JOURNAL OF CONTROVERSIAL IDEAS

Article

Treatment for Gender Transition & Parental Obligations

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Submitted: 16 August 2025, accepted: 6 April 2026, published: 10 May 2026

Abstract: Proponents of gender transition procedures argue that parents have a moral obligation to support and facilitate a child or adolescent in the decision to transition medically. In this paper, we challenge this idea. We contend that parents of children and adolescents have a moral obligation to oppose medical transition. To argue for this claim, we present and draw conclusions from a series of cases that are similar in their morally relevant details to cases involving medical transition for children and adolescents. Given such similarity, we contend that, on pain of irrationality, one must issue the same judgments across the board. If one does not make the same judgments about the cases, then the onus is on the defender of medical transition for children and adolescents to highlight a morally significant asymmetry. We argue that no such asymmetry exists.

Keywords: cross-sex hormone treatment; puberty blocking treatment; parenting; obligations; bioethics

How to cite: Smith, E.; Rusavuk, A. L. Treatment for Gender Transition & Parental Obligations *Journal of Controversial Ideas* **2026**, *6*(1), 8; doi:10.63466/jci06010008.

1. Introduction

Proponents of pharmaceutical and surgical gender transition procedures—whether that amounts to puberty blocking treatment (PBT), cross-sex hormone treatment (CSHT), or sex reassignment surgery (SRS)—argue that the choice about whether to undergo a transition procedure is primarily up to the person making the decision. In other words, the person deliberating about transitioning from one gender to another—where "gender" refers to "the psychological and cultural characteristics associated with biological sex" (Cretella, 2017, p. 287)—is the main authority on the matter. Regardless of whether the people are adolescents or adults, if they decide to undergo a transition procedure, then they should be allowed to make the transition. The logic of this conclusion is

supported in various ways. Some argue that requiring psychological assessment and referral prior to treatment is dehumanizing (Ashley, 2019) and undermines autonomy of consenting adolescents (Maung, 2024). Moreover, "mental readiness" as a prerequisite to such treatments contributes to patient distress and thus this gatekeeping is a "form of systemic discrimination" (Verbeek et al., 2022, p. 830). On the informed model of consent underlying these views, trans individuals "are the only ones who are best positioned, in the context of their lived experience, to assess and judge beneficence" (Cavanaugh et al., 2016, p. 1149). Accordingly, minors with "decisional capacity" have "both the right and the legal authority" to pursue such care (Clark & Virani, 2021, p. 162). In the end, "clinicians must practice epistemic humility and recognize trans peoples' embodied knowledge as legitimate, valid, and important" (Jacobsen, 2024, p. 2).

It has been argued that this implies that parents of children and adolescents (i.e., legally dependent young people) who choose medical transition have no 'veto power' over that decision in most cases (cf. Priest, 2019). Indeed, proponents of gender transition procedures argue that such parents have a moral obligation to support a child or adolescent in the decision to transition, assuming that the child or adolescent does not have a recognized psychological pathology that may influence the decision. Failure to offer support, one might claim, not only denies children and adolescents the ability to play a role in shaping their own lives, it also is essentially unloving, often leading to depression, social ostracization, and even suicide (cf. Wolford-Clevenger et al., 2017).

Additionally, failure to support offspring in their choices to transition is in tension with official recommendations of some medical authorities, who hold that parents should accommodate choices to transition in the interests of their offspring's physical and mental well-being (Coleman et al., 2012). Regardless of whether the parents believe that the child or adolescent is mistaken in the decision to transition, whether they think that transitioning will be in some way harmful, or whether they hold religious beliefs that are opposed to gender transition, some still argue that such parents ought to facilitate the transition.

In this paper, we challenge the idea that parents have a moral obligation to facilitate a child's or adolescent's choice of medical transition. Instead, we contend that parents of children and adolescents have a moral obligation to oppose the decision to transition using pharmaceutical and/or surgical procedures. To argue for this claim, we present and draw conclusions from a series of cases that are similar in their morally relevant details to cases involving medical transition for children and adolescents. Given such similarity, we contend that, on pain of irrationality, one must issue the same judgments across the board. If one does not make the same judgments about the cases, then the onus is on the defender of surgical or medical transition for children and adolescents to highlight a morally significant asymmetry. In the next section, we present and elaborate on two initial cases. In the final section we respond to potential objections.

2. Section 1

For each of the following cases, we pose the following question: Do the parents have a moral obligation to oppose the child's choice? With this question in mind, consider the first case:

> **Case 1**: Brian, who is 12 years old, recently made some friends at school who ascribe to a religion that practices, as an initiation rite, an extreme form of genital mutilation, which, according to the religion's dogma, must be performed during one's

> adolescent years; otherwise, the prospective member will not be accepted into the group. Initially skeptical, Brian spent months thinking about whether to convert to this new religion. Eventually, Brian becomes convinced that the religion is true. Brian received the primary motivation to convert to the religion upon undergoing a powerful religious experience. This religious experience consisted in a personal, revelatory feeling of certainty that the new religion is true. With this newfound assurance, Brian requests an operation for the type of genital mutilation that is required to be initiated into the religion.[1]

We maintain that Brian's parents have a moral obligation to oppose the request to undergo the initiation rite. The primary reason for this judgment is that Brian is at a developmentally formative stage of life. Children and adolescents have not, at those stages of life, developed the critical thinking skills and cognitive capacities necessary for making responsible, informed judgments on monumental, life-altering decisions (Johnson et al., 2009; Sturman & Moghaddam, 2011).[2] This is due partly to their lacking a wide variety of experiences that provide opportunities to learn, as well as to their lacking the cortical development associated with competent decision-making ability. If they lack such development and experience, then they should not make decisions that unnecessarily constrain how they begin their adult lives (cf. Jorgensen et al., 2024). As such, their parents are justified in exercising discretion for them regarding momentous decisions such as the initiation rite. Given both the lack of requisite cognitive abilities and experience, along with the life-altering nature of the religious initiation procedure, Brian's parents are obligated to deny him the opportunity to participate in the initiation rite.

Such are the judgments we maintain you should have about Case 1. If you do not think that Brian's parents should oppose his request, then our argument is not directed towards you. However, we assume that most readers will share our judgments about Case 1. So, notice that we can keep the structure and relevant moral aspects of the case the same, while changing other, less relevant secondary moral details. If so, then our judgments about the modified case should be the same as our judgments about Case 1. Consider, then, the second case:

> **Case 2**: Bruce, who is 12 years old, has for the last several months been thinking about transitioning to another gender. In other words, Bruce is experiencing gender incongruence. Born biologically a male, Bruce is now thinking about surgically transitioning to female. This transition will involve undergoing surgery that will significantly alter Bruce's reproductive organs, and consequently Bruce's hormone production. Eventually, Bruce becomes convinced that surgical transition is the right thing to do. Bruce received the primary motivation to transition from a personal, revelatory feeling that transitioning is the right thing to do. Bruce just does not feel like a boy or feel masculine, but instead feels like a girl and feels feminine. With this newfound assurance, Bruce requests an operation for the type of surgical procedure that facilitates transitioning to female.

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[1] We can assume, in this case and in the others that follow, that the procedures in question are carried out by medical professionals.

[2] As an anonymous reviewer helpfully commented, it is also worth noting that adolescents tend to be more socially influenced than adults (cf. Shrier, 2020).

As with Case 1, we maintain that Bruce's parents have a moral obligation to oppose the request to undergo the SRS. The primary reason for these judgments is the same as in Case 1: Bruce does not have the requisite cognitive development for such a momentous decision. As such, Bruce's parents would be reasonable to hold that he is ill-prepared to make decisions that could rob himself of future autonomous decisions.[3]

That Case 1 involves a religious belief while Case 2 involves a belief about one's gender identity is the only major difference between the two cases, but this is a morally irrelevant difference. Given that the morally relevant aspects of the two cases are the same—that is, given that they are both significant life decisions[4], the child lacks requisite cognitive development, and both are legally dependent on parents—our judgments should be the same in both cases, on pain of irrationality. Put formally, the argument can be stated as follows:

(1) The correct judgments for Case 1 are that the parents have a moral obligation to oppose the child's choice.
(2) If the aspects that justify the correct judgments for Case 1 are also present in Case 2, and there are no additional aspects in Case 2 that count against making the same judgments in Case 2 as are made in Case 1, then the correct judgments for Case 2 are the same as those that are made for Case 1.
(3) The aspects that justify the correct judgments for Case 1 are also present in Case 2, and there are no additional aspects in Case 2 that count against making the same judgments in Case 2 as are made in Case 1.
(4) Therefore, the correct judgments for Case 2 are the same as those that are made for Case 1, namely, that the parents have a moral obligation to oppose the child's choice.

If you do not give the same judgments for Case 2 as for Case 1, then there must be some morally relevant asymmetry between the two cases. However, we have been unable to detect any asymmetries. Therefore, our judgments about Case 1 should be the same as our judgments about Case 2. So, we conclude that parents have a moral obligation to oppose children's and adolescent's choices of SRS. We extend this argument to apply both to PBT and CSHT in response to objections in the next section.

Note the limited scope of our conclusion: we are only claiming warrant for such paternalism as long as the child or adolescent is under parental care. We are not claiming that legally independent and cognitively competent individuals should not have a legal right to transition, nor are we claiming that parents ought to interfere even once their offspring have become legally independent. Furthermore, we are not assuming that what provides sufficient justification for parental paternalism also provides sufficient justification for legal paternalism regarding adult agents (cf. Godwin, 2020). We remain neutral in this paper on whether parental paternalism and legal paternalism regarding adult agents are on a par; our focus is limited to the former. These caveats, however,

[3] For example, Feinberg (1980) argues that children possess rights that must be preserved until they can freely exercise them in the future. We can apply this view to irreversible interventions in adolescence that foreclose major life options later.

[4] In this context, decisions in both cases are *significant* because they carry implications for future mental health, reproductive health (e.g., infertility), and sexual function; in short, these decisions have life-long consequences.

are not sufficient to allay potential worries. So, in the next section, we address some objections to our argument.

3. Section 2

An initial response would, of course, attempt to identify some asymmetry between Case 1 and Case 2. If there are relevant moral differences between the two cases, then we may be justified in giving different judgments. For instance, a proponent of gender transition procedures could argue that there is a difference between a religious belief and a belief about one's gender. In particular, the difference is that a religious belief is a claim about the way the world is independently of one's psychology, whereas a belief about one's gender is an intrinsically subjective belief, which can be true regardless of what reality is like "out there." The reason why this difference is salient is that we have privileged access to first-person phenomenological experiences about which we cannot be mistaken.

In contrast, no one has privileged access to facts about the way the world is outside of one's psychology. So, whereas Brian could be (and almost certainly is) mistaken about his religious belief, Bruce cannot be mistaken in a belief about gender. In other words, if Bruce thinks and feels that he is female rather than male, then Bruce is, and Bruce cannot be wrong about that. But if Bruce's request for SRS is based on a belief about which Bruce cannot be wrong, whereas Brian's request for the religious initiation rite is based on a belief about which he most likely is wrong, then there is a relevant moral difference between Case 1 and Case 2, and we are justified in giving different judgments.

However, it is incorrect to assume that Bruce's and Brian's beliefs are different in kind (cf. Chappell, 2022). The proponent of gender transition procedures objects that a belief about one's gender is different in kind from a religious belief insofar as the former is something which one cannot get wrong and the latter is something one can easily get wrong. However, religious experiences also involve beliefs that are intrinsically subjective; that is, they are beliefs about oneself insofar as they are beliefs about one's own experiences. A person who has a revelatory experience cannot be wrong in believing that the revelatory experience occurred; it is just as much a subjective belief as a belief about one's gender. So, a person who bases a decision on a religious experience, as Brian does in Case 1, has just as privileged access to a foundation for making a decision as the person who bases a decision on any other sort of intrinsically subjective belief, such as a belief about one's gender.

However, one might object that, even if a religious belief can be intrinsically subjective, there is still a significant difference between such a religious belief and a belief about one's gender. For the person who bases a decision on the former is still making a decision based on a claim about the way the world is outside of one's psychology, which is not the case with the latter. Even if a person cannot be wrong about a subjective religious belief, that person could nevertheless go wrong when making inferences about the world on the basis of that belief, such as believing in a supernatural realm. For example, even if Brian cannot be wrong about his subjective religious experience, Brian could easily go wrong when inferring things about the world from the religious experience. In contrast, a belief about one's gender is not the type of belief from which one infers other beliefs about the way the world is outside of one's psychology; the ramifications of one's belief about one's gender are more limited. Put differently, the objection is that we have good reason

for thinking that Brian's religious claims about the world are delusional but that Bruce's subjective claims about gender are accurate.

In response, it is not clear that people cannot be wrong in their beliefs about first-personal experiences and feelings (cf. Ozturk, 2023). For instance, it seems possible to deceive oneself about the nature of one's experiences, such as when a person suffering from anorexia convinces herself that she is obese even though she is not. However, we need not contest the claim that first-personal experiences and feelings are infallible. For it is also not clear that all religious beliefs are of the type from which one infers other beliefs about the way the world is outside of one's psychology. Spirituality can be a wholly personal affair, involving claims only about one's religious experiences. For example, adherents of some types of religious mysticism may be committed only to claims about their personal experiences.

Nevertheless, even if it is true that religious beliefs have wider potential ramifications than beliefs about one's gender, this point is irrelevant to our argument. For Brian's decision to convert is based on the subjective religious experience—not directly on claims about a supernatural realm, a divine purpose for the world, and so on. Even if Brian were to infer beliefs about a supernatural realm or a divine purpose for the world from his belief about the subjective religious experience (all of which, of course, could be wrong), Brian does not decide to convert—and does not request the procedure for the initiation rite—on the basis of these other beliefs. So, even if religious beliefs are different from beliefs about one's gender, in that the former have a wider scope for ramifications than the latter, this difference does not affect the moral symmetry between Case 1 and Case 2.

There are other ways in which we can change this type of vignette to account for other potentially morally salient factors. For example, rather than having Brian spending months thinking about whether to convert, we could change the vignette to where Brian spends a few years wrestling with the question. We could also add that Brian's wrestling with whether he should convert causes intense psychological distress and suicidal ideation. Furthermore, just as advocates of gender-affirming care claim that transitioning increases life satisfaction, we make a similar claim: in general, religious engagement and religiosity contribute to one's physical and mental well-being (George et al., 2002; Jokela, 2022; Powell et al., 2003; Weber & Pargament, 2014), and in adolescence in particular (Chen & VanderWeele, 2018). However, even if we were to add these details to the vignettes, we hold that it is still clear that Brian's parents have a moral obligation to oppose him undergoing the initiation rite. The same would go, *mutatis mutandis*, for judgments about altered vignettes about Bruce.

Another way in which a proponent of gender transition procedures might respond would be to agree that children and adolescents should not be allowed to undergo SRS until a time when they become legally independent of their parents. However, even if they should not be allowed to undergo SRS, they should be allowed to choose other ways to transition medically, such as PBT and CSHT (cf. Priest, 2019).

The reason, an objector might say, for why children and adolescents should be allowed to choose PBT and CSHT, but perhaps not SRS, is that the former two options do not involve drastic changes, whereas the latter does. Put differently, if a child or adolescent receives SRS, there is little one can do to reverse that decision later in life, if so desired. However, one might claim that both PBT and CSHT are not as irreversible as SRS. Hence, on the possibility that a person retracts, later in life, the decision to

transition, if the transition consisted only in PBT or CSHT, there will not be lingering drastic consequences.

Further, one might argue that children and adolescents should be allowed to choose PBT and CSHT because those methods of transitioning are what some medical experts say are best practices. Given that we trust the directions of medical experts for other areas of healthcare, and that their training affords them the knowledge to issue authoritative guidance on healthcare, then we should also trust their specific guidance when it comes to gender transition procedures. To ignore guidance on gender transition from medical experts, while at the same time accepting their guidance in other areas of healthcare, appears to be unacceptably inconsistent.

In response, note that we can change the details of the cases to be analogous to PBT and CSHT, rather than SRS. For example, consider the following two cases, which are modified to address PBT:

> **Case 3**: Brian, who is 12 years old, recently made some friends at school who ascribe to a religion that practices, as an initiation rite, regularly drinking a concoction that significantly disrupts normal hormone production, which, according to the religion's dogma, must be performed during one's adolescent years; otherwise, the prospective member will not be accepted into the group. Initially skeptical, Brian spent months thinking about whether to convert to this new religion. Eventually, Brian becomes convinced that the religion is true. Brian received the primary motivation to convert to the religion upon undergoing a powerful religious experience. This religious experience consisted in a personal, revelatory feeling of certainty that the new religion is true. With this newfound assurance, Brian requests a regular supply of the concoction that is required to be initiated into the religion.
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> **Case 4**: Bruce, who is 12 years old, has for the last several months been thinking about transitioning to another gender. Born biologically male, Bruce is now thinking about transitioning to female. The transition procedure will involve regularly taking medications that block testosterone and other hormones associated with normal sexual development for boys, which is in line with official medical recommendation. Eventually, Bruce becomes convinced that PBT is the right thing to do. Bruce received the primary motivation to transition from a personal, revelatory feeling that transitioning is the right thing to do. In other words, Bruce does not feel male or masculine, but instead feels female and feminine. With this newfound assurance, Bruce requests to receive the hormone blocking medications.

We maintain that these two cases remain structurally similar, and that you should make the same judgments as in Case 1 and Case 2. That is, the judgments you should make about both Case 3 and Case 4 are that the parents have a moral obligation to oppose the requests.

That the consequences of PBT are not as drastic as those of SRS is not a sufficient reason to give different judgments, for several reasons. First, the consequences associated with PBT are *significant enough* to warrant parental intervention. For blocking pubescent development leads both to physical changes, such as stunted development of sexual organs and abnormal bone mineral density development (Perry et al., 2008), as well as to psychological changes (Auyeung et al., 2013; Davison & Susman, 2001). Put differently, endogenous substances such as estrogen, progesterone, and testosterone (as

well as 'upstream' substances such as gonadotropin-releasing hormone) have distinctive mental effects along with familiar anatomical effects (Gasbarri et al., 2012; Nguyen et al., 2017; Vuoksimaa et al., 2012).

The second reason why the less severe consequences of PBT compared to SRS are not sufficient reasons to give different judgments is that there is a significant chance that people who undergo either PBT or CSHT in either childhood or adolescence will still have to live with enduring consequences if the decision to transition is retracted later in life. In other words, though the consequences of PBT and CSHT are not as pronounced as SRS, the consequences are often the same in that they are not completely reversible (Hruz et al., 2017). As such, one's decision to undergo *any* sort of transition procedure (apart from social transition that may involve merely dressing and acting differently) is a *significant* life decision. If proponents of gender transition procedures grant that children and adolescents should not be allowed to choose SRS because of the wide-reaching effects of that decision, then they should also hold that children and adolescents should not be allowed to choose either PBT or CSHT, since these latter two have just as wide-reaching, though less drastic, effects as the former.

Further, if some medical authorities hold that children and adolescents should not be allowed to choose SRS because of the wide-reaching effects of that decision, then they should also hold that children and adolescents should not be allowed to choose either PBT (as a first-step treatment) or CSHT (as a down-the-road treatment after PBT), since the effects of the former and the effects of the latter are of the same type, though the effects of surgery are more drastic than the effects of hormonal interventions. Put more directly, insofar as expert medical advice supports PBT and CSHT for children and adolescents, but not SRS, then such advice should be changed so as to oppose the former. For the same reasons that justify opposing the choices of children and adolescents to transition surgically also justify opposing their choices to transition via PBT and CSHT.

Note that the claims in the previous paragraph do not denigrate medical authority: medical experts are uniquely qualified to inform us about the effects of surgeries and hormones on the body.[5] Instead, the point is that many medical issues are not *purely* medical issues; that is, correct judgments on many medical issues involve consulting more (but not less) than the effects of surgeries and hormones on the body. When making decisions about healthcare—especially when adults make decisions about the healthcare of children and adolescents—we must take into consideration moral and legal factors, such as the harm the procedure may cause, or whether the procedure involves violating a moral or legal standard, in addition to the biological data.

However, you might think that medical authorities have taken into consideration all relevant factors when formulating guidelines, and, though there may be risks involved with the different types of medical transition, there are even greater risks for the well-being of children and adolescents if they are not allowed to transition. For example, you might think that denying a child or adolescent the opportunity to transition in some way runs the risk of that person committing suicide, which is much worse than any consequence that might follow if the person is permitted the opportunity to transition medically.

[5] It is worth noting, though, that some medical agencies are capable of making political decisions that are not evidence-based. Witness, for example, the fiasco with the CDC's guidance on masking during the COVID-19 pandemic.

In response, note first that the evidence on whether gender transition procedures mitigate suicidality is mixed (Lewis et al., 2025; Cass, 2024; Marques et al., 2023; Jackson, 2023; Littman, 2021; Day et al., 2019; Dhejne et al., 2011). In 2025, the U.S. Department of Health and Human Services published a report concluding that the overall quality of evidence for the benefits of gender-affirming medical transition in minors, including suicidality outcomes, is low (U.S. Department of Health and Human Services, 2025). Given the lack of clear evidence that gender transition procedures mitigate suicidality, we should not appeal to a reduction of suicidality as a reason for implementing gender transition procedures, since it is not clear that there is such an effect. The epistemic standard applied here is the following: *Where evidence is uncertain and risks of harm are substantial and irreversible, the default ethical stance toward minors should be precautionary.*[6]

Nevertheless, we can ask whether there would be strong reason to implement gender transition procedures if there were clear and abundant evidence that such procedures mitigate suicidality. And the answer to this is "no." The reason for this is that there are other ways of mitigating suicidality in people experiencing gender dysphoria that do not involve significant physical alterations, as does using gender transition procedures (Heathcote et al., 2024). Alternative interventions include, among others, talk therapy, cognitive behavioral therapy, and integration into loving communities (Busa et al., 2018). Feeling socially accepted and supported is compatible with being denied the opportunity to transition medically at a young age. Parents and caregivers looking out for their child's future can still provide social acceptance, support, and love, even if they also deny their child an opportunity to transition medically.

Finally, suppose we are wrong to assume that most, if not all, children and adolescents do not possess the requisite cognitive abilities to make momentous decisions. That is, let's grant that some precocious children and adolescents have an intellectual ability to make competent decisions that is comparable to the abilities of many adults. Should young people such as these be allowed to choose any sort of gender transition procedure without parental intervention? Would parents of these children and adolescents have a moral obligation to intervene?

We maintain that, even if some children and adolescents have unusually mature intellectual abilities to make significant life decisions, parents still have a moral obligation to oppose the decisions of such precocious children to transition medically. The reason for this is that even precocious children and adolescents are fallible. The fact that they are precocious does not mean that they will always, or even often, make the right decisions for transformative experiences such as gender transition procedures. There are many significant life decisions that parents and/or the government tend to preclude from children and adolescents regardless of their level of advancement, such as physician-assisted suicide. Gender transition procedures for children and adolescents should also be among such life decisions that parents oppose. As long as children and adolescents are legally dependent upon their parents, the parents are morally responsible for providing the type of guidance and support that facilitates their offspring eventually to become responsible adults; and the need for such guidance and support remains even for unusually intelligent children and adolescents.

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[6] For example, see Sunstein (2005) and Ross (1998).

As long as there remains a moral role for parents to fulfill in guiding and supporting their offspring, they have an obligation to oppose any decision the effects of which could be detrimental and could persist long after the person has matured into adulthood. Doing so is partly constitutive of facilitating maturation into adulthood, since it is an attempt to ensure that children and adolescents are not constrained, when starting their adult lives, by the consequences of choices they made in their youth.[7]

We conclude that legal policies and medical directives that allow for or prescribe gender transition procedures are unwarranted. Parents have a moral obligation to oppose the choices of their children and adolescents to transition medically. As a corollary, we contend that any medical guidance that supports gender transition for children and adolescents is wrong and should be revised.

Author Contributions: E.S. and A.L.R. made equal contributions to the production/completion of the paper.

Funding: This research received no external funding.

Acknowledgments: Special thanks to Dan Demetriou, Dwight Stanislaw, and anonymous reviewers for helpful comments on earlier versions of this paper.

Conflicts of Interest: The authors declare no conflict of interest.

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[7] We do not say anything here about the legal obligations of parents who have precocious children and adolescents who request to transition. Several states have adopted a 'mature minor' doctrine, which allows, typically on a case-by-case basis, an adolescent who has demonstrated competency to make medical decisions independently of his or her parents (cf. Will, 2005).

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