautmann v. Christie, 211 N.J. 300, 48 A.3d 1005 (N.J. 2012) (upholding special license plate decals for drivers under the age of 21) *with* Bd. of Educ. of Topeka, 347 U.S. 483 (1954) (finding race-based school segregation unconstitutional).

For example, states may implement a maximum age limit for certain professions.[124]

Placing a parental consent or judicial oversight requirement on minors who wish to undergo GCS may be seen as a restriction or hindrance to their bodily autonomy. Viewed under a rational basis and New Jersey's laws against age-based discrimination, there is justification for such restrictions. The exercise of additional oversight must be "devoid of unreason and arbitrariness."[125] There may, however, be some arbitrariness to eighteen as the age of majority, but setting eighteen as the age of majority serves the overall goal of protecting minors until most are able to better understand their actions. Such restrictions, therefore, have a real and direct relationship to the goal of ensuring that minors and their families understand all of the risks, benefits, and alternatives of GCS before making a life-altering decision. This approach is supported by scientific research, which shows that young people do not fully mature physically or in their ability to make sound decisions until their early or mid-twenties.[126]

iii. Analogous Case Law

Again, no court opinions directly discuss a minor's ability to provide informed consent. There is an area of law that extensively discusses the rights of minors to make medical decisions, the rights of the parents to be informed of and consent to those decisions, and whether the consent of one or both parents is necessary for a minor to receive certain medical treatments, a minor's right to consent to an abortion.[127] This somewhat analogous issue is also biased by political and emotional undertones; nevertheless, the analysis employed by our courts may provide some guidance and applicability here.

The New Jersey Supreme Court ("NJSC") has protected the right of minors to obtain abortions without parental consent or approval.[128] In the court's view, such consent or notification legislation "burdens the

124 *See, e.g.*, Mass. Bd. of Ret. v. Murgia, 427 U.S. 307, 311–17 (1976) (holding a state may force police officers to retire at the age of fifty because the rule is rationally related to a legitimate state interest).

125 Katobimar Realty Co., 118 A.2d at 123.

126 *Understanding the Teen Brain*, STANFORD MED. CHILD.'S HEALTH, https://www.stanfordchildrens.org/en/topic/default?id=understanding-the-teen-brain-1-3051 (last visited Oct. 9, 2023).

127 *See, e.g.*, Planned Parenthood, Sioux Falls Clinic v. Miller, 63 F.3d 1452, 1459 (8th Cir. 1995) (challenging a judicial bypass and parental notification statute); Doe v. Chapman, 30 F.4th 766 (8th Cir. 2022), vacated on appeal; Planned Parenthood v. Farmer, 165 N.J. 609, 612 (2000)).

128 Planned Parenthood v. Farmer, 165 N.J. 609, 612 (2000) (quoting Right to Choose v. Byrne, 91 N.J. 287, 306 (1982)).

'fundamental right of a woman to control her body and destiny.'"[129] The *Farmer* opinion balanced the State's interest in "preserving the family and protecting rights of parents [with] the right of a young woman to make the most personal and intimate decision whether to carry a child to term."[130] A minor has the right to "personal dignity and autonomy" under the "Constitutions of the United States and of this State."[131] The New Jersey Constitution provides greater protection in this area than its federal counterpart.[132]

On the other hand, the NJSC also recognized that "the State may place certain restrictions on a minor[]. . . in order to protect her from her own immaturity."[133] The NJSC has found that statutes requiring consent of one or both parents have been upheld by the Supreme Court of the United States ("SCOTUS") as long as the minor has access to an override by judicial process.[134] In 1992, SCOTUS upheld a Pennsylvania statute requiring parental consent, which included a "bypass" procedure in the event that the parent refused to provide such consent.[135] The New Jersey high court acknowledged that other state courts relied on federal case law to uphold their respective state laws.[136]

The NJSC weighed the time-sensitive nature of a pregnancy heavily while reviewing consent procedures for a minor to receive an abortion.[137] The court reasoned that consent could delay an abortion and a bypass procedure would take at least one month.[138] Thus, the "passage of time creates substantial difficulties, including, among others, increased costs."[139] In doing so, the NJSC explained that "[t]he brevity of the gestation period and concerns about confidentiality create special burdens on minors who wish to have an abortion."[140] The NJSC noted that "every week of delay increases the risk of health problems

129 Planned Parenthood v. Farmer, 165 N.J. 609, 612 (2000) (quoting Right to Choose v. Byrne, 91 N.J. 287, 306 (1982)).

130 *Id.* at 612.

131 *Id.*

132 *Id.* at 613.

133 *Id.*

134 *See id.* at 621–24 (discussing various SCOTUS cases).

135 Planned Parenthood v. Casey, 505 U.S. 833, 899 (1992).

136 *Farmer*, 165 N.J. at 628.

137 *See id.* at 634.

138 *See id.*

139 *Id.*

140 *Id.* at 626.

associated with the abortion procedure and decreases the opportunity to obtain it."[141]

The justices went on to find that a notification requirement creates the same practical obstacles as a consent requirement. When discussing the possibility of making judicial bypass more available through the use of "video-conferencing," the NJSC explained that such procedures were "not generally accessible and may be cost prohibitive."[142] Finally, the NJSC recognized that the New Jersey Legislature allowed minors to make certain health care decisions related to "sexuality, reproductive decisions, substance abuse treatment, and placing . . . children for adoption."[143]

The NJSC historically has permitted minors to exercise bodily autonomy and consent to certain medical procedures as discussed above.[144] Nonetheless, it is important to acknowledge three critical deficiencies in the NJSC's prior holdings in order to determine the requisite consent requirements for GCS. First, the NJSC has granted minors special rights to consent to an abortion. This holding, however, has not been expanded to apply to relatively minor and partially reversible procedures like piercings and tattoos. The NJSC has not acted to allow minors to consent to such relatively innocuous body alterations, nor has the court allowed for special consent rules when a patient's life is in danger. For example, there is no special rule that would allow a minor to consent to a double mastectomy without the consent of her parent, even if the minor patient carried genetic markers, putting her at high risk for breast cancer in the future. Thus, despite compelling arguments to expand the principles in *Roe*[145] and *Farmer* to other areas of law, the NJSC has been reluctant to do so.[146]

This brings us to the second point of caution: the invalidation of *Roe*.[147] On June 24, 2022, SCOTUS overturned *Roe*, stating the decision was wrongly decided.[148] In so doing, the majority held a woman did not

141 *Id.*

142 *Farmer*, 762 A.2d at 635.

143 *Id*. at 638 (citing N.J.S.A. §§ 9:17A-1, 4, and 9:2-16).

144 *See, e.g.*, Planned Parenthood v. Farmer, 165 N.J. 609 (2000).

145 Roe v. Wade, 410 U.S. 113 (1973).

146 Joye v. Hunterdon Cent. High Sch., 826 A.2d 624, 176 N.J. 568 (N.J. 2003); *Roe*, 410 U.S. at 113. (acknowledging "There is no question that Article I, paragraph 1 forms the basis of several decisions implicating highly personal family-planning issues, such as sterilization and reproductive choice[,]" but declining to extend protection from bodily fluid collection to minors attending public schools).

147 *Roe*, 410 U.S. at 113.

148 Dobbs v. Jackson Women's Health Clinic, 142 S. Ct. 2228 (2022).

have a Constitutional right to an abortion.[149] Consequently, many of the cases relied on by the NJSC and New Jersey state courts concerning a minor's ability to consent to an abortion have been invalidated.[150] Although New Jersey courts have made it clear that the New Jersey Constitution itself protects a woman's right to choose, the recent overturning of federal legal precedent in this area pumps the breaks on any effort to analogize the cases to novel legal questions.[151]

Finally, the fleeting nature of pregnancy makes it difficult for a minor to obtain judicial intervention. The NJSC articulated this concern when the court rejected parental consent and notification laws, even if such laws allowed for a judicial bypass.[152] Aside from a minor enduring another year or two of the unpleasantries of body dysphoria, there is no commensurate exigency issue here. Moreover, advancements in technology and the utilization of teleconferencing platforms in judicial proceedings today increases the accessibility of a judicial bypass for minors seeking GCS.

Based on the above analysis, a minor might have an independent liberty interest in GCS, but is not able to consent to such an irreversible procedure without independent oversight. Although parental consent is not required for an abortion in New Jersey, even after *Dobbs*, a minor's right to consent to other medical procedures has not been acknowledged by judicial precedent. Finally, there is no time constraint impacting the right to GCS. In other words, there is little harm that can befall a patient for waiting until the age of majority or applying for judicial intervention.

3. Unilateral and Bilateral Parental Consent

When it comes to parental consent, medical providers, hospitals, and courts inevitably face situations where parents disagree with the course of a minor's treatment. Assuming that parental consent is sufficient to provide informed consent for GCS procedures on minors, the legal and medical communities must determine an equitable way to settle disagreements between parents. Unfortunately, the New Jersey Legislature and courts have provided little guidance on whether both

149 *Id.* at 2283 (holding that a person does not have a Constitutional right to an abortion and, therefore, abortion laws are subject to rational basis scrutiny).

150 Planned Parenthood v. Farmer, 165 N.J. 609, 762 A.2d 620 (N.J. 2000) (relying in part on: Parenthood v. Casey, 505 U.S. 833, 851 (1992) (overturned), *Roe*, 410 U.S. at 153 (overturned); Stenberg v. Carhart, 530 U.S. 914 (overturned)).

151 Planned Parenthood v. Farmer, 762 A.2d 620, 626 (N.J. 2000) (finding the right to obtain an abortion under both the federal and State constitutions).

152 *Id.*

parents must consent to medical procedures on a minor's behalf. This may be due to difficulty: (1) determining if a second parent is known; (2) determining if the second parent is "in the picture"; and (3) actually obtaining consent from both parents.

One example of a New Jersey law that addressed dual consent for minors is an earlier iteration of New Jersey marriage law, which stated, "[a] marriage or civil union license shall not be issued to a minor under the age of 18 years, unless the *parents* . . . consent thereto . . . . Consent . . . by a parent or guardian who is mentally incapacitated shall not be required."[153] This law implied that both parents needed to give consent.[154]

Marriage, like GCS, is a life-altering decision. The New Jersey Legislature, therefore, might have intentionally placed an emphasis on obtaining both parents' consent for a minor to marry. This creates a balance between the difficulties in finding both parents to consent for ordinary or even moderately important decisions while requiring both parents to consent to decidedly life-altering decisions. The 2014 iteration of N.J.S.A. § 37:1.6 also addressed situations where one parent is unable to consent due to "mental incapacity."[155] The legislative requirement of judicial approval for marriages prior to age sixteen shows that consent of both parents is not sufficient to protect the interests of minors in certain situations. Finally, the repeal of the statute eliminated a minor's right to marry, even with both parents consenting, indicating the New Jersey Legislature's evolution in statutory development away from age-specific carve-outs to an irreducible minimum age, eighteen, for life-altering decisions.

4. Judicial Intervention

Cases surrounding the rights of mentally disabled persons, and the power of their guardians to make life-altering decisions on behalf of the infirm, provide useful insights for the development of minors' ability to consent to GCS. While hearing cases related to a mentally disabled person and their guardian's ability to consent, New Jersey courts keep in mind the wishes of both parties and what is in the best interest of the legally incapacitated patient. These cases are helpful in providing context as to whether a dual parental consent policy is sufficient to

153 N.J.S.A. § 37:1.6 (2014) (repealed) (emphasis added) (noting New Jersey law does not currently allow minors to marry under any circumstances).

154 *Id.*

155 *Id.*

safeguard the rights of the minor patient or whether judicial oversight is required.[156]

The NJSC requires the appointment of an independent guardian when deciding to sterilize a mentally disabled person.[157] *In re Grady* examined the ability of a mentally handicapped woman to provide informed consent.[158] In that case, the parents of a 19-year-old woman with Down's Syndrome provided their daughter with birth control pills.[159] The woman's parents feared, however, that if anything happened to them, their daughter would not be able to obtain birth control.[160] As a result, her parents took their daughter to Morristown Hospital for a sterilization procedure, but the hospital refused to perform the surgery.[161] The woman's parents requested judicial authorization for the procedure and the judge appointed a special guardian.[162]

The trial court in *Grady* found that the patient's right to obtain sterilization conflicted with the right to be free from sterilization.[163] To balance these rights, the court set forth five conditions that must be met before a court can grant a guardian's request for sterilization.[164] The conditions included incapacity and an appointed guardian ad litem.[165]

On appeal, the NJSC affirmed the right to sterilization but set forth a different standard "for judicial authorization of sterilization."[166] The court explained that the parties were acting in the patient's best interest, but she nevertheless could not consent, so sterilization in that case was neither compulsory nor voluntary, and lacked personal consent "because of a legal disability."[167] The NJSC found that the parents were "unquestionably" eligible to assert rights on behalf of their daughter.[168] The court held, however, "**we believe that an appropriate court must make the final determination whether consent to sterilization**

156 *See, e.g.*, *In re* Grady, 85 N.J. 235 (1980); *In re* Jobes, 529 A.2d 434 (N.J. 1987) (decision to withhold life support from an incompetent patient must be based on clear and convincing evidence).

157 *In re* Grady, 85 N.J. 235 (1980).

158 *Id*.

159 *Id.* at 242.

160 *Id*.

161 *Id*.

162 *Id*. at 242–43.

163 *In* re Grady, 85 N.J. at 242–43.

164 *Id.*

165 *Id.* at 268.

166 *In re* Grady, 85 N.J. at 244, 249–50.

167 *Id.* at 247.

168 *Id*. at 251.

should be given on behalf of an incompetent individual. It must be the court's judgment, not just the parents' good faith decision, that substitutes for the incompetent's consent."[169] The reasoning of the court's decision was analogous to decisions routinely made by lower courts in adoption and child custody cases.[170] The NJSC acknowledged that it was in the minority on this issue, but stated that courts in other jurisdictions did *not* have the power to approve the sterilization of an incompetent person.[171]

Relatedly, the NJSC reviewed certain guardianship rules and regulations in *In re Promulgation of Guardianship Services Regulation*.[172] The case examined the Office of the Public Advocate's objections against guardianship rules and regulations which, in the opinion of the Advocate, impinged on the rights of biological parents and "mentally retarded" minors.[173] The regulations allowed for the Division of Developmental Disabilities ("DDD") "to make decisions affecting the health, safety, and personal welfare of a minor" in a manner roughly equivalent to their biological parents.[174] The guardianship, in this case, was designed to be temporary, and parental rights were not terminated.[175] The Advocate argued that DDD had "blanket authority to make decisions – elective surgery is the most prominently mentioned – that may have irreversible consequences not in the best interests of the child."[176] The Court agreed with the Public Advocate and explained, "[w]e note that the Legislature, in the Developmentally Disabled Rights act, *has put certain of these more extreme decisions beyond the authority of even a parent or legal guardian*."[177] Ultimately, the Court set forth standards that require certain medical decisions to be approved by a hearing officer.[178]

169 *Id.* at 251 (emphasis added).

170 *Id*. at 251 (acknowledging this reasoning was a departure from *Quinlan*, but stated that the *Quinlan* case involved a matter of life and death, and such a distinction to allow death was more "instinctive" than calculable).

171 *Id.* at 260–61.

172 *In re* Promulgation of Guardianship Services Regulation, 103 N.J. 619 (1986).

173 *Id.* at 621–22.

174 *Id.* at 624.

175 *See id.* at 630.

176 *Id.* at 640.

177 *Id.* (citing N.J.S.A. § 30:6D-5(a)(4) (requiring guardian ad litem and court approval for shock treatment, psychosurgery, sterilization, or medical, behavioral, or pharmacological research) (emphasis added).

178 *Id.* at 641.

The advantage of judicial intervention is also illustrated in a recent case from South Carolina involving a child who was born intersex.[179] The child was a ward of the State of South Carolina and sued both the State and medical professionals for performing a gender "corrective" surgery on him as an infant.[180] The child eventually recovered $440,000 from the hospital that performed the surgery.[181] The child's claim was based on the premise that "[l]egal minors are considered incapable of giving informed consent."[182]

Caroline Lowry describes informed consent as a "powerful tool" for those who underwent gender surgery as minors.[183] She outlines the following required disclosures for informed consent: "(a) diagnosis; (b) nature and purpose of treatment; (c) material risks and outcomes; (d) skills or status risks; (e) alternatives; (f) prognosis if treatment declined; (g) prognosis with treatment; (h) conflicts of interest."[184] Lowry's analysis, however, only focuses on younger children. She argues that "corrective" surgeries on intersex children should be considered "experimental" and proposes a parental consent carve-out that would require parents to obtain judicial approval for such surgeries.[185]

Pat Newcombe discusses similar arguments in her analysis of *M.C. ex rel. Crawford v. Amrhein*.[186] The plaintiff in *Crawford* argued that the surgery was merely cosmetic and not medically necessary.[187] The *Crawford* plaintiff further contended that gender surgeries cause irreversible damage to intersex children's physical bodies—often leaving them sterile, infringing on their fundamental rights to bodily

179 Caroline Lowry, *Intersex in 2018: Evaluating the Limitations of Informed Consent in Medical Malpractice Claims as a Vehicle for Gender Justice,* 52 COLUM. J. L. & SOC. PROBS. 322, 323–24 (2018) (defining the term "intersex" to describe a variety of conditions in which a person is born with reproductive or sexual characteristics that do not fit the traditional definitions of male or female).

180 Lowry, *supra* note 181179179, at 323–24.

181 Lowry, *supra* note 181, at 322.

182 Lowry, *supra* note 181, at 338 (citing Patricia L. Martin, *Moving Toward an International Standard in Informed Consent: The Impact of Intersexuality and the Internet on the Standard of Care*, 9 DUKE J. GENDER L. & POL'Y 135, 149 (2002)).

183 Lowry, *supra* note 181, at 337–38.

184 Lowry, *supra* note 181, at 337–38 (citing Patricia L. Martin, *Moving Toward an International Standard in Informed Consent: The Impact of Intersexuality and the Internet on the Standard of Care*, 9 DUKE J. GENDER L. & POL'Y 135, 146–47 (2002) (internal quotations omitted).

185 Lowry, *supra* note 181, at 351–52.

186 Pat Newcombe, *Blurred Lines – Intersexuality and the Law: An Annotated Bibliography*, 109 L. LIBR. J. 231, 232-33 (2017).

187 Newcombe, *supra* note 188, at 232–33.

integrity and procreation.[188] The constitutional issues raised in *Crawford* were eventually dismissed.[189] Newcombe explains that physicians and parents often feel pressure to perform gender-normalizing surgeries out of fear that the child would otherwise suffer psychological damage.[190]

Other commentators have made similar arguments in recent years, advocating for judicial oversight.[191] Like Newcombe, these commentators focus on young children who never had the ability to assent to surgery and, therefore, were at the complete mercy of the decisions made by their parents and medical providers early in life.[192]

Intersex cases focus on young children who were forced into surgery at a young age, as well as on the many adult transgender individuals who do not want gender surgery.[193] In recent cases involving older children who agreed to GCS with their parents' permission, they have filed claims against their former doctors after the children reached the age of majority and regretted their decision to undergo surgery.[194] In a more famous example, former transgender child, Chloe Cole, announced she was suing her doctors for performing a double mastectomy on her when she was a minor and coercing her parents into agreeing to the procedure.[195] Examples like the case of Chloe Cole raise questions as to whether the assent of parents is sufficient to protect the health of the minor.

Lawmakers in Texas and other conservative areas also question the sufficiency of parental consent, in part based on a parent's own

188 Newcombe, *supra* note 188, at 231.

189 M.C. ex rel. Crawford v. Amrhein, 598 F. App'x 143, 150 (4th Cir. 2015).

190 Newcombe, *supra* note 188, at 223.

191 *See generally* Ashley Huddleston, Note, *Intersex Children in Foster Care: Can the Government Elect Sex Assignment Surgery?*, 22 BROOK. J.L. & POL'Y 987 (2014) (arguing that intersex children in state custody should not have gender corrective surgery without judicial approval).

192 *See id.*; Newcombe, *supra* note 188.

193 Doran Shemin, *My Body is My Temple: Utilizing the Concept of Dignity in Supreme Court Jurisprudence to Fight Sex Reassignment Surgery Requirements for Recognition of Legal Sex*, 24 AMERICAN UNIV. J. OF GENDER, SOCIAL POLICY & THE LAW 491, 492 (2016).

194 *E.g.*, Taylor Penley, *De-transitioned teen sues Kaiser Permanente for performing double mastectomy on at 13: "Intentional Fraud"*, Fox (April 26, 2023), https://www.foxnews.com/media/de-transitioned-teen-sues-kaiser-permanente-performing-double-mastectomy-intentional-fraud.

195 Edie Heipel, *Former Trans Kid Chloe Cole Sues Doctors for Medical Malpractice*, NATIONAL CATHOLIC REGISTER, (Nov. 11, 2022), https://www.ncregister.com/cna/former-trans-kid-chloe-cole-sues-doctors-for-medical-malpractice.

potential maladies.[196] Concerns raised by lawmakers often reference the condition of Munchausen Syndrome by Proxy.[197] People with this disorder produce or fabricate symptoms of illness in others under their care: children, elderly adults, disabled persons or pets. It most often occurs in mothers (although it can occur in fathers) who intentionally harm their children in order to receive a benefit for themselves.[198] The incidence rate of children under sixteen years old who suffer abuse by a caregiver with Munchausen by proxy is approximately 0.5 in 100,000.[199] A newer study puts the incidence of FDIA at an average of 1.3 percent, with some studies showing as high as 6 percent.[200] According to the Cleveland Clinic, the current estimate for FDIA incidence is about 1 percent, but this figure is likely inaccurate due to underreporting.[201]

Finally, judicial intervention creates a check on medical professionals who guide both minors, and their parents, in treatment recommendations. Medical professionals, like judges and legal professionals, hold a position of trust with their patients. No person, however, is completely free from personal and financial biases. These biases were the subject of contention in the recent Vanderbilt controversy, in which the hospital stood to make "a lot of money" performing gender-affirming surgery on minors.[202] Though perhaps taken out of context in that case, the fact remains that both physicians and medical or surgical institutions stand to profit from GCS.[203]

---

196 *See* Letter from Greg Abbot, Governor Tex., to Commissioner Masters (Feb 22, 2022) (available at: https://www.documentcloud.org/documents/21272649-abbott-letter-to-masters).

197 *Id*. Note that this is referred to in some newer materials as "Factitious Disorder Imposed by Another" or FDIA.

198 R.J. McClure, P.M. Davis, S.R. Meadow & J. R. Sibert, *Epidemiology of Munchausen Syndrome by Proxy, Non-Accidental Poisoning, and Non-Accidental Suffocation*, 75 ARCHIVES OF DISEASE IN CHILDHOOD 57 (1996).

199 *Id.*

200 *Factitious Disorders*, CLEVELAND CLINIC (Dec. 3, 2020), https://my.clevelandclinic.org/health/diseases/9832-an-overview-of-factitious-disorders.

201 McClure*, supra* note 200; *Factitious Disorders*, CLEVELAND CLINIC (Dec. 3, 2020), https://my.clevelandclinic.org/health/diseases/9832-an-overview-of-factitious-disorders.

202 Timothy H.J. Nerozzi, *Vanderbilt Universtiy Temporarily Pauses Gender Change Operations for Minors*, FOX NEWS (Oct. 8, 2022, 1:54 PM), https://www.foxnews.com/us/vanderbilt-university-temporarily-pauses-gender-change-operation-minors (reporting that Vanderbilt anticipated the surgeries would bring in "a lot of money.").

203 Jennifer Whitlock, *Gender Confirmation Surgery (GCS)*, VERRYWELL, (April 26, 2023), https://www.verywellhealth.com/gender-confirmation-surgery-gcs-3157235

From a legal standpoint, courts have long been suspicious of judges, arbitrators, and others in positions of neutrality making decisions in which the arbiter has a pecuniary interest. In *Marshall v. Jerrico*, the United States Supreme Court held that a judge who obtained direct financial benefit from the issuance of warrants was not permitted to preside over such cases.[204] The New Jersey Appellate Division expressed similar concerns when considering issues concerning neutrality, stating "[the] requirement of neutrality in adjudicative proceedings safeguards the two central concerns of procedural due process, the prevention of unjustified or mistaken deprivations and the promotion of participation and dialogue by affected individuals in the decision-making process."[205] Such philosophy is based on the long-standing New Jersey precedent which prevents interested parties from acting as arbitrators or other similar-situated neutrals.[206]

Although financial interest is a factor, New Jersey courts still require a showing of actual bias to sustain a constitutional claim against a government entity.[207] It is, however, "another situation" (a more concerning one) where a judge or neutral "has a direct, personal, substantial, [or] pecuniary interest in [the outcome]."[208] New Jersey's "neutrality requirements" help guarantee that "life, liberty, or property will not be taken on the basis of an erroneous or distorted conception of the facts or the law."[209] In cases of GCS, the surgeon, institution, or both, have a direct, pecuniary interest in the outcome of the patient's and parents' ultimate decision.

5. Liberties and Personal Destiny

Imagine waking up in the morning and looking in the mirror only to see something staring back at you. A grotesque thing. A shell of a body that encompasses a vibrant yet hidden person underneath. You'd

(reporting the cost of GCS to exceed $100,000, depending on the type of surgeries performed).

204 Marshall v. Jericho, Inc., 446 U.S. 238, 249–50 (1980).

205 State ex rel. Cumberland v. One 1990 Ford, 852 A.2d 1114, 1121 (N.J. Super. 2004) (citing Carey v. Piphus, 435 U.S. 247, 259–262, 266–267, (1978)).

206 Barcon Associates, Inc. v. Tri-County Asphalt Corp., 430 A.2d 214, 220 (N.J. 1981) (stating that "[a]n arbitrator cannot, if challenged by the other side, be allowed to participate in the resolution of a dispute when such a manifest conflict of interest exists" and vacating an arbitration award where the arbitrator did not disclose a potential monetary interest in one of the parties).

207 Fraternal Ord. of Police, Newark Lodge No. 12 v. City of Newark, 212 A.3d 454, 479 (N.J. Super. Ct. App. Div. 2019).

208 *Ex rel. Cumberland*, *supra* note 207 at 1121 (internal quotations omitted).

209 *Ex rel. Cumberland*, *supra* note 207 at 1121–22 (citing Mathews v. Eldridge, 424 U.S. 319, 344 (1976)).

want to smash the mirror. Every mirror. But it's more than that – it's what you see every time you catch your reflection anywhere. Even your own shadow betrays who you are, and you can feel the wrongness of your body every day. This is how a person with gender dysmorphia feels. Every American, including minors, are guaranteed the freedoms of choice and self-determination.[210] Regardless of how developed or undeveloped a minor's brain may be, minors still retain their basic rights. Therefore, blanket bans or restrictions on medical assistance available to minors is an affront on their basic human rights.

6. Other Sources of Consideration

The final sources to review are those that speak directly to GCS, but do not possess any binding or persuasive legal authority. First, is the requirement for GCS set forth by Aetna, a large health insurance company. Aetna will approve GCS if the patient meets certain criteria, however, the requirements are more stringent for anyone under the age of 18.[211] Similarly, New Jersey Medicaid requires a person to be at least twenty-one and give informed consent for a sterilization procedure.[212] A sterilization procedure is defined as one performed for the purpose of rendering an individual permanently incapable of reproducing.[213] Of course, GCS is not done for the purpose of sterilization, but it can result in the same.

C. Policy-Building and Recommendations

The first question to consider when determining the policy for informed consent for GCS is whether a minor can consent without the approval or knowledge of a parent or guardian. Though our courts have been steadfast in allowing minors to obtain abortions under the auspices of bodily autonomy and personal destiny, courts have been redescent to expand their holdings to apply to other surgical

210 *In re* Farell, 514 A.2d 1342, 212 N.J.Super. 294, 300–01 (N.J. Super. 1986). *Cf. In re* Roche, 687 A.2d 349, 296 (N.J. Super. 1996) (explaining the similarities in the rights of minors and persons adjudicated to be incompetent).

211 *See Gender Affirming Surgery*, AETNA, https://www.aetna.com/cpb/medical/data/600_699/0615.html (last updated Jan. 5, 2023).

212 N.J. ADMIN. CODE § 10:54-5.41(c).

213 *Id.* at § 5.41(b).

procedures.[214] SCOTUS's decision in *Dobbs* cast doubt on the viability of expanding this line of jurisprudence.[215]

Furthermore, the legislative carve-outs created for psychological counseling and the treatment of certain diseases do not provide a consistent or predictable course of legislative direction. For example, the New Jersey Legislature allows a sixteen-year-old to obtain outpatient treatment for psychological disorders – like gender dysphoria – but the minor cannot be prescribed any medication without parental consent.[216] Because the minor cannot consent to medication for the treatment of psychological disorders, a minor would not be able to consent to GCS, which inherently requires the administration of medication for surgery.

In addition to analyzing past and present legal authority, the biological science affecting the decision-making capabilities of minors must be considered. There exists physiological evidence that the area of the brain charged with forethought and decision-making is not fully formed until the early or mid-twenties.[217] The current age of majority is perhaps lower than it should be based on the science of neurodevelopment. Allowing the minor alone to consent to GCS would mean allowing a person younger than the age of majority to make choices that could result in permanent body alteration and loss of fertility. Therefore, at the irreducible minimum, consent beyond that of the minor should be required for GCS.

Second, assuming parental consent is sufficient to perform GCS, the consent of both parents is advisable. Despite the lack of similar laws requiring the consent of both parents to perform medical procedures, GCS procedures performed on a minor with the consent of only one parent, especially where an acrimonious relationship exists between the two, creates the risk of pulling healthcare providers and institutions into litigation. Allowing single-parent authorization where two parents are available would also deprive the right of one parent to have a voice in a life-altering medical procedure for his or her own child. Therefore, as a matter of practice and policy, providers, institutions, and courts should seek to obtain the consent of both parents unless: 1) the second

214 Based on research conducted as of the date of this Article, no New Jersey cases have been found that bestows upon a minor a Constitutional right to consent to a specific, non-emergent surgical procedure other than abortion.

215 *See* Dobbs v. Jackson Women's Health Org., 142 S. Ct. 2228 (2022).

216 N.J. STAT. ANN. § 9:17A-4

217 Heather Roebuck, Martin Leever, Douglas MacDonald & Steven Shumer, *Tanning Beds: Is It Ethical to Ban Minors?*, 11 J. OF THE DERMATOLOGY NURSES' ASSOC. 13, 17–18 (2019) (citing Mariam Arain et al., *Maturation of the Adolescent Brain*, 9 NEUROPSYCHIATRIC DISEASE AND TREATMENT 449, 449–61 (2013)).

parent is deceased or permanently incapacitated; 2) the parental rights of the second parent have been terminated by court order; or 3) the single consenting parent certifies that the other parent is not involved in the child's life and his or her whereabouts are unknown.

The final issue, and perhaps most important, is whether the consent from the patient and both parents is legally sufficient.[218] Because these surgeries can cause sterilization by their very nature (i.e., castration on men), care must be taken when making the decision to perform them on a person who lacks the legal capacity for consent. New Jersey has special processes that institutions must follow before performing certain medical procedures on mentally incapacitated adults. Regulations define these procedures and include, without limitation, sterilization, shock therapy, and psychosurgery.[219] Even where sterilization is allowed, the patient must be at least twenty-one years old if the institution expects reimbursement from Medicaid.[220] Allowing a legally incompetent minor to undergo a procedure that a legally incompetent adult could not undergo at eighteen would result in prima facie legal inequity.

Of course, to preserve liberties and effectuate the desires of minors struggling with gender incongruence, society can allow such a person to undergo medically advised surgery under the right circumstances. Those circumstances are that the legally incapacitated minor could have the wherewithal to participate in the informed consent process. Due to the differences in development and general immaturity of the brain's frontal lobe during adolescence, the ability of a particular minor to understand and consent to GCS must be evaluated. To avoid making arbitrary decisions based on birthdates alone, courts should be willing and required to evaluate requests for GCS. Medical facilities and physicians should set policies and procedures that require judicial approval in these scenarios.

New Jersey has already established a framework for judicial approval in cases where a person cannot consent to a sterilizing procedure. As discussed above, *In re Grady* is the most salient case on this issue and provides an excellent case example for future policy setting. In *Grady,* both parents and the court-appointed guardian agreed

218 It is assumed throughout this Article that the minor is a willing, eager, and voluntary participant in these procedures. Of course, no irreversible procedure should be performed against the protestations of an adolescent patient without judicial intervention.

219 N.J.S.A. 30:6D-5(a)(4).

220 N.J.A.C. 10:54-5.41 (c).

that sterilization would be the best course of action for the patient.[221] The NJSC, however, was concerned with parents making this decision for an incompetent person, even if such a decision was, in fact, in the patient's best interest.[222] In that case, the patient could not understand the ramifications of sterilization because of permanent incapacity.[223] Here, the minors undergoing these surgeries would be giving their approval, but the fact remains that they are still legally incompetent to make such a decision. Following *Grady*, a decision to perform medical sterilization on a legally incompetent person requires court intervention and approval.

There exist two differences between *Grady* and the current issue. First, the procedure here is *de facto* sterilization rather than purposeful sterilization. The Court did make a point of this in its opinion and recognized that purposeful sterilization had a sordid past, especially when it came to institutionalized persons.[224] That is not a factor in this case. The Court also explained that a decision resulting in sterilization was an "awesome" one and required scrutiny.[225] From a regulatory guidance perspective, the reimbursement law requiring a person to reach the age of twenty-one before sterilization also defines the procedure as one being done for the *purpose* of sterilization. Here, the procedure is done to reduce body dysphoria but may have the same effect as sterilization.

Most cases that touch on this issue consider the decision against the backdrop of permanent disability. The patients in those decisions will never become competent adults. Here, we are dealing with young people who will eventually reach the age of maturity. State Medicaid regulations place that age at twenty-one for this decision, and Aetna has not defined a lower limit. It's difficult to say whether the Court would have come to a different conclusion had the person in *Grady* been capable of one day becoming competent to make her own decision. Thus, one can only analyze the case as it applies to a person who is presently incompetent as a matter of law. In such cases, the NJSC has required judicial intervention, notwithstanding parental consent.[226]

Grady is instructive here because it struggled with similar questions of legality and ethics in performing certain irreversible and

221 *In re* Grady, 85 N.J. 235, 244 (1980) (explaining the procedural history of the case).

222 *Id.* at 272 (remanding for a determination of the incompetent person's best interest based on clear and convincing evidence).

223 *Id.* at 268.

224 *Id.* at 245–46.

225 *Id.* at 244.

226 *Id.* at 272–73.

sterilizing procedures on persons who lack legal capacity. The question is whether two key differences would change *Grady's* result. The first difference, the reason for incapacity, strengthens the need for judicial approval. If a patient will never be able to make her own decision, like in *Grady*, someone else may make such a decision on her behalf for her benefit. On the other hand, a person who is incapacitated due to minority will eventually reach majority. Preventing irreparable harm from a legal perspective[227] and doing no harm[228] on the medical side supports postponing any surgeries until the minor can consent. This delay, however, can be psychologically damaging to the minor. An independent judge can approve a minor's surgery in those situations – protecting the rights of all involved.

From a malpractice protection perspective, the patient undergoing these procedures will eventually reach majority and, therefore, could bring an action against providers and institutions in the event of a change of heart. Therefore, not only does judicial intervention protect the right of the minor, but it also provides the most protection for the industry in the event of a future lawsuit. Further, adding judicial oversight helps the legal community achieve its ultimate goal of protecting the rights of incompetent patients.

The second difference in *Grady* is purposefulness. In that case, the goal of the procedure was sterilization. Justices in the *Grady* case expressed concern over the history of that particular procedure and its use on the mentally incompetent.[229] However, this was only one aspect of the Court's reasoning. The opinion also discussed the right to reproduction, the irreversible nature of the procedure, and the right to control one's future and destiny.[230] Here, the purpose is different, but the result will be the same (depending on the particular type of GCS performed). Current practice and future policy should be based on prior court instruction, even if the particular reason for the surgery differs. This is so because the outcome is the same and significantly and irreversibly impacts the patient's health, future, and destiny. The courts have already undergone the difficult task of creating a procedure that protects all parties in similar situations.

227 Winter v. Natural Resources Defense Council, Inc., 555 U.S. 7 (2008) (including the prevention of irreparable harm as a component for issuing a temporary injunction).

228 *Greek Medicine*, NAT'L INST.S OF HEALTH, https://www.nlm.nih.gov/hmd/greek/greek_oath.html (last visited Feb. 17, 2023) (explaining the phrase "first, do no harm" is attributed to the ancient physician's Hippocratic Oath).

229 *In re* Grady, 85 N.J. at 245–46

230 *See generally id*.

Building on precedent, legal and medical practitioners should continue to exercise caution when performing or allowing the performance of procedures that will, with certainty, result in the sterility of a minor. Though court approval may not be required for certain other procedures like chemotherapy or surgical removal of a reproductive organ in a child due to malignancy, the weighted consequences of gender dysmorphia are not so dire or time-sensitive. Thus, institutions and medical providers should seek judicial approval for GCS. Courts should, in turn, welcome such a process for the benefit of all parties. Judicial efficiency may be hampered to a small degree, but the number of minors seeking such surgeries will likely be small, and independent oversight is a key component of protecting the rights and health of people who lack legal capacity.[231]

V. CONCLUSION

This analysis does not provide an in-depth review of traditional or contemporary ethical philosophies as they may apply to the topic at hand. Rather, the analysis contained in this Article heavily relies upon applying established approaches to an evolving legal conundrum. The Article is also written without the benefit of long-term, reliable studies from unbiased sources related to regret and long-term complication statistics. Future works may analyze this question with a more philosophical approach. Other works may focus on whether pre-surgical hormone therapies cause sterility or similar long-term effects, making special consent for GCS moot and, instead, asking whether a special consent procedure is needed for certain hormone treatments. Moreover, the legal community may wish to revisit the issue after long-term data have been obtained. Finally, the courts may elect to create a procedural avenue to hear these cases efficiently or establish a process for appointing an independent medico-legal arbiter to oversee these decisions.

231 Cohen-Kettenis PT, Owen A, Kaijser VG, Bradley SJ, Zucker KJ, *Demographic characteristics, social competence, and behavior problems in children with gender identity disorder: a cross-national, cross-clinic comparative analysis*, J ABNORM. CHILD PSYCHOL. 31, 41–53 (2003) (putting the rate of "gender disorder" in children at about one percent).