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Alicia Ouellette

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BODY MODIFICATION AND ADOLESCENT DECISION MAKING: PROCEED WITH CAUTION

ALICIA OUELLETTE*

The observation that adolescence is a time of experimentation and self-expression is neither surprising nor troubling. Nonetheless, a parent facing a sixteen-year-old with a new tongue ring, an oozing tattoo, or an unrelenting desire for breast augmentation might well be both troubled and surprised by today's version of youth experimentation. Although precise statistics are not available, the evidence suggests that body modification, whether through cosmetic surgery, Botox injections, body piercing, or tattooing, is very much a part of youth culture in the United States today.¹ Anecdotal reports of "the graduation boob job"² and mother-daughter cosmetic surgery³ are regular fodder on cable television. In some communities, rhinoplasty (the so-called "nose job") and belly button piercings are practically a rite of passage.⁴ Indeed, the American Society of Plastic Surgeons reports that in 2010, "nearly 219,000 cosmetic plastic surgery procedures were

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* Associate Dean & Professor of Law, Albany Law School. The author thanks the participants in the Maryland School of Law Roundtable on Adolescent Decision Making for their comments on this paper, and Professors Christine Chung and Dede Hill for their support and feedback. She also gratefully acknowledges the helpful research assistance of Albany Law student Mary D'Agostino.

1. See Laurie E. Scudder, *Teens and Body Art—Into the Mainstream*, MEDSCAPE NURSES (Feb. 5, 2007), <http://www.medscape.org/viewarticle/551430> (discussing the increased prevalence of body modification among adolescents).

2. See, e.g., *20/20: Why are Parents Buying Their Girls the Gift of Surgery?* (ABC News television broadcast June 24, 2005), available at <http://abcnews.go.com/2020/story?id=875821> (reporting on the phenomena of parents paying for the breast augmentation surgery of their teenagers).

3. See, e.g., *The Real Housewives of Orange County: Friends, Enemies, and Husbands* (BRAVO television broadcast Nov. 12, 2009), available at <http://www.bravotv.com/the-real-housewives-of-orange-county/videos/mother-daughter-cosmetic-surgery> (showing a mother and daughter getting their plastic surgery consultation together); Diane Mapes, *Mom-Daughter Duos Go Under Knife*, MSNBC (May 7, 2010, 8:25 AM), http://www.msnbc.msn.com/id/36993283/ns/health-skin_and_beauty/t/mom-daughter-duos-go-under-knife/#.TpImTpzEnF4 (recounting stories from plastic surgeons who believe that mother-daughter plastic surgery is becoming more popular).

4. For a historical account of cosmetic surgery, see generally ELIZABETH HAIKEN, *VENUS ENVY: A HISTORY OF COSMETIC SURGERY* (1997); KATHY DAVIS, *DUBIOUS EQUALITIES & EMBODIED DIFFERENCES: CULTURAL STUDIES ON COSMETIC SURGERY* (2003). For a more modern perspective on the use of cosmetic surgery on teenagers, see generally FREDERICK N. LUKASH, *THE SAFE AND SANE GUIDE TO TEENAGE PLASTIC SURGERY* (Debbie Harmsen ed., 2010).

performed” on adolescents between the ages of thirteen and nineteen.⁵ Other reports state that Botox was injected into Americans between the ages of thirteen and nineteen nearly 12,000 times in 2008,⁶ and that forty percent of “millennials” (the generation that is now between the ages of eighteen and twenty-eight) have tattoos and twenty-five percent have piercings other than ear piercings.⁷ A different study found that twenty-four percent of teenagers have tattoos.⁸

Despite the prevalence of body modification in the adolescent population, legal literature has paid scant attention to the topic.⁹ In contrast, there is a strong trend in the legal literature advocating for increased decision-making rights among adolescents in the medical context.¹⁰ Superficially at least, the argument for increased decision-making rights supports increased choice for adolescents for cosmetic medical interventions as well. On closer examination though, caution is warranted before expanding adolescent decision-making authority with respect to

5. *Plastic Surgery for Teenagers Briefing Paper*, AM. SOC'Y OF PLASTIC SURGEONS, <http://www.plasticsurgery.org/news-and-resources/briefing-papers/plastic-surgery-for-teenagers.html> (last visited Feb. 2, 2012).

6. See Catherine Saint Louis, *This Teenage Girl Uses Botox. And, No, She's Not Alone.*, N.Y. TIMES, Aug. 12, 2010, at E1. Although some of these injections may have been to treat excessive sweating or facial twitching, a significant portion appears to have been simply to shape the face. *Id.*

7. PEW RESEARCH CTR., MILLENNIALS – A PORTRAIT OF GENERATION NEXT: CONFIDENT. CONNECTED. OPEN TO CHANGE. 1 (2010).

8. See Anne E. Laumann & Amy J. Derick, *Tattoos and Body Piercings in the United States: A National Data Set*, J. AM. ACAD. DERMATOLOGY 413, 413, 414 tbl.1 (2006); see also C.W. Nevius, *Teen Body Piercing: Rite of Passage*, S.F. CHRON., Nov. 8, 2005, at B1 (describing the growth in the tattoo and piercing businesses).

9. But see Annemarie Bridy, *Confounding Extremities: Surgery at the Medico-Ethical Limits of Self-Modification*, 32 J.L. MED. & ETHICS 148 (2004); Alicia Ouellette, *Shaping Parental Authority over Children's Bodies*, 85 IND. L.J. 955, (2010), for articles that discuss the legal and ethical issues surrounding adolescent body modification.

10. See, e.g., Paul Arshagouni, “*But I'm an Adult Now . . . Sort Of*”: *Adolescent Consent in Health Care Decision-Making and the Adolescent Brain*, 9 J. HEALTH CARE L. & POL'Y 315, 316 (2006) (suggesting a new method “for determining when adolescents can and should be allowed to make independent health care decisions”); Melinda T. Derish & Kathleen Vanden Heuvel, *Mature Minors Should Have the Right to Refuse Life-Sustaining Medical Treatment*, 28 J.L. MED. & ETHICS 109, 110 (2000); Rhonda Gay Hartman, *Coming of Age: Devising Legislation for Adolescent Medical Decision-Making*, 28 AM. J.L. & MED. 409, 411 (2002) (describing how the presumption that minors lack capacity in the medical context “is tenuous at best” and there is “little, if any evidence, to support it”); Adele D. Hofmann, *A Rational Policy Toward Consent and Confidentiality in Adolescent Health Care*, 1 J. ADOLESCENT HEALTH CARE 9, 9 (1980) (proposing an approach for future policy based on “contemporary adolescent cognitive and psychosocial developmental principles”); 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 251, 303 (2005) (arguing that state laws should rest on the presumption that adolescents aged fourteen to seventeen have the decisional capability to make health care decisions); Michelle Oberman, *Minor Rights and Wrongs*, 24 J.L. MED. & ETHICS 127, 127 (1996) (stating that the law governing adolescent health care decision making does not fully take into account adolescent capacity); Jennifer L. Rosato, *Let's Get Real: Quilting a Principled Approach to Adolescent Empowerment in Health Care Decision-Making*, 51 DEPAUL L. REV. 769, 770 (2002) (proposing a restructuring of the health care consent laws based more on the reality of adolescents' decision-making capabilities).

cosmetic body modification¹¹—in or out of the medical context. In fact, research in developmental science reveals immaturities in adolescent cognition—impetuosity, risk-taking, and susceptibility to peer pressure—that are directly relevant to decisions about body modification.¹² As such, policies that protect adolescents from unnecessary risk—such as age restrictions and parental consent laws—are warranted in the context of cosmetic body modification.

This essay examines the phenomenon of body modification among adolescents from a legal perspective. In particular, it culls together the law of body modification and positions it generally within the law regarding adolescent decision making.¹³ It then briefly reviews the ways in which the law of adolescents is shaped both by our understanding of the parent-child relationship and the available scientific evidence concerning brain development and executive function.¹⁴ The essay then considers how the law's principal approach to body modification in adolescents—a requirement of parental consent—works for and against adolescents in practice.¹⁵ The essay argues that although the scientific research into the development of the adolescent brain and executive functioning support increased decision-making authority for adolescents with respect to most health care, cosmetic body modification is different.¹⁶ Requirements for parental consent for body modification are an appropriate means of protecting adolescents from the limitations of their cognitive function. However, laws that give parents ultimate control over adolescent bodies fail to respect the developing autonomy and liberty interests of teens. Neither parental consent alone nor a parent's veto should be the sole determinant of whether an adolescent's body is cosmetically modified through medical intervention.¹⁷ Modification should take place, with parental consent, only when the adolescent has made a persistent, unambiguous, and informed choice, and, without parental consent, in the rare case in which medical professionals agree

11. As used in this paper, the term "cosmetic body modification" does not include reconstructive surgery or other interventions used to correct a clear abnormality or malformation, such as a cleft lip or palate. Instead, it refers to invasive interventions used to improve or change an otherwise "normal" appearance. Obviously, the distinction between "normal" and abnormal appearance is not always clear. How to clarify the distinction is a topic for another paper. Functionality is certainly one factor.

12. See Laurence Steinberg, *Cognitive and Affective Development in Adolescence*, 9 TRENDS IN COGNITIVE SCI. 69, 69 (2005) (explaining that adolescents experience significant changes in brain functioning related to response inhibition and risk taking).

13. See *infra* Part II.

14. See discussion *infra* Parts III–IV.

15. See *infra* Part III.

16. See *infra* Part V.

17. See discussion Part VI; see also Comm. on Bioethics, *Informed Consent, Parental Permission, and Assent in Pediatric Practice*, 95 PEDIATRICS 314, 315 (1995) (discussing the development of the child as a "person" and that adolescents should be involved in the decision-making process as much as their cognitive abilities allow).

with a determined adolescent that body modification is urgent to prevent psychological or other harm.¹⁸

I. THE LAW OF ADOLESCENCE

The law of adolescence reflects the threshold state of the teenager—neither adult nor child. Betwixt and between, the law takes something of a scattershot approach to adolescent decision making. At times, the law affords little or no weight to the choices of teenagers, or limits their choices in order to protect them.¹⁹ Thus, teenagers cannot legally purchase alcohol;²⁰ those under eighteen can't vote,²¹ serve on juries, or gamble legally.²² Depending on the state, an adolescent's consent to sexual activity may be invalid and the act of sex with the teen deemed statutory rape.²³ At other times, the law gives as much respect to the decisions of teenagers as it does those made by adults.²⁴ Older teens can drop out of high school, hold jobs, and drive cars.²⁵ In some cases, juveniles may be tried and sentenced as adults for crimes they commit while teenagers.²⁶

18. See Hazel Beh & Milton Diamond, *Ethical Concerns Related to Treating Gender Nonconformity in Childhood and Adolescence: Lessons from the Family Court of Australia*, 15 HEALTH MATRIX 239, 244–45 (2005) (using a case study of a minor's gender identity dysphoria to illustrate that these types of medical decisions should be made based on the adolescent's individual circumstances, even if he or she is not mature enough to be involved in the decision-making process).

19. See generally Megan E. Hay, Note, *Incremental Independence: Conforming the Law to the Process of Adolescence*, 15 WM. & MARY J. WOMEN & L. 663 (2009) (discussing the historical development of the laws governing children and arguing for a revised legal framework for adolescent decision making).

20. See National Minimum Age Drinking Act, 23 U.S.C. § 158 (2006) (withholding ten percent of a state's federal highway fund allotment if the purchase or possession of alcohol for people under age twenty-one remains legal).

21. U.S. CONST. amend. XXVI, § 1.

22. See, e.g., FLA. STAT. ANN. § 849.086(12)(b) (West 2000) (prohibiting any person under eighteen years of age from gambling); MICH. COMP. LAWS ANN. § 432.219(3)(a) (West 2001) (making gambling under the age of twenty-one punishable as a misdemeanor); N.Y. JUD. LAW § 510(2) (McKinney 2003) (prohibiting jurors from being less than eighteen-years-old).

23. See, e.g., ALA. CODE § 13A-6-70(c)(1) (LexisNexis 2005) (deeming those under sixteen years of age to be incapable of providing consent); OHIO REV. CODE ANN. § 2907.04(A) (LexisNexis 2010) (prohibiting anyone eighteen-years-or-older from engaging in sexual conduct with anyone who is known to be younger than sixteen).

24. See *In re Gault*, 387 U.S. 1, 41 (1966) (holding that juveniles must be afforded the same procedural due process rights as adults).

25. See, e.g., MD CODE ANN., TRANSP. § 16-103 (LexisNexis 2009 & Supp. 2011) (prohibiting the Department of Motor Vehicle administration from issuing a provisional driver's license to anyone under age sixteen and six months); W. VA. CODE ANN. § 18-8-11 (LexisNexis 2008) (taking away the driver's license of a student who drops out of high school).

26. See generally OFFICE OF JUVENILE JUSTICE & DELINQUENCY PREVENTION, OFFICE OF JUSTICE PROGRAMS, U.S. DEP'T OF JUSTICE, TRYING JUVENILES AS ADULTS IN CRIMINAL COURT: AN ANALYSIS OF STATE TRANSFER PROVISIONS (1998) (providing a comprehensive overview of the circumstances, in which juveniles may be transferred from juvenile court and tried as adults).

The complexity of the law of adolescence is especially acute in the medical arena.²⁷ For the vast majority of medical decisions, the law treats adolescents under the age of eighteen like young children. That is, except in the situations discussed below, teenagers' decisions about health care have no legal weight until they have reached the age of legal consent.²⁸ Instead, the law vests parents with decision-making authority for their teenagers.²⁹ Thus, a physician cannot legally treat an adolescent without parental consent in most cases.³⁰ There are some exceptions, however. For example, the law of many states treats certain teens—those who are pregnant, emancipated, and married—like adults.³¹ And a handful of jurisdictions recognize through statutory or case law a “mature minor” doctrine that grants decision-making authority about healthcare to mature adolescents.³² In addition to affording decision-making power to teenagers based on status, laws in many states allow teens to make their own decisions about certain adult-like interventions, such as drug treatment, contraception, and abortion.³³ And even in states in which parental notification or consent is required before a minor can obtain an abortion, the Supreme Court has held that the state must provide an alternative procedure whereby the minor can obtain an abortion if she is mature enough to make an

27. See David M. Vukadinovich, *Minors' Rights to Consent to Treatment: Navigating the Complexity of State Laws*, 37 J. HEALTH L. 667, 667–68 (2004) (explaining that while the law governing the right to refuse medical treatment for adults is clear, the state of this same type of law for minors is unclear).

28. See Comm. On Pediatric Emergency Med. & Comm. on Bioethics, *Consent for Emergency Medical Services for Children and Adolescents*, 128 PEDIATRICS 427, 427 (2011) (noting that adolescents can consent absent parental consent in some cases, but not others).

29. *Parham v. J.R.*, 442 U.S. 584, 603 (1979) (noting that “parents can and must make” medical decisions regarding their teenage children). See generally Lawrence Schlam & Joseph P. Wood, *Informed Consent to the Medical Treatment of Minors: Law and Practice*, 10 HEALTH MATRIX 141, 148–52 (2000) (describing that doctors must obtain parental consent prior to performing most medical procedures on minors).

30. See Comm. On Pediatric Emergency Med. & Comm. on Bioethics, *supra* note 28, at 427.

31. See GUTTMACHER INST., STATE POLICIES IN BRIEF: AN OVERVIEW OF MINORS' CONSENT LAW 1 (2012) (indexing the variety of state laws that treat pregnant minors as adults); see also CAL. FAM. CODE §§ 7000–7002 (West 2004) (defining emancipation under California law); 410 ILL. COMP. STAT. ANN. 210/1 (West 2011) (permitting a minor who is either married, pregnant, or a parent to consent to medical care).

32. The mature minor doctrine is generally a common law matter, though a few states such as Ohio and Illinois have adopted the doctrine by statute. See 410 ILL. COMP. STAT. ANN. 210/1 (West 2011); MISS. CODE ANN. § 41-41-3(3) (2009); NEV. REV. STAT. ANN. § 129.030(2) (LexisNexis 2010); OHIO REV. CODE ANN. §§ 3709.241, 3719.012, 5122.04 (LexisNexis 2008); *In re E.G.*, 549 N.E.2d 322, 328 (Ill. 1989); *Younts v. St. Francis Hosp. & Sch. of Nursing, Inc.*, 469 P.2d 330, 337 (Kan. 1970); *Bach v. Long Island Jewish Hosp.*, 267 N.Y.S.2d 289, 291 (N.Y. Sup. Ct. 1966); *Lacey v. Laird*, 139 N.E.2d 25, 27 (Ohio 1956); *Cardwell v. Bechtol*, 724 S.W.2d 739, 745 (Tenn. 1987); *Belcher v. Charleston Area Med. Ctr.*, 422 S.E.2d 827, 837 (W. Va. 1992). *But see* *Commonwealth v. Nixon*, 761 A.2d 1151, 1154 (Pa. 2000) (rejecting the mature minor doctrine in Pennsylvania). For more specifics about the workings of the mature minor doctrine, see Arshagouni, *supra* note 10, at 336.

33. See, e.g., 410 ILL. COMP. STAT. ANN. 210/4 (West 2011) (allowing minors twelve years or older to consent to drug treatment); TENN. CODE ANN. § 68-34-107 (2006) (permitting minors to receive contraception supplies and information without parental consent).

informed decision in consultation with a physician or, even if she lacks such maturity, if the abortion would be in her best interests.³⁴

II. THE LAW OF BODY MODIFICATION

The laws surrounding body modification on adolescents differ somewhat depending on the setting in which the modification takes place.³⁵ Cosmetic body modification procedures take place both in and out of the medical setting.³⁶ Those interventions that involve the most physical risk, professional skill, or medical training—such as surgical interventions, Botox, and hormone injections—are ordinarily performed by medical professionals.³⁷ Some medical professionals also perform lower risk modifications such as body piercings and tattoos.³⁸ Of course, tattoos and piercings are also available at many distinctly nonmedical shops, malls, and parlors.³⁹

In the healthcare setting, the general rule requiring parental consent for minors applies to minors seeking body modification through plastic surgery, injection, or other interventions.⁴⁰ There are a handful of cosmetic interventions that are subject to specific restrictions at law.⁴¹ For example, a federal law bans female genital cutting on girls under the age of eighteen.⁴² But, with respect to nose

34. *Hodgson v. Minnesota*, 497 U.S. 417, 423 (1990); *Bellotti v. Baird*, 443 U.S. 622, 642–44 (1979); *Planned Parenthood of Cent. Mo. v. Danforth*, 428 U.S. 52, 74 (1976).

35. Aglaja Stim, *Body Piercing: Medical Consequences and Psychological Motivations*, 361 LANCET 1205, 1208 (2003) (stating that the United States does not have any generally-applicable regulations for body artists and that only thirteen states exercise control over tattoo establishments and only six of these apply the regulations to body piercing establishments).

36. *Id.* at 1207.

37. See *Avoid at All Cost (No Matter How Cheap): Do-It-Yourself Botox*, THE AM. SOC'Y FOR AESTHETIC PLASTIC SURGERY, <http://www.surgery.org/consumers/plastic-surgery-news-briefs/avoid-cost-no-matter-cheap--do-it-yourself-botox-1035624> (last visited Jan. 19, 2012) (evaluating the risks of doing Botox at home and urging those considering botox injections to see a medical professional).

38. Stim, *supra* note 35, at 1207.

39. *Id.*

40. Diana Zuckerman & Anisha Abraham, *Teenagers and Cosmetic Surgery: Focus on Breast Augmentation and Liposuction*, 43 J. ADOLESCENT HEALTH 318, 322 (2008) (stating that a teenager under eighteen can get cosmetic surgery, including breast augmentation, as long as there is parental consent).

41. See, e.g., 18 U.S.C. § 116 (2006) (prohibiting the cutting of female genital of a minor under eighteen years of age except for when it is necessary for the health of the minor).

42. For example, 18 U.S.C § 116 (2006) states:

(a) Except as provided in subsection (b), whoever knowingly circumcises, excises, or infibulates the whole or any part of the labia majora or labia minora or clitoris of another person who has not attained the age of eighteen years shall be fined under this title or imprisoned not more than five years, or both.

(b) A surgical operation is not a violation of this section if the operation is –

(1) necessary to the health of the person on whom it is performed, and is performed by a person licensed in the place of its performance as a medical practitioners; or
(2) performed on a person in labor or who has just given birth and is performed for

jobs, tummy tucks, liposuction, Botox injections, or growth and sex hormones, U.S. law turns to parents to make decisions for adolescents, unless the teenager is medically emancipated or otherwise vested with decision-making capacity.⁴³ Thus, the minor adolescent will almost never receive a desired intervention without parental consent.⁴⁴ As long as a parent consents to the procedure, however—and the procedure is performed by a licensed medical provider—the law is generally satisfied.⁴⁵ Even breast implants, which are regulated by the FDA and subject to some age guidelines, are available off-label to teenagers, so long as a parent consents.⁴⁶

Outside the healthcare setting, body modification procedures for minors may be harder to come by—or more readily available—than medical modifications. Availability depends upon state law.⁴⁷ While some states do not place age limits on piercing or tattooing,⁴⁸ others, such as South Carolina, make it illegal to tattoo or pierce the body of person under the age of eighteen, regardless of parental consent.⁴⁹ The vast majority of states require consent before an adolescent can be tattooed, and many require parental consent before a minor can have a part of the

medical purposes connected with that labor or birth by a person licensed in the place it is performed as a medical practitioner, midwife, or person in training to become such a practitioner or midwife.

(c) In applying subsection (b)(1), no account shall be taken of the effect on the person on whom the operation is to be performed of any belief on the part of that person, or any other person, that the operation is required as a matter of custom or ritual.

43. Zuckerman & Abraham, *supra* note 40, at 322.

44. See Sonja Shield, *The Doctor Won't See You Now: Rights of Transgender Adolescents to Sex Reassignment Treatment*, 31 N.Y.U. REV. L. & SOC. CHANGE 361, 363 (2007) (lamenting the legal barriers teens face when seeking sex-reassignment surgery).

45. See *id.* (stating that a parent must consent to a minor getting the procedure).

46. Zuckerman & Abraham, *supra* note 40, at 319. The FDA approved saline-filled breast implants for breast augmentation in women age eighteen or older and for breast reconstruction in women of any age. *Id.* at 319. Silicone gel-filled breast implants are approved for breast augmentation in women age twenty-two or older and for breast reconstruction in women of any age. CTR. FOR DEVICES & RADIOLOGICAL HEALTH, U.S. FOOD AND DRUG ADMIN., FDA UPDATE ON THE SAFETY OF SILICONE GEL-FILLED BREAST IMPLANTS 5 (2011).

47. See *Tattoos and Body Piercings for Minors*, NAT'L CONFERENCE OF STATE LEGISLATURES, <http://www.ncsl.org/default.aspx?tabid=14393> (last updated Oct. 2011) (noting that state regulations prevent minors from obtaining tattoos and body piercings without parental consent).

48. *Id.* (providing that in some states minors can obtain tattoos and body piercings with parental permission).

49. S.C. CODE ANN. § 44-34-60 (2010). Tattooing a minor is also illegal, regardless of parental consent, in California, Iowa, Maine, New York, Oklahoma, and Washington. CAL. PENAL CODE § 653 (West 2010); 720 ILL. COMP. STAT. ANN. 5/12-10 (2002 & Supp. 2011); IOWA CODE ANN. § 135.37 (West 2007 & Supp. 2011); ME. REV. STAT. ANN. tit. 32, § 4203 (1999); N.Y. PENAL LAW § 260.21 (McKinney 2008); OKLA. STAT. ANN. tit. 21, § 842.1 (West 2002 & Supp. 2011); WASH. REV. CODE ANN. § 26.28.085 (West 2005).

body other than the earlobe pierced.⁵⁰ Some states have very specific laws. For example, Florida requires a written notarized consent before a minor may obtain a tattoo or body piercing, and the physical presence of a parent if the adolescent is less than sixteen-years-old.⁵¹ West Virginia specifically prohibits piercing of a minor's genitalia or nipples.⁵² Georgia prohibits tattooing of an adolescent unless it is performed by physician or osteopath, and then only with parental consent.⁵³ In Virginia, not only is consent required before a minor can be tattooed or have a body part pierced, the minor's parent must be present during the procedure.⁵⁴ Texas allows a parent to consent to a tattoo on a minor only to cover an existing tattoo deemed offensive or obscene.⁵⁵

Thus, the law generally vests parents with decision-making authority about modifying their adolescent children's bodies so long as the modification takes place in a medical setting.⁵⁶ Outside the medical setting, a parent may be unable to give an effective consent even for an otherwise lawful procedure (e.g., tattooing or piercing) in one state, and a minor may be able to obtain the modification (e.g., nipple or nose piercing) without the consent of or notice to the parent in another.⁵⁷ These variations play out in odd ways. For example, a seventeen-year-old West Virginian with permissive parents can get breast implants, but not a nipple piercing.⁵⁸ And a seventeen-year-old Vermonter must have parental consent to have a mole removed by a physician but not to have her eyebrow or nipple pierced.⁵⁹ These variations in law raise questions about the rationale for the current rules.

III. REASONS FOR THE RULES

The complexity of law respecting decision making by teenagers reflects the varied roles adolescents play in our constitutional system, and the interests that arise from each. First, teenagers are rights-bearing citizens, and in some cases, the

50. *Tattoos and Body Piercings for Minors*, *supra* note 47 (outlining how some states prohibit minors from obtaining tattoos, and how other states prevent minors from obtaining body piercing or tattoos without parental consent).

51. FLA. STAT. ANN. §381.00787 (West 2012).

52. W. VA. CODE R. § 64-80-13.1 (2011).

53. GA. CODE ANN. § 16-5-71(a) (2011).

54. VA. CODE ANN. § 18.2-371.3 (2009).

55. TEX. HEALTH & SAFETY CODE ANN. § 146.012 (West 2010).

56. *Tattoos and Body Piercings for Minors*, *supra* note 47. To be sure, ethical principles and good medical practice require that an adolescent assent to treatment. Tara L. Kuther, *Medical Decision-Making and Minors: Issues of Consent and Assent*, 38 ADOLESCENCE 343, 351 (2003). Assent is not required by law, however, and is, in any event, less meaningful than informed consent. *Id.*

57. *See infra* notes 47–50.

58. W. VA. CODE R. § 64-80-13.1 (2011).

59. 20-4 VT. CODE R. § 18:3.6 (2012) (establishing procedures for tattooing a minor but explicitly leaving the decision about whether to perform a body piercing on a minor up to the "sound judgment" of registered body piercers).

law protects them as such.⁶⁰ Second, teenagers are minors, “whose immaturity, inexperience, and lack of judgment may sometimes impair their ability to exercise their rights wisely.”⁶¹ As such, states often seek to protect teens from the consequences of poor decision making.⁶² And finally, minor adolescents are part of an autonomous family unit, over which parents have a constitutionally protected right of control.⁶³ Although these interests have been analyzed in depth elsewhere,⁶⁴ it is useful to review briefly how the Supreme Court understands and balances each before considering their weight in the context of body modification.

The first interest, that of the teenager as a rights bearing citizen,⁶⁵ is in many respects the least robust. The Supreme Court has consistently declared adolescents to be “persons” generally “protected by the same constitutional guarantees against government deprivations as are adults.”⁶⁶ In a case recognizing a minor’s right to terminate her pregnancy, the Court explained that “[c]onstitutional rights do not

60. See, e.g., *Carey v. Population Servs. Int’l*, 431 U.S. 678, 692 (1976) (noting that minors possess constitutional rights just as adults do).

61. *Hodgson v. Minnesota*, 497 U.S. 417, 444 (1990) (citing *Bellotti v. Baird*, 443 U.S. 622, 634–39).

62. See *supra* notes 48–55 and accompanying text (describing the various state regulations for the tattooing and piercing of minors).

63. Parents have the rights “to bring up a child in the way he should go.” *Prince v. Massachusetts*, 321 U.S. 158, 164, 166 (1944) (“It is cardinal . . . that the custody, care, and nurture of the child reside first in the parents, whose primary function and freedom include preparation for obligations the state can neither supply nor hinder.”). The “primary role of the parents in the upbringing of their children is now established beyond debate as an enduring American tradition.” *Wisconsin v. Yoder*, 406 U.S. 205, 232 (1972).

64. See, e.g., Katharine T. Bartlett, *Re-Expressing Parenthood*, 98 YALE L.J. 293, 295–98 (1988) (describing the traditional view of “parenthood as exchange” and a new construction of the relationship between parent and child, away from parents’ rights toward parents’ responsibility for constructing a nurturing relationship with their child); James G. Dwyer, *Parents’ Religion and Children’s Welfare: Debunking the Doctrine of Parents’ Rights*, 82 CALIF. L. REV. 1371, 1374 (1994) (arguing that the “proffered justifications for parents’ rights are in fact unsound” and that the “law confer[s] on parents simply a child-rearing *privilege*, limited in its scope to actions and decisions not inconsistent with the child’s temporal interests”); Martha Minow, *What Ever Happened to Children’s Rights?*, 80 MINN. L. REV. 267, 268 (1995) (advocating for international human rights for children as a means of respecting children as human beings without displacing or undermining parents); Barbara Bennett Woodhouse, *“Out of Children’s Needs, Children’s Rights”*: *The Child’s Voice in Defining the Family*, 8 BYU J. PUB. L. 321, 321 (1994) (introducing the idea of an “adult’s relationship with children as one of trusteeship rather than as one of ownership”); Barbara Bennett Woodhouse, *Hatching the Egg: A Child-Centered Perspective on Parents’ Rights*, 14 CARDOZO L. REV. 1747, 1811 (1993) (considering parents as fiduciaries entrusted with their children’s care and empowered to care for them).

65. E.g., *Bellotti v. Baird*, 443 U.S. 622, 634 (1979) (concluding that “the child’s right is virtually coextensive with that of an adult”); *Planned Parenthood of Cent. Mo. v. Danforth*, 428 U.S. 52, 74 (1975) (describing that the constitution protects both minors and adults alike).

66. *Bellotti*, 443 U.S. at 643–44 (holding that a minor’s right to abortion requires that statutes requiring parental consent contain a judicial bypass procedure). See also *Danforth*, 428 U.S. at 74 (stating that minors possess constitutional rights); *Goss v. Lopez*, 419 U.S. 565, 574 (1975) (stating that young people possess due process rights even within a school setting); *In re Gault*, 387 U.S. 1, 30–31 (1967) (stating that juveniles must be afforded due process in a delinquency hearing).

mature and come into being magically only when one attains the state-defined age of majority.”⁶⁷ Thus, the Court has recognized, for example, that adolescents have a first amendment right to wear black armbands in protest of the Vietnam War,⁶⁸ due process rights in juvenile proceedings,⁶⁹ and an interest in freedom from unnecessary medical treatment and confinement.⁷⁰

Protection of the adolescents’ interests as a rights holder is tempered, however, in almost all cases, by the state’s interest in accounting for “the peculiar vulnerability of children; their inability to make critical decisions in an informed, mature manner; and the importance of the parental role in childrearing.”⁷¹ The state’s interest in protecting minors justifies “state-imposed requirements that a minor obtain his or her parent’s consent before undergoing an operation, marrying, or entering military service.”⁷² It also allows states to criminalize conduct involving minors, such as the sale or exposure to dangerous products and activities, in a manner that would be unconstitutional if it involved adults.⁷³ In other words, it is well settled that “the States validly may limit the freedom of children to choose for themselves in the making of important, affirmative choices with potentially serious consequences.”⁷⁴

Although the protection of teenagers through the curtailment of the liberties often draws sharp criticism among advocates for adolescent rights, the Supreme Court’s recognition that teenagers are not fully formed adults was celebrated by

67. *Danforth*, 428 U.S. at 74.

68. *Tinker v. Des Moines Indep. Cmty. Sch. Dist.*, 393 U.S. 503, 514 (1969).

69. See *In re Gault*, 387 U.S. at 10, 30–31 (holding that juveniles charged with committing delinquent acts receive basic due process protections, including the privilege against self-incrimination, rights to counsel, notice of charges, and ability to confront and cross-examine adverse witnesses); see also *Safford Unified Sch. Dist. No. 1 v. Redding*, 129 S. Ct. 2633, 2638 (2009) (holding a student’s rights were violated by strip search at school); *In re Winship*, 397 U.S. 358, 368 (1970) (interpreting the Due Process clause in juvenile delinquency cases to require the “beyond a reasonable doubt” standard of proof); *Haley v. Ohio*, 332 U.S. 596, 600–01 (1948) (holding that a minor prosecuted in the adult criminal justice system retains the basic constitutional rights in those proceedings). *But see* *Schall v. Martin*, 467 U.S. 253, 265 (1984) (holding that pretrial preventive detention of juveniles does not constitute punishment, in part because “juveniles, unlike adults, are always in some form of custody”); *McKeiver v. Pennsylvania*, 403 U.S. 528, 545 (1971) (holding that the right to jury trial is not required by the Due Process clause during the adjudicative stage of juvenile proceedings).

70. See *Parham v. J.R.*, 442 U.S. 584, 600 (1979) (“[A] child, in common with adults, has a substantial liberty interest in not being confined unnecessarily for medical treatment . . . under the Fourteenth Amendment.”).

71. *Bellotti*, 443 U.S. at 634. See also *New Jersey v. T.L.O.*, 469 U.S. 325, 341 (1985) (noting that in public schools, the Fourth Amendment rights of students are not automatically coextensive with the rights of adults).

72. *Hodgson v. Minnesota*, 497 U.S. 417, 444–45 (1990).

73. See, e.g., *Ginsberg v. New York*, 390 U.S. 629, 638 (1968) (upholding a law regulating the sale of obscene materials to minors under seventeen and finding law did not constitute “an invasion of such minors’ constitutionally protected freedoms”).

74. *Bellotti*, 443 U.S. at 635.

juvenile justice advocates when the Supreme Court held in *Roper v. Simmons*⁷⁵ that the death penalty could not be applied to adolescent offenders. In addition to two lines of reasoning not relevant to this essay, Justice Kennedy, writing for the majority in *Roper*, reasoned that adolescents lack the maturity necessary to be held as morally reprehensible as adult offenders.⁷⁶ Critically, Kennedy relied on research in developmental science that confirms “[a] lack of maturity and an underdeveloped sense of responsibility . . . in youth . . . often result[s] in impetuous and ill-considered actions and decisions.”⁷⁷ Further, Kennedy cited studies that demonstrated that youth are especially susceptible to external and peer pressure, and that their identities are more transitory and less fixed than that of adults.⁷⁸ Consistent with its conclusion that juveniles cannot be trusted to exercise their own right to make medical decisions, the Court concluded that the differences between adults and adolescents are legally significant when it comes to criminal punishment.⁷⁹ According to the majority in *Roper*:

The susceptibility of juveniles to immature and irresponsible behavior means “their irresponsible conduct is not as morally reprehensible as that of an adult.” Their own vulnerability and comparative lack of control over their immediate surroundings mean juveniles have a greater claim than adults to be forgiven for failing to escape negative influences in their whole environment.⁸⁰

In addition to state-sponsored protections for vulnerable youth, the Supreme Court has affirmed the important role of parents in care, custody, and control of adolescents.⁸¹ Parental control is rooted in familial autonomy.⁸² The Court has long recognized the “family as a unit with broad parental authority over minor children” in which the parents have the authority to raise children as the parents see fit.⁸³ The right to familial autonomy allows parents to make most decisions about the care

75. 543 U.S. 551, 572–73 (2005) (“The differences between juvenile and adult offenders are too marked and well understood to risk allowing a youthful person to receive the death penalty despite insufficient culpability.”).

76. *Id.* at 571 (finding that the death penalty is not a proportional punishment where a criminal’s culpability is diminished because of youth and immaturity).

77. *Id.* at 569 (quoting *Johnson v. Texas*, 509 U.S. 350, 367 (1993)).

78. *Id.* at 569–70.

79. *Id.* at 569 (finding that certain crucial differences between those under eighteen and adults prevent juvenile offenders from being classified as if they were the same as the worst adult offenders).

80. *Id.* at 570 (citation omitted).

81. *Prince v. Massachusetts*, 321 U.S. 158, 166 (1944) (finding that “the custody, care and nurture of the child reside first in the parents,” as there are certain functions of parents that the state cannot perform or inhibit).

82. *See id.* at 166 (finding that past court decisions recognized family life as a protected realm that the state must refrain from infringing on).

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

and keeping of children without government oversight or interference.⁸⁴ Parental authority extends to medical decision making for adolescents.⁸⁵ Indeed, in a case involving psychiatric care for a teenager, the Court said parents “can and must” make medical judgments for children.⁸⁶ “Most children, even in adolescence, simply are not able to make sound judgments concerning many decisions, including their need for medical care or treatment,”⁸⁷ reasoned the Court. The child’s wishes are essentially irrelevant. “The fact that a child may balk at hospitalization or complain about a parental refusal to provide cosmetic surgery does not diminish the parents’ authority to decide what is best for [a] child.”⁸⁸

Of course, parental rights are not unfettered. They must be balanced against the State’s interest in protecting children and preservation of the child’s rights.⁸⁹ Thus, States may limit parental rights through abuse and neglect proceedings,⁹⁰ child labor laws,⁹¹ and mandatory vaccination laws.⁹² With respect to medical

84. “Choices about marriage, family life, and the upbringing of children are among associational rights [the Supreme] Court has ranked as ‘of basic importance in our society,’ . . . rights sheltered by the Fourteenth Amendment against the State’s unwarranted usurpation, disregard, or disrespect.” *M.L.B. v. S.L.J.*, 519 U.S. 102, 116 (1996) (citation omitted). Parents therefore have a constitutionally protected “liberty interest . . . in the care, custody, and management of their child . . .” *Santosky v. Kramer*, 455 U.S. 745, 753–54 (1982). *See also Stanley v. Illinois*, 405 U.S. 645, 651 (1972) (noting that the “rights to conceive and to raise one’s children have been deemed ‘essential’ and ‘basic civil rights of man’”) (citation omitted); *Prince*, 321 U.S. at 166 (finding that the rule that “the custody, care and nurture of the child reside first in the parents” is well-settled); *Meyer v. Nebraska*, 262 U.S. 390, 399 (1923) (noting that the liberty interest guaranteed by the Fourteenth Amendment includes the right to “establish a home and bring up children”); *Hurlman v. Rice*, 927 F.2d 74, 79 (2d Cir. 1991) (finding that a parent cannot be deprived of his or her custody interest in a minor child without due process); *van Emrick v. Chemung Cnty. Dep’t of Soc. Servs.*, 911 F.2d 863, 867 (2d Cir. 1990) (finding that the liberty interest of parents in the “care, custody, and management of their child . . . includes a significant decision-making role concerning medical procedures . . .”) (citation omitted).

85. *See, e.g., Parham*, 442 U.S. at 603 (finding that because most children cannot make sound judgments on certain issues, parents have the ability and responsibility to make judgments for their children on those issues).

86. *Id.*

87. *Id.*

88. *Id.* at 604.

89. *See id.* at 630 (finding that children have rights and interests that limit even parental rights).

90. The State has a profound interest in the welfare of the child, particularly his or her being sheltered from abuse. For example, in “[e]mergency circumstances . . . in which the child is immediately threatened with harm” a child may be taken into custody by a responsible State official without court authorization or parental consent, although “the mere ‘possibility’ of danger” is not enough. *Hurlman v. Rice*, 927 F.2d 74, 80–81 (2d Cir. 1991) (citation omitted). If it was, officers would always be justified in seizing a child without a court order whenever there was suspicion that the child might have been abused. *See id.* The law thus seeks to strike a balance among the rights and interests of parents, children, and the State. *See Hollingsworth v. Hill*, 110 F.3d 733, 739 (10th Cir. 1997) (relying on statutory schemes that balance the protected interests); *see also Robison v. Via*, 821 F.2d 913, 921 (2d Cir. 1987) (citing the well-established rule that officials can take a child from the parent without their consent if an emergency exists).

91. *See, e.g., Wisconsin v. Yoder*, 406 U.S. 205, 228–29 (1972) (holding that while the state had a compelling interest in “compulsory schooling,” Amish children were allowed to quit schooling and begin working after graduating eighth grade because of their parents’ religious belief in preparing for

decision making, then, States can take certain choices out of the hands of parents through prohibitions (laws against female circumcision, for example),⁹³ mandates (mandatory vaccination laws),⁹⁴ or laws that shift decision-making power to the minor (for contraception or drug treatment).⁹⁵ And when the interest of the youth is especially strong, such as with decisions about whether to carry a pregnancy to term, the State cannot totally divest an adolescent of decision-making power by giving a parent the right to veto an abortion.⁹⁶ Nonetheless, the general rule and operating presumption at law is that parents are best equipped to make medical decisions for their adolescent children.⁹⁷ That rule applies to body modification

life in the Amish community); *Sturges & Burn Mfg. Co. v. Beauchamp*, 231 U.S. 320, 325–26 (1913) (upholding prohibition against work by children under the age of sixteen in hazardous occupations). “Constitutional rights do not mature and come into being magically only when one attains the state-defined age of majority. Minors, as well as adults, are protected by the Constitution and possess constitutional rights.” *Planned Parenthood of Cent. Mo. v. Danforth*, 428 U.S. 52, 74 (1976). *See also* *Goss v. Lopez*, 419 U.S. 565, 581 (1975) (finding that minors facing suspension have a constitutional right, under the Due Process Clause, to, at a minimum “rudimentary precautions against unfair or mistaken findings of misconduct and arbitrary exclusion from school”); *Tinker v. Des Moines Indep. Cmty. Sch. Dist.*, 393 U.S. 503, 511 (1969) (holding that school children possess fundamental rights under the Constitution, including freedom to express their views, in the absence of valid reasons to disallow that expression); *In re Gault*, 387 U.S. 1, 13 (1967) (holding that both the Bill of Rights and the Fourteenth amendment protect both adults and minors).

92. *See, e.g.*, *Vernonia Sch. Dist. 47J v. Acton*, 515 U.S. 646, 656 (1995) (“For their own good and that of their classmates, public school children are routinely required . . . to be vaccinated against various diseases.”); *Zucht v. King*, 260 U.S. 174, 176–77 (1922) (finding that a statute mandating compulsory vaccination for schoolchildren was within the state’s police power to regulate public health).

93. Female circumcision is illegal regardless of parental consent. *See, e.g.*, 18 U.S.C. § 116 (2006) (prohibiting the cutting of female genital of a minor under eighteen years of age except for when it is necessary for the health of the minor); 720 ILL. COMP. STAT. ANN. 5/12–34 (West 2002 & Supp. 2011) (“[W]hoever knowingly circumcises, excises, or infibulates, in whole or in part, the labia majora, labia minora, or clitoris of another commits female genital mutilation. Consent to the procedure by a minor . . . or by the minor’s parent or guardian is not a defense”); *see also* WIS. STAT. ANN. § 146.35 (West 2006) (“Consent by the female minor or by a parent of the female minor to the circumcision, excision or infibulation” may not be “asserted as a defense to prosecution.”).

94. In terms of mandatory vaccinations, a state may require them even if parents do not consent. *See supra* note 92 and accompanying text.

95. In some states, “[a] minor has the same capacity as an adult to consent to . . . treatment for or advice about *contraception other than sterilization*.” *See, e.g.*, MD. CODE ANN., HEALTH-GEN. § 20-102(c)(5) (West 2009) (emphasis added). In Maryland, a person under the age of eighteen “has the same capacity as an adult to consent to treatment for and advice about drug abuse . . . [and] alcoholism.” *Id.* § 20-102(c)(1)–(2) (West 2009) (emphasis added). *But see id.* § 20-102(c-1) (West 2009) (“The capacity of a minor to consent to treatment for drug abuse or alcoholism . . . does not include the capacity to refuse treatment” in a certified “inpatient alcohol or drug abuse treatment program . . . for which a parent or guardian has given consent.”).

96. *See Danforth*, 428 U.S. at 74 (holding that the State cannot give a third party the ability to veto the decision of a woman and her physician to terminate her pregnancy).

97. *See, e.g.*, Rosato, *supra* note 10, at 771–72 (explaining that the general rule that parents are the only persons capable of giving consent for their minor child is based on the rationale that children lack the required experience and maturity, as well as the belief that “parents know best what will serve their own child’s interests”).

procedures except where state law makes an exception for tattooing or body piercing.⁹⁸

IV. TRENDS AND CALLS FOR INCREASED DECISION-MAKING AUTHORITY FOR TEENS

The default rule giving parents medical decision-making authority over the bodies of their adolescent children has drawn criticism.⁹⁹ Medical, bioethical, and legal scholars persuasively argue for increased autonomy for adolescents with respect to medical decision making,¹⁰⁰ and some state courts and legislatures have afforded teenagers medical decision-making authority.¹⁰¹ Mechanics of the laws or proposals for law differ: some call for individual assessment of each adolescent's maturity;¹⁰² others for across the board lowering of the age of majority;¹⁰³ and still others call for a kind of "sliding scale" that would give adolescents an increasing

98. See *supra* note 49 and accompanying text.

99. See *supra* note 10 and accompanying text.

100. See *supra* note 10 and accompanying text.

101. See, e.g., 410 ILL. COMP. STAT. ANN. 210/1 (West 2011) (stating that for the purposes of medical treatment, a minor who is married, pregnant, or a parent, or any person over eighteen, has the same legal capacity, powers, and obligations as someone of legal age); MISS. CODE ANN. § 41-41-3(3) (LexisNexis 2009) (stating that any female, regardless of age, may consent to any medical treatment in relation to pregnancy or childbirth); NEV. REV. STAT. ANN. § 129.030(2) (LexisNexis 2010) (noting that the consent of a minor's parents or guardians is not required for treatment when the minor is married, has had a child, or in imminent danger due to a health risk); OHIO REV. CODE ANN. §§ 3709.241, 3719.012 (LexisNexis 2005), OHIO REV. CODE ANN. § 5122.04 (LexisNexis 2008) (providing that a minor may give consent to treatment for venereal diseases, conditions caused by drug or alcohol abuse, or non-medical outpatient mental health services); see also *In re E.G.*, 549 N.E.2d 322, 327-28 (Ill. 1989) (finding that where a minor is determined mature enough to control her own health care, she may do so); *Younts v. St. Francis Hosp. & Sch. of Nursing, Inc.*, 469 P.2d 330, 337 (Kan. 1970) (finding that a parent's consent "may not be necessary or required" and a minor's consent would be sufficient depending upon "his ability to understand and comprehend the nature of the surgical procedure, the risks involved and the probability of attaining the desired results in the light of the circumstances which attend"); *Bach v. Long Island Jewish Hosp.*, 267 N.Y.S.2d 289, 290-91 (N.Y. Sup. Ct. 1966) (holding that there are exceptions to the rule that minors must have a parent's or guardian's consent to act); *Lacey v. Laird*, 139 N.E.2d 25, 34 (Ohio 1956) (finding that surgery performed on an eighteen-year-old with her consent, but without parental consent, was not an assault and battery); *Cardwell v. Bechtol*, 724 S.W.2d 739, 749 (Tenn. 1987) (noting that mature minors "appreciate the nature, the risks, and the consequences of the medical treatment involved"); *Belcher v. Charleston Area Med. Ctr.*, 422 S.E.2d 827, 835 (W. Va. 1992) (finding that mature minors "may be involved in the medical decisions that affect their livelihood"). *But see* *Commonwealth v. Nixon*, 761 A.2d 1151, 1155 (Pa. 2000) (rejecting the mature minor doctrine in Pennsylvania).

102. See, e.g., Rosato, *supra* note 10, at 787-88 (finding that the trend with regards to how the law should treat adolescents in the juvenile justice context favors "requiring an individualized determination of competence," although that approach might not be the best with regards to health care decision making).

103. See, e.g., Andrew Newman, *Adolescent Consent to Routine Medical and Surgical Treatment: A Proposal to Simplify the Law of Teenage Medical Decision-Making*, 22 J. LEGAL MED. 501, 531-32 (2001) (arguing that the age of consent should be 16 years old in the healthcare setting); see also Mutcherson, *supra* note 10, at 255 (arguing that the age of consent should be lowered to fourteen and that parents and adolescents share decision-making responsibility for most healthcare decisions).

ability to decide about a given treatment depending on the expected therapeutic benefit.¹⁰⁴ The nuances of the arguments and proposals for increased medical decision-making rights for adolescents are beyond the scope of this essay,¹⁰⁵ but consideration of the main points of argument helps illuminate their application to body modification. Although the arguments are rooted in bioethics, moral theory, developmental science, public health, and public policy, they make similar basic points.

First, adolescents are rights bearing citizens who deserve respect as full human persons.¹⁰⁶ Although their ability to exercise their rights, or to act as fully autonomous beings may be developing, the adolescent has rights to bodily integrity, self-determination, and privacy.¹⁰⁷ To best respect the person of the adolescent, these rights should be recognized and protected to a degree commensurate with the ability of the individual involved to exercise them.¹⁰⁸ The costs of disrespecting the adolescent as a rights bearing person are high.¹⁰⁹ As Professor Jennifer Rosato, a strong proponent of increased decision-making rights for adolescents argues, failure to respect the “burgeoning autonomy” of adolescents will likely harm “their personhood, especially when the health care decision involves the exercise of moral judgment. If adolescents cannot make these decisions for themselves, they may be forced to live a life they have not chosen and certain future opportunities may be foreclosed to them permanently.”¹¹⁰

To measure the ability of adolescents to engage capably in medical decision making, and address the law’s discordant approach to adolescent decision-making

104. See, e.g., Martin T. Harvey, *Adolescent Competency and the Refusal of Medical Treatment*, 13 HEALTH MATRIX 297, 298 (2003) (arguing that adolescent competency should be determined on a sliding scale); Arshagouni, *supra* note 10, at 359 (arguing that adolescents should be given a presumption of capacity in low risk, routine health procedures with no long term consequences and should be presumed not to have decision-making capacity for high risk medical procedures, or procedures that have longer-term consequences, absent evidence to rebut that presumption).

105. For a summary of the arguments, see Arshagouni, *supra* note 10, at 352–59.

106. See Mutcherson, *supra* note 10, at 273 (noting that autonomy is a positive notion in that it encourages each person to be his own man or woman and reinforces that no individual is the possession of another).

107. See *id.* at 319–20 (finding that adolescents have a right to self-determination and bodily integrity); see also *Planned Parenthood of Cent. Mo. v. Danforth*, 428 U.S. 52, 74–75 (1976) (finding that adolescents have a right to privacy).

108. See Arshagouni, *supra* note 10, at 359 (arguing that adolescents should be given independence and autonomy commensurate with their abilities).

109. See Rosato, *supra* note 10, at 790 (noting that a failure to respect the rapidly increasing autonomy of adolescents, especially regarding their moral judgment in healthcare decisions, is likely to harm to their personhood because it will prevent them from making choices for themselves); see also Arshagouni, *supra* note 10, at 316 (advocating for a better formulation to determine when adolescents should be allowed to make their own health care decisions, as the current model encourages poor medical decisions, such as putting off necessary medical treatment, as a result of the lack of autonomy and privacy).

110. Rosato, *supra* note 10, at 790.

capacity,¹¹¹ proponents reference developmental science.¹¹² Reference to developmental science makes sense, explains Professor Rhonda Gay Hartman:

[T]he presumptive decisional incapacity that undergirds legislation governing minors is tenuous at best. Despite its century-old shelf life, there is comparatively little, if any, evidence to support it. The Supreme Court's observation that adolescent inexperience and vulnerability impede capable judgment for decision-making is, and was, not supported by any evidence beyond the collective "conventional wisdom" of a majority of the justices. . . . [R]esults from other studies related to adolescent cognitive development and capacity for decision-making contravene the presumption of incapacity that underlies legislation. These studies, along with evolving societal and cultural norms, should inform and shape *parens patriae*.¹¹³

Reference to science in determining the rights and responsibilities of adolescents is also an approach apparently endorsed by the Supreme Court in *Roper*.¹¹⁴

The science is fairly compelling. Consistently, research on the development of adolescent decision making, judgment, and brain development supports the capacity of adolescents in medical decision making, when the criteria for measuring decisional capacity in adults are applied.¹¹⁵ Capacity for medical decision making exists (for adults) when a person has the ability to comprehend information relevant to the decision, the ability to rationally deliberate in accordance with personal values and goals, and the ability to communicate with caregivers.¹¹⁶ In other words, an adult is deemed to have capacity to make her own medical decisions so long as she understands the risks, benefits, and alternatives of proposed medical options, and can make and communicate an informed decision about what course to take.

111. Rhonda Gay Hartman, *Adolescent Autonomy: Clarifying an Ageless Conundrum*, 51 HASTINGS L.J. 1265, 1287 (2000).

112. See, e.g., Vivian E. Hamilton, *Immature Citizens and the State*, 2010 BYU L. REV. 1055, 1063–64 (2010) (arguing for decisional autonomy for adolescents in healthcare based on research by developmental scientists); see also Hartman, *supra* note 10, at 411 (noting that since the Supreme Court's decision in *Wisconsin v. Yoder*, 406 U.S. 205 (1972), studies of "adolescent cognitive development and capacity for decision-making" conflict with the presumption underlying legislation that adolescents are incapable of making decisions, and that even in *Yoder*, the majority relied not on scientific studies but merely the justices' "conventional wisdom"); Arshagouni, *supra* note 10, at 345 (encouraging policy makers to refer to science to understand adolescent development).

113. Hartman, *supra* note 10, at 411.

114. *Roper v. Simmons*, 543 U.S. 551, 569 (2005).

115. See Hamilton, *supra* note 112, at 1099–1118 (summarizing the most recent research on adolescent brain development); see also Arshagouni, *supra* note 10, at 347–52 (describing the research on adolescent brain and cognitive development).

116. Jessica Wilen Berg et al., *Constructing Competence: Formulating Standards of Legal Competence to Make Medical Decisions*, 48 RUTGERS L. REV. 345, 351 (1996).

Society does not demand that adults make good decisions, just that they understand and appreciate the nature of the situation and the potential consequences of the chosen courses of action.¹¹⁷ Developmental research shows that by age fifteen or sixteen, adolescents are just as adept as adults in understanding and reasoning from facts, processing information, and assessing and appreciating the nature of a given situation.¹¹⁸ That is, their cognitive and informational processing abilities are mature.¹¹⁹ These abilities—understanding and reasoning from facts, processing information, and assessing and appreciating the nature of a given situation—are roughly the equivalent of the abilities measured in assessing decision-making capacity in adults.¹²⁰ Because adolescents generally meet the criteria for decision-making capacity applied to measure capacity in adults, and because the ability of adolescents to communicate is not in question, proponents argue that the presumption of incapacity applied to adolescent medical decision making is misplaced.¹²¹

To be sure, as the Supreme Court recognized in *Roper*, the cognitive abilities and mature judgment of adolescents is deficient in certain contexts.¹²² The quality of their decision making decreases when adolescents have to assess and react to risk quickly, to make decisions in new environments, and to act in the presence of peers.¹²³ Their decisions may be “impetuous and ill-considered,” especially if made without time for deliberation or when influenced by peer pressure.¹²⁴ Some proponents of increased decision making for adolescents account for these limitations in their proposals for change.¹²⁵ For example, Paul Arshagouni proposes a rule that would give adolescents the presumptive right to make low-risk medical decision but not high-risk decisions because of the scientific evidence concerning

117. *Id.* at 352 n.22.

118. Hamilton, *supra* note 112, at 1109 (citing various studies that have found a sixteen-year-old's reasoning and information processing skills as “essentially indistinguishable” from an adult's skills).

119. *Id.*

120. *Id.*

121. *Id.* at 1137–38, 1139. See also Lois A. Weithorn & Susan B. Campbell, *The Competency of Children and Adolescents to Make Informed Treatment Decisions*, 53 CHILD DEV. 1589, 1596 (1982) (noting that research does not support “policies which deny adolescents the right of self-determination in treatment situations on the basis of a presumption of incapacity to provide informed consent”); Rosato, *supra* note 10, at 785 (referring to studies that “support the abandonment of the incompetence presumption,” but adding that these studies have had little effect on the law in this area).

122. *Roper v. Simmons*, 543 U.S. 551, 569 (2005).

123. *Id.* Abigail A. Baird & Jonathan A. Fugelsang, *The Emergence of Consequential Thought: Evidence from Neuroscience*, 359 PHIL. TRANSACTIONS ROYAL SOC'Y B 1797, 1801–03 (2004) (describing increased propensity for unnecessary risk taking by teens and providing explanation with neuroscience).

124. *Roper*, 543 U.S. at 569 (quoting *Johnson v. Texas*, 509 U.S. 350, 367 (1993)).

125. See, e.g., Hartman, *supra* note 10, at 411 (noting that *parens patriae*, the philosophy that government proactively should protect minors' welfare, “is central to crafting cohesive legislation that recognizes adolescent legal autonomy for medical decision-making”).

risk taking by adolescents.¹²⁶ But Arshagouni is in a minority. Most scholars argue that the deficiencies (impulsiveness, excessive risk-taking, susceptibility to peer pressure) are not relevant in the healthcare context to the same degree they are in the juvenile justice context.¹²⁷ After all, most medical decisions are unlikely to be impetuous or heavily influenced by peer pressure given the private context in which they are made and the necessary involvement of the adult professionals.¹²⁸ Even the scholars willing to assume that decisional competence criteria is the same in both context argue that “the balance of interests weighs much more favorably toward giving older adolescents the ability to make their own health care decisions.”¹²⁹

Specifically, proponents argue that the state’s interest in promoting the development of fully capable, mature, engaged, and functioning citizens is served by respecting adolescent autonomy in the healthcare.¹³⁰ Essentially, the argument is that adolescents need to be given the opportunity to work out their decision-making “muscles” in order to develop them more fully.¹³¹ Giving adolescents the power to direct their own medical care gives them the opportunity to make important choices for themselves, choices they will have to live with, in a presumptively safe environment—one that is relatively separate from peer influence, and one that necessarily involves the adolescent with adult professionals who serve as a sounding board during the decision-making process.¹³² Respecting adolescents’ choices in this context allows them to develop and learn.¹³³ It “is likely to improve their self-esteem and sense of control in the short term, and make them better decision-makers and citizens in the long-term.”¹³⁴ By contrast, protecting adolescents from the consequences of their decisions hinders their development.¹³⁵

126. Arshagouni, *supra* note 10, at 359.

127. Donald L. Beschle, *Cognitive Dissonance Revisited: Roper v. Simmons and the Issue of Adolescent Decision-Making Competence*, 52 WAYNE L. REV. 1, 36–41 (2006).

128. See Laurence Steinberg et al., *Are Adolescents Less Mature than Adults?: Minors’ Access to Abortion, the Juvenile Death Penalty, and the Alleged APA “Flip-Flop”*, 64 AM. PSYCHOL. 583, 586, 592–93 (2009) (discussing the difference between adolescents’ decisions to commit crimes, which typically are influenced by peer pressure, and how medical decisions, specifically whether or not to have an abortion, are made after consultations with adults).

129. Rosato, *supra* note 10, at 790; see also Hamilton, *supra* note 112, at 1138 (noting studies show that adolescents want to make health care decisions and that they have the ability to make mature decisions).

130. Rosato, *supra* note 10, at 790 (noting that adolescents gain a sense of self-worth from being involved in decisions that affect them).

131. *Id.* at 790, 793.

132. See, e.g., Steinberg et al., *supra* note 128, at 592 (explaining that adolescents are just as capable as adults in making mature decisions in several situations, including those involving medical decision making, when peer pressure is less of a factor and objective information is available).

133. Rosato, *supra* note 10, at 790.

134. *Id.*

135. *Id.* at 793 (stating that allowing adolescents to make their own decisions helps them develop into their own person).

The fact that adolescents may sometimes make bad decisions does not outweigh society's need to develop mature adolescents and engaged citizens "with their entitlement to life-deciding liberty intact."¹³⁶ Moreover, the involvement of professional adults in medical decision making minimizes the risk of devastating consequences.¹³⁷

The rights and science-based arguments for giving adolescents increased decision-making authority in the healthcare context are buttressed by policy arguments. For example, there is reason to believe that vesting adolescents with decision-making authority can improve the relationship between doctor and patient by ensuring confidentiality, which results in better health care for the adolescent.¹³⁸ It also promotes public health by ensuring that risk-taking adolescents get health care without fear of parental repercussions.¹³⁹ And it may protect adolescents from the consequences of their own behavior, especially where sexuality or other morally charged issues are involved.¹⁴⁰ Together, the rights, science, and policy arguments for increasing decisional autonomy for adolescents are compelling. The question is whether they apply with equal force to cosmetic body modification.

V. WITH BODY MODIFICATION, CAUTION IS IN ORDER

The arguments for increased decision-making authority for adolescents are persuasive with respect to most healthcare decisions.¹⁴¹ They are not so robust, however, with respect to cosmetic body modification—even that which occurs in the medical setting. Although the rights of adolescents to bodily integrity, self determination, and privacy are no less implicated by body modification than they are by other medical interventions, developmental science suggests that a competing interest, the need to protect adolescents as vulnerable, still-developing persons, is far greater in the context of body modification than with respect to health care generally.¹⁴² Specifically, cosmetic body modification differs from

136. Hamilton, *supra* note 112, at 1061.

137. Mutcherson, *supra* note 10, at 304.

138. Cf. Abigail English & Madlyn Morreale, *A Legal and Policy Framework for Adolescent Health Care: Past, Present, and Future*, 1 HOUS. J. HEALTH L. & POL'Y 63, 63–64, 72, 105–06 (2001) (emphasizing the importance of physician-patient confidentiality in improving medical care for adolescents).

139. Mutcherson, *supra* note 10, at 270–71 (describing common situations, such as substance abuse, mental illness and venereal disease, where adolescents can exercise medical decision-making autonomy).

140. *See id.* at 269–71 (noting practical benefits of "healthcare emancipation statutes," including protecting minors from harm they might cause themselves).

141. *See supra* Part IV.

142. *See Ouellette, supra* note 9, at 982–83 (arguing that medical interventions for children are justified "only if necessary to meet the child's needs," and that when parents choose unnecessary surgery for a child they "turn a healthy child into a patient and compromise a child's interests in bodily integrity, safety, and freedom from confinement"); Mutcherson, *supra* note 10, at 303 (advocating a rule

other medical interventions in at least three ways that are critical given what science tells us about adolescent decision-making capacity.

First, cosmetic body modification involves unnecessary risk taking as compared to other medical interventions.¹⁴³ No illness, injury, or organic cause demands intervention to prevent degradation or deterioration.¹⁴⁴ No physical benefit offsets the physical risks.¹⁴⁵ To be sure, some cosmetic interventions may provide psychological or other benefits, but cosmetic modification is by definition, elective and nonurgent.¹⁴⁶ Yet, the risks are substantial. With cosmetic surgeries such as breast reconstruction and liposuction, skin is cut or pierced, and bodies are anesthetized.¹⁴⁷ There is a risk of nerve damage, infection, reactions to anesthesia, scarring, and death.¹⁴⁸ With growth or gender hormones, there is risk of musculoskeletal pain, aggression, and aggravation of kidney problems, diabetes, hypertension, and cancer.¹⁴⁹ Even the less risky modifications that take place outside of the doctor's office are not risk free.¹⁵⁰ Tattooing poses the risks of infection (including hepatitis and HIV), allergies, removal problems, MRI complications, keloid formation, scarring, and dissatisfaction.¹⁵¹ Body piercing can pose the risk of scarring, rejection, migration of the piercing, keloid formation, and

in which adolescents fourteen or older could make binding decisions, along with parents, about medical care, but noting medical care "does not refer to care intended only to provide aesthetic enhancement").

143. See, e.g., Arshagouni, *supra* note 10, at 360 (noting the high risks associated with cosmetic surgery).

144. See, e.g., Bishara S. Atiyeh et al., *Aesthetic/Cosmetic Surgery and Ethical Challenges*, 32 *AESTHETIC PLASTIC SURGERY* 829, 829–31 (2008) (noting that the focus of cosmetic plastic surgery is "on improved appearance for its own sake," and is "life-enhancing, not life-saving").

145. An exception might be breast reduction surgeries, and surgeries to remove excess skin after massive weight loss. *Breast Reduction: Procedure, Risks, Benefits, Recovery*, WEBMD, <http://www.webmd.com/healthy-beauty/breast-reduction> (last visited Jan. 24, 2012). Breast reduction surgery can relieve back pain and removal of a skin flap reduces risk of infection. *Id.* For these reasons, the surgeries are not merely cosmetic, and may be subject to a different analysis. *Id.*

146. Zuckerman & Abraham, *supra* note 40, at 318, 320–21.

147. Zuckerman & Abraham, *supra* note 40, at 319.

148. *Id.*

149. See Rahul K. Parikh, *Growth Hormones for Kids*, SALON (Oct. 31, 2008, 6:44 AM), http://www.salon.com/env/vital_signs/2008/10/31/growth_hormones_kids/ (providing a pediatrician's view on the use of hGH in healthy kids); see also David B. Allen & Norman Foster, Commentary, *hGH for Short Stature: Ethical Issues Raised by Expanded Access*, 144 *J. PEDIATRICS* 648 (2004) (cautioning against over-use of hGH and mentioning concerns about its safety that periodically arise); Michael Freemark, Editorial: *Growth Hormone Treatment of "Idiopathic Short Stature": Not So Fast*, 89 *J. CLINICAL ENDOCRINOLOGY AND METABOLISM* 3138, 3138–139 (2004) (discussing potential concerns over use of hGH in healthy kids, although the long-term risks of prolonged treatment are unknown); Linda D. Voss, *Growth Hormone Therapy for the Short Normal Child: Who Needs It and Who Wants It?*, 136 *J. PEDIATRICS* 103, 104 (2000) (claiming there is little justification for cosmetic endocrinology without more significant data).

150. See *Tattoos & Permanent Makeup*, U.S. FOOD & DRUG ADMIN., <http://www.fda.gov/cosmetics/productingredientsafety/productinformation/ucm108530.htm> (last updated Feb. 1, 2010) (outlining the various complications that can result from tattooing).

151. *Id.*; U.S. FOOD & DRUG ADMIN., THINK BEFORE YOU INK: ARE TATTOOS SAFE? (2008).

in rare cases, hepatitis and HIV.¹⁵² Tongue piercing may cause dental fractures, gum damage, and changes in mastication and speech.¹⁵³ Given the lack of corresponding health benefit, the physical risks posed by cosmetic interventions suggest a need for caution before they are used, especially in a population prone to impulsivity and unnecessary risk taking as a matter of immature brain development.¹⁵⁴

Notably also, mounting evidence suggests that the population of persons drawn to cosmetic body modification may be especially vulnerable to reckless behavior.¹⁵⁵ Between six and fifteen percent of patients seeking cosmetic treatments suffer from body dysmorphic disorder, a severe mental disorder that affects body perception and often leads sufferers to seek multiple unnecessary surgeries.¹⁵⁶ Women who received cosmetic breast augmentation are two times more likely than women of the same age who did not receive surgery to commit suicide, or die from alcohol or drug abuse.¹⁵⁷ At least some studies suggest poor outcomes in terms of self-esteem and quality of life for those who undergo cosmetic surgery.¹⁵⁸ And teens that engage in tattooing and body piercing are far more likely to be engaged in other high-risk activities involving illegal drugs, sex, truancy, and thoughts of suicide.¹⁵⁹ The nature of risks posed by cosmetic body modification, the propensity of adolescents generally to engage in reckless behavior, and the particular vulnerabilities of people who seek cosmetic body modifications, suggest a need for limitations on their availability to adolescents.¹⁶⁰

Second, decisions for medical and nonmedical cosmetic body modification are more susceptible to peer influence than are other medical decisions.¹⁶¹ Most medical decisions are made in the context of the confidential physician-patient

152. Scudder, *supra* note 1.

153. *Id.*

154. *Id.*

155. See Sean T. Carroll et al., *Tattoos and Body Piercings as Indicators of Adolescent Risk-Taking Behaviors*, 109 J. PEDIATRICS 1021, 1023, 1026–27 (2002) (discussing the link between participants with tattoos and/or body piercings, and likelihood of engaging in risk-taking behavior and at a greater degree than those without tattoos or piercings).

156. Kristen Nugent, *Cosmetic Surgery on Patients with Body Dysmorphic Disorder: Cutting the Tie That Binds*, 28 DEV. MENTAL HEALTH L. 77, 80 (2009).

157. David B. Sarwer et al., *Cosmetic Breast Augmentation and Suicide*, 164 AM. J. PSYCHIATRY 1006, 1007 (2007).

158. See, e.g., Roberta J. Honigman et al., *A Review of Psychosocial Outcomes for Patients Seeking Cosmetic Surgery*, 113 PLASTIC RECONSTRUCTIVE SURGERY 1229 (2004).

159. See Carroll et al., *supra* note 155, at 1021–24 (discussing how teenagers with tattoos and body piercings are more likely to explore other risky activities); Joan-Carles Suris et al., *Piercing Among Adolescents: Body Art as Risk Marker*, 56 J. FAM. PRAC. 126, 126 (2007) (“Body piercing among young people has been linked with risk behaviors such as the abuse of legal and illegal substances, risky sexual behavior, school truancy and running away, suicide ideation and attempts, and delinquent behavior.”).

160. Suris et al., *supra* note 159, at 126–27 (providing an overview of risky behavior linked to teens with tattoos and body piercings).

161. Scudder, *supra* note 1.

relationship.¹⁶² Shrouded in privacy, they are insulated from peer pressure. Decisions by teens for cosmetic body modification are much more public. Teens are bombarded with images of cosmetically enhanced models in the media.¹⁶³ The pressure to meet a culturally defined ideal of beauty is tremendous.¹⁶⁴ Reports of teens seeking cosmetic procedures to escape peer pressure are common.¹⁶⁵ An available study also suggests that peer influence is a significant motivating factor for teens who seek cosmetic body modification.¹⁶⁶ Even proponents of cosmetic surgery for teenagers use escape from peer pressure as a good reason to choose surgical modification.¹⁶⁷

Third, the role of the medical professional differs with respect to cosmetic body modification as compared to other medical interventions.¹⁶⁸ In the healthcare context generally, a physician limits options for invasive procedures to those that are medically effective as measured by objective scientific criteria.¹⁶⁹ This professional guidance acts as safeguard against impulsive and reckless decision making. Cosmetic surgery is by its very nature less concerned with medical efficacy.¹⁷⁰ Its goal is aesthetic and social improvement.¹⁷¹ The American Academy

162. See AMA COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, CODE OF MEDICAL ETHICS OP. 5.05 (last updated 2007), available at <http://www.ama-assn.org/resources/doc/code-medical-ethics/505a.pdf> (discussing the duty confidentiality in the physician-patient relationship).

163. See Julie M. Albrigh, *Impossible Bodies: TV Viewing Habits, Body Image, and Plastic Surgery Attitudes Among College Students in Los Angeles and Buffalo*, *New York*, 15 CONFIGURATIONS 103, 103 (2007) (discussing how teens are affected by the messages regarding body image they view in the media); *Today: Why Teens Want to Have Plastic Surgery* (NBC News television broadcast May 7, 2003) (discussing the pressure of constantly seeing "perfect girls, perfect faces, [and] perfect bodies" in magazines and on TV).

164. *Pressure to be Perfect*, BBC NEWS (OCT. 7, 1998, 1:14 GMT), <http://news.bbc.co.uk/2/hi/health/187703.stm> (describing common pressures and negative thoughts woman experience in trying to meet society's ideal of beauty).

165. Mary Powers, *Teens and Plastic Surgery: Maybe Not the Greatest Idea in the World*, *Vero BEACH J.*, Sept. 19, 2000, at C1 (noting how the media and peer pressure are influencing a new generation of patients interested in plastic surgery); *Today: Today's Health* (NBC News television broadcast June 25, 2009) (describing how young girls seek cosmetic surgery to "fit in"); see also *Today: Why Teens Want to Have Plastic Surgery*, *supra* note 163.

166. See, e.g., James A. Farrow et al., *Tattooing Behavior in Adolescence: A Comparison Study*, 145 *AM. J. DISEASES CHILD.* 184 (1991) (characterizing motivations for tattooing in adolescents, including low self-esteem and peer pressure). Concededly, the available data is sparse. Given the popularity of cosmetic procedures for adolescents, further research is warranted to determine the culture, emotional, and economic factors behind the increase.

167. See, e.g., LUKASH, *supra* note 4, at 11–12, 27 (describing the anguish caused by youth bullying over appearances and opining that plastic surgery is a good option to help alleviate such issues).

168. See, e.g., Marc G. Simon, *The Physician's Duty to Screen Patients for Elective Surgery*, 20 *ARIZ. L. REV.* 669, 671 (1978) (exploring the unique duties owed to patients requesting plastic surgery).

169. See generally David L. Sackett et al., *Evidence Based Medicine: What it Is And What it Isn't*, 312 *J. BRIT. MED. ASS'N* 71 (1996) (explaining the process of evidence-based practice, by which physicians use objective scientific criteria to make judgments about a patient's care).

170. See Zuckerman & Abraham, *supra* note 40, at 3 (stating that cosmetic surgery is mainly concerned with changing a person's body image). *But see* *AM. BD. OF PLASTIC SURGERY*,

of Facial Plastic and Reconstructive Surgery code of ethics says only “[a] member must not perform a surgical operation that is not calculated to improve or benefit the patient.”¹⁷² The degree to which cosmetic or social interventions benefit a patient is a subjective measure.¹⁷³ Few studies have examined even the frequent claims that cosmetic surgery provides psychological benefit.¹⁷⁴ No study has shown any long-term benefit of plastic surgery on adolescents.¹⁷⁵ In fact, no conclusive studies indicate “cosmetic surgery improves overall body image or quality of life for adolescents or adults.”¹⁷⁶ Without an evidence base to guide them, cosmetic surgeons are left to their own subjective judgments about what procedures make sense for a given patient. And if media reports are to be believed, some cosmetic surgeons have exercised questionable judgment when deciding to acquiesce to a request for cosmetic procedures.¹⁷⁷ For this reason, there is simply no guarantee that a professional adult decision maker committed to the preserving the health of the adolescent can be counted on to counter impulsive risk taking by adolescents for body modification.

In sum, voluntary risk taking, the influence of peer pressure, and the possibility for impulsive decision making are very much at play when it comes to cosmetic body modification.¹⁷⁸ Developmental science tells us that risk taking, impulsiveness, and responding to peer pressure are cognitive capacities not yet developed in adolescent brains.¹⁷⁹ For that reason, the presumption of incapacity now applicable at law makes sense.¹⁸⁰ Efforts to expand the authority of

<https://www.abplsurg.org/moddefault.aspx> (last visited Jan. 28, 2012) (noting the mission statement of the American Board of Plastic Surgery includes the performance of effective, safe and ethical surgeries).

171. See Zuckerman & Abraham, *supra* note 40, at 3; LUKASH, *supra* note 4, at 11–12, 27.

172. AM. ACAD. OF FACIAL PLASTIC & RECONSTRUCTIVE SURGERY, CODE OF ETHICS 8 (2000).

173. Neil S. Sadick, Commentary, *The Impact of Cosmetic Interventions on Quality of Life*, DERMATOLOGY ONLINE J. (Aug. 2008), <http://dermatology.cdlib.org/148/commentary/qualityoflife/sadick.html> (“Beauty itself is entirely subjective, and the technical aspects of aesthetic procedures may not result in patient satisfaction.”).

174. Zuckerman & Abraham, *supra* note 40, at 320–21 (opining that few studies have been conducted focusing on psychological benefit of cosmetic surgery and that none have focused on the long-term results of cosmetic surgery in adolescents).

175. *Id.* at 321.

176. *Id.*

177. See, e.g., Allison Adato, *Too Young for Lipo?*, PEOPLE, Nov. 13, 2006, at 131, <http://www.people.com/people/archive/article/0,,20059928,00.html> (describing a case in which a plastic surgeon performed liposuction on a twelve-year-old girl). It is possible that such a case is aberrational. The data collected about the use of cosmetic surgeries is far too vague to determine how many extreme or ethically suspect procedures are performed on a regular basis.

178. Scudder, *supra* note 1.

179. Arshagouni, *supra* note 10, at 347–52 (describing research on adolescent brain and cognitive development).

180. See Melinda G. Schmidt & N. Dickon Reppucci, *Children’s Rights and Capacities*, in CHILDREN, SOCIAL SCIENCE, AND THE LAW 76, 82 (Bette L. Bottoms et al. eds., 2002) (recognizing that under the law minors cannot make informed medical decisions because of their presumed immaturity); NANCY E. WALKER ET AL., CHILDREN’S RIGHTS IN THE UNITED STATES: IN SEARCH OF A NATIONAL

adolescents with respect to their own bodies and health should not extend to cosmetic body modification. As the Supreme Court recognized in *Roper*, where adolescent decision making is compromised, protections may be in order.¹⁸¹ The following section discusses the efficacy of parental consent laws as a protection mechanism.

VI. ROLE OF THE PARENT: SHOULD PARENTS HAVE DECISION-MAKING POWER?

Because adolescents should not be given unchecked decisional authority to engage in body modification, it makes sense to turn to parents to protect adolescents from impulsivity, recklessness, and submission to peer pressure.¹⁸² Assuming adolescents should have access to cosmetic body modification, parental consent rules make sense where the adolescent initiated the request for intervention.¹⁸³ The parent, after all, can generally be trusted to protect a child's best interests.¹⁸⁴ However, parents should not be given sole authority to approve or disapprove of modifications to their children's bodies.¹⁸⁵

Consider two scenarios. In the first, a parent brings a shy withdrawn sixteen-year-old girl named Lisa to schedule a nose job. Noticing that Lisa has a large nose with a slight bump, the surgeon asks the teen if she wants the surgery. Staring at the floor, Lisa says "it's fine." The mother stares hard at the daughter and reminds her "we agreed to this." To the surgeon, the parent says, "let's schedule this."

In the second, sixteen-year-old Fred has worked closely with a pediatrician and a nutritionist to lose weight over a two-year period. Although his family has not been particularly supportive, his efforts have been remarkably successful. With a complete commitment to a healthy diet and exercise, he has lost over 100 pounds. Unfortunately, he has fair skin, which did not shrink to fit his newly fit frame. The

POLICY 142 (1999) (adding that states can limit a minor's ability to make legal decisions because minors generally lack experience and maturity).

181. *Roper v. Simmons*, 543 U.S. 551, 570 (2005) (holding that minors have a different standard for decision making than adults because "[t]heir own vulnerability and comparative lack of control over their immediate surroundings mean juveniles have a greater claim than adults to be forgiven for failing to escape negative influences in their whole environment").

182. See, e.g., AM. SOC'Y OF PLASTIC SURGEONS, POLICY STATEMENT: BREAST AUGMENTATION IN TEENAGERS 1 (2004) (recognizing that because teenagers may be motivated to engage in plastic surgery by a desire to "fit in," it is important to involve parents in the decision-making process). Although it is important to include parents, they may sometimes be the people pressuring the adolescents to obtain the surgery. *Id.*

183. See, e.g., Andy Piker, *Balancing Liberation and Protection: A Moderate Approach to Adolescent Health Care Decision-Making*, 25 *BIOETHICS* 202, 205 (2011) (suggesting that research has shown that adults are often better able to assess an adolescent's best interests and preventing adolescents from making their own healthcare decisions may not be discriminatory since such policies are grounded in the belief that adolescents and adults do not share the same decision-making capacities).

184. See Wanda K. Mohr & Sheila Sues Kennedy, *The Conundrum of Children in the US Health Care System*, 8 *NURSING ETHICS* 196, 199 (2001).

185. See Piker, *supra* note 183, at 205–06 (advocating for an intermediate level of involvement from parents in the healthcare decision-making process for adolescent patients).

weight loss has left him with a great deal of excessive drooping skin (a pannus) at the bottom of his belly and large breasts (gynecomastia) that droop significantly. The large breasts and drooping skin dismay Fred. He wants more than anything to be able to wear a tee shirt without shame, but he continues to hide his body because he feels it is deformed. He would join the school's swim team but for his extra skin. Fred has asked his pediatrician to refer him to a cosmetic surgeon for breast reduction and skin removal. Fred has researched the procedures and is remarkably knowledgeable about all they involve. He has even found a local plastic surgeon that performs post-weight loss surgeries for teenagers without cost. Worried that Fred's distress over his extra skin and large breasts will discourage further weight loss or continued healthy living, the pediatrician makes the referral. Fred's parents, however, refuse to allow Fred to be seen by the surgeon, and they adamantly refuse to consider plastic surgery for their son.

Under the law, Lisa's mother can give effective consent to the surgery, and Fred's parents can veto even the consultation.¹⁸⁶ Both results are problematic. In the first scenario, the parent may well be acting in what she believes to be Lisa's best interest, but her consent is not enough to justify operating on Lisa, given her ambivalence about the procedure.¹⁸⁷ In reality, few surgeons would agree to operate on Lisa give her reluctance.¹⁸⁸ Forcing a reluctant teen to undergo cosmetic surgery is ethically and practically problematic. As a rights-bearing individual who will have to live through and with the surgery, Lisa should have some voice in the decision.¹⁸⁹ In fact, the American Society for Plastic Surgeons urges its members to evaluate the teen for maturity and commitment to the procedure.¹⁹⁰ The ASPS plastic Surgery for Teenagers Briefing paper states:

The most rewarding outcomes are expected when the following exist:
The teenager initiates the request. While parental support is essential, the teenager's own desire for plastic surgery must be clearly expressed and repeated over a period of time. The teenager has realistic goals. The young person must appreciate both the benefits and limitations of plastic surgery, avoiding unrealistic expectations about life changes that will occur as a result of the procedure. The teenager has sufficient maturity. Teenagers must be able to tolerate the discomfort and

186. See Schmidt & Reppucci, *supra* note 180, at 82 (stating that parents have the legal right to make medical decisions on behalf of their children); see also WALKER ET AL., *supra* note 180, at 142.

187. See, e.g., Mary Ann McCabe, *Involving Children and Adolescents in Medical Decision Making: Developmental and Clinical Considerations*, 21 J. OF PEDIATRIC PSYCHOL. 505, 506 (1996) (stipulating the legal requirement that medical decisions be free from coercion should also apply to children).

188. See Douglas J. Opel & Benjamin S. Wilfond, *Cosmetic Surgery in Children with Cognitive Disabilities: Who Benefits? Who Decides?*, HASTINGS CENTER REP., Jan–Feb. 2009, at 19, 19 (describing the preference of cosmetic physicians to postpone “risky” surgery until children are competent to be included in the decision-making process).

189. *Id.*

190. *Plastic Surgery for Teenagers*, *supra* note 5.

temporary disfigurement of a surgical procedure. Plastic surgery is not recommended for teens who are prone to mood swings or erratic behavior, who are abusing drugs and/or alcohol, or who are being treated for clinical depression or other mental illness.¹⁹¹

The recommendations are aspirational only, however, and if stories in the media can be believed, some surgeons appear willing to comply with parents' requests to "fix" a child's face or body to the parents' liking.¹⁹² Whether by force or through professional discipline, some limits on parental choice are necessary.¹⁹³ The parent does not own the child's body.¹⁹⁴ The parent cannot modify it at will.¹⁹⁵ Parental authority comes from a place of trust, wherein the parent is empowered to make medical decisions to promote the child's health and well-being.¹⁹⁶ That authority does not give parents rights to subjugate the child's body to meet the parent's aesthetic wishes. Thus, a provider faced with an aggressive parent can and should decline to participate in cosmetic modification of an adolescent's body.

Likewise, in some rare cases, some mechanism should be available to allow a minor to override a parental veto of a cosmetic modification. The second scenario might present one such case. For Fred, the sought-after modifications may be as important to his physical health as any other health related intervention. Freed of his large breasts and extra skin, Fred will continue his exercise program by joining a swim team. He has met all the criteria set forth by the ASPS, except that he lacks parental support. The legal roadblock he faces in getting the desired treatment is significant. Unless he becomes medically emancipated or he lives in a state that recognizes the mature minor doctrine,¹⁹⁷ he is likely to be stymied until he reaches the age of maturity regardless of the distress and frustration he feels about his body. In such cases, where a mature minor has made a persistent and informed decision for treatment, and a provider agrees that immediate treatment is necessary to prevent long term psychological or physical harm, the lack of parental consent should not be an absolute roadblock to treatment.¹⁹⁸

191. *Id.*

192. See Adato, *supra* note 177, at 131; see *supra* notes 2–3 and accompanying text.

193. See Piker, *supra* note 183, at 206.

194. See *United States v. King*, 840 F.2d 1276, 1283 (6th Cir. 1988) ("Our law views the child as an individual with the dignity and humanity of other individuals, not as property."); see also *Doe v. Bolton*, 410 U.S. 179, 211 (1973) (Douglas, J., concurring) (finding liberty in the fourteenth amendment implies "freedom of choice in the basic decisions of one's life respecting . . . [the] upbringing of children").

195. See *Bolton*, U.S. 410 at 211 (stipulating that the upbringing of children is subject to some control by the state).

196. Mohr & Kennedy, *supra* note 184, at 199. For more on this argument, see Ouellette, *supra* note 9, at 997–98.

197. See, e.g., CAL. FAM. CODE § 7002 (West 2004) (describing the requirements for a person under eighteen to be emancipated); *Younts v. St. Francis Hosp. & Sch. of Nursing, Inc.*, 469 P.2d 330, 337 (Kan. 1970) (adopting the mature minor doctrine in Kansas).

198. See Beh & Diamond, *supra* note 18, at 239–41 (describing a case in which a court overruled a parental veto of gender hormones for a teenage male because failure to do so would harm the minor).

Thus, parents should have limited authority to consent to or deny body modification interventions for youth where such modifications are made available at all during adolescence.¹⁹⁹ Generally, parental consent laws ensure against immature, impulsive, or ill-considered decisions for risky interventions by adolescents.²⁰⁰ Parental consent should be only part of the equation, however.²⁰¹ No adolescent should be forced into body modification. Her repeated and informed desire for the procedure is critical if she is to be respected as full human being. And in some cases, the lack of parental consent should not prevent an adolescent from obtaining cosmetic body modification. When the adolescent has made a persistent, unambiguous, and informed choice, and, medical professionals agree with a determined adolescent that body modification is urgent to prevent psychological or other harm, some mechanism should be available to allow the adolescent to override a parental veto.

VII. FINAL THOUGHTS

If we as a society are concerned about body modification by adolescents, we should proceed with caution. Some procedures may be so risky, or so unnecessary as to justify outright bans, such as those that exist against body piercing and tattooing of minors in certain states.²⁰² An argument could be made, for example, that cosmetic breast augmentation should be banned for persons under the age of twenty-one, because the risks of the procedure are so great,²⁰³ the fact that the breasts have may not be fully developed until the late teens or early twenties,²⁰⁴ and the link that exists between breast augmentation and suicide.²⁰⁵ Bans take the decisions for risky behavior out of the hands of parents and adolescents. They take away choices that could be harmful and save them for adulthood—much like age limits on drinking alcohol, marriage, entering combat. Bans make sense as a means of protecting adolescents from unnecessary risk. The difficulty with bans is that they may paint with too broad a brush. For example, cosmetic surgeons appear to agree that breast augmentation is appropriate in adolescents for reconstructive

199. See Piker, *supra* note 183, at 206.

200. See, e.g., Parham v. J.R., 442 U.S. 584, 603 (1979) (finding that because most children cannot make sound judgments on certain issues, parents have the ability and responsibility to make judgments for their children on those issues).

201. See Piker, *supra* note 183, at 206.

202. See *supra* note 49 for examples of states that ban tattoos regardless of parental consent.

203. *Risks of Breast Implants*, U.S. FOOD & DRUG ADMIN., <http://www.fda.gov/MedicalDevices/ProductsandMedicalProcedures/ImplantsandProsthetics/BreastImplants/ucm064106.htm> (last visited Jan. 28, 2012).

204. See *Normal Breast Development*, WEILL CORNELL PHYSICIANS, <http://www.weillcornell.org/health/normal-breast-development.html> (last visited March 4, 2012) (noting that breast development may continue into the early twenties); AM. SOC'Y OF PLASTIC SURGEONS, *supra* note 182, at 1 (noting FDA concerns that a women's breast may not be fully developed at age eighteen).

205. See Sarwer et al., *supra* note 157, at 1007.

purposes; that is “to correct asymmetry caused by congenital errors, trauma or disease.”²⁰⁶ A broad ban might fail to make such a distinction, or discourage providers from acting in borderline cases.

In any case, this essay is more concerned with procedures that are legally available for teens. Where evidence suggests that cosmetic interventions may indeed serve the best interest of an adolescent, they should be available.²⁰⁷ However, developmental science teaches that adolescents are not sufficiently mature to be vested with unchecked authority over body modification interventions.²⁰⁸ Parental involvement generally, and parental consent laws specifically, serve an important protective role with respect to cosmetic body modification. They are not enough, however. The professional hired to perform the modification should play a critical role in respecting the person of the adolescent, her autonomous choices, and her rights to self determination and bodily integrity.

206. AM. SOC’Y OF PLASTIC SURGEONS, *supra* note 182, at 1.

207. *See, e.g.,* Beh & Diamond, *supra* note 18, at 220–21 (explaining the 2004 case of a thirteen-year-old female named Alex, whose decision to undergo sexual reassignment surgery after being diagnosed with Gender Identity Disorder was upheld, despite significant controversy).

208. *See* Roper v. Simmons, 543 U.S. 551, 571 (2005) (referring to developmental science documenting that that adolescents are developmentally different from adults).