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NAVIGATING PUBERTY BLOCKERS AND CONSENT FOR TRANSGENDER CHILDREN IN INDIA: LEGAL AND MEDICAL PERSPECTIVES

~ *Akshat Chaturvedi*[*]

ABSTRACT

This article critically examines the legal and medical perspectives on the use of puberty blockers and the issue of consent for transgender children in India. With the global advancement in recognising transgender rights, it has become increasingly important to address the unique challenges faced by transgender youth during puberty. This article analyses the existing legal framework in India concerning transgender rights and healthcare, exploring the extent to which it protects the rights of transgender children to access puberty blockers. Additionally, it delves into medical considerations, discussing the efficacy and safety of puberty blockers for transgender youth, as well as the importance of informed consent in medical decision-making. It addresses the role of parents in decision-making, drawing comparisons with international legal frameworks, and proposes recommendations for navigating these challenges, aiming to foster a comprehensive understanding and support system for transgender children in India.

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Keywords: *Puberty blockers, transgender, gender dysphoria, puberty blockers, informed consent, parental authority, minors' autonomy, Transgender Persons (Protection of Rights) Act, 2019*

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I. INTRODUCTION

The administration of puberty blockers for transgender children is a contentious issue globally, and India is no exception. This article explores the legal and medical considerations surrounding their use and the aspect of consent, aiming to provide a comprehensive understanding of the subject.

Transgender children in India face unique challenges and vulnerabilities in life due to societal attitudes towards their issues. The term *'Gender Dysphoria'* is crucial in understanding and addressing the mental health aspects of transgender experiences. The fourth edition of the Diagnostic and Statistical Manual of Mental Disorders ("**DSM-IV**") initially used the term *'gender identity disorder'* to identify the incongruency between an individual's birth sex and their gender identity.[1] However, the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders ("**DSM-V**"), published in 2013, replaced this term with *'Gender Dysphoria'* to better reflect a contemporary understanding and destigmatize the experience of individuals with gender incongruence. The new term, *'Gender Dysphoria,'* shifted the clinical focus from identity itself to the distress associated with the incongruence between one's assigned gender at birth and their experienced or expressed gender.[2] Gender Dysphoria now refers to the distress that may accompany the incongruence between the assigned gender

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[1] Tiffiny A. Ainsvvorth & Jeffrey H. Spiegel, *Quality of Life of Individuals with and without Facial Feminization Surgery or Gender Reassignment Surgery*, 19 QUALITY OF LIFE RESEARCH 1019, 1019 (2010).

[2] *What is Gender Dysphoria?,* AMERICAN PSYCHIATRIC ASSOCIATION https://www.psychiatry.org/patients-families/gender-dysphoria/what-is-gender-dysphoria#:~:text=Gender%20dysphoria%3A%20A%20concept%20designated,diverse%20people%20experience%20gender%20.

at birth and the experienced or expressed gender subsequently.[3] For transgender children in India, the term *'Gender Dysphoria'* signifies the emotional distress caused by incongruence between their assigned gender at birth and their experienced or expressed gender.[4]

According to the Transgender Persons (Protection of Rights) Act, 2019 ("**the Transgender Act**"), *"transgender person means a person whose gender does not match with the gender assigned to that person at birth and includes trans-man or trans-woman (whether or not such person has undergone Sex Reassignment Surgery or hormone therapy or laser therapy or such other therapy), person with intersex variations, genderqueer and person having such socio-cultural identities as kinner, hijra, aravani and jogta."*[5] This inclusive definition covers transgender children irrespective of the fact that they have not gone through any medical procedure. Section 5 of the Transgender Act provides that in the case of a minor, an application for a certificate of identity as transgender can be made by the parent or guardian of such a child.[6] Section 6 provides for the issue of a certificate of identity by the District Magistrate, and that such certificate shall confer rights and be a proof of recognition of the applicant's identity as a transgender person.[7] Rule 6 of the Transgender Persons (Protection of Rights Rules), 2020, provides for the procedure for issuing a certificate of

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[3] DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS, 451 (5 ed. 2013).
[4] Garima Garg, Ghada Elshimy & Raman Marwaha, *Gender Dysphoria*, STATPEARLS PUBLISHING LLC. (2023), https://www.ncbi.nlm.nih.gov/books/NBK532313/.
[5] Transgender Persons (Protection of Rights) Act, 2019, § 2(1)(k), No. 40, Acts of Parliament, 2019 (India).
[6] Id. § 5.
[7] Id. § 6

identity for a change of gender in case a transgender person undergoes medical intervention for a gender-affirming procedure.[8]

In the context of transgender adolescents, the onset of puberty introduces a range of challenges. The issuance of a certificate of identity for a change of gender is contingent upon medical intervention. However, the Act does not explicitly outline the specific requirements for medical intervention in the case of minors. Various concerns revolve around the nature of medical interventions and the necessary consent for such procedures. Clinically, a crucial decision-making process: Whether to allow the natural biological progression of puberty and embrace the associated bodily changes or to intervene with hormone treatment or blockers. This decision becomes important as some individuals may face substantial distress from the undesired physical transformations brought about by puberty. This conflict necessitates an examination of the administration of puberty blockers to transgender minors, considering the intricate balance between acknowledging natural processes and addressing the mental health implications of such changes.

The absence of specific guidelines in the Transgender Act regarding the administration of medical interventions to transgender minors in India, coupled with uncertainties surrounding the long-term effects and risks of puberty blockers, necessitates careful evaluation and consideration of individual circumstances within the existing legal and medical frameworks.

[8] Transgender Persons (Protection of Rights) Rules, 2020. Rule 6.

This paper highlights the challenges faced by transgender children in India and the importance of understanding gender dysphoria in addressing their mental health needs. It introduces key legal definitions and frameworks relevant to transgender rights in India and lays the foundation for the subsequent discussion.

It further delves into the medical guidelines and protocols concerning the administration of puberty blockers. It explains the purpose and effects of puberty blockers, referencing international standards like the World Professional Association of Transgender Health ("**WPATH**") guidelines, and provides a comprehensive overview of the criteria and considerations for prescribing puberty blockers to transgender adolescents.

This article addresses the potential long-term effects, uncertainties, and controversies associated with the use of puberty blockers in transgender minors. It emphasizes the need for careful evaluation and consent processes before administering these interventions. The complexities of obtaining consent for medical treatment, particularly for minors are examined in detail. Different legal frameworks for assessing a minor's capacity to consent are compared, drawing examples from international jurisdictions such as the UK and Australia, and contrasting these with the legal landscape in India. The role of parents in decision-making and the tensions between parental authority and minors' autonomy are also explored. Ultimately, the article offers suggestions and recommendations for navigating the challenges identified in the preceding sections.

II. GUIDELINES CONCERNING PUBERTY BLOCKERS FOR TRANSGENDER CHILDREN

In India, the appropriate Government is required to establish separate HIV Sero-surveillance Centres,[9] provide medical care covering sex reassignment surgery and hormonal therapy with associated counselling,[10] develop a Health Manual aligned with the World Professional Association of Transgender Health Guidelines,[11] review medical curriculum to address transgender health issues,[12] facilitate easy access to healthcare institutions,[13] and implement an insurance scheme covering medical expenses related to Sex Reassignment Surgery, hormonal therapy, laser therapy, and other health concerns.[14]

Section 15(d) of the Transgender Act refers to the health manual in line with the WPATH guidelines on *'Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People.'* It categorizes physical interventions for adolescents under three heads:

1. Completely reversible interventions (puberty suppressors such as GnRHa)
2. Partially reversible interventions (cross-sex hormones)
3. Completely irreversible (gender reassignment surgery)

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[9] Transgender Persons (Protection of Rights) Act, 2019, § 15(a),
[10] Id., § 15(b)(c)
[11] Id.,, § 15(d)
[12] Id. § 15(e),
[13] Id. § 15(f),
[14] Id. § 15(g),

Puberty blockers, also known as gonadotropin-releasing hormone ("**GnRH**") analogues, are medications used to temporarily suppress the onset of puberty. They suppress the change of secondary sex characteristics that a child would have experienced as a result of pubertal development. Puberty blockers delay the development of secondary sexual characteristics, such as breast development or facial hair growth, allowing transgender youth more time to explore their gender identity before making irreversible decisions regarding gender-affirming interventions. According to the WPATH, GnRH analogues should be offered to adolescents having a strong wish for hormones and surgery from Tanner Stage 2 to Stage 4 of pubertal development.[15] According to the Dutch Approach, puberty blockers should be prescribed only after the child has reached Tanner Stage 2–3 of puberty as *"experiencing one's own puberty is diagnostically useful because right at the onset of puberty it becomes clear whether the gender dysphoria will desist or persist."*[16]

WPATH suggests the following criteria for the administration of GnRH analogues to adolescents:

1. *"The adolescent has demonstrated a long-lasting and intense pattern of gender nonconformity or gender dysphoria (whether suppressed or expressed),*
2. *Gender dysphoria emerged or worsened with the onset of puberty,*
3. *Any coexisting psychological, medical, or social problems that could interfere with treatment (e.g., that may compromise treatment adherence) have been*

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[15] ELI COLEMAN ET AL., STANDARDS OF CARE FOR THE HEALTH OF TRANSSEXUAL, TRANSGENDER, AND GENDER NONCONFORMING PEOPLE 13 (2012).

[16] Annelou L. C. de Vries & Peggy T. Cohen-Kettenis, *Clinical Management of Gender Dysphoria in Children and Adolescents: The Dutch Approach*, JOURNAL OF HOMOSEXUALITY, 301–320 (2012).

addressed, such that the adolescent's situation and functioning are stable enough to start treatment,

4. *The adolescent has given informed consent and, particularly when the adolescent has not reached the age of medical consent, the parents or other caretakers or guardians have consented to the treatment and are involved in supporting the adolescent throughout the treatment process."*[17]

Adolescents are eligible for cross-sex hormones once they reach the age of 16 years.[18] This stage is intended to initiate puberty aligned with the desired gender. A male-to-female receives oestrogen to foster the development of secondary sexual characteristics typical of females while, a female-to-male individual receives androgens, for the development of the male secondary sexual characteristics.

Gender Reassignment Surgeries are recommended once the adolescent reaches the age of 18 years to complete the transition process. These two categories of medical interventions aim to afford adolescents sufficient time to make informed decisions. They are designed to provide them with the opportunity to experience and adapt socially to the gender they aspire to before considering irreversible surgery.

Despite various organizations laying down comprehensive guidelines for administering puberty blockers to adolescents, significant issues revolve around obtaining consent for such treatment. These issues pertain to adolescents' capacity to provide informed consent, the role of parents, and the potential involvement of courts. These guidelines and

[17] COLEMAN ET AL., *supra* note 15, at 19.
[18] de Vries & Cohen-Kettenis, *supra* note 16.

consent procedures align with European jurisprudence on consent. However, it remains unclear whether these standards are applicable in India. Further, concerns persist regarding the justification for administering puberty blockers to transgender adolescents, which will also be addressed in subsequent sections.

III. ISSUES WITH THE ADMINISTRATION OF PUBERTY BLOCKERS TO TRANSGENDER ADOLESCENTS

WPATH classifies puberty blockers as *'fully reversible interventions'* and justifies the administration of puberty blockers based on the following goals:

> *"(i) Their use gives adolescents more time to explore their gender nonconformity and other developmental issues; and*
> *(ii) Their use may facilitate transition by preventing the development of sex characteristics that are difficult or impossible to reverse if adolescents continue on to pursue sex reassignment."*[19]

Puberty suppression treatment can be extended for several years, during which an informed decision can be made regarding whether to discontinue hormone therapy or proceed with partially reversible or completely irreversible interventions. While WPATH justifies the use of puberty blockers to mitigate the negative social and emotional consequences of gender dysphoria, the report acknowledges that *"the long-term effects can only be determined when the earliest treated patients reach the appropriate age."*[20]

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[19] COLEMAN ET AL., *supra* note 15, at 25.
[20] *Id.* at 26.

Further, the aforementioned report does not mandate psychotherapy sessions before hormone therapy.[21] It posits that imposing minimum session requirements can impede progress, and mental health professionals can offer more substantial support throughout all stages of gender exploration. This perspective is pertinent given the varying categories of physical interventions. Consequently, it is not obligatory for a transgender adolescent undergoing puberty suppression treatment to automatically progress to receiving cross-sex hormones and Gender Reassignment Surgeries.

WPATH also acknowledges that the administration of puberty blockers is not a 'neutral act.'[22] They have a significant impact on bone strength, the maturation of sexual organs, body morphology, and eventually adult height remains uncertain.[23] According to the NHS website, *"if stopped (puberty blockers), it is not known what the psychological effects may be."*[24]

Many commentators have also highlighted the possibility of post-treatment regrets. According to Professor Scott, the neurological development of the adolescent brain makes them take riskier decisions at a higher rate than adults.[25] The findings of the American Psychiatric Association suggest that around 75% of boys receiving treatment for

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[21] *Id.* at 28.
[22] *Id.* at 20.
[23] *Treatment-Gender dysphoria*, NHS, https://www.nhs.uk/conditions/gender-dysphoria/treatment/.
[24] ibid.
[25] Quincy Bell and Mrs A v. The Tavistock and Portman NHS Foundation Trust, [2020] EWHC 3274.

Gender Identity Disorder ("**GID**") ultimately identify as gay.[26] Further, the data suggests that within the remaining 25%, a majority are expected to adopt a heterosexual orientation, while a minority may transition to a transgender identity.[27]

Considering the uncertainties surrounding the use of puberty blockers as a treatment for transgender adolescents, it becomes necessary to delve into the landscape of consent to ensure informed decisions regarding their administration.[28] There is a need for careful consideration and comprehensive, informed consent processes when discussing the use of puberty blockers with transgender adolescents.

IV. CONSENT AND COMPETENCE IN MEDICAL TREATMENT OF TRANSGENDER ADOLESCENTS

Consent represents the legal and ethical manifestation of the right to have control over one's life and limbs, constituting a pivotal aspect of medico-legal jurisprudence. A doctor can administer treatment to a patient only after obtaining valid consent for medical procedures. Further, it is within a patient's prerogative to decline treatment even if the prescribed treatment could potentially save their life.[29] Generally, if a person has attained the age of 18 years, he is presumed to be mature and capable of

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[26] DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS, 536 (4 ed. 1999), American Psychiatric Publishing.
[27] DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS, *supra* note 26.
[28] Lieke Josephina Jeanne Johanna Vrouenraets et al., *Medical Decision-Making Competence Regarding Puberty Suppression: Perceptions of Transgender Adolescents, Their Parents and Clinicians*, 32 EUR CHILD ADOLESC PSYCHIATRY 2343 (2022), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10576681/.
[29] Omprakash V. Nandimath, *Consent and Medical Treatment: The Legal Paradigm in India*, 25 INDIAN JOURNAL OF UROLOGY 343 (2009).

giving valid consent. This approach is known as the status-based approach, where competence to consent is arbitrarily decided on the basis of age. For example, in the U.S., State of Idaho has imposed a complete ban gender affirming care, including puberty blockers, hormones, and surgeries, for individuals under 18. Further, the U.S. Supreme Court has also temporarily allowed Idaho to enforce this ban, while legal challenges are pending.[30] However, there are various issues surrounding the consent of transgender adolescents in the status-based interpretation of maturity and capacity to give valid consent.

Article 12 of the United Nations Convention on the Rights of the Child (ratified by India on 11.12.1992), requires states *to "assure the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the view of the child being given due weight in accordance with the age and maturity of the child,"* yet the extent of autonomy for a child is circumscribed by their right to protection. Archard substantiates this argument by discussing the rights of adults and children that are exclusive to each other, including constituents of the right to protection.[31] The conflict is not only between the right to autonomy and the right to

[30] Rajesh Kumar, *U.S. Supreme Court Temporarily Allows Idaho's Ban On Gender-Affirming Care On Transgender Minors*, LIVELAW.IN (Apr. 19, 2024), https://www.livelaw.in/more/international/us-supreme-court-temporarily-allows-idahos-ban-on-gender-affirming-care-on-transgender-minors-255533?fromIpLogin=53576.843203795965.

[31] DAVID WILLIAM ARCHARD, CHILDREN, FAMILY AND THE STATE (1 ed. 2003).

protection of the child but also between the rights of children and the rights of parents.[32]

There is another school of thought where the capacity to consent is based on an understanding of the nature and consequences of the proposed treatment. If a child can retain, use, and weigh the information about the treatment, they should be considered competent to consent to it. However, minors must meet a higher threshold than adults to be considered competent. The implications of minors achieving competence are distinct, recognising their specific vulnerabilities and the need to harmonise their well-being with their developing autonomy. In this context, the administration of puberty blockers to transgender adolescents becomes a complex and nuanced issue. This approach emphasises the role of parents and courts in safeguarding the rights and well-being of transgender adolescents.

A. SITUATION IN THE UK AND AUSTRALIA

In the UK, children of 16 years or older are considered to be legally competent to consent to medical treatment similar to that of adults.[33] In *Gillick v. West Norfolk and Wisbech Area Health Authority*,[34] the House of Lords held that minors below the age of 16 years are competent to consent to medical treatment if they have *"sufficient understanding and intelligence to know*

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[32] Alireza Parsapoor et al., *Autonomy of Children and Adolescents in Consent to Treatment: Ethical, Jurisprudential and Legal Considerations*, 24 IRAN J PEDIATR 241 (2014), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4276576/.

[33] Family Law Reform Act 1969, § 8(1) (United Kingdom)

[34] Gillick v. West Norfolk and Wisbech Area Health Authority [1985] 3 All ER 402 (House of Lords).

what they involve." Lord Scarman observed, *"a minor's capacity to make his or her own decision depends on the minor having sufficient understanding and intelligence to make the decision and is not to be determined by reference to any judicially fixed age limit."* The court has the authority to approve medical treatment for a minor even if the parents explicitly refuse consent.[35] Conversely, the court can deny authorization for treatment that parents have agreed to provide.[36]

The assessment of competence in minors in *Gillick* relies on evaluating the patient's understanding of the issues involved. Competence assessments grounded in the patient's understanding involve three components:[37] (i) the ability to understand;[38] (ii) the actual understanding of the subject matter;[39] and (iii) full understanding.[40] Moreover, the patient's ability to understand is more important than their actual understanding of the facts. According to Bristow J., when the patient is *"informed in broad terms of the nature of the procedure which is intended, and gives her consent, that consent is real."*[41] This view has been endorsed by Lord Fraser as well.[42] However, this view was opposed by Lord Scarman who focused on an actual understanding of the treatment. He observed that minors *"should understand*

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[35] Re P (a minor), LGR 301 (1982).
[36] *Id.*
[37] Michael A Jones & Kirsty Keywood, *ASSESSING THE PATIENT'S COMPETENCE TO CONSENT TO MEDICAL TREATMENT*, 2 MED L INT'L 107 (1996).
[38] *Id.*
[39] *Id.*
[40] *Id.*
[41] Chatterton v. Gerson, [1981] 1 All ER 257.
[42] Gillick v. West Norfolk and Wisbech Area Health Authority, *supra* note 34.

the nature of the advice which is being given: she must also have a sufficient maturity to understand what is involved."[43]

It also involves scrutinizing not only the understanding of the issues but also examining the rationality and reasonableness of the decision-making process. Generally, courts reject the rationality or reasonableness of the outcome as a measure of incompetence.[44] However, in cases involving minors, courts often view an irrational outcome as a sign of incompetence. This perspective stems from the belief that a minor might not have understood the implications if the decision appears to be illogical or unreasonable.[45]For instance, in *Re S (A Minor) (Consent to Medical Treatment)*,[46] the situation involved S, a minor with thalassemia, who declined further blood transfusions. Justice Johnson, while not definitively stating that S's true desires were overridden by her Jehovah's Witness mother, found that *"she does not understand the full implications of what will happen. It does not seem to me that her capacity is commensurate with the gravity of the decision which she has made. It seems to me that an understanding that she will die is not enough. For her decision to carry weight she should have a greater understanding of the manner of the death and the pain and the distress."*[47] Consequently, the judge determined that S did not completely grasp the consequences of persistently refusing transfusions, rendering her not '*Gillick*-competent.'

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[43] *Id.*
[44] [1985] 1 All ER 643.
[45] Re S (A Minor) (Consent to Medical Treatment), [1994] 2 FLR 1065.
[46] ibid.
[47] ibid.

In Australia, a similar scenario unfolded. Even though the minor understood the nature of the problem and the proposed treatment, the Court held that the minor lacked *"sufficient capacity and maturity to fully appreciate the matter and to assess the options available to him."*[48]

In both the UK and Australia, it seems that the courts place greater emphasis on a minor's intelligence and maturity to determine their capacity to consent to medical treatment. In *Quincy Bell and Mrs. A V. The Tavistock and Portman NHS Foundation Trust*,[49] the Claimants challenged the treatment protocols as Miss Bell regretted her past treatment and Mrs. A, her mother, expressed concerns about her child's potential treatment. The Divisional Court outlined the circumstances under which a child could be considered competent to provide informed consent to puberty blockers. These guidelines included factors like understanding the consequences of treatment, progression to further medical interventions, potential loss of fertility, impact on sexual function, and uncertainties regarding the treatment's evidence base. The Court of Appeal upheld Tavistock's appeal, stating that the Divisional Court was wrong to lay down any guidelines at all.[50] The Court observed that judicial review is not the forum for deciding contested factual issues or expert evidence. The Court reinforced the principle from *Gillick* that decisions about a person's capacity under 16 years of age for a medical treatment should be made by doctors, and not judges. The Court recognised the complexities of determining children's

[48] In Re A, (1993) 16 Fam LR 715.
[49] Quincy Bell and Mrs. A v. The Tavistock and Portman NHS Foundation Trust, *supra* note 25.
[50] Bell & Anor v. Tavistock and Portman NHS Foundation Trust [2021] EWCA Civ 1363.

competence to consent to puberty blockers but emphasised the importance of clinicians ensuring that such consent is properly informed.

B. SITUATION IN INDIA

In India, consent for medical treatment must be real and valid. The patient must have the capacity and competence to provide such consent. The Indian Majority Act, 1875, establishes the age of majority at 18 years.[51] According to the combined interpretation of Sections 10 and 11 of the Indian Contracts Act, 1872, individuals over the age of 18 years possess the capacity and competence to consent for medical treatment.[52] There is an absolute presumption of incompetence for children under the age of 7 years under criminal law as well.[53] However, this absolute presumption becomes a qualified presumption for children between the ages of 7 and 12 years. The qualified immunity applies only if it is proven that the child in question has not attained sufficient maturity of understanding. The Juvenile Justice Act, 2015 also prescribes certain degrees of punishment for children in conflict with the law. A child aged between 16 to 18 years can be treated as an adult and subjected to corresponding penalties. While criminal law in India acknowledges that children in various age groups exhibit varying levels of understanding and maturity, yet this recognition is absent in civil and contractual matters.

Despite this, courts have adopted a liberal approach to assessing the capacity and competence of minors, recognising that decisional autonomy

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[51] Indian Majority Act, 1875, § 3, No. 9, Acts of Parliament, 1875 (India).
[52] Indian Contract Act, 1875, §§ 11-12, No. 9, Acts of Parliament, 1872 (India).
[53] Indian Penal Code, 1860, § 82, No. 45, Acts of Parliament, 1860 (India).

is a vital aspect of the right to privacy.[54]This right encompasses intimate personal choices related to reproduction as well as choices expressed in public.[55] In the case of *Suchita Srivastava & Anr. v. Chandigarh Administration* the issue of a minor's competence to consent to medical treatment was addressed.[56] An orphaned minor woman became pregnant as a result of rape. The Punjab & Haryana High Court ordered an abortion under Section 3 of the Medical Termination of Pregnancy Act, 1971, considering her inability to care for a child and the absence of a parent or guardian. However, the Supreme Court overturned this decision, emphasising the right to reproductive choice inherent in Article 21 of the Constitution of India.[57] The Court asserted that denying a woman the autonomy to make decisions about her own body would violate her right to privacy.[58] While the case does not specifically address transgender adolescents, it recognises bodily autonomy and the right of minors to make informed choices. It may be providing impetus to discussions on the right of transgender adolescents to consent to gender-affirming interventions such as puberty blockers.

As these principles are not statutorily recognised in India, guardians have the responsibility to look after the health of their wards.[59] They play a crucial role in advocating for the best interests of their children and providing support throughout medical treatment. However, conflicts may

[54] K.S. Puttaswamy v. Union of India, 10 SCC 1 (2017).
[55] Bhairav Acharya, *The Four Parts of Privacy in India*, 50 EPW 32 (2015).
[56] Suchita Srivastava v. Chandigarh Administration, 9 SCC 1 (2009).
[57] *Id.*
[58] *Id.*
[59] Guardians and Wards Act, 1890, § 24, No. 8, Acts of Parliament, 1890 (India).

arise when parental views diverge from those of the minor or when the minor's autonomy is at odds with parental preferences.

C. ROLE OF PARENTS

In cases where minors do not possess the competence for medical treatment as expressed in *Gillick*, parental consent is required unless it is an emergency. The authority of parents to consent to treatment must align with the best interests of the minor. Parents have a responsibility to make decisions regarding consent based on what is most beneficial for the well-being of the child. Common law in Australia recognizes that parental power diminishes gradually as a child matures. A minor is considered capable of giving informed consent when they achieve sufficient understanding and intelligence.[60] The Court questions the role of parents in a minor's medical decisions for two specific reasons: the significant risk of making the wrong decision about what is in a (minor's) best interests,[61]and the particularly grave consequences of making such a wrong.[62]

The Transgender Act outlines the role of parents in the application for a certificate of identity for a minor transgender. However, it does not specify whether parents can refuse to make such an application or withhold consent for any medical treatment recommended by practitioners. In *XXXXXXXXXX v. Director of Health Services*,[63] distressed parents of a child

[60] Secretary, Department of Health and Community Services v. JWB and SMB (Marion's Case), 175 CLR 2018 (1992).
[61] Re A, 16 Fam LR 715 (1993).
[62] *Id.*
[63] XXXXXXXXXX v. Director of Health Services, [2023] SCC OnLine Ker 6244 (Kerala High Court).

born with ambiguous genitalia, diagnosed with *'Congenital Adrenal Hyperplasia,'* approached Kerala High Court for permission to conduct genital reconstructive surgery to raise the child as a female. The Karyotype Report indicated a female chromosomal pattern (46XX), and the child had a uterus, ovaries, and an enlarged clitoris. They were born with a shared urinal and vaginal opening. Even though medical experts recommended the surgery, they were unwilling to proceed without court approval. The writ petition urged the court to issue orders for prompt consideration of the parents' representation and to direct the immediate undertaking of the genioplasty surgery for their daughter. The court held that while the petitioners expressed concerns about the child's health, an examination of the medical records did not substantiate a compelling case necessitating immediate intervention. The court clarified that any intervention should only occur based on the recommendation of a medical board. It further issued the following directions;

> *"(i) The Government shall constitute a State Level Multidisciplinary Committee consisting of experts, which shall include a Pediatrician/Pediatric Endocrinologist, Pediatric Surgeon and Child Psychiatrist/Child Psychologist.*
>
> *(ii) The Committee thus constituted shall examine the petitioners' child within two months and decide whether the child is facing any life-threatening situation by reason of the ambiguous genitalia. If so, permission can be granted to carry out the surgery.*
>
> *(iii) The Government shall issue an order regulating sex selective surgeries on infants and children within three months. Until such time, sex selective*

> *surgery shall be permitted only based on the opinion of the State Level Multidisciplinary Committee that the surgery is essential to save the life of the child/infant."*[64]

The guidelines have been issued for the diagnosis of 'Congenital Adrenal Hyperplasia.' However, they can also serve as a benchmark for establishing procedures to determine whether a transgender adolescent should receive puberty blockers. The similar nature of decision-making processes in both cases raises the importance of adopting a systematic and thorough approach. Perhaps the involvement of a specialised medical board can ensure that such interventions are based on careful evaluation and consideration of the individual's unique circumstances and needs.

V. THE WAY FORWARD

Navigating the administration of puberty blockers to transgender adolescents in India requires careful consideration. The legal framework for medical treatment of minors is complex and multifaceted. The Act lacks specific guidelines regarding medical interventions for transgender minors. This gap raises concerns about the informed consent process and the role of parents in decision-making.

Medical guidelines, such as those provided by WPATH, offer valuable insights into the administration of puberty blockers. However, uncertainties continue to persist with respect to the long-term effects and risks associated with these interventions, emphasising the need for a thorough evaluation and consideration of individual circumstances.

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[64] *Id.*

First, considering the uncertainties and potential consequences associated with such, there is a need for comprehensive guidelines specific to India regarding the administration of puberty blockers to transgender adolescents. These guidelines should address the informed consent process, the role of parents, and considerations for medical practitioners.

Second, the involvement of medical boards is crucial to evaluating and making informed decisions regarding interventions. Specialised medical boards or multidisciplinary committees can help evaluate individual cases and determine the necessity of puberty blockers based on a thorough assessment and consideration of medical, psychological, and social factors
Third, there is a need to focus on advocating for legal reforms that ensure the rights and well-being of transgender minors are protected. This may include amendments to existing laws to address gaps in the legal framework related to consent and healthcare access for transgender individuals.
Fourth, more research and monitoring are essential to track the long-term effects of puberty blockers on both physical health and psychological well-being. Till then, it must be administered only in exceptional cases and on an experimental basis.