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MINORS AND COSMETIC SURGERY: AN ARGUMENT FOR STATE INTERVENTION

*Derrick Diaz**

ABSTRACT:

This article focuses on whether a state may intervene to prevent minors from obtaining medically unnecessary cosmetic surgery. The article concludes that a state may prohibit such a procedure without running afoul of parental liberty interests by showing severe risk of harm to the minor. Furthermore, the article proposes that minors not have access to cosmetic surgery unless found by a court to be medically necessary. If medical necessity has been shown, then the parental presumption must control. However, if medical necessity has not been shown, then the service should be prohibited the same as any regulated service or product prohibited to minors. Lastly, the article proposes the criteria under which a state may distinguish between cosmetic surgeries that are purely cosmetic and those that are medically necessary.

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I. INTRODUCTION

The American Society for Aesthetic Plastic Surgery ("ASAPS")¹ reported that minors² obtained a total of 49,330 cosmetic surgical³ procedures in 2007.⁴ In 2008, there were 42,980 performed on minors.⁵ In 2009 there were 36,841 surgeries performed.⁶ And, in 2010, there were 33,610 performed on minors.⁷ While it is true that the numerical total has declined, the representative percentage performed on minors to total cosmetic surgeries performed has remained nearly constant, at 2.4% in both 2007⁸ and 2008.⁹ In 2009 there was a slight increase up to 2.5%,¹⁰ and then a slight dip to 2.1%¹¹ in 2010. These data show that while the numerical total has been steadily dropping, the overall percentage of cosmetic surgeries performed on minors has remained steady. Moreover, if the percentage of surgeries on minors remains the same, when the grand numerical total increases again, the numerical total of such surgeries performed on minors will also increase.

Dr. Camp et al, in his article on who is providing cosmetic surgery, argues that legislation is unlikely to address some of the risks involved with cosmetic surgery and, thus, the risks ought to be left to the invisible hand of the market to resolve.¹² However, regardless of whether continued

1. The American Society for Aesthetic Plastic Surgery ("ASAPS") was founded in 1967 and is certified by the American Board of Plastic Surgery. ASAPS is an educational organization, sponsoring scientific meetings on advances in cosmetic plastic surgery. See *About ASAPS, THE AMERICAN SOCIETY FOR AESTHETIC PLASTIC SURGERY*, <http://www.surgery.org/consumers/about> (last visited Aug. 15, 2011).

2. Forty-eight states consider seventeen and below the age of minority, and eighteen or above the age of majority. See, e.g., ALASKA STAT. § 25.20.010 (2002); ARIZ. REV. STAT. ANN. § 1-215 (West 2002); CAL. FAM. CODE § 25.1 (2002); HA. REV. STAT. ANN. § 577-1 (2002); D.C. CODE § 46-101 (2001); FLA. STAT. ANN. § 743.07 (2003); LA. CIV. CODE ANN. art. 29; MICH. COMP. LAWS § 722.4. The two exceptions to this rule are found in Alabama and Nebraska, which hold the age of majority at nineteen. ALA. CODE 26-1-1 (2002); NEB. REV. STAT. § 43-2101 (2002).

3. To be clear, these data only refer to cosmetic surgery and do not include plastic surgery performed for reconstructive purposes.

4. The American Society for Aesthetic Plastic Surgery, *Cosmetic Surgery National Data Bank Statistics*, 10 (2007), <http://www.surgery.org/sites/default/files/2007stats.pdf>.

5. The American Society for Aesthetic Plastic Surgery, *Cosmetic Surgery National Data Bank Statistics*, 10 (2008), <http://www.surgery.org/sites/default/files/2008stats.pdf>.

6. The American Society for Aesthetic Plastic Surgery, *Cosmetic Surgery National Data Bank Statistics*, 10 (2009), <http://www.surgery.org/sites/default/files/2009stats.pdf>.

7. The American Society for Aesthetic Plastic Surgery, *Cosmetic Surgery National Data Bank Statistics*, 10 (2010), http://www.surgery.org/sites/default/files/Stats2010_1.pdf.

8. The American Society for Aesthetic Plastic Surgery (2007), *supra* note 3, at 10.

9. The American Society for Aesthetic Plastic Surgery (2008), *supra* note 4, at 10.

10. The American Society for Aesthetic Plastic Surgery (2009), *supra* note 5, at 10.

11. The American Society for Aesthetic Plastic Surgery (2010), *supra* note 6, at 10.

12. Matthew Camp et al., *Who Is Providing Aesthetic Surgery? A Detailed Examination of the Geographic Distribution and Training Backgrounds of Cosmetic Practitioners in Southern California*, 125 PLAST. RECONSTR. SURG. 1257, 1262 (2010).

noninterference is sound policy generally speaking, it is absolutely not so with regard to minors, as states have statutory mandates to protect their health and welfare.¹³ As such, minors should not have access to cosmetic surgery unless found by a court to be medically necessary. If a court declares the surgery medically necessary, then the parental presumption¹⁴ must control. However, if a court finds no medical necessity, then the service should be prohibited like any regulated service or product prohibited to minors.

This article examines whether a state may intervene to prevent parents from obtaining cosmetic surgery for their child or adolescent. First, Part II explains the various foundational concepts regarding cosmetic surgery, differentiates it from plastic surgery, and lays out the risks involved with it. Next, it lays-out the foundational components of informed consent and details the constitutional principles underlying parental consent.

Part III begins with an explanation of the parent-as-trustee paradigm and outlines the parental presumption. It also explains how the parental presumption can be rebutted through the showing-of-harm standard. Part III also proposes that, absent medical necessity and under a best-interests standard, minors should be denied access to cosmetic surgery – or, more precisely, delayed until age of majority. Part IV analyzes two scenarios, using the proposed rule, adapted directly from news headlines.

II. COSMETIC SURGERY ON MINORS IS A RISKY ENTERPRISE

A. The Cosmetic Surgery Rubric

The root “plas” in plastic surgery is a Greek word which means “to form or shape.”¹⁵ And, “plastic surgery” is defined as the “surgical specialty or procedure concerned with the restoration, construction, reconstruction, or improvement in the form, function, and appearance of body structures that are missing, defective, damaged, or misshapen; *encompasses both reconstructive and aesthetic surgery.*”¹⁶ Plastic surgery

13. See, e.g., statutes note 147, *infra*.

14. A fit parent must be granted the presumption that they act in the best interest of their children. *Troxel v. Granville*, 530 US 57, 68, 70 (2000).

15. Robert Kotler, *Cosmetic or Plastic Surgery: What's the Difference?*, WebMd (July 6, 2007), <http://blogs.webmd.com/cosmetic-surgery/2007/07/cosmetic-surgery-or-plastic-surgery-whats-the-difference.html>.

16. *Medical Dictionary: Plastic Surgery*, WebMd, <http://dictionary.webmd.com/terms/plastic-surgery>, citing Stedman's Medical Dictionary 28th ed. (2006) (emphasis added).

is any surgery performed on any part of the body to affect its form, function, or both.¹⁷ Moreover, “surgery” is simply any process requiring an incision (cutting the skin) to perform a medical or medically related procedure.¹⁸

The purposes of plastic surgery are divided into two subgroups: reconstructive and corrective.¹⁹ Reconstructive purposes are for deformities caused by congenital defects, diseases, or traumas.²⁰ Congenital deformities include any number of maladies: webbed toes or fingers; extra fingers or toes; women with abnormally large breasts, which may cause physical problems; facial defects from birth, like a cleft lip or palate, or those causing breathing problems or chronic infections – like those that affect the sinuses.²¹ Deformities resulting from disease include those due to tumors (both cancerous and non-cancerous), or, any surgery performed to replace parts of the body affected by a disease, like cancer.²² Reconstructive purposes also include surgeries performed to reconstruct or replace parts of the body affected by trauma, such as skin grafts for those who have been severely burned or cut.²³

On the other hand, surgeries performed for corrective purposes (“cosmetic surgery”) are for purely aesthetic reasons.²⁴ More specifically, they are performed for reasons other than functional benefit, or correcting deformities, or reconstructing deformities caused by disease or trauma.²⁵ Said simply, cosmetic surgery is solely intended to improve upon what nature has already physically given to a person’s appearance.²⁶ Note: this article only discusses cosmetic surgery because cosmetic surgery is not medically needed, whereas reconstructive procedures are medically

17. Kotler, *supra* note 15.

18. *Surgery*, Medline Plus, National Institutes of Health, <http://www.nlm.nih.gov/medlineplus/surgery.html#cat22> (last visited Aug. 12 2011) (explaining that surgeries involve incisions and cutting into skin).

19. Kuni Simis et al., *After Plastic Surgery: Adolescent-Reported Appearance Ratings and Appearance-Related Burdens in Patient and General Population Groups*, 109 PLAST. RECONSTR. SURG. 9, 9-10 (2002).

20. *Id.*

21. *Medical Dictionary: Reconstructive Surgery*, WebMd, <http://www.webmd.com/healthy-beauty/guide/reconstructive-surgery> (last visited Aug. 12, 2011).

22. *Id.*

23. *Id.*

24. *See* Simis, *supra* note 19, at 9-10.

25. This article's scope encompasses only those surgeries done for cosmetic reasons, which typically include: tummy tuck, cosmetic eyelid surgery, breast augmentation, breast lifts, breast reductions (women), buttock augmentation, buttock lift, cheek implants, chin augmentation, facelift, forehead lift, breast reduction (males), hair transplant, lip augmentation, liposuction, lower body lift, cosmetic ear surgery, or nose reshaping. *Cosmetic Surgery National Data Bank Statistics*, The American Society for Aesthetic Plastic Surgery 10 (2009), <http://www.surgery.org/sites/default/files/2009stats.pdf>.

26. Kotler, *supra* note 15.

necessary – thus, medical necessity will serve as the distinguishing point between the two.

However, before any medical procedure can be performed, the physician must obtain a patient's informed consent. 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.²⁷ *Salgo v. Leland Stanford Jr. University Board of Trustees* was the first case to discuss and use the term "informed consent."²⁸

While *Salgo* did not explain in detail what a physician needed to disclose, it did establish the general principle that the disclosure must be sufficient for the patient to understand the primary reasons for and against the procedure.²⁹ Note, however, that a full and frank disclosure is not required of the physician, but only a disclosure sufficient to inform.³⁰ Generally speaking, though, a disclosure must cover five areas: (1) diagnosis—what the physician has determined is the patient's illness; (2) nature and purpose of proposed treatment—nature of what is to be done and its purpose; (3) risks and consequences—risk: something that might occur as a result of the procedure; consequence: something expected will happen; (4) alternative treatments—the existence of treatments other than that proposed by the physician; and, (5) prognosis if proposed treatment is not undertaken—the physician's voluntary opinion as to what may happen if the patient does not adopt the physician's recommendation.³¹ Counter-intuitively, however, disclosure by a physician to a lack of the physician's medical experience is not usually mandatory. And, even in states where it is required, the disclosure is usually limited to a particular factual

27. *Consent to Medical Treatment*, 3-17 TREATISE ON HEALTH CARE LAW 17.02 (2010).

28. A physician violates his duty to his patient and subjects himself to liability if he withholds any facts that are necessary to form the basis of an intelligent consent by the patient to the proposed treatment. Likewise the physician may not minimize the known dangers of a procedure or operation in order to induce his patient's consent. At the same time, the physician must place the welfare of his patient above all else . . . [And, he must balance this duty by first] explain[ing] to the patient every risk attendant upon any surgical procedure or operation, no matter how remote[, versus the] recog[nition] that each patient presents a separate problem, that the patient's mental and emotional condition is important and in certain cases may be crucial, and that in discussing the element of risk a certain amount of discretion must be employed consistent with the full disclosure of facts necessary to an informed consent. 154 Cal. App. 2d 560, 578 (1957). See also *Canterbury v. Spence*, 464 F.2d 772, 787 (D.C. Cir. 1972) for a more patient-oriented standard ("In broad outline, we [hold] that [a] risk is . . . material when a reasonable person, in what the physician knows or should know to be the patient's position, would be likely to attach significance to the risk or cluster of risks in deciding whether or not to forgo the proposed therapy.").

29. See *Consent to Medical Treatment*, *supra* note 27.

30. *Id.*

31. *Id.*

scenario.³²

B. Cosmetic Surgery Risks

Numerous risks arise when parents seek and obtain cosmetic surgery for their minor children; these risks can be divided into the following categories: general surgery risks, physician-specific risks, patient-specific risks, and parent-specific risks. General surgery risks deal with risks of harm typically involved with all surgeries,³³ and may include: infection, too much bleeding, a poor reaction to anesthesia, accidental injury, pain,³⁴ visible scars, pooling of blood (hematoma), poor healing, fluid accumulation (seroma), numbness or skin sensation changes, skin discoloration, deep vein thrombosis, heart and lung complications, or even death.³⁵

On the other hand, procedure-specific risks vary by the procedure performed, as, for example, those associated with Blepharoplasty (eyelid surgery).³⁶ The procedure-specific risks associated with this procedure

32. See, e.g., *Howard v. UMDNJ*, 172 N.J. 537 (2002) ("New Jersey case law never has held that a doctor has a duty to detail his background and experience as part of the required informed consent disclosure. [However, i]n certain circumstances, a serious misrepresentation concerning the quality or extent of a physician's professional experience . . . can be material to the grant of intelligent and informed consent to the procedure."); *Johnson v. Kokemoor*, 199 Wis. 2d 615, 623 (1996) (concluding that when a physician uses statistics to (mis)represent her/his success rates with regard to a procedure, then evidence may be admitted making statistical comparisons between the success rates of the defendant physician and other physicians); *Taylor v. Albert Einstein Medical Center*, 723 A.2d 1027 (Pa. Super. Ct. 1998) (finding a pediatrician liable due to his "outrageous" behavior of performing heart surgery on a 16-year old patient even though the parents objected to his performance of it due to his lack of credentials) *rev'd in part on other grounds*, *Taylor v. Albert Einstein Med. Ctr.*, 754 A.2d 650 (Pa. 2000). But see *Thomas v. WILFAC, Inc.*, 65 Wash. App. 255, 828 P.2d 597 (1992) (emergency room physician not required to disclose his medical qualifications to patients); *Whiteside v. Lukson*, 947 P.2d 1263 (1997) (holding that a surgeon's lack of experience in performing a particular surgical procedure was not a material fact such that it sufficiently provides a basis of liability on the ground of failure to obtain informed consent); *Duttry v. Patterson*, 771 A.2d 1255, 1259 (Pa. 2001) (holding that the lower court erred as a matter of law because information personal to the doctor, including evidence of experience, whether solicited by patient or not, was irrelevant to the doctrine of informed consent). See generally, Emmanuel O. Iheukwumere, *Doctor, Are You Experienced? The Relevance of Disclosure of Physician Experience to a Valid Informed Consent*, 18 J. CONTEMP. HEALTH L. & POL'Y 373 (2002) (arguing public policy on informed consent should militate in favor of requiring practitioners to disclose their levels of experience to inquiring patients).

33. Yael Halaas, *Eyelid Surgery (Blepharoplasty) Risks*, ALL ABOUT FACIAL REJUVENATION, <http://www.facialplasticsurgery.net/eyelid-surgery-risks.htm> (last updated Jan. 31, 2012) [hereinafter Halaas, *Eyelid Surgery (Blepharoplasty) Risks*].

34. Mary E. Dallas, *1 in 3 Nose Job Patients Has a Mental Illness: Study*, Medline Plus, National Institutes of Health, July 27, 2011, http://www.nlm.nih.gov/medlineplus/news/fullstory_114750.html (finding that of 266 patients surveyed, 33% had moderate to severe symptoms of BDD).

35. See Halaas, *Eyelid Surgery (Blepharoplasty) Risks*, *supra* note 33.

36. *Id.* Blepharoplasty is also referred to as Asian Eyelid Surgery. Many Asians have only a slight crease in their eyelid, so some seek to create a greater crease in the eyelid through this procedure. Yael Halaas, *Asian Eyelid Surgery: Do Your Homework*, ALL ABOUT FACIAL REJUVENATION, <http://www.facialplasticsurgery.net/asian-eyelid-surgery.htm> (last visited Aug. 12 2011) [hereinafter Halaas, *Asian Eyelid Surgery*].

are: dry eye syndrome (but usually temporary), inability to close one's eyes (but usually temporary), pulling down of lower eyelid (ectropion or lid lag) and related eye irritation, pulling inward of the edges of one's eyelids (entropion – which can cause a person's eyelashes to rub against her eyeball), blindness (but extremely rare), double or blurry vision, temporary swelling at the corners of the eyelids, tiny whiteheads on the eyelids, eye asymmetry, eyelid sagging, difficulty blinking or keeping the eyes closed while asleep, sunken eyes or hollowness under the eyes (which may occur if the surgeon removes all or too much of the fat pads under the eyes), and dissatisfaction with the cosmetic results.³⁷

In addition, many physicians themselves pose a risk of harm to minors seeking cosmetic surgery, because many physicians are not board-certified, a fact which does not need to be disclosed to the patient or potential patient. Currently, four specialty boards evaluate and certify physicians for the practice of plastic and cosmetic surgery, and each of them have differing requirements for certification.³⁸ However, a physician need not possess board certification to perform plastic surgery.³⁹ Because of this, and due to a desire by physicians to live a comfortable life and meet financial obligations, many physicians have been migrating into the cosmetic marketplace,⁴⁰ including cosmetic surgery⁴¹ for which the physician need not have been trained.⁴² Furthermore, many physicians feel confident that once they have provided non-surgical cosmetic treatments, they may more easily offer surgical ones.⁴³ From the patient's perspective too, surveys show that once a patient has had a non-surgical technique performed, the patient develops a relationship with the non-plastic surgeon such that they return to that doctor for surgical treatments.⁴⁴

One commentator opined that the difference between earlier practice and this recent trend is the discovery of advertising.⁴⁵ Indeed, as long as the advertisement is paid for, a physician need not prove specialized board certification before advertising.⁴⁶ This is a problem because, unlike

37. See Halaas, *Eyelid Surgery (Blepharoplasty) Risks*, *supra* note 33.

38. Anthony S. Youn, *Yellow Pages Plastic Surgeon*, 115 PLAST. RECONSTR. SURG. 317, 318-19 (2005) (listing the boards: American Board of Plastic Surgery, American Board of Ophthalmology, American Board of Facial Plastic and Reconstructive Surgery, and the American Board of Cosmetic Surgery).

39. See Camp, *supra* note 12, at 1257.

40. *Id.*

41. *Id.* at 1261.

42. *Id.* at 1260.

43. *Id.* at 1258.

44. *Id.*

45. *Id.* at 1262.

46. See Youn, *supra* note 38, at 317.

restrictions on legal advertisements⁴⁷, those seeking such services are left to the whims of those professionals in a position to mislead potential patients⁴⁸ about board certification, surgical training, or experience with the procedure.⁴⁹

Furthermore, a growing part of the cosmetic surgery market is represented by *surgically* untrained physicians⁵⁰ – also a fact which does not require disclosure for informed consent purposes. These are not cases in which surgically trained physicians are simply expanding their practice without certification to include cosmetic surgical treatments; instead, they are not trained at all in surgical technique.⁵¹ In sum, despite the numerous risks associated with surgery, physicians need not obtain specialized board certification or training in surgical technique to perform plastic or cosmetic surgery. For example, though liposuction has a “very real possibility of patient morbidity or mortality [rate] when carried out in an inexpert fashion,” it does not require board certification or even surgical training to perform.⁵²

Furthermore, cosmetic surgery involves patient-specific risks arising from the mental illness of some minors.⁵³ While not conclusive, studies on adults provide a framework for considering relevant psychological issues for minors undergoing cosmetic surgery.⁵⁴ One such study has shown that

47. See generally MODEL RULES OF PROF'L CONDUCT R. 7.4(d)(1)-(2) (2010) (requiring that communications, which include advertisement, by a lawyer shall not state or *imply* that a lawyer is specially certified unless the lawyer has, in fact, been specially certified and the name of the certifying organization is identified in the communication); *Id.* at R. 7.1, cmt. 2 (explaining that such communications are misleading if there is a substantial likelihood it could lead a reasonable person to come to an erroneous conclusion about the lawyer or the lawyer's services for which there is, in reality, *no factual foundation*).

48. See generally *Ohralik v. Ohio State Bar Ass'n*, 436 U.S. 447 (1978) (explaining that in order to reduce the likelihood of professional overreaching and the exertion of undue influence on lay-persons, and to avoid situations where the professional's exercise of judgment for the client will be clouded by his own pecuniary self-interest, a state may further its interest in protection of the public by banning in-person solicitations for legal services).

49. John A. Persing et al., *The Influence of Plastic Surgery "Reality TV" on Cosmetic Surgery Patient Expectations and Decision Making*, 120 PLAST. RECONSTR. SURG. 316, 322-23 (2007). Related to advertisement – cosmetic surgery reality TV shows influence both the expectations and choices of people considering the surgery. Over 95% of cosmetic surgery patients are aware of such TV shows, the majority of whom are "high-intensity" viewers (a regular viewer of at least one show), and four out of five felt they were influenced by them to pursue cosmetic surgery. Moreover, despite the general perception that such shows often downplay surgical risks, high-intensity viewers still consistently, but erroneously, felt fully informed and knowledgeable of the risks through TV viewing.

50. Camp, *supra* note 12, at 1257.

51. *Id.*

52. *Id.* at 1258.

53. Eva C. Ritvo et al., *Psychiatric Conditions in Cosmetic Surgery Patients*, 22 FACIAL PLAST. SURG. 194, 194 (2006).

54. DAVID B. SARWER et al., *Plastic Surgery for Children and Adolescent*, in BODY IMAGE, EATING DISORDERS, AND OBESITY IN YOUTH: ASSESSMENT, PREVENTION, AND TREATMENT 304 (Myles S. Faith et al. eds., 2nd ed. 2009) (providing an overview of the psychological aspects of plastic surgery for young

up to 47.7% of all persons seeking cosmetic surgery meet the criteria for possessing a mental or personality disorder.⁵⁵ Statistics show Body Dysmorphic Disorder (“BDD”) at 5-15%; Narcissistic Personality Disorder at 25%; and Histrionic Personality Disorders at 9.7%.⁵⁶ All these disorders⁵⁷ disturb the rational decision-making process regarding one’s appearance.⁵⁸ Importantly, while the symptoms usually begin in early adolescence, the diagnosis is often missed due to typical adolescent bodily preoccupation.⁵⁹

People with BDD believe the cause of their emotional distress is due to a defective appearance, and often turn to cosmetic surgery for treatment; however, those who undergo psychological treatment have greater success in overcoming those issues.⁶⁰ In one of the largest studies on people with BDD, their dislike of appearance began at age thirteen (plus or minus six years), and the mean age for full BDD onset was age sixteen (plus or minus seven years).⁶¹ Further, the preoccupation can be over any specific part of the body, such as skin, hair, nose, genitals, height, hair, body build, weight, hips, legs, or breasts.⁶² Over the course of the disorder, their preoccupation can be over five to seven body parts, with complaints ranging from specific body-parts to vaguer preoccupations (e.g., body just

people, and using the findings from the adult literature as a framework to consider relevant psychological issues for children and adolescents undergoing these procedures).

55. Ritvo, *supra* note 53, at 194 (explaining that studies show up to 47.7% of patients seeking a consultation for a cosmetic procedure meet the criteria for a mental disorder).

56. *Id.*

57. Additionally, because adolescents with eating disorders often give disproportionate focus to their appearance, they also seek cosmetic surgery due to belief that it will improve their body image. Phillips, *infra* note 64. While there are no studies of individuals with eating disorders obtaining cosmetic surgery, there are case reports. SARWER, *supra* note 54, at 314. For example, in a report of two females (one age nineteen, the other twenty) with eating disorders, one underwent rhinoplasty and the other chin augmentation (both seemingly innocuous and routine cosmetic procedures). *Id.* Though, after surgery, they both experienced remission of their condition for the first few months, the symptoms only returned and worsened, resulting in one needing hospitalization. *Id.* Reports with the same result have also been made when people with such disorders have undergone breast augmentation and liposuction surgeries. *Id.* Therefore, surgery cannot cure people with eating pathologies or their associated body image disturbances. *Id.*

58. *Id.* at 195.

59. *Id.*

60. Canice Crerand, *Body Dysmorphic Disorder and Cosmetic Surgery*, 118 PLAST. RECONSTR. SURG. 167e, 174e (2006) (explaining that as a result of their perceived defect, these patients often turn to plastic surgeons, dermatologists, and other medical professionals for treatment. However, those who instead present for psychiatric and psychological treatment often have greater success).

61. *Id.* at 170e (explaining although most people with BDD do not seek treatment until their thirties, the mean age of full BDD onset is late adolescence).

62. *Id.* at 175e (explaining that 77% of persons with BDD have an obsessive preoccupation with a body part that rises to delusional levels and which may result in violence to others or do-it-yourself cosmetic procedures. In addition, a survey of cosmetic surgeons found that 2% had been physically threatened and 10% reported a threat of both violence and legal action).

doesn't look right).⁶³

Most importantly, a study shows that people with BDD have higher lifetime rates of suicidal ideation and attempted suicide.⁶⁴ People with BDD have a 78% lifetime rate of suicidal ideation, for which BDD was the primary reason 55-70% of the time.⁶⁵ This rate is higher than the lifetime rates for any other psychiatric disorder (e.g., schizophrenia at 40-53%, or major depression at 55-56%).⁶⁶ Moreover, of those studied, 27% had previously attempted suicide, with BDD being the primary reason 36% of the time,⁶⁷ which is estimated to be 6 to 23 times higher than that of the general U.S. population.⁶⁸

Similar to adults with BDD, adolescents with BDD also often seek cosmetic surgery.⁶⁹ In a study of two hundred people with BDD, 71% sought and 64% received cosmetic treatments.⁷⁰ Of these, sixteen of the two hundred were adolescents; and, of them, ten sought cosmetic treatments and nine received them.⁷¹ Moreover, the mean age at which adolescents first sought cosmetic treatment was 14.8 years.⁷² Among those with BDD, rhinoplasty (nose surgery), liposuction (fat removal), and breast augmentation are the most frequently sought after surgical treatments.⁷³ Additionally, a recent study found that for rhinoplasty alone, one in three applicants had symptoms of BDD.⁷⁴ This data is significant because studies of patients after having obtained cosmetic surgery either

63. *Id.* at 171e.

64. Katharine A. Phillips et al., *Suicidal Ideation and Suicide Attempts in Body Dysmorphic Disorder*, 66 THE J. OF CLINICAL PSYCHIATRY 717, 721 (2005).

65. *Id.* at 720 (explaining that of 200 subjects with BDD, 78% reported a history of suicidal ideation. Of those subjects with a history of suicidal ideation, BDD was the primary reason 70.5% of the time. Of the entire sample, BDD was the primary reason 55% of the time).

66. *Id.* at 721-22.

67. *Id.* at 720 (explaining that of 200 subjects with BDD, 27.5% had previously attempted suicide. BDD was reported to be the primary reason for 36% of the sample's 178 suicide attempts. Of those subjects with a history of attempted suicide, 45.5% reported BDD as the primary reason for at least one attempt; and, of the entire sample, BDD was the primary reason 12.5% of the time).

68. *Id.* at 722 (explaining that lifetime suicide attempt rates in BDD are an estimated 6 to 23 times higher than in the general US population, and the study's suicide attempt rate during the 1 month before the intake evaluation (3%) is an estimated 30 times higher than found in the US population).

69. SARWER, *supra* note 54, at 313 (explaining that like their adult counterparts, adolescents with BDD frequently pursue cosmetic surgery and related treatments).

70. *Id.*

71. *Id.*

72. *Id.*

73. Crerand, *supra* note 60, at 171e (explaining that receipt of minimally invasive [e.g., collagen injections] and dental [e.g., tooth whitening] procedures are also common).

74. Mary Dallas, *1 in 3 Nose Job Patients Has a Mental Illness: Study*, Medline Plus, National Institutes of Health, July 27, 2011, http://www.nlm.nih.gov/medlineplus/news/fullstory_114750.html (finding that of 266 patients surveyed, 33% had moderate to severe symptoms of BDD).

show no symptom change at all or show symptoms had worsened.⁷⁵ Either way, the surgery's objective, to improve the patient's personal bodily outlook, was not accomplished.⁷⁶ Indeed, complete remission of BDD is rare, even after therapeutic treatment.⁷⁷

Additionally, BDD is often misdiagnosed due to its concurrent existence with other psychopathologies and the unwillingness of people with BDD to share their distress with others.⁷⁸ They are also frequently able to conceal their BDD symptoms from their clinicians.⁷⁹ Indeed, cosmetic surgeons, precisely because they are not psychopathologists, have been experiencing ongoing difficulty recognizing and screening out applicants with mental disorders.⁸⁰ However, even where a physician recognizes the symptoms and refuses to treat, the applicant may still doctor-shop until the applicant finds one who will perform the procedure.⁸¹ In sum, cosmetic surgery is a danger to adolescents with BDD due to the high risk of condition deterioration,⁸² its diagnosis difficulty by trained mental health professionals, the rare likelihood of symptom remission, and high lifetime rates of suicidal ideation and attempted suicide.

75. SARWER, *supra* note 54, at 314. See also Crerand, *supra* note 60, at 174e ("These investigations suggest that cosmetic medical treatments typically produce no change or, even worse, an exacerbation of [BDD] symptoms. . . . After treatment, some recipients thought that their defect looked better, but they continued to worry about the treated body part (e.g., concerns that the part would become defective again). [And], in other cases, new appearance concerns developed.").

76. *Id.*

77. Crerand, *supra* note 60, at 170e (explaining that BDD tends to be continuous rather than episodic, and that severity of symptoms can fluctuate over the course of the disorder).

78. *Id.* at 170e, 172e (explaining that BDD comorbid psychopathologies include mood and anxiety disorders [75%], obsessive-compulsive spectrum disorders [ranging from 30-78%], substance abuse disorders [ranging from 25-30%], anorexia and bulimia [ranging from 7-14%]. In addition, personality disorders are also commonly present, such as avoidant personality disorder, paranoid, obsessive compulsive disorder, and dependent personality disorders [at 57% for at least one]).

79. See Phillips, *supra* note 64, at 721 (discussing how treated subjects who had experienced suicidal ideation or attempted suicide often did not reveal their BDD symptoms to their treating clinician).

80. David B. Sarwer, *Awareness and Identification of Body Dysmorphic Disorder by Aesthetic Surgeons: Results of a Survey of American Society for Aesthetic Plastic Surgery Members*, 22 AESTHETIC SURG. J., 531, 533-34 (2002) (indicating that 84% of cosmetic surgeons surveyed indicated they had operated on a patient whom they believed appropriate for surgery, only to find afterward that the patient had Body Dysmorphic Disorder. Further, of this number, 43% reported that the patient was more preoccupied with the perceived defect than before surgery and 39% reported that patient simply became preoccupied with a different feature). See generally Eva Ritvo et al., *Psychiatric Conditions in Cosmetic Surgery Patients*, 22 FACIAL PLAS. SURG. 194 (2006) (acknowledging the difficulty in screening out potential patients with mental disorders and giving tips on how cosmetic surgeons, untrained in psychopathology, can recognize such patients).

81. Crerand, *supra* note 60, at 172e (explaining that in a study of 265 cosmetic surgeons 84% had refused to treat, but that the applicants may still engage in doctor-shopping until they find a doctor who will not refuse).

82. SARWER, *supra* note 54, at 314.

C. Medical Decision-Making for Minors

1. Constitutional Affects on Medical Decision-Making⁸³

In *Troxel v. Granville* the Supreme Court held that parents have a fundamental right to the care, custody, and control of their children.⁸⁴ This fundamental right is a liberty interest protected under the Due Process Clause, and includes the rights to establish a home, to bring up children, and to control their education.⁸⁵ The *Troxel* Court also held that a fit parent is presumed to have acted in the best interest of their child(ren) – a parental presumption.⁸⁶ The rationale is that parents have what a child lacks in maturity, experience, and capacity for judgment when making life's difficult decisions⁸⁷; and, due to their natural bond, said affections will lead parents to act in the best interest of their children.⁸⁸

This fundamental parental right includes medical decision-making, on the reasoning that minors are incompetent and lack the ability to make mature decisions about their own well-being.⁸⁹ The rationale underlying informed consent – a patient's comprehension of risks involved for a competent medical decision – cannot be satisfied when a patient cannot understand a physician's disclosure, when a patient cannot exercise competent independent judgment, or when both occur.⁹⁰ Hence, special rules apply to those deemed incompetent.⁹¹ One category of those deemed

83. Not considered here is *Parham v. JR*, a 1979 US Supreme Court case adjudicating whether due process is required for minors committed, by parents, to a state mental hospital. 442 US 584. Indeed, the language regarding cosmetic surgery is entirely restricted to the the following: "The fact that a child may . . . complain about a parental refusal to provide cosmetic surgery does not diminish the parents' authority to decide what is best for the child. . . . Neither state officials nor federal courts are equipped to review such parental decisions." *Id.* at 604. First, *Parham* dealt with legal disputes between minors and parents; whereas, regarding cosmetic surgery and for the purposes of this article, the minor and parent are unified in their interest in obtaining cosmetic surgery for the minor. Second, the term cosmetic surgery was not defined; thus, it is not clear whether the Court intended to use the phrase in the corrective or reconstructive sense. Third, *Parham* did not discuss whether cosmetic surgery, if used in the corrective sense, is health care or, as this article avers, is a non-medical service or product. Fourth, no discussion was had on the countervailing risks of harm, which may result from cosmetic surgery. Lastly, the Court's holding, that a fact-finding hearing need not be given, *id.* at 620-21, is wholly inapplicable to the matter at hand.

84. 530 U.S. 57, 65-66 (2000).

85. *Id.* at 65 (citing *Meyer v. Nebraska*, 262 U.S. 390, 399, 401 (1923)).

86. *Id.* at 68.

87. *Parham v. J.R.*, 442 U.S. 584, 602 (1979).

88. *Id.*

89. Kimberly M. Mutcherson, *Whose Body Is It Anyway? An Updated Model Of Healthcare Decision-Making Rights For Adolescents*, 14 CORNELL J. L. & PUB. POL'Y 253, 259 (2005). See also U.S. Cong., Office of Tech. Assessment, *Adolescent Health-Volume III: Cross-Cutting Issues in the Delivery of Health and Related Services, Consent and Confidentiality in Adolescent Health Care Decisionmaking* OTA-H-467 123 (Washington, D.C.: U.S. Government Printing Office, June 1991).

90. *Id.*

91. *Id.*

incompetent is minors and, thus, physicians must obtain informed consent from parents, who are presumptively deemed competent on behalf of the minor.⁹²

2. State Intervention Exceptions

Though parental deference remains the default rule, it is not as weighty as it once was,⁹³ as a state may now intervene if it believes a medical procedure to be in a child's best interest.⁹⁴ Exceptions to parental deference exist where emergent needs take priority over parental rights and adolescent incompetence.⁹⁵ The first exception is a medical emergency, which is 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."⁹⁶ Another exception occurs when a child is in the

92. American Academy of Pediatrics Committee on Bioethics, *Informed Consent, Parental Permission, and Assent in Pediatric Practice*, 95 PEDIATRICS 314, 314 (1995) ("We now realize that the doctrine of 'informed consent' has only limited direct application in pediatrics. Only patients who have appropriate decisional capacity and legal empowerment can give their informed consent to medical care. In all other situations, parents or other surrogates provide informed permission for diagnosis and treatment of children with the assent of the child whenever appropriate."). Additionally, as an ethical concern, though not legally mandated, some physicians also seek assent from minors before they proceed. See *Id.* at 315-16 (defining "assent" as: 1. Helping the patient achieve developmentally appropriate awareness of the nature of his or her condition. 2. Telling the patient what he or she can expect with tests and treatment(s). 3. Making 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). 4. Soliciting an expression of the patient's willingness to accept the proposed care. Regarding this final point, we note that no one should solicit a patient's views without intending to weigh them seriously. In situations in which the patient will have to receive medical care despite his or her objection, the patient should be told that fact and should not be deceived.). See also Mutcherson, *supra* note 89, at 298 (defining "assent" as "essentially a right to notice and comment" that is "secondary to a right to consent").

93. Jennifer L. Rosato, *Using Bioethics Discourse to Determine When Parents Should Make Healthcare Decisions For Their Children: Is Deference Justified?*, 73 TEMP. L. REV. 1, 9 (2000) (explaining that instead of intervening only when serious harm is threatened, courts now intervene whenever it believes that intervention will further the child's best interests. The increased intervention has been facilitated by broad language of many abuse/neglect statutes that permit intervention where a necessary medical treatment has been denied).

94. *Id.* (stating that courts have taken a more active role in requiring medical care for children); see also Walter Wadlington, *David C. Baum Memorial Lecture: Medical Decision Making for and by Children: Tensions Between Parent, State, and Child*, 1994 U. ILL. L. REV. 311, 331 (noting courts are moving away from rules allowing interference in only life-threatening cases).

95. See Mutcherson, *supra* note 89, at 263.

96. ANGELA R. HOLDER, TREATISE ON HEALTH CARE LAW § 19.02 (Matthew Bender & Company, Inc. 2010) (explaining that parental consent is not required unless the physician can locate the parents by phone; however, if it is the case that the parent(s) cannot be located, then the physician cannot be held liable for providing medical care without parental consent and additionally depends on the severity of the injury, the risk in intervening, and the degree of resulting disability). See also *Luka v. Lowrie*, 136 N.W. 1106 (Mich. 1912); *Sullivan v. Montgomery*, 279 N.Y.S. 575 (City Ct., Bronx Cty., 1935); Cynthia R. Jacobstein and Jill M. Baren, *Emergency Department Treatment of Minors*, 17 EMERGENCY MED. CLINICS OF N. AM. 341 (1999); Committee on Pediatric Emergency Medicine, American Academy of Pediatrics, *Policy Statement: Consent for Emergency Services for Children and Adolescents*, 111 PEDIATRICS 703 (2003); American

possession of a divorced parent without legal custody.⁹⁷ Similarly, a child who becomes acutely ill, and in the temporary control of one who is not the parent, may be given necessary medical treatment, even if not an emergency, if the parents cannot be located.⁹⁸ Special exceptions also exist for legal guardians.⁹⁹ In addition, some states have exceptions for sensitive types of treatment – i.e., substance abuse, mental health, STDs, HIV testing,¹⁰⁰ or adolescent pregnancy.¹⁰¹

Cosmetic surgery on minors, however, does not fit into any of the above exceptions. First, cosmetic surgery is not medically necessary; thus, it is classified as elective surgery rather than emergency care.¹⁰² Second, divorced parents or legal guardianship are not at issue. Third, third-party consent for cosmetic surgery on a minor is unlikely or rare. Lastly, cosmetic procedures do not concern treatments for STDs, substance abuse, or HIV testing.

Another exception is emancipation, through which minors “attain

Academy of Pediatrics, *Consent for Medical Services for Children and Adolescents*, 92 PEDIATRICS 290 (1993); Rice, *Medicolegal Issues in Pediatric and Adolescent Emergencies*, 9 EMERGENCY MED. CLINICS OF N. AM. 677 (1991); Sullivan, *Minors and Emergency Medicine*, 11 EMERGENCY MED. CLINICS OF N. AM. 841 (1993). Albert K. Tsai et al., *Evaluation and Treatment of Minors: Reference on Consent*, 22 ANNALS OF EMERGENCY MED. 1211 (1993). Cora C. Breuner, *The Adolescent Traveler*, 29 PRIMARY CARE 983 (2002).

97. Holder, *supra* note 96 (explaining that as far as the physician is concerned, the parent in possession has custody of the child and thus cannot be held liable if the divorced parent without legal custody provides consent for a procedure). *See also, e.g.*, Taylor v. R.D. Morgan & Assocs., Ltd., 563 N.E.2d 1186 (Ill. App. Ct. 1990).

98. However, a non-emergency but necessary treatment that could result in any form of consequential risk (e.g., surgery) should not be done without consent of a parent. Holder, *supra* note 96.

99. *Id.*

100. *See, e.g.*, ALA. CODE § 22-8-6 (LexisNexis 2006) (venereal disease, pregnancy, drug dependency or any other reportable disease); V.I. CODE ANN. TIT. 19 § 291 (1995) (providing for examination, treatment, counseling, hospitalization and medical or surgical care to minors for pregnancy, communicable disease and drug or substance abuse without the need for parental consent); DEL. CODE ANN. TIT. 13 § 710 (2009) (providing minors authority to consent to care for pregnancy and communicable diseases); MICH. COMP. LAWS ANN. § 333.5127 (West 2001) (venereal diseases, specifically including HIV); MICH. COMP. LAWS ANN. § 333.9132 (West 2001) (pregnancy, pre-natal care); MICH. COMP. LAWS ANN. § 333.6121 (West 2011) (substance abuse); and MICH. COMP. LAWS ANN. § 330.1707 (West 1999) (outpatient mental health services for minors over 14).

101. Mutcherson, *supra* note 89, at 263-64 (explaining that twenty-eight states and the District of Columbia grant adult status to pregnant women for the limited purpose of bringing their child to term; thus, a physician is legally bound to provide prenatal care as though she were not a minor. Moreover, the treating physician often has no legal obligation, and sometimes no statutory right, to report the adolescent pregnancy to her parents). *See also, e.g.*, *Risking the Future: Adolescent Sexuality, Pregnancy and Childbearing*, NATIONAL RESEARCH COUNCIL (1986).

102. *Choosing Cosmetic Surgery*, WEBMD, at <http://www.webmd.com/healthy-beauty/guide/choosing-cosmetic-surgery>. *See also* *Elective Surgery*, ENCYCLOPEDIA OF SURGERY, at <http://www.surgeryencyclopedia.com/Ce-Fi/Elective-Surgery.html> (explaining that elective surgeries are planned and thus non-emergency surgical procedures. They may be further classified as either medically required [e.g., cataract surgery], or optional [e.g., breast augmentation or implant] surgery).

legal adulthood before reaching the age of majority.”¹⁰³ Emancipated minors have legal authority to: sign binding contracts, own property, keep their earnings, and disobey their parents.¹⁰⁴ Regarding healthcare, while an emancipated adolescent may consent to treatment without parental consent,¹⁰⁵ the adolescent alone is responsible for payment.¹⁰⁶ Most

103. Mutcherson, *supra* note 89, at 266 (citing Carol Sanger and Eleanor Willemssen, *Minor Changes: Emancipating Children in Modern Times*, 25 U. MICH. J.L. REFORM 239, 244 (1992)). Depending on jurisdiction, emancipation can be obtained automatically pursuant to statute or by court order. See, e.g., ALA. CODE § 26-13-1, 26-13-2, 26-13-4, 26-13-6 (LexisNexis 2006) (requiring a minor be emancipated by leave of the court); CAL. FAM. CODE § 7002 (West 2004); 750 ILL. COMP. STAT. ANN. 30/3-1, 30/3-2, 30/4, 30/5 (requiring a minor be emancipated by leave of the court); MINN. STAT. 144.341 (West 2011) (granting emancipation to minors who are living independently); R.I. GEN. LAWS § 14-1-59.1 (2003) (requiring a minor be emancipated by leave of the court). Moreover, emancipation can be obtained through status of minor, such as in the military, or pregnant, or married. See, e.g., ALA. CODE § 22-8-4 (LexisNexis 2006) (requiring a minor to be at least fourteen and a be high school graduate, married or pregnant); ALASKA STAT. § 25.20.025 (2010); ARK. CODE ANN. § 20-9-602 (2005); CAL. FAM. CODE § 6911, 6922 (West 2004) (requiring a minor to be living apart from parents and managing his/her own financial affairs); FLA. STAT. ANN. § 743.064, 743.0645 (West 2005); IDAHO CODE ANN. § 39-4302, 39-4303 (2011); 410 ILL. COMP. STAT. ANN. § 210/1 (West 2002) (requiring a minor to be married, a parent him/herself, or to have parental consent); IND. CODE ANN. § 16-36-1-3(a) (West 2002) (requiring a minor to be married, divorced, in the military, or at least fourteen and living apart from parents); KAN. STAT. ANN. § 38-123b (2000) (requiring a minor to be at least sixteen); KY. REV. STAT. ANN. § 214.185 (LexisNexis 2007); MD. CODE ANN., HEALTH. § 20-102 (LexisNexis 2009); MISS. CODE ANN. § 41-41-3 (2009) (requiring a minor to have the intelligence to understand procedure and its consequences); MONT. CODE ANN. § 41-1-402 (2011) (requiring a minor be married, pregnant, a high school graduate, or living separate from parents, and financially self-sufficient if the medical care is for the minor's child); NEV. REV. STAT. ANN. § 129.030 (West 2008) (requiring a minor to be living apart from parents for at least four months, married or been married, a mother, in danger of a serious health hazard, or able to understand the nature, purpose, and need for medical care and voluntarily request the care); N.J. STAT. ANN. § 9:17A-4 (West 2008) (granting discretion to healthcare provider to inform parents); OR. REV. STAT. ANN. § 109.640 (West 2003) (requiring a minor to be at least fifteen and that provider involve the parents); 28 PA. CODE § 27.97; R.I. GEN. LAWS § 23-4.6-1 (2002) (requiring a minor to be at least sixteen, married, or a parent); S.C. CODE ANN. § 20-7-280 (1985); TENN. CODE § 63-6-229 (2010); VA. CODE ANN. § 54.1-2969(A)-(B) (2009) (requiring a court order); WYO. STAT. ANN. § 14-1-101(b) (2011) (requiring a minor to be married, on military active duty, the treatment need must be exigent, and the parents or guardian cannot be located, or the minor must be living away from parents and managing her/his own affairs). Lastly, In circumstances where it is not clear whether the adolescent is emancipated, a jury may determine the question. See, e.g., *Wood v. Wood*, 135 Conn. 280, 63 A.2d 586 (1948); *Parker v. Parker*, 230 S.C. 28, 94 S.E.2d 12 (1956).

Among the most frequently considered factors are: whether the child is living at home, whether the child is paying room and board if living at home, whether the parents are exercising disciplinary control over the minor, whether the child is independently employed, whether the child has been given the right to retain wages and spend them without parental restraints, whether the child is responsible for debts incurred and the extent of the parents' contributions toward the payment of outstanding bills, whether the child owns a major commodity such as a car, and whether the parent has listed the child as a dependent for tax purposes. ANGELA R. HOLDER, *TREATISE ON HEALTH CARE LAW* § 19.03 (Matthew Bender & Company, Inc. 2010) (citing *Katz, Schroeder & Sidman, Emancipating Our Children: Coming of Legal Age in America*, 7 FAM. L.Q. 211 (1973)).

104. Mutcherson, *supra* note 89, at 266.

105. See, e.g., *Lacey v. Laird*, 139 N.E.2d 25 (Ohio 1956); *Carter v. Cangello*, 164 Cal. Rptr. 361 (Ct. App. 1980).

106. See, e.g., *In re Marriage of Koltay*, 646 P.2d 405 (Colo. App. 1982); *Banks v. Banks*, 686 S.W.2d 50 (Mo. 1985); *Bopp v. Bopp*, 671 S.W.2d 348 (Mo. 1984); *French v. French*, 599 S.W.2d 40 (Mo. 1980); *Accent Serv. Co. v. Ebsen*, 209 Neb. 94 (1981); *Knoll v. Kitcher*, 100 A.D.2d 686 (1984); *Cidis v. White*, 71 Misc. 2d 481 (Dist. Ct. 1972); *Bryant v. Mutual Hosp. Servs.*, 669 N.E.2d 427 (Ind. App. 1996); *Proctor*

importantly, because emancipated adolescents have the right to provide informed consent, the restrictions in this article do not, and cannot, bind them.

3. The Mature Minors Doctrine Should Not Control

Lastly, mature minors constitute a quasi-exception in many states. The mature minors doctrine holds that “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.”¹⁰⁷ Essentially, mature minors are those deemed socially and psychologically mature enough to make their own healthcare decisions, even if not emancipated.¹⁰⁸ And, the doctrine generally only applies to adolescents age fourteen and above.¹⁰⁹

A fair legal argument can be made that mature minors demonstrate a competent understanding of cosmetic surgery risks sufficient to provide exception to any proposed regulation. The mature minors doctrine has an extensive history in the courts, and is not in the scope of this article to challenge such an entrenched legal doctrine. That said, it *is* in the scope of this article to demonstrate that states should intervene to protect minors from obtaining medically unnecessary cosmetic surgeries without oversight. With this in mind, the following recent scientific findings demonstrate that mature minors might not, in fact, be capable of understanding fully the risks involved with cosmetic surgery and are, additionally, susceptible to external coercive forces (e.g., peers or parents).

First, through the use of MRI,¹¹⁰ two observations show that the

Hosp. v. Taylor, 279 Ill. App. 3d 624 (1996).

107. James Morrissey et al., Consent and Confidentiality in the Health Care of Children and Adolescents, 43 (1986).

108. Claire C. Obade, *Patient Care Decision-Making: A Legal Guide for Providers*, Mature and Emancipated Minors 5:3 (2010 Westlaw). See also Mutcherson, *supra* note 89, at 268 (explaining further that mature minors may be deemed mature enough to consent even though, unlike emancipated adolescents, such minors still live at home, are not making contributions to room and board, or are not parents, married, or in any of the military forces).

109. Angela R. Holder, *Treatise on Health Care Law*, 3-19 Treatise on Health Care Law § 19.01 (2010 LexisNexis, Matthew Bender & Company, Inc.). See also *Cardwell v Bechtol*, 724 S.W.2d 739 (1987) (“[R]ecognition that minors achieve varying degrees of maturity [is] part of the common law . . . [And, is] known as the Rule of Sevens: under the age of seven, no capacity [to consent]; between seven and fourteen, a rebuttable presumption of no capacity; between fourteen and twenty-one, a rebuttable presumption of capacity.”).

110. See, e.g., Kenneth K. Kwong et al., Dynamic Magnetic Resonance Imaging of Human Brain Activity During Primary Sensory Stimulation, 89 PROC. NAT’L ACAD. SCI. 5675 (1992) (early use of functional MRI to image the brain).

MRI measures the response of atoms in different tissues when they are pulsed with radio

differences between adults and adolescents actually go to the very biology of their brains.¹¹¹ The first observation is that adolescents rely more on the amygdala, the area of the brain associated with the primitive impulses of aggression, anger, and fear.¹¹² Adults, on the other hand, tend to rely on the frontal lobes, a cerebral area associated with impulse control and good judgment.¹¹³ The second observation is even more crucial: the regions of the brain associated with impulse control, risk assessment, and moral reasoning develop last and are not complete until late adolescence or beyond.¹¹⁴

Second, and in a similar vein, scientists actually characterize as “deficient”¹¹⁵ the adolescent inability to perceive and make a cost-benefit analysis.¹¹⁶ In fact, a study of one thousand adolescents showed that psychosocial maturity is incomplete until age nineteen, at which point it plateaus.¹¹⁷ Researchers found that adolescents “score[d] lower [than adults] on measures of self-reliance and other aspects of personal responsibility [and] have more difficulty seeing things in long-term

waves that are under the influence of magnetic fields thousands of times the strength of the earth's. Each type of tissue responds differently, emitting characteristic signals from the nuclei of its cells. The signals are fed into a computer, the position of those atoms is recorded, and a composite picture of the body area being examined is generated and studied in depth.

Florence Antoine, Cooperative Group Evaluating Diagnostic Imaging Techniques, 81 J. NAT'L CANCER INST. 1347, 1348 (1989).

111. Brief for the Am. Psychological Assoc., and the Mo. Psychological Assoc. as Amici Curiae Supporting Respondent, *Roper v. Simmons*, 543 US 551 (2005) (No. 03-633), 2003 U.S. Briefs 633, 10.

112. *Id.* at 10 (explaining that the adolescent frontal lobe is immature and underdeveloped, resulting in a lesser check on the amygdala, and that one “hallmark of frontal lobe dysfunction is difficulty in making decisions that are in the *long-term best interests* of the individual.” However, as adolescents mature into adults, their brains shift the locus of brain activity from the amygdala to the frontal lobes).

113. *Id.*

114. *Id.* at 11, 18 (concluding that response inhibition, emotional regulation, planning and organization continue to develop between adolescence and young adulthood). There are two more precise reasons why this is the case: both myelination and pruning are incomplete in those areas of the adolescent brain related to impulse control, risk-taking, and self-control. As to the first, myelin is what insulates the brain's neural fibers (axons), which use electrical impulses to carry information, and speeds the neural signal along its pathway. The process of insulating the brain's neural fibers is called myelination, which is a continuing process throughout adolescence and into adulthood. As to the second, “Gray matter, which comprises the outer surfaces, or cortices, of the brain, is composed of the brain cells (or neurons) that perform the brain's tasks, such as the cognition and higher functions that are carried out in the frontal lobes.” As maturation of the brain occurs, this gray matter decreases through a process called pruning (similar to the pruning of a flower bush to strengthen remaining branches), which results in the functional improvement of the brain's reasoning centers by improving neural efficiency – which also is incomplete in adolescents. *Id.* at 17-20.

115. *Id.* at 8.

116. *Id.* at 5-6 (citing Laurence Steinberg & Elizabeth S. Scott, *Less Guilty by Reason of Adolescence: Developmental Immaturity, Diminished Responsibility, and the Juvenile Death Penalty*, 58 AM. PSYCHOLOGIST 1009, 1012 (2003)).

117. *Id.* at 7.

perspective.”¹¹⁸ On average, adolescents are risk takers to a much greater degree than adults, and while they undervalue the true consequences of their actions, they instead often value peer approval, fun-seeking, and impulsivity.¹¹⁹ Essentially, teenagers have a tendency to make bad judgments.¹²⁰

Third, these deficiencies are even more glaring upon entry of stress and peer pressure,¹²¹ which operate with special force on the adolescent mind¹²² because adolescents have a heightened susceptibility to daily stresses compared to adults.¹²³ This adds to the already skewed cost-benefit analysis resulting from physiological differences.¹²⁴ Furthermore, already risk-prone and impulsive adolescents have a high tendency to surround themselves with others like-minded, which reinforces their behavior.¹²⁵

In sum, these scientific findings should give pause to applying the mature minors exception to state regulation prohibiting cosmetic surgery. Indeed, such a prohibition is not a permanent one, but is necessarily restricted to those in the age of minority. Therefore, the proposed regulation simply acts as a delay until the age of majority rather than a lifetime ban. More importantly, these scientific findings demonstrate that mature minors biologically cannot understand fully the risks involved with cosmetic surgery or make an accurate cost-benefit analysis without undue external influence.

III. PARENT-AS-TRUSTEE PARADIGM

A. Getting to *Parens Patriae* by Showing Risk of Harm

The point of inquiry is whether a minor's parent's consent for a cosmetic procedure can or should be trumped by a state. Regarding

118. *Id.* See also Bonnie L. Halpern-Felsher & Elizabeth Cauffman, *Costs and Benefits of a Decision: Decision-Making Competence in Adolescents and Adults*, 22 J. APPLIED DEVELOPMENTAL PSYCHOLOGY 257, 268-271 (2001).

119. Brief for the Am. Psychological Assoc., *supra* note 111, at 6-7.

120. *Id.* at 5.

121. *Id.* at 7-8.

122. *Id.*

123. *Id.* at 8.

124. *Id.*

125. *Id.* at 8. (citing Jeffrey Jensen Arnett, *Reckless Behavior in Adolescence: A Developmental Perspective*, 12 DEVELOPMENTAL REV. 339, 354-55 (1992)). See also Denise B. Kandel & Kenneth Andrews, *Processes of Adolescent Socialization by Parents and Peers*, 22 INT'L J. ADDICTIONS 319, 334-335 (1987); Jeffrey Jensen Arnett, *Adolescent Storm and Stress, Reconsidered*, 54 AM. PSYCHOLOGIST 317, 321 (1999) ("Unlike conflict with parents or mood disruptions, rates of risk behavior peak in late adolescence/emerging adulthood rather than early or middle adolescence.").

cosmetic surgery on adolescents, as of this writing there are no reported cases involving adolescent refusal of elective treatment.¹²⁶ This is probably because a physician is unlikely to perform such a procedure on a minor against their will and without court order.¹²⁷ More importantly, because 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.¹²⁸ Hence, inquiry into this matter need not focus on disagreements between adolescent and parent, but on the relationship between the parent and state.

Alicia Ouellette argues that Asian-eye surgery proves the need to “reconceptualize the legal roles of parents in medical decision-making to protect children from well-meaning but misguided parents.”¹²⁹ She opens with reference to a speech given by a cosmetic surgeon celebrating the miracles of modern medicine and how he, a Euro-American man, performed cosmetic surgery on his adopted daughter’s Asian eyes.¹³⁰ 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.”¹³¹ He finished by commenting that, after he performed the surgery, his adopted Asian daughter “now has big round eyes that stay open and shine even when she smiles.”¹³²

Ouellette points out that this procedure provided no medical or functional benefit.¹³³ She argues that serious questions are raised about the limits of parental authority over the rights of a child when a parent can have a non-medical and non-functional surgery performed.¹³⁴ She concludes that medical decision-making laws ought to be redesigned, with a focus on protecting children from well-meaning but misguided parents – a parent-as-trustee paradigm.¹³⁵ However, rather than wrestle with the task

126. Holder *supra* note 96, at 19.04.

127. *Id.*

128. *Cidis v. White*, 71 Misc. 2d 481 (Dist. Ct. 1972); *see also* Holder, *supra* note 96, at 19.01.

129. Alicia Ouellette, *Eyes Wide Open: Surgery to Westernize the Eyes of an Asian Child*, 39 HASTINGS CTR. REP. 15, 16 (2009).

130. *Id.* at 15.

131. *Id.*

132. *Id.*

133. *Id.* at 16.

134. *Id.* (arguing that this adoptive father deprived his child of a biological marker which she may have later preferred to keep, and highlights a failure in the current medical decision-making model).

135. Ouellette writes that the difficulty lay in current “procedure-specific” laws, which focus on restrictions stemming from specific types of procedures, rather than a broader standard of parent-as-trustee. For example, several states require a child to be vaccinated regardless of parental choice, and other states

of redesigning health-related family law, there exists a body of law which can be extended to cover these concerns.

In this vein, begin with the language of one court:

While acknowledging that parents have primary custody rights over their children, we noted that this right is not akin to a property right, but is *more in the nature of a trust* which may be subject to the well-being of the child as perceived by the courts of this state.¹³⁶

A state's protection of children from harm is referred to as *parens patriae* authority, and trumps parental constitutional rights;¹³⁷ however, the U.S. Supreme Court narrowed this authority in *Troxel v. Granville*.¹³⁸ The *Troxel* Court held that states infringe on parental rights when they broadly grant, if found to be in the child's best interest, *any* person the right to petition for court-ordered visitation over parental objection.¹³⁹ Notably, the Court held that fit parents must be granted the presumption that they act in the best interest of their children,¹⁴⁰ and, thus, parental

mandate that parents cannot deny their children life-sustaining treatment. Many more require court approval for sterilization of a minor. She continues that it is only in procedure-specific scenarios where parental discretion is limited, and that cosmetic surgery does not lay within this zone of limited parental deference. Thus, she argues, parents may elect to have cosmetic surgeries without consideration of the rights of the child. *Id.* However, it cannot be true that all health-related family laws are procedure-specific, rather than holding a standard of parent-as-trustee. It is more likely that application and re-application of the parent-as-trustee paradigm over years has resulted in an entrenched doctrine of how such a paradigm procedurally fits into fact-specific scenarios. Were this not the case, then parental authority over one's child would be more akin to a property right, because that is the only other major operational paradigm historically employed in the United States. See also *Schaffer v. Schaffer*, 884 N.E.2d 423, 428 (Ind. Ct. App. 2008) (citing *Collins v. Gilbreath*, 403 N.E.2d 921, 923 (1980) (explaining that when a third party has cared for a child as her/his own, the mere protest by a biological parent is not enough to deny visitation to said third party and is because parents do not have a property right in their children – they are instead trustees)).

136. *Schaffer*, 884 N.E.2d at 428 (emphasis added). See also *Gilbreath*, 403 N.E.2d at 923 ("Although the legal right of a parent to custody of a child is superior to the legal right of all others, this right is not absolute. [A] parent's right of custody is not akin to a property right, but is more in the nature of a trust which may be subject to the well-being of the child as perceived by the courts of this state."); *Carignan v. State*, 1970 OK 82, 5-6 (1970) ("A parent's right to a child is not a property right in the general sense, but more in the nature of a trust . . . The parental rights to the child must yield when the welfare of the child demands.").

137. See *Prince v. Massachusetts*, 321 U.S. 158, 166-67 (1944) (noting that a state, as *parens patriae*, has authority to intrude on parental autonomy to protect a child from ill health or death); *Parham v. J.R.*, 442 US 584, 603 (1979) ("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.") (internal citations omitted); *Alfred L. Snapp & Son v. P.R.*, 458 U.S. 592, 600 (1982) (citing *Mormon Church v. U.S.*, 136 U.S. 1, 57 (1890) ("This prerogative of *parens patriae* is inherent in the [legislative] supreme power of every State [and serves] a most beneficent function . . . often necessary to be exercised in the interests of humanity, and for the prevention of injury to those who cannot protect themselves.")).

138. 530 US 57 (2000).

139. *Id.* at 72-73.

140. *Id.* at 68.

determinations must be accorded special weight.¹⁴¹

Courts across the country wrestled with an interpretation of *Troxel* that would balance *parens patriae* authority with *Troxel's* parental presumption.¹⁴² One interpretation requires a showing of harm to rebut the parental presumption.¹⁴³ Here, strict scrutiny is used to determine whether a compelling state interest warrants intrusion into family life,¹⁴⁴ and typically rejects “any compelling interest short of harm to the health or welfare of a child”¹⁴⁵ – as is consistent with U.S. Supreme Court precedent.¹⁴⁶ In a word, avoidance of harm is the “polestar” and “constitutional imperative” necessary for rebutting the parental presumption and justifying state intrusion into family life.¹⁴⁷

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. First, no traditional

141. *Id.* at 70.

142. *Moriarty v Bradt*, 177 NJ 84, 109 (2003).

143. *Id.* (citing Kristine L. Roberts, *State Supreme Court Applications of Troxel v. Granville and the Courts' Reluctance to Declare Grandparent Visitation Statutes Unconstitutional*, 41 FAM. CT. REV. 14, 15 (2003)).

144. *Moriarty*, 177 NJ at 109.

145. *Id.* at 109-10.

146. *Wisconsin v. Yoder*, 406 U.S. 205, 230 (1972) (reasoning that interference with Amish child-rearing not justified because the children were not physically or mentally harmed by receiving a religious education); *Stanley v. Illinois*, 405 U.S. 645, 649 (1972) (requiring proof of parental unfitness along with harm to child before ending an unwed father's parental rights); *Pierce v. Society of Sisters*, 268 US 510, 534 (1925) (holding that because children were not harmed by parental decision to send their child to private schools, the state's interest was inadequate to justify interference in family life); *Meyer v. Nebraska*, 262 U.S. 390, 403 (1923) (striking down a state law that prohibited children from learning a foreign language because it was not “so clearly *harmful* as to justify its inhibition with the consequent infringement of rights long freely enjoyed”).

147. *Moriarty*, 177 NJ at 113. *See also* ARIZ. REV. STAT. § 8-847(D) (LexisNexis 2011) (requiring courts to consider health and safety of the child as a paramount concern at each six month periodic review hearing); ARK. CODE ANN. § 9-27-102 (LexisNexis 2011) (explaining state policy as requiring best interest of child be paramount and take precedence at all stages of juvenile court proceedings); IDAHO CODE § 16-1601 (LexisNexis 2011) (declaring that health and safety of child is primary concern and state policy when child's life, health or welfare are endangered); KAN. STAT. ANN. § 38-2201(b)(1) (LexisNexis 2011) (construing liberally the state child welfare code to consider the safety and welfare of child as paramount in all proceedings); LA. CHILDREN'S CODE ANN. ART. 675(A) (LexisNexis through 2009 Reg. Sess.) (explaining that health and safety of child is paramount when developing state child welfare case plans); MASS. GEN. LAWS ANN. CH. 119, § 1 (LexisNexis 2011) (ensuring the protection of children from the harmful effects of parent's destructive behavior and that health and safety of child is paramount); NEB. REV. STAT. ANN. § 43-533(2) (LexisNexis 2011) (explaining that as a guiding principle state and local government resources shall be utilized to help meet the safety needs and best interests of children); N.J. STAT. ANN. § 30:4C-11.1(a) (LexisNexis 2011) (explaining that health and safety are of paramount concern when determining reasonable efforts in placement of child); N.M. STAT. ANN. § 32A-4-28(A) (LexisNexis 2011) (explaining that consideration of child's physical, mental, and emotional welfare be considered in proceedings to terminate parental rights); N.C. GEN. STAT. ANN. § 7B-507(d) (explaining that health and safety are of paramount concern when determining reasonable efforts in placement of child); WASH. REV. CODE ANN. § 13.34.020 (LexisNexis 2011) (explaining that when the health and safety of child and the legal rights of the parents are in conflict, the rights and safety of child are paramount and prevail).

exceptions are involved with it to warrant parental deference. For example, cosmetic surgery neither involves emergent care (i.e., non-emergency and non-prenatal), nor public health exceptions (i.e., STDs, substance abuse, or HIV testing).

Second, however, cosmetic surgery does involve significant risks of harm. Not only do general surgery risks exist (ranging from infection, heart and lung complications, to death), but, numerous serious procedure-specific risks exist which vary by cosmetic procedure performed. Moreover, the physician-specific risks (lack of training and lack of certification) pose additional problems on potential patients. Additionally, as Ouellette points out, parent-specific risks arise when parents, thinking they have in mind the best interest of their minor, are actually doing them a disservice.¹⁴⁸

Third, and most importantly, numerous patient-specific risks exist. 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. Moreover, BDD preoccupations range from preoccupations over one's hair to one's genitalia to one's legs; thus, performance of even a seemingly innocuous cosmetic procedure (e.g., rhinoplasty) can agitate BDD symptoms. Additionally, because cosmetic surgeons have no psychopathological training, they have difficulty diagnosing people with BDD, who still seek and obtain cosmetic surgery in high rates. For example, 84% of cosmetic surgeons found that patients who they thought without a mental disorder found the patient actually possessed one after surgery had been performed.¹⁴⁹ This is, at least in part, due to the ability of such applicants to conceal their BDD symptoms from physicians.¹⁵⁰ Finally, studies show that people with BDD have high lifetime rates of suicidal ideation at 78%, higher than any other mental disorder, and suicide attempts at 27%.

Therefore, due to the serious risks of harm to the health and welfare of minors, the parental presumption of a fit-parent is rebuttable in the area of cosmetic surgery. Moreover, a state's interest in prohibiting cosmetic surgery for minors is compelling because, as shown, minors merit heightened protection. Indeed, it is now certain that even by late adolescence important aspects of brain maturation remain incomplete and, most pertinent, in those areas of the brain associated with responsibility,

148. Ouellette, *supra* note 129, at 16.

149. See Sarwer, *supra* note 78.

150. See Phillips, *supra* note 64, at 721 (discussing how treated subjects who had experienced suicidal ideation or attempted suicide often did not reveal their BDD symptoms to their treating clinician).

evaluation of long-term best interests, impulse control, and risk control. Thus, 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.

B. Best Interests Standard and Justifications for the Medical Necessity Rule

Once the parental presumption has been rebutted, the minor's best interest should be addressed.¹⁵¹ There is no standard definition of "best interests of the child"; however, the term generally refers to state court deliberations deciding what type of service, action, or order will best serve a minor's interest.¹⁵² A best interest standard is appropriate in cosmetic surgery cases because it is already used in medical disputes involving exercise of *parens patriae* authority on a minor's behalf against parental wishes.¹⁵³

The appropriate rule, under the best interest standard, is a requirement of medical necessity. Medical treatment is necessary when it is needed to treat an acute condition (like a broken leg), but which does not rise to the level of life-saving treatment – treatment necessary to avert death or permanent disability.¹⁵⁴ Cosmetic surgery, however, generally is not needed to treat an acute condition. Further, where such a surgery is needed to treat an acute condition, the surgery often falls under the reconstructive plastic surgery rubric.

Additionally, there are compelling reasons justifying a medical necessity rule when minors seek cosmetic surgery. First, cosmetic procedures are not medically necessary, whereas reconstructive procedures are – thus, medical necessity serves as the distinguishing point between the

151. *Moriarty*, 177 NJ at 117 (explaining that once potential for harm has been shown, and thus the parental presumption deemed rebutted, the court should make a determination that is in the child's best interest based on statutory factors).

152. *Determining the Best Interests of the Child: Summary of State Laws*, Child Welfare Information Gateway, U.S. Dept. of Health & Human Svcs., March 2010, http://www.childwelfare.gov/systemwide/laws_policies/statutes/best_interest.cfm.

153. *See generally* *In re Grady*, 85 N.J. 235, 259 (1981) (explaining that medical cases involving a best interest determination most often involve minors and abortion, sterilization, blood transfusions, or life sustaining treatment); *Id.* at 252 (explaining that child custody, adoption, and sterilization of a minor all entail serious and permanent consequences; therefore, independent judicial decision making is the best way to protect the rights and interests of the minor and to avoid abusive parental decisions). While child custody, adoption, and sterilization are in no way directly analogous to cosmetic surgery, they all share serious and permanent consequences – that is, they all share an inherent risk of harm to the health and welfare of the minor. Further, they all involve potential parental abuses meriting judicial oversight. *See also* *V.H. v. K.E.J.*, 382 Ill. App. 3d 401 (2008) (holding that a ward's best interests did not support a tubal ligation).

154. *Holder*, *supra* note 96, at 19.04.

two. Second, without medical necessity, cosmetic surgery is only medically related and, thus, cannot merit protection under traditional state healthcare policies. While indisputable that cosmetic procedures do involve some medical practices, such practices are only a means¹⁵⁵ to an end – unlike the ends involved with sterilization, blood transfusion, abortion, or life-sustaining treatment. Instead, the end – patient’s objective – involved is more analogous to an unnecessary purchase of a service or product. As such, a cosmetic procedure found to be medically unnecessary can be regulated the same as any other product restricted to those under the age of eighteen or twenty-one. Moreover, minors are already prohibited, through regulation, from obtaining licenses to drive cars, boats, airplanes, etc., or from purchasing products like alcohol, cigarettes, etc. Due to the aforementioned risks of harm to minors, regulation of cosmetic surgery is equally warranted, if not more so, than regulation of these.

Third, it is rationally unsound to conflate healthcare with medically unnecessary cosmetic surgery. The American Academy of Cosmetic Surgery defines cosmetic surgery as:

Cosmetic surgery is a subspecialty that uniquely restricts itself to the enhancement of appearance through surgical and medical techniques. It is specifically concerned with maintaining normal appearance, restoring it, or enhancing it toward some aesthetic ideal.¹⁵⁶

On the other hand, the American Heritage Medical Dictionary¹⁵⁷ defines “healthcare” as “the prevention, treatment, and management of illness and the preservation of mental and physical well-being through the services offered by the medical and allied health professions.”¹⁵⁸ The phrase “preservation of mental and physical well-being” refers to engagement with a medical professional for the purpose of preventing illness and disease;¹⁵⁹ hence, the word “preservation.” Next, the American

155. While the means include medical technology, they also include the physician’s themselves. That is, simply because the individual providing the procedure is a medical doctor does not necessarily lead to the conclusion that the procedure itself is medical or even medically necessary. Instead, the ends – or patient objectives – of the procedure define what is medical or medically necessary. As such, that a medical doctor performs a cosmetic procedure does not turn the procedure into healthcare, a medical practice, or medically necessary surgery.

156. American Academy of Cosmetic Surgery, http://www.cosmeticsurgery.org/patients/criteria_brochure.pdf (last visited Aug. 15, 2011).

157. The American Heritage Stedman’s Medical Dictionary (2d ed. 2004).

158. *Id.*

159. See generally Norman Sartorius, 47 CROAT MED. J. 662, 662 (2006) (interpreting similar phrases as

Heritage Medical Dictionary defines “medical” as “1. [R]elating to . . . the study or practice of medicine. 2. Requiring treatment by medicine.”¹⁶⁰ And lastly, the term “medicine” involves “[a]ny substance administered in the treatment of disease.”¹⁶¹

Therefore, because cosmetic surgery does not involve treatment or prevention of illness or disease in any fashion, it cannot be said to be healthcare. Furthermore, because it does not entail the practice or treatment *by* medicine (administration of a substance to treat an illness or disease), it cannot be “medical” either.

Neither does cosmetic surgery involve treatment or prevention of mental illness or disease. In fact, the need to screen out people with mental disorders is widely recognized by cosmetic surgery providers.¹⁶² This is most probative evidence for the proposition that cosmetic surgery is not used to treat or prevent mental illness in minors; that is, if it were used for such an end, then cosmetic providers would not try to screen them out. For these reasons, and due to the numerous risks involved, minors should be prohibited from making a cosmetic surgery purchase absent medical necessity.

C. The Medical Necessity Rule

The medical necessity rule can be used to differentiate between

proactive prevention of disease and illness), can be viewed at http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2080455/pdf/CroatMedJ_47_0662.pdf. See also The New Oxford American Dictionary (2001) (defining “health” as “The state of being free from illness or injury.”).

160. The American Heritage Stedman’s Medical Dictionary (2d ed. 2004). See also The New Oxford American Dictionary (2001) (defining “medical” as “[r]elating to the science of medicine, or to the treatment of illness and injuries.”).

161. Any substance administered in the treatment of disease; a remedial agent; a remedy. *State v Stoddard*, 215 Iowa 534, 245 NW 273, 86 ALR 616; *Kelly v Carroll*, 36 Wash 2d 482, 219 P2d 79, 19 ALR2d 1174; *Waldo v Poe (DC Wash)* 14 F2d 749. Anything, however simple, administered in the treatment of disease or disorder of the human system. *Kelly v Carroll*, 36 Wash 2d 482, 219 P2d 79, 19 ALR2d 1174. The science and art of preserving health and preventing and curing disease. *Lowman v Kuecker*, 246 Iowa 1227, 71 NW2d 586, 52 ALR2d 1380. A technical word, denoting a science or art comprehending, not only therapeutics, but the art of understanding the nature of diseases, the causes that produce them, as well as knowing how to prevent them, – hygiene, sanitation, and the like. Ballentine’s Law Dictionary (3d ed. 2010).

162. Ritvo, *supra* note 53, at 194 (“Patients with body dysmorphic disorder and narcissistic and histrionic personality disorders are suffering from psychiatric illnesses that interfere with their judgment and can lead them to make poor choices when considering cosmetic procedures.”). See also Crerand, *supra* note 60, at 167e (“Because of the frequency with which persons with body dysmorphic disorder pursue cosmetic procedures, providers of cosmetic surgical and minimally invasive treatments may be able to identify and refer these patients for appropriate mental health care.”); Kazuhiro Hayashi, *Importance of a Psychiatric Approach in Cosmetic Surgery*, 27 AESTHETIC SURG. J. 396, 396 (2007) (“It is sometimes beneficial to prioritize psychiatric treatment instead of focusing solely on surgical treatment to achieve better outcomes in patients undergoing cosmetic surgery who have psychiatric disorders. Preoperative psychiatric screening should be routine in the practice of cosmetic surgery.”).

cosmetic surgeries that are, in fact, necessary and those that are not. A medical treatment is necessary when it is needed to treat an acute condition that does not rise to the level of life-saving treatment,¹⁶³ whereas cosmetic surgery, however, is usually not necessary for treating acute conditions. Further, where such surgery is needed to treat an acute condition, the surgery often falls within the reconstructive plastic surgery rubric. However, due to a plethora of varying circumstances, there are still occasions where the line between cosmetic and medically necessary surgery is not so clear.¹⁶⁴ It was precisely this question that a New York court addressed in *Stevens v GHI*.¹⁶⁵

In *Stevens*, Judge Barbara Jaffe awarded to insurance claimant, a seventeen year old male, reimbursement for a mastectomy, which corrected his gynecomastic condition (excessive breast tissue). Both plaintiff's pediatrician and his pediatrician's partner recommended surgery to correct the deformity and resulting emotional pain.¹⁶⁶ For example, to avoid embarrassment, 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 remained.

Both doctors wrote a letter to plaintiff's insurance company for pre-authorized coverage of the procedure. They explained that the procedure was medically necessary because the condition was "inhibiting his psychosocial development."¹⁶⁷ The insurance company indicated it is only medically necessary when its purpose is to treat an illness or condition, and is not solely for the patient's convenience. However, because the plan did not set forth the specific criteria for medical necessity, the court was satisfied that it was, in fact, medically necessary based on the letters and testimony that the procedure was intended to treat his condition and not solely for convenience.¹⁶⁸

Furthermore, the plan stipulated that the procedure would only be covered when it is reconstructive related and performed "because of congenital disease or anomaly . . . which has resulted in a functional

163. Holder, *supra* note 96, at 19.04.

164. Mary Brophy Marcus, *Cosmetic surgeries: What children will do to look 'normal'*, USA TODAY, June 25, 2009, available at http://www.usatoday.com/news/health/2009-06-24-cosmetic-surgery-kids_N.htm.

165. *Steven S. v. GHI*, No. 24464, slip op. 828 (N.Y.S.2d 2004). *aff'd sub nom. Schulman v. Group Health, Inc.*, 816 N.Y.S.2d 806 (2006).

166. *Id.* at 2.

167. *Id.*

168. *Id.* at 3.

defect.”¹⁶⁹ Thus, the issues before the court were whether the insurance company correctly excluded plaintiff both because the surgery was primarily intended to improve his appearance and because his emotional problems did not constitute a functional defect.

First, because the insurance company did not contest that gynecomastia was a congenital anomaly, the court deemed the point conceded.¹⁷⁰ Second, by conducting a means-ends analysis, the court reasoned that improvement to plaintiff’s appearance was not itself the end; instead, his improved appearance was the means to the end: that he be able to function as a normal adolescent. Therefore, that the end resulted in an improved appearance did not warrant the conclusion that the surgery was purely cosmetic.¹⁷¹

Third, because the plan did not define “functional defect,” the court itself defined it simply as “an impairment in [plaintiff’s] functioning.”¹⁷² The court reasoned that plaintiff’s impairment was a fear of any circumstance which might lead to exposure of his chest to others, and thus he avoided any normal adolescent activity which might lead to such exposure.¹⁷³ The court went further by delineating two groups of defects: those which are relatively common (like a large nose or heavy acne), and those which are objective and tangible. The court then reasoned that gynecomastia is objective, tangible, and an unusual source of turmoil, even though teens commonly avoid activities due to “existing or imagined” abnormalities – such as large nose, heavy acne, or “diminutive breasts on an adolescent female.”¹⁷⁴ Although the aforementioned large nose, heavy acne, and breast size are objective and tangible, they are still “relatively common.”¹⁷⁵ On these grounds the court concluded that the plaintiff’s emotional problems constituted a functional defect.

However, the court also noted that psychological factors are also to be considered. The court reasoned that in cases where the reaction to a minor anomaly is irrational (a major irrational reaction to a minor anomaly), then psychological treatment should be indicated rather than surgery. The court then determined that plaintiff’s anomaly was not minor and that his reaction was a rational one; that is, there was no independent psychological reason for the emotional impairment, such as a mental

169. *Id.* at 2-3.

170. *Id.*

171. *Id.*

172. *Id.* at 4.

173. *Id.*

174. *Id.*

175. *Id.*

disorder. In support, the court noted that plaintiff's pediatricians recognized his reaction as a reasonable result of the condition.¹⁷⁶ It also noted the pediatrician's conclusion that his avoidance of normal adolescent activities constituted an impairment or defect in his functioning as a normal adolescent.¹⁷⁷

The court concluded that the insurance company failed to prove the mastectomy was performed for purely cosmetic reasons. Rather, the court held that it was "medically necessary to eliminate plaintiff's physical anomaly and impaired functioning."¹⁷⁸ By concluding with this language, the court indicated that the outcome actually hinged on whether the procedure was either medically necessary or purely cosmetic. In sum, if any impaired functioning is found, then a procedure cannot be purely cosmetic because, by virtue of the impaired functioning alone, the procedure must be medically necessary.¹⁷⁹

The rules distilled from the *Stevens*' analysis, which can be divided into four prongs, provide a framework to more precisely separate purely cosmetic surgery from those medically necessary.¹⁸⁰ First prong: does the impairment hinder a minor's normal physical function? Furthermore, is the proposed surgery intended to treat a present or future clinically verifiable disease, deformity, or injury?¹⁸¹ If the answer to either of these

176. *Id.*

177. *Id.*

178. *Id.*

179. That is, if found to be purely cosmetic, then the procedure could not have been medically necessary. Likewise, if plaintiff did not possess a functional defect (physical or psychological), then the procedure could not have been medically necessary. Furthermore, if the anomaly was a severe defect which did not affect functionality, then it would fall in the reconstructive category. This is precisely why the court began its analysis by, using the plan's language, bifurcating the functional defect and medically necessary analysis, but then concluded with the more logical conflation of the two. Essentially, the court engaged in a medical necessity analysis twice: once very quickly under the terms and language of the plan, and once again for the overall analysis.

180. At the very outset, it is worthwhile acknowledging that the medical necessity test is an objective one, rather than a subjective one, which has the potential to be exercised in a heavy-handed way. However, the very purpose of the medical necessity test is precisely to prevent, on a case-by-case basis, prohibition of surgery on conditions which do, in reality, have deleterious affects upon a minor's medical well-being; indeed, the *Stevens* plaintiff is a prime illustration of this. That is, rather than formulate a regulation which categorically prohibits cosmetic surgery on minors, the medical necessity test softens the restriction by providing an avenue for non-apparent harms to merit surgery. Moreover, an objective standard provides a means by which psychopathologies can be identified by a neutral party, and those individuals identified will benefit more from psychological treatment, to treat the root of it, rather than provide a quick but temporary cosmetic fix. Furthermore, leaving the restriction within subjective limits would only result in a flaccid requirement that minors simply provide a really good reason why the purported condition is an impairment; something which could, for efficiency's sake, be satisfied by simply writing an essay at a provider's office. Lastly, it is helpful to bear in mind that because the regulation is necessarily restricted to the minority aged, it is, in reality, only a delay until the age of majority – not a life-time ban.

181. Hodges, et al., *Prophylactic interventions on children: Balancing human rights with public health*, 28 J. MED. ETHICS 10, 10 (2002) (arguing that cosmetic surgery will only serve the best interests of a child

is yes, then the proposed surgery is reconstructive rather than corrective, and the parental presumption must control.¹⁸² The opinion of a medical doctor should provide sufficient evidence under this prong.

Second prong: determine whether the physical anomaly is: (1) objectively tangible, and (2) unusual or relatively common. 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. For example, the *Stevens* court reasoned that a large nose, heavy acne, or diminutive breasts are relatively common, even though they are objectively tangible anomalies. On the other hand, in plaintiff's case, the court reasoned that gynecomastia – objectively tangible – is an unusual condition because few males suffer from it.¹⁸³ Evidence of objective tangibility and unusual-or-common may be provided by a pediatrician.

Third prong: determination of the minor applicant's psychological health. This prong has two subparts: (A) whether the emotional distress felt by the applicant is an irrational reaction to a minor anomaly; and, (B)

when it is to treat a present or future illness or disease, the least invasive option, provide a net benefit, the individual be competent enough to provide informed consent with the exception of medical urgency, the intervention is part of standard practice, and that without intervention the individual will absolutely - 100% certainty - develop a disease or illness). Many of the factors listed in this article, however, are judicially unreasonable and inadministerable. First, if medical necessity is determined to exist then the parental presumption must take precedence over any court determination of least invasive option. Second, again, if found to be medically necessary then the parental presumption would be accorded significant deference in determining what is and is not a net benefit to a minor. Third, absent an exception, minors are already deemed incompetent to provide informed consent and thus a competence requirement is not helpful to a medical necessity determination. Fourth, again, if medical necessity is found, then parents are presumed competent to determine performance of a procedure, whether standard practice or not. Lastly, the world is a big place and circumstances so varied (even within the same procedure) that absolute - 100% - certainty of future disease or illness eventuation may not always be available; indeed, is not 90% or 80% eventuation sufficient? It is, and to hold otherwise would be unreasonable.

182. *Compare* *Harrison v. Aetna Life Ins. Co.*, 925 F. Supp. 744, 756 (1996) (concluding surgery was medically necessary to correct a diagnosed skeletal deformity of plaintiff's jaw and to correct the bite of his teeth as he grew into adulthood), and *Baker v. Physicians Health Plan of N. Ind. Group Health Plan*, 2007 U.S. Dist. LEXIS 48778, NO. 1:05-CV-348-TS, 16-17 (2007) (upholding plaintiff's claim of medical necessity for mammoplasty - breast reduction surgery - because plaintiff swore an affidavit that she had chronic back, neck, and shoulder pain), and *Vass v. Board of Trustees of Teachers' & State Employees' Comprehensive Major Medical Plan*, 108 N.C. App. 251, 258 (1992) (agreeing that eye surgery - keratotomy - was medically necessary "to stop the worsening of . . . condition in his right eye, which had become an impediment to his ability to work and perform his daily activities"), *with* *Viveros v. State Dep't of Health and Welfare*, 126 Idaho 714, 717 (1995) (concluding plaintiff's argument that ear surgery was medically necessary was not supported by the evidence because plaintiff did not show that surgery would improve plaintiff's hearing), and *Squillace v. Wyo. State Emples. & Officials' Group Ins. Bd. of Admin.*, 933 P.2d 488, 492 (1997) (concluding that evidence supports board determination of non-medical necessity because plaintiff was not presently or in the future at risk of harm or functional impaired).

183. That said, there may be occasions, of course, where a large nose or heavy acne may, in fact, be unusual; such as an unusually large nose or unusually heavy acne, etc.

whether there is an independent psychopathological reason for the emotional impairment, such as body dysmorphic disorder, narcissistic personality disorder, or histrionic personality disorder? If the answer to either of these questions is yes then psychological treatment should be indicated rather than cosmetic surgery. Evidence under this prong must be provided by a psychologist or psychiatrist.¹⁸⁴

Fourth prong: would a reasonable minor in the applicant's position be hindered from normal functioning by the condition (e.g., avoiding normal childhood/adolescent activities)? This requires a factual analysis of whether the applicant minor has, in fact, been hindered from normal functioning. Then, a determination of whether the hindrance is objectively reasonable. The opinions of a psychiatrist or psychologist should be sufficient for a determination under this prong.¹⁸⁵

IV. APPLICATIONS

A. Proposal

Minors should not have access to cosmetic surgery unless a court finds the proposed surgery is medically necessary. If a court finds the procedure is medically necessary, then the parental presumption must control. However, if medical necessity is not evident to a court, then the service should be prohibited the same as any regulated service or product prohibited to minors.

B. Application Scenarios

1. Scenario One

A parent is seeking ear surgery – otoplasty – for her seven year old child.¹⁸⁶ The child's ears (1) protrude a little, and (2) the right ear is curled significantly more than the left.¹⁸⁷ The child explains that she has not been

184. *Compare* Harrison, 925 F. Supp. at 756 (agreeing that plaintiff's reaction to skeletal deformity in jaw was rational based on expert testimony), *with* Viveros, 126 Idaho at 717-18 (noting that nothing on record supports plaintiff's assertion that he presently suffers from psychological injury due to his ears; and, the only evidence adduced from record is that surgery *might* relieve some possible future psychological injury).

185. *See* Baker, 2007 U.S. Dist. LEXIS 48778, NO. 1:05-CV-348-TS, 30-31 (citing evidence on record that chronic neck, back, and shoulder pain resulting from large breasts does materially hinder normal function), and Vass, 108 N.C. App. at 258 (agreeing that plaintiff's myopic condition is reasonable hindrance to plaintiff's ability to work and perform daily activities).

186. Hilary Moss, *7-Year-Old Samantha Shaw Gets Plastic Surgery to Prevent Bullying*, HUFFINGTON POST (Apr. 14, 2011); Kristin Kane, *Childhood Plastic Surgery to Combat Bullying: A Disturbing Trend*, *Doctor's Say*, FOX NEWS LATINO (May 18, 2011), <http://latino.foxnews.com/latino/health/2011/05/18/childhood-plastic-surgery-combat-bullying>.

187. *Id.*; Kane, *supra* note 186.

teased, but the mother contends, instead, that she has been teased by adults.¹⁸⁸ The mother further explains that the procedure is a preventative measure against future childhood bullies.¹⁸⁹

The threshold inquiry is whether otoplasty risks are sufficient to rebut the parental presumption. The general-surgery risk that is most problematic is anesthesia, because young children are put under to keep from fidgeting during surgery and there are always risks of adverse reaction to it.¹⁹⁰ The procedure-specific risks involve blood clot, infection, unfavorable scarring, cosmetic dissatisfaction, asymmetry, and numbness.¹⁹¹ Due to the numerous risks of harm to the child's health and welfare, there is potential for the parental presumption to be rebutted absent a showing of medical necessity.

The first prong of the medical necessity test is whether the impairment hinders the minor's normal physical function; and, is the proposed surgery intended to treat a present or future clinically verifiable disease, deformity, or injury? In this case, the answer to the first question is no, because nothing indicates an adverse effect upon the child's hearing. However, the answer to the second question is yes because the child's right ear is significantly more curled than the left – thereby indicating a deformity. On this ground, medical necessity should be found for the excessively curled right ear alone; however, the mother presented two issues. The second issue, the slight protrusion of both ears, is not a deformity and neither is it a result of disease nor injury.

The second prong of the test is whether the physical anomaly is (1) objectively tangible, and (2) unusual or relatively common? In this case, both the slight protrusion and the excessively curled ear are objectively tangible. However, only the slight protrusion of the ears is relatively common; the excessively curled ear is not common because most ears are symmetrical.

The third prong of the test requires a determination of the minor applicant's psychological health. Here, the child has not indicated a negative affect on her psychological health, whereas the mother has voiced concern. Thus, unless medical necessity is found for the protrusion of the ears, the mother's concern over bullying that has not yet materialized should carry no weight in a parent-as-trustee paradigm. Procedurally,

188. *Id.*

189. *Id.*

190. *Otoplasty: Is Your Child a Candidate for Ear Surgery?* ALL ABOUT FACIAL REJUVENATION (Feb. 16, 2011), at <http://www.facialplasticsurgery.net/otoplasty.htm>.

191. *Id.*

because the child has not voiced psychological harm, the analysis need not progress to the two additional subfactors – irrational reaction or independent psychopathological reason.

The fourth prong of the test asks whether a reasonable minor in the applicant's position would be hindered from normal functioning by the condition (e.g., avoiding normal childhood/adolescent activities)? In this case, the child has not indicated hindrance to normal functioning and thus, procedurally, further inquiry into whether the hindrance is objectively reasonable is not necessary.

In conclusion, medical necessity has been found only for the excessively curled ear, but not for the slight protrusion of both ears. The significantly curled ear is a deformity indicating medical necessity. Therefore, for the curled ear, the mother's wishes should control under the parental presumption. However, the slight protrusion of both ears failed all four tests: it caused no hindrance to normal bodily function and neither is it a deformity; the perceived physical anomaly is relatively common in children, no harm to psychological health is indicated, and the child has not indicated hindrance to normal childhood functioning. Thus, no medical necessity is found for the mother's perceived protrusion of the ears, so this particular surgery should be prohibited – or, more precisely, delayed until age of majority. Instead, surgery should only be performed on the one significantly curled ear to make it symmetrical to the other.

2. Scenario Two

A sixteen-year-old adolescent asks her mother for liposuction to remove seven pounds of fat from her calves – that is, three-and-a-half pounds per leg.¹⁹² The daughter stated that her lower legs have made her self-conscious and limited her fashion choices, preventing her from wearing capri pants and knee-high boots.¹⁹³ The mother stated that her daughter's weight is normal, but that she has always been heavy below the knees.¹⁹⁴ The daughter is said to be five feet, ten inches,¹⁹⁵ although she appears six feet tall in a photo.

The threshold inquiry is whether the risks involved for liposuction are sufficient to rebut the parental presumption. While all surgeries involve general-surgery risks, those of particular concern here are bleeding and

192. Mary Brophy Marcus, *Cosmetic surgeries: What children will do to look 'normal,'* USA TODAY (Jun. 25, 2009), at http://www.usatoday.com/news/health/2009-06-24-cosmetic-surgery-kids_N.htm.

193. *Id.*

194. *Id.*

195. *Id.*

reaction to anesthesia.¹⁹⁶ Procedure-specific risks of liposuction include contour irregularities (e.g., poor skin elasticity and unusual healing), which may become permanent; damage beneath the skin from the thin tube used during liposuction (cannula), which may give skin a permanent spotted appearance; fluid accumulation (seromas) that can form under the skin and may need to be drained by a needle; temporary or permanent numbness; severe skin infections (may be life-threatening); puncture of internal organ that may occur if cannula penetrates too deeply; fat embolism caused by pieces of loosened fat that have broken away and become trapped in a blood vessel and gathered in the lungs or traveled to the brain (this constitutes a medical emergency); kidney and heart problems from fluids being injected and suctioned out (potentially life-threatening); and all these risks increase if the surgeon is working on larger surfaces of the body or is doing multiple procedures during the same operation.¹⁹⁷ Due to the numerous risks of harm to the minor's health and welfare, the parental presumption should be rebutted absent medical necessity.

The first prong of the medical necessity test is whether the impairment hinders the minor's normal physical function; and, is the proposed surgery intended to treat a present or future clinically verifiable disease, deformity, or injury? In this case, the minor has indicated neither that the perceived anomaly hinders the normal physical function of her legs, nor that it resulted from disease, deformity, or injury. Because the answer to both these questions is no, reconstructive surgery is ruled out.

The second prong of the test is whether the physical anomaly is (1) objectively tangible, and (2) unusual or relatively common? In this case, without photos, it cannot be determined if three-and-a-half pounds of fat per calf is objectively apparent; under normal conditions, a judge could easily make this determination by looking with her eyes or through expert opinion. Additionally, expert opinion may be helpful when determining whether the perceived anomaly is unusual or relatively common. However, for discussion purposes, it will be assumed that it is both objectively apparent and relatively common.

The third prong of the test requires a determination of the minor applicant's psychological health. Factor A of prong three: is the emotional distress felt by the applicant an irrational reaction to a minor anomaly? Here, the minor did indicate that her lower legs made her self-conscious. But, while expert opinion is most suitable for this factor, it will be

196. *Liposuction: Risks*, MAYO CLINIC (Aug. 7, 2010), at <http://www.mayoclinic.com/health/liposuction/MY00079/DSECTION=risks>.

197. *Id.*

assumed that an expert would opine three-and-a-half pounds of fat per calf a minor anomaly and that liposuction is an irrational reaction to it. Furthermore, factor B of prong three: is there an independent psychopathological reason for the emotional impairment, such as body dysmorphic disorder (BDD)? In this case, because an expert would presumably find the reaction an irrational one, for discussion purposes, an expert's concern that such reaction stems from BDD will also be presumed. Thus, psychological treatment should be indicated rather than cosmetic surgery.

The fourth prong of the test asks whether a reasonable minor in the applicant's position would be hindered from normal functioning by the condition (e.g., avoiding normal childhood/adolescent activities)? In this case, the daughter stated that the perceived anomaly limited her fashion choices. For discussion purposes, it is assumed that an expert would opine that particular fashion restrictions alone are not in the domain of normal adolescent activity concerns. Moreover, it is assumed that a reasonable adolescent, with the same minor anomaly, would not have been prevented from wearing capris or knee-highs.

In conclusion, medical necessity has not been found for the desired liposuction. The applicant has failed all four tests. First, not only is the perceived anomaly a non-deformity, there is no hindrance to normal bodily function. Second, even assuming the perceived anomaly was objectively tangible, three-and-a-half pounds of fat per calf is not unusual. Third, due to concerns over the irrational reaction, a mental disorder may be indicated – thus, meriting psychological treatment over cosmetic surgery. Fourth, particular fashion restrictions alone are not in the domain of normal adolescent activity concerns. Therefore, this minor should be prevented, through regulation, from obtaining the desired liposuction until age of majority.

V. CONCLUSION

Minors should not have access to cosmetic surgery unless found by a court to be medically necessary. If medical necessity has been shown, then the parental presumption must control. However, if medical necessity has not been shown, then the service should be prohibited the same as any regulated service or product prohibited to minors.

Medically unnecessary cosmetic surgeries can be regulated because the parental presumption is rebuttable by showing risks of harm to a minor's health and welfare. First, numerous patient-specific risks arise due to the high probability of applicant mental disorders, a physician's

lack of psychopathological training for sufficient screening, subsequent worsening of the mental disorder, and BDD's high lifetime rate of suicidal attempts. Second, significant risks due to both general surgery and procedure-specific complications provide additional grounds for rebutting the parental presumption. Third, physician-specific risks further increase the danger of cosmetic surgery due to the lack of specialized-training and its non-mandatory disclosure for informed consent purposes. Fourth, regarding parent-specific risks, well-meaning but misguided parents can exert coercive force over the minor to have the surgery.

Additionally, in a parent-as-trustee paradigm, the best interest of the minor standard should prevail, with medical necessity as the rule. First, without medical necessity, cosmetic surgery is only medically *related*, and thus cannot merit protection under traditional state healthcare policies. Second, it is rationally unsound to conflate healthcare with medically unnecessary cosmetic surgery because it involves neither treatment nor prevention of disease or illness.

Lastly, a medical necessity determination can be made through a four-pronged analysis. First, does the impairment hinder a minor's normal physical function; and, is the proposed surgery intended to treat a present or future clinically verifiable disease, deformity, or injury? Second, is the physical anomaly (1) objectively tangible, and (2) unusual or relatively common? Third, what is the state of the minor applicant's psychological health? Fourth, would a reasonable minor in the applicant's position be hindered from normal functioning by the condition (e.g., avoiding normal childhood/adolescent activities)?

Dr. Camp et al argue that legislation is unlikely to address some of the risks involved with cosmetic surgery and, thus, the risks ought to be left to the invisible hand of the market to resolve; that is, market forces should control the risks involved with cosmetic surgery.¹⁹⁸ However, regardless of whether continued noninterference is sound policy generally speaking, it is absolutely not so with regard to minors, as states have statutory mandates to protect their health and welfare. When it comes to cosmetic surgery on minors, states must have an intervening hand in preventing the potentially harmful effects of *caveat emptor*.

198. Camp et al., *supra* note 12, at 1262.

