Note

Designer Minor: Creating a Better Legal Regime for Pediatric Cosmetic Procedures

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INTRODUCTION

The growing phenomenon of pediatric cosmetic surgery has long made international headlines. In 2001, the parents of a 15-year-old in Nottinghamshire, England received global attention for arranging a breast enlargement surgery for their daughter's birthday.[1] "You've got to have breasts to be successful," their daughter explained, "[e]very other person you see on television has had implants. I used to pray that my boobs would grow. Then I just thought, what's the point when I can have implants when I want?"[2]

Teenagers' growing interest in cosmetic procedures is attributable to "an increase in self-awareness and desire to 'fit in' with their peers."[3] Issues of body image, self-esteem, and psychological functioning in teenagers also contribute to the increasing popularity of pediatric cosmetic procedures.[4] These issues are amplified by the rise of social media and "selfies," which evidently increase appearance-based

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1. Helen Carter, *Parents Defend Breast Implants for Girl, 15*, GUARDIAN (U.K.) (Jan. 4, 2001), https://www.theguardian.com/uk/2001/jan/05/helencarter [https://perma.cc/S9E4-CJGY].

2. *Id.*

3. Rod J. Rohrich & Min-Jeong Cho, *When Is Teenage Plastic Surgery Versus Cosmetic Surgery Okay? Reality Versus Hype: A Systematic Review*, 142 PLASTIC & RECONSTRUCTIVE SURGERY 293e, 293e (2018).

4. *Id.*; *see also* Valerie Ulene, *Plastic Surgery for Teens: Too Soon?*, L.A. TIMES (Jan. 12, 2009), https://www.latimes.com/archives/la-xpm-2009-jan-12-he-themd12-story.html [https://perma.cc/Z9B6-W53L] ("Of course American teens want to undergo these procedures . . . . Because teens take every imperfection (real or perceived) seriously, physical differences, however minor, can influence what they think of themselves and how they behave.").

bullying and cause teenagers to be hyper-aware of their appearances.[5] Likewise, the COVID-19 pandemic and transition to virtual Zoom learning has caused what is colloquially known as the "Zoom Boom," a notable increase in the number of cosmetic procedures performed during the pandemic.[6] Like social media and selfies, "[l]ockdown and remote work have meant hours of staring at our own faces on video calls—and prompted interest in going under the knife."[7]

In addition to teenagers, adolescent pre-teens and young children undergo cosmetic surgical and non-surgical procedures every year.[8] For pre-teens and young children, the request for a pediatric cosmetic procedure is most often initiated by a parent or guardian on the child's behalf.[9] In many cases, these procedures are "products of parental judgments about a child's best interests . . . . They were, by definition, elective, and were effected at the parent's request, not on the recommendation of a physician."[10] Thus, for better or worse, "it is the parents who seek out medical or surgical modifications, find a willing provider, and give their consent to size, shape, sculpt, or mine their children's body for social, aesthetic, familial, or cultural reasons."[11]

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5. Rohrich & Cho, *supra* note 3; *see also* Madhubanti Sadhya, *The Legal and Ethical Discourse on Cosmetic Surgeries in Children*, 8 GNLU L. REV. 160, 164 (2021) ("With the rise of social media platforms, which are thronged by young people, several menacing trends are coming to light. Some of these platforms have in-built software called 'filters' that apply virtual effects on appearances like making eyes and lips larger, teeth whiter and skin smoother and teenagers seeking cosmetic procedures have often expressed the desire to mimic Snapchat and Instagram filters.").

6. Sally Meeson, *Why Plastic-Surgery Demand Is Booming Amid Lockdown*, BBC (Sept. 16, 2020), https://www.bbc.com/worklife/article/20200909-why-plastic-surgery-demand-is-booming-amid-lockdown [https://perma.cc/9NWA-63ZU]; Danielle Braff, *Plastic Surgeons Say Business Is Up, Partly Because Clients Don't Like How They Look on Zoom*, WASH. POST (Dec. 8, 2020), https://www.washingtonpost.com/road-to-recovery/plastic-surgery-cosmetic-covid-zoom/2020/12/07/6283e6d2-35a2-11eb-b59c-adb7153d10c2_story.html [https://perma.cc/3FR8-TDD4] ("Jon Mendelsohn, medical director of Advanced Cosmetic Surgery & Laser Center in Cincinnati, said injectable procedures such as Botox and fillers were up 90 percent compared with the same period last year.").

7. Meeson, *supra* note 6.

8. For example, Johns Hopkins Medicine reports that "[e]ar pinning . . . (also called otoplasty[]) . . . is most commonly performed on children at age 5 or 6." *Treatments and Procedures: Ear Pinning*, JOHNS HOPKINS MED., https://www.hopkinsmedicine.org/otolaryngology/specialty_areas/facial-plastic-reconstructive/cosmetic/ear-pinning.html [https://perma.cc/8P6L-74WH].

9. Alicia Ouellette, *Shaping Parental Authority over Children's Bodies*, 85 IND. L.J. 955, 960 (2010).

10. *Id.*

11. *Id.* at 957.

The troubling nature of this phenomenon is most clearly illustrated by anecdotal evidence. Consider the case of a White man who reportedly "westernized" the eyes of his adopted child.[12] In a speech celebrating the "miracles of modern medicine," the man took pride in the results of a blepharoplasty (eyelid surgery) performed on his adopted daughter's Asian eyes:

> He explained that like many of those of Asian descent, she lacked a fold in her upper eyelid; which, in his view, was a problem for her "because it made her eyes small and sleepy and caused them to shut completely when she smiled." He finished by commenting that . . . his adopted Asian daughter "now has big round eyes that stay open and shine even when she smiles."[13]

In addition to surgical modifications like blepharoplasties, parents can obtain non-surgical cosmetic procedures for their children. One of the most controversial of these non-surgical procedures is human growth hormone (HGH) injections.[14] Some parents arrange HGH injections for their children of average height, "in the hopes that the drug will enable them to grow tall enough to become successful basketball players."[15] Other parents are concerned that their children's short stature will negatively impact their quality of life.[16] For example, 6-year-old Nicole Costa received the HGH, Humatrope, after her doctors estimated she would be fully grown at four feet, eight inches.[17] She later testified at a Food and Drug Administration (FDA) advisory committee meeting "that she could not imagine what her life would have been like without the human growth hormone (HGH) injections she received."[18] However, even if some recipients of HGH injections

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12. Derrick Diaz, *Minors and Cosmetic Surgery: An Argument for State Intervention*, 14 DEPAUL J. HEALTH CARE L. 235, 253 (2012) (quoting Alicia Ouellette, *Eyes Wide Open: Surgery to Westernize the Eyes of an Asian Child*, 39 HASTINGS CTR. REP. 15, 16 (2009)).

13. Diaz, *supra* note 12.

14. Ouellette, *supra* note 9, at 956, 961–63 ("Parents have used that power to . . . modify the facial features of children with Down Syndrome, to inject human growth hormone (HGH) into healthy children, to enlarge the breasts of or suck the fat from teenagers . . . .").

15. *Id.* at 962.

16. Melissa Healy, *Healthy Kids Can Be Taller with Growth Hormones*, BALT. SUN (Sept. 28, 2003), https://www.baltimoresun.com/news/bs-xpm-2003-09-28-0309290318-story.html [https://perma.cc/5382-5TVP] ("[V]arious research . . . showed how short people are more likely to be bullied and teased in school, to consider themselves lonely, to have reduced marriage rates and be perceived as having lower competence than people of ordinary height.").

17. Vita Maria Salvemini, Note, *Idiopathic Short Stature or Just Plain Short: Why the Federal Government Should Regulate the Administration of Human Growth Hormone to Healthy Children*, 38 GA L. REV. 1105, 1105 (2004).

18. *Id.*

are later pleased with the results, it is questionable whether such procedures are appropriate for children. Consider a child who is just five years old:

> That child will receive hormone injections six times weekly for as long as ten years, until the child reaches adult height because that otherwise healthy child is predicted to be shorter than the average height adult or because his parents just want him to be taller than his predicted adult height and they have found a physician willing to prescribe treatment.[19]

Needless to say, pediatric cosmetic procedures can be troubling.[20] On the one hand, there is an innate sense of discomfort with the idea that parents can arrange breast implants for their 15-year-old, "westernize" the eyes of their adopted Asian daughter or inject their children with HGH to increase their chances of becoming successful basketball players. On the other hand, there is a gray area in which pediatric cosmetic procedures may be well-intentioned or even in the minor's best interest.[21] For instance, a parent might arrange a cosmetic procedure out of concern for their child's mental health,[22] or

19. *Id.* at 1105–06. Despite this involved process, HGH injections "will not make a short person tall; a child who would have been five feet tall as an adult without the injections would likely be five feet, one and one-half inches or five feet, two inches after treatment." Ouellette, *supra* note 9, at 962.

20. *See* Ouellette, *supra* note 1212, at 17 ("The nature of the surgery makes the case especially troubling. For some people, the shape of the eye is an integral part of ethnicity, a component of identity. A change to it may, therefore, go deeper than the removal of a mole or the pinning of a child's ears. In choosing the surgery, the father took from his daughter the ability to make her own choice about her identity.").

21. *See* Laura T. Coffey, *Can Plastic Surgery Be Good for Teens?*, TODAY (Mar. 30, 2010), https://www.today.com/parents/can-plastic-surgery-be-good-teens-2D80556266 [https://perma.cc/2DWB-9PX3] ("[W]hen a teen seeks out plastic surgery to correct a noticeable physical defect or to change a body part that's caused prolonged psychological distress, that can be a good thing, doctors say.").

22. For example, parents may arrange for a child's otoplasty (ear surgery) after protruding ears "provoke teasing and name calling. ('Dumbo' is a common taunt[])" and when teasing "caus[es] intense emotional strain." Mary Duenwald, *How Young Is Too Young to Have a Nose Job and Breast Implants?* N.Y. TIMES (Sept. 28, 2004), https://www.nytimes.com/2004/09/28/health/how-young-is-too-young-to-have-a-nose-job-and-breast-implants.html [https://perma.cc/S2C6-6RZD]. However, such parental concern is not without its own controversies. *See, e.g.*, Shlomo Kravetz, Aron Weller, Rivka Tennenbaum, David Tzuriel & Yael Mintzker, *Plastic Surgery on Children with Down Syndrome: Parents' Perceptions of Physical, Personal, and Social Functioning*, 13 RSCH. DEVELOPMENTAL DISABILITIES 145, 153 (1992) (performing plastic facial surgery on children with Down Syndrome did not improve social functioning despite parents' contrary perceptions).

as in the case of Nicole Costa's HGH injections, future career opportunities.[23]

Whether their intentions are pure or misguided, parents are given immense discretion with regard to the care of their children.[24] Despite the fact that states have the authority to intervene in private family matters when there is substantial risk of harm to a minor, states rarely, if ever intervene to prevent parents from obtaining a cosmetic procedure for their child.[25] In fact, the state may never become aware of a pending procedure or the potential harm to the minor, especially in the case of young children who have little to no involvement in the decision to receive a cosmetic procedure.

In the United States, there are no age restrictions for cosmetic surgeries aside from the Food and Drug Administration's prohibition of saline and silicone breast implants for those under age 18.[26] Since the state is largely absent in this realm, the only real barrier parents face in obtaining a cosmetic procedure for their child is finding a willing provider. Under a most cynical view, some providers may not adequately consider a child's best interest for financial or other reasons,[27] such as deference to parents or personal convictions about "normal standards of attractiveness."[28] Indeed, "[t]he presumption that parents in consultation with physicians would act for the children's best interest does not hold in a situation where parents allow extreme surgical intervention to align children's bodies towards social

23. Nicole Costa's mother stated, "I'm thinking about when she's 25 and walking into a courtroom with an attache case, or into a hospital with a stethoscope . . . . Being 4-foot-8—that just didn't cut it." *Supra* note 16.

24. *See* RESTATEMENT OF THE L. CHILD. & THE L. § 2.30(1)(a) (A.L.I., Tentative Draft No. 1, 2018) ("A parent or guardian has broad authority to make medical decisions for a child.").

25. *See infra* Part II.C.

26. Sadhya, *supra* note 5, at 173. But even then, cosmetic surgeons can make an "off label" use of breast implants for minors. *Id.*

27. *See* Dennis J. Baker, *Should Unnecessary Harmful Nontherapeutic Cosmetic Surgery Be Criminalized?*, 17 NEW CRIM. L. REV. 587, 609 (2014) ("Surgeons motivated by monetary compensation seem to be willing to perform these harmful operations as a quick fix for self-esteem issues, when psychological counseling would provide a harmless cure.").

28. In addition to financial incentives, some providers believe that minors' appearances should "conform to normal standards of attractiveness." Dan O'Connor, *A Choice to Which Adolescents Should Not Be Exposed: Cosmetic Surgery as Satire*, 15 J. HEALTH CARE L. & POL'Y 157, 157 (2012) ("[I]mproving a teen's life by structurally improving his or her physical appearance to conform to normal standards of attractiveness is a good thing." (quoting FREDERICK N. LUKASH, THE SAFE AND SANE GUIDE TO TEENAGE PLASTIC SURGERY 3 (Debbie Harmsen ed., 2010))).

acceptability but also exposes them to medical risks with no demonstrable medical benefit."[29]

In sum, pediatric cosmetic procedures are laden with unanswered legal and ethical questions—when, if ever, is it ethically appropriate for a minor to receive a cosmetic procedure? When, if ever, is it legally appropriate for the state to supersede a parent's decision, not to withhold treatment, but to elect unnecessary procedures for their children? These questions deserve more attention. Despite data to the contrary, most existing medical and legal literature assumes that recipients of cosmetic procedures are adults.[30] Moreover, there is a lack of professional guidance for pediatric cosmetic procedures,[31] leaving an already vulnerable population unprotected and exposed to unnecessary bodily invasions and risks of harm.

This Note will address the ethical and legal implications of pediatric cosmetic surgery and discuss the competing interests of (1) children's rights, (2) parental liberties, and (3) state interests. Part I will map the landscape of pediatric cosmetic surgery, including its risks and potential benefits. Part II will explain the current legality of such procedures, detailing relevant legal doctrines such as mature minor, bodily integrity and informed consent, constitutional principles of parenthood, and the state's parens patriae power. Part III proposes a new and improved legal regime requiring prior authorization of all cosmetic surgeries and high risk non-surgical procedures for children under the age of fourteen. This multifaceted approach balances traditional doctrines with contemporary solutions to provide a blueprint for greater state oversight of pediatric cosmetic surgery.

I. THE LANDSCAPE OF PEDIATRIC COSMETIC PROCEDURES

Creating a new and improved legal regime for pediatric cosmetic procedures requires careful definition of terms and delineation of scope. The first two Sections of this Part attempt to disentangle the phrase "pediatric cosmetic procedures" into understandable components. Section A defines "pediatrics," focuses on the 0–17 age group

29. Sadhya, *supra* note 5, at 173–74.

30. As of November 2021, a search of "cosmetic surgery" on Google Scholar yields approximately 105,000 results. But a search of "pediatric cosmetic surgery" yields just two results.

31. Rohrich & Cho, *supra* note 3, at 295e. The American Society of Plastic Surgeons (ASPS) has published some guidelines for cosmetic surgery performed on teenagers. *Briefing Paper: Plastic Surgery for Teenagers*, AM. SOC'Y PLASTIC SURGEONS, https://www.plasticsurgery.org/news/briefing-papers/briefing-paper-plastic-surgery-for-teenagers [https://perma.cc/4EYU-3FUB].

(i.e., minors), and explains the "Rule of Sevens" as a guide to understanding minors' decision-making capacities as they progress to adulthood. Section B differentiates "cosmetic," "reconstructive," and "plastic" surgeries and explains why reconstructive surgeries are outside the scope of this Note and not included in the proposed solution. The last two Sections of this Part survey the landscape of pediatric cosmetic procedures. Section C identifies trends in the type and frequency of pediatric cosmetic procedures and explores existing professional guidance while Section D explains the physical and psychological risks and potential benefits such procedures involve.

A. UNDERSTANDING PEDIATRICS, MINORS, AND THE RULE OF SEVENS

Pediatrics is defined as "a multifaceted specialty that encompasses children's physical, psychosocial, developmental, and mental health."[32] There is no strict age cutoff for pediatrics, nor is one recommended by the American Academy of Pediatrics (AAP).[33] Traditionally, pediatric medicine was limited to those under age 21, but this rigid approach has since been abandoned by the AAP.[34] Although pediatrics can extend past the legal age of adulthood, parents typically do not have legal authority over their children's health care after age 18, unless they are called upon to make decisions for an incapacitated child.[35] As such, this Note will focus on individuals in the 0–17 age group (i.e., legal minors), who are generally subject to parental control.[36]

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32. Amy Peykoff Hardin & Jesse M. Hackell, *Age Limit of Pediatrics*, 140 PEDIATRICS 1, 1 (2017) https://pediatrics.aappublications.org/content/pediatrics/140/3/e20172151.full.pdf [perma.cc/8WGJ-WCRK].

33. *Id.* ("Although adolescence and young adulthood are recognizable phases of life, an upper age limit is not easily demarcated and varies depending on the individual patient. The establishment of arbitrary age limits on pediatric care by health care providers should be discouraged.").

34. *Id.* at 1–2.

35. *See generally* Erin S. DeMartino, David M. Dudzinski, Cavan K. Doyle, Beau P. Sperry, Sarah E. Gregory, Mark Siegler, Daniel P. Sulmasy, Paul S. Mueller & Daniel B. Kramer, *Who Decides When a Patient Can't? Statutes on Alternate Decision Makers*, 376 NEW ENG. J. MED. 1478 (2017).

36. Even while limiting this discussion's focus to the 0–17 age group, enriching the debate surrounding pediatric cosmetic procedures can help inform regulation of in utero gene editing and so-called "designer babies," which encompass many of the same ethical issues. *See* Erika Check Hayden, *Should You Edit Your Children's Genes?*, 530 NATURE 402 (2016), https://www.nature.com/news/should-you-edit-your-children-s-genes-1.19432 [https://perma.cc/8EKT-7TY6] (discussing the fact that many people with genetic conditions would not change their condition by altering their DNA).

It is important to note that individuals in the 0–17 age group are not homogenous in their development; indeed, competence and decision-making capacities can and do change rapidly as children progress to adulthood. To help conceptualize a child's development, the "Rule of Sevens" is often used in pediatric medicine and research to extrapolate age thresholds for minors' decision-making capacities.[37]

The Rule of Sevens states, roughly, that children under age 7 do not have the capacity necessary to make their own decisions; children from 7–14 years of age are presumed not to have this capacity until proven otherwise in individual cases, and children over age 14 are presumed to have capacity to make their own decisions and lead their own lives, unless proven otherwise.[38]

In other words, the Rule of Sevens is a guide to ascertain the status of minors' decision-making capacity, specifically, when decision-making capacity is presumably non-existent (age 0–7), developing (age 7–13), and mostly developed (age 14+).[39]

B. DIFFERENTIATING "COSMETIC," "RECONSTRUCTIVE," AND "PLASTIC" SURGERY

Delineating the scope of "cosmetic" is challenging because "cosmetic surgery," "reconstructive surgery," and "plastic surgery" are often used interchangeably despite key differences.[40] The American College of Cosmetic Surgeons (ACCS) defines "cosmetic surgery" as "a unique discipline of medicine focused on enhancing appearance through surgical and medical techniques. Cosmetic surgery can be performed on all areas of the head, neck and body. Because treated areas function properly but lack aesthetic appeal, cosmetic surgery is elective."[41] By contrast, "reconstructive surgery is performed to treat

37. *See* D.S. Wendler, *Assent in Paediatric Research: Theoretical and Practical Considerations*, 32 J. MED. ETHICS 229, 230 (2006).

38. *Id.*

39. David B. Waisel, *Informed Consent: The Core of Pediatric Bioethics*, SOC'Y FOR PEDIATRIC ANESTHESIA (Oct. 17, 2008), https://www2.pedsanesthesia.org/meetings/2008annual/syllabus.iphtml [https://perma.cc/JC75-U3NR].

40. *See* Diaz, *supra* note 12, at 238.

41. *About Cosmetic Surgery*, AM. ACAD. COSM. SURGERY, https://www.cosmeticsurgery.org/page/CosmeticSurgery [https://perma.cc/F5NU-4D86]. In this context, "elective" simply means "relating to, being, or involving a nonemergency medical procedure and especially surgery that is planned in advance and is not essential to the survival of the patient." *Elective*, MERRIAM-WEBSTER MED. DICTIONARY, https://www.merriam-webster.com/dictionary/elective#medicalDictionary [https://perma.cc/LUD3-G6VW].

body parts affected aesthetically or functionally by congenital defects, developmental abnormalities or trauma."[42]

The distinction between reconstructive and cosmetic surgery can be extremely subtle, especially because the same type of surgery can be cosmetic or reconstructive depending on context. For example, rhinoplasties (nose surgeries, colloquially known as "nose jobs") are a type of plastic surgery that can be performed cosmetically to "enhance[] facial harmony and the proportions of [the] nose," or reconstructively to "correct impaired breathing caused by structural defects in the nose."[43] Thus, what separates cosmetic and reconstructive surgeries may not always be the procedure itself so much as the purpose for it. Nevertheless, the reconstructive-cosmetic distinction is important for a variety of legal, ethical, and logistical reasons.[44]

In *Steven S. v. GHI*, the court grappled with the reconstructive-cosmetic distinction in addressing whether an insurance company wrongly refused to reimburse a 17-year-old male patient for a gynecomastia operation (male breast reduction) resulting from excessive breast tissue.[45] The insurance company classified the procedure as "cosmetic" because it provided no material health benefit.[46] However, the patient's condition was significantly impacting his psychological development. He "never engaged in chest exposing activities (e.g., swimming). He even declined admission to an out-of-state university due to fear of living in a dormitory where his chest might be seen. And, although he made efforts to lose weight, and did so by eight sizes, his gynecomastia [excessive breast tissue] remained."[47] Finding for the 17-year-old plaintiff, the court held that his gynecomastia operation

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42. *Reconstructive Procedures*, AM. SOC'Y PLASTIC SURGEONS, https://www.platicsurgery.org/reconstructive-procedures [https://perma.cc/9XE9-4NTL]. Cleft lip and palate repair are examples of reconstructive surgery, both "restoring function to the lips and mouth and producing a more normal appearance." *Cleft Lip and Palate Repair*, AM. SOC'Y PLASTIC SURGEONS, https://www.plasticsurgery.org/reconstructive-procedures/cleft-lip-and-palate-repair [https://perma.cc/YHM6-ZLKQ].

43. *Rhinoplasty*, AM. SOC'Y PLASTIC SURGEONS, https://www.plasticsurgery.org/cosmetic-procedures/rhinoplasty [https://perma.cc/N5EU-2S4D].

44. *See, e.g.*, *Briefing Paper: Plastic Surgery for Teenagers*, *supra* note 31 ("Although health insurance does not pay for cosmetic plastic surgery, coverage is often provided when a procedure alleviates physical symptoms or improves a body function.").

45. Diaz, *supra* note 12, at 260 (citing Steven S. v. GHI, 787 N.Y.S.2d 828, 830 (Civ. Ct. 2004), *aff'd sub nom*. Schulman v. Group Health, Inc., 816 N.Y.S.2d 806 (App. Term 2006)).

46. *Id.*

47. *Id.*

was neither a "cosmetic surgery" nor outside the scope of his insurance policy.[48] In fact, the court found that it was more aptly characterized as a "reconstructive surgery performed 'because of congenital disease or anomaly of a covered child, which has resulted in a functional defect.'"[49] In this way, *Steven S.* helps illustrate the subtle reconstructive-cosmetic distinction and its legal significance.

To differentiate between reconstructive and cosmetic surgeries, it is helpful to remember that reconstructive surgeries may have a functional benefit and are performed on "congenital defects, developmental abnormalities, and trauma," whereas cosmetic surgeries are focused on "enhancing appearance" and provide no functional benefit.[50] The distinction considers whether the impairment (i.e., the physical characteristic to be altered) "hinder[s] a minor's normal physical function"[51] and whether "the proposed surgery [is] intended to treat a present or future clinically verifiable disease, deformity, or injury."[52] If the "impairment" hinders the child's physical function and is intended to treat a disease, deformity, or injury, then the surgery is reconstructive and not cosmetic. To provide further clarity, the table below contains a non-exhaustive list of procedures considered within and outside the scope of this Note.

48. *Id.* at 262.

49. *Steven S.*, 787 N.Y.S.2d at 830.

50. *Compare About Cosmetic Surgery*, *supra* note 41 (defining "cosmetic surgery"), *with Reconstructive Procedures*, *supra* note 42 (defining "reconstructive surgery").

51. Diaz, *supra* note 12, at 262.

52. *Id.* at 262–63.

Procedures considered cosmetic and within the scope of this Note.	**Procedures considered reconstructive* or otherwise outside the scope of this Note.**
Breast Augmentation Breast Lift Brow Lift Buttock Augmentation Chin Augmentation Otoplasty (Ear Surgery) Eyelid Surgery Facelift Liposuction Neck Lift Rhinoplasty (Nose Surgery) Human Growth Hormone (HGH) Injections[53]	Surgical Correction of Congenital Anomalies* Cleft Lip and Palate Repair* Septoplasty (Deviated Septum Correction)* Hand Surgery (Improve Strength, Function, Flexibility)* Giant Nevi Removal* Circumcision[54] Genital Surgery (Ambiguous Genitalia) and Gender Affirming Health Care (e.g., Gender Reassignment Surgery)[55] Breast Reduction[56]

In addition to "cosmetic" and "reconstructive" surgeries, some procedures are referred to as "plastic" surgeries. The American Academy of Cosmetic Surgery (AACS) defines "plastic surgery" as "a surgical specialty dedicated to reconstruction of facial and body defects due

53. Admittedly, HGH injections are not "surgery" but rather are a non-surgical cosmetic procedure worthy of consideration given the high risks involved. *See* Ouellette, *supra* note 9, at 962 (describing the physical, psychological, and psychosocial risks of HGH injections).

54. There is some debate as to whether male circumcision should be deemed a cosmetic procedure. However, circumcision is not considered "cosmetic" for purposes of this Note because there is evidence that it offers at least some physical health benefit, such as decreased risk of infection. Brian J. Morris & Aaron A. R. Tobian, *Legal Threat to Infant Male Circumcision*, 167 JAMA PEDIATRICS 890, 890 (2013).

55. Genital surgery on ambiguous genitalia (for example, "intersex" infants) and gender-affirming health care are not considered "cosmetic" for purposes of this Note. The intricacies of sex and gender and the unique psychological implications such surgeries have on minors' development make genital surgery and gender-affirming health care deserving of discussion in their own right. For background on the legal and ethical issues of pediatric cosmetic genital surgery, see generally Anne Puluka, *Parent Versus State: Protecting Intersex Children from Cosmetic Genital Surgery*, 2015 MICH. ST. L. REV. 2095 (2015); and Robert Hupf, *Allyship to the Intersex Community on Cosmetic, Non-Consensual Genital "Normalizing" Surgery*, 22 WM. & MARY J. WOMEN & L. 73 (2015). For discussion of transgender youth's health care issues, see generally *Outlawing Trans Youth: State Legislatures and the Battle over Gender-Affirming Healthcare for Minors*, 134 HARV. L. REV. 2163 (2021).

56. Breast reduction surgeries are most often performed on women with macromastia (abnormally large breasts) to resolve issues including "[c]hronic back, neck and shoulder pain . . . [c]hronic rash or skin irritation under the breasts . . . [n]erve pain . . . [and] [r]estricted activity." *Breast Reduction Surgery*, MAYO CLINIC, https://www.mayoclinic.org/tests-procedures/breast-reduction-surgery/about/pac-20385246 [https://perma.cc/MUN5-U6H4]. In such cases, breast reduction is not "cosmetic" because it offers functional benefit.

to birth disorders, trauma, burns, and disease. Plastic surgery is intended to correct dysfunctional areas of the body and is reconstructive in nature."[57] However, plastic surgery can be, and often is, performed for aesthetic reasons, meaning "reasons other than functional benefit, or correcting deformities, or reconstructing deformities caused by disease or trauma."[58] If performed for aesthetic reasons, plastic surgery "is solely intended to improve upon what nature has already physically given to a person's appearance."[59] Thus, plastic surgery is a sub-specialty that can be either "reconstructive" or "cosmetic."

C. EXPLORING CURRENT TRENDS IN PEDIATRIC COSMETIC PROCEDURES AND THE NEED FOR PROFESSIONAL GUIDANCE THAT PROVIDERS ADHERE TO

One limitation of studying the 0–17 age group is the lack of available data on the number and types of cosmetic procedures performed annually.[60] The most recent available data reporting on the 0–17 age group was published in 2019 by the Aesthetic Society,[61] a professional society comprised of board-certified plastic surgeons who practice cosmetic medicine.[62] To collect this data, the Aesthetic Society worked with an independent research firm to project nationwide statistics

57. *About Cosmetic Surgery*, *supra* note 41.

58. Diaz, *supra* note 12, at 238; *see Cosmetic Surgery vs. Plastic Surgery*, AM. BD. COSM. SURGERY, https://www.americanboardcosmeticsurgery.org/patient-resources/cosmetic-surgery-vs-plastic-surgery [https://perma.cc/JEK5-S3LY] (noting that many plastic surgeons choose to complete additional training in cosmetic surgeries).

59. Diaz, *supra* note 12, at 238.

60. Professional societies utilize different age groups to report statistics. The ASPS, for example, provides statistics for the 13–19 age group, whereas the Aesthetic Society provides statistics for those age 17 and under. *Compare Plastic Surgery Statistics Report*, AM. SOC'Y PLASTIC SURGEONS (2019), https://www.plasticsurgery.org/documents/News/Statistics/2019/plastic-surgery-statistics-report-2019.pdf [https://perma.cc/4TFN-Y8WW], *with Aesthetic Plastic Surgery National Databank Statistics*, AESTHETIC SOC'Y, (2019) [hereinafter *Aesthetic Plastic Surgery Statistics (2019)*], https://www.surgery.org/sites/default/files/Aesthetic-Society_Stats2019Book_FINAL.pdf [https://perma.cc/T9AY-7Z4V].

61. The Aesthetic Society did not report on the 0–17 age group in its 2020 Report. Thus, the most recent data is from 2019. *Compare Aesthetic Plastic Surgery National Databank Statistics*, AESTHETIC SOC'Y, (2020) [hereinafter *Aesthetic Plastic Surgery Statistics (2020)*], https://cdn.theaestheticsociety.org/media/statistics/aestheticplasticsurgerynationaldatabank-2020stats.pdf [https://perma.cc/EL84-MS6A], *with Aesthetic Plastic Surgery Statistics (2019)*, *supra* note 60.

62. *Aesthetic Plastic Surgery Statistics (2019)*, *supra* note 60. The Aesthetic Society is "dedicated to the art, science, and safe practice of aesthetic surgery and cosmetic medicine." *About the Aesthetic Society*, AESTHETIC SOC'Y, https://www.smartbeautyguide.com/about [https://perma.cc/WT89-9PNE].

from a sample of 331 board-certified plastic surgeons.[63] However, not all pediatric cosmetic procedures are performed by board-certified plastic surgeons, so the available statistics likely underreport the actual occurrence of pediatric cosmetic procedures, particularly those that are non-surgical. Despite the limitations of available data on the 0–17 age group, the Aesthetic Society's annual report helps identify the frequency, types, and trends of pediatric cosmetic procedures as they are performed today.

According to the ASPS, some of the most popular cosmetic surgeries in 2019 for the 13–19 age group were rhinoplasty (nose surgery), breast augmentation, otoplasty (ear surgery), and liposuction.[64] The Aesthetic Society also reported that the most popular cosmetic surgeries for the 0–17 age group were liposuction, breast augmentation, and otoplasty (ear surgery).[65] Even more widespread than pediatric cosmetic surgeries are cosmetic non-surgical procedures. Cosmetic non-surgical procedures include minimally invasive procedures and the emerging field of "aesthetic medicine."[66] The Aesthetic Society reports that the most popular non-surgical cosmetic procedure in 2019 for the 0–17 age group was laser hair removal (15,180 procedures), followed by botulinum toxin, including Botox (4,571 procedures).[67]

In 2018, a systematic review of existing guidelines for pediatric cosmetic surgery showed a dangerous lack of standards.[68] In response to this review, ASPS published a press release detailing newly developed professional guidance to help surgeons ascertain when pediatric plastic surgeries are appropriate.[69] The 2018 guidelines note the importance of parental consent and assessing the physical and emotional

63. *Aesthetic Plastic Surgery Statistics (2019)*, *supra* note 60, at 3. The Aesthetic Society reports that "the overall survey portion of this research has a standard error of +/– 5.26% at a 95% level of confidence." *Id.*

64. *Plastic Surgery Statistics Report*, *supra* note 60, at 15.

65. *Aesthetic Plastic Surgery Statistics (2019)*, *supra* note 60, at 15.

66. *What Is Aesthetic Medicine?*, AM. ACAD. AESTHETIC MED., https://www.aaamed.org/aesthetic_med.php [https://perma.cc/7G7N-4ZUU] ("The exciting field of Aesthetic Medicine is a new trend in modern medicine . . . patients are now requesting quick, non-invasive procedures with minor downtime and very little risk. As a general rule, the needle is increasingly replacing the scalpel.").

67. *Aesthetic Plastic Surgery Statistics (2019)*, *supra* note 60, at 16.

68. Rohrich & Cho, *supra* note 3.

69. *American Society of Plastic Surgeons Weighs in on Growing Popularity of Teen Plastic Surgery*, AM. SOC'Y PLASTIC SURGEONS (Aug. 22, 2018), https://www.plasticsurgery.org/news/press-releases/american-society-of-plastic-surgeons-weighs-in-on-growing-popularity-of-teen-plastic-surgery [https://perma.cc/8JSZ-V8XF].

maturity of the patient while recommending age minimums for specific procedures.[70] However, data from 2019 shows that these guidelines were largely ignored or simply unknown by surgeons. Liposuction, for example, was not recommended for any patient under the age of 19,[71] and yet 4,314 liposuction procedures were performed on teenagers in 2019.[72] There are no available statistics for the number of liposuction procedures performed on children under age 13, but there is anecdotal evidence that they do occur:

> Brooke Bates was twelve years old when her parents persuaded a plastic surgeon to use liposuction to remove thirty-five pounds of fat and fluid from her body. Brooke and her parents were initially thrilled with the results, but the surgery did not keep Brooke from putting weight back on. When the weight returned in less than a year, the parents returned Brooke to the operating room for a tummy tuck.[73]

Brooke's story sheds light on some providers' ignorance to or disobedience of professional guidance. Simply put, pediatric cosmetic procedures occur by the thousands each year, and what little professional guidance exists is evidently ignored or unknown by many providers.

D. RISKS AND POTENTIAL BENEFITS OF PEDIATRIC COSMETIC PROCEDURES

"First, do no harm" is perhaps the most iconic part of the Hippocratic Oath that many medical students take before becoming doctors.[74] This notion of harm is frequently criticized as too ambiguous, and some propose a different mantra; that is, "doctors should help their patients as much as they can by recommending tests or treatments for which the potential benefits outweigh the risks of harm."[75] Pediatric cosmetic procedures might not be considered "treatment" in the traditional sense, but this proposed risk-benefit analysis is useful nonetheless.

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70. *Id.* In addition, ASPS provides specific guidance for teenage plastic surgery. *See Briefing Paper: Plastic Surgery for Teenagers*, *supra* note 31 (suggesting legal and ethical considerations that plastic surgeons should consider before performing plastic surgery on teenagers).

71. *American Society of Plastic Surgeons Weighs in on Growing Popularity of Teen Plastic Surgery*, *supra* note 69 ("Unless performed as part of a breast reduction surgery, it is not recommended that a teenager undergo liposuction.").

72. *Plastic Surgery Statistics Report*, *supra* note 60, at 15.

73. Ouellette, *supra* note 9, at 963.

74. Robert H. Shmerling, *First, Do No Harm*, HARV. HEALTH BLOG (June 22, 2020), https://www.health.harvard.edu/blog/first-do-no-harm-201510138421 [https://perma.cc/7V7X-J7HB].

75. *Id.*

1. The Physical Risks and Benefits Associated with Cosmetic Procedures

There is an abundance of physical risks associated with cosmetic procedures, particularly for minors.[76] With regard to surgery, harm can result from general risks such as infection, organ complications, and even death or physician-specific risks such as error due to lack of training and certification.[77] Some risks are surgery-specific; for example, "breast implant surgery has been shown to increase the likelihood of insufficient lactation for breastfeeding. Breast implants also interfere with preventative or diagnostic mammography . . . and breast implants may lead to a failure to detect approximately fifty-five percent of cancerous breast tumors."[78] In fact, the FDA estimates that forty percent of patients who receive breast implants will face at least one serious complication within three years of the surgery.[79] Most concerning is the statistic that women who receive breast implants "are twice as likely as women of the same age who did not undergo surgery to commit suicide or die from substance abuse."[80] Notwithstanding these facts, the Aesthetic Society reports that 3,329 breast augmentation surgeries were performed on minors in 2019.[81]

In addition, minors face particular risk because, biologically, their bodies are still developing:

> Several doctors express their reservations against cosmetic surgery in minor patients in their stage of pubertal development since they lack the physical maturity to undergo these procedures. As an example, breast sizes can change when a female steps into adulthood from her teens. For this reason alone, it might not be advisable for teenagers and minors to undertake certain cosmetic procedures such as cosmetic breast enhancement or rhinoplasty (surgical reshaping of the nose) since tissues, bones and cartilages are still in the process of development and are yet to reach their full growth.[82]

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76. Diaz, *supra* note 12, at 240 ("[T]hese risks can be divided into the following categories: general surgery risks, physician-specific risks, patient-specific risks, and parent-specific risks.").

77. *Id.* at 256; *see also, e.g.*, *In re* Estate of Powell, 408 N.W.2d 525, 527 (Mich. Ct. App. 1987) ("Michael Powell, then a five-year-old boy, underwent cosmetic surgery. During the administration of anesthesia, he experienced respiratory failure and cardiac arrest. The resulting loss of oxygen severely damaged his brain and nervous system.").

78. Katherine Cohen Cooper, *Can I See Some ID? Banning Access to Cosmetic Breast Implant Surgery for Minors Under Eighteen*, 27 J.L. & HEALTH 186, 190 (2014).

79. *Id.*

80. *Id.* at 207. Future studies should examine whether the relationship between breast augmentation, suicide, and substance abuse is causative or correlative.

81. *Aesthetic Plastic Surgery Statistics (2019)*, *supra* note 60, at 15.

82. Sadhya, *supra* note 5, at 166.

Non-surgical cosmetic procedures, while typically less invasive than cosmetic surgeries, can be equally problematic. HGH injections are one of the riskiest non-surgical procedures.[83] In addition to the significant time commitment, HGH injections "may cause musculoskeletal pain and aggravation of kidney problems. It poses long-term risks of diabetes, hypertension, and cancer."[84] Indeed, the long-term risks of HGH injections are just as, if not more, severe than some surgeries.[85]

2. The Psychological Risks and Benefits Associated with Pediatric Cosmetic Procedures

Some research indicates that "cosmetic surgery involves patient-specific risks arising from the mental illness of some minors."[86] Studies show that pediatric cosmetic procedures may lead to body dysmorphic disorder, a mental health disorder that manifests as an obsessive preoccupation with real or perceived flaws in one's appearance.[87] Other studies indicate that cosmetic procedures do not

83. Salvemini, *supra* note 17, at 1124; Am. Acad. of Pediatrics Comm. on Drugs & Comm. on Bioethics, *Considerations Related to the Use of Recombinant Human Growth Hormone in Children*, 99 PEDIATRICS 122, 124–25 (1997) (discussing potential risks associated with HGH therapy and treatment alternatives).

84. Ouellette, *supra* note 9, at 962.

85. *Compare id.*, *with Otoplasty*, MAYO CLINIC, https://www.mayoclinic.org/tests-procedures/otoplasty/about/pac-20394822 [https://perma.cc/YHZ7-W3KJ] (reporting that risks of otoplasty include scarring, asymmetry in ear placement, changes in skin sensation, problems with stitches, overcorrection, bleeding, infection, an adverse reaction to anesthesia, and allergic reaction to surgical tape or other materials used during or after the procedure). Most of these risks are minor compared to the risk of developing a persistent medical condition such as diabetes, hypertension, or cancer.

86. Diaz, *supra* note 12, at 242 (citing Eva C. Ritvo, Ilan Melnick, Gina R. Marcus & Ira D. Glick, *Psychiatric Conditions in Cosmetic Surgery Patients*, 22 FACIAL PLASTIC SURGERY 194, 194 (2006)); *see also* David B. Sarwer, Alison L. Infield & Canice E. Crerand, *Plastic Surgery for Children and Adolescents*, *in* BODY IMAGE, EATING DISORDERS, AND OBESITY IN YOUTH: ASSESSMENT, PREVENTION, AND TREATMENT 304 (Linda Smolak & J. Kevin Thompson eds., 2d ed. 2009) (assessing the psychological impact of children and adolescents who undergo cosmetic procedures).

87. Diaz, *supra* note 12, at 242 ("There is nearly a 50% chance that a person seeking cosmetic surgery has symptoms of BDD, which typically begins around thirteen years of age and full onset occurring at approximately sixteen."); *see also Body Dysmorphic Disorder*, MAYO CLINIC, https://www.mayoclinic.org/diseases-conditions/body-dysmorphic-disorder/symptoms-causes/syc-20353938 [https://perma.cc/AHN8-P9PE] (discussing the signs and symptoms of body dysmorphic disorder); Cooper, *supra* note 78, at 207 ("As many as fifteen percent of 'patients seeking cosmetic treatments suffer from body dysmorphic disorder, a severe mental disorder that affects body perception and often leads sufferers to seek multiple unnecessary surgeries.'").

result in improved psychological functioning.[88] In the case of HGH injections, "[s]tudies show that in the long run, the psychosocial adaptation and self-esteem of treated children is comparable to a placebo group, and repeated injections increase the child's negative self-image and associated stigmatization of height as a defining feature of the child's existence."[89] In other words, a pediatric cosmetic procedure tells the child that their physical appearance, while fully functional, is insufficient, and this can become central to the child's confidence and self-image.

Lastly, some argue that altering a child's appearance is inappropriate regardless of any psychological benefit a child may gain. Cassandra Aspinall, a senior social worker at Seattle Children's Hospital, explains this perspective:

> Some surgeries done on facial anomalies are meant to manage human interaction by changing appearance, and human interaction is always complex. When I work with these families, I try to find out what has been done to stop other people's reactions to the child's facial difference. I can't think of any situation where a person who is being singled out because of racial or ethnic differences would be told that they should just change their race or religion to avoid someone else's prejudice.[90]

That said, there is at least some indication that cosmetic procedures can result in psychological benefit. For example, cosmetic procedures might increase self-esteem, confidence, and a sense of belonging, resulting in improved mental health outcomes.[91] Likewise, cosmetic procedures might lessen the trauma a child would otherwise endure from appearance-based bullying.[92] After all, there is no shortage of anecdotal evidence that children, and especially teenagers, engage in or acquiesce to bullying behavior.[93] The inference here is that

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88. Ouellette, *supra* note 9, at 963.

89. *Id.*

90. Alice Dreger, *For Kids, Plastic Surgery Not Always the Answer*, ATLANTIC (May 21, 2013), https://www.theatlantic.com/health/archive/2013/05/for-kids-plastic-surgery-not-always-the-answer/276077 [https://perma.cc/BPQ6-34X2].

91. *See* Coffey, *supra* note 21 ("[W]hen a teen seeks out plastic surgery to correct a noticeable physical defect or to change a body part that's caused prolonged psychological distress, that can be a good thing, doctors say.").

92. *Id.*; *see also* Kirsty Lee, Alexa Guy, Jeremy Dale & Dieter Wolke, *Adolescent Desire for Cosmetic Surgery: Associations with Bullying and Psychological Functioning*, 139 PLASTIC & RECONSTRUCTIVE SURGERY 1109, 1117 (2017) (finding that bullied adolescents are more likely to express interest in cosmetic surgery than their non-bullied peers).

93. Coffey, *supra* note 21 ("Teens can be mean. Just ask Jen Selter, Jon Escalante and Hannah Olson. For years, Selter endured taunts because of her nose size. Kids ridiculed her by saying she looked like a pelican and by calling her 'butter face'—code for 'She's hot, but her face!' Escalante deliberately grew his hair out to hide ears that had branded him with the nickname 'Dumbo.' And Olson's self-confidence flagged as she

"improved" appearance leads to less taunting, more friends, increased self-esteem, and better psychological development.[94] Because the psychological benefit, if any, resulting from cosmetic procedures is questionable, it has been suggested that the burden should be "on the medical profession to prove that invasive surgery is the only available [psychological] treatment and that it is the lesser of two evils."[95]

In sum, pediatric cosmetic procedures can have deleterious effects on the physical and psychological health of minors. The physical risks are well documented and understood by surgeons, but more research is needed to understand the psychological impact such procedures have on minors. Whether the psychological impact is largely positive or negative remains to be seen and likely varies case by case.

II. LEGAL CONSIDERATIONS OF PEDIATRIC COSMETIC SURGICAL AND NON-SURGICAL PROCEDURES

The law surrounding minors' rights, parental liberties, and state interests in pediatric medicine is incredibly complex. There is tension between the minor's right to "privacy and freedom of choice over their own body,"[96] "the parents' right to raise and provide for their children as they see fit,"[97] and "the state's responsibility to care for the child's best interest."[98] This section explains this tension and identifies key legal doctrines affecting minors, parents, and the state in the context of pediatric cosmetic procedures. Section A discusses legal doctrines affecting minors, such as the mature minor doctrine, the right to bodily integrity, and informed consent or assent. Section B discusses

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tolerated 'horrifying' name-calling after developing DDD-size breasts as a teen.").

94. *See Briefing Paper: Plastic Surgery for Teenagers*, *supra* note 31 ("Teens frequently gain self-esteem and confidence when their physical problems are corrected. In fact, successful plastic surgery may reverse the social withdrawal that so often accompanies teens who feel different."); *see also* Victoria Thompson, *Teens Choose Plastic Surgery to Boost Self-Esteem*, ABC NEWS (Nov. 16, 2010), https://abcnews.go.com/Nightline/teen-plastic-surgery/story?id=12163764 [https://perma.cc/Z4MH-KTDE] ("While adults tend to have plastic surgery to stand out from the crowd, teens tend to have surgery to change the parts of their body they believe are flawed so that they can fit in with their peers, experts say.").

95. Baker, *supra* note 27, at 613 ("If a person is suffering mental anguish because of her body image, then the appropriate medical response would be to provide psychological counseling, not invasive surgery involving serious bodily harm and long-term harmful complications.").

96. Danielle Hawkes, *Elective Surgery—When Parental and Medical Opinion Supersedes a Child's Right to Choose*, 11 J.L. & FAM. STUD. 565, 569 (2009).

97. Elchanan G. Stern, *Parens Patriae and Parental Rights: When Should the State Override Parental Medical Decisions?* 33 J.L. & HEALTH 79, 88 (2019).

98. *Id.*

parents' fundamental right to direct the upbringing of their children and make medical decisions on their behalf. Finally, Section C explores the authority of the state to intervene when necessary to prevent harm to a child.

A. CHILDREN'S LEGAL RIGHTS: "MATURE MINORS," THE RIGHT TO BODILY INTEGRITY, AND INFORMED CONSENT

Pediatric cosmetic procedures implicate several legal doctrines involving minors, such as the "mature minor" doctrine, the right to bodily integrity, and informed consent or assent. This section first discusses the mature minor doctrine and explains why, despite its extended discussion in legal scholarship, it is largely irrelevant in the context of pediatric cosmetic surgery. Next, this Section discusses the child's right to bodily integrity. Lastly, this Section discusses informed consent and assent, emphasizing the importance of these ethical and legal concepts in pediatric cosmetic surgery.

1. The Mature Minor Doctrine Is Largely Irrelevant to Pediatric Cosmetic Procedures

The mature minor doctrine is worth mentioning because of its misplaced dominance in legal scholarship on pediatric cosmetic procedures.[99] The mature minor doctrine is relevant insofar as it enables courts to consider a mature child's wishes regarding their medical care. In many states, it can be "invoked in situations where the child is sufficiently mature to make her own health care decisions."[100] For example:

> If a minor is of sufficient intelligence and maturity to understand and appreciate both the benefits and risks of the proposed medical or surgical treatment, then the minor may consent to that treatment without parental consent. Essentially, mature minors are those deemed socially and psychologically mature enough to make their own healthcare decisions, even if not emancipated.[101]

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99. *See* Diaz, *supra* note 12, at 250 (arguing that the mature minors doctrine should not control in situations where a minor is "mature," but wants to get a cosmetic procedure against their parents' will); Baker, *supra* note 27, at 619 ("What is being proposed is that the mature minor test be abandoned for cases involving unnecessary nontherapeutic cosmetic surgery that risks harm.").

100. 1 SUSAN O. SCHEUTZOW, *Minors*, *in* HEALTH LAW PRACTICE GUIDE § 11:15 (2022).

101. Diaz, *supra* note 12, at 250. The mature minor doctrine usually only applies to those age 14 and above. *Id.* In this way, it is like the Rule of Sevens. *See supra* notes 37–39 and accompanying text (describing the Rule of Sevens). However, it is distinct in that the mature minor doctrine evaluates minors' decision-making capacities on a case-by-case basis and may kick in before the age of 14 if the minor is sufficiently mature. *See* Michael Hayes, *The Mature Minor Doctrine: Can Minors Unilaterally Refuse*

The mature minor doctrine is most often invoked when a minor seeks to consent to rather than refuse medical treatment against the wishes of the parents.[102] Further obscuring the use of the mature minor doctrine is the distinction, or lack thereof, between medical treatment and elective procedures. If a minor is deemed "mature," then "[a] parent [cannot] consent to procedures or treatments that provide no health benefit to a mature minor when the minor objects to such treatment even if the treatment does not pose a risk of harm to the minor's health."[103] Theoretically, then, if a mature minor objects to a cosmetic procedure that their parent has arranged, they cannot be forced to partake. Realistically, this is difficult to enforce. Consider the following dialogue:

> **Parent:** "You're 13 years old now, and I think it's time we fix that nose. I'll call Dr. Nicky."
>
> **Child:** "No, thanks. I don't want surgery."
>
> **Parent:** "Trust me, you'll thank me when you're older."

As the parent picks up the phone to call Dr. Nicky, a lightbulb appears above the 13-year-old's head—"*AHA!* As long as a court deems me a 'mature minor' under the mature minor doctrine, I cannot be forced to have nose surgery against my will. It offers me no health benefit and I vehemently object! I will call my lawyer right away." For obvious reasons, this scenario is unlikely to occur—except in fictional books and movies.[104] Indeed it is far more likely that the child, facing significant pressure from the parent, will reluctantly acquiesce to the parent's wishes.

On the other hand, some scholars fear scenarios in which the mature minor doctrine could enable minors to get cosmetic procedures without the consent of a parent.[105] Although a minor's right to obtain

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Medical Treatment?, 66 U. KAN. L. REV. 685, 694–95 (2018) (describing various jurisdictions' common-law "mature minor" doctrines and recognizing that a minor's age is not the determinative factor in deciding whether they can consent to medical treatment).

102. Hayes, *supra* note 101, at 688 n.16 ("[I]t appears that a minor's right to consent to medical treatment against parental wishes is on surer footing than the right to refuse treatment.").

103. RESTATEMENT OF THE L. CHILD. & THE L. § 2.30 cmt. b., illus. 2 (A.L.I., Tentative Draft No. 1, 2018) ("A court will not order that a procedure with no health benefits be undertaken against a mature minor's will.").

104. *See, e.g.*, JODI PICOULT, MY SISTER'S KEEPER (2009) (telling a fictional story of a 13-year-old girl who hires a lawyer to become medically emancipated after she is asked to donate a kidney to her older sister); MY SISTER'S KEEPER (Warner Bros. Pictures 2009).

105. *See* Diaz, *supra* note 12, at 250 (arguing that the mature minor doctrine should not apply in the context of cosmetic surgery because it would enable minors to obtain

cosmetic procedures against the wishes of their parents is outside the scope of this Note, it is worth mentioning that this scenario is unlikely to come to fruition, at least with cosmetic surgeries. Because cosmetic procedures are not covered by health insurance and can cost thousands of dollars out-of-pocket,[106] most, if not all, minors would be unable to afford significant cosmetic procedures without parental support, even if a court deemed them "mature" under the doctrine.[107]

The most likely scenario in which the mature minor doctrine might be used in this context is if a noncustodial parent sues a custodial parent for arranging a cosmetic procedure for their child.[108] If the child is deemed "mature," the court may assess the child's attitude toward the procedure in deciding whether to intervene.[109] But even in this limited scenario, there are reasons for courts to be wary. Some scientific considerations discourage application of the mature minor doctrine to pediatric cosmetic procedures altogether—"scientific findings demonstrate that [even] mature minors biologically cannot understand fully the risks involved with cosmetic surgery or make an accurate cost-benefit analysis without undue external influence."[110] Simply put, the mature minor doctrine is a tenuous crutch on which to lean for pediatric cosmetic procedures.

2. Minors Have a Legal and Ethical Interest in Bodily Integrity and Informed Consent

Justice Cardozo once wrote that "[e]very human being *of adult years* and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault, for which he is liable in damages."[111] More than one century later, legal scholars still debate whether the constitutional right to bodily integrity articulated by

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such surgeries on their own).

106. *Aesthetic Plastic Surgery Statistics (2019)*, *supra* note 60.

107. Diaz, *supra* note 12, at 253 ("[B]ecause hospitals will not admit patients for elective procedures without proof of financial capability (i.e. health insurance), minors are almost never admitted absent parental signature on financial responsibility forms.").

108. *See, e.g.*, *In re* Marriage of Boldt, 176 P.3d 388 (Or. 2008) (finding that in a non-custodial mother's suit against a father's plan to circumcise their child, the court must consider social norms and the child's own wishes).

109. *Id.*

110. Diaz, *supra* note 12, at 252.

111. Schloendorff v. Soc'y of N.Y. Hosp., 105 N.E. 92, 93 (N.Y. 1914) (emphasis added).

Justice Cardozo applies to minors.[112] The seminal case of *Cruzan v. Director of Missouri Department of Health* helped guide this debate, recognizing a constitutional right to refuse unwanted medical treatment as long as the patient is a "competent person."[113] In addition, the Supreme Court has recognized the minor's right to bodily integrity in the context of reproductive health care,[114] and scholars have posited that this right applies in other contexts as well.[115] In addition to its legal foundation, bodily integrity is a "moral principle, deeply embedded in American legal tradition, that no person, even a parent, may subordinate the life, liberty, or body of another for his or her own purposes."[116] The ethical principal of bodily integrity is directly implicated in the context of pediatric cosmetic procedures,[117] as such procedures constitute physical—and often permanent—intrusions that a minor may or may not want.

Like bodily integrity, informed consent is a foundational legal and ethical tenant of medicine,[118] and is typically required before medical procedures can be performed.[119] The rationale behind informed

112. *Compare* Hayes, *supra* note 101, at 690–91 (asserting that states have a greater interest in restricting the authority of minors to refuse medical treatment), *with* B. Jessie Hill, *Constituting Children's Bodily Integrity*, 64 DUKE L.J. 1295, 1295 (2015) ("[A] child's right to bodily integrity applies within the family, giving the child the right to avoid unwanted physical intrusions regardless of the parents' wishes.").

113. Cruzan *ex rel.* Cruzan v. Dir., Mo. Dep't of Health, 497 U.S. 261, 278 (1990). The Court does not explicitly define "competence" in *Cruzan*, but notes that "[a]n incompetent person is not able to make an informed and voluntary choice to exercise a hypothetical right to refuse treatment or any other right. Such a 'right' must be exercised for her, if at all, by some sort of surrogate." *Id.* at 280.

114. Carey v. Population Servs., Int'l, 431 U.S. 678 (1977) (striking down a state law which prohibited contraception from being distributed to those under age 16); Belotti v. Baird, 443 U.S. 622 (1979) (holding that states cannot require parental consent to a minor's abortion procedure unless they also provide for a judicial bypass that would allow the minor to seek judicial permission).

115. Hill, *supra* note 112, at 1297–98.

116. Ouellette, *supra* note 9, at 955–56.

117. "When parents elect to modify a child's body with medically unnecessary surgery or medical treatments, they turn a healthy child into a patient and compromise a child's interests in bodily integrity, safety, and freedom from confinement." *Id.* at 983.

118. Aviva L. Katz & Sally A. Webb, *Informed Consent in Decision-Making in Pediatric Practice*, 138 PEDIATRICS 1, 2 (2016) ("The current concept of informed consent in medical practice has roots within both ethical theory and law.").

119. Diaz, *supra* note 12, at 239 ("The underlying rationale ensures that a competent patient understands the nature and risks of the procedure, through physician disclosure, sufficient to form a competent medical judgment as to their treatment."); *see also* Douglas S. Diekema, *Parental Refusals of Medical Treatment: The Harm Principle as Threshold for State Intervention*, 25 THEORETICAL MED. & BIOETHICS 243, 243 (2004) ("It is well established in American law that a patient must give informed consent before a

consent is to ensure "a patient's comprehension of risks involved for a competent medical decision."[120] However, the information required for informed consent is often too difficult for a minor to comprehend. Informed consent requires discussion of "details of the surgery, benefits, possible consequences and side effects of the operation, potential risks and adverse outcomes as well as their probability and severity; alternatives to the procedure being considered and their benefits, risks and consequences; and the anticipated outcome."[121] This kind of robust discussion is difficult to achieve even with adults, let alone minors.

Legally, minor patients are deemed "incompetent" because they are unable to give informed consent, and are thus dependent on a surrogate decision-maker.[122] In the case of minors, that surrogate decision-maker is most often a parent or guardian "who [is] presumptively deemed competent on behalf of the minor."[123] Notwithstanding the fact that minors cannot give legal consent,[124] it is common practice to get minor "assent" (i.e., an expression of approval or agreement).[125] To get assent from minor patients, the American Academy of Pediatrics (AAP) encourages providers to "[h]elp the patient achieve a developmentally appropriate awareness of the nature of his or her condition," "[t]ell the patient what he or she can expect with tests and treatments," "[m]ake a clinical assessment of the patient's understanding of the situation and the factors influencing how he or she is responding (including whether there is inappropriate pressure to accept testing or therapy)," and "[s]olicit an expression of the patient's willingness to accept the proposed care."[126]

However, minors will often assent to things their parents want by virtue of the influence parents have over them. Indeed, the AAP acknowledges this dynamic:

> Decision-making by children and adolescents is usually influenced by their parents' point of view and may not be entirely voluntary or autonomous. Unless there is significant coercion perceived by clinicians, this situation is not

physician may administer treatment.").

120. Diaz, *supra* note 12, at 239.

121. *Briefing Paper: Plastic Surgery for Teenagers*, *supra* note 30.

122. Diaz, *supra* note 12, at 246 ("[I]nformed consent . . . cannot be satisfied when a patient cannot understand a physician's disclosure, when a patient cannot exercise competent independent judgment, or when both occur.").

123. *Id.* at 247.

124. However, minors can give consent if they are legally emancipated or the mature minor doctrine is invoked by a court. *See* Katz & Webb, *supra* note 118, at 4.

125. *Id.* at 2.

126. *Id.* at 8.

> unacceptable, because medical decision-making cannot, and should not, occur in a vacuum, isolated from all other concerns.[127]

Thus, minor assent is often easy to obtain, and parental consent is rarely questioned. After all, "most parents care about their children . . . [and] they will usually be better situated than others to understand the unique needs of their children, desire what's best for their children, and make decisions that are beneficial to their children."[128] However, as some of the aforementioned anecdotes illustrate,[129] this is not always the case.

For this reason, parental consent is more problematic in the context of pediatric cosmetic procedures. Parents often consent to standard treatment that is considered medically necessary or wise, such as taking a child to a pediatrician for an annual checkup. In such cases, the parent's consent on behalf of the child is less troublesome. It is unlikely that a grown child will regret their parent's decision to take them to annual checkups with a pediatrician, but it is much more likely that a child will regret their parent's decision to permanently alter their appearance since "[m]aking decisions about surgically 'fixing' someone's appearance is much more complicated than making a decision to medically manage asthma or diabetes."[130]

In sum, informed consent is challenging in the context of pediatric cosmetic procedures; unlike standard treatment that is medically wise or necessary, there is less certainty that a child would give informed consent if they could. Moreover, the fact that minors are often unable to participate fully in the decision-making process places their bodily integrity at increased risk. Despite this vulnerability, minors' bodily integrity is often deprioritized at the expense of parents' competing right to direct the upbringing of their children.

B. PARENTS' FUNDAMENTAL RIGHTS

The Supreme Court has long recognized that "parents have a fundamental right to the care, custody, and control of their children" protected by the Due Process Clause.[131] Accompanying this right is the presumption that parents have the best interest of their children at

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127. *Id.* at 2–3.

128. Diekema, *supra* note 119, at 244.

129. *See* discussion *supra* Introduction.

130. Dreger, *supra* note 90.

131. Diaz, *supra* note 12, at 246 (citing Troxel v. Granville, 530 U.S. 57, 65–66 (2000)); *see also* Meyer v. Nebraska, 262 U.S. 390, 401 (1923); Pierce v. Soc'y of Sisters, 268 U.S. 510 (1925); Hayes, *supra* note 101, at 687 ("Parents' natural (i.e. pre-political) duty to make decisions for the good of the family is protected by the U.S. Constitution . . . .").

heart—that "parents have what a child lacks in maturity, experience, and capacity for judgment when making life's difficult decisions; and, due to their natural bond, said affections will lead parents to act in the best interest of their children."[132] The Supreme Court reiterated this presumption in *Parham v. J.R.*, a case in which minors challenged the constitutionality of a Georgia law enabling parents to voluntarily commit their children to mental institutions against the child's will:

> That some parents "may at times be acting against the interests of their children" . . . creates a basis for caution, but is hardly a reason to discard wholesale those pages of human experience that teach that parents generally do act in the child's best interests. The statist notion that governmental power should supersede parental authority in all cases because some parents abuse and neglect children is repugnant to American tradition.[133]

These traditional American ideals about the family unit has led some scholars to suggest that minors should not have the right to refuse medical treatment against the wishes of their parents because doing so would "undermine the moral order and authority of the family."[134] As such, parents are afforded wide latitude in making medical decisions for their minor children, including those deemed to be "elective."

However, this right is not unlimited; it must be taken in context with the parents' legal obligation to provide for the child's welfare.[135] For example, a parent cannot consent to a procedure for their child that offers no health benefit and poses a "substantial risk of serious harm to the child's physical or mental health."[136] Rather, parents are supposed to make medical decisions for their children based upon the child's best interest.[137] That said, determination of the child's best interest most often hinges on the judgment of parents and providers, and it is rare for courts to become involved. Moreover, providers are generally deferential to parent choice. Rather than determining the

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132. Diaz, *supra* note 12, at 246.

133. Parham v. J.R., 442 U.S. 584, 602–03 (1979).

134. Hayes, *supra* note 101, at 687. Hayes writes that the family unit "provides the primary locus of care, nurture, responsibilities, and moral formation within society." *Id.* at 694.

135. *Parham*, 442 U.S. at 603 ("Nonetheless, we have recognized that a state is not without constitutional control over parental discretion in dealing with children when their physical or mental health is jeopardized.").

136. RESTATEMENT OF THE L. CHILD. & THE L. § 2.30 cmt. b. (A.L.I., Tentative Draft No. 1, 2018).

137. SCHEUTZOW, *supra* note 100 ("When a health care provider believes a parent is making a decision that is not in the best interest of the child, the provider should generally contact the local children's services agency."); *see also* Diaz, *supra* note 12, at 237 ("[T]he parental presumption can be rebutted through the showing-of-harm standard.").

best interest of the child "de novo," providers tend to identify "a harm threshold below which parental decisions will not be tolerated."[138] In other words, parents can often find a provider to perform a cosmetic procedure on their child, so long as the procedure does not fall below the harm threshold applied by that individual provider. By this standard, the procedure need not be in the best interest of the child, it need only be approved by the parent and "stomachable" by the provider.[139]

Despite traditional deference to parents, courts have found at least some aspects of children's health care to warrant additional oversight and protection, so it would not be entirely unprecedented for courts to impose additional safeguards on pediatric cosmetic procedures. For example, with regard to institutionalization of children for mental health purposes, the Supreme Court held that "[t]he risk of error inherent in the parental decision to have a child institutionalized for mental health care is sufficiently great that some kind of inquiry should be made by a 'neutral factfinder' to determine whether the statutory requirements for admission are satisfied."[140] The presumption that parents will act in the best interests of their children is given less deference in the context of mental health institutionalization. So, while parents generally have the power to make decisions for their children, some decisions are scrutinized more than others based on the potential harm that a child might endure if the parent does not have the child's best interests in mind. The state thus plays an important role by limiting parental authority in contexts where there is a high risk of harm to the minor.

C. THE STATE AND PARENS PATRIAE

Although the state can and does override parental decisions when necessary to protect the child from harm, the state is reluctant to "step on parents' toes" in all but extreme cases.[141] Parens patriae "is

138. Ouellette, *supra* note 9, at 970 (quoting Douglas S. Diekema, *Parental Refusals of Medical Treatment: The Harm Principle as Threshold for State Intervention*, 25 THEORETICAL MED. & BIOETHICS 243, 243 (2004)).

139. This concerning phenomenon has long been recognized with regard to the institutionalization of minors. James W. Ellis, *Volunteering Children: Parental Commitment of Minors to Mental Institutions*, 62 CALIF. L. REV. 840, 840 (1974) ("In most states, parents may commit their children to mental institutions without a hearing or any other form of judicial scrutiny. If a parent wants a child committed, and a hospital will accept the child as a patient, no legal authority will hear the child's protest. Moreover, the child-patient has no standing to petition for release from the institution until he or she reaches the statutory age of majority.").

140. Ouellette, *supra* note 9, at 972 (quoting *Parham*, 442 U.S. at 584).

141. *See* Hayes, *supra* note 101, at 692 ("While the State does have the right to act

the common law legal doctrine which gives the state the power to intervene when children, or those who can't take care of themselves, are being neglected."[142] Based on the doctrine of parens patriae, the state can "override parental decisions in cases where the court held the child's best interest was served otherwise."[143] Put differently, the state may "act to protect the welfare of children even when the state's actions conflict with the parent's wishes."[144] Parens patriae is based on the notion that "minors cannot properly evaluate their long-term bodily interests or adequately understand the numerous aforementioned risks and, therefore, states have an interest in ensuring their health and welfare."[145]

Situations in which parens patriae takes precedence over the parental presumption occur most often in medical emergencies, defined as "any condition that requires prompt treatment to alleviate pain or in which delay of treatment could increase the risk to the health of the patient or, ultimately, anything causing a child to be frightened or hurt."[146] As such, the state typically intervenes to order medical treatment for a child whose parents, for religious reasons or otherwise, refuse such treatment to the child's detriment.

Curiously, there are few scenarios in which the state intervenes to prevent an elective procedure for a child. Since cosmetic procedures are non-emergent by definition, the medical emergency justification for parens patriae will never apply in this context. Moreover, "where a parent chooses to use medicine or surgery for a child (as opposed to when a parent refuses medicine or surgery) courts are generally unwilling to consider the child's best interests when the desired intervention has the support of even one licensed medical provider."[147] In addition, the Supreme Court has made clear that determinations of a child's best interest weigh in favor of parents, not the state.[148]

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for the sake of minors who cannot act or [sic] themselves and who lack adequate caretakers under the doctrine of *parens patriae*, the people charged by both nature and the law with the welfare of minors are the minors' parents.").

142. Stern, *supra* note 97, at 91.

143. *Id.* at 88.

144. 2 THOMAS A. JACOBS, CHILDREN & THE LAW: RIGHTS AND OBLIGATIONS § 10:8 (2021).

145. Diaz, *supra* note 12, at 257.

146. *Id.* at 247 (quoting ANGELA R. HOLDER, TREATISE ON HEALTH CARE LAW § 19.02 (2010)).

147. Ouellette, *supra* note 9 at 969.

148. Diaz, *supra* note 12, at 254–55 (citing Troxel v. Granville, 530 U.S. 57 (2000)) ("The Court held that fit parents must be granted the presumption that they act in the

Cases in which a court intervenes in a child's elective surgery are therefore extremely rare. In fact, as of this writing, Oregon is the only state to have addressed the issue. *In re Marriage of Boldt* tells the story of an Oregon mother and member of the Russian Orthodox Church who sought to enjoin her ex-husband from having their 12-year-old son, "M," circumcised as part of his conversion to Judaism.[149] The Oregon Supreme Court held that the decision to circumcise M fell within the father's authority as the custodial parent:

> We conclude that, although circumcision is an invasive medical procedure that results in permanent physical alteration of a body part and has attendant medical risks, the decision to have a male child circumcised for medical or religious reasons is one that is *commonly and historically made by parents in the United States*. We also conclude that the decision to circumcise a male child is one that generally falls within a custodial parent's authority, unfettered by a noncustodial parent's concerns or beliefs—medical, religious or otherwise.[150]

Thus, the mother's objection to M's circumcision did not constitute "a sufficient change in circumstances demonstrating father's inability to properly care for M."[151] However, the court also noted that "at age 12, M's attitude regarding circumcision . . . is a fact necessary to the determination of whether mother has asserted a colorable claim of a change of circumstances sufficient to warrant a hearing concerning whether to change custody."[152] In other words, if the father attempted to force M to get circumcised despite M's objection, that fact could be relevant in determining whether the father was fit to care for M. Although circumcision is not considered a "cosmetic" surgery for purposes of this Note, the *Boldt* court's holding bears on the state's power to intervene in parents' decisions to arrange cosmetic procedures for their children. It suggests that the state has less authority when the decision is commonly and historically made by parents in the United States. Unlike circumcision, pediatric cosmetic surgeries like liposuction and breast augmentation are not commonly

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best interest of their children."); *see also* Hayes, *supra* note 101, at 714–15 ("Parents have the inherent moral authority to make decisions for the good of their children and the family; it is only when they fail in their duties that the state may exercise its *parens patriae* rights.").

149. *In re* Marriage of Boldt, 176 P.3d 388, 390 (Or. 2008).

150. *Id.* at 394 (emphasis added). Interestingly, the Court's language here seems to suggest that invasive medical procedures permanently altering the body and posing medical risks to the child would *not* be afforded the same protection if such procedures were *not* commonly and historically arranged by parents in the United States.

151. *Id.*

152. *Id.* ("That is so because forcing M at age 12 to undergo the circumcision against his will *could* seriously affect the relationship between M and father, and *could* have a pronounced effect on father's capability to properly care for M.").

performed on minors, further strengthening the case for parens patriae to apply.

In a later case, the Oregon Supreme Court distinguished *Boldt*, holding that a custodial parent's medical decision-making, or lack thereof, can be relevant to custody determinations despite *Boldt's* broad assertion that "medical decisions generally fall within a custodial parent's authority, 'unfettered by the noncustodial parent's concerns or beliefs.'"[153] The court noted that "evidence in the record showed that mother's struggles with medical decision-making . . . were symptomatic of a larger issue created by mother's anxious attachment parenting style, which was becoming increasingly detrimental to child's well-being."[154] Moreover, the court emphasized that custody modification was justified due to a change in the custodial mother's "ability or inclination to care for the child in the best possible manner."[155]

These Oregon custody cases raise interesting questions about the relationship between pediatric cosmetic procedures and the state's authority to override parental authority on such matters. Oregon's case law suggests that some states may be more willing to override parental authority if the elective procedure is (1) uncommon, (2) not historically arranged for children by their parents, (3) a byproduct of an unhealthy parenting dynamic, or (4) indicative of a parent's inability to care for their child's best interest. However, the state's power to protect minors with regard to pediatric cosmetic procedures is limited insofar as it is difficult for these cases to actually reach the court system outside of custody disputes.[156] Moreover, if they do reach the court system, it is unclear if other states would follow Oregon's reasoning in *Boldt* and *Botofan-Miller* since Oregon's approach is not binding on other jurisdictions.

To summarize, a variety of legal doctrines affect children, parents, and the state in the context of pediatric cosmetic procedures. The "mature minor" doctrine, while discussed extensively in legal scholarship, is mostly irrelevant to cosmetic procedures since it is rare that a child will be able to successfully obtain or avoid a cosmetic procedure using the doctrine. Minors' legal and ethical interest in bodily integrity and informed consent is extremely relevant, but often conflicts with parents' fundamental right to direct the upbringing of

153. *In re* Botofan-Miller, 446 P.3d 1280, 1291 (Or. 2019).

154. *Id.*

155. *Id.*

156. As previously explained, minors are unlikely to sue their parents. *See* discussion *supra* Part II.A.1.

their children and make medical decisions on their behalf. The state can use its parens patriae authority to protect the wellbeing of children but must be careful not to infringe on parental liberties. These competing legal doctrines create a complex web of rights and responsibilities between children, parents, and the state. The result to date has been a legal regime that fails to protect children from the potential harms of pediatric cosmetic procedures.

III. CREATING A BETTER LEGAL REGIME FOR PEDIATRIC COSMETIC SURGERY

Pediatric cosmetic procedures raise important ethical and legal questions about the balance of power between minors, parents, and the state. The presumption that parents act in the best interest of their children affords parents wide discretion to alter their children's appearances through cosmetic procedures, notwithstanding the risk to the child's bodily integrity. State intervention is therefore warranted under parens patriae to safeguard minors' bodily integrity.

The extent of state intervention should depend on the vulnerability of the minor's bodily integrity; that is, the age of the minor, permanence of the procedure, and risk of harm. These considerations form the basis for this Note's proposal to implement a state-mandated prior authorization for all pediatric cosmetic surgeries for minors under age 14. Part III details this proposal and, in so doing, lays the groundwork for a better legal regime for pediatric cosmetic procedures.

Section A recommends prior authorization for pediatric cosmetic surgeries and high-risk non-surgical procedures, such as HGH injections, for children under age 14. Section B discusses the potential for criminalization of certain procedures and explains why a blanket ban on pediatric cosmetic procedures is unwarranted. Finally, Section C argues that prior authorization is logistically feasible, even in states that would face the greatest burden.

A. PEDIATRIC COSMETIC SURGERIES AND HIGH-RISK NON-SURGICAL PROCEDURES FOR CHILDREN UNDER AGE 14 SHOULD REQUIRE PRIOR AUTHORIZATION BY STATE MEDICAL BOARDS

Prior authorization should be required for all cosmetic surgeries performed on minors under age 14. This age threshold was chosen based on the Rule of Sevens, or the notion that children's decision-making capacity is either non-existent or still developing before they reach the age of 14.[157] There is an obvious limitation to the Rule of

157. *See supra* notes 37–39 and accompanying text for a discussion of the Rule of

Sevens approach; that is, "[m]inors of the same age may show different levels of maturity . . . Age, context and development all play a role in decision-making competence."[158] However, from a policy perspective, age thresholds are logistically necessary despite their arbitrary nature.[159] Moreover, age thresholds can always be changed to reflect the most up-to-date empirical research on child development. For now, however, the Rule of Sevens is a useful tool that can inform our understanding of minors' decision-making capacities.

Prior authorization should be handled by state medical boards, the administrative agencies tasked with ensuring medical quality, setting licensure criteria, and overseeing licensees.[160] In general, state medical boards consist of physicians and public members appointed by state governors.[161] The authority of state medical boards is delineated by state statutes governing the practice of medicine.[162] Known as medical practice acts, these statutes authorize state medical boards to discipline licensees for "'unprofessional conduct,' which may include violations of codes of medical ethics, conduct that brings the medical profession into disrepute, or other unspecified forms of 'dishonorable conduct.'"[163]

Sevens.

158. Petronella Grootens-Wiegers, Irma M. Hein, Jos M. van den Broek & Martine C. de Vries, *Medical Decision-Making in Children and Adolescents: Developmental and Neuroscientific Aspects*, 17 BMC PEDIATRICS 1, 1 (2017).

159. Consider, for example, drivers' licenses, alcohol, R-rated movies, cigarettes, car rentals, etc.

160. "State medical boards are the agencies that license medical doctors, investigate complaints, discipline physicians who violate the medical practice act, and refer physicians for evaluation and rehabilitation when appropriate. The overriding mission of medical boards is to serve the public by protecting it from incompetent, unprofessional, and improperly trained physicians." Drew Carlson & James N. Thompson, *The Role of State Medical Boards*, 7 ETHICS J. AM. MED. ASS'N 311, 311 (2005); *see also* Nadia N. Sawicki, *Character, Competence, and the Principles of Medical Discipline*, 13 J. HEALTH CARE L. & POL'Y 285, 286 (2010) ("As the state agencies responsible for the licensure and discipline of physicians, medical boards serve as the gatekeepers of the medical profession.").

161. *See* Sawicki, *supra* note 160, at 290–91 ("Modern medical boards generally include some public members but are dominated by physicians appointed by the governor."); s*ee, e.g.*, *Complaints,* MINN BD. MED. PRAC., https://mn.gov/boards/medical-practice/consumers/complaints [https://perma.cc/A4F6-NUFP] ("The Board of Medical Practice (BMP or Board) consists of sixteen Board members appointed by the Governor; nine Board members must be doctors of medicine, one Board member must be an osteopath, and five members must be public members.").

162. *See, e.g.*, MINN. STAT. § 147.01 (providing the rules governing Minnesota's Board of Medical Practice).

163. Sawicki, *supra* note 160, at 293.

State medical boards are best equipped to oversee prior authorization of pediatric cosmetic surgeries for several logistical reasons. First, pediatric cosmetic surgeries can be performed in a variety of health care settings such as hospitals, ambulatory surgery centers, and even in-office.[164] The impracticality and cost of requiring individual health care entities, regardless of size and resources, to establish an internal committee and hold prior review weighs in favor of a state-run approach. Second, internal committees overseen by individual health care entities could lead to variable conclusions that set confusing precedents for providers. In other words, state medical boards are best equipped to establish clear and consistent standards for licensed providers.

Existing medical practice acts delegate broad authority to state medical boards and, as such, mandatory prior authorization for pediatric cosmetic surgeries is probably permissible under existing law. However, evidence suggests that state medical boards are more or less zealous regulators depending on the political party in power.[165] Consistent and sustainable oversight will thus require state legislation to establish specific standards and procedures for prior authorization. Therefore, states should pass legislation requiring providers to obtain prior authorization from state medical boards to perform pediatric cosmetic surgery and high risk non-surgical procedures on children under the age of 14.

1. The Role of an Ad-Hoc Committee in the State Medical Board's Prior Authorization Process

State medical boards could rely on ad-hoc committees to inform their decisions about whether to authorize pediatric cosmetic surgery on a case-by-case basis. The purpose of the ad-hoc committee would be to act as an additional set of eyes to protect the child's best interest, similar to a guardian ad litem or a "'person, not necessarily a lawyer, who in a litigated matter stands in the place of a party deemed legally

164. *See generally* Varun Gupta, Rikesh Parikh, Lyly Nguyen, Ashkan Afshari, Bruce Shack, James C. Grotting & K. Kye Higdon, *Is Office-Based Surgery Safe? Comparing Outcomes of 183,914 Aesthetic Surgical Procedures Across Different Types of Accredited Facilities*, 37 AESTHETIC SURGERY J. 226 (2017) (comparing complication rates of aesthetic surgeries between office-based surgical suites, ambulatory surgery centers, and hospitals).

165. Denise F. Lillvis & Robert J. McGrath, *Directing Discipline: State Medical Board Responsiveness to State Legislatures*, 42 J. HEALTH POL., POL'Y & L. 123, 149 (2017) ("We have thus demonstrated that state medical boards discipline more when there exists unified government and a liberal legislature and less when unified government coincides with a conservative legislature.").

incompetent.'"[166] The role of a guardian ad litem is to "make recommendations that connect the factual investigation with reliable and relevant science—or nonscientific methodologies—for allocating parental rights and responsibilities."[167] Here, the ad-hoc committee would conduct a similar function using its collective expertise to make recommendations in the best interest of the child.

The ad-hoc committees should consist of individuals with expertise to account for the nature of the surgery as well as the child's physical and mental health; for example, (1) a provider familiar with the nature and risks of the cosmetic surgery,[168] (2) a pediatrician, and (3) a social worker or child psychologist. If a provider fails to seek approval before performing cosmetic surgery on a child under age 14, they should face disciplinary action and, in cases of bad faith or blatant disregard for the child's wellbeing, possible suspension or revocation of their medical license.

The ad-hoc committee's analysis should consider the risk of harm and potential benefit the procedure poses to the child.[169] This risk-benefit assessment would be designed to determine whether a reasonable person could find that the procedure is in the best interest of the child.[170] For example, the committee could consider the risk of mental and emotional harm if the child progresses to adulthood with an "objectively tangible" physical anomaly.[171] The committee should

166. Dana E. Prescott, *Inconvenient Truths: Facts and Frictions in Defense of Guardians Ad Litem for Children*, 67 ME. L. REV. 43, 44 (2014).

167. *Id.* at 61.

168. To avoid a conflict of interest, the provider sitting on the ad-hoc committee should be someone other than the provider seeking to perform the procedure.

169. Derrick Diaz's four-factor "medical necessity test" is a helpful framework with which to analyze the risks and benefits posed by a procedure to a child. *See* Diaz, *supra* note 12, at 265–66 (explaining that the first prong of the test is whether the impairment to be fixed hinders the minor's normal physical function, the second prong asks whether the physical anomaly is objectively tangible and whether it is unusual or relatively common, the third prong considers the effect of the current physical condition on the minor's mental health, and the fourth prong asks whether a reasonable minor in the patient's position would be hindered from normal functioning by the condition). The name of Diaz's test is somewhat counterintuitive since cosmetic surgeries are elective and, by definition, unnecessary. Thus, I refer to it as a "risk-benefit analysis" instead of Diaz's "medical necessity" terminology.

170. *Id.* at 255 ("With regard to cosmetic surgery on minors, numerous risks of harm exist sufficient to both rebut the parental presumption and to justify a state's interest in such prohibitive regulation.").

171. *Id.* at 263 ("Determining objective tangibility requires analysis of whether the physical anomaly is objectively apparent. Determining whether the physical anomaly is unusual or relatively common requires a determination of whether the applicant's anomaly is one that minors are often or normally subject to.").

also assess the reasonableness of the child's reaction; "whether the emotional distress felt by the [minor] is an irrational reaction to a minor anomaly" and "whether there is an independent psychopathological reason for the emotional impairment, such as body dysmorphic disorder."[172] Finally, the committee should consider if the child would "be hindered from normal functioning by the condition (e.g., avoiding normal childhood/adolescent activities)."[173]

The ad-hoc committee should also consider whether the need for the procedure is immediate; in other words, whether waiting until the child reaches the age of 14 will result in irreparable harm. In some cases, it might be inadvisable to wait if the alternative is psychological trauma due to appearance-based bullying throughout one's childhood. However, unless the committee "finds convincing evidence that the proposed intervention will address the individual child's immediate need, the intervention [should] be put off until the child is able to make her own decision."[174] This line of reasoning, developed by Alicia Ouellette, is called the "parent-as-trustee paradigm," which reframes the parent's interest in their children's health as a "trust," assigning parents "trustee-like powers and responsibilities over a child's welfare and future interests."[175]

In this relationship, the parent, as "trustee," makes all decisions in the interest of the child rather than for their own purposes or those of a third party.[176] The parents can "protect, nourish, and preserve the child's welfare," but cannot "limit a child's future ability to make her own autonomous choices as an adult unless the limitation on the child's developing rights to autonomy is necessary to preserve the child's welfare now."[177] The ad-hoc committee should consider this parent-as-trustee reasoning to "decide whether [the decision] is one that can be reserved for the child once she reaches maturity. If the decision can be reserved, it would be reserved. If not, then the [committee] would approve the intervention" if it believes that it will serve the child's interests.[178]

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172. *Id.* at 263–64.

173. *Id.* at 264.

174. Ouellette, *supra* note 9, at 999.

175. *Id.* at 956.

176. *See generally id.* (explaining the "parent-as-trustee-paradigm").

177. *Id.* at 996–97. Ouellette argues that "a parental decision to elect a preventive mastectomy or hysterectomy for a child carrying genes predictive of breast or uterine cancer would be considered an 'improvement' beyond the parent-trustee's ordinary power in most cases." *Id.* at 997.

178. *Id.* at 999.

Lastly, a parent's decision should be "afforded presumptive deference and remains beyond review except to the extent that its exercise is inconsistent with his duties to the beneficiary or deemed an abuse of discretion."[179] Consistent with the longstanding fundamental right to parenthood, parents should be given the benefit of the doubt during the ad-hoc committee's review. In "close call" cases, the committee's recommendation should weigh in favor of parents, assuming the minors themselves do not object. In this way, the prior review process would forbid cosmetic procedures that pose an unreasonable risk of harm to the minor without stifling the autonomy of the parents.

Taken together, these factors should lead committees to approve pediatric cosmetic surgeries and high risk non-surgical procedures if one could reasonably conclude that the procedure is in the child's best interest. Some of the specific factors include whether the child's physical trait is objectively tangible and causing distress that is neither unreasonable nor indicative of an underlying psychological condition. Importantly, the role of the ad-hoc committee is not to replace parental judgment with their own individual opinions, but to assess whether an individual could reasonably conclude that the procedure would serve the child's best interests.

B. COSMETIC PROCEDURES THAT POSE AN UNREASONABLE DANGER TO MINORS MAY BE CRIMINALIZED

Some might argue for a different legal regime; that is, that all cosmetic surgeries be criminalized. One perspective is that "[cosmetic] procedures are a form of physical harm, not a form of medicine," and should be criminalized based on the "harm principle."[180] However, rather than criminalizing all cosmetic surgeries for adults and children and letting a jury excuse procedures deemed "reasonable,"[181] the law should take a more predictable approach. Criminalizing specific procedures for certain age groups is a viable solution but should only be used in cases where the risk of harm is extreme. For example, "[a] nose job (rhinoplasty) . . . is carried out under proven safe medical conditions that are designed both to limit the risk of death or long-term injury and to minimize the pain of the operation and the pain of recovery," so criminalization of rhinoplasties is unwarranted.[182] By

179. *Id.* at 996.

180. Baker, *supra* note 27, at 587.

181. *Id.* at 604 ("Whether or not such surgery is reasonable is a question of fact for the jury. The jury is likely to accept that a rhinoplasty is reasonable because the violence . . . is a one-off harm that is aimed at providing a long-term benefit.").

182. *Id.*

contrast, there is a strong professional consensus that liposuction should never be performed on minors due to the dangers involved.[183] Thus, the case for criminalization of liposuction is stronger. Ultimately, it should be up to state legislators to decide, based on collaboration with state medical boards and published guidance from professional associations, to determine which cosmetic procedures, if any, warrant criminalization.

Most importantly, if states choose to criminalize certain pediatric cosmetic procedures, specificity is imperative. Surgeons must be able to know exactly what conduct is permitted and prohibited. Otherwise, criminalization could have the unintended effect of stifling surgeries that could fall within the scope of a vague criminalization statute, including reconstructive surgeries that offer children functional benefit. Likewise, criminalization of all pediatric cosmetic procedures is an overuse of parens patriae; indeed, there are scenarios in which a cosmetic procedure may be in the child's best interest. In sum, a blanket ban on pediatric cosmetic procedures would completely disrupt the balance between parents' fundamental rights and state interests, affording the state too much power in this regard. If a state so chooses to criminalize pediatric cosmetic procedures, it should designate specific procedures for particular age groups.

C. PRIOR REVIEW IS FEASIBLE EVEN FOR STATES WITH THE GREATEST BURDEN

Some might argue that a mandated prior review is too arduous and burdensome on state medical boards. However, it is feasible even in states with the greatest burden. In 2019, there were 13,386 cosmetic surgeries performed on minors across the United States.[184] Assuming that regional demographics track similarly for adults and minors, the largest concentration of these surgeries (22.7% or 3,038 pediatric cosmetic surgeries) occurred in the South Atlantic

183. *American Society of Plastic Surgeons Weighs in on Growing Popularity of Teen Plastic Surgery*, *supra* note 69 ("While a rhinoplasty or ear surgery can be performed safely by a board-certified surgeon and are, in many cases, appropriate for an adolescent, other cosmetic procedures such as breast augmentation, liposuction or injectables are typically not recommended for minors for several reasons."); *see also* Diana Zuckerman, *Teenagers and Cosmetic Surgery*, 7 VIRTUAL MENTOR 253, 254 (2005) ("Liposuction also carries potentially serious risks. Primary risks include infection, damage to skin, nerves, or vital organs, fat or blood clots (that can migrate to the lungs, leading to death), and excessive fluid loss that can lead to shock or death. In addition, the different techniques are associated with complications such as skin or deep tissue damage, lidocaine toxicity, and fluid accumulation in the lungs.").

184. *Aesthetic Plastic Surgery Statistics (2019)*, *supra* note 60, at 15.

(Delaware, Florida, Georgia, North Carolina, South Carolina, Virginia, and West Virginia) which has a total population of roughly 59 million.[185] The most highly populated state in the South Atlantic is Florida, with a population of 21.48 million or 36 percent of the region.[186] Thus, assuming that 3,038 pediatric cosmetic procedures were performed in the South Atlantic, and Florida accounts for 36 percent of those, there would be roughly 1,106 cosmetic surgeries performed on minors in Florida in 2019. Moreover, this estimate includes the 14–17 age group, so it most certainly overstates the number of surgeries that would require prior authorization. Simply put, requiring prior authorization for pediatric cosmetic surgery for children under age 14 is feasible, even in states that would face the greatest burden. For those states like Florida which may have a higher-than-average number of pediatric cosmetic surgeries performed annually, the state medical board might consider appointing a standing, rather than ad-hoc committee, to issue recommendations.[187] Lastly, and perhaps most importantly, any administrative burden is a small price to pay for safeguarding minors' bodily integrity and preventing unreasonable risks of harm.

185. *See id.* at 20; *Delaware*, CENSUS REP. (2019), https://censusreporter.org/profiles/04000US10-delaware [https://perma.cc/5UAQ-JJPB] (reporting the population of Delaware as 973,764); *Florida*, CENSUS REP. (2019), https://censusreporter.org/profiles/04000US12-florida [https://perma.cc/NC8G-J4YD] (reporting the population of Florida as 21,477,737); *Georgia*, CENSUS REP. (2019), https://censusreporter.org/profiles/04000US13-georgia [https://perma.cc/6PFZ-B2UG] (reporting the population of Georgia as 10,617,423); *North Carolina*, CENSUS REP. (2019), https://censusreporter.org/profiles/04000US37-north-carolina [https://perma.cc/JLW5-7NXZ] (reporting the population of North Carolina as 10,488,084); *South Carolina*, CENSUS REP. (2019), https://censusreporter.org/profiles/04000US45-south-carolina [https://perma.cc/X4R4-95E5] (reporting the population of South Carolina as 5,148,714); *Virginia*, CENSUS REP. (2019), https://censusreporter.org/profiles/04000US51-virginia [https://perma.cc/8EKH-TU4A] (reporting the population of Virginia as 8,535,519); *West Virginia*, CENSUS REP. (2019), https://censusreporter.org/profiles/04000US54-west-virginia [https://perma.cc/G7EU-MJ83] (reporting the population of West Virginia as 1,792,147).

186. *Florida*, *supra* note 185.

187. The establishment of standing committees is consistent with guidance from the Federation of State Medical Boards (FSMB). *Elements of a State Medical and Osteopathic Board*, FED'N OF STATE MED. BDS. 5 (Apr. 2015), https://www.fsmb.org/siteassets/advocacy/policies/elements-modern-medical-board.pdf [https://perma.cc/D3XP-RMQP] ("To effectively facilitate its work, fulfill its duties and exercise its powers, the Board may establish standing committees.").

CONCLUSION

Pediatric cosmetic surgery is currently underregulated, providing little guidance to providers, too much power to parents, and not enough protection to minors. Current limitations on parental authority are demonstrably insufficient to protect minors' bodily integrity. Prior authorization of cosmetic surgeries for children under age 14 by state medical boards would provide an additional layer of oversight without stifling the autonomy of parents. With the support of ad-hoc committees, state medical boards could ensure that pediatric cosmetic procedures are performed only when the child's interests are adequately considered and, consistent with parens patriae, the risk of harm is not unreasonable. Criminalization is another viable option but should be reserved for specific age groups and procedures in which there is wide medical consensus that the risks of harm outweigh the benefits of the procedure when performed on minors. Effective regulation of pediatric cosmetic procedures requires a multifaceted approach to protect the thousands of children who undergo such procedures each year. The prior authorization process proposed herein attempts such a multifaceted approach by balancing children's rights, parental liberties, and state interests to create a better legal regime for pediatric cosmetic procedures.