



Understanding Youth Self-Consent in Gender-Related Health Care

Improving medical care for transgender and non-binary youth: confidentiality, consent, and gender-affirming treatment options

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Many transgender and non-binary (TGNB) youth who seek gender-affirming care have parents or legal guardians who are unsupportive or unavailable. In some clinics in Washington, youth cannot access gender-affirming health care without the consent of one, or sometimes all, parents or legal guardians.

Gender-affirming care can be critical — even lifesaving — for certain patients. Many physicians and other care providers are interested in providing it to their adolescent patients when appropriate. But physicians may be unfamiliar with the legal framework of assessing whether a minor can consent to their own care or how to proceed in the absence of an agreement between a minor's parents or legal guardians.

The law in this area is both nuanced and evolving. This article seeks to provide grounding in these issues with an understanding of what should be considered and documented in determining issues of consent in this area. However, physicians and their care teams should consult with their risk management policies to ensure they are allowed to document the valid consent of minors as described in this article.

For family physicians interested in providing gender-affirming care, this article:

- details the medical therapies recommended for gender transition in youth;
- describes a model legal framework, including factors to consider in determining whether a youth can give informed consent and is a “mature minor” able to make their own gender-affirming medical decisions;
- explains how clinics in Washington are navigating consent with adolescents;
- provides a link to four case studies outlining medical and legal considerations; and

- offers suggestions to improve medical care access for TGNB youth.

Evidence-based Guidelines for Transgender Care

Most physicians use one or more of the following evidence-backed guidelines for transgender care when treating TGNB populations:

- *The World Professional Association for Transgender Health: Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People, 7th version, 2012.* (WPATH)¹
- *Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline, 2017* (Endocrine Society)²
- *UCSF Transgender Care & Treatment Guidelines, regularly updated by topic* (UCSF)³

The information in this article and the case discussions online align with these guidelines.

Treatment Options

Gender-affirming medical care for adolescents includes treatments to promote improved congruence of physical appearance with gender identity or desired presentation. These treatments may include puberty blockers, hormone therapy, surgical interventions, and other services.

Puberty blockers: Puberty blockers function to delay the onset of pubertal changes for adolescents in sexual maturity rating stage ⁴ 2-4 (on average, age 8-14) to give time for the young person and their family to explore a social transition and decide whether they want to pursue treatments that result in more permanent changes or have greater risk.

The risks of puberty blockers include stunted growth (although this can also be an intended effect) and decreased bone density (when used without testosterone or estrogen).

Continued on Page 18 >>

Hormone treatment: Hormone treatment can begin any time after sexual maturity rating stage 2 has started. The effects of hormonal therapy vary based on whether the person secretes endogenous estrogen or testosterone during puberty. Additionally, the number, degree, and timing of changes will differ from person to person.

For people who secrete endogenous **estrogen** during puberty, testosterone is the medication of choice. Testosterone use can result in facial and body hair growth; fat distribution to the abdomen; muscle growth; voice deepening; facial structure changes; Adam's apple development; decreased hip widening; increased height; clitoral enlargement; and labial enlargement. The major risks of testosterone therapy, if taken in excess, include blood clots, stroke, and menstruation.

For people who secrete primarily endogenous **testosterone** during puberty, hormone therapy consists of two medications: testosterone blockers and estrogen. This combination of testosterone blockers and estrogen can result in breast enlargement; genital size decrease; decreased final height; and fat distribution to thighs, buttocks, and breasts. The risks of estrogen are blood clots, decreased bone density, and increased risk of cancer in estrogen-responsive cancers.

Hormone therapy can result in transient infertility, but the extent of this varies by individual.⁵ Many transgender men carry a pregnancy to term even after years on testosterone.^{6,7} Since the ability to reproduce biologically related offspring is unpredictable, fertility preservation strategies are a part of informed consent prior to starting hormone therapy.

Surgery: Surgical options are vast; the most common are:

- breast augmentation to create breasts in someone flat chested;
- chest reconstruction to remove breast tissue to appear flat chested;
- genital surgery to create a vagina (vaginoplasty); and
- genital reconstruction that allows the person to urinate standing up (metoidioplasty)

To avoid repeat surgeries as the body grows, surgery is typically not done until puberty has completed. Since surgery is the most medically risky and irreversible of treatments, parents, legislators, the public, and physicians and other providers are cautious about offering this option to minors.

The Importance of Confidential Care

Care teams and parents have a shared interest in the health and safety of adolescents. Keeping family members involved with gender-related medical transitions can be important to the success of the adolescent.^{8,9} Involved and supportive family members can help with concrete needs like transportation to the clinic, assistance with taking medications regularly, and advocating for the youth by communicating their goals to the care teams. Supportive family members can also help to create a positive self-identity of the TGNB youth, fight for their rights and respect in social situations, and learn resiliency skills that will help their youth face discrimination. Parents are not the only people who can provide

these supports to youth.

However, family members are not always available or capable of assisting in these ways. Too often, transphobia and misinformation about gender diversity leads families to reject and act in physically and emotionally hostile ways towards their TGNB youth.¹⁰ A physician or member of their team may be the first person a TGNB youth can safely talk to. Without confidentiality, many minors must choose between foregoing medical care or facing family rejection or violence. Gender transition or gender affirmation is a journey that is psychological, social, behavioral, and expressive. Gender expression through clothing, mannerisms, speech, and the physical body matter different degrees to different TGNB people. For many, medical transition is one piece that is vital and lifesaving. Unlike other forms of health care where a provider identifies a disease and treats it, being TGNB is not a pathology — yet providing access to medical transition has been proven to improve health outcomes.¹¹

Do Minors Have Legal Authority to Consent to Gender-Related Medical Treatment?

Under RCW 26.28.015, minors in Washington are generally not allowed to consent to their own medical care. The law “generally emphasizes and re-emphasizes parents’ decision-making rights and the ‘fundamental’ role these occupy in our constitutional order.”¹² The U.S. Supreme Court discussed this issue in *Parham v. J.R.*, which was an unsuccessful challenge to Georgia state law permitting parents to institutionalize their minor children.

However, there are several exceptions to this general rule, in both statutory and common law. In Washington, there are statutory exceptions that allow youth to consent to abortions, birth control, mental health treatment, and emergency medical services.¹³

Furthermore, courts have recognized that withholding certain time-sensitive services from minors can have grave consequences. Therefore minors, the courts have found, should be able to consent to these types of care over a parental veto.

In the 1975 case *State v. Koome*, the Washington Supreme Court established that “subjection of a minor woman’s decision to terminate an unwanted pregnancy to absolute and potentially arbitrary parental veto clearly constitutes a substantial burden on her rights similar to those held unconstitutional in *Roe and Doe*.”¹⁴ *State v. Koome* also reinforced the principle that minors’ rights are not inferior to those of adults, with the caveat that minors’ rights may be curtailed by the state when “some peculiar state interest exist[s] in regulation of the protection of children.”¹⁵

Both sentiments are echoed at the U.S. Supreme Court. In *Bellotti v. Baird*, the Supreme Court held that a Massachusetts statute requiring parental consent for minors’ abortions was unconstitutional.¹⁶ While the court conceded that “the States validly may limit the freedom of children to choose for themselves in the making of important, affirmative choices with potentially serious consequences,” it also held that “the abortion decision

differs in important ways from other decisions facing minors, and the State is required to act with particular sensitivity when it legislates to foster parental involvement in this matter.”¹⁷

The court in *Bellotti* contrasts deciding to have an abortion with deciding to get married; while a “minor not permitted to marry before the age of majority is required simply to postpone her decision ... a pregnant adolescent ... cannot preserve for long the possibility of aborting.”¹⁸ Abortion is time-sensitive, and not allowing the minor to make the choice could result in permanent negative consequences. Similarly, the physical changes that occur during puberty are time-sensitive, and not allowing the minor to make the choice about intervening with these changes could result in permanent negative consequences.

Washington also has a common law exception under the “mature minor” doctrine to the absolute parental consent requirement for most types of medical treatment for minors. Washington’s mature minor doctrine is different than other states in that it allows the treating physician to decide whether the minor is mature. Minors or providers can also file a court petition asking the court to determine mature minor status, but a court order is not legally required to proceed with care. Still, physicians are often hesitant to provide or withhold treatment to a minor based on the minor’s consent out of a fear of liability.¹⁹ Under Washington’s mature minor doctrine, a physician may, but is not required to, determine that a minor is mature enough to consent to their own medical care when the factors set out below are documented. Whether a physician can use the mature minor doctrine in their practice depends on their organization’s own policies.

Washington’s mature minor doctrine comes from *Smith v. Seibly*, a 1967 decision by the Washington Supreme Court.²⁰ The plaintiff was 18, which was below the age of majority at that time. He underwent a vasectomy, and then sued the doctor, arguing that his consent had not been valid because he was a minor. The facts of the case are unusual, as patients rarely sue providers arguing that their own consent was not valid.

However, the Court in *Smith v. Seibly* laid out the factors that must be followed when determining whether a minor is mature enough to consent to their own care when under the legal age of consent. Those factors include “age, intelligence, maturity, training, experience, economic independence or lack thereof, general conduct as an adult and freedom from the control of parents.”²¹ The court did not prescribe a minimum age for a patient to be determined a “mature minor,” which distinguishes the mature minor doctrine from emancipation, for which the minor must be 16.²² Rather, the court held in *Smith v. Seibly* that “the mental capacity necessary to consent to a surgical operation is a question of fact to be determined from the circumstances of each individual case.”²³ This places the burden of determining maturity on the treating physician, who must do so on a case-by-case basis.

How can Physicians Determine and Document Maturity in Adolescent Patients?

The factors for determining when a minor should be deemed “mature” are laid out in *Smith v. Seibly*. Many institutions have created policies based on these factors, operationalizing when the doctrine can be employed and what must be documented. One useful policy has been developed by Public Health – Seattle & King County.²⁴ Although Public Health’s interpretation is simply one interpretation and not necessarily applicable outside of entities controlled by this specific agency, it is useful as a model policy.

According to this policy, the minor must meet criteria for capacity. The capacity decision is made by the patient’s physician and typically consists of assessing four components: understanding, appreciation, reasoning, and expression of a choice.^{25,26} Second, the physician must document that the minor meets one or more of the “mature minor” criteria seen in the chart below.²⁷

Mature Minor Criteria (must meet one or more)
<p>Freedom from parents or guardian: lives apart, manages their own affairs?</p> <ul style="list-style-type: none"> The youth is living apart from their parents or guardians and is managing their own affairs.
<p>Age and maturity?</p> <ul style="list-style-type: none"> The youth is able to provide reliable information and make important decisions with good insight and judgment.
<p>Self-supporting?</p> <ul style="list-style-type: none"> The youth is financially independent from parents or guardians or is involved in a work-training program.
<p>Training and experience?</p> <ul style="list-style-type: none"> The youth has sufficient training and experience to make knowing and intelligent health care decisions.
<p>General conduct as an adult?</p> <ul style="list-style-type: none"> The youth demonstrates the general conduct of an adult.

How are Clinics in Washington Navigating Consent in Adolescents?

There is significant variability in how clinics in Washington are handling this issue. Some clinics simply will not offer care to minors at all, while others will only provide care if both parents consent. Clinics trying to meet some of the needs of TGNC minors might offer certain confidential services, like birth control to stop menses or counseling for psychosocial distress around gender identity discovery, discrimination, or other issues.

We contacted 13 clinics that offer gender-affirming health care. Most gave different answers for how they navigate consent for minors. The chart on page 20 captures how some Washington clinics that provide transition-related care to adolescents navigate consent.

Continued on Page 20 >>

Approaches to consent:

Wait for the adolescent to reach age 18 before providing any medical intervention.

All parents/legally authorized medical decision makers must sign consent.

One parent/legally authorized medical decision maker must sign consent.

Youth age 16 and up can consent to gender-affirming confidential care.

Minors deemed mature can consent using the mature minor rule at any age. The physician is required to document this status, and the facts leading them to this determination, in the medical record.

Special circumstances:

For children in foster care or incarceration systems, a court order is needed.

Consultations related to gender identity are deemed mental health care, which minors can receive without the consent or notification of a parent or guardian.²⁸ Therefore, youth can self-consent for confidential mental health care at age 13, although this consultation would not include provision of medical or surgical therapy.

Certain care that can relieve gender incongruence, such as treatment to stop menstruation, can be deemed reproductive care. As such, this kind of treatment can be provided confidentially at any age.²⁹

The wide range of examples here show the varying degrees of comfort of clinics in Washington to interpret the mature minor doctrine as it applies to gender-affirming medical intervention of TGNB minors. All these approaches can be deemed legal and appropriate. All these interpretations carry associated legal risks, as treating minors confidentially brings up concerns for minors' rights, privacy, and non-discrimination, as well as parental rights.

Next Steps

Gender identity development begins in infancy. Thus, the age to allow youth to begin to seek services for gender-related medical care can be as soon as the child can express their thoughts about their gender. While some may say that preteens are not ready to make complex health decisions, it is worthwhile to remember that the youngest patients would be making a decision about the most reversible treatment (puberty blockers) and youth would be making such a decision with a trained medical provider.

Individual case solutions to establishing legal consent typically delay time to treatment. This can cause distress to a patient and in some cases constitutes a form of discrimination. Youth with the mature minor status can avoid such delays. However, many physicians will not utilize this status without training and support

from a legal or risk management team.

To provide clearer guidance to providers while expanding access to gender-affirming care for youth, the Washington state legislature would need to clarify consent rules for minors seeking gender-related health care services, as it has done with abortion, birth control, mental health, and emergency services. Legislative action is needed to help care teams, clinics, adolescent patients, and their families understand the rules, and to help patients to know their rights. Until legislative change occurs, The National Center for Medical-Legal Partnership, legal aid offices, and other community-based organizations should offer guidance for navigating the unique patient and family logistics complicating consent for TGNB minors.

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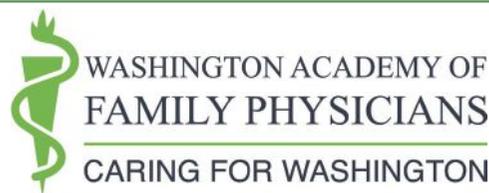
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 13. See RCW 9.02.100, RCW 71.34.530, and RCW 7.70.050.
 14. *State v. Koome*, 84 Wash. 2d 901, 905, 530 P.2d 260, 264 (1975).
 15. *Id.*
 16. *Bellotti v. Baird*, 443 U.S. 622, 623, 635, 99 S. Ct. 3035, 3038, 3044, 61 L. Ed. 2d 797 (1979)
 17. *Id.*
 18. *Id.*
 19. This fear of liability may be unfounded, as battery suits against doctors treating minor patients under the doctrine are largely unheard of. See Lawrence Schlam & Joseph P. Wood, M.D., *Informed Consent to the Medical Treatment of Minors: Law and Practice*, 10 Health Matrix 141, 163 (2000) (“Indeed, no court has rejected the doctrine itself since 1941, and no doctor has
 20. *Smith v. Seibly*, 72 Wash. 2d 16, 21–22, 431 P.2d 719, 723 (1967).
 21. *Id.*
 22. RCW 13.64.010
 23. *Id.*
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 30. For more information, see <http://www.washingtonmlp.org/>



Case studies webpage QR code



Policy: WAFP Supports the Provision, Opposes the Criminalization of Gender-Affirming Care

The Washington Academy of Family Physicians states its full support for any family physician providing gender-affirming care to all those who need it, including transgender youth. Additionally, WAFP opposes the criminalization of physicians providing gender-affirming care.

Case Examples

CASE 1: DIVORCED PARENTS, PARENTING PLAN, ONE SUPPORTIVE PARENT: Rae, age 11, is interested in starting puberty blockers. He is using he/him pronouns at school and at home, but his parents have not allowed him to get a whole new wardrobe yet. His parents are divorced, and both have equal medical decision-making rights. He has started developing breasts but has not had a period yet. The parents do not get along. However, mom, who is in clinic, and Rae both report that dad is “on board,” but he is regularly hard to reach due to his work schedule. What issues should you consider in determining whether to prescribe today?

Discussion



Legal: If the clinic’s policy requires two-parent consent, and it is unlikely that you will get written/verbal consent from the father, the supportive parent can petition the court for a change in the parenting plan that would allow them to make unilateral decisions about gender care. However, this can be a long and costly process, and a positive outcome is not guaranteed.



Medical: Requiring two-parent consent can prolong the time to starting treatment, which can be very distressing for the adolescent. Rae may grow increasingly anxious about beginning menstruation. While hormonal birth control methods are a route for suppressing menstruation, these come with their own risks and not all are as effective as a GnRH agonist. Further, only GnRH agonists can halt the other changes such as breast development, and GnRH agonists have a positive safety profile. GnRH agonists are typically given in the form of a shot or an implant, which can be stopped or removed to allow natal puberty to proceed if desired.

CASE 2: DIVORCED PARENTS, PARENTING PLAN, ONE SUPPORTIVE PARENT, OLDER TEEN: Jamie is 16 and has autism spectrum disorder. She lives with her dad 90 percent of the time in Spokane. Her mom took a job in Seattle to finance a special aide Jamie has at school. Jamie comes in with her mom to your clinic in Seattle on the one weekend per month she lives with her mom. Mom supports Jamie starting estrogen, but Jamie says her dad probably “wouldn’t love the idea” since he laughed at the drag queens in the TV show “POSE” that Jamie was watching. What issues should you consider in determining whether you should prescribe today?

Discussion



Legal: The legal obstacles here are similar to those of the previous scenario. Getting two-parent consent may require changing the parenting plan in court, which will cost time and money, and there is no guaranteed positive outcome. Since Jamie is an older teen, however, the provider may want to analyze her under the mature minor factors (see next scenario), to determine whether they believe she is mature enough to make her own gender-affirming medical decisions.



Medical: The rate of autism spectrum disorder is higher in the TGNB population than the cisgender population. Some clinics are prepared for assessing for persistence of gender identity diversity in neuro-atypical youth while others refer out to other providers to assess this, which can delay care. Issues with dual parental consent could also delay care.

Additionally, it is important to not put Jamie in harm's way if she returns to a father who would discard, humiliate, or harm her if or when he notices Jamie developing breast tissue. Some ways to mitigate this: suggest Jamie wear looser clothing in Spokane; seek out support from a school counselor; or join an extracurricular activity that allows for playful gender expression, such as a drama club. Since Jamie cannot change schools easily due to the intact support of the educational aide, she can be started on low doses of estrogen and testosterone blockers so that changes are more gradual until there is a safe time or way to come out to her dad. The physician could also inquire about other supportive adults Jamie has in Spokane. Finally, a hormonal implant may be a more discrete route of administration for a teenager who is concerned about prescription bottles being found at home.

CASE 3: NO CONSENTING PARENTS, OLDER TEEN: Carter was living with his mom until age 13 when he and his mom were in a car accident. His mom died, and he had severe injuries. He moved to Blaine to live with his dad, whom he hadn't spoken to in a few years. Things went well while Carter was healing, but two years later, they started fighting about his long hair and the tight colorful sweaters he wore to school. Carter's dad eventually threw him out of the house after finding him cuddling with a boy in his bedroom and shouting, "No gays in my house!" Carter stayed at a friend's house that night. His dad would not let him come back, despite trying multiple times. He bounced between friends' houses until he finished his junior year of high school and plans to take his GED soon. Now 16, he comes into the youth homelessness clinic because he has realized that, even though his dad thought he was gay, Carter now knows he is non-binary. He does not care what pronouns you use, but he does want to start estrogen.

What issues should you consider in determining whether you should prescribe today?

Discussion



Legal: Considering the lack of parental involvement and Carter's age, Carter is a good candidate for analysis under the mature minor doctrine, depending on whether the practice's policies allow this. To meet the standards established in *Smith v. Seibly*, the physician must document which mature minor factors are met when writing the clinic

note:

- Freedom from parents or guardian: lives apart, manages their own affairs
- Age and maturity
- Self-supporting
- Training and experience
- General conduct as an adult

Since there are no clear legal criteria yet, it will be up to the risk management policies of each institution to determine how many factors will be sufficient, and how factors are weighed against each other. If he is not considered a mature minor, his path to care will be impeded by the lack of parental consent. He may choose to seek emancipation, which would require going to court.



Medical: While safe and secure housing are priorities for Carter, his estrogen therapy should not be contingent on that. As a minor who has experienced homelessness and family rejection, Carter probably has many coping skills developed to be mature and organized enough to walk into a clinic and ask for health care. A team-based approach with him is important to best ensure Carter is supported and can safely begin estrogen therapy. As the team gets to know Carter, they can start him on a low dose of medication and continue to stress the importance of follow-up meetings and communication at least via the patient portal. With good coordination by a social worker assisting Carter with housing, getting a phone, and enrolling in Medicaid, the physician would have many reasons to believe that Carter can follow up with questions and side effects of hormone therapy. Additionally, there would be no therapeutic benefit to Carter in trying to contact his dad for consent and doing so may put the patient at increased risk of harm.

CASE 4: SUPPORTIVE PARENTS, MEDICAID COVERAGE: Max, age 15, is seeking chest reconstruction and is on Medicaid. They have used a binder to flatten chest tissue since age 12. Max has given this considerable thought and even brought a list of surgeons to clinic. Both parents support Max's decision.

What issues should you consider in determining whether you should refer to surgery today?

Discussion



Legal: Two-parent consent plus Max's consent certainly meets consent requirements.¹ Additionally, according to the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) rules, youth on Medicaid have a right to comprehensive coverage of medically necessary care until the youth turns 21. Youth who are on Medicaid should be counseled on their options early to establish a care plan that suits their goals, their timeline, and the medical interventions related to their gender care needs. More information about this can be found in the "EPSDT: A Guide for States" document available at:

https://www.medicaid.gov/medicaid/benefits/downloads/epsdt_coverage_guide.pdf



Medical: With two parents supporting Max's decision, they are likely to have good surgical outcomes and assistance during recovery. Max also shows dedication and education about the surgery by bringing a list of surgeons. Max's binding may be benign but, depending on how long the binder is worn and how tight the binder, it may be limiting their breathing and contouring rib growth and final lung capacity. Proceeding with surgery could prevent the side effects of binding for additional years, even though the adolescent may still be growing chest tissue. Shared decision making between the physician, the patient, and the family about the risks and benefits

¹ RCW 70.02.130

of surgery would best help the family make an informed decision. The greatest challenge may be obtaining preauthorization for the procedure from the health insurance carrier, but Max should be able to get coverage for his needs if they are medically necessary, safe and effective, and not experimental.

² See, for example, <https://medical-legalpartnership.org/> and <http://www.washingtonmlp.org/>